Isle of Man
Government

Reiltys Ellan Vannin

COMMISSION OF INQUIRY
INTO THE CARE OF YOUNG PEOPLE

MAY 2006

The Report into the care and support given by Government and the agencies of Government to Samantha Barton and George Green and into the care and support systems for children and young people who have behavioural and emotional problems

Chairman: Mark Everall QC

Expert Assessor: Rob Hutchinson CBE

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COMMISSION OF INQUIRY
INTO THE CARE OF YOUNG PEOPLE

The Council of Ministers
DOUGLAS
Isle of Man

On the 15 October 2004, you asked me to chair an independent Statutory Inquiry following the deaths of Samantha Barton and George Green and into the care and support systems for young people with behavioural and emotional problems and to make recommendations as to how such an event could, as far as possible, be avoided in the future. I am pleased to submit my report to you.

I appointed Rob Hutchinson CBE as expert assessor to assist me in my task.

I take responsibility for this report and also am pleased to confirm that my colleague and assessor Mr Hutchinson fully endorses its findings and its recommendations.

Yours sincerely

Mark Everall QC

Rob Hutchinson CBE

COMMISSION OF INQUIRY
INTO THE CARE OF YOUNG PEOPLE

TERMS OF REFERENCE

1. To inquire into the level and effectiveness of the care and support provided by the government and the agencies of government to Samantha Barton and George Green and to determine whether they had any relevance to the circumstances surrounding and leading to their deaths.

2. To inquire generally into the level and effectiveness of the care and support systems, including through care, provided to children of secondary school age or above on the Isle of Man who have behavioural and emotional problems, taking account, where considered necessary, of the care and support received in their earlier years.
   In so doing, the Inquiry will take into account all relevant influences on such children.

3. To make recommendations as to how the welfare of such young people may be safeguarded so as to avoid, as far as possible, a similar tragedy occurring in the future.

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CHAPTER 1

INTRODUCTION AND SUMMARY OF CONCLUSIONS

Introduction

1.1 On or about 8 February 2002, two young people Samantha Barton and George Green were murdered by Peter Newbery.

1.2 On 15 December 2003, Peter Newbery was convicted by a jury of their murder and was sentenced to life imprisonment. On 30 September 2004, the Staff of Government Division dismissed his appeal against conviction. A number of matters of concern relating to the care of young people were aired during and following these events. In early 2004, the Council of Ministers indicated that they would commission an Inquiry into these matters of public concern.

1.3 On 15 October 2004, I was appointed by the Council of Ministers to conduct a Public Inquiry.

1.4 My Terms of Reference are:

> (1) To inquire into the level and effectiveness of the care and support provided by the government and the agencies of government to Samantha Barton and George Green and to determine whether they had any relevance to the circumstances surrounding and leading to their deaths.
>
> (2) To inquire generally into the level and effectiveness of the care and support systems, including through care, provided to children of secondary school age or above on the Isle of Man who have behavioural and emotional problems, taking account, where considered necessary, of care and support received in their earlier years. In so doing, the Inquiry will take into account all relevant influences on such children.
>
> (3) To make recommendations as to how the welfare of such young people may be safeguarded so as to avoid, as far as possible, a similar tragedy occurring in the future.

1.5 The width of my Terms of Reference is such that, in effect, there have been two Inquiries, one centred on the care and support provided to Samantha Barton and George Green, the other centred on the level and effectiveness of the current care and support to children and young people with emotional and behavioural problems. Accordingly I held the Inquiry in two Parts, although inevitably Part 1 was relevant to Part 2[1].

1.6 Part 1 in itself was potentially very wide. Samantha was born on 18 May 1985. George was born on 27 December 1985. Each was sixteen when murdered. I considered it appropriate and proportionate to consider in more detail the years immediately preceding the murders, in particular in Samantha's case the period after her return to the Island in February 2001 and in George's case, his return to the Island for contact during 2001 and for Christmas 2001.

[1] For the arrangements for and the process of the Inquiry, see chapter 2

1.7 I have sought to be thorough and rigorous. However, all involved cannot fail to be conscious of the horror of the murders and the continuing grief suffered by the families of Samantha and George.

1.8 Samantha's mother asked that there be a balanced picture of her daughter. She said of Samantha:

> "Despite all that is said and written about her, Samantha wasn't a bad kid. She had a lovely nature at times as lots of people have said and as much as she could be a little devil, she could also be an angel. She was my child and despite everything, I loved her deeply."
>
> "Although Samantha had her problems and caused all sorts of problems for others, at the end of the day she wasn't a bad kid. She just needed more love and care than most but sadly didn't get it for one reason or another. I hope a balanced picture of her emerges during the course of the Inquiry. It would be misleading and grossly unfair to demonise her."

1.9 Angela Gilman, Samantha's social worker from 1999 to 2002, described her as follows:

> "Samantha was an outgoing, extrovert young woman who appeared to enjoy the attention of her peers, from whom she would seek involvement. She was impulsive and could become anxious which often led to Samantha becoming verbally aggressive. Samantha could change from being well mannered to rude in an instance. She appeared to enjoy being in control of situations and disliked being told what to do or where to go. Samantha was strong willed and had a mind of her own, which often resulted in her views of the world being distorted. She often appeared happy and confident but beneath the façade she was lacking self confidence. She appeared to identify with others whose lifestyle included living on the periphery of society and whose behaviours were often unacceptable."
>
> "When Samantha was in a positive frame of mind she could be thoughtful, kind, energetic, happy and at times considerate. However, when she was faced with problems she could revert to showing aggression, lack of empathy for others, self centred and egotistical. In my opinion, this was due to a level of immaturity that Samantha showed, on an emotional level and sometimes cognitive level."

1.10 George's family have given this description of him[2]:

> "In December 1985 a much awaited son, brother, grandson, brother in-law, cousin and nephew was born. George was instantly loved and adored. George soon grew up into a lovely boy, very sweet natured and always willing to help you. You would only have to read several of the letters and cards that we received, to show how much George was loved. George got into a little bit of bother, like most teenagers do, but he never deserved to die in these circumstances."

[2] Taken from the impact statement presented at the sentencing hearing of Peter Newbery

In the words of his mother:

> "He wasn't a worldly boy and when he was little, I confined him to playing in the garden at home. It was not until he went to secondary school that he would meet his friends away from the home."
>
> "His behaviour became a problem when he was around 13 and this together with other factors led to a position where I could no longer cope …"
>
> "…I know that George could be difficult but he also had many positive qualities…"

His father Edric Green said:

> "When he was young, George was a normal happy child. He went to Murray's Road Primary School and did okay there. In his spare time he enjoyed riding his bike and we would go out in the boat fishing all the time. We would also take the dogs for a walk at night. We were particularly close and George was no trouble at all."
>
> "As he got older he began to want to spend more time with his mates and by the time he was 12 or 13 he started getting into trouble. He then started doing as he pleased and although very big for his age, failed to recognise that he was still only a boy."

1.11 Sylvia Morrison, George's social worker, described him as follows:

> "When I first met him in 1997 George appeared to be a polite boy who was willing to co-operate with me. He started having trouble in school in 1998 but remained friendly towards me. However, I did witness his rude and demanding behaviour towards his mother and I was aware that he was displaying similar behaviours in school. George had a good sense of humour, we often shared a joke together. George was easily led by others, he had no insight into the consequences of his behaviour and didn't seem to care what happened to him which I thought was sad. He became increasingly aggressive as time went by towards both those who looked after him and his peers but although he was never aggressive towards me he did become more demanding in his requests when I would telephone him."

1.12 The Report looks at the care and support provided to Samantha and George by those outside their families. Samantha and George's parents loved them dearly. But they were not able to care adequately for their children. This is why they sought help in the first place. When they agreed to the Government taking on responsibility for looking after the children, many emotional and behavioural problems were already present.

1.13 The families' distress and grief are well known and well understood. Less well known, but of importance, is the effect on the staff at Leece Lodge campus of the murder of Samantha, who lived on the campus and about whom they were concerned[3].

1.14 I have been aware that in having to re-live the events leading up to 8/9 February 2002, not only the grieving families but also the social workers and residential care staff,

[3] see chapter 9, para 9.138 ff.

some of whom also had built up personal relationships with either George or Samantha, will have been distressed.

1.15 Previous Inquiries into the deaths of children have suggested that one should judge a person's actions by reference to what was and should reasonably have been in his or her mind at the relevant time. The Inquiry is not entitled to criticise him or her for not knowing or foreseeing what a reasonable person would neither have known nor foreseen. However, the Inquiry has the benefit of hindsight. I hope that the Inquiry has used that wisely when it has considered its recommendations as to the future.

1.16 Those working with troubled children with emotional and behavioural problems have a difficult task and they all deserve the understanding and support of the wider public. The Inquiry draws attention to and makes recommendations about adopting the corporate parent approach to the care and support for looked after children (chapter 21 and 30). There is a need to recognise that care and support for looked after children is a responsibility for all in Government and for the wider public.

1.17 I have taken into account the unique legal, jurisdictional, historical and cultural background of the Isle of Man. It is important to remember that Samantha and George felt that they belonged on the Island. The public are understandably proud of the Island's independence and history. However the Island should not lose sight of the need to achieve high standards of care and support for all its children and young people, including those with emotional and behavioural problems - standards which can stand comparison with the best internationally. The public of the Isle of Man are entitled to no less.

1.18 I am solely responsible for the content of this Report and any weaknesses it may have. However, I am delighted that Rob Hutchinson CBE, the expert assessor, endorses this Report. His knowledge, insight and support at all stages of the Inquiry have been invaluable and I am very grateful to him. The names of the Inquiry Team are recorded in Appendix 18. Each has played their part to the full and richly deserves the warm public tribute which I pay to them. They have been unfailing in the help and support given to me. It is invidious to make mention of individuals, but some have carried a large workload and made exceptional contributions. Apart from Rob Hutchinson, to whom I have paid tribute above, I wish to thank publicly Alex Verdan, Advocate to the Inquiry, whose grasp of the evidence and conduct of the public hearings were masterful, Ceri White, Assistant to the Advocate to the Inquiry, and Laurance O'Dea, Legal Assistant to the Inquiry.

1.19 The Inquiry has been a real team effort. It is the hope of the full Inquiry team that the failings in the care and support given to Samantha and George can be avoided for the future. The Inquiry team hope that the conclusions which the Inquiry has reached on the level and effectiveness of the current care and support systems for children and young people with emotional and behavioural problems will enable the often troubled lives of such children to be lived safely, constructively and with proper fulfilment. It is also to be hoped that the recommendations will lead to the services for these vulnerable and difficult children and young people winning the confidence of the Manx public and instil in them a sense of pride.

1.20 I set out below a summary of my conclusions.

SUMMARY OF CONCLUSIONS

What was the level and effectiveness of the care and support provided to Samantha and George ?

Samantha

1.21 Samantha came to the attention of the Social Services Division when she arrived on the Island in 1992. In 1995, aged 10, she was received into voluntary care[4]. Until her placement at St David's Alternative Support Centre in Wales for that purpose in summer 1997, social services failed to carry out a proper assessment of Samantha's needs or to make a plan for her long term care. This should have been done far earlier and the failure to do so meant that she remained at home longer than she should have done having regard to her best interests (chapter 4).

1.22 From July 1997 to November 1998, Samantha was in placements in Wales and England. While not entirely successful, the care and support received was appropriate. However, the move back to the Island in November 1998 was not made as part of a considered plan; it was correctly said that Samantha had "left in crisis and appeared to be returning in crisis". In February 1999, Samantha was placed at St Catherine's Centre for Girls, Liverpool where she remained until November 2000; the placement was planned and was appropriate. In due course, it became unsuccessful. After offences committed in England, Samantha was sentenced in November 2000 to a six month Detention and Training Order and served her sentence in the St Catherine's secure unit (chapter 5).

1.23 On 27 February 2001, aged 15, Samantha returned to the Island. Given that social services were aware of the lack of the specialist resources on the Isle of Man required to meet Samantha's needs effectively, a formal assessment of the advantages and disadvantages of the return was essential but social services failed to carry one out. Angela Gilman had been Samantha's social worker since September 1999 and since late 2000, Ms Gilman had identified that, if she returned to the Island, Samantha would need a placement that had a very clear structure, very clear boundaries and a staff team who were very specialised and experienced. In January 2001, Ms Gilman reported that Samantha had no formal educational qualifications and no work experience; that she had few positive role models in her life and saw little need to work for a living; and that she needed to learn life skills, which would be a key area of work to enable her to participate in society and avoid social exclusion. She added that given her immaturity and vulnerability, Samantha would need to be looked after for the best part of twelve months (chapter 6).

Maple Avenue

1.24 Samantha was at Maple Avenue from 8 March[5] to 20 April 2001. It was not an appropriate placement and it did not meet Samantha's assessed needs (chapter 7).

1.25 Nugent Care should not have been asked by social services to set up this placement and Nugent should not have accepted the placement of Samantha. At that stage,

[4] Chapter 3 contains the overview of her placements 1985 to 2002.
[5] When first arriving, Samantha spent a short period in Barrule Cottages

Nugent lacked the necessary experienced staff and were heavily committed in setting up their other projects on the Island.

1.26 There was no provision made for educational or vocational needs and inadequate attempts to occupy her days constructively. Social services failed to provide a written care plan or a placement agreement with Nugent. Social services failed to agree with Nugent a written support package setting out the care and support.

Derby Road

1.27 On 20 April 2001, Samantha moved to 22, Derby Road and remained there until 3 September 2001 (chapter 8).

1.28 The decision to move Samantha from Maple Avenue to Derby Road was not made on welfare grounds but was made following an "instruction" given by Mr Geoff Cannell, the political member for the Social Services Division and at that time one of the members for the constituency of Onchan, within which lay Maple Avenue. Mr Cannell now maintains that he did not think that he had the power to give an instruction and that he did not do so on this occasion. However, Mr Cannell is a very forceful personality and expects his views to prevail and the Inquiry is satisfied that he expected that his "requirement", upon which he "insisted", would take place, namely that Samantha would be moved from Maple Avenue and would be moved to Leece Lodge [6].

1.29 Derby Road not an appropriate placement and it did not meet Samantha's assessed needs. David Cooke said that it was a "disaster". Samantha should not have been moved from Maple Avenue without a proper plan and proper arrangements for her short term and longer term care. There was no need to do so, other than the "instruction" to do so by the political member. No proper risk assessment was carried out.

1.30 For much of the time, Samantha was out of control at Derby Road. She was living a dangerous lifestyle. She was involved in drug taking, abuse of alcohol and criminality; she was out late at night on occasions; regularly there were large groups of young people staying over night at what was described by one young person as "a party house". Samantha was clearly not ready to live on her own and the time spent at Derby Road was not used as part of a process of preparing her for adult life and independence.

1.31 Social services failed to ensure that there was a written care plan or placement agreement with the care providers and these failings contributed to the vagueness and lack of structure in the arrangements for Samantha's care. The care and support given by Nugent Care during the day was appropriate and effective within the confines of what they were asked to do. But the limited role given to the Nugent workers and the unsuitable arrangements meant that Samantha's placement at Derby Road was an unconstructive time for her and placed her at risk of harm. After four weeks, the Nugent overnight live-in staff were withdrawn because Samantha was deemed a physical risk to them. Thereafter Manx Family Services (MFS) provided the care and support for Samantha in the evening and at night. However, like Nugent during the day, MFS' role was limited. MFS' supervision by periodic visits or by checking on her from outside was inadequate to ensure that Samantha was safe.

[6] Paragraph 8.2 – 8.21

Leece Lodge

1.32 On 3 September 2001, Samantha moved to Leece Lodge 2 where she lived unitl her death (chapter 9).

1.33 The decision to move Samantha from Derby Road to Leece Lodge 2 was not made on welfare grounds. All social services staff, apart from David Cooke, believed that there was an "instruction" to move her to Leece Lodge, which Mr Cannell had repeated in July and August and which had to be followed. Ms Gilman was not consulted about the merits of a placement at Leece Lodge, and did not visit Leece Lodge prior to the placement and was not involved more than peripherally in the decision making. Ed Coates, her manager, was not involved in detailed discussions about the move to Leece Lodge. Neither he nor Angela Gilman were involved in formulating the care package for Samantha at Leece Lodge.

1.34 The care and support at Leece Lodge 2 was wholly inadequate. The placement did not meet her needs. There were no boundaries on her behaviour or structure to her life, both of which she needed.

1.35 At Leece Lodge 2, there was no care plan, no placement agreement, no support package and a lack of clarity as to the objective of the placement. There were no real limits, rules or controls. There was no structure to her days and to her life. There was no one on the campus who was responsible for her. There was no one supervising her. For two and a half months she was without a keyworker and when one was appointed her role was too limited and her experience insufficient. There was no plan as to how Samantha was to be moved towards independence: in particular, no plan as to how to seek to engage Samantha in education, training or constructive leisure pursuits. Samantha was involved in drink, drugs and criminality. This lifestyle was dangerous, both to her physical wellbeing and to her emotional and behavioural wellbeing. The care and support provided at Leece Lodge 2 was described by social services as a "minimum intervention package". It fell below the level of that which should have been expected if an attempt was to have been made to meet Samantha's need to prepare, even at this late stage, for independence.

1.36 Social services failed in its responsibility to carry out an assessment of Samantha's needs, to make and update her care plan and to approve the package of support to be provided by the service provider actually caring for Samantha. Angela Gilman remained Samantha's social worker throughout the placement at Leece Lodge. It was her responsibility to satisfy herself that proper care and support for Samantha was put in place and remained in place. Regrettably, she failed to discharge this responsibility adequately or effectively.

1.37 Ms Gilman bore front line responsibility for Samantha; but responsibility also lay with her immediate manager: her line manager was Ed Coates. He should have made sure that those things for which Ms Gilman was responsible were actually carried out and carried out appropriately: that Ms Gilman was appropriately supervising Samantha's care at Leece Lodge. Ultimately, Trevor Noden and other senior managers remained responsible for Samantha and should have managed the Social Services Division in such a way that they could be assured that the welfare of Samantha, a child in the care of the DHSS, was being met.

George

1.38 In January 1998, when George was twelve, his name was first entered on the Child Protection Register[7]. Social services had been involved with George's family, in particular his sister Kathryn, for some years and an assessment of George's needs should have already been made by 1998. In 1999, George was received into voluntary care and placed at Cummal Shee. In January 2000, to the surprise of social services, a care order was made by the magistrates in criminal proceedings (chapter 10). This galvanised social services into action and, having carried out an initial assessment (which should have been done far earlier), social services placed George at Eden Grove, a residential home in Cumbria with good educational facilities.

1.39 From March 2000 until his death, George remained at Eden Grove save for short home visits to the Island. Eden Grove was well chosen by social services as meeting his needs, in particular his educational needs. The level and effectiveness of the care and support for George at Eden Grove was very good (chapter 11).

1.40 While at Eden Grove in the period March 2000 to October 2001, George returned to the Island for periods of contact with his family. It became clear that during contact on the Island George was out of control and was putting himself at risk and that contact was jeopardising the Eden Grove placement. In October 2001 George refused to return to Eden Grove, at the conclusion of a contact period; he was eventually returned on 24 October following fruitful co-operation between social services and police. Future contact was suspended (chapter 12, paragraphs 12.1 to 12.29 and 12.75 to 12.77). Social services should have faced up to having to make the decision to suspend contact on the Island sooner than October 2001, which was 18 months into the placement.

1.41 However, a decision was made to permit George to return for Christmas contact from 21 December to 7 January 2002. Social services made no proper assessment of the advantages and risks involved in allowing George to return to the Island for Christmas 2001. Given the view expressed in October 2001 by Sylvia Morrison, George's social worker, that by remaining on the Island George would "endanger himself or others", the Christmas visit should not have taken place without a proper assessment (paragraphs 12.30 and 12.78).

1.42 Once the decision to allow George to return for Christmas had been made, a detailed care and support package involving near continuous supervision of George should have been made in order for there to be any chance of the contact visit succeeding. Given the high probability that the visit would go wrong, there needed to be a clear and firm contingency plan involving sanctions capable of being imposed, such as immediate return to England, in the event of George not complying with the plan for the visit. The plan as drawn up fell short of what was necessary to provide adequate care and support during the visit.

1.43 The plan as to which service providers would be involved and the plan as to where George would be accommodated during the visit were changed without George's social worker, Sylvia Morrison, or her line manager Ed Coates, being properly aware of the changes at the time. As a child in care, George remained throughout the direct responsibility of social services. The events of December 2001 reveal a situation where social services were not aware - to an unacceptable degree - of changes of plan for George. A service provider, in this case Richard Kneen of MFS, took the lead in

[7] Chapter 10 contains the overview of his placements 1985 to 2002.

making fundamental changes in the plan for a looked after child. This highlights the need for social services to be aware of and to monitor what is going on in the life of the child for whom they are responsible. Sylvia Morrison and Ed Coates did not know the full situation; they should have been in firm control of such major decisions and changes in plan (paragraphs 12.30 ff and 12.78 ff).

1.44 On 29 December 2001, George was arrested for a criminal offence. It was realised that George was at risk, that he needed to be under a form of control until his return to Eden Grove on 7 January and that he should be charged and detained overnight before being produced in court. The Juvenile Court remanded George in custody until 7 January. On 7 January 2002, Richard Kneen and Carl Faragher persuaded George to attend the ferry terminal, although ultimately the return did not take place that night[8].

1.45 Attempts to return George to Eden Grove after 7 January 2002 were flawed and opportunities which had reasonable chance of effecting his return were not taken (paragraphs 12.56 and 12.87). Social services failed to learn the lesson of October 2001 and to a lesser extent the lesson of 30 December to 7 January 2002: that it could use George's arrests for criminal offences to bring some control into his life and to effect his return to Eden Grove. George was arrested on 7 January, 16 January, 17 January, 20 January, 31 January and 6 February. An appropriate adult was with him on each occasion and those appropriate adults were all child care professionals (with the exception of his sister on 31 January). George admitted the offences to the police on, at least, the 20 January, 31 January and 6 February. He was never charged. He was given police bail to his mother's address on each occasion.

1.46 Social services did not liaise sufficiently closely with the police concerning George's return to the Island for Christmas 2001 or in their attempts to effect his return to Eden Grove. Unlike the October 2001 visit when social services wrote to the police and then met with the police, the police were not invited to either of the planning meetings on 10 and 21 January 2002. This was a failure of inter-agency co-operation.

1.47 The arrangements made after 7 January for George's care on the Island were inadequate and had no chance of controlling his behaviour or reducing the risks to him from his behaviour.

1.48 Both in making the arrangements for Christmas contact and in seeking to return George to Eden Grove, there was an absence of proper care planning and assessment and a failure of management supervision and oversight of social work practice.

The role of the political member

1.49 It is regrettable that a clear statement of the principles, and their practical application in the Social Services Division, governing the extent to which a political member or Minister could give an instruction to an official was not better known to political members and officials alike. The misunderstanding and lack of clarity in the practical and proper extent of the role of political member and departmental officer in connection with Samantha's placements was unacceptable, involving as it did the welfare of a young person for whom the DHSS had a statutory responsibility (chapter 20).

[8] See below

Social Services

1.50 At Maple Avenue, Derby Road and Leece Lodge social services failed to act appropriately in the handling of Samantha's care and support. Where a child or young person is "looked after" by social services, he or she remains the responsibility of social services whether the care and support is provided directly by them or provided by a service provider. Social services still remain directly responsible for the young person. Social services must be satisfied that it knows what is happening in the child's life.

1.51 During the period considered in Part 1, within the Social Services Division there was either an absence of policies or, where policies existed, they were not complied with. This latter feature is a telling reflection on the ineffectiveness of management at all levels. Trevor Noden accepted there was a problem in the Social Services Division with implementation of policies: putting them into practice. Moreover, the Inquiry has been struck by the evidence of persistent failure to comply with existing policies. Part 1 reveals a failure in carrying out proper assessments, in care planning and the reviewing of care plans. The supervision of social workers by their managers and in turn the supervision of managers themselves was inadequate and ineffective. The record keeping and the management of the social work files of Samantha and George fell a long was below standard: David Cooke said he was "appalled" by the state of the files (chapter 17).

1.52 The system for commissioning and monitoring care services was, and remains, at the heart of the work of social services on the Isle of Man. In the relevant period, the system was not effective (chapter 18).

Education

1.53 In March 1997, Samantha was suspended from school. The provision of education for Samantha during the times when she was on the Island from March 1997 to February 1999 was seriously deficient. During her placements in England and Wales, Samantha received education funded by social services. Between February 2001 and February 2002, there was no proper plan nor arrangements made to offer Samantha education or vocational training or other preparation for employment. This was a serious deficiency in the care and support for a young person who was soon to be leaving care and who needed as much help as possible to move towards independence (chapter 13).

1.54 In April 1999, George was suspended from school. Thereafter his education on the Island was minimal and inadequate for his needs. From March 2000 George received appropriate education at Eden Grove, funded as part of the placement by social services (chapter 13).

What relevance did the care and support have to the circumstances surrounding and leading to the deaths ?

1.55 Precisely when and why Peter Newbery murdered Samantha and George remains unknown. Equally the extent and nature of the association (if any) between Samantha and George and Peter Newbery in the months preceding the murders remains unknown [9].

1.56 Peter Newbery was responsible for, and stands convicted of, the murders of Samantha and George. The Inquiry is clear that none of the actions or failures of the departments or agencies of the Government led directly to the deaths of these young people. Where a person has the mentality to commit the murder of children, such a person may take the opportunity to do so, despite the very best endeavours of all those involved in the care of children. Whilst procedures, policies and strategies can be put in place to minimise the risks posed by such a person, absolute protection of all children at all times is impossible.

1.57 The Inquiry, whilst highly critical at the lack of effective care and support for Samantha at many different levels in different organisations, also recognises that she had been an emotionally and behaviourally challenging young person since she was a small child. The Inquiry therefore recognises the difficulty that any social service authority would have had in managing her behaviour. Whilst the Inquiry believes she should have been offered a great deal more care and support, it finds itself unable to draw a direct link between this lack of care and support and her death.

1.58 Nevertheless, both before and after Samantha's return to the Island in 2001, there was no proper assessment of her needs and no proper planning for her future. Her placements at Maple Avenue, Derby Road and Leece Lodge were not preceded by a risk assessment, by any proper planning or any proper assessment of what she needed in the placement. Thus, Samantha was largely unsupervised and the life arranged for her was mostly unstructured, undirected and aimless. She had little care and support. She was left to her own devices. She was involved in drugs, alcohol and criminality. Given Samantha's emotional and behavioural problems, this left her more vulnerable than she would otherwise have been. She was plainly at risk (chapter 9).

1.59 Peter Newbery was arrested in November 2001. He was assessed to be "a high risk to women"[10]. Had he been charged and remanded in custody, he would not have been at liberty in February 2002. The Inquiry has considered in chapter 15 whether he should have been charged in November 2001. In January 2002 the police received the results of a forensic examination of the clothing of the alleged victim of the November sexual assault. The Inquiry has concluded[11] that, on receipt of this new evidence in late January 2002, there was sufficient evidence to charge Newbery and that there was an opportunity to ask the court to remand Newbery in custody. The decision whether to remand in custody would have been for the court to make.

1.60 Would events have turned out differently if Samantha had been warned that Peter Newbery was a danger to women? Samantha and Peter Newbery were both placed in Cummal Shee for a period in 1997. They had a relationship of some kind (chapter 15). The relationship was not recorded in her social work file. There was no evidence that Samantha was associating with Newbery in 2001-2002. There was no specific reason to warn Samantha against Newbery, beyond any general warning which might have been given to those in care homes or to those caring for teenagers in residential care. Furthermore, there was no close watch kept on whom Samantha was associating with. Samantha was unsupervised and largely left to her own devices. Newbery's motive for murder, and the precise circumstances in which it occurred, remain unknown.

[9] See chapter 15

Even if she had become aware of a general warning about Newbery, it cannot be known whether it would have been effective to protect her from him.

1.61 George returned to the Island on 21 December 2001 for a Christmas visit. While George remained on the Island after 7 January, he was unsupervised and he too was largely left to his own devices. Given his activities during previous contact visits, he too was vulnerable and at risk.

1.62 The attempts to effect George's return to Eden Grove were flawed[12]. George was arrested on a number of occasions. These arrests presented opportunities to seek to effect George's return to Eden Grove but they were not taken[13]. Had they been taken, there is a reasonable chance that George would not have been on the Island on 8 or 9 February 2002 (paragraphs 12.87 to 12.91).

1.63 It is likely that George would have left the Island on the ferry on the night of 7 January 2002 had it not been for the intervention of his father at the ferry terminal[14].

The current care and support for children and young people with emotional and behavioural problems and the way forward

Children and Young People's Strategy

1.64 The Children and Young People's Strategy is an impressive document. Inevitably there is a degree of overlap between the recommendations in the present Report and the actions proposed in the Strategy. However this Report and its recommendations should be seen as running in parallel to the Strategy. The Report does not replace it. Both must be read together.

1.65 The Children and Young People's Strategy contains many features which, if implemented, would improve the level and effectiveness of care and support systems for young people with emotional and behavioural difficulties. The Inquiry has sought to highlight and strengthen these initiatives in its Report and Recommendations.

1.66 The Inquiry is concerned that other strategies and policies over time have lost their impetus and therefore their effectiveness. Many worthwhile recommendations and proposals have been made but not implemented. For example, in 2002 Ofsted in its inspection reported that on average about one third of looked after children had special educational needs and that "urgent action" was required. In the same year, a Joint Protocol was issued by the Department of Education and the Social Services Division called The Education of Children in Public Care. It is a detailed and comprehensive document setting out the rationale, policies and respective roles and responsibilities for meeting the educational needs of looked after children. But the Inquiry heard evidence that the basic requirements of the Protocol are not being complied with: five out of the six children in one residential unit did not have a personal education plan (chapter 26, paragraphs 26.59).

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[10] see chapter 15, para 15.29
[11] see chapter 15, para 15.50
[12] See chapter 12
[13] see chapter 12
[14] see chapter 12

1.67 Many good policy documents are in existence on the Island. There are many good proposals across a broad range of subjects. Much of the current weakness in care and support for young people is not due to the lack of policies or proposals, but rather to the inability to put the policies and proposals into practice effectively. The Inquiry seeks to find ways to strengthen the way that services for children and young people are delivered. Substantial resources are devoted to young people with behavioural and emotional problems. It is important that they are deployed effectively.

Accountability and structures

Minister for Children

1.68 At the political level, the Chief Minister has many other responsibilities which limit the time he can devote to the children and young people's agenda. The Inquiry, whilst recognising the progress that has been achieved in moving to a more corporate approach, considers that a Minister or Member for Children would be able to monitor, evaluate, prioritise and develop services for young people across departments in an even more productive way. The Inquiry believes that the appointment of a politician with responsibility for children and young people, reporting directly to the Chief Minister, should be made initially for the duration of the Children and Young People's Strategy 2005-2010. The Inquiry does not believe it is necessary to create a large infrastructure. The appointment is one which will create clear political accountability for delivering better outcomes for children and young people on the Isle of Man. The Strategy requires a significant change in management and professional practice (paragraphs 30.8 ff).

1.69 A senior official for children and young people needs to be appointed who reports to the Minister or Member for Children and whose role will be primarily a strategic and co-ordinating one between departments (paragraph 30.13).

Commissioner for Children and Young People

1.70 The Inquiry believes that a Commissioner for Children and Young People should be appointed. It is of the firm view that the Commissioner is necessary in order to ensure that services for children and young people with emotional and behavioural problems, and indeed all children, become and remain effective (chapter 29).

Costing the implementation plan

1.71 The Inquiry believes that there should be financial implementation plan for the Strategy (paragraph 30.19 ff).

Leadership

1.72 The Inquiry has expressed concern at the absence of monitoring of performance by senior social services staff and the Chief Executive of the DHSS. The apparent isolation of the Department of Education in working with other departments has been referred to earlier in this Report. The seeming lack of urgency in achieving change on a range of Government policies was discussed at the Strategy Seminar. All of these observations reinforce the need for strong and decisive leadership in delivering effective services. The Inquiry has made recommendations designed to evaluate, review and train senior government officials and thereby to establish the leadership and management skills and behaviour required to deliver the new inter-agency and performance managed agenda (paragraphs 30.74 ff).

Inter-agency co-operation

1.73 Effective inter-agency working is at the heart of achieving better outcomes for children and young people with behavioural and emotional difficulties. There are some examples of successful inter-agency working at strategic, managerial and professional levels, but not enough. Achieving this remains a major challenge for Government. One example of inter-agency working is in the support of the principle of "corporate parenting", which has been used on many occasions during the course of this Inquiry[15]. The concept of "corporate parent" to looked after children supports the overall aims of the Children and Young People's Strategy in encouraging the joint responsibility by different departments of Government for the well-being of children and young people. The Inquiry recommends that the Social Policy Committee formally adopts the principle of "corporate parent" (paragraph 30.63).

1.74 In order to support the Chief Minister's desire to introduce a new culture of inter-agency working in Government, the Inquiry believes that it is necessary if a change of culture is to be brought about and embedded, to place a statutory duty on agencies to work in partnership together (paragraphs 30.69 ff).

Performance management and external inspection

1.75 The proper collection and monitoring of data is essential. Without adequate monitoring and review of data, the effectiveness of care and support for children and young people including those with emotional and behavioural problems is reduced.

1.76 Current collection and monitoring of data is inadequate. The Inquiry has recommended that the quality of the data collected and monitored is improved and that it is monitored more widely within departments as well as between departments (these appear in chapters 24, 25, 26, 28 and 30).

1.77 There must be external monitoring of the effectiveness of the relevant departments. Some departments have already introduced regular external inspection (for example the police force) but others have not. The Inquiry believes that independent external inspection is an essential step for evaluating and reinforcing not only the effectiveness of individual services, but also the way services are working together (paragraphs 24.26 ff and 30.40 ff). All relevant Government departments should negotiate an external inspection from another jurisdiction, such as England and Wales, Scotland, Northern Ireland or Ireland, at regular and sensible intervals, rather than on an ad hoc basis. It has specifically recommended the introduction of external inspection of the Social Services Division.

1.78 Reports of such inspections should be made public. The Inquiry has been made aware of the view held by many that there is much ill-informed comment about social services and children and young people cared for by social services. By making reports public, children, young people and their families and the wider public are able better to judge the work of social services.

[15] see chapter 21

Early years

1.79 The Inquiry believes that more emphasis should be given to Early Years if the problems that families experience in later years are to be avoided. The Inquiry therefore has set out recommendations in Chapter 27 above. While these are long term solutions, they are important and should be implemented as a matter of priority.

Consulting young people

1.80 To involve young people in decision-making at policy and operational levels requires a paradigm shift in approach from a wide range of individuals and agencies. Consultation and involvement of young people will, almost always, produce better solutions on issues that affect them. However, the process of involving young people needs careful planning and preparation. The Inquiry has made recommendations (chapter 29).

Social Services Division

Commissioning and monitoring the service providers

1.81 The Inquiry was profoundly concerned by the evidence received in Part 1 about the lack of clarity on policies, responsibilities, roles, communication and monitoring between the Social Services Division and the providers of services[16]. An effective service cannot be run unless each party is clear what service it is they should be running and the division is able to reassure itself of the quality of service it has commissioned for the children and young people for whom it remains responsible.

1.82 The Inquiry recognises that the division has invested in a Contracts Manager post and that expertise is developing. It also heard from providers that the work of the current postholder has been welcomed by them. However the service level agreements need improving (paragraphs 24.35 ff).

Accommodation strategy

1.83 The Isle of Man has a low ratio of children in foster placements to residential placements. The residential homes run by St Christopher's and the Isle of Man Children's Centre are showing improvement in focus and delivery of care. But one external expert expressed great concern from a financial and child safety point of view about the large number of small homes. The high costs and the potential isolation of young people in single occupancy homes both suggest that a cost/benefit analysis of these homes should be part of a wider examination of the way in which care is being delivered. Whilst the Inquiry has heard positive evidence from some professionals and young people about how the small homes provided by Manx Family Service fill a gap, which other services cannot provide, nevertheless the Inquiry remains concerned at the number of small units and the overall proportion of young people who rely on them. The Inquiry believes significant financial savings as well as improved outcomes for children and young people can be achieved by substantially increasing fostering and reducing residential placements (paragraph 24.40).

[16] see chapter 18

1.84 The Inquiry has recommended that an accommodation strategy for looked after children be drawn up with a view to increasing the number of children placed in foster homes as well as clarifying the specific roles played by its residential homes. Not only should the role of the existing residential provision be re-assessed, but a determined policy introduced to reduce the residential provision in favour of a significantly better paid fostering, adoptive and kinship service. The Inquiry has made a number of recommendations in relation to the priority of increasing foster placements and reviewing and reducing the reliance on residential care.

1.85 At present there is no clear strategy on how its existing homes are to be used: is a particular home to be used for short term, medium term or long term placements ? The Inquiry recommends that a residential strategy should be drawn up listing the purpose and function of its residential homes and residential provision.

1.86 All small homes for children must be subject to the same inspection and regulatory regime as children's homes (paragraph 24.55 to 24.59).

Leaving Care

1.87 The arrangements for young people leaving care are inadequate. Therefore, the Inquiry has recommended that the housing needs of children and young people with emotional and behavioural problems must be clearly stated and met in the Review of Public Sector Housing. The Inquiry has already commented unfavourably on the inadequacy of, and failings in, the care and support offered to Samantha as part of her move to independence. In the case of some children, the absence of proper after care support, which includes accommodation, education, training and employment, will mean that there is a high likelihood that progress made in the young person's life while in care, is undone in the immediate period after leaving care.

1.88 There has been insufficient progress in the provision of after care services, which remain inadequate and insufficiently effective. The provision of adequate after care services is an integral part of the care and support for looked after children and must be recognised as such. The Inquiry recommends that the Director of Social Services draws up a strategy for the After Care for looked after children with particular attention being given to the transitional arrangements of young people from children's to adults' services (paragraphs 24.82 to 24.84).

Management

1.89 The Inquiry has been concerned by the many examples of poor management within the Social Services Division. Reports by the Internal Audit Division of the Treasury into Children and Families Services in 2002 and 2004 revealed severe and persistent failings. The recent Report by the NSPCC sets out the results of its audit of 47 current cases in social services. It identified a number of areas of serious concerns. It indicates a continuation of the same dire problems that were seen during Part 1: poor records and record keeping, few formal assessments, limited care plans and poor management oversight (paragraphs 24.120 to 24.134).

1.90 The Inquiry is sympathetic to the argument about senior staff having to carry out an excessive range of duties. However, it does not regard this as a sufficient justification for the apparent lack of management oversight of basic professional performance in cases which the NSPCC audited, referred to above, which directly replicates management's failure to ensure relatively simple policies and procedures were implemented in relation to the care and support of Samantha and George.

1.91 The NSPCC Report also calls into question the determination, commitment and ability of those senior managers responsible for Children and Families' Services to deliver in the future the changes that are required.

1.92 Ensuring compliance with policies and procedures is of the utmost importance in the protection and support of children with emotional and behavioural difficulties. The Inquiry has been told that in some cases it is difficult to ensure that staff comply with these policies and procedures. Managers should tackle any lack of compliance with the utmost firmness. Managers should be expected to ensure that policies and procedures are followed, and that no one should be left in doubt that failure to comply with policies and procedures can (and will) lead to disciplinary action. The Inquiry has concluded, as a result of what it heard in evidence in Part 1 and has read in the NSPCC Report, that there is a casual attitude to policies such as recording, care planning and the like, all of which potentially undermine the safety and well-being of children. This cannot be allowed to continue and it is management action that will ensure it does not.

Education

1.93 A review by Ofsted in 2004 of the recommendations in the 2002 Osfted Inspection of the Department of Education found that there "has been much very satisfactory improvement". In particular, the new planning system on the Isle of Man, a new emphasis on school improvement supported by a new approach in budget setting and the ability to obtain new data, were all signs of progress.

1.94 However, in other areas there had not been progress and the review noted mixed performance in special educational needs (SEN) and in improving access to education. In particular, it was noted that full-time education had not been made available to suspended pupils and there appeared to be a lack of progress in performance management, particularly for SEN and access to education. The review concluded

> "that successful implementation will require strong leadership from both the Department and senior officers so that the Education Service as a whole can follow the new directions which have been set in motion since the Inspection".

1.95 The law as it stands places the responsibility on the parent for ensuring that children receive their education. Whilst the Inquiry understands and supports the need to reinforce parental responsibility, it does not accept the fact that the Department of Education should abrogate its responsibility for being properly informed of children out of school or its role in providing flexible and imaginative support and provision for those children unable – for whatever reason – to access standard educational provision. Therefore the Inquiry recommends that there be a statutory duty on the Department of Education to provide appropriate education for each child on the Island and that the department monitors the education of looked after children (paragraphs 26.33 to 26.42). The Inquiry also makes recommendations about the power to suspend and about the education to be provided for suspended children (paragraphs 26.43 to 26.48).

1.96 Support to improve behaviour within schools was noted by Ofsted in 2002 to be "unsatisfactory". The continued absence of a Behaviour Support Plan is unacceptable (paragraph 26.54 to 26.58).

1.97 The Inquiry recognises the recent establishment of the Secondary Referral Unit at key stage 3 for six children and was impressed by the commitment of the staff. It is apparent however, that there is a significant need for more support for children with similar problems at Key Stage 4. The pressures on the schools to manage children with these difficulties is growing and if this group of children are not to fall out of the system altogether as Samantha Barton did, then new resources must be found to meet these needs (paragraph 26.49 to 26.53).

1.98 The Inquiry believes that there still exist difficulties with inter-agency working and with the acceptance by the Department of Education of its share of corporate responsibility for the education of the Island's children. The Inquiry has noted the absence of an education presence within the Youth Justice Team and the seeming reluctance to fund such a post without new funds (paragraphs 26.74 and 28.36 ff).

1.99 Educational provision for children and young people with emotional and behavioural problems has some way to go before it can be said to be adequately effective (chapter 26).

Youth Offending

1.100 The creation and operation of the Youth Justice Team is a credit to those who established it and those who work within it. The Inquiry wishes to be reassured that it is not in the words of one person who attended the Youth Offending Seminar, "built on sand". The Inquiry sees no advantages to the YJT continuing under its current inadequate governance arrangements and believes that its success may be jeopardised by the absence of a proper statutory basis; the Magistrate's Association referred to its "tenuous foundations". Accordingly it is recommended that it be placed on a statutory basis (paragraph 28.26). Furthermore the Inquiry recommends that a specific Chief Executive or Chief Officer should be accountable for the Youth Justice Team and for delivering the Youth Justice Strategy (paragraph 28.29).

1.101 The Inquiry has recommended that additions are made to the Youth Justice Team (paragraph 28.32).

1.102 The Youth Justice Team is making an effective contribution to the support and management of young people with emotional and behavioural difficulties who are at risk of offending or re-offending.

CHAPTER 2

THE INQUIRY

Establishing the Inquiry

2.1 On 15 October 2004 I was appointed by the Council of Ministers to conduct a Public Inquiry.

2.2 This Inquiry was established by the Council of Ministers pursuant to the Inquiries (Evidence) Act 2003. It is, however, independent the Council of Ministers, of departments of Government and of every other public or private body. That independence has been central to our work.

2.3 The Inquiry's Terms of Reference are set out at beginning of chapter 1.

The Inquiry Panel

2.4 I appointed Mr Rob Hutchinson as my expert assessor to help me consider and analyse the evidence. He has a long and distinguished career in Social Services and most recently was Director of Social Services in Portsmouth. He was formerly Director of Social Services and Strategic Director of Portsmouth City Council. He was for some years the Chair of the Children and Families Committee of the Association of Directors of Social Services. He is also Chair of Research in Practice at Dartington, a trustee of the NSPCC, Chair of The International Initiative, a trustee of the Youth Advocacy Service and a trustee International Social Services. During the course of the Inquiry he was awarded a CBE. Mr Hutchinson gave advice on matters within his area of expertise throughout the Inquiry. His knowledge and support were of enormous value and I am very grateful to him.

2.5 Ms Kay Heward-Meadow and then Ms Julia Simpson and most recently Ms Linda Buckley have been the Secretaries to the Inquiry. They have been responsible for the administrative and secretarial work of the Inquiry. I should like to express my public thanks to them for all the hard work they put in to making the Inquiry run smoothly

2.6 Mr Laurance O'Dea of the Treasury Solicitors, London, was Legal Assistant to the Inquiry.

2.7 Mr Alex Verdan was Advocate to the Inquiry. He was assisted by Ms Ceri White. Both are members of the Bar of England and Wales. Mr Verdan advised me on matters of law, evidence and procedure and presented the evidence. His role was to assist the Inquiry, rather than to prove a particular case.

Inquiry accommodation

2.8 The Inquiry Secretariat was based at 23, Athol Street, Douglas. The Inquiry documentation was kept there securely.

2.9 The Inquiry sat in the Promenade Suite of the Villa Marina, Douglas.

What form did the Inquiry take?

Public or private

2.10 This Inquiry has been conducted in public. On two occasions I gave permission to witnesses to withhold their identity from the public and the parties, although their identity was known to the Inquiry. I did this because these two witnesses were themselves young people and did not want their identity revealed.

Format

2.11 I decided that the Inquiry would be divided into two parts. Part 1 was primarily backward looking and was concerned with discovering what care and support was provided to Samantha and George, what was the level and effectiveness of such care and support, and in determining whether they had any relevance to the circumstances surrounding and leading to their deaths. This Part considered paragraph 1 of the Terms of Reference, and the conclusions that could be drawn on the matters referred to in paragraph 1 from the evidence. Part 2 was concerned with wider questions. In Part 2, I was concerned generally with the level and effectiveness of the care and support systems provided to children of secondary school age or above on the Isle of Man who have behavioural and emotional problems. In Part 2, the Inquiry was forward looking and directed to the question as to what recommendations might properly be made which may help such children and avoid, so far as is possible, a tragedy similar to that which befell Samantha and George happening again.

Adversarial or inquisitorial

2.12 I decided that this Inquiry would be inquisitorial and not adversarial in nature. In Part 1, the Advocate to the Inquiry would decide which witnesses it was necessary to call to give evidence and he would examine them. A list of the witnesses who gave oral evidence is found in Appendix 1.

Identifying Interested Parties

2.13 A number of bodies and individuals expressed an interest in the work of the Inquiry. Therefore, it was decided to recognise people who had a legitimate interest in the work of the Inquiry as 'Interested Parties'. Also, a number of witnesses not represented as Interested Parties asked to be represented by lawyers at the Part 1 hearings. A list of Interested Parties and Represented Witnesses and their Representatives can be found in Appendix 2.

2.14 Most Interested Parties were public bodies or individuals involved with Samantha and George's cases who wished to be involved in Part 1 and would, I thought, help the Inquiry with its work. At an early stage we received an application for the families of Samantha and George to be granted that status also. I decided that it would be right to grant that application given the obvious human interest the families would have into an investigation into their deaths.

2.15 I decided that Interested Parties would not be allowed to call or cross-examine witnesses. The Advocate to the Inquiry agreed to consider any requests to call additional witnesses and on occasion did so and agreed to accept requests for

particular lines of questioning to be put to witnesses. I am grateful to all advocates for their sensible cooperation in this regard. Those representing Interested Parties were allowed to re-examine witness whom they represented.

2.16 At the end of the oral evidence, representatives of Interested Parties who wished to do so were allowed to make time limited closing submissions, which could be supplemented with written submissions.

Preparing for the Inquiry

Preliminary hearings

2.17 On 8 December 2004, 23 March 2005 and 10 May 2005 the Inquiry held preliminary hearings.

2.18 The first preliminary hearing considered: the structure of the Inquiry: Part 1 and Part 2; the conduct of the Inquiry, including: the nature of the Inquiry, Interested Parties, gathering evidence, access to evidence and adducing evidence; the scope of the Inquiry; list of issues; criticism of individuals or organizations; the timing of Part 1; the arrangements for Part 2; the media; expenses including legal costs and representations arising from the Opening Statement. A minute's silence was held in memory of Samantha and George.

2.19 The second preliminary hearing considered in particular the redaction of material to be disclosed to Interested Parties; and undertakings in respect of disclosed material given by Interested Parties.

2.20 The third preliminary hearing considered in particular further timetabling, representation for certain ex-Nugent employees and again the question of undertakings.

Gathering witness statements

2.21 In order to structure the work in Part 1, a list of issues was produced which reflected the Terms of Reference, the issues can be found at Appendix 3.

2.22 The Legal Assistant to the Inquiry wrote to everyone who might be able to give relevant evidence asking them to produce a witness statement. A questionnaire was included that set out matters arising from the list of issues, which it was thought they would be able to speak about. In most cases these requests were made through the Interested Parties and I am grateful for their assistance with this.

2.23 A bundle of witness statements was prepared by the Secretariat and copies were made available to the Interested Parties. The Interested Parties and other individuals who were provided with documents signed confidentiality undertakings that they understood that they had to keep the material confidential and only use it for the purposes of the Inquiry.

Gathering documents

2.24 The Secretariat wrote to the relevant public bodies asking them to produce all relevant documents. One of the more difficult tasks that fell to the Secretariat was

managing the vast amount of documentation that was produced in response. The Inquiry team has considered over 250 files, nearly 100,000 pages of documentation.

2.25 This work was made particularly difficult because of the late supply of some relevant material by some of the Interested Parties and by others. However in most cases the problems were temporary and solved quickly due to the good sense and cooperation of those concerned.

2.26 The documents were read and assessed by the Inquiry team and bundles of relevant material – the core bundles - were produced. Copies of these bundles were made available to Interested Parties in the same way referred to in paragraph 25 above. The material was made available in hard copy form.

2.27 A searchable electronic version of all the statements and documents was also produced to accompany the bundles.

Part One

Opening the Inquiry and hearing evidence

2.28 The hearings began on 23 May 2005 when the Advocate to the Inquiry made his Opening Statement. That statement identified the matters which the Inquiry would need to focus on over the following months. That afternoon Opening Statements from the other Interested Parties were received.

2.29 The first witness, Angela Gilman, Samantha's social worker, was called on 24 May 2005. After this, the Advocate to the Inquiry called a further 56 witnesses. A list of the witnesses who gave oral evidence can be found at Appendix 1.

2.30 In the case of Peter Newbery, it was decided that the most appropriate way to hear his evidence was to use a video link from the Courts of Justice in Douglas. I am most grateful to the Isle of Man Courts of Justice for enabling the Inquiry to use the court and its facilities on this day and also for permitting the Inquiry to use a court for two of the preliminary hearings.

2.31 The written statements of a further 57 witnesses were put into evidence without the need for them to attend the Inquiry. The oral evidence was completed by 20 July 2005. A list of the witnesses whose statements were read into the evidence can be found at Appendix 4.

2.32 Final submissions from the Interested Parties and Advocate to the Inquiry in relation to Part 1 were heard on 14 September 2005.

Publishing evidence and data protection

2.33 All oral evidence was simultaneously transcribed using a system called Livenote. The systems proved very useful.

2.34 I believed it was important that the Inquiry should conduct its work as openly and transparently as possible. I wanted to give those with an interest in the evidence as much access to it as possible, at the same time ensuring the safe conduct of the proceedings. In particular, I wanted those who might be able to contribute to Part 2 to have a convenient way of learning about the issues raised in Part 1.

2.35 As a result an Inquiry website was established (http://www.gov.im/cso/commission). Statements provided to the Inquiry and transcripts of each day's evidence were placed on this website. The Inquiry website will remain open for three years following the submission of this Report.

2.36 Before statements and transcripts were published by placing them on the website or disclosing them to the Interested Parties, the Inquiry took advice from specialist counsel on the necessary redaction to the material, given the duty I was under, as a data controller, to comply with data protection principles in relation to all personal data pursuant to the provisions of the Isle of Man Data Protection Act 2002.

2.37 The Inquiry concluded it was necessary to disclose data for the exercise of its Commission functions. It was confirmed that the Inquiry might lawfully process non-sensitive personal data without the consent of the data subject. The Inquiry team was of the view that disclosure of the sensitive personal data relating to the Barton and Green families that remained in the core files was necessary for the exercise of the Inquiry's public function and therefore did not take steps to redact it from the core files. The families were advised that their material was to be disclosed. Rose Burnell objected to such disclosure. After careful consideration that objection was overruled. It was made clear that other sensitive and/or unnecessary data such as telephone numbers, addresses and in particular names of young people would be removed from the statements before they were placed on the website or before they were disclosed to the Interested Parties and that the security of such information would be strictly monitored by the Inquiry team. It was agreed that statements and transcripts of the public hearings would be placed on the website, it being in the public interest to make this information available. All individuals whose material was to be disclosed were also advised. Again no objections were received.

The involvement of the media

2.38 It was agreed that the media in the form of representatives from newspapers could have free access to the Inquiry room and listen to the evidence.

2.39 I allowed television and radio media to be present if they wished on the opening day of the Inquiry when the Advocate to the Inquiry made his opening statement. That occasion apart, I did not permit television and radio broadcasting of the Inquiry, nor permit photographs to be taken. I took into account the nature of the Inquiry itself , the sensitive nature of some of the evidence and the need for witnesses to be as relaxed as possible when giving their evidence and not to feel intimidated by having to give their evidence in the glare of publicity.

Legal expenses

2.40 Under the 2003 Act I was able to order that the expenses (including legal costs and disbursements) incurred by any person interested in the subject-matter of the Inquiry for the purpose of his attendance or legal representation, or both, be paid by either another person so interested (section 5(2)(a)) or by the Treasury out of money provided by Tynwald for that purpose (section 5(2)(b)).

2.41 I have recommended that the costs of the following be paid from public funds:

1.	Alexander Harris	Barton Family and Green Family.
2.	Pamela Pringle	Ex employees of Nugent Care and other individuals.
3.	Pamela Pringle	Manx Family Services.
	Pamela Pringle	Ex employees of Nugent Care now with St Christopher's.
4.	Nabarro Nathanson	Priory Care.
5.	Carters	Lesley Moorcroft.
6.	Andrew Bridson	Damian Bradley.
7.	Steven Coren	Mrs Brenda Cannell MHK

Dealing with potential criticism

2.42 I made clear at the preliminary hearings that some individuals or organisations could be criticised in this Report and that out of fairness I would adopt a procedure that allowed those concerned to address any criticism. The procedures for the representation of Interested Parties and Represented Witnesses and the preparation of their statements seemed to me already to meet those requirements. However I proposed taking an extra step to ensure proceedings were conducted fairly.

2.43 I made it clear that I would make no findings significantly adverse to an individual or organisation without ensuring that they first had a proper opportunity to answer the criticism. Wherever it was possible to do so, the witness would be informed by the Inquiry team of the nature of the potential criticism before they were called to give evidence. Where that was not possible, either because of the time at which grounds for the potential criticism emerged or otherwise, arrangements would be made either for the witness to respond in writing, or for the witness to be recalled so that they could answer the criticism. At the preliminary hearing, I made it clear that I would particularly welcome representations on these procedures. I received no suggestions indicating a need to amend the proposed arrangements and so they were put into practice in the course of the Inquiry.

2.44 Notices of Criticism were sent to individuals where it appeared they may be criticised for their conduct in relation to matters covered by the Inquiry's Terms of Reference. Each witness was given the chance to address these points during the course of their evidence.

Part Two

Preparing for Part Two

2.45 The second term of reference required us to inquire generally into the level and effectiveness of the care and support systems, including through care, provided to children of secondary school age or above on the Isle of Man who have behavioural and emotional problems, taking account, where considered necessary, of care and support received in their earlier years. In so doing, the Inquiry took into account all relevant influences on such children.

2.46 The third term of reference was to make recommendations as to how the welfare of such young people may be safeguarded so as to avoid, as far as possible, a similar tragedy occurring in the future.

2.47 It was apparent early on that in responding to these wide ranging terms I was being asked to make recommendations with wide potential impact.

The seminars

2.48 Part 2 of this Inquiry was designed to be a way for such wider consideration to occur.

2.49 First, we invited written submissions from the public at large. About 30 such submissions were received and I am very grateful to those who took the trouble to send them in.

2.50 Secondly, Mr Hutchinson, Ms White and I visited a numbers of resources in the Isle of Man in order to see first hand how they worked. A list of these resources appears at Appendix 8.

2.51 Thirdly, the Inquiry organised a series of six seminars which were held in October and November 2005. They were conducted in public at the Villa Marina. The seminars covered the following aspects:

1. Young People's Safety;
2. Young People's Education and Learning;
3. Young People's Health;
4. Young People's Offending;
5. The Voice of Young People; and
6. Strategy.

2.52 A wide range of people were invited to the seminars. These included practitioners and managers from social services, the police, prison, health and education services, academics, teachers, lawyers and commentators; and senior government officials and ministers and members of Tynwald. They included external experts from the UK. A full list of those who took part in the seminars can be found in Appendix 9. The seminars were chaired by Alex Verdan and attended by Rob Hutchinson and me. They were a most valuable source of ideas and are discussed further in chapter 23 of this Report. I am most grateful to all those who took part.

2.53 Fourthly, I considered a wide range of documents relevant for Part 2, these appear in Appendix 10.

2.54 Final submissions from the Interested Parties and Advocate to the Inquiry in relation to Part Two were heard on 7 November 2005.

Closing the Inquiry

2.55 On 7 November 2005, I formally closed the evidence-gathering process of the Inquiry. Since that date I have received and considered some further material. This material has been sent to all the Interested Parties for their comments where appropriate.

CHAPTER 3

AN OVERVIEW OF SAMANTHA'S PLACEMENTS

3.1 Samantha Lynda Barton was born in Dublin on 18 May 1985. Her mother was Rose Burnell (nee Barton). Mrs Burnell, who was born on 1 July 1965, was aged only nineteen when Samantha was born. Samantha's father was David Thomas who was born on 23 April 1963. Samantha had one full sibling, her older sister Lyndsey Marie Barton who was born on 23 March 1984.

3.2 Samantha was born with a small hole at the base of her spine, a medical condition called 'spina bifida occulta'; this was successfully operated on when she was 10 months old.

3.3 Samantha's problems and difficulties, and her mother's inability to care for and cope with her, became apparent very early on in her life. Mrs Burnell confirmed in oral evidence that Samantha had temper tantrums when she was as young as 18 months. Sadly, Samantha's problems and difficulties worsened as she became older and it would seem that her mother's ability to provide appropriate care and to control Samantha correspondingly declined. It is indicative of Rose Burnell's understanding and insight that she continued to suggest in oral evidence that the root cause of Samantha's difficulties was likely to be organic. Despite numerous psychiatric and paediatric assessments - the most recent psychiatric assessment being by Dr Dunne in December 2001 - none suggested an organic cause to her difficulties. Dr Dunne confirmed previous opinions that Samantha did not have a treatable psychiatric condition.

3.4 Mrs Burnell and Mr Thomas did not marry. In February 1986, when Samantha was less than 1 year old, Mr Thomas was remanded in custody and Mrs Burnell took Samantha and Lyndsey to live near relations in Manchester. Mrs Burnell met and subsequently married Joseph Burnell in 1988 and on 13 June 1989 Samantha's half brother Philip Burnell was born.

3.5 Mrs Burnell lived in Manchester with Samantha and Lyndsey until May 1991. It was during this very early stage in her life that Samantha came to the attention of Social Services. Samantha was first received into voluntary care by Manchester City Council in 1988 when aged only 3: she moved in and out of voluntary care from then on following numerous requests by her mother for Samantha and Lyndsey to be looked after because of her mental ill-health or her inability to control them. Mr Burnell was reported by Mrs Burnell to have been violent. When in voluntary care in March 1991 Samantha was described by her foster carer as impossible to control, wild, disobedient and aggressive. Mrs Burnell continued to have the misfortune to suffer frequent bouts of mental ill health throughout Samantha's life, sometimes requiring hospital admission. Throughout Samantha's life, Mrs Burnell consistently complained that Samantha was uncontrollable.

3.6 In May 1991, Mrs Burnell moved with Samantha and Lyndsey to Dublin where they lived until May 1992. In Dublin, Samantha came to the attention of Dublin Social Services. Samantha spent a short period in voluntary care. In July 1991 Samantha was seen by a consultant child psychiatrist at The Children's Hospital, Dublin whose overall impression was that Samantha was in a prejudicial situation, presenting in crisis and that the background suggested considerable ambivalence on the part of Mrs

Burnell and a seemingly unsatisfactory and violent relationship with Samantha's father from whom Mrs Burnell was separated. Samantha was referred for psychological assessment. In December 1991, there was an initial assessment by a clinical psychologist who carried out a cognitive assessment which indicated Samantha to be functioning within the low average range of ability with a full-scale IQ of 80. The psychologist was told by Samantha's school that Samantha had settled well at school and that her behaviour there was not a cause of concern, but that her attendance was very poor and this was interfering her progress. The assessment was not completed because Mrs Burnell moved home and the hospital did not have Mrs Burnell's new address.

3.7 In May 1992, Mrs Burnell moved to the Isle of Man with Samantha and Lyndsey. Samantha was aged 7. It would seem Mrs Burnell decided to come to the Island to join her sister, Theresa Barton, who had moved there some years previously.

3.8 The fact that Mrs Burnell and the girls moved frequently before May 1992 is likely to have made it more difficult for statutory agencies in any one area to have provided consistent care and support. However, Samantha was now aged seven. The opportunity for effective early intervention had been lost. It is likely that Samantha's emotional and behavioural difficulties were well formed.

3.9 By August 1992, Samantha and Lyndsey had come to the notice of the Social Services Division of the Department of Health and Social Security. Social services had requested and been sent some information on the family by Manchester Social Services, including a copy of their closing summary written when the family left Manchester and moved to Ireland [17]. In October 1992 Samantha was seen by Dr Balakrishna, associate specialist in psychiatry at Ballamona Hospital, who noted that although it was difficult to carry out an assessment, Samantha was having severe behavioural problems, Mrs Burnell was finding it difficult to cope and Samantha might need to be placed in a children's home in the near future. Dr Balakrishna formally referred Samantha to social services. In December 1992, the social worker for children with special needs introduced herself to Mrs Burnell and offered assistance.

3.10 In 1993, Mrs Burnell was admitted to hospital on 2 occasions. On the first occasion, Samantha and her sister were cared for by their aunt Theresa. The second occasion was in October 1993 when Samantha, aged eight, and Lyndsey were received into voluntary care and placed with foster carers. A form "The Plan for Child Looked After by Local Authority" was completed in December 1993: that part of the form recording the long term objectives for the child was left blank, although the plan seems to have been to return Samantha and Lyndsey to Mrs Burnell, possibly within 3 months. The form also recorded that, following discharge from hospital, Mrs Burnell would be unable emotionally to resume care of Samantha. In April 1994, although a phased return to Mrs Burnell was planned, it was pre-empted when the foster parents found Samantha's behaviour uncontrollable and were unable to continue to care for her. Samantha returned home. Lyndsey joined her a month or so later. This was the first of many unplanned changes of placement in Samantha's life.

3.11 In January 1995, Social services closed their case on Samantha. The closing summary stated that the social worker had had no contact with the family since summer 1994 and Mrs Burnell had made no approach for further assistance; the girls'

[17] Manchester Social Services closing summary sent to Dublin Social Services; and further information sent by Manchester Social Services sent to Dublin Social Services.

headmaster was reported as stating that they were coping with school although their appearance and ability to concentrate had greatly deteriorated since returning home.

3.12 In June 1995, Samantha was again received into voluntary care and placed at Knottfield, a residential unit: her mother again saying that she was unable to control her. She was aged 10.

3.13 On 11 October 1995, she was moved to Cummal Shee, when Knottfield were unable to contain her behaviour.

3.14 Of greater significance than these actual placements is that 1995 was another opportunity for the Social Services Division to consider Samantha's case in detail, to assess her needs and to devise an appropriate care plan. On 24 July 1995, social services held an initial Child Protection Case Conference. Samantha and Lyndsey's names were placed on the Child Protection Register under the category of emotional abuse. In summer 1996, Samantha went back home but that broke down after only 3 weeks and she returned to Cummal Shee, her mother being unable to cope.

3.15 In March 1997, an attempt was made to place Samantha with foster parents but this broke down after only 8 days. The foster carers complained of aggressive and destructive behaviour and she was returned to Cummal Shee. It was acknowledged during the Inquiry's oral hearings that, given Samantha's level of difficulties, it was likely that only experienced and specialist foster carers would have been able to look after her successfully. There was a lack of such specialist foster carers on the Island.

3.16 It should be noted that, for a period during 1997, Peter Newbery was also placed at Cummal Shee.

3.17 In June 1997, Samantha, then aged 12, was placed in the Juvenile Justice wing of the Isle of Man Prison when she refused to accept bail conditions confining her to Cummal Shee. She was released after a week, only when she accepted the bail conditions. At the time, this episode caused an outcry among sections of the public and media at the imprisonment of so young a child.

3.18 In July 1997, she was placed at St David's Alternative Support Centre, a specialist one-on-one unit run by Marlowe Child and Family Service in Pembrokeshire. This was Samantha's first placement in the United Kingdom by the Social Services Division and was initially intended to be short term, for some 6 weeks in order to provide an assessment. In fact, the Marlowe placement continued for some 16 months.

3.19 On 16 October 1997, Samantha was made subject to a care order by the Juvenile Court sitting at Douglas, pursuant to section 53 of the Children and Young Persons Act 1966, on the grounds that Samantha was in need of care and protection and was beyond the control of her mother. This order was not contested by Mrs Burnell.

3.20 In summer 1998, she was moved to a project in Gloucester, again run by Marlowe Family Services. It is difficult to form a view on the success or not of these two UK placements; Mary Miles, one of Samantha's key workers at St David's, certainly spoke of it being a benefit to Samantha at the beginning but Trevor Noden, now the social services' Assistant Director Children and Families, thought that by the end it was no longer on balance a success.

3.21 On 2 November 1998 Samantha was readmitted to Cummal Shee on return from the UK [18]. This was again unsuccessful. The attempt by her social worker to arrange for Samantha to resume education on the Island was cursorily rebuffed. In December 1998, she was placed again with her aunt Theresa Barton. Theresa Barton told the Inquiry in evidence that she only saw this as a short term placement and described how she found caring for Samantha not to be a problem save for the fact that Samantha would go out at night and not come back. She gave graphic evidence of one occasion where Samantha was missing for 2 weeks and agreed that she could not control this very worrying aspect of Samantha's behaviour. She also agreed that in light of this issue it would not have been realistic for Samantha to have been placed with her permanently.

3.22 During November 1998, Ruth Bithell, having become her social worker in August 1995, ceased to be Samantha's social worker. Angela Oldroyd became her social worker until September 1999.

3.23 By early 1999, the specialist one to one or two to one project on the Island was not available. On 1 February 1999, social services applied for admission to St Catherine's Centre for Girls, Orrell House, St. Helen's Merseyside**,** run by the Nugent Care Society, a charitable organisation based in Liverpool. The social services' Care Plan was said to be "essentially unchanged" and the aim was to re-integrate Samantha on Island in a two to one project. Pending that placement, if she continued to abscond, social services would want to explore whether they could apply in England for a secure accommodation order on welfare grounds.

3.24 On 3 February 1999, Samantha was moved to St. Catherine's Centre for Girls. In May 1999, she was placed by the Nugent Care Society in the St Catherine's secure accommodation unit for 72 hours. An application was made by social services to transfer her care order to England so that she could be placed in secure accommodation for a longer period but the application was refused by the magistrates in Douglas; they were recorded as saying to Samantha that if she did not "behave", the correct course would be for social services to re-apply. The Inquiry was not told that a further application was made.

3.25 In September 1999, Angela Gilman became Samantha's social worker.

3.26 In November 2000, Samantha was sentenced by St. Helen's Juvenile Court to a 6 month Detention and Training Order for an offence of violence. She was initially sent to HMP Styal in England and then transferred to Laboure House, St Catherine's secure unit.

3.27 On 27 February 2001, Samantha moved from St Catherine's secure unit to the Isle of Man. She moved firstly to Barrule Cottages and then onto Maple Avenue, Onchan, both run by Nugent Care. In April 2001, she moved to Greeba holiday flats at 22A Derby Road, owned by Manx Family Services but run by Nugent Care. On 4 September 2001, Samantha was moved to Leece Lodge 2, run by Nugent Care.

3.28 It is necessary to consider why she returned to the Island and to analyse the decision-making process in respect of each of these placements (save the very brief stay at Barrule Cottages). It is also necessary to examine:

[18] See chapter 4.

(a) whether Samantha should have been placed there and who ultimately made the decision she should be;
(b) the care and support offered by the DHSS, Nugent Care and Manx Family Services; and
(c) the relationship and communication between the DHSS and Nugent Care and MFS.

3.29 The Advocate to the Inquiry told the Inquiry in his Opening that, on his calculation, Samantha had moved over 50 times in her short life. The social services witnesses who gave evidence, in particular Trevor Noden and Ed Coates, for most of the relevant period a principal social worker, accepted that the social services had not been successful in providing Samantha with stability or permanence.

CHAPTER 4

ISLE OF MAN FROM 1995 TO JULY 1997 AND FROM 2 NOVEMBER 1998 TO 3 FEBRUARY 1999

Knottfield

4.1 On 27 January 1995, Social Services had closed Samantha's case. Samantha was nine. Since summer 1994 there had been no social work involvement with her and Mrs Burnell had sought no help. Samantha was said to be "coping" at school, but with her appearance and ability to concentrate greatly deteriorated. On 30 June 1995, a duty social worker, Mr Alec Merchant, was called to the family home. He later reported that when he had attended, Mrs Burnell said "I don't want her, take her away" and that Samantha appeared to be a very sad little girl. On that day, Samantha was again received into voluntary care at Mrs Burnell's request, who said she was unable to cope with Samantha. Prior to this event, the contemporary documents reveal a picture of very unstable lives being lived at home with Mrs Burnell and her new partner. She was placed at Knottfield, a residential home run by Isle of Man Children's Centre where she remained until she moved to Cummal Shee on 11 October 1995. The case was allocated to a social worker, who left the Island in July leaving no record of her involvement. A new social worker, Ruth Bithell, took over the case on 1 August 1995.

4.2 On 12 July 1995, a Post Admission Conference was held by social services. It was agreed that Mrs Burnell would have daily contact with Samantha and that the placement would be reviewed in three months (27 September 1995). On 24 July 1995, social services held an initial Child Protection Case Conference. Samantha and Lyndsey's names were placed on the Child Protection Register under the category of emotional abuse. In August 1995, the social worker, Ruth Bithell, recorded that she had encouraged Mrs Burnell to co-operate with a Care Programme but without success.

4.3 On 30 August 1995, an emergency Case Review was organised as a response to Samantha's difficult behaviour and because there was a question whether Knottfield was a suitable placement for Samantha. It was decided that Knottfield was meeting Samantha's needs and that she would remain there. Contact with Mrs Burnell would be more structured and, initially, more limited. However, only two weeks later, a planning meeting on 13 September set out more frequent visits home. By October Knottfield staff felt that the placement was not succeeding.

Cummal Shee: 11 October 1995 to 28 July 1997

4.4 On 11 October 1995, Samantha was moved to Cummal Shee. Cummal Shee was a residential unit in Tromode just outside Douglas for eight young people aged 10-17 years. It was run by NCH Action for Children and fully funded by the Isle of Man Government.

4.5 The placements at Cummal Shee occurred 10 years ago and they have not been the focus of the Inquiry [19]. NCH are not an interested party and no one has received a formal notice of criticism relating to them. Furthermore the Inquiry decided that it would not invite evidence from NCH in relation to Cummal Shee. Thus, there are only limited conclusions which can be drawn from the time at Cummal Shee and none critical of NCH.

4.6 In relation to this period, it should also be noted that there was a lack of any alternative residential resource on the Island.

4.7 Records show that Mrs Burnell was told by the social worker that care proceedings would be taken if she decided to have Samantha home. On 12 October 1995, a planning meeting was held.

4.8 Samantha remained at Cummal Shee for 9 months until 19 July 1996. At this point she went home, a decision taken by the then principal social worker and not agreed with by her social worker, Ruth Bithell. Samantha was allowed to return to her mother's care despite the clear evidence suggesting that her mother was not able to meet her needs. Rehabilitation broke down and, after only 3 weeks, on 12 August Samantha was returned to Cummal Shee. It is recorded at this time that it was believed that there was insufficient evidence to take care proceedings.

4.9 Samantha remained at Cummal Shee for a further 7 months. In March 1997, Samantha was suspended from her school [20]. On 5 March 1997, at the Juvenile Magistrates' Court Samantha pleaded guilty to 7 assaults on staff on occasions in November 1996 and January and February 1997; she was given a conditional discharge for 12 months. Although she had received a formal caution in the previous year, these were her first criminal convictions. In March 1997, an attempt was made to place Samantha with foster parents. Her placement survived only eight days due to her behaviour. On 16 March 1997, Samantha returned to Cummal Shee. She regularly absconded from Cummal Shee.

4.10 On 22 April 1997 a child protection case conference was held. The conference recommended that care proceedings be started and that an assessment be undertaken in a residential setting off the Island. It was noted that funding would have to be justified and "may be three cornered ie social services, health and education". Samantha's offending, violent behaviour and absconding in dangerous circumstances continued. In May, Mrs Burnell kept Samantha at her home against advice from social services and also gave notice of her wish to remove Samantha from voluntary care. This prompted social services to obtain a Place of Safety Order on 14 May 1997 in order to return Samantha to Cummal Shee and to commence care proceedings on 20 May 1997.

4.11 On 4 June 1997 she appeared in the Juvenile Court charged with a criminal offence. She was remanded in custody and placed in the Juvenile Justice wing of HM Prison because she refused to accept the bail conditions. She returned to Cummal Shee on 10 June after 6 days when she accepted the bail conditions. She remained there for 6 weeks. She continued to abscond and re-offend. She was arrested again and held in the police station for 2 days.

[19] See chapter 1
[20] Samantha's education is discussed in chapter 13.

4.12 On 28 July 1997, she was placed at St David's Alternative Support Centre in Pembrokeshire, initially for assessment and to manage the immediate crisis [21].

4.13 As part of the material to support the application for a care order (which was eventually heard on 16 October 1997) a number of reports were prepared. Dr Ubeysekara, consultant child and adolescent psychiatrist at Brynffynnon Child and Family Centre, reported that there was no evidence to suggest formal psychiatric disorder and concluded that Samantha had had an unstable and insecure upbringing from a very early age with multiple carers, inconsistent management, unhealthy physical and emotional experiences, and seemed to have learnt to receive a lot of attention from the carers through her unacceptable behaviours. He recommended a fuller psychiatric assessment. In his Assessment Report dated 6 October 1997, Steve Miller , Director of Care at the Marlowe Child and Family Services was of the opinion that Samantha's difficulties were the result of childhood experience, not psychiatric disorder or personality disorder; that she was a very needy child with very poorly developed social and relationship skills, with an emotional age between five and eight; that her behaviour could be such that it would be impossible to safely contain her in a normal environment; that her behaviour was quite containable within her current placement at St David's; and that her behaviour with her family indicated that a return home would be disastrous.

4.14 The review report in August on Samantha by Paul Thomas, the Service Manager at St David's, recorded that Samantha was responding to clear and consistent boundaries; that she reacted when she did not get own way or to family contact; that inconsistency and confusion were features of Samantha's relationship with Mrs Burnell.

Cummal Shee: 2 November 1998 to 3 February 1999

4.15 At the beginning of November 1998, her placement at Marlowe Family Services in Gloucester (to which she had moved after her placement at St David's) [22] was no longer successful and Samantha was placed again at Cummal Shee. The application form for admission records the concern at the placement but notes that there was no other placement available. The placement was intended to be only short term (anticipated 4 to 6 weeks) and the social services plan was to organise a special one to one, or two to one, residential placement for Samantha on the Island.

4.16 On her return, her offending behaviour continued. She was charged with offences and between 12 and 23 November 1998 she was remanded in custody at HM Prison. She was released on bail and in due course placed on probation. In December 1998, she was placed as a short term arrangement with her aunt Theresa Barton (see chapter 3 above). On 3 February 1999, she was placed at St Catherine's Centre, St Helen's.

4.17 The Interested Parties at the Inquiry did not dispute that by 1996 and thereafter until 2000, the DHSS had very grave concerns about the suitability of Cummal Shee. In 1994, the McManus Report had found [23]:

[21] see chapter 5
[22] See chapter 5
[23] MacManus Report, Part 2, para 5.130. See also para 5.133.

> "In practice, Cummal Shee has acted as a remand home, children's home, juvenile bail hostel and place of safety – in effect for any child who could not be accommodated at home, at the Isle of Man Children's Centre or with foster parents. The reason that children with such a variety of needs had been placed there was because the relatively small numbers of children requiring care meant that it was thought impractical for varying types of accommodation and regime to be provided. The consequences have been dire."

4.18 Matters had not resolved by 1996. In a Memo from David Cooke, Director of Social Services, to the Chief Executive of DHSS dated 19 April 1996, Mr Cooke wrote:

> "9. … The division has referred some very difficult young people to the unit and we have expected CS to cope. This is probably totally unreasonable when you consider that we have no back up services of child psychology an effective child psychiatric service. Most of the children are excluded from their school with only an hour a week of education provided (the minimum statutory requirement).
> 10.In addition, the Department do not have the resources to be able to move children on from CS at the most appropriate time to a more appropriate placement. We have no after care resources and a limited number of specialist foster parents. The failure to move young people on from the unit has, I am certain, led to increased problems within the unit….
> 12.In addition, moves are also being made to discharge back to their parents care, some individuals in the unit. This is far from ideal but in the present circumstances it is felt to represent a better option than remaining in the unit.
> 13.Clearly this is a totally unacceptable set of circumstances. Staff at the unit have asked Trevor Noden to close the unit down for a while to give staff time to recover from what they see as an impossible situation of attempting to manage their present residents. This is clearly unacceptable. It is very possible that if the unit were inspected by the SSI at the present time that pthey would recommend either immediate closure or at least temporary closure."

In his letter on 13 February 1996 to David Gibson, Deputy Director of Social Services, Roger Woodcock, manager of Cummal Shee in 1996 had expressed similar concerns [24]. Trevor Noden wrote a Report dated 1 May 1996 proposing major changes.

4.19 In 1998, Trevor Noden commissioned a report from Julie Kent, Co-Director for Group Care and Community Care Studies at De Montford University and Chris Payne, Co-Director and also of National Institute for Social Work. In their Interim Report dated 15 January 1999, they concluded that[25] "it was difficult to establish that residence at Cummal Shee was of any benefit to young people living there".

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[24] "I have attempted on a number of occasions to communicate my concerns about the present violent and aggressive group of YP and the pressure on CS to provided 3 residential units when it is only just funded/staffed for 1 unit. … I do feel there is an urgent need to revisit the (unsigned) project agreement….As I see it, at present CS is a crisis unit, a remand centre, a therapeutic unit, a long term care home, a preparation for fostering resource, a semi-independent unit, a sin bin, a dustbin!!..."

[25] "Interim Conclusions ii). It was difficult to establish that residence at CS was of any benefit to YP living there. Day to day in CS seemed at close range to be a battle between YP and staff. Staff continuously struggled to impose control and structure, YP continually strove to undo it. As a result of

4.20 It is not for this Inquiry to decide whether the many concerns expressed are justified or not. To repeat, the Inquiry did not explore this in any detail and did not hear from NCH. However, it is plain that at that time senior officials in the Social Services Division and at the top of the DHSS considered that Cummal Shee was not working because it had to meet the needs of too disparate a group of children and young people, including those with severe behavioural and emotional difficulties. The DHSS in its Closing Submissions [26] accepted that in essence Cummal Shee was being used inappropriately for a multiplicity of roles. It was unable to meet all the wide and unrealistic objectives set for it by Social Services. As such, it failed. This has important lessons to be carried in to Part 2 of this Inquiry. While acknowledging the practical difficulties involved, care must be taken not to use a resource for a range of purposes which are incompatible with each other; there must be a focus on the purpose of each of the resources providing for the care of children.

4.21 Furthermore, these very grave concerns were not communicated to the social workers on the ground who were making the decisions about whether to place young people at Cummal Shee, thus arguably depriving them of critical 'welfare' information which they should have known in order to be able to make those placement decisions. In particular, neither Angela Oldroyd, Samantha's social worker at the time, nor Sylvia Morrison, George's social worker [27], were told about these very grave concerns when they were placing Samantha and George. David Cooke, the Director of Social Services, in consultation with senior managers made the decision not to tell social workers. He agreed in evidence that they should have been told. It is unnecessary now to consider whether, had the social workers been given such information, they would have been placed at Cummal Shee anyway, given the lack of alternative.

4.22 All witnesses who gave evidence on this subject stressed the lack of any alternative placements on the Island. There was nowhere else on the Island for Samantha to be placed. There were no specialist foster parents experienced at dealing with exceptionally difficult children. Her placement with foster parents failed. The only realistic options were placements in the UK.

4.23 It was agreed that Cummal Shee was an unsuccessful placement for both Samantha and George and one that was, from the outset, likely to be so. Ed Coates went as far as to say, agreeing with the parents, that he thought Cummal Shee compounded the children's problems and made them worse.

Conclusions

4.24 By 1995, it is likely that Samantha had experienced long term emotional damage due to inconsistent parenting and much instability. Until her placement at St David's for that purpose in summer 1997, there is no evidence that a proper assessment of Samantha's needs or the making of a plan for her long term care was carried out by social services. Such an assessment should have been done in the period 1992 to July 1995. Reception into care in 1995 was another opportunity to assess Samantha's needs.

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this power struggle, daily living was chaotic and at times frightening, physical standards of care were poor and care practice focussed on containment...rather than on amelioration of individual circumstances that had brought the YP to CS in the first place."

[26] Para 181

[27] See chapter 10

4.25 Furthermore, it should have been plain from at least 1995 that Mrs Burnell was not capable of meeting Samantha's needs. There should have been an assessment in 1995 of whether a return home in the future was realistic and, if as would have been overwhelmingly likely, the assessment showed that Samantha could not return home, a care plan providing her with a permanent and stable alternative home should have been drawn up. Ed Coates, principal social worker from 1998 [28], says in his statement [29] that with hindsight it is clear that this should have been done.

4.26 With a proper system of assessment and care planning (which is supervised and implemented in practice), this should have occurred at the time and without recourse to hindsight when it is too late for the individual child. Ed Coates suspects that the absence of a clearer structure of assessment meant that Samantha remained in her "dysfunctional family" far longer than she should have done [30]. The Inquiry considers that to be likely.

4.27 Again, no proper assessment of her needs, and how to meet them, was carried out on or before Samantha's return to the Island in November 1998.

4.28 The DHSS accepted [31] that crisis management was unfortunately often the situation social services found themselves in with Samantha and a settled period of care was never achieved for her. In Part 2, the Inquiry considers whether the current policies and practice of assessments and care planning are adequate**.**

4.29 The Inquiry considers that, given the difficulties which senior management believed to exist about placing too disparate a group of children at Cummal Shee, there should have been detailed consideration of a UK placement for Samantha from October 1995 and significantly earlier than July 1997, almost 2 years later.

[28] Now Child Care Co-ordinator
[29] Second statement p 36
[30] Second statement p 46
[31] Closing Submissions on behalf of DHSS

CHAPTER 5

UK PLACEMENTS

Marlowe Care Services 28 July 1997 to 2 November 1998

5.1 On 28 July 1997, Samantha was placed at St David's Alternative Support Centre, Pembrokeshire, a specialist one-to-one unit run by Marlowe Child and Family Services. The care plan was to return Samantha to the Island. In July or August 1998, she was placed at a project in Gloucester, again run by Marlowe Child and Family Services, where she remained until November 1998. These specific placements have not been the focus of the Inquiry. They are however an important part of Samantha's care history.

5.2 The evidence suggests that the move to St David's was initially relatively successful. That success was not sustained. The care plan at first was for the placement to be short term (i.e. 6-8 weeks) in order to manage a crisis and assess Samantha before a return to the Island. The placement lasted longer because there was no alternative on the Isle of Man. On 16 October 1997, Samantha was made subject to a care order by the Juvenile Court sitting at Douglas, pursuant to section 53 of the Children and Young Persons Act 1966, on the grounds that Samantha was in need of care and protection and was beyond the control of her mother. This order was not contested by Mrs Burnell.

5.3 The care plan, by which is meant social services' proposal for how they would care for Samantha, was to return Samantha to the Isle of Man. From the record of the hearing, it seems that the hope of social services was to set up a unit similar to St. David's on the Island, although it was acknowledged that this would not be likely within 6 months and Samantha would remain at St. David's in the meantime. Samantha's Guardian ad Litem agreed that there should be a care order but questioned the care plan and recommended to the court that a placement be found at a residential school with therapeutic input, which was only available off the Isle of Man. A note on the file of the advocate acting for social services states that the justices expressed the hope that Samantha could stay at St David's until a permanent therapeutic and educational placement could be found.

Conclusions

5.4 The care plan was central to the planning and carrying out of its responsibilities by social services. There was no proper record of the justices' reasons for granting the care order or their reactions to the Guardian's views on the care plan. Significantly there was no proper record on social services' file of the court's reasons for granting the order nor a record of the court's view as to the Care Plan.

5.5 In early 1998, it was still the plan that Samantha would return to the Island when a one to one specialist unit had been established for her. The Social Services records do not reveal when this plan was abandoned or at least postponed. What is known is that social services signed a contract with Marlowe Care Services to move Samantha from St David's to the project in Gloucester on the 11 May 1998 with an agreement that the placement would commence on the 1 August 1998.

5.6 The Inquiry heard via video link from Mary Miles, Samantha's key worker at the first Marlowe project, Pembrokeshire. She considered the placement to be the right type for Samantha and thought in its early days it was successful. Her opinion was very much a personal one based on the positive relationship she developed with Samantha. It is also of note that she considered Samantha would have excelled in a foster placement and later was to offer to foster her. Nevertheless, despite her good relationship with Samantha, she received violence from Samantha in an incident in which Samantha slapped Ms Miles around the face and punched her in the mouth causing extreme pain and causing her tooth to penetrate her lip.

5.7 Towards the end of her placement at St David's, Samantha's behaviour worsened. She committed a series of offences and continued to do so after she left. One such instance of offending included being driven in a stolen car to a house and breaking in. The house was Shell Cottage, where she had lived initially when placed in Pembrokeshire. It was thought by social services that Samantha's desperate wish to come home caused her extremely disruptive behaviour during the Marlowe placements.

5.8 In July or August 1998, Samantha moved to Face to Face in Gloucester, a project run by Marlowe Child and Family Service. The placement did not prove successful. Her behaviour continued to deteriorate. She committed a series of criminal offences. On 8 October 1998, Ed Coates, at that time the recently appointed Principal Social Worker in the Long Term Management Team, wrote a Memo to Trevor Noden, at that time Service Manager :

> "Attached you will find care plans on both Lyndsey and Samantha…
>
> For Samantha, the clarity about care planning that is required is likely to be part of a process of seeking a secure placement for her. I think it would be true to say that we couldn't justifiably seek a secure place for Samantha without a clearer sense of where we would place her and how we would meet her needs once such a placement were ended. If we do not place her in secure we will need to return her to the Island in any case, as the current arrangements are not only very costly but also totally unsatisfactory.
>
> As things stand, this department, indeed the Island, doesn't have the resources to meet these girls' separate let alone their joint needs…
>
> I understand that there is political opposition to returning Samantha to the Island but in terms of care planning this is opposition which cannot be allowed. Cummal Shee…..cannot care for Samantha as well.
>
> There have been for many months now proposals around possible resources for Samantha all of which have not come to fruition. I believe that we now need to be thinking imaginatively about how we could meet both girls' needs…in a way which doesn't necessarily fit with the residential resources currently provided. The process of setting up a resource that is tailored to the girls needs now needs to begin in some sort of meaningful way before we further any discussions with the girls."

5.9 The care plan dated 30 September 1998 was prepared by the social worker Ruth Bithell and stated:

> "Samantha's Needs
>
> Samantha needs a structural environment where she is given firm constant handling within a setting where she has some contact with other children but also can be given individual attention and can be securely contained whenever she is in emotional crisis.
>
> She needs to have limited and structural contact with her mother and her sister but rehabilitation with either or both is not an option whilst Samantha's behaviour remains so demanding. She should not be considered for fostering.
> …
>
> Future
>
> Samantha is thirteen years old and will therefore need care for several years yet.
>
> It seems most important to me that she is given a period of stability and that plans that are set in place now should see her through at least the next three years. It should not be considered a stepping stone to fostering because I feel this may set her up to fail. She needs to be told that she will stay where she is with the authority that the Care Order gives.
>
> This care plan needs to be considered alongside the care plan devised for her sister."

5.10 Samantha's behaviour continued to deteriorate. On 2 November 1998, Samantha was moved back to Cummal Shee. This move was not made as part of a considered plan for Samantha along the lines proposed by Mr Coates and Ms Bithell or otherwise. The Project Manager at Cummal Shee, Roger Woodcock, expressed his concern on 17 November 1998 that Samantha had "left in crisis and appeared to be returning in crisis".

5.11 By early 1999, the specialist one to one or two to one project on the Island, mooted during the care proceedings in October 1997, was not available. On 1 February 1999, social services applied for admission to St Catherine's Centre for Girls, Orrell House, St. Helen's Merseyside**,** run by the Nugent Care Society, a UK registered charity based in Liverpool. The social services' care plan was said to be "essentially unchanged" and that the aim was to re-integrate Samantha on Island in a two to one project. Pending that placement, if she continued to abscond, social services would want to explore whether they could apply in England for a secure accommodation order on welfare grounds.

St Catherine's Centre for Girls, St Helen's

5.12 On 3 February 1999, Samantha was moved to St. Catherine's Centre for Girls. The evidence suggests that this placement was of the type that Samantha needed and that it could have been successful. It was thought it would be a positive environment for Samantha that would attempt to contain her, something which Angela Oldroyd felt Samantha needed. Initially the documents show that it was viewed as an excellent placement, meeting many of Samantha's needs. The placement had many ups and

downs. There were incidents of alcohol, solvent and drug abuse. There were reports of her staying out late and of violence to herself and to others. There were reports of Samantha having a relationship with an older man and staying at his flat; in April 1999 she had a negative pregnancy test. However, at the Child Care Review on 18 February 2000 it was recorded that "…there has been a lot of progress ... Feedback from school very positive … very settled [in the placement] and is making excellent progress … well-placed and making excellent use of St. Catherine's now …".

5.13 By the end of the placement Trevor Noden considered that the placement was clearly proving unsuccessful. Samantha herself wanted to be with her mother and wanted to return to the Isle of Man. She had withdrawn her cooperation and her behaviour had deteriorated significantly causing grave concern such that she was admitted to secure accommodation. Angela Oldroyd, Samantha's social worker, attempted unsuccessfully to have Samantha's transferred to England in order that Samantha could be placed in secure accommodation for a longer period [32].

5.14 On 2 November 2000, Samantha was arrested and charged with serious assaults. She was granted bail on condition that she resided away from St Helen's and as directed by social services. Given that no other suitable accommodation was found by social services, she was brought back to the Island, where temporary arrangements were made for her. On 28 November 2000, she appeared at St. Helen's Juvenile Court and was sentenced to a 6 month Detention and Training Order. She was initially sent to HMP Styal, England, and then on 11 December transferred to Laboure House, St Catherine's secure unit, to serve her sentence.

5.15 On 27 February 2001, Samantha was released from the secure unit and returned to the Island. Under the terms of her sentence, she remained formally under the supervision of Angela Gilman until 25 May 2001.

[32] See chapter 3, para 3.24

CHAPTER 6

THE DECISION TO ALLOW SAMANTHA TO RETURN TO THE ISLE OF MAN IN 2001

6.1 On 27 February 2001, Samantha returned to the Island, where she lived until she was murdered twelve months later on 8/9 February 2002. Since summer 1995, social services had believed that Samantha should live off the Island until a specialist unit could be established for her on the Island. Yet when she returned to the Island, it was not to the specialist unit as proposed in the care proceedings in October 1997 or by Ed Coates and Ruth Bithell in autumn 1998 [33].

6.2 The lead up to Samantha's return in February 2001 was as follows. At the Child in Care Review Meeting on 20 July 2000, it was recorded that Samantha's levels of cooperation were low but it was agreed that:

> "a sense of planning for Samantha's future on the Island is vital".

However, it was noted that there was no possibility of a move back to the Island before Samantha was "ready for independence". In oral evidence, Angela Gilman, Samantha's social worker, said this was the view of everyone present at that meeting.

6.3 On 18 August 2000, Ed Coates, principal social worker, was reported to be unhappy with a return to the Island because there did not exist the right sort of placement for Samantha.

6.4 It is important to note that Angela Gilman had assessed Samantha, correctly on the evidence, to need:

> "a very clear structure, very clear boundaries and a staff team who were very specialised and experienced"[34].

Ed Coates told the Inquiry that, while conscious of the complexities of her view, he would not disagree with the broad tenor of Ms Gilman's assessment [35]. It was acknowledged that no such placement existed on Island: hence Samantha's earlier placements at Marlowe Family and Child Services and at St Catherine's. On 22 August 2000, Angela Gilman recorded that she had a telephone call with Samantha:

> "Sam wanting to know when she is returning to Island. Explained that I will need a strategy and had discussed this with Roger Woodcock of Cummal Shee/Priory. Now looking at formal plan of proposal to put to placement committee of move from St Catherine's to White Hoe (Nugent) then Leece Lodge, then outreach. But all this must include Sam working in full partnership with us and not going off and rebelling."

[33] See chapter 5
[34] Day 2: 46
[35] Day 11: 49: 4

6.5 By 14 September 2000, the decision, agreed with Ed Coates, had been made that planning for Samantha's return to the Isle of Man should commence.

6.6 In her referral form to the Children and Families Resource Panel meeting on 10 January 2001, Angela Gilman described Samantha as a very needy young person who can behave when she wants to and is lovely to be with. She reiterated that Samantha needed firm boundaries and a firm structure and a small support team made up of people very experienced in working with difficult young people. She pointed out that Samantha had no formal educational qualifications and no work experience. She said that Samantha had had few positive role models in her life and saw little need to work for a living. She needed to learn life skills, which would be a key area of work to enable her to participate in society and avoid social exclusion. She added that given her immaturity and vulnerability, Samantha would need to be looked after for the best part of 12 months.

6.7 In general, Ed Coates the Principal Social Worker agreed with Ms Gilman's assessment.

6.8 The panel's decision on 10 January 2001 is not formally recorded in the documents provided to the Inquiry but a handwritten note is found on a copy of Ms Gilman's report:

> "Agreed AG & FC [Francis Charlton of Nugent Care] … to discuss the possibility of a community package jointly with Lyndsey -) Bring back to next meeting…" [36].

The Resource Panel met on 7 February 2001 and noted:

> "Staff visiting SB in [St Helen's]; Making initial plans for her return – difficulty with property, agencies want 1 year's funding".

At the Resource Panel Meeting on 21 February 2001, it was recorded that:

> "Nugent will house SB when she returns, property identified at Douglas Head; was planned to house all 3 [Samantha, Lyndsey and a third young person] together but behaviour (of [the third young person]) makes that potentially untenable".

6.9 The plan had initially been to place Samantha at White Hoe, a residential unit, which Nugent opened on 18 December 2000. Staff from there went to see Samantha in the St Helen's secure unit [37]. However, it would appear that by 10 January 2001, the plan had changed and Samantha was to be accommodated with Lyndsey [38] in a special project.

6.10 In her evidence, Angela Gilman having been asked whether she thought the project met the criteria she had identified in her report of 10 January 2001 said in evidence[39] that she thought it was: "…as good a fit as we could get at the time." Trevor Noden,

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[36] This accords with social work diary sheet for 10 January 2001 "decision for Nugent to look after Sam and Lyndsey in community placement"
[37] Donna Lever Day 24:17: 6-18.
[38] Angela Gilman in her Report for the panel on 10 January 2001 had advised against placing the two sisters together.
[39] Day 2: 69:13

then Services Manager, told the Inquiry that he did not now think that Maple Avenue was an appropriate placement for Samantha; but that at the time he thought it was the most appropriate of the few resources which social services had available [40].

6.11 In oral evidence Ed Coates listed the following factors as ones which made him change his mind about whether Samantha should return to the Island when she did:

(a) Samantha had ceased to make positive use of the education at St. Catherine's;
(b) the care resources at St Catherine's were clearly strained as evidenced by her imprisonment;
(c) Samantha wished to return to the Isle of Man and was approaching her 16th birthday;
(d) a return to the Isle of Man would satisfy Samantha's cultural needs.

6.12 Some or all of these factors weighed with others when they considered the merits of the decision to return Samantha. Angela Gilman took into account her strong wish to return and what she described as her "cultural identity". Gill Owen, Assistant Director of Nugent Care Society in England, told the Inquiry that everybody involved at the time thought the move was appropriate and that if Samantha was going to return, it should be done at that time. However, she was not involved in deciding the appropriateness of the care and support package for Samantha on the Island [41] .

Conclusions

6.13 It is difficult to question the first two factors identified by Mr Coates. However, in the circumstances it is likely that too much weight was attached to Samantha's wishes and what social services referred to as her "cultural needs" in the decision to return to the Island. This is not the only occasion when arguably too much importance was attached to her wishes [42]. Clearly, given her age it was important to ascertain her wishes and feelings. However, given her lack of emotional maturity and understanding and personality, it is arguable that her wish to return to the Isle of Man should not have been a determinative factor.

6.14 More significant, however, is the failure of social services to carry out a formal assessment weighing up all the advantages and disadvantages of a return to the Island. Furthermore such an assessment should have taken into account any available alternative placement and should have required consideration of what alternatives off-Island might be available. For such an important and complex decision, such an assessment could be seen as essential, particularly bearing in mind that, first, no other projects in the UK were looked at in any detail and, secondly, social services were very aware of the lack of the specialist resources on the Isle of Man that would be required to meet Samantha's needs effectively. Furthermore, such an assessment would have made social services focus on the ingredients of the support package necessary for Samantha in the event of a return.

6.15 Linked to the failure to carry out a formal assessment was a failure to plan ahead. The need to plan for return had been spoken of in September 2000. Samantha's release date from the secure unit (namely February 2001) was known by the end of

[40] Day 19:108:2, 17
[41] Day 18:87: 23.
[42] In September 2001 when she was placed at Leece Lodge 2, one reason given for not placing staff to live with her was that she did not want them.

November. Yet on her return it was still necessary to place her in temporary accommodation at Barrule Cottages for four weeks. Failure to plan the detail of her return made her care and support on Island less effective than it should have been. The Inquiry concludes that this failure to plan ahead is one of many examples of the poor oversight of Samantha's case by social services' management.

CHAPTER 7

MAPLE AVENUE

7.1 The Inquiry has already considered the decision to return Samantha to the Island: how it was taken and whether it was an effective way to meet her needs. It turns now to the placements on the Island in 2001 – 2002.

7.2 On 27 February 2001, Samantha moved from St Catherine's secure unit temporarily to Barrule Cottages, Maughold, and then on 8 March 2001 to 77, Maple Avenue, Onchan, both run by Nugent Care. Barrule Cottages was a holiday let and always intended to be temporary. Maple Avenue was a unit with 'live in' staff. On 20 April 2001, she moved to Greeba holiday flats at 22a Derby Road, owned by Manx Family Services but run by Nugent Care, where she remained until 3 September 2001.

The decision to place at Maple Avenue

7.3 There were no specific resources on the Island suitable to meet her needs. Priory House, White Hoe and Isle of Man Children's Centre were not appropriate; even if they had been suitable[43], existing smaller projects were full[44]. However, Social Services decided that Nugent Care Society should find a placement for Samantha and would look after her on her return to the Island. Consideration had been given to placing her at White Hoe but that was ruled out. The first property available and identified by Nugent was too close to the home of one of the staff who would be working with Samantha. Maple Avenue was identified by Nugent and agreed to by Social Services. In reality, it, or something similar, was the only placement available.

7.4 Nugent was new on the Island. It had been awarded the contract in 2000. It was still in the process of taking over or opening its various projects on the Island[45]. Francis Charlton was the project manager of Nugent on the Island. Damian Bradley was operations manager and in effect deputy project manager. He told the Inquiry that Nugent were first asked to provide a placement for Samantha at the allocation panel on 10 January 2001[46]. In oral evidence, he also alleged that he said to Francis Charlton "do you think we are ready for this?", meaning that Nugent were new on the Isle of Man and were 'bedding in' and Samantha was a very difficult child[47]. This comment, or indeed its sentiment, is not recorded anywhere in writing. He said that Francis Charlton felt contractually obliged and committed to taking Samantha and so Nugent had to move on in a positive way.

7.5 Donna Lever was a Team Leader at Maple Avenue. The staff at Maple Avenue included Anne Curphey, Julie Lavin, Donna Whelan and Kathy Whelan. Anne Curphey was George Green's aunt.

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[43] Their suitability has not been explored by the Inquiry
[44] Ed Coates second statement, p 59, para 11
[45] See further chapter 9
[46] [Day 16: 102:14]
[47] [Day 16: 104; 106:21-25; 110:25]

Care and support offered at Maple Avenue

7.6 It was generally acknowledged in oral evidence that this placement did not meet the criteria which Angela Gilman had assessed Samantha to need, namely a very clear structure, very clear boundaries and a very experienced and specialist staff team[48]. To this extent, it did not meet her needs. Ms Gilman told the Inquiry, not for the first time, that there were no other options and that Maple Avenue was the best that could be provided at the time. Francis Charlton agreed that Samantha needed a firmness of approach and experienced staff[49] and said Maple Avenue was the best that could be done[50]. He said "in reality she needed a closed therapeutic secure environment"[51]; he added that "we were trying to put something together without enough planning".

7.7 It was agreed that Social Services failed to provide a written care plan or a placement agreement with Nugent. In additional there was no written support package. The overall aim of the placement was understood by Nugent to be to prepare Samantha for independence.

7.8 Donna Lever said that Samantha engaged with some of the staff: this she described as the limit of its success.

7.9 The evidence showed that Samantha did not receive education, whether formal or informal, did not have a structured programme of activities for her day and did not receive any specialist help, for example, counselling. Thus, the placement stood little chance of beginning to assist Samantha to acquire some of the life skills she would need as she moved towards independence.

7.10 Ann Curphey said that there certainly was an attempt to impose boundaries. After working with Samantha, she thought that she needed live-in staff.

7.11 Nugent had only recently arrived on the Island and were still recruiting. Damian Bradley said that Nugent did not have the experienced staff at Maple Avenue, or at least a sufficient number of experienced staff[52]. The experience level of the staff was variable. In what was in reality not a specialist placement, this is not surprising. However, it is surprising, given that social services had specifically assessed Samantha to require specialist staff, insufficient numbers of staff with experience were provided. Anne Curphey was a residential social worker with 20 years experience of working with children and young people; but she had had no specialist training in how to deal with young people with severe emotional and behavioural difficulties and told the Inquiry that she would have preferred to have had it. While she was able to work with Samantha, she felt her lack of training "put up barriers".

7.12 Samantha's Aunt Theresa Barton told the Inquiry that, while placed at Maple Avenue, Samantha visited her. However, Aunt Theresa did not visit Samantha's accommodation at Maple Avenue[53].

[48] See chapter 6, para 6 ff
[49] Day 12: 119:1-4
[50] [Day 12: 120:1]
[51] [Day 12: 120:4-5]
[52] [Day 16: 110:16]
[53] Day 16: 24:23

The relationship and communication between Social Services and Nugent at Maple Ave

7.13 The Inquiry heard no evidence to suggest that communication from Nugent to social services was a problem. Perhaps the fact that this was the only unit with live-in staff may explain why they were more aware of what was happening with Samantha and so better able to communicate the same to social services.

7.14 However, there was a failure within Nugent to pass on information about Samantha to at least some of those working with her at Maple Avenue. Donna Lever did not read Samantha's Social Services file. Anne Curphey was not briefed about Samantha and did not read her social work files.

Conclusions

7.15 It appears from the evidence given to the Inquiry that of the three on-Island placements Maple Avenue was the one which most matched the three criteria identified by Angela Gilman in her report to the Children and Families Resource Panel in January 2001[54], but perhaps only because of the live-in staff. Nevertheless, Trevor Noden accepted in his evidence that it was not an appropriate placement. The placement did not meet Samantha's assessed needs.

7.16 Nugent should not have been asked by social services to set up this placement and Nugent should not have accepted this placement. At that stage, Nugent lacked the necessary experienced staff and were heavily committed in setting up their other projects on the Island.

7.17 During the short period she spent there, it is the inevitable conclusion that Samantha did not receive adequate care and support to match her needs. There was no provision made for her educational and vocational needs and there was inadequate attempt to occupy her days constructively.

7.18 Social Services failed to provide a written care plan or a placement agreement with Nugent. Social Services failed to agree with Nugent a written support package setting out the care and support to be provided at Maple Avenue.

[54] "A very clear structure, very clear boundaries and a staff team who were very specialised and experienced": see chapter 6

CHAPTER 8

DERBY ROAD

8.1 On 20 April 2001, Samantha, aged 15 years and 11 months, moved to 22 Derby Road, Douglas. She remained there until 3 September 2001.

The decision to move to Derby Road

8.2 During April 2001, there were concerns about the behaviour of Samantha and visitors at Maple Avenue. Representations were made to the member for Social Services Division, Mr Geoff Cannell MHK, by among others Mr John Houghton MHK. Mr Cannell was one of three members for Onchan. He was the political member for the Social Services Division from October 1999 to November 2001, when he was not re-elected in the general election.

8.3 On 18 April 2001, Mr Geoff Cannell wrote a note to David Cooke:

> "Further to our telephone conversation earlier today, please will you arrange for Francis Charlton to attend our divisional meeting on Thursday morning. I shall require him to personally fully explain the circumstances which led to the Barton sisters being accommodated at Maple Avenue, Onchan and produce Nugent Care's solution to my requirement to have them transferred to alternative premises forthwith." (emphasis added)

David Cooke sent the Note to Trevor Noden and wrote in handwriting a note at the bottom of the page:

> "Trevor,
> I've had a very difficult telephone conversation with Geoff Cannell this morning. … he is being put under "considerable pressure" by other residents in the same area as the project accommodating the Barton girls. John Houghton is once again making allegations that boys are climbing in thro' back windows of the house to "have sex with the girls". Geoff Cannell has indicated that he feels that politically he doesn't feel it's possible to keep the girls in the house beyond the weekend. Incidentally he has no solutions himself".

8.4 On 18 April 2001, a Resource Meeting in respect of Samantha and Lyndsey was held. Representatives from Priory, MFS and IOM Children's Centre were present; Nugent were not represented. Angela Gilman attended. The minutes state that Samantha appeared to be creating difficulties; she did not want to be in a "project"; she wanted freedom; her behaviour influenced Lyndsey; her mother had a major impact on her stability; and the minutes also referred to violence and criminal damage. Discussions were held about options for Samantha. The Social Services diary sheet records that no decision was reached and that options considered included Mrs Burnell looking after them in a house and "leaving the girls to their own devices". The meeting was adjourned to 9am the next day.

8.5 A Briefing Paper was prepared about the "Barton Family". The Inquiry was told that it was written by Trevor Noden. It is stated to be for the "Department Meeting 20 April 2001" but it seems likely to have been intended for the Divisional Political Meeting on 19 April. It stated that Samantha and Lyndsey:

> "are once again stretching the resources of the Dept and their behaviour is highlighting problems within the system".

The Briefing Paper went on to say that neighbours were complaining about their presence in Maple Avenue, that it would be very difficult to find private accommodation for them, that no residential unit on Island feels able to cope with them and that it was not thought likely that UK will take Samantha because of her behaviour and age. The cottage at Leece Lodge would be available "in six weeks' time". It concluded that "the hope of working successfully with these young women is very, very limited indeed and it is felt that they will continue to offend and be totally disruptive … We may however very soon be in a position where we have nowhere to place these young people, and in particular Samantha".

8.6 On 19 April 2001 at 9 am Ms Gilman met Mr Noden [55]. Her social work diary records: "… final decision for girls to be placed at 22A Derby Road, ground floor flat (MFS), little staff support though, although Trevor agreed for any overtime for myself and Alex."

8.7 On the same day, there was a Divisional Political Meeting. It was attended by Mr Cannell and Mr Cooke. Francis Charlton and Trevor Noden joined the meeting between 10.20 and 11.30 am. There was some discussion about criticisms of Nugent made by Mr Houghton. Mr Noden said that it was suggested that Samantha and Lyndsey be moved to Hope Street (sic), Douglas, which would be staffed and the assistance of the police sought. The minutes state:

> "Mr Cannell said that this was not an acceptable solution and insisted that the girls need to be managed securely, i.e. at Leece Lodge or a similar unit and not at a private address in a residential area. While this will mean making alternative plans for other children/ young people, Messrs Noden and Charlton agreed that a move to Leece Lodge would be progressed as soon as possible with Hope Street being used as a short term option only. Mr Cannell thanked Mr Charlton and Mr Noden for attending the meeting …".

8.8 On 20 April 2001, Samantha was placed at 22A, Derby Road. It was Good Friday of the Easter weekend. The second stage of the move, namely to Leece Lodge took place over four months later, on 3 September 2001.

8.9 The move to Leece Lodge is considered in chapter 9.

8.10 Trevor Noden in his statement to the Inquiry and in his oral evidence maintained that there had been a political instruction by Mr Cannell, as member for the Social Services Division, to move Samantha from Maple Avenue. He said that it was given on 19 April 2001; he understood the political member to be his direct boss [56]. He believed that Mr Cooke had the same understanding. He said that he feared disciplinary proceedings if he did not follow it[57]. When Mr Cannell's denial was put to him, Mr Noden was very clear in his understanding [58]. He said that this was a unique experience. He said that he was very concerned that professional decision-making was being influenced by a politician. Confirming his written statement to the

[55] Day 3: 206
[56] Day 19:113:18-19
[57] Day 19:113 - Day 19:116
[58] Day 19:118 - 119

Inquiry, Mr Noden discussed the issue of the instruction to move to Leece Lodge with David Cooke on a number of occasions; David Cooke never said the instruction did not need to be followed [59].

8.11 Mr Cooke told the Inquiry that he did not regard what Mr Cannell had said on 19 April as a political instruction, although he referred to it as appearing to be one. He accepted that the record of the meeting suggested it was[60]:

> "I believe that I didn't regard that as political instruction, although I can't argue that it was recorded as that. I felt that we weren't going to move that person purely and simply because a politician had said that. That's absolutely clear in my mind. I gave no instruction for her to be moved because of a political instruction".

However, he thought that Mr Cannell was seeking to give an instruction [61]:

> "Q. So let's break that down. Let's be clear about this. Did the political Member at the time give an instruction?
>
> A. He was quite clear, yes.
>
> THE CHAIRMAN: Sorry, you are talking about the Mr Houghton occasion or about 19th April?
>
> A. I am assuming it is the 19th April, sir.
>
> THE CHAIRMAN: Yes. So on 19th April, the political Member instructs you to move Sam?
>
> A. That is my understanding of what he did. I then talked to him about the problems that that would indicate and that -- you know, there was a range of problems that we give. He in fact didn't instruct a move to Leece Lodge he looked -- or somewhere similar. My view is we should look to what are the needs of the young person and how those needs can best be met, on a very limited estate, really, on the island.
>
> MR VERDAN: Let's be clear, because I am not. You are saying they would give an instruction, but you are saying you wouldn't follow it; you would carry out the welfare exercise?
>
> A. Yes. That was a tactic I used to deal with this situation. …"

8.12 At that time Mr Cooke thought that, in theory, a political member could give an instruction on an operational social work matter but that they should not [62]. He said that there had been three occasions when he had received such a direct instruction, the last of which was on 19 April 2001, but that he had not succumbed [63]. When shown his memo to Bryan Morris dated 20 February 1998 saying that an instruction from John Houghton MHK, who was at that time the political member for social services,

[59] Day 19:120:4-23
[60] Day 21: 44:24
[61] Day 21: 47:20 to 48:8
[62] Day 21: 50:9 – 51:9
[63] Day 21: 51: 11 - 52

had to be followed, he said that he could not remember the occasion. But he accepted that on that day his understanding must have been that instruction could be given by the political member and should be followed [64]. David Cooke also accepted that his letter to Roger Woodcock dated 23 February 1998 confirmed his view that the instruction had to be followed [65]. Mr Cooke wrote a memo to John Houghton on 23 February 1998 explaining why the instruction would in fact not be followed [66]. Furthermore, David Cooke agreed these memos suggested that the service providers on the Island were being told that political members could give instructions on such matters [67].

8.13 David Cooke said that these documents highlighted the awkward political situation which existed and he understood therefore why it was that Trevor Noden thought an instruction had been given on 19 April 2001 [68]. David Cooke said he did not remember talking to Trevor Noden after the meeting [69] and that he had not assured Mr Noden that Mr Cannell had not given an instruction [70]. He said that he should have done so [71]. He added that Trevor Noden would not have been disciplined for not following an instruction and he was concerned that Trevor Noden thought this [72]. He said that he only appreciated that Mr Noden feared being disciplined when he became aware of Mr Noden's evidence to the Inquiry [73].

8.14 Mr Cannell told the Inquiry that he did not give a political instruction and indeed that he did not have the power to give such an instruction: "I was never in a position to consider myself capable of issuing instructions" [74]. He added that instruction was possible neither in theory nor in practice. His points of contact in the division were David Cooke and David Gibson, Deputy Director of Social Services [75]. He said that his constituents had raised concerns with him about the behaviour of young people at Maple Avenue [76]. On 18 April 2001 he wrote, in his role as political member, the note to David Cooke [77]. He said that he did not appreciate at the time that officers in social services from Trevor Noden downwards thought a political instruction had been issued; and that had he done so, he would have been extremely concerned [78].

8.15 Neither Angela Gilman, Samantha's social worker, nor Ed Coates, the principal social worker, were involved in the decision to end the placement at Maple Avenue and move her to Derby Road. This was a very unusual situation[79]. Although those making the decision at senior management level had some knowledge of the case, they did not have a report or recommendation from Ed Coates or from Angela Gilman. Mr Coates told the Inquiry that he did not think the move from Maple Avenue was made for welfare considerations. He agreed that his and Angela

[64] Day 21: 53:13-14
[65] Day 21: 57:22
[66] Day 21: 58:24
[67] Day 21: 64
[68] Day 21: 60-61
[69] Day 21: 61:23-25
[70] Day 21: 67
[71] Day 21: 69
[72] Day 21: 62
[73] Day 21: 63
[74] Day 23:132:12
[75] Day 23:121
[76] Day 23:126
[77] Day 23: 135
[78] Day 23: 140-141
[79] Day 11: 50: 25

Gilman's sense of feeling disempowered affected how he worked on the case, in that he was less involved [80]. Trevor Noden told the inquiry that it was fair to say the move from Maple Avenue (and the later move from Derby Road) had nothing to do with traditional social work care planning and for this reason he could understand Angela Gilman's sense of powerlessness [81].

Conclusions as to the decision to move to Derby Road

8.16 The clear conclusion on the evidence is that the decision to move Samantha from Maple Avenue to Derby Road was not made on welfare grounds.

8.17 Mr Cooke understood Mr Cannell to have sought to give a political instruction but that he, Mr Cooke, had deflected Mr Cannell from the insistence on a move to Leece Lodge. Mr Noden believed a political instruction had been given. The written documents indicated that it was an instruction; and they were not corrected.

8.18 Mr Cooke did nothing to correct the impression which Mr Noden had been left with. Mr Cooke accepted that he should have clarified the position for Mr Noden [82].

8.19 Mr Cannell maintains that he did not think that he had the power to give an instruction and that he did not do so on this occasion.

8.20 Mr Cannell is a very forceful personality and expects his views to prevail. Given the evidence of Mr Cooke and Mr Noden, the Inquiry is satisfied that he, Mr Cannell, expected that his "requirement" (upon which he "insisted") would take place, namely that Samantha would be moved to Leece Lodge.

8.21 The Inquiry considers further the role of politicians in chapter 20 [83].

Care and support

8.22 The uncontradicted evidence to the Inquiry was that there was no written care plan, no placement agreement and no written support package.

8.23 There was no educational or vocational plan in place during Samantha's time at Derby Road.

8.24 There was therefore, unsurprisingly, a lack of clarity as what the care and support was to be offered to Samantha.

8.25 Derby Road was an emergency placement. It was intended to be short term, for a matter of weeks, not four and a half months [84].

8.26 Donna Lever was a Team Leader working for Nugent. She said that when Samantha was first placed there, there were no staff living in Derby Road and that she provided outreach support particularly over weekends, going in to check Samantha was safe

[80] Day 11: 53:-54
[81] Day 19:124:6-9
[82] Day 21: 68:9
[83] See also chapter 9
[84] Damian Bradley: Day 16: 127.

and had food and doing her laundry [85]. A document entitled "Outreach Information for Linzi and Sam Barton 20.4.01" set out what was to be provided: 2 staff members available each day from 4-7pm; each was to be given £4 per day for personal items; the Team Leader was available 11am to 4pm Monday to Friday and a mobile telephone number was given.

8.27 Shortly thereafter and following a professionals' meeting, two residential staff were put in as 'caretakers' living upstairs to sort out any problems or difficulties with the placement [86]. It was termed an "After Care Project". There are no proper records of how long these staff were there; the Inquiry was told it was for only a short period. In mid-May immediately following her sixteenth birthday, it was recorded in Nugent records that Samantha was objecting to staff living in, was refusing to comply with requests that visitors leave by midnight and police were being called regularly when young people refused to leave; that Samantha seemed to be under the influence of drugs and/or alcohol regularly; and that Samantha was out late on occasions. Lyndsey was by this time in prison; she was due for release on 26 July 2001.

8.28 Following an assault by Samantha on a member of staff on 21 May 2001, these live-in staff were withdrawn. Donna Lever said at the time Samantha was very clear she did not want staff in the project and it was felt that putting staff in would set her up to fail, make her more aggressive and would criminalize her further [87]. The evidence given to the Inquiry suggested this was an unusual response given that one of Samantha's needs had been assessed to be living with specialist staff and that Samantha's behaviour worsened considerably afterwards. One option, of placing Samantha in secure accommodation for a short period, was not available [88]. Nevertheless, the Inquiry was not told of any proper assessment of the risks for Samantha in the absence of live-in staff. Donna Lever was among a number of witnesses who said that Samantha was not ready to live on her own.

8.29 The decision to pull out the staff appears to have been a joint decision by at least Nugent and social services [89]. Angela Gilman was on leave at the time, from about 3 May until 22 May 2001 [90].

8.30 The position was summarised at the Children and Young Families Resource Panel on 23 May 2001 where it was reported that staffing for Samantha was increasingly difficult because she was assaulting staff. The Panel was also told on 22 May that neither MFS nor Nugent could access the property and that there had been a number of incidents in the property where people as young as twelve had been drinking and/or taking drugs. Trevor Noden said that it was unacceptable that "service providers were providing a place for young people to gather".

8.31 In June 2001, Donna Lever moved to be Team Leader of Leece Lodge 3. From about June 2001, Samantha received support from Nugent Care during the day, primarily through Mark Hoswell and Trish Wilson. They consistently co-worked the case. Manx Family Services offered support in the evening from various members of staff, including Philip Kneen and Ned Guest.

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[85] Day 24: 7: 17 – 8:3
[86] Day 24: 8: 13-19
[87] Day 24: 11: 19-25
[88] Francis Charlton: day 12:124; Adrian Venn: Day 13: 36 -37.
[89] Damian Bradley: Day 16: 125 -126
[90] Day 2: 111

Day time

8.32 Nugent Care were responsible for providing care and support from 8 am to 6 pm , seven days a week. The residential care workers were Mark Hoswell and Trish Wilson. They were specifically selected for that role, probably by Francis Charlton [91] . Nugent and Mr Charlton are to be commended for going through the process of specifically selecting the residential workers to work with Samantha and for the choice made. They were supervised on a regular basis by Adrian Venn, who was their Team Leader [92].

8.33 Mark Howell had 12 years' experience. He told the Inquiry that his role was to encourage Samantha towards independent living by having daily contact and assisting her with the basic necessities for living [93]. Samantha was his only responsibility at the time so he was able to provide one to one care[94]. He said that he had an effective working relationship with Samantha and was able to impose boundaries[95]. He thought overall that, during the day, she did very well at Derby Road . He was asked whether he could see what she needed and he told the Inquiry [96]:

A. " … It might boil down to that she needed a daily shop. Some days she would like to do that on her own and some days she would like someone to go with her. She might just like to get out of the premises and do a bit of window shopping on the street, you know. So she really dictated the way that my role actually took place. But obviously I had set guidelines I had to adhere to from management, but I was willing to give her time to actually -- if she wanted to do something.

Q. You focused on physical and practical needs. I was, I suppose, thinking a little bit more about emotional ones. During the course of your involvement, were you able to understand what her emotional needs were?

A. Yes. I think from my log books, really, I know I wrote about the state of things we were doing but also the state of her health and humour, if you like, how her moods were. And over the period of time I was working with her I think, from my point of view, it was working well, because she became more happy. Her health improved. She tended to eat more regularly. You know, so to me it was working, basically, the routines I was carrying out with her.

Q. So you think from your perspective the placement was working out well?

A. To some extent, yes. I mean, we were working towards independent living. Sam had come back from quite a tight regime of secure from Across into an own unit as such. Obviously there were hiccups in that process of fitting back into society after being isolated, but I think overall she did very well."

8.34 Apart from a couple of visits to the job centre, there is no evidence that any steps were taken towards seeking employment or vocational training for Samantha.

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[91] Day 13: 14 – 14
[92] Day 7: 150:6 ff
[93] Day 7: 141: 5-15
[94] Day 7: 146:16-24
[95] Day 7: 147: 15-25
[96] Day 7: 148:14 - 149:18

8.35 In May 2001, Samantha admitted taking ecstasy. She was thought by Donna Lever to be misusing drugs and alcohol. Theresa Barton understood Samantha to be smoking cannabis at Derby Road [97]. By 23 August 2001, Ms Gilman thought that there was a risk of Samantha using drugs and alcohol to the point of danger and accidental overdose [98] .

8.36 The Inquiry recognises that self-motivation to deal with drug use is a key element. However, there was no plan as to how to work with Samantha about her substance abuse. She accompanied Lyndsey on some occasions when Lynsdey had appointments at the Drug and Alcohol Team in Hill Street [99]. Her first recorded referral in her own right was on 29 August 2001 [100].

8.37 In late July, it had been decided that on her release from prison on 26 July Lyndsey would be placed back with Samantha in Derby Road for a short period before going for drug detoxification treatment; it was felt likely that Lyndsey would have a "last blast prior to detox". Surprisingly in the Inquiry's view, it was recorded that it was not known how Lyndsey's presence might affect Samantha.

8.38 On 4 August 2001, Donna Whelan, a residential social worker, recorded that she visited Derby Road; Samantha, who appeared high, said that Lyndsey had "injected" last night and would not allow Ms Whelan to wake Lyndsey because others were in the flat. Ms Whelan noted: " I am very concerned about the girls".

8.39 On Sunday 5 August 2001, a Nugent worker attended at 22A Derby Road at noon. She found Mrs Rose Burnell there, who said that she was concerned about the girls; they had been out of their heads on drugs for 2 weeks. The worker noted that Samantha's personal hygiene was of concern, her skin was awful and her lips chapped. There were eight young lads asleep in a back bedroom; the house was a complete mess. An emergency meeting to review the placement was suggested. The duty social worker, Kenny Best, was alerted and he arranged for paramedics and police to attend. For a while, Samantha would not let them enter but eventually they entered by back door. Lyndsey was said to be in a deep sleep.

8.40 At the strategy meeting on 14 August 2001, it was also agreed that Angela Gilman would pursue the possibility of Samantha "staying briefly" with Miss Mary Miles in Wales.

8.41 On 15 August 2001, Ms Gilman wrote a Pre-sentence Report on Samantha in connection with charges of assault on the social worker on 21 May at Derby Road, criminal damage on 12 and 18 April and possession of cannabis on 9 July. She said that to some extent social services had lost all power and control over Samantha. She recommended a 6

8.42 month sentence suspended for three months in order to enable those working with Samantha to maintain "a form of motivation". On 16 August, Samantha was conditionally discharged for 18 months.

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[97] Day 16: 31:8-11

[98] Day 3: 17: 25; in oral evidence she accepted that the assessment applied equally to the Island though written in respect of Liverpool.

[99] Day 7: 155; 157: 19-23- 158

[100] See chapter 14

8.43 A further strategy meeting took place on 17 August. No progress in finding alternative accommodation was reported. What were called "supervisory visits" during the day and night were to continue.

8.44 On the night of 16-17 August, Samantha spent the night at Leece Lodge 2 after security was breached at Derby Road. When visited, Derby Road was found to be filthy.

8.45 Mr John Houghton MHK joined a night police shift on 24 August 2001. On 30 August, he wrote to the Minister for the DHSS a letter which included the sentence:

> "Other clients of the Department had either visited or were making their way to the home of the Barton sisters at Derby Road to obtain drugs."

8.46 On 25 August, the Nugent Communications Book records that a police raid took place at 22A Derby Rd; the police entered through Lyndsey's bedroom window.

8.47 On 29 August 2001, Samantha was arrested for permitting her premises to be used for drugs. On 1 September, Samantha told Mark Howell that she had called an ambulance for Lyndsey the previous evening because she had taken her "meds and smack and was well out of it".

8.48 Often during the day, the Nugent workers could not gain entrance to Derby Road. Samantha might be asleep late into the morning. The door would be locked or barred. Sometimes Samantha was reluctant to allow the workers to enter.

8.49 MFS carried out some day time supervision in the latter part of Samantha's stay at Derby Road. The evidence about this was not clear [101] .

Night time

8.50 The problems at Derby Road appeared to increase in the evening and night when large groups of young people would congregate at the property and "party" [102].

8.51 A number of witnesses spoke of being present at Derby Road, including YP1 [103], YP2, Kathryn Green and Lyndsey Barton. In the witness statements of YP1 and YP2, they say that they knew Samantha "very well" and saw her frequently. Both describe Derby Road as "a party house". YP1 stated:

> "A number of people myself included regularly used to stay the night at Derby Road… there would always be lots of people there…".

YP2 stated:

> "Sam did what any other 15 year old would have done which was have lots of mates round and have parties".

[101] Philip Kneen [Day 7: 73; 84; 85:24].
[102] Mark Hoswell said that the situation was definitely different at night compared to during the day, the day being relatively quiet and trouble free [Day 7: 165:21-166: 2].
[103] Young Person One. YP1 and 2, whose identities were known to the Inquiry, were not required to give their names publicly. This step was necessary to preserve the anonymity of their private lives and to assist the Inquiry.

Both report extensive use of drugs at Derby Road. YP1 said: "Drugs were always around, it was a part of life. We would often stay up all night on drugs… Everybody who was there was doing drugs." YP2 said: "Just about everybody who used to go round to Derby Road… used to be into drugs. It was mostly party drugs such as cannabis, ecstasy and speed…". Lyndsey Barton said:

> "all it was for, Derby Road, was basically house parties for smoking dope and that was it, really, parties and having a smoking session".[104]

8.52 In her oral evidence, Lyndsey Barton said when asked about noise levels at Derby Road, "Do you mean… that mostly the nights were quite noisy?" "Oh, it was a mad house"[105].

8.53 Kathryn Green told the Inquiry:

> "Derby Road became the place to hang out...It got a reputation of being a party house...there was people coming in through windows and things like that, when Samantha would be asleep and say I was sleeping there too. She didn't know how they were getting in through the windows, because she would lock them at night but they were still getting in. Nine or ten people were visiting her...When Sam moved in there it was everybody just, instead of meeting up in town would just meet there."

8.54 There was a conflict between the evidence of these witnesses and those of MFS workers as to the frequency of visits at night by MFS. It is not necessary to resolve it. However, it is clear that the level and frequency of MFS visits was insufficient to prevent the "partying", reports of which exist from numerous sources.

8.55 The Inquiry has considered the level of care and support offered by MFS in the evenings and night. They certainly only saw their role as being to 'keep Samantha safe.' They did not see their role as being interventionist or proactive. Philip Kneen told the Inquiry:

> "all we could really do was keep her safe because she didn't want to do anything else" [106]

He said that all he was asked to do was check on Samantha; if he had been asked to do more he would have done it, but he was not asked [107]. In his statement to the Inquiry he said:

> " … we were asked to keep Samantha safe and that is what we tried to do. If there was anyone there who wouldn't leave we called the police. If there were only a few friends there who we knew, we let them stay but if there were a lot, we called the police. When we visited we checked that she was OK, that she had enough food, clean clothes and that there were no undesirable people there. Samantha was checked every two hours. First in the evening, sometimes till 2am and then from about 9.00am through till 11pm or later. …

[104] Day 10: 91
[105] Day 10: 92
[106] Day 7: 70-72
[107] Day 25:37:24]

> An oldish man started staying and we threw him out but he would be there again in the morning so after 3-4 days we put his things out on the street and he left."

He also said:

> "We used to get rid of anyone who wasn't supposed to be there. We used to search the building including the loft for any young people because they used to go and hide."

In his further statement, he said:

> "I carried out my duties as I was told, which was that we were there to check the property, make sure there were no undesirables and to make sure that Samantha was there. Our role did not include handing out monies, drug and alcohol counselling, transporting from place to place or engaging in planned activities."

8.56 Ed Coates the principal social worker at the time said that his understanding was that keeping Samantha safe was not MFS' sole purpose [108] .

8.57 Philip Kneen was an unqualified residential social worker with 3 years' experience employed by MFS; in oral evidence [109] he said he received a 2-3 week induction, was made aware of the staff handbook and received on the job training. He received daily informal and monthly formal supervision from Victor Whiteside, his supervisor [110]. He did not read Samantha's social service file or the MFS file and did not think it necessary or appropriate to do so, as he would be told anything that was relevant by Victor Whiteside [111]. However he was not aware, for example, of Samantha's interests [112]. His co-worker was Ned Guest, who had 2 years' experience. Philip Kneen and Andrew (Ned) Guest reported direct to either Richard Kneen or Victor Whiteside.

8.58 Philip Kneen said he was visiting Derby Road every 2 hours and then towards the end of the placement every hour, from 8pm to 3am [113]. The visits he explained were primarily to deal with the numbers of young people visiting the house and their behaviour whilst there. He said the most he had seen there was twenty. He said they were not noisy and he saw evidence of alcohol use but not drug use whilst Samantha lived there although he saw young people 'under the influence' [114]. He did not see his role as an interventionist one, for example, to try and help her deal with her drug problems [115].

8.59 The checks conducted by MFS in the evening were sometimes done from outside the house by peering through the window or letterbox [116]. Philip Kneen said that:

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[108] Day 11: 88: 15
[109] Day 7: 59
[110] Day 7: 64
[111] Day 7: 65-67
[112] Day 7: 75: 19-20
[113] Day 7: 73; Day 7: 84-85
[114] Day 7: 90 -93
[115] Day 7: 99
[116] Philip Kneen Day 25:23:25

> "going into the house aggravated things, so we didn't like to aggravate [Samantha] by going into the house [117]" .

8.60 The consequence of this method of checking was that a visual check could not allow the MFS workers to know whether anyone was upstairs or what they were doing [118]. Also, Samantha and those in the house would not necessarily know that a check was happening, thereby re-enforcing in their minds that they were free to continue with their activities. There seems to have been a lack of clarity about what the MFS staff were meant to do. Philip Kneen maintained: "I wasn't there to monitor the activities of all the other kids that went to the house". When re-called to give further evidence, Philip Kneen said they always went into the house after dark because "it was never quiet at night. There was always people in there" and he claimed that MFS entered the house 4 or 5 times an evening [119].

8.61 The Inquiry heard evidence from Philip Kneen of an occasion when the door of Derby Road was "kicked down" by Ned Guest [120]. Philip Kneen explained that "the door was kicked down because we were not allowed in" [121]. Adrian Venn said that he would only countenance kicking down a door to a young person's home in a life threatening situation [122] .

8.62 If Philip Kneen is correct about this incident, it was, in itself, an inappropriate way of gaining entry to a young person's home (it not being a true emergency) and was indicative of the poor quality of care by MFS staff at that time.

The accommodation at 22A Derby Road

8.63 22A Derby Road was bought by MFS in 2000 in order to do it up into four flats and to use it as a leaving care project; at the time that Samantha moved in, it had not been done up [123]. MFS agreed to make it available for Samantha. It received £20 per day for doing so [124] . Having only one or two days notice, basic tidying up was done by MFS by taking out the old furniture and cleaning the interior [125]. It was a large four story building with various points of entry. The front door was secure but the back door was not at various times. Mr Venn said Samantha complained about feeling unsafe there [126] and there are recordings in the Nugent log to that effect. Samantha's flat was on the ground floor with her bathroom and lavatory on the first landing.

8.64 Concerns were expressed in oral evidence about the physical state of the property with wide ranging descriptions of its condition and at least two professional witnesses saying they would not have been happy with their own children being placed there.

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[117] Day 25:27:2
[118] Day 25:27:5
[119] Day 25:27-28
[120] Ned Guest is now in Canada and did not have the opportunity to give evidence to the Inquiry about this incident.
[121] Day 7:122 - 124]; Day 25: 29.
[122] Day 13: 29: 13-16
[123] Richard Kneen [Day 8:58]
[124] Day 25: 58
[125] Day 25: 53
[126] Day 13: 28:25

8.65 Donna Lever said that internally the building had not been lived in for a while and was in need of repair but that she arranged contract cleaners to clean the carpets, walls, kitchen and bathroom prior to the girls moving in[127]. She said this made it better but it was far from ideal. In retrospect she was not happy placing the girls there and she may have voiced her concern then that it was a very large building and difficult to ascertain who was in the empty rooms upstairs. She said that she would not have been comfortable there and she would not have wanted her own teenage children there[128].

8.66 Donna Lever and a number of other witnesses said that the condition of the property deteriorated but that Samantha kept her bedroom and living area tidy [129]. The floors above the ground floor flat and half landing were not supposed to be used by Samantha or others. However, although locks had been put on the doors of the rooms of the other floors to prevent their use, the doors were forced open during the course of the summer [130]. This enabled these rooms to be used by the constant stream of casual visitors to the house. This added to the poor conditions in the house. Richard Kneen told the Inquiry that he would not have used it except as an emergency placement[131].

8.67 The situation was best summarised by Adrian Venn who said he would not describe it as 'derelict' but it was in need of decorating at least. He said:

> "it needed freshening up; it needed a make-over. It would be very difficult to have a sense of pride, a sense of ownership, in a building such as Derby Road was at the time" [132].

He continued:

> "My own personal and professional yardstick is that I should be happy to place a young person in accommodation that my own children would live in. Derby Road, I wouldn't ask my sons to live there."[133]

8.68 Angela Gilman did not visit the property before Samantha was placed there but did so later on 20 April 2001.

Social Services' monitoring of the care provided by Nugent Care and MFS at Derby Road

Communication

8.69 The evidence suggests that the MFS workers did not read the social service files nor the Nugent Care ones; and that there was no formal system for the sharing of information between the two service providers.

[127] Day 24: 9: 10-16
[128] Day 24: 10: 13-17
[129] Day 24: 14: 4-18, 25
[130] Day 25: 40: 18
[131] Day 25: 52
[132] Day 13: 27:20
[133] Day 13: 27: 10-15

8.70 Mr Hoswell explained that he would contact Angela Gilman direct if he had an issue to discuss with her. Adrian Venn shared his misgivings about Derby Road with Mr Charlton and Mr Bradley. However, it seems that no-one from Nugent management discussed them with social services although he agreed someone should have done so [134].

8.71 Nugent and MFS should have sent regular written reports to social services, but Ms Gilman said that she did not receive them on either a regular or weekly basis [135].

8.72 Communication between Nugent and MFS staff was informal. Adrian Venn told the Inquiry that at the time he thought it was adequate, but has since accepted that it was not effective. These informal means did not accord with best practice: there was no agreed formal means of sharing or pooling information about what was going on in Samantha's life. For example, Mark Hoswell never saw MFS' log book but he did quite often, normally by chance, see the workers and thereby discuss issues and he did telephone MFS on occasion with concerns [136]. This log book was not available to the Inquiry. It has never been found, allegedly having been handed to the police in the aftermath of the murders[137].

8.73 Philip Kneen accepted that communication between MFS and Nugent Care was not very effective [138]. Consequently he was unaware of some of what was going on in Samantha's life.

8.74 When he took over management responsibility, Adrian Venn arranged for the residential social workers in his team (Mark Hoswell and Trish Wilson) to read Samantha's social service file. He himself did not read Samantha's social services file, which he frankly told the Inquiry he should have done. It is important that those working with a child or young person should have read the key documents on the child: this enables them to understand better how to care for the child.

8.75 Not surprisingly therefore neither the DHSS, Nugent Care nor MFS were aware of all the significant events which occurred at Derby Road. Put simply, key information relating to Samantha's care was not shared and no one had the full picture. All agreed that the full picture now known by all was even more alarming than what was known then.

Monitoring of service providers

8.76 In 2001 and 2002 the monitoring of service providers by social services was done primarily through Partnership Meetings and visits by social workers[139]. Accordingly social services were not aware whether Nugent or MFS were carrying out their responsibilities towards Samantha. Ed Coates told the Inquiry that Angela Gilman did not visit the placements frequently enough or read the service providers logs [140]. Ms Gilman in her oral evidence drew a distinction with reading the records and logs

[134] Day 13: 38
[135] Angela Gilman: Day 3:6-7
[136] Day 7: 151:2-17; 153: 9-14; 180: 2-6
[137] As to the MFS records on George, see chapter 12
[138] Day 7: 125
[139] Ed Coates [Day 11: 77-80]
[140] Day 11: 79

at St Catherine's, implying that she read such Derby Road logs as she was provided with.

8.77 Ed Coates accepted that in the summer of 2001 he did not know the precise detail of the service provided by MFS for Samantha and agreed that this was a dangerous situation to be in. He explained this was because they were a new service and the DHSS was quite trusting of it and reliant on it. He told the Inquiry [141] :

> "Q. Why didn't you know what MFS were providing?
>
> A. Well, I think the amplification will sort of help with that, which is to say, I think, that there were – the department was quite trusting of that organisation. We were very grateful to that organisation, because they had resolved a number of difficulties for us with an enormous amount of flexibility. I think increasingly we were becoming aware that, whilst there was a very positive, flexible response, that there were downsides to this, and some of the downsides were lack of information and lack of, as it were, structures and processes within them as a growing organisation. So I think we were becoming aware at that point that it wasn't – that we didn't know absolutely everything about how things were operating then. And I would say I did have some concerns about those, which I did discuss with my line manager and in partnership meetings, but again, it was a developing service and getting people to understand what the needs for those things were took time."

8.78 Mr Coates said that although at the time social services had a fuller picture of what Nugent were providing, he was not sure now that, because of the inadequate system for monitoring service providers, Nugent was actually delivering that provision [142].

8.79 He continued [143]:

> "A. [Nugent and MFS] came from very different origins and they had a very different flavour. If I may sort of take a moment just to distinguish between the two organisations. MFS were an organisation who were growing up, as it were, from nothing. A small number of people. You have heard from the directors at the time, who had operated from other care providers, but they were starting a new organisation. They didn't have a culture that had procedures and policies. They didn't have a culture that had a lot of paperwork and support. They weren't actually giving us a huge amount of information and saying. "This is what we are offering, do you want it or not?" They were building it up as they went along. Nugent Care, on the other hand, were an already established organisation who had a large amount of paperwork and supportive information which, as it were, painted a picture of the sort of services that we would be buying from them.
>
> Q. I follow.

[141] Day 11: 84 - 85
[142] Day 11: 85
[143] Day 11: 85 - 86

A. But they were different. The realities were slightly different from the image that those papers presented."

8.80 Social services were in a dangerous position in 2001 in not knowing in some detail what their service provides were providing for a child for whom social services had statutory responsibility[144].

Conclusions

8.81 Earlier in this chapter, the Inquiry set out its conclusions on the decision to place Samantha at Derby Road.

8.82 Derby Road was an emergency placement and Samantha had to be moved there very quickly [145]. Not for the first time in Samantha's life in care, the Inquiry heard that there were said to be no other options. Adrian Venn said that it was not the right placement: the building was not good and the move was rushed but there were not many options [146]. Angela Gilman thought this placement met her three criteria less than Maple Avenue. The witnesses did not think that the move was made on traditional 'welfare' grounds or as a result of 'care planning.' Trevor Noden thought it was an unsuccessful placement and probably less successful than Maple Avenue. Ed Coates thought Derby Road was a "completely inappropriate" placement. No witness strongly disagreed with him. David Cooke, Director of Social Services, told the Inquiry that Derby Road was a "disaster" as a placement[147] .

8.83 The Inquiry respects the frankness displayed by Mr Cooke, Mr Noden and Mr Coates in voicing such opinions. The Inquiry is of the same view.

8.84 Yet it should be noted that from time to time in 2001, unrealistic views were expressed of Samantha's progress at Derby Road. For example, at a Strategy Meeting on 23 July 2001 on Samantha and Lyndsey (who was due for release from prison on 26 July), it was stated that "Recently Sam has been managing living independently with fairly minimal intervention by staff."

8.85 Derby Road was an inappropriate placement for Samantha. It was a less appropriate placement than Maple Avenue. The decision that she leave Maple Avenue and move there was taken by social services. It is recognised that the placement was an emergency placement and was intended to be temporary. Damian Bradley reminded the Inquiry that "Stopgap situations are not the most appropriate places, but we work in the real world and sometimes stopgap situations happen [148] " .

8.86 The Inquiry is clear that Samantha should not have been moved from Maple Avenue without a proper plan and proper arrangements for her short term and longer term care. There was no need to do so, other than the "instruction" to do so by the political member [149] .

[144] Day 11: 85 - 86
[145] eg Adrian Venn [Day 13: 24: 23-25]
[146] Day 13: 26: 5-9
[147] Day 20:8:15
[148] Day 16:115
[149] See above.

8.87 No proper risk assessment was carried out. A risk assessment would have exposed the weaknesses in the proposed placement.

8.88 Even if there had been no alternative but to do so, there should have been a careful assessment of her needs, a clear care plan based on that assessment and a clear placement agreement setting out who was to provide what services in order to meet those needs. Social services had the responsibility to do that. The lack of clarity meant that service providers did not provide what social services understood them to be providing [150]. Furthermore, even if it had been necessary to move her to Derby Road on an emergency basis, this should only have been a temporary move and she should not have remained there for over four months.

8.89 For much of the time, Samantha was out of control at Derby Road [151]. She was living a dangerous lifestyle. She was involved in drug taking, abuse of alcohol and criminality; she was out late at night on occasions; regularly there were large groups of young people partying or staying over night at Derby Road. She was a very troubled girl. She realised at times the lack of wisdom of living with Lyndsey while Lyndsey was abusing drugs, yet wanted to remain with her. Samantha was clearly not ready to live on her own and the time spent at Derby Road was not used as part of a process of preparing her (even at such a late stage) for adult life and independence.

8.90 The lack of a written care plan and placement agreement contributed to the vagueness and lack of structure in the arrangements for Samantha's care at Derby Road. The arrangement felt temporary [152]. There was no appropriate plan with which to work towards independence. The arrangements put in place did not help to keep her safe from harm.

8.91 The evidence suggests that the care and support given by Nugent Care and Mark Hoswell and Trish Wilson during the day was appropriate and effective within the confines of what they were asked to do. They saw their role as being to encourage her towards independent living by assisting her with everyday basic necessities. However, this role was too limited. An insufficient attempt was made to give structure to her day or to prepare her for employment and living on her own. The evidence given to the Inquiry makes plain that the limited role given to the Nugent workers and the unsuitable arrangements meant that Samantha's placement at Derby Road was an unconstructive time for her and placed her at risk of harm.

8.92 Once the decision to withdraw live in staff had been made and endorsed by social services, care could only have been provided in the evening and at night by visits along the lines of visits every hour or so and by staff remaining with Samantha. Given the high level of risk that Samantha posed for herself - drugs, alcohol, criminality, aggression - and given that it was plain that she was not ready to live on her own, checking on her from outside was inadequate to ensure that Samantha was safe. The evidence suggests that evenings and nights remained times of great difficulty and that Samantha remained very vulnerable. MFS saw their role as limited. Richard Kneen thought Samantha had been protected while at Derby Road, adding:

> "to put it bluntly she was alive when she left" [153].

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[150] See above.
[151] eg Damian Bradley: Day 16:128 – 129; Victor Whiteside Day 9: 38-39.
[152] Adrian Venn: [Day 13: 23 - 24]
[153] Day 8: 166:12-13

8.93 Significantly, as a result of the evidence relating to the care and support offered by MFS at Derby Road, the DHSS have decided to carry out an independent review of MFS, whose practices were described by Ed Coates as "crude and unimaginative". MFS remains a service provider on the Island and accordingly the decision to hold a review is a responsible course [154].

8.94 It is, the Inquiry believes, the inescapable conclusion arising from the evidence relating to the placement at Derby Road that that Samantha was not ready to live on her own or equipped for so-called independent living.

8.95 Samantha was in the care of social services. Although Nugent were caring for her at Derby Road, assisted by MFS, social services remained responsible for her care. The Inquiry concludes that Angela Gilman and her principal social worker Ed Coates were primarily responsible. It is recognised that both felt a degree of powerlessness given the involvement of more senior managers in the case at times. More senior mangers, such as Trevor Noden and David Cooke, must also bear responsibility for the failings of the placement. Social services failed in its responsibility to ensure that there was an assessment of her needs, a clear care plan based on that assessment and a clear placement agreement setting out what services Nugent and MFS were to provide. Deciding the level of care and support provided to Samantha and ensuring that it remained adequate was the responsibility of social services.

8.96 Samantha's social worker should have assured herself that the accommodation itself was suitable and remained so. Social services should have monitored the level and effectiveness of what Nugent and MFS were providing for Samantha. Monitoring of Nugent and MFS was inadequate [155] . Samantha's social worker should have known and made sure that she knew what was happening in Samantha's life. Her managers should have made sure that she was doing so.

[154] See further chapter 18
[155] See chapter 18

CHAPTER 9

LEECE LODGE 2

The move to Leece Lodge

9.1 At the time of Samantha's move from Maple Avenue, the intention had been that Samantha should move to Leece Lodge (see chapter 7, above). Derby Road was a temporary placement which stretched beyond the time scale originally envisaged.

9.2 On 3 May 2001 a Divisional Political Meeting was held. The minutes record:

> "Mr Cooke reported that Lyndsey Barton was currently on remand. Mr Cannell queried if the plan to move the Bartons to Leece Lodge was still going ahead, which Mr Cooke affirmed. …"

9.3 At a Resource Panel meeting on 9 May 2001, it is recorded that:

> "Trevor Noden confirmed that the political instruction that the girls be placed at Leece Lodge remained and that this should remain the assumption unless otherwise informed…Placement at LL to continue as plan for SB, despite reservations from the panel that this would be a retrograde move & possibly impact on other placements" (emphasis added)

9.4 At the Resource Panel on 23 May 2001, Trevor Noden "reminded the Panel that the decision had been made to move SB to Leece Lodge and said that decisions made by the panel should be adhered to as far as possible".

9.5 On 26 July 2001 a Divisional Political Meeting was held. The minutes record:

> "Mr Cannell asked when Samantha Barton would be accommodated at Leece Lodge as per his previous instruction. Mr Cooke advised that there would probably be more problems were she to be placed there, as she would impact on the current residents." (emphasis added)

9.6 As noted in chapter 8, in late July, it had been decided that on her release from prison on 26 July Lyndsey would be placed back with Samantha in Derby Road for a short period before going for drug detoxification treatment; it was felt likely that Lyndsey would have a "last blast prior to detox".

9.7 On 4 August 2001[156], Donna Whelan, a residential social worker working for Nugent, recorded that she visited Derby Road; Samantha, who appeared high, said that Lyndsey had "injected" last night and would not allow Ms Whelan to wake Lyndsey because others were in the flat. Ms Whelan noted: "I am very concerned about the girls". On Sunday 5 August 2001, a Nugent worker attended at 22A Derby Road at noon. She found Mrs Rose Burnell there, who said that she was concerned about the girls; they had been out of their heads on drugs for two weeks. The social worker noted that Samantha's personal hygiene was concerning, her skin was awful and her

[156] Some events in Samantha's placement have been included in both chapters 8 and 9 in order to assist the narrative

lips chapped. There were eight young lads asleep in a back bedroom; the house complete mess. An emergency meeting to review the placement was suggested.

9.8 On 8 August 2001, a strategy meeting was held on Lyndsey and Samantha because Mrs Brenda Cannell MHK had been requesting that the girls be moved out of the area:

> "complaints had been made to Mrs Cannell about threatening behaviour exhibited by the girls or the people they attracted to Derby Road."

It was recorded that

> "Mrs Cannell has informed Richard Kneen that she is aware of his responsibility for the property and Richard feels his position of offering Derby Road as somewhere for the girls to remain is now untenable".

It was decided that Richard Kneen was to explore possibility of renting somewhere rural on the girls' behalf. Damien Bradley was to contact Nugent Care in Liverpool to see if an off-Island placement could be found.

9.9 The Inquiry has not been given any document relating to the "request" by Mrs Cannell referred to in meeting of 8 August [157] .

9.10 On 14 August 2001 a Strategy Meeting on Samantha and Lyndsey was held to update the current situation with the girls and with finding alternative accommodation. In Ed Coates' absence, it was chaired by Julia Gilbert, who also managed Lyndsey's case [158]. Angela Gilman, Damian Bradley (from Nugent), Alex Watson and Richard Kneen (from MFS) also attended. Both girls had been seen by Damian Bradley in the previous week under the influence of "some substance". Samantha was said to be more challenging since Lyndsey had been released from prison. Nugent could offer nowhere off-Island. No alternative accommodation was available in a rural location or in bed and breakfast. It was concluded that Leece Lodge was the only resource "worthy of any further consideration". After the strategy meeting, Julia Gilbert met David Cooke and David Gibson and an Addendum records that it was agreed that the current placement was "highly unsatisfactory". Leece Lodge was "felt on balance not to be a viable alternative" for five reasons. Four concerned the four existing residents who would be disrupted. In addition the likely positive outcomes for Samantha and Lyndsey were thought to be "unclear" given their lack of co-operation with staff so far. It was decided that Derby Road was unsuitable, but as there was no alternative, the girls could not be placed elsewhere; and that David Gibson would brief Mr Cannell.

9.11 At the strategy meeting on 14 August 2001, it was also agreed that Angela Gilman would pursue the possibility of Samantha "staying briefly" with Miss Mary Miles in Wales.

9.12 On 15 August 2001, Ms Gilman wrote a Pre-sentence Report on Samantha in which she said that to some extent social services had lost all power and control over Samantha [159]. On 16 August, Samantha was conditionally discharged for 18 months.

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[157] Simcocks in their letter to the Inquiry 26 July 2005 point out that the social worker's diary sheet wrongly refers to 9 May instead of 8 May

[158] There is some confusion as to who was managing Samantha's case at this point: see chapter 17

[159] See chapter 8

9.13 On 16 August 2001, there was a Divisional Political meeting attended by Mr Cannell and David Gibson; Mr Cooke did not attend . The minutes record:

> "Mr Gibson reported that the Barton girls were still causing problems in their current accommodation. Mr Cannell stated that, as far as he was concerned, an undertaking had been given to him that they would be moved to Leece Lodge at a previous meeting in May, and he felt that this should now occur as soon as possible. At the time in May, he understood that there were three brothers in placement who were shortly due to be placed elsewhere, and he had agreed – for their sake - to hold off placing the Bartons until the situation with the boys was settled . Mr Gibson explained that it was felt to be very difficult to place the Bartons at Leece Lodge given that all the Units were currently occupied by children with a similar range of difficulties. Mr Cannell stated that it was unreasonable for members of the Community to suffer disruption from the Barton girls and that they should be placed in our accommodation where at least they would not be causing disruption to the Community . His expectation was that the girls would be placed at Leece Lodge as soon as possible. Mr Gibson said that Officers would do their best to deal with what was a very difficult situation." (emphasis added)

9.14 Mr Cannell then left for 2 weeks' annual leave and was due to return for the next Divisional Political Meeting on 6 September.

9.15 A further strategy meeting took place on 17 August. No progress in finding alternative accommodation was reported. What were called "supervisory visits" during the day and night were to continue.

9.16 On night of 16-17 August, Samantha spent night at Leece Lodge 2 after her security had been breached at Derby Road.

9.17 On 22 August, the social work diary records a meeting "to discuss accommodation" and that the girls had to leave by 4 September. A Children and Families Resource Panel met that day. It recorded that "the girls must leave Derby Road within a few days" and that there were "continuing political pressures re the accommodation of the girls". Two proposals were formulated, the preferable one being that Samantha move straight to Leece Lodge 2.

9.18 On 23 August a meeting took place at Nugent premises in Willaston, chaired by Francis Charlton and attended by Damian Bradley, Diane Watts, Adrian Venn, Donna Lever and Stella Shimmin at which arrangements for Samantha at Leece Lodge 2 were discussed.

9.19 The evidence from all the social service witnesses, save David Cooke, was that the placement at Derby Road was ended as a result of continuing political pressure from Geoffrey Cannell MHK and because of an instruction having been given by Mr Cannell to move Samantha.

9.20 As the Inquiry has noted above in chapter 8, the Inquiry is satisfied that given what Mr Cannell said at meetings (his "expectations" and "his insistence" regarding the implementation of his views), coupled with his forceful manner no professional officer was left in any doubt about his intentions as to Samantha's placement at Leece Lodge.

9.21 Whether a political instruction was given or not, it is important to note that the social work professionals thought one had been given and so did not exercise their professional judgment in deciding on the placement. Moreover, more than one witness spoke of feeling disempowered. Furthermore, Mr Cannell lacked professional expertise in this field; this meant that he had insufficient knowledge to test the professionals as to the likely success of any support and care package which might have made Leece Lodge more successful than , or just as unsuccessful as, the previous two recent placements.

9.22 David Cooke and Trevor Noden tried to buy time to find Samantha an alternative, and more suitable, accommodation. It should be borne in mind that political instruction or not, social services had had five months from the Divisional political meeting on 19 April in which to find a more suitable alternative to Derby Road and Leece Lodge, and had not been able to do so. Trevor Noden said that by the end of the summer, social services had nowhere else to offer and were therefore accepting the inevitability of a move to Leece Lodge. David Cooke said that there was no alternative [160]. However, Trevor Noden told the Inquiry that had there not been political pressure, Samantha would not have been placed at Leece Lodge 2; social services would have looked for an alternative private rented house similar to Maple Avenue, or possibly a bit more rural [161].

9.23 Trevor Noden did not tell Mr Cannell what the arrangements for Samantha's care and support would be at Leece Lodge [162].

Conclusions

9.24 The Inquiry has already stated some conclusions in respect of the political "instruction" in chapter 8 above [163]. Mr Cannell had made it clear that he "required" Samantha to be placed at Leece Lodge. This was conveyed as an instruction to senior staff. Subsequently, he reiterated his "previous instruction" to move Samantha to Leece Lodge and that he expected it to happen.

9.25 It was understood by all senior staff , save David Cooke, as an instruction which had to be followed. Although senior management sought to delay implementation, Mr Cooke did not resist the "instruction", as he should have done in this case, by confirming the boundaries of accepted practice in relation to decisions affecting children's welfare.

9.26 Senior management never presented Mr Cannell with the five reasons that were agreed as being arguments against the placement at Leece Lodge.

Mrs Brenda Cannell MHK

9.27 Richard Kneen made a separate allegation that he felt under massive pressure from Brenda Cannell MHK to have Samantha moved from Derby Rd. In the light of Mrs Cannell's position as a member of the House of Keys, it was a serious allegation.

[160] Day 21: 76 - 77
[161] Day 20:2-3
[162] Day 20: 8
[163] To which reference should be made

9.28 Mrs Cannell has represented the constituency of East Douglas (of which the Derby Ward local authority constituency forms part) as a Member of Tynwald since 1996. Previously, she represented the Derby Ward constituency (including Derby Road) on Douglas Corporation between 1992-95. In August 2001, in addition to her constituency duties, Mrs Cannell had the following responsibilities relevant to young people and social services: Member for the Department of Education and Chairman, Student Awards Committee and Chairman, Select Committee on the Petition for Redress of Grievance of Jill Dugdale [164].

9.29 In August 2001, following complaints from constituents, Mrs Cannell made several representations to social services relating to reported activities at 22A Derby Road. She spoke to Trevor Noden, then the Service Manager, and to Julia Gilbert, who was chairing meetings concerning Samantha's case for a period [165]. The thrust of Mrs Cannell's representations was that Samantha and Lyndsey's placements at Derby Road - and, in particular, the apparent failure to provide adequate control or supervision - had been causing a number of her constituents in the neighbourhood very serious difficulties; that the situation had deteriorated and had become intolerable; and that a more appropriate placement should be found for Samantha. She also pointed out that the property in Derby Road was apparently being operated in breach of planning law.

9.30 Later in August 2001, Mrs Cannell asked Richard Kneen to meet her to discuss Samantha and Lyndsey. Mr Kneen was accompanied to this meeting by Victor Whiteside. At the meeting, Mrs Cannell made the same points [166] .

9.31 Mrs Cannell did not "instruct" or seek to instruct social services what to do about Samantha.

9.32 Given what was happening at Derby Road, the fact that representations of this nature were made by the constituency member was understandable. Indeed, by August 2001, Richard Kneen himself was expressing concern that the girls continued placement at Derby Road had implications for the reputation of MFS [167] . Mrs Cannell accepts that she made her representation in strong terms. However, these were legitimate representations for a member of Tynwald to make on behalf of her constituents.

9.33 Mrs Cannell only recalls one meeting between herself and Mr Kneen and Mr Whiteside. She does not recall a second meeting. Mr Kneen and Mr Whiteside, by contrast, think they can recall a second meeting to update Mrs Cannell on Samantha.[168] It is unnecessary to make a finding about whether there was a second meeting.

9.34 Mrs Cannell recalls that she telephoned Mr Kneen on 3 September 2001: this recollection is based on her own memory and, particularly, her diary note of that date.

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[164] At a sitting of Tynwald on 14th July 1999, the following motion was approved: "That a Select Committee of five Members be appointed to consider the Petition of Redress of Grievance of Jill Dugdale presented at Tynwald assembled at St. John's on 6th July 1998, to the extent that it seeks a review of the policy of the Department of Health and Social Security on the range of types of services which are offered, or could be offered to members of the handicapped community, their families and their carers; and report."

[165] Whether she was "managing" Samantha's case for a while is not clear: see chapter 17

[166] Day 8: 74: 9

[167] Minutes of strategy meeting on 17 August 2001.

[168] Day 8: 65: 17 (described as *"conversation"*, but meaning 'meeting'); Day 9:41:22.

It is possible that Mr Kneen and Mr Whiteside may have confused this telephone call with a second meeting.

9.35 Richard Kneen made certain serious allegations about what Mrs Cannell said to him when they met.

9.36 In his written statement to the Inquiry, Mr Kneen said:

> "Mrs Cannell said she didn't care where Samantha went as long as it was out of her area and then went on to say that she could go to Ramsey. I asked why Ramsey and she relied [sic] because it was Alan Bell's constituency and she didn't like Alan Bell."

He continued:

> "Derby road [sic] was not ideal but I was against the move to Leece Lodge and told Mrs Cannell that I didn't believe it was a safe place for Sam because of its isolation and it being a difficult place to supervise if staff weren't in residence. She replied she didn't care."

9.37 These allegations were first aired in Richard Kneen's letter of 10 February 2005 sent to the Inquiry. There are no documents originating in 2001 to corroborate these allegations.

9.38 These allegations were much diluted in the oral evidence given by Mr Kneen. The allegation that Mrs Cannell said that she did not care was not corroborated by Mr Whiteside at all. In particular, in respect of the alleged remark about not caring, Mr Kneen said that he did not think it was meant by Mrs Cannell as meaning that she did not care about Samantha [169] . He told the Inquiry.

A. "…she said, "It doesn't matter", or, "I don't care", pr something like that.
Q. So this allegation which in fact you make in your statement you say occurred at the second meeting?
A. Yes.
Q. It is only right and proper – because again this is a potentially very serious allegation, Mr Kneen, which you appreciate?
A. Of course, yes.
Q. For you to give as precise a detail of the context in which those comments were made.
A. The context. I don't think she meant it as – I don't think she meant, "I don't care about Samantha Barton". I don't think that was what she was saying. I think it was in the context more like, "I really don't want to know about this. As long as it goes away, I am happy". I think it was made in that sort of context.
Q. I see. Well, that is a very important distinction, because the headline quote, "I don't care", could be misconstrued if it was not explained in the way that you are now attempting to. Do you agree?
A. Absolutely.

9.39 This was the first indication given by Mr Kneen that the remark did not bear the more serious and adverse meaning.

[169] Day 8: 79:20

9.40 Mr Kneen told the Inquiry that he felt "intimidated". Mr Whiteside said that at the meeting (or meetings) Mrs Cannell had not been unfriendly or said anything "inappropriate".

9.41 On all the evidence, the Inquiry concludes that at the meeting Mrs Cannell, on being told by Mr Kneen that MFS had a number of properties but that they were all full, asked whether MFS had anywhere in Ramsey which might be available. Mr Kneen replied by stating that discussions were ongoing with a sympathetic landlord who was expecting one of his flats in Ramsey to become vacant. When Mrs Cannell left the meeting, she understood that, as and when the flat became vacant, Samantha would move there. Mrs Cannell did not say that "she didn't care where Samantha went as long as it was out of her area" or that she "did not care" about Samantha. Furthermore, the Inquiry does not find, on the evidence, that Mrs Cannell responded to the question "Why Ramsey?", that it was Alan Bell's constituency and that she did not like Alan Bell.

9.42 Richard Kneen told the Inquiry that he appreciated that the allegation about not caring was "a potentially very serious allegation" [170]. It plainly was. It was first made in the letter dated 10 February 2005 which was intended to convey his views to the Inquiry. The words used in that letter (and repeated in his written statement) could only bear one meaning and that a meaning adverse to Mrs Cannell. If Mr Kneen believed that the remark bore the innocuous meaning he gave it in oral evidence, he should never have written the letter and statement in the terms which he did. Those terms could only be read in one way. Mr Kneen was irresponsible in submitting the letter and statement in those terms to the Inquiry.

9.43 The Inquiry re-iterates that Victor Whiteside did not make such an allegation in either his written or oral evidence.

Events at Leece Lodge

9.44 Leece Lodge 2 was a semi-detached cottage on a campus, some 2 miles out of Douglas, in a semi-rural, location, near what is now Nobles Hospital. Also on the campus were two other units: Leece Lodge 1, the semi-detached property adjoining Leece Lodge 2, and Leece Lodge 3, a separate unit, some 100 metres away. The campus was owned by the Government but operated by Nugent Care. Leece Lodge 1 and 3 had four young people living there and staff living in.

9.45 Prior to Samantha's move to Leece Lodge, Nugent had considered the arrangements for the placement. At the meeting at the Nugent premises at Willaston on 23 August 2001 [171] , arrangements for Samantha's placement were discussed:

> "tenancy agreement to be drawn up for Sam Barton – what is expected from her, what she can expect from us, 9 – 5 support during day to help her with her daily tasks. No named member of staff to help her but a support group to be put in place … to be given an emergency telephone number for the night times. If she assaults staff, damages the property, brings drugs to the property – she will be arrested and charged. Looking at removing the care order after a three month period. … Sam to be given a key and two sets of spare keys will be held by staff".

[170] Day 8: 79:20
[171] See above

9.46 Damian Bradley told the Inquiry that he and a number of staff were concerned about the placement. He thought Leece Lodge was not appropriate for Samantha in her own right because it was very close to Priory House, it was difficult to control the comings and goings, it was out of town and there were staff which may lead to conflict [172]. At the time he thought Francis Charlton had not felt able to say no and it concerned him that Nugent accepted young people when it was not appropriate to do so[173].

9.47 Francis Charlton confirmed in his evidence that there was no alternative and there was an expectation that Nugent would take Samantha because they had an unused facility at Leece Lodge 2 [174].

9.48 Damian Bradley prepared a paper for a senior managers' meeting about the placement to help them focus the concerns he knew they had about this placement[175]. Among other things it said:

> "Nugent Care will be warehousing Sam Barton. It has to be accepted from the start, Nugent Care stands little chance of having any impact on Sam Barton."
>
> "Professionals – out with Nugent Care see this move as folly – but recognise at this time nothing else is possible."
>
> "Sam should not have any team placed with her a LL2. By adopting this approach, the risk to team members should be minimalised and Sam should not be at risk of being further criminalized by the Care System."
>
> "The next stage in the process should include:-
>
> Sam's Care Order being revoked as part of the second stage of the process. When the above happens a new tenancy agreement should be drawn up, which should included – an appropriate system to withdraw the tenancy and remove Sam from the LL site…."

9.49 Damian Bradley told the Inquiry that he had used the term 'warehousing' because it had been used to him but could not remember who had used it [176]. He said that it was not his view [177]. He agreed that the reference to 'folly' possibly should read 'Professionals both within and without NC see this move as a folly' [178]. The document also said 'SB should not have any team placed with her at LL2' by which he meant live-in staff [179].

9.50 The paper also referred to Samantha's care order being revoked as part of the second stage of the process.

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[172] Day 16: 137:10-18
[173] Day 16: 139: 8-13
[174] Day 15: 86-88.
[175] Day 16: 140: 21 – 141:7
[176] Day 16: 144: 20-145:2
[177] Day 16: 145:20
[178] Day 16: 149:21; see also Francis Charlton Day 15: 105-107
[179] Day 16: 150: 4-8

9.51 Samantha was placed at Leece Lodge 2 on 3 September 2001. She went there unwillingly; a large number of people had to assist the move out of Derby Road. She was seen later by Diane Watts and Adrian Venn.

9.52 On 5 September 2001, Adrian Venn wrote a letter to Samantha, which was copied to her social worker Angela Gilman, repeating "the arrangements for you living at Leece Lodge 2":

> "You will remember that I spoke to you yesterday, when I gave you a front door key for Leece Lodge 2 (and a new toothbrush!). It would be a good idea just to repeat now in this letter, the arrangements for you living at Leece Lodge 2.
>
> Leece Lodge 2 is presently being provided with the electricity, water and heating all included, at no cost to you.
>
> Your benefits are what you should use to buy food etc. You will <u>not</u> be given any money by the staff.
>
> There is a regular bus service that runs along Strang Road, so public transport is easily available. The staff at the Leece Lodge campus will <u>not</u> provide you with lifts.
>
> There is a public telephone a short walk away in Strang village
>
> Leece Lodge 2 is provided for you only, as your home. <u>Nobody else is to live there with you</u> and regular visits will be made by staff each day to make sure that this is the case. Anyone who should not be there, will be moved on.
>
> Please remember that you are on a campus with other young people, staff and members of the public literally passing by your front door ever day: it is your personal responsibility to live peacefully. If you need any assistance with looking for a job, or perhaps applying for a college or training course, then this could be done with the help of staff.
>
> Yours sincerely,
> Adrian M Venn, Team Leader.
> Copy: Damian Bradley, Diane Watts, Donna Lever, Angela Gilman (SSD)"

9.53 On the same day, Ms Gilman visited Samantha at Leece Lodge.

9.54 On 5 September 2001, the Children and Families Resource Panel met. The minutes record that: Samantha and Lyndsey were at Leece Lodge; while in the long term Lyndsey should not be accommodated, until it can be guaranteed that she can be kept out the situation should just be monitored [180]. The minutes continued:

> "The possibility of revoking Samantha's care order should be explored. If the courts can be shown that Sam is not co-operating and the care order were revoked, then the Department would not have legal responsibility for either girl".

[180] The Inquiry notes that Lyndsey's presence appears to be clearly contrary to the requirement that no one was to live with her at Leece Lodge 2.

9.55 Ms Gilman told the Inquiry that it never became part of the plan that the care order should be revoked [181].

9.56 A report was written on 9 September reviewing Samantha's first five days at Leece Lodge: It stated that Samantha's aggression was inter-sibling and had not involved others; that police were involved daily/twice daily; that there was no evidence of involvement in offending behaviour, but that it was clearly a possibility. On 10 September, Francis Charlton wrote to Samantha saying that she had not complied with any of the requests made of her and warning that if behaviour did not improve staff would be put into Leece Lodge 2.

9.57 Miss Gilman saw Samantha on a number of occasions in September. On 6 September she took Samantha to the DHSS office at Markwell House. On 10 September Ms Gilman took Samantha to an initial appointment at the Drug and Alcohol Team: Samantha told the clinic that she took ecstasy, "pot" and valium; that she did not have a very close relationship with her mother; and that marks on forearms were caused by scratching herself [182].

9.58 On 11 September she took her to the job centre; on 13 September she and Samantha went shopping together; on 24 September she visited Samantha at Leece Lodge.

9.59 After her first month, a report for senior Nugent management recorded that young people were still visiting regularly and that Samantha had said that she became lonely and bored if friends were not around; that on four or five occasions, Samantha had entered Leece Lodge 1 uninvited and, when her demands were not met, she had threatened violence and been verbally abusive; she had recently been charged with a public order offence. Diane Watts wrote to police that there was

> "limited through-care support offered to Samantha who is living independently. There is a key to the property at Leece Lodge 1 although they do not have direct responsibility for the Leece Lodge 2 house".

9.60 On 23 October 2001, it was decided that staff would work with Samantha on a "more structured basis": Diane Watts would see Samantha on Tuesdays, travel with her to the Job Centre to sign on and spend time with her in town afterwards; Ms Watts would visit three times per week and Liz Dickson would visit twice per week, sometimes in evening; Ms Watts and Ms Dickson would evaluate work undertaken and adjust their input as necessary; and a monthly report would be sent to Ms Gilman and Mr Coates.

9.61 Although Theresa Barton, Samantha's aunt, was having less contact with Samantha than in the past [183], she visited her at Leece Lodge on occasion. She told the Inquiry that Samantha had made Leece Lodge 2 quite homely and was proud of it [184]. This was borne out by other witnesses.

9.62 Young people continued to congregate at Leece Lodge 2 and police attended on a frequent basis to collect children or young people reported missing.

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[181] Day2:137
[182] See further chapter 14
[183] Day 16: 33
[184] Day 16: 32:22-25

9.63 On 24 October 2001, she was arrested and found to be in possession of ecstasy and cannabis for which she was later convicted (following a search of Leece Lodge).

9.64 On 13 November Ms Gilman wrote a pre-sentence report for Samantha's appearance at the Juvenile Court on 15 November charged with a number of offences. The court was told that Samantha

> "[was being] offered a minimum intervention package of care by Nugent Care in order to facilitate independence".

Ms Gilman told the Inquiry that by August 2001 social services had lost all power and control over Samantha [185], a view she had also expressed in this report.

9.65 On 18 November, Samantha went on holiday in England for five days with Liz Dickson.

9.66 On 23 November 2001, Samantha was discharged from the drug and alcohol team's caseload for failing to attend appointments.

9.67 On 26 November 2001, a Child in Care Review was held. In answer to the question "are the child's needs being met ?", the minutes record: "increasingly so, but there are worries about some self care and she does need on-going care if and when it can be offered". The current Care Plan was said to be "to look after Samantha for the remainder of her childhood and to plan for Samantha's transition to independence". Action planned included "consider developing a nurturing care plan for Samantha", "explore employment/training and support possibilities", "commence search for suitable accommodation", "liaise with psychiatrist for further advice on Sam". The next review was due on 11 February 2002.

9.68 During December, Samantha's life remained unstructured and continued to involve worrying incidents. On 7 December, her wallet was found to contain a large amount of money [186]; on 10 December she was arrested for shoplifting and had £100 in her possession; in early December, she was reported to have been seen at the ferry terminal and to be getting taxis to go there at 6 or 7 am.

9.69 On 14 December, she referred herself to the Drug and Alcohol Team and was seen at the Team on 7 January 2002. The history given by Samantha was that: she took diazepam and cannabis daily, amphetamine, ecstasy and dihydrocodeine weekly and that she had smoked heroin for the first time the previous week. Of her alcohol consumption, she said that she was not sure of the amount, but she drank to "get drunk". Samantha said that she did not think offending related to alcohol or drug use. She said that she had "always been naughty" and had taken overdoses in past. She said that she was committing offences weekly. She said that recently she suffered from anxiety, depression, sleep problems, thoughts of self-harm and hallucinations.

9.70 On 17 December 2001, Samantha was sentenced to 28 days custody suspended for 12 months for a range of offences [187].

9.71 The minutes of the Children and Families Resource Panel held on 28 December 2001 recorded that, seemingly in relation to the Leece Lodge campus at Christmas, "Sam -

[185] Day 3:5:23
[186] Anne Curphey Day 15:32
[187] See chapter 19

brilliant- seems to have enjoyed life. Lyndsey has been with mum…. George Green and [another young person] around and no concerns". Again at the Children and Families Resource Panel held on 9 January 2002, the minutes record that Nugent reported "no concerns" about Samantha.

9.72 On 15 January 2002, Diane Watts, Team Leader of the Outreach Team responsible for Samantha wrote "Progress Report No 2" on Samantha, stating that Samantha had "enjoyed a more settled lifestyle, that the placement at Leece Lodge had been a "stabilising influence for Samantha", that she was receiving support and engaging with her key worker and recommending continued placement at Leece Lodge 2. In the light of the overwhelming evidence received about Samantha by the Inquiry, this report did not reflect the reality of Samantha's situation at the time. Ms Watts herself told the Inquiry that the report was probably more positive than was justified in reality [188].

9.73 On 15 January 2002, the Nugent log for Samantha written by Charles Buist, a residential worker at the Leece Lodge campus, records [189] that she or one of her guests had kicked the front door of Leece Lodge 1; "Leece Lodge 2 was full of young people, the music was very loud … I felt that to knock and complain would have led to a more serious situation so left SB and co to get on with it … ".

9.74 In January 2002, Nugent staff at Leece Lodge 1 and Leece Lodge 3 thought that illegal drugs were being used at Leece Lodge 2 and Nugent reported their concerns to the police. The police required further intelligence before they could act and Nugent staff kept observation over the weekends of 19-20 and 26-27 January. The Inquiry was told that no further evidence was obtained from this surveillance.

9.75 On the night of 16 January 2002, Samantha, whilst under the influence of drink, and maybe other intoxicants, was arrested for a public order offence and held overnight by the police. On 18 January, Samantha, along with others including George Green, was arrested for burglary (trespassing in an unoccupied flat and using its electricity) when she and the others were found in a flat at Clifton Terrace, Douglas after neighbours complained of the loud noise and music.

9.76 The Nugent log records that late on the night of 18 January, Samantha was asking the staff if she could use the telephone at Leece Lodge 1 to order a taxi; and that at 2.20 am on 19 January, a taxi collected Samantha from Leece Lodge 2.

9.77 On 21 January, Lyndsey who was in prison, rang the staff at Leece Lodge to inform them that she was worried about Samantha talking of trying to kill herself; she gave the staff a number on which Samantha could be reached. Nugent staff rang Samantha and visited her in the flat where they reported her to be "off her head on alcohol, valium and cannabis". The staff tried to persuade her to come with them; she would not and they left her there with several young people. Later, staff were called again and asked to collect Samantha from Douglas where Samantha was causing a disturbance. Returning in the car with Samantha, she said "life is not worth living … I want to sleep & never wake up"; she vomited in the car and when back at Leece Lodge 1.

9.78 On 22 January, Samantha asked to be able to sit in Leece Lodge 1 for a while, complaining that she was lonely and bored.

[188] Day 14:62:3
[189] Day 14: 135-136

9.79 Leece Lodge 2 was a place for young people to congregate during the night. The police would come to Leece Lodge looking for young people reported as missing from home. The Leece Lodge log reveals instances of drunks at her property, searches of the premises by the police for missing young persons, an instance of giving her key to others and allowing them to use the premises when she was not present, and of young people leaving her property and running off into fields nearby.

9.80 Charles Buist, a residential social worker, told the inquiry that George Green visited Leece Lodge 2 more and more during January and February 2002[190].

9.81 During her period at Leece Lodge 2, Samantha lost weight. Samantha reported to the DAT team on 7 January 2002 that she had lost two stone in the previous five months. Ms Dickson, her outreach key worker, was concerned about the extent of her visible loss of weight [191].

9.82 On 24 January 2002, Samantha was sentenced to 14 days custody suspended for 12 months for theft (committed prior to her sentence on 17 December). On the night of 25 - 26 January, Samantha was arrested for a public order offence. On 28 January, Samantha was arrested for theft; she was high on drink and drugs.

9.83 On 31 January 2002, Samantha together with George Green and two other young people, visited Social Services Division at Hilary House asking to see either Angela Gilman or Ed Coates. Mr Coates passed a message down to them that Angela Gilman would be in touch the following week. Police intelligence recorded that both Samantha and George were "high". Also on 31 January, Samantha attended at the Drug and Alcohol Team accompanying another young person.

9.84 On 31 January, there was a Team Meeting for the Leece Lodge Campus. The minutes record that a review on Samantha was due on 11 February and that

> "we will be suggesting her Care Order is revoked. DW [Diane Watts] agreed to call at SB's on Mon/Tues to discuss with SB the options for her moving on to her own accommodation".

9.85 In the Nugent Weekly report on Samantha, dated 4 February 2002, it was reported that Samantha had requested that "a flat be found for her off the Leece Lodge campus". This was to be looked into when the care order was revoked which was going to be requested at the review on 11 February.

9.86 On 5 and 6 February, attempts were made by Leece Lodge staff to assist Samantha in obtaining and completing the appropriate forms for her income support payments but these attempts met with little success. Arrangements were made for Anne Curphey to assist her. On 7 February, when Samantha was got up and Leece Lodge staff explained that Anne Curphey would be coming to assist her, Samantha "refused assistance and was being totally unco-operative". Ms Gilman in her Supplementary Statement says that on that day she rang Samantha, who "sounded happy".

[190] Day 14:141:10
[191] Day 9: 143

9.87 On 8 February 2002, Leece Lodge staff gave Samantha her wake up call. Later in the morning, she spoke to staff and said that she was going to attend Lyndsey's appearance in court that day. That night, Samantha's body was discovered by police in Leece Lodge 2.

Threats made to Samantha

9.88 There are two suggestions of threats being made to Samantha in the latter part of her time at Leece Lodge 2.

9.89 The first was on 30 January when the log records that Samantha telephoned and said that she had heard that Leece Lodge 2 was going to be "done over" by some "smackhead" who knew where she lived. The Inquiry was not told of any action that was taken as a result of this report by Samantha.

9.90 The Inquiry also heard evidence about another alleged threat made to harm Samantha. Voirrie Moore in her statement to Inquiry says that she told the police that Samantha visited Priory House shortly before her death (about two weeks, she thought) and was agitated and worried; that two "fellas" were after her about drugs and she was frightened that she would be "kneecapped". In a later statement, prepared at the request of the Inquiry, Ms Moore said that she "passed this information on to Samantha's social worker, Angela Gilman, by way of a telephone call shortly after Samantha told me of her concerns"; and that she is not sure if it was before or after her May 2002 statements that she told the police: "it was just mentioned in general conversation, it was common knowledge about the alleged threats".

9.91 Detective Sergeant Turner says [192] that Ms Moore did not mention this in either of her two statements to police in May 2002 in connection with the criminal investigation surrounding Samantha's death and that DC Lowe, the officer who took the statements, has no recollection of being told this and made no note of being told this.

9.92 Ms Gilman says [193] that she cannot recall a conversation with Ms Moore in January 2002 and no conversation was recorded by her; furthermore Ms Gilman also states that she has never heard of the threats of kneecapping to Samantha Barton from any source; had she done so, because of the seriousness of such a threat, she most certainly would have acted to share this information with the appropriate services.

9.93 Given that neither Ms Gilman nor the police have a recollection or a contemporaneous note of being told this and given that Ms Moore has no contemporaneous record [194] of either the conversation with Samantha or the telephone call to Angela Gilman, the Inquiry concludes that it would be unsafe to rely on Ms Moore's recollection about this alleged threat. It is more likely that she recollects the more general threat which Leece Lodge staff recorded on 30 January 2002.

[192] DS Turner letter to Inquiry dated 22.11.05
[193] Letter dated 7.12.05 from David Gibson to Inquiry.
[194] Letter from Pamela Pringle, Advocate, to the Inquiry 16.1.06

Nugent Care Society Isle of Man

Early days and management difficulties

9.94 Nugent Care Society ("Nugent") is a charity registered in the Isle of Man. It was set by the Nugent Care Society which is a charity registered in England ("Nugent Care Liverpool"). In reality, Nugent Care Liverpool supervised Nugent on the Island [195].

9.95 As noted earlier[196], Nugent was new on the Island and were still setting up their project on the Island. Francis Charlton was appointed project manager in summer 2000. At first, his appointment was probationary until April 2001, but because of some concerns held by the Assistant Director for Children's Residential and Community Services for Nugent Care Liverpool, Ms Gill Owen, the probationary period was extended to October 2001. He was suspended by Nugent Liverpool on 21 January 2002 and, following disciplinary proceedings, his employment was terminated on 19 February 2002 [197] .

9.96 Nugent was awarded the contract in 2000. Francis Charlton arrived on Island in October 2000. There were three projects: the first to run the three units on the Leece Lodge campus; the second to run the White Hoe residential home and the third to set up and run the secure unit. Nugent took over the running of Leece Lodge 3 on 1 October 2000; it re-opened Leece Lodge 2 on 13 November 2000; and White Hoe Residential Unit was opened on 18 December 2000. On 2 April 2001, Nugent opened Leece Lodge 1.

9.97 Damian Bradley and Adrian Venn had been appointed to their posts before Francis Charlton but arrived on Island after him.

9.98 Damian Bradley was Deputy Project manager from December 2000 to September 2002 when he left to be chief executive of MFS.

9.99 Damian Bradley had an operational role in respect of the projects but this ceased at a point in September 2001 when he took on financial and other roles and Mr Charlton took on the operational role [198]. Mr Bradley told the Inquiry that Mr Charlton supervised Adrian Venn and Diane Watts; and that he supervised Donna Lever who managed the Maple Avenue placement [199]. Mr Bradley's supervision role and his operational role increased after Mr Charlton's suspension in January 2002.

9.100 There were continuing difficulties in establishing the projects on the Island.

9.101 There had been delays and social services were pressing for progress. However, Nugent Care Liverpool made clear that they did not wish to jeopardise the welfare of children by commencing services prematurely. Mr John Kennedy, Director of Nugent Care Liverpool, wrote on 7 December 2000 to David Gibson [200]:

> "NC will provide a service which is safe and appropriate or no service at all".

[195] Oral submissions on behalf of Nugent: Day 27:77
[196] See chapter 7
[197] Damian Bradley Day 15: 153 - 154
[198] Damian Bradley Day 15: 142-143; Day 15: 156-157
[199] Damian Bradley Day 15: 157-158
[200] Day 18: 155:5

9.102 The same letter referred to Gill Owen and Francis Charlton making Nugent Liverpool aware of the "critical problems which exist within the childcare provision in the IOM". Gill Owen told the Inquiry that the problem was that service providers could not provide the level of support for the number of children requiring services[201].

9.103 Gill Owen said that Nugent was being asked "to run before it could walk" [202]. Nugent had a variety of staff from a wide geographical area and they needed more time to gel together. Very properly, in June 2001 Nugent Liverpool carried out an audit of the Nugent project on the Island and it revealed problems in connection with recording, monitoring, procedure and practice. There was also a management report following a complaint made by a Nugent employee, Sarah Heselwood, which revealed concerns in relation to managerial relationships on the Island, inductions, appraisals, probation periods, and supervision. It revealed that procedures and policies were not being followed [203].

9.104 The Inquiry also heard evidence which suggested that the management of Samantha's placement at Leece Lodge 2 took place against a background of professional differences between Francis Charlton and Damian Bradley.

9.105 In addition, there were tensions between Nugent and its parent organisation, Nugent Liverpool. The latter thought the former might be seeking to establish itself as an organisation independent of Nugent Liverpool. While undoubtedly causing some tensions within Nugent, the management failings by Nugent were not caused by them.

9.106 However, the difficulties experienced by Nugent in getting the project set up are likely to have made Mr Charlton feel under more pressure to accept Samantha at Leece Lodge 2 at the request of social services without going through Nugent's normal procedures and in the face of professional opinion that it was an unsuitable placement. The difficulties within Nugent are also likely to have contributed to the pressures on senior management and in turn to have lead to the failure by senior managers to supervise staff adequately: both Diane Watts and Alex Cowie told the Inquiry that they were not supervised properly. In Alex Cowie's case, this did not lead to any adverse consequences. In Diane Watts' case, the failure to supervise meant that her failings were not picked up and remedied by more senior managers.

Nugent on the Isle of Man and Nugent Liverpool

9.107 During 2001, although Gill Owen came to the Island 15 times, she described her management style as 'distant' [204]. She supervised Francis Charlton; she told the Inquiry that he was reluctant to be supervised and used a number of tactics to avoid being supervised [205].

9.108 Ms Owen told the Inquiry that she did not know whether Nugent's procedures had been followed when placing Samantha at Leece Lodge 2 but that initially she assumed they had been complied with [206]. She later realised that they had been

[201] Day 18: 156: 12-157: 3
[202] Day 18: 157
[203] Day 18: 158
[204] Day 18:72
[205] Day 18:74
[206] Day 18: 100 - 101

bypassed but understood that there had been no alternative [207]. She said that she herself would not have bypassed the procedures but she thought it was a difficult question because she did not know the pressures at the time [208]. She accepted that she must have received a memo to her dated 10 August 2001 from John Kennedy which referred to Leece Lodge as a possibility for the Bartons, although she could not remember it [209]. Francis Charlton told the Inquiry that Gill Owen was stunned when she was told that Samantha had been placed at Leece Lodge 2; Ms Owen could not remember being stunned but agreed she probably was [210]. Ms Owen said that it was Mr Charlton's responsibility as project manager on the Island to point out to social services that the placement was unacceptable [211]. The Inquiry agrees.

9.109 After Samantha had been placed, Gill Owen said that she was not told by anyone from Nugent or social services that there was a problem with the placement and therefore she did not take it any further [212].

Assessment of the care and support at Leece Lodge

Merits of the decision to place at Leece Lodge 2

9.110 Again the Inquiry heard that there were thought to be no other options on the Island for Samantha [213]. Angela Gilman thought this placement met her three criteria less than Maple Avenue. Again, the witnesses thought that the move was made neither on traditional "welfare" grounds nor as a result of "care planning". Trevor Noden said there was strong professional opposition to the move.

9.111 Dr David Dunne, a general psychiatrist, who examined Samantha for the purpose of one of her criminal court appearances, expressed the view to the Inquiry that the placement at Leece Lodge 2 was a good arrangement. However, his view was based on only limited information.

9.112 There were well-documented concerns about moving Samantha to Leece Lodge namely its location, its proximity to another residential unit, the effect on the other young people residing there and the difficulty in controlling the comings and goings [214]. Liz Dickson, her keyworker, thought Samantha was not mature enough to live at Leece Lodge 2 [215]. Significantly, Trevor Noden said he did not think it was a safe placement for Samantha.

9.113 Nugent were under particular pressure from social services to provide services because of the delays and other difficulties in setting up the projects on the Island. The Inquiry concludes that Nugent allowed themselves to succumb to that pressure to take Samantha at Leece Lodge 2.

[207] Day 18: 141-142
[208] Day 18: 142
[209] Day 18: 148
[210] Day 18: 148-149
[211] Day 18: 150
[212] Day 18: 153
[213] See for example, Francis Charlton Day 15: 105-107
[214] For example, Alex Cowie Day 14: 95-97
[215] Day 9: 118

9.114 The evidence from Nugent Care employees who worked at Leece Lodge suggests that the majority had grave concerns about the inappropriateness of Leece Lodge for Samantha both before and during the placement.

9.115 There was no package of support and no clear plan. There were no boundaries on her behaviour or structure to her life, both of which, the Inquiry agrees, she needed [216].

9.116 Nevertheless, with a sufficient support package, appropriate staffing levels and a clear plan, Leece Lodge 2 could have been a more appropriate placement. Its location away from a residential area of Douglas had some advantages [217]. Mark Hoswell, Samantha's care worker in the latter stages of her time at Derby Road, had a favourable view of Leece Lodge as a placement for Samantha, subject to staffing; in particular he saw the role and choice of key worker as vital[218].

9.117 The major failure was in the arrangements for Samantha's care and support while at Leece Lodge 2.

9.118 The "minimum intervention package" actually provided was never likely "to facilitate independence" for Samantha.

Assessment and care planning

9.119 The arrangements for the placement were a failure.

9.120 As with so many periods in her life there was an absence of any detailed care plan. Such a plan should have set out the analysis of the needs of the young person, with proposals on how to meet them. There was no proper assessment of Samantha's needs at this stage. There was no review of her previous placements to determine her next plan. There was no plan as to how Samantha was to be moved towards independence: in particular, no plan as to how to seek to engage Samantha in education, training or constructive leisure pursuits. The plan should have included details about which individuals were to be involved and who was to be accountable for delivering the plan. The plan should have been initiated by social services, normally the social worker, in discussion with the care providers.

9.121 Ms Gilman was not consulted about the merits of a placement at Leece Lodge [219], and did not visit Leece Lodge prior to the placement and not involved more than peripherally in decision making [220]. Ed Coates, her manager, told the Inquiry that he was not involved in detailed discussions about the move to Leece Lodge and that this decision had already been made before his involvement[221]; neither he nor Angela Gilman were involved in formulating the care package for Samantha at Leece Lodge[222].

[216] See eg Adrian Venn Day 13:62
[217] The absence of neighbours and security of tenure
[218] Day 7: 171-172
[219] Day 2: 139 - 140
[220] Day 2: 149
[221] Day 11: 91
[222] Day 11: 93: 19

9.122 Neither the social worker nor her manager produced a care plan or communicated any proposals to Nugent as to what was expected of them, save in a very superficial way. There was an absence of direction and control by social services.

9.123 As well as the absence of a written care plan, there was no placement agreement and no written support package. Nugent Care's usual admission procedure - whereby there was an assessment process to determine whether the placement was appropriate and, subsequently, an individualised care package was devised - was bypassed.

9.124 Consequently and unsurprisingly, there was a lack of clarity as to what care and support was to be offered to Samantha. It was clear, however, that Samantha was to live alone without staff, despite the experience of Derby Road and despite her assessed needs which should have suggested otherwise. In reality, Samantha received very little care and support to help her move towards independence.

Responsibility for Samantha at Leece Lodge

9.125 Prior to Liz Dickson becoming her outreach keyworker in mid November 2001[223], the evidence shows that no one was directly responsible for Samantha. Moreover, there was a lack of clarity as to what role the staff at Leece Lodge, whether manager or worker, were supposed to play in respect of Samantha.

9.126 As well as the Project Manager Francis Charlton and Deputy Project Manager Damian Bradley, there were four team leaders at Nugent. Adrian Venn was Team Leader from December 2000 until he became a senior team leader in March 2002 [224]. Mr Venn was team leader of Samantha's two workers at Derby Road. On the move to Leece Lodge 2, Mr Venn told the Inquiry that there was an overlap between him and Diane Watts [225] in respect of Leece Lodge 2. This overlap ceased on 18 October when Mr Venn was assigned to a non-operational role setting up the secure accommodation unit.

9.127 Diane Watts was another of the team leaders. She told the Inquiry that initially she looked after Leece Lodge 1 and Leece Lodge 2 but in October 2001 she moved to the Willaston office to look after the outreach team[226]. The only other person in the outreach team was Liz Dickson. The outreach team was responsible for Samantha and 2 other children[227]. Ms Watts told the Inquiry that she spent 2-3 hours a week with Samantha[228]. Donna Lever had become team leader of Leece Lodge 3 in May/June 2001. When Diane Watts moved to be team manager of the Outreach Team in October 2001, Donna Lever became team leader of Leece Lodge 1 as well as Leece Lodge 3.

9.128 All the staff at Leece Lodge 1 and Leece Lodge 3 told the Inquiry that they had no formal responsibility for Samantha and Leece Lodge 2. Diane Watts told the Inquiry that there was a staff team set aside to work specifically with Samantha [229] , and this

[223] For when Liz Dickson began as Samantha's outreach worker, see further below
[224] Day 13: 6 - 8
[225] Day 13: 7-8
[226] Day 14:6
[227] Day 14:7
[228] Day 14:8
[229] Day 14:28:14-19

team was replaced by the outreach team in late October 2001[230]. However, she could not remember their names [231] and could not point to a contemporary document identifying them[232]. The Inquiry concludes that Ms Watts is mistaken about this. There are no documents or plan suggesting that the staff on the Leece Lodge campus had responsibility for Samantha. After the murder, Ms Watts wrote an undated and unsigned document referring to there having been initially four identified workers for Samantha, but no names were given in the document. In her letter to the police dated 18 October 2001, Ms Watts said that the staff at Leece Lodge 1 "do not have direct responsibility for Leece Lodge 2" [233] .

9.129 There was a failure of management in Nugent at the time when Samantha was at Leece Lodge 2. The Inquiry heard no evidence to suggest that anyone in the management structure took control of Samantha's placement at Leece Lodge 2 and sought to make sure that there was an experienced key worker [234] from the start and that rules were clear and were to be complied with [235] .

9.130 Mr Charlton was project manager and from a point in September 2001 until his suspension in January 2002 had operational responsibility for the projects. Until September 2001, Mr Bradley had operational responsibility and he resumed operational responsibility after 21 January 2002.

9.131 As project manager and in his operational role, Mr Charlton bears responsibility for the areas in which the Inquiry has found failings. Mr Bradley, as deputy, bears some share of responsibility for the management failings. Frankly and very properly, he told the Inquiry that he accepted some responsibility for not making sure that there was a keyworker from the start and that campus staff were clear about their role and the rules and also for ensuring that there was from the start a system for recording events and concerns about Samantha [236] .

Keyworker

9.132 Initially no key worker, or person in a similar role, was appointed to work with Samantha. This was an error. It meant that in practice there was little or no constructive support given to Samantha. The Inquiry is clear that, as many witnesses for example Mark Hoswell [237], told the Inquiry, a keyworker was important.

9.133 The evidence given to the Inquiry was unclear as to whether Liz Dickson took up her role as Samantha's key worker in mid-October [238] or mid-November 2001. That there should be no clear record of when it occurred is itself symptomatic of the unacceptable lack of clear plans and packages of support for Samantha. Ms Dickson said that her first real involvement with Samantha was when she went on holiday

[230] The Inquiry has noted the care programme dated 23 October 2001 which identified Liz Dickson (from the outreach team) and Diane Watts as starting to work with Samantha: see above
[231] Day 14:29:14
[232] Day 14:36:6
[233] See above
[234] Francis Charlton told the inquiry that he condoned the absence of a keyworker: Day 15: 112
[235] Day 13: 73-74
[236] Day 18: 7 - 12
[237] Day 7
[238] As stated in the written care programme dated 23 October 2001

with her on 18 November 2001 [239] . On balance, it is more likely that Ms Dickson became involved as keyworker after this holiday, which was two and a half months after Samantha was placed at Leece Lodge 2.

9.134 Liz Dickson was an "outreach care worker". She was unqualified but training to be a residential social worker. She had had two and half years' experience with young people but no experience with young people with behavioural problems [240]. She did not read reports on Samantha before becoming her keyworker and the social work files she was shown – on her initiative - were two years out of date [241]. Her role was to attend on Samantha and then take her to appointments, job interviews, doctors, visits to family, and to offer general guidance on day-to-day matters. She told the Inquiry that normally she saw her on Tuesdays to attend the unemployment office and on other days when there were appointments[242]. She did not see her every day [243] . She worked normal office hours[244]. Ms Dickson told the Inquiry that her role was not to challenge or seek to set boundaries for Samantha or question her behaviour [245].

9.135 Liz Dickson's supervisor was Diane Watts. However, Liz Dickson told the Inquiry that she received no supervision from Ms Watts [246]. Ms Dickson was not kept informed about significant events in Samantha's life while at Leece Lodge 2: for example the talk of suicide, the sightings at the ferry terminal, Leece Lodge staff's concern about drugs at Leece Lodge 2 [247].

9.136 Through no fault of her own, Ms Dickson's care and support for Samantha was inadequate and she was unable to provide Samantha with what she needed at this stage. Samantha had a good 'working' relationship with her and it can be understood why at face value, Dr Dunne was impressed. Liz Dickson was genuine in her evidence and in her fondness for Samantha. Samantha warmed to her and to her non-confrontational approach. Ms Dickson saw her role as one of befriending Samantha and providing her with the limited degree of services that had been agreed for Samantha rather than to effect change or to challenge her well established behaviour pattern. To that extent, she was successful. She was given her remit and carried it out well.

9.137 However, Samantha was in need of much greater care and support. Ms Dickson was a well intentioned but inexperienced and unqualified worker who in her own words, was allowed by her manager, Diane Watts, to carry out her work in any way she pleased. She appears to have been given no specific goals to achieve and once established, was not asked to try to move the relationship she had formed with Samantha on, so that change might have been achieved or even contemplated by Samantha. The responsibility for that must rest with her managers, in particular Diane Watts, at Nugent and with social services. Diane Watts did not herself provide or arrange for others to provide the level of care and support which Samantha needed.

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[239] Day 9: 96: 20-21
[240] Day 9: 101: 3-6
[241] Day 9: 102. However, Angela Gilman said that Samantha's records were not two years out of date.
[242] Day 9: 106: 12-17
[243] Day 9: 107: 25
[244] Day 9: 108: 16-21
[245] Day 9: 105
[246] Day 9: 125
[247] Day 9: 138, 147, 151

Nugent care staff on the Leece Lodge campus

9.138 As discussed above, Nugent's normal admission procedure had been by-passed. Samantha's placement was to be different to that envisaged for a resident at Leece Lodge 2. Mr Venn told the Inquiry that Samantha was offered a completely different type of care and support to that which Nugent had envisaged in their statement of purpose and function [248] and that Samantha was not offered an individualised programme or regularised structure; nor had she gone through the normal referral system [249].

9.139 The Inquiry heard evidence from a number of Nugent staff on the Leece Lodge campus. They were unsure what rules pertained to Samantha's placement and did not enforce such rules as they thought may exist. Samantha was thus effectively left to do as she pleased; for example, she could leave the campus in the middle of the night and stay out all night and there was no system for the staff to know she had gone or when she had gone, especially as there were no waking night staff. Since she was allowed out at night, she was not reported as a "missing person". One of the few rules was that people could not stay over but in reality many did and ultimately nothing was done [250]. The culture of care for Samantha at Leece Lodge was permissive. She was rarely challenged. Boundaries were not imposed. She was not sanctioned: there were no sanctions. All this was aggravated by the fact that many of the staff were wary of her given her history of violence and aggression.

9.140 Jacqueline Baker, a residential worker on the Leece Lodge campus, told the Inquiry that Samantha's regime was inconsistent with the strict regime for other young people on the campus [251]. Leece Lodge 2 and Samantha were a magnet for other young people on the campus and from Priory House, Tromode [252]

9.141 There were two staff living in at Leece Lodge 1 and 3 and two young people in each [253]. The key to Leece Lodge 2 was held by Leece Lodge 1 staff [254]. The staff thought they needed to be no more than 'good neighbours' to Samantha.

9.142 There was no system for night time checks or supervision of Samantha, although night time was a period of major risk and problems [255]. Some staff asked Francis Charlton to provide extra staff after 8 pm in order to cope with Leece Lodge 2, but attempts to employ more staff were unsuccessful [256].

9.143 Typical of the evidence given was that of one Leece Lodge staff member, Kathleen Cooke [257]. She told the inquiry that, correctly, she did not see Samantha as her responsibility but that she was there to offer help and support if she could, as good neighbours would [258]. She did not know Samantha very well but she did not think she

[248] Day 13: 52:9-12
[249] Day 13: 53:5; 54:13
[250] Or, according to Diane Watts, could be done about it. Day 14:52
[251] Day 13: 137; Damian Bradley Day 18: 14
[252] Alex Cowie, Day 14: 95-97
[253] With whom the staff had their hands full: Jacqueline Baker. See also Alex Cowie, Day 14
[254] Jacqueline Baker Day 13: 127
[255] Diane Watts Day 14:51:17-21; and see Francis Charlton Day 15: 121 and day 15: 126; Damian Bradley Day 18: 4-5.
[256] Day 15: 125-126.
[257] Kathleen Cooke Day 13.; see also, for example, the evidence given by Jacqueline Baker on Day 13, by Alex Cowie on Day 14
[258] Day 13: 13: 90: 4-9; 91:17

was ready for independent living[259] ; she referred to her lack of a job, the way she lived, her associates, her criminal lifestyle, her drug use and her lack of budgeting and cooking skills and the fact that she did not want to be taught anything [260]. She and other staff thought Samantha needed a staffed property. She and other staff felt 'powerless'[261] : there was a rule against people staying at Leece Lodge 2 but they did [262] ; there was no real system for controlling visitors [263]. It was the understanding of the staff that Samantha was using drugs[264]. She thought Samantha was at risk[265]. The picture she painted for the Inquiry was one of a placement where there was very little control of Samantha and where boundaries were not or could not be imposed [266].

9.144 Alex Cowie, a senior residential social worker, based at Leece Lodge 1 told the Inquiry that at first there was no system for recording information about Samantha [267]. Commendably in the view of the Inquiry, Ms Cowie and others were very concerned about this; Ms Cowie raised it with Francis Charlton and Ms Cowie started a log book to record events and concerns.

9.145 Francis Charlton told the Inquiry that rapidly staff became concerned as to the appropriateness of the placement and reported their concern to him[268].

9.146 The Inquiry received written and oral evidence from a number of the staff working on the Leece Lodge campus. It is not right that the staff at Leece Lodge staff should be subject of criticism. They acted well towards Samantha. They felt concerned for her and the situation. It was not a situation of their making. There were differences of approach by the Leece Lodge staff and some were more proactive than others and some made their objections louder than others. Some suspected what the right course of action was [269] but there was no proper plan for Samantha.

9.147 The Inquiry noted the fact that many of the Leece Lodge staff attended several of the hearing days even when they were not required to give evidence. The Inquiry also records that when Eddie Tinsley, a residential worker at Leece Lodge, was asked at the conclusion of his evidence whether there was anything else he wished to tell the Inquiry, he said that he was sorry and sad about what happened to Samantha at Leece Lodge [270]. The Inquiry has no reason to doubt that that is a sentiment shared by all his colleagues who worked on the Leece Lodge campus while Samantha was there [271].

Samantha's safety

9.148 Kathleen Cooke told the Inquiry that at a staff meeting probably in January 2001 some weeks before Samantha was murdered, staff voiced concerns to Francis

[259] Day 13: 93:23
[260] Day 13:94:9-25; 118:11
[261] Day 13:113: 10-20
[262] Day 13: 114:17-23
[263] Day 13: 115:12
[264] Day 13: 117:3
[265] Day 13: 118:15
[266] Day 13: 119:11
[267] Day 14:98-99
[268] Day 15: 123: 23
[269] The Inquiry has noted the example of Alex Cowie.
[270] Day 14:182.
[271] The Inquiry also records that Mark Hoswell, Samantha's worker at Derby Road, also attended many days of the hearings, even when not required to give evidence.

Charlton that Leece Lodge 2 should be staffed and Eddie Tinsley [272] and some other male members of staff volunteered to go in and keep certain inappropriate visitors away; Mr Charlton said it would be looked into [273]. Francis Charlton told the Inquiry that he remembered the request and that Nugent looked into providing extra staff. He attempted to get extra staff via an agency but was unsuccessful [274]. There had been no changes to the placement arrangements by the time of the murders. Jacqueline Baker told the Inquiry of similar concerns being raised at staff meetings earlier in the placement [275].

9.149 Trevor Noden told the Inquiry that Leece Lodge 2 was not a safe placement for Samantha[276]. He agreed that the attempt at trying the 'no staff option' at Derby Road failed abysmally[277]. Yet the placements at Maple Avenue and Derby Road were never reviewed in an attempt to learn from them. The Inquiry has reached the firm conclusion that the lack of suitable arrangements for her care at Leece Lodge 2 left Samantha more vulnerable, both emotionally and physically, than she would otherwise have been. It was the arrangements for her care and support (the lack of supervision, keyworker, clear rules, staff who were clearly responsible for her, a clear plan) and not so much the physical location that left Samantha unsafe at Leece Lodge.

The police

9.150 Chief Inspector Young told the Inquiry that the police were concerned at the time at the lack of supervision of Samantha at Leece Lodge 2. He fed that concern back to social services via Sergeant Power (as he then was) who was in charge of the family protection unit [278]. In this role, Sergeant Power met Alec Merchant weekly. The involvement of the police is discussed more fully in chapter 19.

Social services

9.151 Social services had the responsibility to carry out an assessment of Samantha's needs, to make and update her care plan and to approve the package of support to be provided by the service provider actually caring for Samantha. In all these areas, they fell short.

9.152 Social services failed to make clear in writing to Nugent what its expectations for Samantha's care and support were and failed to ensure that its expectations were being met. Social services should have known what was going on in Samantha's life and about the specifics of the care being provided by Nugent. In so far as information was not being passed to them, social services should have taken active steps to make sure they received proper information about the young person for whom they bore responsibility. For example, Ms Gilman told the Inquiry that she only met Samantha's keyworker once, and that she should have met her more frequently [279].

[272] Eddie Tinsley Day 14: 166-167
[273] Day 13: 95:16 – 96:13
[274] Day 15: 125
[275] Day 13: 135
[276] Day 19:135: 1-4
[277] Day 19:139:20
[278] Day 5: 85
[279] Day 3: 87-88

9.153 Angela Gilman remained Samantha's social worker throughout the placement at Leece Lodge. It was her responsibility to satisfy herself that proper care and support for Samantha was put in place and remained in place. Regrettably, the Inquiry finds that she failed to discharge this responsibility adequately or effectively.

9.154 In her work as Samantha's social worker, Angela Gilman fell below the standard to be expected of a social worker. She told the Inquiry that she was not aware that there was not going to be a key worker for Samantha from the outset [280], a service which she thought Samantha needed [281]. More significantly, in the period September to November 2001 Ms Gilman said that she did not know who was responsible for Samantha within Nugent or at Leece Lodge[282]. She had no input as to what was going to happen at Leece Lodge [283], but she thought that she had seen the documents purporting to be the tenancy agreement[284]. The documents, she told the Inquiry, were brief and insufficiently clear[285].

9.155 Angela Gilman told the Inquiry that she did not know who was responsible for Samantha at Leece Lodge or who was managing her case [286]. This lack of knowledge is unacceptable. She told the Inquiry that she was unaware of a number of factual events which took place whilst Samantha was living there. Ms Gilman told the Inquiry that Diane Watts wrote the care programme dated 23 October 2001 without her input whereas setting the care programme was ultimately her responsibility [287] and that she had thus been 'sidelined' [288]. Very properly, she accepted in her evidence that there was a 'vacuum of responsibility' which allowed Diane Watts to do things which were the social worker's to do[289]. In all this, the care and support by social services fell short.

9.156 Social services told the Inquiry that they were not aware of the many of the key significant events which occurred during this placement. Ms Gilman told the Inquiry that that she was not aware at the time of various concerning reports of Samantha's behaviour: for example on 7 December 2001 Samantha being found with a large amount of cash; on 13 December 2001 being seen at the ferry terminal at 6am; in January 2002, staff being concerned that Leece Lodge 2 was being used to deal drugs and informing the police; on 7 January 2002 Samantha self-referring to the DAT and disclosing important drug history [290]. In particular, Ms Gilman was not receiving weekly written reports from Nugent [291].

9.157 In addition, Nugent told the Inquiry that that throughout the placement a weekly summary should have been sent to the social worker but the evidence given to the Inquiry was that it was not [292]. Once again, it would seem as if key information relating to Samantha's care was not shared and social services did not have the full

[280] Day 3: 19:23-25
[281] Day 3: 22: 8-11
[282] Day 3: 21: 1-3; Day 3: 79:16-18, 80, 81:1-2
[283] Day 3: 29: 14
[284] Day 3:30:19-25
[285] Day 3: 48:23
[286] Day 3: 79:16-18, 80, 81:1-2
[287] Day 3: 81:19; 82:1
[288] Day 3: 82: 25
[289] Day 3: 84-85 Diane Watts said that, for example, on one occasion she had to write a report on Samantha when Ms Gilman had failed to do so.
[290] Day 3: 90-94; 94:12
[291] Day 3: 93-94
[292] Day 3: 93-94

picture. And again, all agreed that the full picture once known by all was even more alarming than the information contemporaneously available.

9.158 The Inquiry heard and read much evidence about the frequency with which Angela Gilman met Samantha during the placement at Leece Lodge. Nugent were not providing, directly, the care and support which Samantha needed. Given the very limited role being played by Nugent in providing care and support (no structured plan for Samantha, no key worker initially and latterly an inexperienced keyworker), the social worker should have had a more prominent place in the care and support being provided. In the first two weeks of October 2001, Angela Gilman saw Samantha on five occasions, the last of which was 9 October. In the following four months until her death, Ms Gilman saw Samantha twice: on 9 November 2001 and 22 January 2002. In the same period, she telephoned Samantha once: on 7 February 2002. Furthermore, the Inquiry notes Ms Gilman's social work record of her visit to Samantha on 22 January 2002, the morning after her talk of suicide. The record does not set out any analysis or thinking by Ms Gilman of the significance, if any, of the events the previous evening [293]. Earlier, following the 26 November 2001 Child in Care Review, Ms Gilman told the Inquiry that she did not follow up the suggestion made by Nugent that more staff be provided for Samantha [294]. Given Samantha's circumstances, this level of contact was manifestly inadequate.

9.159 Ed Coates was the Principal Social Worker in the Long Term Team (which is now the Care Management Team) from 1998 to December 2001 when he was promoted to his current level as Care and Contracts Manager which post he took up in April 2002. He is now the Child Care Co-ordinator. As principal social worker, he was Angela Gilman's line manager. However, for a period it was not clear who was managing Samantha's case. Mr Coates told the Inquiry that he felt "disempowered" [295]and that for a period, Julia Gilbert, who was managing Alex Watson who was Lyndsey's social worker, managed Samantha's case as well [296]. It was an informal arrangement. Mr Coates said that although there were good reasons for the arrangement (not least Mr Coates' extensive workload), it should have been formalised. It manifestly should have been formally recorded who was managing the case. Julia Gilbert did not really accept that she was "managing" Samantha's case [297]. She told the Inquiry that for a short period only from mid-July to mid-August 2001 she had chaired reviews[298].

9.160 Angela Gilman remained Samantha's social worker and bore front line responsibility for her. But responsibility also lay with her immediate manager: her line manager was Ed Coates. Her manager should have made sure that those things for which Ms Gilman was responsible were actually carried out and carried out appropriately: that Ms Gilman was appropriately supervising Samantha's care at Leece Lodge.

9.161 In the circumstances of this young person, Ms Gilman and her immediate manager Mr Coates felt to a large extent disempowered. Ultimately responsibility for Samantha therefore lay with more senior management. Trevor Noden told the Inquiry, that after the move to Leece Lodge 2 political pressure on Social Services eased off and Samantha became less of a priority for senior managers [299]. She went

[293] Day 3: 106-107
[294] Day 3: 88-89
[295] Day 11: 99
[296] Day 11: 108 – 110; Day 12: 87-89.
[297] See also chapter 17
[298] See chapter 9
[299] Day 19: 151: 21-25

"off the political radar" [300]. However, the Inquiry is clear that Trevor Noden and other senior managers remained ultimately responsible for her and should have managed the Social Services Division in such a way that they could be assured that the welfare of Samantha, a child in the care of the DHSS, was being met [301].

Conclusions

9.162 Social services failed to act appropriately in the handling of Samantha's care and support at Leece Lodge 2. Francis Charlton told the Inquiry that, from his brief experience of child care on the Island, service providers were more involved in decision making than maybe they were in England [302]. However, the Inquiry is clear that where a child or young person is "looked after" by social services, he or she remains the responsibility of social services whether the care and support is provided directly by them or provided by a service provider. In the latter situation social services still remain directly responsible for the young person. Social services must be satisfied that it knows what is happening in the child's life. This is a matter to which the Inquiry returns in Part 2.

9.163 There was no care plan, no placement agreement, no support package and a lack of clarity as to the objective of the placement. There were no real boundaries, limits, rules or controls. There was no structure to her days and to her life. There was no one on the campus who was responsible for her. There was no one supervising her. Samantha was involved in drink, drugs and criminality. This was a lifestyle which can be described as dangerous, both to her physical wellbeing and to her emotional and behavioural wellbeing.

9.164 Although the language used is unattractive [303], the Inquiry has concluded that Damian Bradley's August 2001 'briefing document' was an accurate description when it described the placement as 'warehousing' Samantha and when he referred to the move being seen by some as a 'folly.' Social services certainly accepted that the care and support provided at Leece Lodge 2, such as it was, was a "minimum intervention package". It fell below the level of that which should have been expected if an attempt was to have been made to meet Samantha's needs, even at this late stage.

[300] Ed Coates [Day 11:107:14]
[301] See further chapter 17
[302] Day 15: 129-131
[303] The Inquiry notes that, two months earlier, the unattractive description "warehousing" was also used, inappositely on that occasion, in connection with George's placement at Eden Grove in a Children and Families Resource Panel document in June 2001

CHAPTER 10

OVERVIEW OF GEORGE'S PLACEMENTS

10.1 George James Green was born on 27 December 1985. His mother was Margaret Green who was born 31 May 1953. His father Edric Green was born 12 January 1951. George had three full siblings: Jennifer Green born 21 October 1978, Shirley Green born 8 March 1982 and Kathryn Green born 16 June 1983. He had two half-sisters, Suzanne and Jacqueline, Mrs Green's daughters from her first marriage.

10.2 Social Services had been involved with the family since 1983 because of concerns about verbal and physical abuse of Mrs Green and the children by Mr Green and concerns held by Social Services for Kathryn. The family had been known to the health visiting services since 1982[304]. As late as 1998, the main focus within the Social Services Division was actually Kathryn, George's older sister.

10.3 Throughout the period from 1998 to 2002 Sylvia Morrison was George's social worker[305]. She was a member of the Long Term Team (now Care Management Team) of which Ed Coates was the Principal Social Worker. Mr Coates had supervisory responsibility for George's case. He initially chaired some In Care Review Meetings regarding George but this was taken over Bryan Morris, the Division's Child Care Co-ordinator, shortly after George's move to Eden Grove [306].

10.4 Work with George began when his name was placed on the Child Protection Register.

10.5 The initial Child Protection Case Conference has held on 16 January 1998[307] when George was 12. The family had been known to Social Services for some years by this point and direct work was being undertaken with George's elder sister Kathryn at the time. The CPCC was triggered by George's poor behaviour; a long history of aggression, violence and alcohol misuse in the family was noted. George's name was placed on the Child Protection Register under the category of physical and emotional abuse.

10.6 In January 1998 Ms Morrison did not carry out an assessment of whether George should remain with his family but concentrated on preventative work in order to assist him in staying within the family home[308]. She further accepted that she should have made a full assessment of George at this time[309].

10.7 On 11 February 1998, Mr Green was sentended to 100 days imprisonment suspended for two years together with a suspended sentence supervision order for the offence of unlawful assault on his nineteen year old daughter. Probation service supervision sessions focussed on anger management, use of alcohol and family relationships. While complying with terms of his supervision, it was reported that he would not address the need to enhance his parenting[310].

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[304] Minutes of Child Protection Conference 16.1.98
[305] Ms Morrison had become George's social worker in October 1997: Day 4: 2
[306] Ed Coates statement W9.
[307] Day 4:13:12-14
[308] Day 4:14:4
[309] 4:13:12-14
[310] Letter from his Probation Officer to Trevor Noden 7.7.98 10/28/266

10.8 Through 1998 and until summer 1999, George's Child Protection registration as a child at risk of physical and emotional abuse was periodically renewed. His behaviour was deteriorating at school and at home where his family were having difficultly managing his behaviour. An educational psychologist's report on 15 October 1998 measured his IQ at 90, the lower end of average, and concluded that because of his behaviour he had special educational needs and would benefit from a structured behaviour programme.

10.9 On 23 April 1999 Mr Green was convicted of a public order offence arising out of an incident at the home when police officers attended. He was sentenced to 80 days imprisonment and his suspended sentence activated. The opinion of the probation officer at that time, M L Hulme, was that Mr Green had deeply entrenched views on disciplining his children and was unable to accept that many of their problems stemmed from his volatile personality often fuelled by alcohol; and that Mrs Green compensated for this by being too soft on the children. The probation service ceased to be involved with the family. He remained in prison until July.

10.10 On 29 April 1999 there was a major incident at Ballakermeen School. George was extremely abusive and threatened a teacher. He did not attend mainstream education again[311].

Cummal Shee

10.11 In May 1999 George was charged with actual bodily harm and attempted robbery. His mother refused to have him home and he was received into voluntary care[312] and was placed at Cummal Shee. Kathryn had been in Cummal Shee and Mr and Mrs Green were aware of the facility. His mother, despite having concerns about the behaviour of the young people at Cummal Shee, agreed for George to be placed there. His father was apparently not at home when George was taken but learnt where he had gone that evening. George remained at Cummal Shee for an indeterminable period.

10.12 At the end of Part 1 of the Inquiry, the Advocate for the DHSS suggested for the first time that George was not received into voluntary care and placed at Cummal Shee in May and that this occurred only in November 1999. The May 1999 date had appeared, unchallenged, in the chronologies prepared by the Inquiry Team and was based on a police document; it was mentioned and accepted by Sylvia Morrison and Ed Coates in their oral evidence, and was confirmed by George's parents. It was unfortunate that this dispute was raised after months of oral evidence that could have been used to determine the point. The Inquiry considered that it would not have been proportionate to recall witnesses and delay the closing of Part 1 of the Inquiry in order to seek to clarify this further. Social Services stated that their records and those of Cummal Shee do not mention a May 1999 admission. However, the Inquiry believes that that fact is not conclusive given the poor standard of record keeping within Social Services revealed throughout the Inquiry. Moreover, the Inquiry is concerned that the Social Services were unable to rely sufficiently upon their records to state categorically whether George was admitted in May or not. On balance, the Inquiry believes that there was a short admission in May 1999 but is unable to

[311] As to education, see chapter 13
[312] under CYPA 1966, s82

indicate how long that admission was for: it may be that admission was only for a matter of hours, equally the admission may have been significantly longer.

10.13 In November 1999, George's father requested that George be removed from the home and he was again received into voluntary care and was re-admitted to Cummal Shee.

10.14 Ms Morrison told the Inquiry that the admission to Cummal Shee was an emergency. But she admitted that, having worked with the family for years, she could see it was coming. If this was right, it seems a shame that the move from home could not have been more planned.

10.15 There appears to be have been no plans to move George to any other placement and the aim was that George be rehabilitated home to his mother. However, although Child in Care Reviews referred to a plan to asses whether he could go home, no assessment had yet been made as to whether this would be feasible. George's behaviour continued and he acquired a string of criminal convictions[313]. Social Services had not commenced care proceedings in George's case and had no intention of so doing.

10.16 Sylvia Morrison, George's social worker, said in oral evidence that she was not aware of the interim report by Julie Kent into Cummal Shee dated May 1999[314], or of Ms Kent's opinion that "It was difficult to establish that residence in Cummal Shee was of any benefit to young people living there," when she arranged for George to be placed there. She said that had she known about this report she may have made a different decision. However, the options were limited. Ms Morrison had considered foster parents but none were available who could cope with George's behaviours. There were no other appropriate residential units on the Island. She said Cummal Shee was the only available placement at the time.

10.17 The Inquiry has already stated its conclusions about the suitability of Cummal Shee as a placement for Samantha. These conclusions apply equally to George.

10.18 It was agreed by most of those giving evidence to the Inquiry that Cummal Shee was an unsuccessful placement for George and one which was from the outset likely to be so for the reasons explained in chapter 4. Ed Coates went as far as to say, agreeing with the parents, that he thought Cummal Shee compounded the children's problems and made them worse.

10.19 Both parents were uneasy about George going to Cummal Shee but accepted that he remain there[315].

10.20 George's care order was made on 13 January 2000 by the Juvenile Court sitting at Douglas pursuant to section 50 of the Children and Young Persons Act 1966. This came as a surprise to all involved with George. Given that this care order was made in criminal proceedings, there was no formal care plan lodged with the Court by Social Services. However, it would seem that the care plan at this point was reintegration home to his family.

10.21 The care order galvanised social services into action. Ms Morrison carried out an assessment of George's needs which was considered at a meeting on 28 February

[313] See Appendex 14
[314] Chapter 4
[315] Mrs Green Day 22: 31-35; Mr Green Day 22: 92-97

2000. The assessment concluded that his home life was volatile and chaotic; that the parental care was inconsistent; that his behaviour was anti-social; that neither George nor his parents would keep contact arrangements; and that he needed a long term programme, a complete change of placement and a clear, defined care plan, which might not be available on the Island. They began to look for an off-Island placement with significant educational input and firm boundaries. Ms Morrison told the Inquiry:

"We felt we couldn't offer him a full education programme [on-Island]. He wasn't receiving safe boundaries, even though he was offered structured daily programmes. And he was still getting into trouble. So we felt it had to be off the island."[316]

10.22 They chose Eden Grove.

Eden Grove

10.23 On 6 March 2000, George was remanded in custody charged with arson. On 23 March 2000, George was sentenced to a number of custodial sentences but was released on licence that day to enable him to take up his place at Eden Grove, a specialist educational residential placement in Cumbria run by Priory Care. The plan was that he would stay there to complete his education, i.e. until June 2002. Periodically whilst at Eden Grove, George returned to the Isle of Man for contact with his family and friends.

Return for Christmas 2001

10.24 He returned to the Island in December 2001 for Christmas contact. He was due to return to Eden Grove on 7 January 2002 but refused and remained on the Island. By this point in his life, George had 49 convictions for a variety of offences of violence, drug related crime [317] and dishonesty.

Conclusions

10.25 As to George's removal from home and the need to place at Cummal Shee, Ms Morrison told the Inquiry that having worked with the family for years, she would see that the breakdown in relationships and the consequent need to place George outside the family was coming. Given the involvement of social services with the family and Kathryn's behaviour, the Inquiry concludes that it should have been appreciated before 1999 that an assessment of George's needs was required and steps taken in the light of that assessment. His acceptable behaviour in primary school should have been viewed as only a temporary period of calm. As soon as his behaviour deteriorated at secondary school, it should have been recognised that George needed help.

10.26 The need for a proper assessment of George's needs was plain by the time he was placed at Cummal Shee in 1999 and should not have awaited the making of a care order by the Juvenile Court in criminal proceedings in January 2000.

[316] Day 4:35: 14
[317] George had no drug convictions

10.27 As with Samantha, the system for making assessments and care planning was not effective in George's case.

10.28 The Inquiry recognises that some help was given to the family prior to 1999, for example parenting classes. It recognises also that Mr Green rejected some offers of assistance and make it difficult for effective assistance to be given. Therefore the Inquiry believes that it would not be safe to conclude that further or more effective assistance could have been given by agencies of the government or that more effective preventative work could have been done with the family. However, early and full assessment would have allowed Social Services to determine the likelihood of the Green family complying with any preventative work and to plan for George accordingly.

10.29 As with Samantha, there was a very limited range of placements available for a child with emotional and behavioural difficulties on-Island. There was, in and around 1999, a shortage of foster carers able to handle someone with behaviour such as George's[318]. The fact that George did not appear to be improving at Cummal Shee, combined with the lack of any meaningful education (at least from May 1999); the lack of any clear boundaries; the problems with the individuals that George was associating with; and the limited available resources on the Isle of Man, should have served as the catalyst for Social Services to begin a search to secure an appropriate residential placement off-Island.

10.30 Finally, too late in the course of Part 1 to make it reasonably practicable to investigate further, the suggestion was made by the advocates for DHSS that George was first admitted to Cummal Shee in November and not in May 1999 [319]. The Inquiry believes that whether George was first in voluntary care and in Cummal Shee in May or November is not material to the broad picture of the level and effectiveness of care and support provided to George; and that the conclusions reached by the Inquiry hold good whether it was in May or November 1999.

[318] Sylvia Morrison Day 4: 31:7-11
[319] see above

CHAPTER 11

GEORGE AT EDEN GROVE

11.1 George was placed at Eden Grove on 23 March 2000, some three months after a care order was unexpectedly granted in the criminal courts. He was fourteen. According to Ed Coates and Sylvia Morrison, the intervening months had been spent looking for an appropriate resource. Social services did not suggest to the Inquiry that an attempt to find a placement akin to Eden Grove was made before they were granted a care order in January 2000. The Inquiry has already noted the delay in proper assessment and care planning.

11.2 Eden Grove was a 51 week (or, according to some witnesses, 50 week) educational placement situated in Bolton, Appleby, Cumbria. It is run by Priory Care, an organisation with resources both on island and in the UK. Priory Care were represented at the Inquiry as an Interested Party.

11.3 Eden Grove was identified as an appropriate placement for George because it offered a broad range of education from 9 am – 4pm Monday to Friday, something George had not received since, it appears, 1998. Its remote location and strict regime whereby each hour of the day was accounted for also made it attractive as a placement.

11.4 In accordance with Eden Grove's established practice, a detailed assessment was undertaken before offering George a placement. Specifically, the then Principal of Eden Grove, Ian McCready, and Andy Jones, Head of the 16+ Unit, visited George in prison on the Isle of Man. Despite his age, it was decided to accept George into the 16+ Unit for a trial period of 1 month. He arrived at Eden Grove on 23 March 2000 and during that initial period a number of multi-disciplinary assessments were carried out, including educational, psychological and psychiatric. In his report, Dr Terry Bruce, Consultant Psychiatrist, noted that George enjoyed his delinquent lifestyle and would want to return to it immediately on return to Isle of Man; that although there was no sign of thought disorder or delusional thinking, he was exhibiting signs of a conduct disorder; George required very firm containment and there was a grave risk of secure accommodation being needed. He concluded:

> "Although there are indications that George was in trouble before going up into secondary school the main problems seemed to have arisen over the last year or so. In George's case his conduct disorder has spilled over into patterns of delinquency which now seem well entrenched and will prove difficult to shift.
> Although George has settled quite well into the Eden Grove regime he will start to test boundaries over the next few months and will require very firm containment".

11.5 Following the initial assessment period it was concluded that Eden Grove could assist by devising and implementing a very specific, tailored programme that would be constantly reviewed and adapted as appropriate. Specifically, Liz Casling who was in charge of George's education at Eden Grove said in her witness statement to the Inquiry that:

> "George was always subject to a very tight routine and there was never any lack of clarity as to what was expected of him. The Post-16 Unit consisted of

> seven young people all on totally individualised programmes in line with their particular needs. Within the Post-16 Unit, most activities were supervised/delivered on a one-to-one basis and this was always the case with key skills. As George was in a high risk category, enhanced staffing was always in place and often activities were supervised/delivered on a 2-to-1 basis".

11.6 When the outcome of this initial assessment was a recommendation that he stay, social services planned for George to remain at Eden Grove until he finished his education in Summer 2002.

11.7 The Inquiry finds that Eden Grove was an appropriate placement for George. It was well chosen for its location, regime and educational opportunity. The staff worked hard with George and clearly cared about him. It is clear from the documentary and oral evidence that, at least at first, the placement was a successful one.

11.8 Eden Grove offered a comprehensive educational programme. George originally attended Carlisle College but in, it seems, November 2000 he refused to go any more. He was then taught in the in house temporary programme where he was fully compliant. He also received vocational training and had been working in a variety of placements.

11.9 The care offered to George at Eden Grove appears to have been exemplary. He had a good relationship with one member of staff in particular, Andy Jones. George did not behave consistently well whilst in Cumbria but Eden Grove staff strove to maintain a firm and caring regime throughout his period at the school. In his Opening Statement at Part 1 of the Inquiry, the Advocate for the families said:

> "In the main, no criticism is made as to George's placement at or of Eden Grove. Both Mr and Mrs Green wish to place on record their sincere thanks to the staff at Eden Grove for their magnificent work but they give particular thanks and praise to … Andy Jones in whom they and George had the utmost trust and confidence."

11.10 Eden Grove's isolated location, taking George away from his peer group on the Isle of Man, the staff to pupil ratios, the structured programme, the consistency of expectations, rules and boundaries, all contributed to what was a positive placement. That said, Dr Bruce was correct in his prediction that George would at times push the boundaries at Eden Grove, most notably after his return from home visits to the Isle of Man.

11.11 At Eden Grove, George received vocational, independent living education or key skills from 9.00am – 4.00pm, Monday to Friday [320]. Liz Casling told the Inquiry[321]:

> "George was enabled to continue his education and given a chance to achieve external accreditation. He was producing work and achieving at a level commensurate with his ability. He was also given the opportunity to gain vocational skills that would secure him future employment. Most importantly, he was well cared for, and allowed to be a child".

[320] Day 6: 74
[321] Day 6: 83-83

11.12 The placement was initially a success with George motivated and cooperative. Thereafter, George's behaviour fluctuated [322]. As early as September 2000, Andy Jones was writing to social services expressing serious concern at George's attitude and behaviour. He advised social services to look into other placements in case Eden Grove broke down because of George's reluctance to attend college. Liz Casling told the Inquiry:

> "…there were very very many times when George's behaviour was very much on the limit of us actually having to terminate his placement, in his aggressive behaviour towards staff, his responses to them, his refusal to actually enter into his programme" [323].

11.13 Despite the deterioration in behaviour, George only once got into trouble with the police while he was at Eden Grove. On 21 September 2001, he was arrested for stealing a mobile phone. There were, in addition, incidents in July 2001 and September 2001 where George was caught by staff attempting to purchase drugs in Penrith. In July, upon being discovered, he subsequently absconded from the unit for a few hours.

11.14 George's behaviour deteriorated further throughout 2001. Eden Grove continued to relate his poor behaviour to home contact visits. The question of home visits and their detrimental effect on George's placement at Eden Grove are considered in chapter 12[324].

11.15 Towards the end of 2001, Eden Grove staff felt that George had been doing well again. He had been working in a number of different jobs, including dry-stone walling in the period leading up to Christmas. George had received money for this work and had saved his earnings. Staff were impressed by his effort and industry.

11.16 George returned to the Isle of Man for the Christmas break and failed to return to Eden Grove at the end of the visit on the agreed date 7 January 2002.

11.17 The communication between social services and Eden Grove school was good. The Eden Grove staff were proactive in their handling of the challenges presented by George and social services were constantly kept appraised, by way of formal and informal reports, of George's behaviour and progress. Liz Casling described the working relationship as "extremely productive" with dates and times for meetings and correspondence always being kept and the lines of communication being "very upfront", as Ian McCready put it in his evidence to the Inquiry. It is clear from the oral evidence and the documents provided to the Inquiry that there were frequent discussions about George's behaviour between Sylvia Morrison and Ed Coates, from the Isle of Man end, and Andy Jones, Ian Noble, Liz Casling and Pat McKenzie from Eden Grove. Child care reviews also fully involved Eden Grove staff.

11.18 There is some suggestion that Eden Grove did not feel they were properly informed about how weekend contact on the Island had gone.

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[322] "We went in peaks and troughs with George": Liz Casling: Day 6:101:6
[323] Day 6:107:12
[324] Paragraphs 12.12

Conclusion

11.19 The preliminary view of the Inquiry, having read the documentary evidence provided by the Interested Parties, was that no criticism could be made of the care and support for George at Eden Grove. In the light of all the evidence and submissions made, the Inquiry concludes that the level and effectiveness of the care and support provided at Eden Grove was very good.

11.20 Sylvia Morrison, Ed Coates and social services kept in touch with Eden Grove appropriately in order that they could be assured that George was being cared for properly.

11.21 Furthermore, the Inquiry concludes that Ms Morrison and Mr Coates should be commended for their choice of placement which went a long way to meeting George's needs, including his all important educational needs. Social services made the right decision in placing George at Eden Grove and in being prepared to take the sole responsibility for financing the placement.

CHAPTER 12

RETURN TO ISLE OF MAN FOR CHRISTMAS 2001

Earlier contact visits while at Eden Grove: March 2000 – October 2001

12.1 George's contact with family and friends was fraught with difficulty. His contact took place on the Isle of Man over weekends. The frequency of contact varied, it was generally about six weekly.

12.2 The decision that George should go home for contact was made by social services. The reasoning behind the decision was varied but was based on George's wish to return to the Isle of Man for contact and the need, which social services believed existed, for him to retain cultural links with the Island.

12.3 There is also some dispute between Ms Morrison and the Green family as to their willingness to travel to Cumbria for contact. Sylvia Morrison said in evidence that social services would have funded George's parents to attend contact in the UK had they thought it appropriate[325]. She stated that she had asked George about his family visiting him in the UK but he had wanted to see his friends on the Island as well. Furthermore, George had a large extended family so it would have been difficult to arrange for each of them to go over. Ms Morrison also suggested that Mrs Green had ruled out contact in the UK because of her full time job [326] and other tasks at the weekend[327]. She had spoken about this on the phone with Mrs Green and, possibly, gone to visit her too; but she had to accept that there was no contemporaneous recording of this[328].

12.4 However, Mrs Green told the Inquiry that social services did not offer to pay the cost of contact in England. When she and Mr Green visited for prize day in July 2000 (when George received an award for good behaviour and progress), although social services paid for the ferry, the family had to pay the cost of accommodation and other necessary expenses [329]. It should be noted, though, that Mr Green did not himself suggest that the family visit George in Cumbria instead of George coming to the Island [330].

12.5 Social services determined when George would visit the Isle of Man. Eden Grove would be notified and at the agreed date and time George would be delivered by Eden Grove staff to the ferry at Heysham.

12.6 Initially, George stayed with his mother during home contact. This did not go smoothly. After a particularly troublesome contact over the Christmas 2000-2001, MFS were engaged to supervise George's contact in February 2001. It was decided that they would accommodate him when on Island rather than his staying with his family. It was MFS' responsibility to meet him off the boat, accommodate him and ferry him to and from contact and activities. However, as Ms Morrison told the

[325] Day 4:38:9 – 12
[326] Day 4:43:10-18
[327] Day 4:57:20, Day 4:58:1
[328] Day 4:59:19
[329] Day 22:64-67
[330] Day 22: 106-107

Inquiry, the flaw was that when George was left at his family home, he would run off and do as he wished [331] .

12.7 At first, George complied and stayed at his MFS placement during contact. Over time, however, he absconded more and more as the limited documentation available shows and as Mrs Green described to the Inquiry [332].

12.8 In October 2001, he was allowed a contact where he stayed wholly at his mother's house, which was risky [333]. It was not successful and he failed to return on time to Eden Grove. George thereafter refused to stay at the MFS placement and, voting with his feet, stayed with his mother or friends, often Samantha Barton.

12.9 The type of support offered to George during contact is somewhat sparsely documented. The few available and relevant documents (such as the timetable of activities and the unsigned service level agreement with MFS) seem to indicate that George's time was meant to be split into periods where he could see his friends, see his family or engage in activities. Clearly, when George absconded during contact, these timetables were not adhered to. Mrs Green described to the Inquiry how George would behave when on the Island for contact. He was allowed unsupervised contact with his family, from which he often absconded [334]. Richard Kneen, director of MFS, accepted that he and MFS might have underestimated how serious George's behaviour was on the ground, but that at the time he thought he was taking it seriously [335]; that MFS' supervision of George was not as successful as he had hoped [336]; and that there was "some truth" in the suggestion that arranging contact where George had unsupervised contact with his family was tantamount to allowing him to run off because his mother was unable to control him [337].

12.10 Victor Whiteside, another director of MFS at that time, frankly accepted in his oral evidence that MFS supervision of George was not effective and that George went missing [338]. He recognised from the beginning that the task of supervising George was not going to be easy [339].

12.11 Very few contacts went smoothly. From some of the earliest contacts, George absconded and returned to his delinquent lifestyle whilst on the Island. He drank, took drugs and, according to his own account, indulged in criminal activity – although he was not arrested again by the Isle of Man constabulary until October 2001 [340].

12.12 From about September 2000, Eden Grove staff complained about the detrimental effect of home contact upon George's behaviour and attitude. The contrast between the seriousness of his behaviour on Island and that in Eden Grove was plain, as was the contrast as to the level of supervision employed. It was made clear to social

[331] Day 4: 54-56
[332] Day 22:43-45
[333] Richard Kneen Day 8:113
[334] See also Day 22:62-63
[335] Day 8:108-110
[336] Day 8:117:18
[337] However, Richard Kneen suggested that it was necessary because the on-island visits would help George when he returned permanently and because he had "rights": Day 8:110-111.
[338] Day 9:60:5
[339] Day 9:60
[340] As to his criminal record, see Appendix 14

services that George's home visits to the Isle of Man were having a detrimental effect on his performance and behaviour at Eden Grove. This was not unusual and there was often a period of adjustment when a pupil returned to Eden Grove after a home visit. In George's case the change in behaviour and attitude was pronounced. Eden Grove was concerned regarding the activities that he was undertaking during periods of home leave. George was quite vocal about this to Eden Grove staff; full details were recorded and notified promptly to social services. For example on his return after his contact in January 2001, Eden Grove staff reported to social services their concerns about his drink and drug misuse on the Island and his involvement in criminal activities.

12.13 Eden Grove suggested that more contact should take place in Cumbria with less frequent visits to the Isle of Man. Social services did not follow this advice.

12.14 Social Services had considered reducing the contact from 6 weekly but had concluded that it needed to be regular since the eventual plan was to return him to the Island [341]. Ms Morrison suggested contact took place in the family home, unsupervised because social services did not want to be seen as interfering. When asked why, when George was placing himself in danger, she did not interfere, she said:

"I felt at that time there was nothing else we could do if George was going to maintain contact with his family, except to ban him coming back to the Isle of Man" [342]

12.15 There was no formal assessment of the advantages and risks involved in contact on the Island [343]. Senior managers of social services were aware that soon after the placement at Eden Grove the staff noticed a negative connection between his progress at the placement and home contact. Trevor Noden told the Inquiry that he knew from the start that home contact would need to be carefully managed and that Mrs Green could not control George. He explained that:

"we were trying to achieve a very fine balance between allowing George the contact that he wanted and in fact research suggests young people in care need, against not allowing him contact and supervising him properly. So I think there was a very fine balance to be achieved there." [344]

12.16 Trevor Noden agreed that the department took a long time to change its mind about contact on the Isle of Man [345]. Ms Morrison was unclear why the decision to suspend contact on the Island was not taken sooner; and she frankly conceded that social services should "possibly" have looked at terminating contact before they did [346].

12.17 George's father wrote a letter to Isle of Man social services dated 18 April 2001 expressing his concern at George's behaviour during contact on the Island – mixing with people involved in drink and drug misuse and residents of care homes where no control existed and who were getting into trouble - and his alarm at what he perceived as a lack of supervision of his son and the need for stronger supervision on visits to the Island. Mr Green told the Inquiry:

[341] Day 4:61:10
[342] Day 4:62-63
[343] Ed Coates Day 11: 128-131
[344] Day 20: 22-28
[345] Day 20:28:13
[346] Day 4:68:24

"he [George] was coming home and he was more or less left to his own devices. He was running with the same people that he had been running with over here, and he was getting into trouble all the time. He wasn't returning home. He wasn't doing nothing. There was one particular time when I was up the house we had to get the paramedics out to him. He come in, whether it was drink or drugs or what, I don't know what it was, but we had to get the paramedics out and everything and he was just left. They weren't doing nothing at all" [347]

12.18 Communication between MFS and social services as to the success or otherwise of each contact visit appears to have been poor. The records of MFS obtained by the Inquiry through social services and the police show very few written accounts of how contact progressed, albeit that MFS now claim there are records missing after handing George's file to the police after the murder [348]. The police have provided to the Inquiry what they say is the full extent of the file given to them. It contains notes of contacts but only very few and each contains only scant detail.

12.19 Sylvia Morrison told the Inquiry that she requested written records but that they were not forthcoming. Ms Morrison told the Inquiry that she received verbal reports [349]. In all, the Inquiry is struck by how little information from MFS there is in social services' files. It appears that there were regular meetings pertaining to George and his contact and that MFS, social services and Priory attended these. The impression formed by the Inquiry is that Ms Morrison may not have had a full picture of what occurred during contact on the Island.

12.20 Yet again the shortcoming in social service record keeping has meant that it is not fully clear when Sylvia Morrison requested that Priory Care take on the role of supervising George during contact (Ms Morrison says June, Priory say September 2001). On balance, the Inquiry finds that the possibility of Priory Care taking over George's supervision from MFS was first raised in June 2001; the Initial Referral Form to Priory Outreach and Aftercare Team completed by Sylvia Morrison is undated but bears a fax date "June 2001". The minutes of Children and Families Resource Panel meeting on 19 September 2001 record that George's last home visit went badly when he went missing and that he would " probably require reintegration on the IOM over next year as due to leave care" and that social services "agree to shift responsibility of accommodating /facilitating contact visits from MFS to Priory". This was an agreement in principle. Priory (on the Isle of Man) became more involved in planning contacts but did not take over the supervision or arrangements at this point as they did not have suitable accommodation.

12.21 At the meeting on 24 September, social services asked Priory's outreach team to assist with George's visit to the Isle of Man, scheduled to commence on 28 September 2001. Priory could not assist for that visit due to a lack of resources and that was made clear to social services at the meeting. It was agreed with social services that Priory would assist MFS by providing outreach services for George's scheduled return to the Isle of Man for the period 23-25 November and any future visits. The record states that the intention was to "accommodate/supervise George for weekend 23-25 November and any future visits, barring Xmas/New Year when George will be at his mother's with intensive support offered" – but the record does not say by whom. This is contrary to the evidence of Richard Kneen of MFS who

[347] Day 22:104:9
[348] See below
[349] Day 4: 51-53

said that he approached Priory when he believed that MFS might not have had enough staff to cover the Christmas period.

12.22 George was due to spend the weekend commencing 28 September 2001 on the Island to attend a family wedding and to stay with Mrs Green. George came for the weekend. As on previous visits, he refused to return to Eden Grove at the end of the visit and remained on the Island.

12.23 It is necessary to examine how this was dealt with.

12.24 Prior to his return in September 2001, Sylvia Morrison, wrote to the police alerting them to the fact that George was returning to the Isle of Man to attend a family wedding. On 5 October 2001 Ms Morrison met with Sergeant Richard Power, Ms. Crapper (legal advisor to social services) and Victor Whiteside of MFS. At this meeting it was acknowledged that it was unlikely George would return voluntarily to Eden Grove on the 11 October 2001. Ms Morrison is to be commended for these actions: initiating this multi-disciplinary working and sharing of information, together with the anticipation of events and consideration of resolution of anticipated events, namely George's refusal to return to Eden Grove.

12.25 A Social Services Planning Meeting was held on 9 October 2001 with attendance by Ian McCready from Eden Grove and by representatives from MFS and Priory. It noted that there were reports of George being seen out under the influence of "substances" and that there was a "real possibility that George spends considerable amounts of time (possibly overnight) with Lyndsey Barton at Leece Lodge". It was decided to continue attempts to return George to Eden Grove and MFS and Priory Care Outreach team were to co-ordinate resources on achieving this. All future home visits to the Island were stopped until further notice.

12.26 On 11 October 2001, George was arrested and charged with offences of criminal damage and public order. He was detained overnight by the police. Juan Corlett, a social worker, had made on behalf of social services a statement for the police dated 11 October 2001 in which he said that

> "[due to George's] behaviour, failure to co-operate and his present apparent disregard for authority, IOM social services … cannot place George in any kind of accommodation on the Island. I would suggest that George remains in police custody pending a court appearance".

On 12 October 2001, the Juvenile Court remanded him in custody and he remained in custody.

12.27 He appeared in court on 23 October 2001. Ms Morrison prepared a report dated 22 October 2001 in which she stated that she was concerned that if George remained on the Island he would "endanger himself or others" and she asked the court "to consider placing George into police custody and for the police to escort George onto the boat at 7.45pm on 23 October 2001". On 23 October 2001, he received a conditional discharge for twelve months from the Juvenile Court.

12.28 George was back at Eden Grove on 24 October 2001.

12.29 Initially, his behaviour on return was poor. But during November he worked for a builder 5 days a week, leaving the campus at 7.30 am and returning at 5pm. Reports from work were good and as the Educational/Vocational Progress Report notes: "the fact that he is getting up and going willingly speaks for itself" . Ms Casling told the

Inquiry that this was very positive and that his good behaviour was instrumental in the decision to allow him home for Christmas. He left for the Christmas contact keen to return and continue his successful work experience placement[350]. Ms Casling told the Inquiry that Eden Grove thought it probable that George would revert to a criminal or dangerous lifestyle over the Christmas contact notwithstanding his recent good behaviour in Eden Grove[351].

Contact visit to Isle of Man for Christmas: December 2001 – February 2002

12.30 The longer term plan since March 2000 was that George would return to the Island in June 2002 at the end of the academic year. Despite the increasingly harmful effects of his visits back to the Island, this long term plan was never re-considered or a fresh assessment undertaken by social services. The Inquiry heard from a number of witnesses, the social worker and her managers Ed Coates and Trevor Noden, that it was thought that George needed to return to his cultural roots. This belief was strongly held by a number of social services witnesses. The Inquiry thinks it likely that this contributed to what amounted to an assumption that George should return and a failure adequately to consider alternatives as part of an assessment. The die was cast for a return despite the increasing evidence that George would be unwilling and unable to resist the delinquent activities of his peers when back on the Island.

The plan for Christmas contact

12.31 Despite the problems of earlier contacts and despite the decision during the October 2001 visit that contact home should be suspended, it was nevertheless decided that George should be permitted to go home for Christmas. There were attractive arguments for this course. George's 16th birthday fell on 27 December. Eden Grove was closed for the Christmas period between 24 December and 4 January and all the children were due to go home. Staff would have to be brought in specially to care for George had he remained [352]. Liz Casling told the Inquiry [353]:

> "I think it was a balance of reality, of what would be achievable and what would not be. I think it was certainly felt that if George was completely stopped from going home, that he would then - - and he had voiced - - he would ensure that his placement at Eden Grove came to a stop, by committing an act, or committing a violent act, that would be such that we would have to exclude him, and he had voiced that, and it was keeping the balance of him having Eden Grove there for him and him choosing to cease it on his own actions, I think. So it was a very difficult balance".

If the home leave over Christmas 2001 had not been allowed, Liz Casling concluded that

> "I don't have any illusions that he would have participated in the programme cooperatively at all".

[350] Day 6:101:13
[351] Day 6:102-103; and Ian McReady Day 6:138-139
[352] In November 2001, Trevor Noden gave Ms Morrison permission to fund the family to visit Cumbria over Christmas 2001: see Trevor Noden Day 20:44
[353] Day 6: 91

12.32 Mrs Green in evidence said that she would not have liked to stop George coming home at that time and that it was the only decision that could be made [354]:

> "Q … Do you think he should have been allowed back that Christmas? It is a hard question, I know.
> A. I wouldn't have liked to stop him coming back for that Christmas, because I think he might have tried to come back on his own anyway.
> Q. Did he really want to come back for that Christmas and his birthday?
> A. Yes. I don't think it would have worked, us going over there for Christmas. Maybe the other breaks, but the Christmas break, obviously he wants to see his sisters --
> Q. You have got all your other children here, haven't you?
> A. Yes.
> Q. So that maybe wouldn't have been a good idea?
> A. No.
> Q. So do you think it was the right decision to allow him to come back for Christmas and his 16th? Remember Eden Grove was closed.
> A. I think it was the only decision, really."

12.33 The plan which was drawn up for the visit was that George would return for his contact visit on 21 December 2001. George was to be met by MFS. He would stay in MFS accommodation at Foxdale until 24 December. He would spend a few days over Christmas between 24 and 28 December with his mother, would return to MFS accommodation from 28 to 31 December, stay with his mother from 31 December to 2 January and then stay in MFS accommodation until 7 January 2002. George was due to return to Eden Grove on 7 January 2002. There appears to have been no contingency plan drawn up in case George did not adhere to the original plan. It was accepted by everyone that the plan was unlikely to work.

12.34 Social services told the Inquiry that they arranged for Priory and MFS jointly to supervise the final 2001 Christmas contact. Priory Isle of Man concurred with this statement. This was disputed by Richard Kneen who claimed that he approached Priory when he feared MFS did not have sufficient staff to cover the contact alone; and that when he realised he did indeed have enough staff he informed Priory and they were delighted not to be needed.

12.35 Anne Seed, line manager for the Priory Outreach Team staff, told the Inquiry that the plan was that there was to be 24 hour staff cover whereby one member of staff from MFS and one from Priory would be with George at all times; this plan was devised by social services, MFS and Priory[355]. The Priory involvement in the plan was written up by Anne Seed. Ms Seed did not see a copy of the full written plan for the December contact.

12.36 A planning meeting took place at Hillary House on 23 November 2001 attended by Sylvia Morrison and Bryan Morris, the Child Care Co-ordinator, from social services, Anne Seed, outreach manager, and Eamonn Moore, team manager, from Priory and Richard Kneen of MFS to discuss the framework for George's return over the Christmas holidays. There is a handwritten note made by Sylvia Morrison, which refers to "outreach will maintain daily contact". Priory have a typed note of this meeting. It records that "outreach (MFS and Priory) will maintain daily contact with George during this period". Ms Morrison set out the plan in a document dated 28

[354] Day 22: 48
[355] Anne Seed Day 7:12-14

November which again refers to outreach being provided by MFS and Priory. Anne Seed produced a staff rota for Priory's supervision of George which provides Priory staff for 24 hour cover when George is not staying with his mother [356]. She sent this document to Sylvia Morrison on 14 December under cover of a letter in which she said that she would liaise with Richard Kneen "regarding this joint piece of work". She also sent the rota with a covering letter to Richard Kneen.

The change of plan as to Priory's involvement

12.37 On 21 December 2001, Anna Koning, a member of the Priory outreach team, was ready to start her shift following George's arrival on the Island on that day. Anne Seed told the Inquiry[357] that Anna Koning rang Richard Kneen to find out when her shift would commence and that Richard Kneen said that she would not be required and she should ring back on 22 December 2001 to make sure that MFS had sufficient staff on duty. As requested, Anna Koning telephoned Richard Kneen on 22 December 2001 and the telephone attendance note of that discussion, prepared by Ms Koning, reads:

> "I contacted Richard Kneen at lunch time to be advised if I would be required to work with the above young person. Richard advised me that my services were not required for today and the duration of George's visit. He indicated that his staff team was sufficient to cover the young person's timetable. I immediately contacted Kenny Best via mobile phone to inform him of the situation".

12.38 Thus, Priory contacted [358] social services immediately and spoke to the duty social worker, Kenny Best. However, there is no evidence one way or another as to whether the message was passed on to Sylvia Morrison on Monday, 24 December save for her surprise in the witness box that Priory had not been involved in that period. No one from social services intervened to suggest to either Priory or MFS that Priory should remain involved over the crucial Christmas period. Priory had no further contact with social services until 8 January 2002 [359].

12.39 Social services and Priory state that they arranged for Priory and MFS jointly to supervise the final 2001 Christmas contact. However, Richard Kneen stated that he approached Priory when he feared MFS did not have sufficient staff to cover the contact alone. He said that when he realised he did indeed have enough staff he informed Priory and they were delighted not to be needed. He accepts that he made this call without reference to social services. Anne Seed, on the other hand, says Priory staff were frustrated not to be involved. The Inquiry received a statement from Voirrie Moore, late wife of Eamonn Moore, which partly backs up Mr Kneen's evidence.

12.40 The Inquiry notes that Sylvia Morrison approached Priory in summer/autumn 2001. The Inquiry notes that Anne Seed drew up a staff rota for the Christmas contact and wrote to MFS with questions about the contact. It is known that Priory staff attended meetings on George throughout the autumn and winter. In material respects, Mr

[356] But the document makes no reference to what staff, if any, would be involved when George would be staying with his mother
[357] Day 7:20-21
[358] Anne Seed Day 7:21:2 – 7:22
[359] Day 7:28:11

Kneen's evidence was not borne out by the contemporaneous documents and, as to when Priory was invited to assist, was inconsistent. The Inquiry concludes that Priory's intended role was accurately described to the Inquiry by social services and by Anne Seed.

12.41 The Inquiry concludes that Priory were involved at the behest of social services, not MFS; that they had played a large role in planning the contact with MFS; and that they were released from that role after a phone call from Richard Kneen without consultation with social services.

The change of plan as to accommodation

12.42 On 21 December 2001, George arrived on the Island for his Christmas contact. He visited his mother that day. However, he absconded on 21 December when his mother dropped him in town [360]. He never stayed in the MFS accommodation provided at Foxdale. He was due to go to his mother's on 24 December. Richard Kneen telephoned the duty social worker on 21 December and informed him that George had gone missing. They arranged to meet at George's mother's the next morning. The care plan was amended so that George could stay at his mother's. Richard Kneen maintained that it was the duty social worker, Kenny Best, who changed the plan and that he agreed with the decision. The Inquiry notes, however, that while it may have been Mr Best who made the formal decision to change the plan, as duty social worker and knowing little about the case, he would have relied heavily on what Richard Kneen told him. Mr Best told the Inquiry that he has no proper recollection of these events.

12.43 It is accepted that the duty social worker should have informed the out of hours principal social worker, Julia Gilbert, at the time and the allocated social worker on Monday 24 December. Mr Best says that he has no specific memory of doing so in this case but that was his practice on every occasion. Ms Gilbert also has no memory but accepts that one of the logged emergency calls would have been from Mr Best about this issue. Mr Best has not been able to check the out of hours duty log to see his record: the log is missing. His practice was to ask the secretary to type up a copy of the relevant log and pass it to the allocated worker. Given it was the Christmas period he does not know when the note would have been passed to Ms Morrison but points to that fact that the situation was discussed at the Children and Families Resource Allocation Panel on 28 December 2001 as evidence that it had reached the relevant people by then.

12.44 The Inquiry was told that Ms Morrison was not informed about George's failure to go to MFS accommodation over the weekend he returned at Christmas 2001. It appears that Ms Morrison was in work that Monday but was then on leave. She could have been informed on that Monday. It appears that either Mr Best did not pass on the information on 24 December or he did so and it did not reach Ms Morrison. Given the difficulties surrounding George's contact on the Island, the Inquiry cannot hide its surprise that, despite it being Christmas Eve, Ms Morrison did not enquire herself how George's contact was progressing before she went on leave. Given the change in George's accommodation, the plan needed to be reviewed. Richard Kneen did not contact Ms Morrison or Ed Coates direct [361]; the Inquiry is surprised that he did not

[360] Day 7:25
[361] Day 8:126-128

contact Ms Morrison or Ed Coates about the need to review the plan when he had not heard from either of them about doing so.

12.45 Ms Morrison told the Inquiry that she received no written reports of George's Christmas contact until February 2002. Richard Kneen accepted that the written record of the Christmas contact may not have been delivered to Ms Morrison until February 2002 but said that she was verbally updated. Ms Morrison appears not to have known either that Priory was not involved or that George was not staying at Foxdale.

12.46 At the Children and Families Resource Allocation Panel on 28 December 2001, chaired by Ed Coates and attended by representatives from MFS and Priory IOM, it was recorded in connection with Leece Lodge that "George Green and [another young person] around and no concerns"; and in connection with George that he was "not using the resources on offer. Has stayed with Mum – MFS have seen him a lot and Margaret will continue to look after him. Likely problems will occur when he is due to go back".

12.47 Richard Kneen told the Inquiry that, while at his mother's home, MFS generally visited George three times a day and that George was there not 50% of the time [362]. In his criminal statement in 2002, he had described it as "calling in every day to check everything was all right" and added that because of the snow, there was no visit on Boxing Day. Margaret Green told the Inquiry that it seemed to be as long as they had seen him for five minutes "that was it" [363]; and that for most of the time he was left to his own devices [364]. The Inquiry notes that this is very different from a regime of close supervision of George designed to keep him away from delinquent behaviour.

12.48 On 28 December 2001, George was arrested for a public order offence. Early in the morning on 29 December (at 0046 hours), Richard Kneen attended the police station as the appropriate adult [365] and at 1.29 am George admitted the offence and was cautioned.

12.49 Later on 29 December 2001, George was arrested for theft from a motor vehicle. Victor Whiteside from MFS attended the police station. Victor Whiteside made representations to the custody sergeant that George had indicated to him that once out of the Police Station he would absent himself from his local address and furthermore that MFS were unable to control him. George was charged immediately and detained. A Certificate of Detention, in accordance with section 41 (6) and (7) of the Police Powers and Procedure Act 1998, was signed by the Custody Sergeant stating that there was nowhere safe for George to reside (as had happened in October 2001).

12.50 George appeared in court on 30 December 2001. He was also charged with theft from a car between 26 and 29 December and criminal damage to a car on 28 December. He was remanded in custody until 7 January 2002. Edric Green told the Inquiry that both he and Mrs Green had refused to provide a bail address in the hope that George would be escorted back to Eden Grove [366].

[362] 8:135
[363] 22:49
[364] 22:49
[365] Day 8:140
[366] Day 22:124

12.51 On 7 January 2002, George received a conditional discharge for 12 months from the Douglas Juvenile Court. He was due to return to Eden Grove that evening. During the course of the day, George absconded but later made his way to the docks and met Richard Kneen, Carl Faragher[367] and, possibly, one other in the waiting room at the ferry terminal, apparently willing, if not eager, to board the boat. Richard Kneen told the Inquiry that George "didn't want to go, but he was going to get on the boat" [368].

12.52 It is agreed by all concerned that George's father, Edric Green, then joined the group while they waited for the boat. There was some dispute between witnesses, and between the oral evidence and the contemporaneous written documentation, as to what happened next. Richard Kneen told the Inquiry that George was at the terminal ready to depart when Mr Green came in. George said to Mr Green that he did not want to go back and could he stay with him. Mr Green replied that he could always stay with him and before he had finished his sentence, which ended with Mr Green saying that he thought George should return to Eden Grove, George had run off [369].

12.53 Mr Green's account of events to the Inquiry was at variance with other witnesses. Mr Green said he went to the ferry terminal on 7 January 2002 in order to travel with George on the boat over to the UK and have a good talk with him. He says there was no social worker there when he arrived and George was talking to one of his friends. Mr Green said that he told George about his plan to take the boat with him but George just said, he would be wasting his money and he ran off [370]. Later in his evidence, Mr Green said that George "was going as I got there … He had no intentions of going [back to Eden Grove]"[371] . He accepted he had had "a couple of drinks", later saying this had been three pints of bitter [372].

12.54 Because of the inconsistency in the oral evidence given to the Inquiry and some disparity between Mr Kneen's written and oral accounts of the incident, the Inquiry believes that events on 7 January 2002 are most reliably recorded in the accounts given close to the events in question and which are set out in the paragraphs below. They contain a consistent core account and the Inquiry finds that they are more likely to be an accurate account of what occurred.

12.55 In his witness statement made on 23 March 2002 in the criminal proceedings, Richard Kneen said:

> "On Monday 7th January 2002, George was dealt with by the court and given a Conditional Discharge. George agreed that he would go back to Eden Grove that day. This was the day he was originally meant to go back.
> One of our staff Andrew (Ned) Guest took George to the prison at 3 p.m. that day for him to collect his things. George did a runner at the prison. George was located by myself and Ned in Strand Street at about 5 p.m. He refused to come with us but stated that he would meet us at the Sea Terminal at 7.15 p.m. George did meet us and as the departure of the boat was called we started to walk with him towards the departure area. Just at that point George's dad Eddie turned up. George then had a change of mind and asked Eddie if he could stay with him. Eddie told George that he could always stay

[367] Priory outreach worker
[368] Day 8:146:10
[369] Day 8: 146
[370] Day 22:116-118
[371] Day 22:119-120
[372] Day 22:118 and 22:120

> with him. George then did a runner. I don't know if we reported him missing to the Police or not. We did liaise with Eden Grove to tell them George wasn't on the boat."

Carl Farager, a Priory outreach worker, in his social work notes at the time wrote:

> "At 6.45 p.m. George arrived at the terminal on time he was saying that he will go, once his mum has given him £20. He said that he will not go without seeing her. He made several phone calls but could not find her. Richard offered to pay the £20 but George refused. He then phoned his dad. His dad arrived (drunk) and said that he could stay overnight at his house and then he would travel with George next day. George then ran out of reception and disappeared followed a few minutes later by his dad. 8.00 p.m."

Syliva Morrison in her social work notes records the contents of a telephone call from Richard Kneen on 9 January 2002:

> "he did go to the boat but then Mr Green said that he could stay overnight with him and he ran off".

Attempts to return George after 7 January

12.56 George thereafter refused to return to Eden Grove. Attempts were made by MFS and social services to persuade him to return. It appears that a number of tickets were booked for George to return but he rejected them. He continued to live a delinquent lifestyle and was arrested six times from 7 January until his death, though he was never charged.

12.57 The Inquiry received evidence that George was in the company of Samantha on a number of occasions. On 14 January, George was at Leece Lodge 2. On 16 January 2002, George and Samantha attended at the DAT clinic. He was arrested later that day while attempting to prevent the arrest of Samantha [373]. They were both arrested on 17 January for burglary [374]. On the morning of 31 January 2002, they attended at social services at Hillary House and both appeared to be "high" [375]. Lyndsey Barton told the Inquiry that George had become friends with Samantha when she came back to the Island in early 2001, and they had met through Lyndsey and Katharyn Green who were best friends [376].

12.58 On 10 January 2002 a meeting was held, attended by Ed Coates, Victor Whiteside of MFS and Anne Seed of Priory [377] to agree a plan for George's return to Eden Grove. It was agreed to stop purchasing daily tickets for George but to have daily contact with him to encourage him to return, to keep speaking to Mrs Green about the consequences of his not returning, to offer to purchase new clothing if he returned

[373] Letter Dickinson Cruickshank to Inquiry 25.7.05
[374] Social service record by Alex Watson
[375] See chapter 14
[376] Day 10:110
[377] Anne Seed Outreach Client Notes for 10 January 2002. Sylvia Morrison's Diary Sheets record only events on 9 January, 10 January (but not the meeting) and 7 February 2002

and to attempt to get George on the boat on Friday 11 or Monday 14 January. If this was unsuccessful, it was to be reviewed with Sylvia Morrison and/or Ed Coates.

12.59 Victor Whiteside indicated that there were ongoing attempts after 7 January to get George back to the UK. He telephoned Eden Grove each morning to let them know whether he had got George on the boat. He tried perhaps six times to get George on the boat between 7 and 21 January, going round to his mother's in the morning, waking him up and attempting to persuade him to return [378].

12.60 On 21 January 2002, a further meeting was held. It was attended by Sylvia Morrison, Ms Casling from Eden Grove, Anne Seed and Eammon Moore from Priory, Victor Whiteside from MFS and, for part only, Mrs Green; apologies were received from Debbie Evans of Ballakermeen High School. Again, the police were not invited to the meeting. It was agreed that Eammon Moore would meet George once a week to try to "persuade" George to return to Eden Grove (and the promise of a bike if he returned) and also to encourage him to attend a training centre on the Isle of Man for aptitude tests; that the Careers Service would look at college and training centre to ascertain what would be available; and that there was "no point in arranging tickets for George unless we are convinced he wants to return to Eden Grove". Mrs Green wanted George to return to Eden Grove.

12.61 However, at the meeting there was consensus that "It is highly unlikely that George will want to or will return to Eden Grove". Ms Morrison told the Inquiry that:

> "There was no formal decision taken at the meeting on the 21st January 2002 or at any other time that George was to remain on the Island although it was felt unlikely that he would return to the UK".

It heralded a change in emphasis: returning George remained the ultimate plan but plans should be made in the event that he remained on Island [379].

12.62 Thereafter, there was a further diminution of the effort to persuade George to return. Richard Kneen in his written statement to the Inquiry said:

> "It was agreed that it would be pointless trying to get him back to Cumbria due in part to the expense that would be incurred. It was agreed by Ed Coates and Bryan Morris that we stop looking after him".

In his statement for the criminal proceedings, he said:

> "following the meeting on 21st January, MFS had no further involvement with George until the afternoon of 6th February when I was surprised when Ed Coates contacted me asking if I had any ideas how we could get George back to Eden Grove" (emphasis added).

12.63 Mr Kneen in oral evidence to the Inquiry said that it was not a fair description of the meeting to say that MFS had been told to 'give up trying' to get George back. Instead, they were being asked not to book the ferry, staff, car etcetera unless they were sure George was getting on the boat [380]. Between 21 January and 7 February,

[378] Day 9:82-85
[379] Victor Whiteside Day 9:86
[380] Day 8:148

MFS tried to meet with George each day and tried to talk to him to persuade him to return [381].

12.64 Ms Morrison had a chance meeting with George on 29 January 2002 and had arranged a meeting with him for 5 February which he failed to attend.

12.65 On 6 February 2002, Ed Coates, having spoken to Mr Green, contacted MFS to ask them to try again [382]. On 7 February, Victor Whiteside spoke to George and to his father. Mr Green agreed that, if necessary, he would travel back to the UK with George and MFS staff in the following week [383].

12.66 During the course of 8 February 2002, neither Victor Whiteside nor Mr Green had been able to contact George on his new mobile telephone number. On 8 or 9 February 2002[384], George was murdered by Peter Newbery.

Arrests during January and February

12.67 George's first arrest following his release from prison on 7 January took place on 9 January, when he was arrested for handling stolen goods. Richard Kneen acted as appropriate adult but told the Inquiry that he could not remember the occasion . The police told the Inquiry that there was insufficient evidence to charge him at that stage and further enquiries were needed [385]. He was released on police bail to return to the police station on 20 February. The Inquiry notes that the course taken successfully by Victor Whiteside on 29/30 December was not available on this occasion because there was insufficient evidence to charge George.

12.68 On 16 January 2005, George was arrested for a public order offence at about midnight. Initially, the police called Margaret Green to act as an appropriate adult but she refused. Juan Corlett was duty social worker and attended. He allowed George to be granted police bail to his mother's address until 5 February. Mr Corlett told the Inquiry that there was nothing on the out-of-hours duty log to indicate where George should be bailed or that he required a remand in custody because he had no appropriate accommodation on the Island or that every effort should be made to effect George's return to Eden Grove.

12.69 In addition, Mr Corlett said that other information - such as his criminal records, a specific person to contact upon arrest or inappropriate bail addresses - would have been helpful but was not available. Mr Corlett stated that it was policy to give the allocated social worker a verbal account of the incident alongside a photocopy of the written account from the log book. A copy would be given to the team secretary for typing. If the social worker was not in, the written account would have been left in their tray and a verbal account given to his or her line manager. There is no record of Sylvia Morrison being away that day.

12.70 The police indicate that in relation to this offence, George was bailed to allow police officers to prepare their statements and for consideration of further charges [386].

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[381] Day 8:149
[382] Ed Coates Day 12:40
[383] Day 9:88
[384] The Inquiry was told that the coroner made no finding as to on which of these two dates the murder occurred.
[385] Letter Dickinson Cruickshank to Inquiry 25.7.05
[386] Letter Dickinson Cruickshank to Inquiry 25.7.05

12.71 On the night of 17 - 18 January, Alex Watson acted as an appropriate adult for George when he was arrested for suspected burglary. It was deemed inappropriate to interview him in the early hours and he was bailed without interview. The police accepted George giving his mother's address as a bail address and Ms Watson had been given no information either verbally or in writing to indicate that George should not return there. She did know George attended school in the UK but nothing more about his case. She wrote up the events in the out of hours duty log book. Following further investigations by the police, the case was not proceeded with.

12.72 On 20 January 2002, Kenny Best, duty weekend social worker, acted as appropriate adult for George when he was arrested on suspicion of theft of a mobile phone. George admitted the offence. The two others arrested with him did not admit their involvement. The police told the Inquiry that George was released on police bail until 16 February so that further enquiries could be made in order to enable the other two to be charged with George. Given that George had admitted the offence, the Inquiry is surprised that he was not charged. Mr Best now has a very limited recollection of events but concluded that neither he nor the police had any concerns about bailing George to his mother's address. Mr Best wrote in the duty log at the time:

> "George admitted responsibility… Mrs Green, who had earlier agreed to have George home, had phoned to say she couldn't now have him and was requesting Police assistance at her home due to a fight involving her daughter, Kathryn, "D" and others. Following much deliberation regarding the possibility of keeping George at police HQ, the custody sergeant again contacted Mrs Green. She advised that matters at home had been resolved and she would have George back".

12.73 On 31 January 2002, George was arrested for theft from a shop of goods valued at £125 [387]. George's sister Jennifer Charles acted as his appropriate adult, although she was unfamiliar with the role. Both the police record at the time and Ms Charles' statement to the Inquiry make clear that George admitted the theft. Despite his admission in the interview, he was not charged at that stage but was granted police bail to return on 16 February and the papers forwarded to the Family Protection Unit for their recommendation as to charge. Ms Charles told the Inquiry that she did not ask to where he was bailed, the police asked her no questions about bail addresses and that no mention was made of Eden Grove. She suggested that George was under the influence of substances during the interview. She told the Inquiry:

> "4. At the Police station I met George. … He was clearly off his head because he was laughing a lot. I did not ask him what he had taken but it would have been obvious to anyone that he had taken something. I did not ask either George or the Police about a Social Worker being present…
> 6. During the interview, … George still seemed to be off his head and he was quite happy to talk to the Police. George was interviewed about shoplifting at a clothes shop in Douglas. During the interview George was shown various items that I understand had been found in his possession when he had been arrested. Some of these were clothes that he was being accused of stealing but there was also a packet of carpet tacks which he explained were for mum as she had some carpet to put down…
> 7. George admitted that he had shoplifted the clothes. He was asked why he had done it and his response was "Well what would you do if you were

[387] Letter Dickinson Cruickshank to Inquiry 25.7.05

> getting threatened to have your kneecaps broken – you'd just do it wouldn't you?" The male Police Officer said something like "We're not here about that, we're just here about the shoplifting." These may not have been the exact words used by George and the Officer but they are as close as I can remember. …
> 9. I do not remember being given any options or having any discussions about bail apart from a couple of questions that I asked the Police. I had no idea what should be happening. I was just given a piece of paper to sign and I signed it. I did not read it in detail and I did not know what the form was for other than for George to be released. I did not know anything about bail and I was asking the Police officers whether I had to pay any money to get George released or whether I would have to pay money if he didn't turn up when he was supposed to. I do not know whether George was bailed to a particular address or told to go anywhere upon his release. I did not ask for him to be bailed to a particular place and there was no discussion about keeping him in custody. It just seemed to be a routine process. As far as I knew he was free and that was it…
> 11. I did not have any contact with Social Services about the interview either beforehand or afterwards. Nobody told me that they should be informed about the interview."

12.74 On 6 February 2002, George was arrested for shoplifting from an HMV store and for a public order offence. At about 5pm, Simon McCann, an outreach worker with Priory, attended as George's appropriate adult because there was no one from social services available. Mr McCann sat through the interview where George admitted the offence of theft to the police. Despite admitting the offence, George was not charged but he was given police bail to return on 16 February and the file was sent to the Family Protection Unit. Mr McCann told the Inquiry that his role was confined to ensuring the interview was conducted properly and bail arrangements were not part of his remit. He was aware of George's circumstances, having been updated at team meetings by Eamonn Moore. Social services gave him no information. He recorded a full account of the interview and aftermath in the outreach client notes and updated Eamonn Moore, though not Sylvia Morrison.

Conclusions

Contact on Island contact while at Eden Grove: March 2000 to October 2001

12.75 The Inquiry accepts that there were strong arguments for allowing contact on the Island, but it concludes that social services should have carried out an assessment of the benefits and risks to George of contact on the Island. Once it became clear that during contact, George was out of control and was putting himself at risk and that contact was jeopardising the Eden Grove placement, the need for such assessment became urgent. Social services should have faced up to having to make the decision to suspend contact on the Island sooner than October 2001, which was 18 months into the placement. There was a failure by the social worker Sylvia Morrison and by her manager to grasp the nettle.

12.76 Given the important effect which his contact on the Island had on George's wellbeing at Eden Grove, communication of information from the service provider supervising contact on the Island, MFS, to social services about that contact was not satisfactory. MFS should have provided far more detailed information. Social services should have insisted on being kept properly informed.

12.77 The Inquiry commends Ms Morrison for initiating the inter-agency co-operation and liaison between police and social services during the October 2001 visit and notes the unfavourable contrast with the Christmas 2001 visit. The Inquiry also commends the police for working with social services to effect George's return in October. In particular, the Inquiry notes:

(i) The warning by Sylvia Morrison that George was to return for contact was not repeated at Christmas.
(ii) The meeting between care provider and social services and the police, which took place in October to discuss how to deal with George[388]
(iii) Juan Corlett, the duty social worker at the time of the arrest on 11 October 2001, made it clear that a return to Eden Grove was important and made a specific request to the police in relation to George's detention to aid his return

The decision to return at Christmas2001

12.78 Despite the plain evidence that during contact George was involved in offending and delinquency and that visits to the Island were jeopardising his placement at Eden Grove and despite there having been a decision to suspend contact on the Island after the events of October 2001, social services made no proper assessment of the advantages and risks involved in allowing George to return to the Island or in arranging for him to remain in England for Christmas 2001. Such assessment would inevitably involve a review of earlier contact visits on the Island. Social services management should not have sanctioned a return without such an assessment. The Inquiry acknowledges that the decision would be finely balanced. Given the view expressed by Ms Morrison in October 2001, that by remaining on the Island George would "endanger himself or others"[389], the Christmas visit should not have taken place without this proper assessment.

12.79 Once the decision to allow George to return for Christmas had been made, a detailed care and support package involving near continuous supervision of George was required in order for there to be any chance of the contact visit succeeding. Furthermore, and most importantly given the high probability that the visit would go wrong, there needed to be a clear and firm contingency plan involving sanctions capable of being imposed, such as immediate return to England, in the event of George not complying with the plan for the visit. The plan as drawn up fell short of what was necessary to provide adequate care and support during the visit.

12.80 If, following assessment, such plans were seen to be unrealistic and not capable of implementation, then this would have pointed to the planned return being an unwise move.

12.81 These important decisions and plans required management input and were not ones to be borne by the frontline social worker alone.

12.82 These failures reveal an absence of proper care planning and assessment and a failure of management supervision and oversight of social work practice.

[388] Such a meeting was not repeated in December or January, despite the fact that it could be anticipated that returning George to Eden Grove in January 2002 would be problematic.
[389] See above

12.83 The plan as to which service providers would be involved was changed without the proper and considered involvement of social services. Furthermore the plan as to where George would be accommodated during the visit was changed without George's social worker or her line manager being properly aware of the change at the time that it was made. As a child in care, George remained throughout the direct responsibility of social services. The events of December 2001 reveal a situation where social services were not aware - to an unacceptable degree - of changes of plan for George. A service provider, in this case Richard Kneen of MFS, was taking the lead in making fundamental changes in the plan for a looked after child [390]. This highlights the need for social services to be aware of and to monitor what is going on in the life of the child for whom they are responsible. Sylvia Morrison and Ed Coates did not know the full situation; they should have been in firm control of such major decisions and changes in plan. By the Children and Families Resources Allocation Panel meeting on 28 December 2001, Ed Coates knew that George was at home rather than in MFS accommodation. Social services should have arranged an urgent meeting to consider what action needed to be taken given the change in plan. This meeting should have included staff who knew the case. If Ms Morrison was on holiday, the meeting should have been arranged by Ed Coates.

Care and support

12.84 On 29 December 2001, there was a realisation that George was at risk, that he needed to be under a form of control until his return to Eden Grove on 7 January and that he should be charged and detained overnight before being produced in court. Victor Whiteside of MFS and the police officers involved on that day are to be commended for the sensible course adopted. The Juvenile Court concluded that the only safe course was to remand George in custody until 7 January. On 7 January 2002, Richard Kneen and Carl Faragher were successful in persuading George to attend the ferry terminal, although ultimately the return did not take place that night.

12.85 The responsibility for George, as a child in care, remained with social services. In the period after 7 January 2002, arrangements for his care and support viewed overall were inadequate and ineffective. George's daily life on the Island put him at risk. Being placed with his mother was not going to be successful; she had realistically made clear that she could not control him. He was not supervised by social services or service providers. There was no programme for his day and, had there been one, little chance of him following it. There was no proper arrangement for his accommodation on the Island. He was involved in criminality and substance abuse.

12.86 "Daily outreach cover" while with his mother over the Christmas period was not adequate to prevent him returning to his delinquent ways. After 7 January 2002, George was receiving "regular contact" from MFS and Priory with the aim of persuading him to return, but was "unsupervised". Without supervision and control on the Island, George was at risk. Trevor Noden wrote in his statement for the Inquiry that because George was refusing to return, he was "beyond our control". The arrangements made for George up to 7 January were inadequate and had no chance of controlling his behaviour. Similarly, the arrangements made after 7 January were also inadequate and had no chance of controlling his behaviour.

[390] Anne Seed Day 7:24

Attempts at return

12.87 The decision that he should return to Eden Grove was plainly correct. However, the Inquiry concludes that attempts to effect George's return thereafter were flawed. There was no firm, carefully thought through plan to get George back to Eden Grove. By the meeting on 21 January 2002, there was no firm direction given by senior managers in social services. It is noted that no manager from social services attended the meeting [391]; no proper note of the meeting was made by social services. No manager in social services was firmly in charge [392].

12.88 Furthermore, in their attempt to effect the return, social services should have initiated closer inter-agency co-operation and liaison with the police.

12.89 Following 7 January 2002, social services asked the police to assist in bringing about George's return. Richard Power was the Detective Sergeant [393] attached to the Family Protection Unit between 1999 to 2003. There was an outstanding warrant issued in Cumbria for George's arrest for theft of a mobile telephone. Social services met with Sergeant Power to discuss the possibility of using this as a mechanism to effect George's return to England. Sergeant Richard Power spoke to the Cumbrian police who were unwilling to come to the Island to collect George (probably due to the minor nature of the offence and relative expense of travelling to the Island) and the Isle of Man police had no power to execute the English warrant. This avenue was not explored further [394].

12.90 However, if there had been closer liaison with the police by social services a way through might have been found. The Chief Constable, when asked whether there were missed opportunities, said that if the importance of returning George had been made clear to the police, he thought that they could have done something more positive to assist social services and "we would have ensured he would have got back to Eden Grove"[395]. In his oral evidence, Inspector Young gave an account [396] of an adult escorted back to Holland by the Isle of Man Constabulary. The Chief Constable said that a higher level of police officer could have been involved had it been made known by social services that it was of critical importance; and that he or she could have, amongst other things, made representations to senior officers in Cumbria about the execution of the outstanding warrant – perhaps offering to pay for the Cumbrian police to travel to the Island [397].

12.91 Inspector Power told the Inquiry that he also arranged for police to visit George at his mother's to try and persuade him to return but since they had no legal power to force him to go back, there was nothing they could do when he refused [398]. However, if the police had been more closely involved by social services, there may have been more chance of successful persuasion. As the Chief Constable said[399]:

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[391] Day 11:171
[392] See oral evidence of Ed Coates Day 11:168-169
[393] Inspector, at the time of giving evidence
[394] Day 6:96 ff
[395] Day 17:21-23
[396] Day 5:94
[397] Day 17:27-29
[398] Day 6:41-42; see also Inspector Young Day 5:94
[399] Day 17:24

> "By sitting down with him and care providers and saying look it is desperately important you go back there. Whilst here you are offending, drug taking, it's going to end in tears … It would be more about using persuasion, influencing and negotiation skills with him as opposed to just clapping him in handcuffs and taking him away without any power to do so"

12.92 The Inquiry concludes that social services did not liaise sufficiently closely with the police concerning George's return to the Island for Christmas 2001 or in their attempts to effect his return to Eden Grove. Unlike the October 2001 visit when social services wrote to the police and then met with the police, the police were not invited to either of the planning meetings on 10 and 21 January 2002. This was a failure of inter-agency co-operation. By not taking the same approach at Christmas 2001 as taken in October 2001, social services were deprived of the similar help from the police with the potential problems relating to George's visit to the Isle of Man in December and his return to Eden Grove the succeeding January.

12.93 Social services failed to learn the lesson of October 2001 and to a lesser extent the lesson of 30 December – 7 January 2002: that it could use George's arrests for criminal offences to bring some control into his life and to effect his return to Eden Grove. George was arrested on 7 January, 16 January, 17 January, 20 January, 31 January and 6 February. An appropriate adult was with him on each occasion – with the exception of his sister on 31 January, those appropriate adults were all child care professionals. George admitted the offences to the police on, at least, the 20 January, 31 January and 6 February. He was never charged. He was given police bail to his mother's address on each occasion.

12.94 The Inquiry was told [400] that when a young person is arrested, he can be held without charge for only a limited period. If he is not charged with an offence, he must be granted police bail with a requirement that he returns to the police station on a particular date; no other condition can be imposed. If he is charged with an offence, either the young person can be bailed by the police to attend at court or he can be held in custody until he is produced in court. The court will then decide whether to remand on bail or in custody.

12.95 Had the police charged George with one of the many offences for which he was arrested and had social services liaised with the police effectively, George could have been detained and brought before the Juvenile Court which could have remanded him in custody or granted him bail on condition that he resided at Eden Grove. The court could have sentenced him, as in October 2001 or 7 January 2002, in such a way as to encourage him to comply with the request to return to Eden Grove. Since there were a number of occasions where George admitted the crime for which he was arrested, it is possible that with greater liaison with social services, and more imagination on the parts of professionals, one of these admissions could have resulted in a swift charge, George being held overnight and either remanded in custody or bailed to Eden Grove when he appeared in front of the magistrates.

12.96 Social services, Ed Coates and Sylvia Morrison should have had this as a firm plan. The police should have been made aware of this plan. The duty social work team should have been made aware of this plan and sufficient information should have been available to the individual duty social worker so that he or she would know how best to handle the situation if called out when George was arrested, as could reasonably have been anticipated. Again, the October 2001 visit is an example of

[400] Inspector Young: Day 5

how it could have been managed. The Inquiry concludes that this realistic opportunity to return George to Eden Grove was lost. In the absence of such a plan and in the absence of such information being available to them, the Inquiry concludes that the individual duty social workers, Juan Corlett, Alex Watson, Kenny Best and Simon McCann bear no responsibility for failing to alert the police as to the appropriateness of charging and detaining George.

12.97 However, the Inquiry concludes that while social services bear prime responsibility, the police bear some responsibility for failing to work together with social services more effectively to bring about George's return to Eden Grove. The police were aware of his prolific offending. The police arrested George on a number of occasions in January and February and, in the light of his admission of guilt on at least three of the occasions [401], he could have been charged. The fact that he should have been back at Eden Grove was known to at least some police officers [402]. Inspector Young accepted that in retrospect it would have been reasonable to consider seeking a remand in custody around the 17 - 20 January 2002, on the basis of "repeat offending" and this might have presented the opportunity to contain George's behaviour and/or to consider the options open to the authorities to arrange for his return to Eden Grove [403].

12.98 The Inquiry concludes that by the date of the arrests on 20 January and 6 February, it should have been plain that his mother's address was not a suitable address to bail George to [404]. The police should have initiated liaison about George's repeated offending with social services as a matter of urgency. This may have led to social services and police re-examining the steps which could be taken to bring an end to George's offending and to ensure his return to Eden Grove. The Inquiry reiterates that events following the arrests in October 2001 and on 29 December 2001 show what could be accomplished.

12.99 The Inquiry concludes that the mechanisms for close and prompt liaison between social services and police were inadequate in 2001 and 2002. Furthermore there was some ill-feeling between police and social services at that time, each believing that the other was not taking sufficient steps to control delinquent behaviour and offending by children in care. This is discussed further in chapter 19.

12.100 The Inquiry heard evidence that George may have been under a misapprehension that when he attained sixteen years at Christmas 2001, he could no longer be required to return to Eden Grove. Evidence from Ed Coates was that, at that time, social services frequently ceased to look after children on attaining sixteen years [405]. Indeed, "Young Person One" gave evidence that he was taken out of his care home and put into a bed and breakfast establishment at sixteen years of age. As Trevor Noden told the Inquiry [406]:

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[401] It should also be noted that some of the arrests/admitted offences occurred while George was on police bail

[402] In particular Sergeant Power and Inspector Young

[403] See Inspector Young Day 5:104 and 5:108

[404] He received no control while there and was highly likely to continue with his delinquent lifestyle including re-offending

[405] Day 12:46. No figures are available for the number leaving care at 16; but there has been a move away from young people leaving care at 16 in the last three to four yours

[406] Day 20:189

> "If George got the view that the care order would end at sixteen, he would be no different to many young people of that age who sometimes in their own mind developed a view that at sixteen they could leave care. I think that was a fairly common view for young people to have".

Ian McCready, the Principal of Eden Grove, thought that George did not understand that having attained his sixteenth birthday, he could still not leave Eden Grove before May 2002 [407].

12.101 Regrettably, no evidence was given that anyone clearly advised George that he was mistaken in his belief and that the fact he was sixteen was irrelevant in relation to his return to Eden Grove. The care order made on the 13 January 2000 by the Juvenile Court under Children and Young Persons Act 1966, section 50, was due to last until the age of 18 years.

12.102 Moreover, Mr Coates agreed in his oral evidence [408] that because of a lack of clear communication within social services and between social services and the service providers, no one was saying "this is what we need to do, this is who needs to do it" and there was, therefore, the opportunity for the family and George to get a confused message. In the light of this and the decision to reduce efforts to effect a return, the Inquiry has concluded that George and his family were being given confused messages about whether he really had to return to Eden Grove in early 2002.

12.103 The Inquiry does not overlook the fact that it is likely that George's misapprehension is likely to have been fostered by the family itself [409]. The Inquiry accepts that Mr Green did not intend to dissuade George from returning to Eden Grove and at most was only envisaging a short delay and that, in a calmer frame of mind, he would not have intended to impede the successful return of George to Eden Grove. Indeed, on 7 February 2002, he told Ed Coates that he would travel back with George to England. However, by his ill-chosen words and intervention on 7 January, Mr Green gave George the glimmer of a hope that he could prolong his stay on the Island.

12.104 The Inquiry accepts that Mrs Green realised that George should return to Eden Grove, but she had long been unable effectively to set boundaries or instil proper behaviour in George [410]; and it is likely that she would have made no impact on George of the necessity of his returning to Eden Grove. However, the family's attitude was only a minor factor in allowing George to think that he did not need to return.

12.105 Furthermore, by acquiescing in George's refusal to live in the MFS accommodation at Foxdale, social services and MFS had paved the way for George to believe that he did not have to comply with the requirement to return to Eden Grove.

12.106 Kathryn Green told the Inquiry that she and George visited Sylvia Morrison on 7 February 2002 because George wanted to return to Cumbria but were told by Ms Morrison that George had lost his place at Eden Grove. Jacqueline Entwhistle, George's half-sister, told the Inquiry that she bumped into George and Kathryn in town on the afternoon of the 7 February and that Kathryn gave her the same account that same afternoon. Kathryn Green and Jacqueline Entwhistle said they could fix the

[407] Day 6:149
[408] Day 11: 170
[409] See also chapter 16 below.
[410] And to her credit, she had realised this and had sought social services assistance in looking after George as a consequence. See also Anne Seed Day 7:36

date because it was the day when Kathryn came out of prison [411]. Ms Morrison denied seeing George or Kathryn on this date and said that she was due in a meeting when reception telephoned her to tell her George and Kathryn were downstairs asking to see her. She said she asked the receptionist to give them a slot for 8 February because she was busy and did not go downstairs at all [412].

12.107 The Inquiry concludes that the evidence of Ms Morrison is the more reliable on this aspect. It is consistent with her social work record made at the time or shortly thereafter. George persistently refused to return to Eden Grove. On 7 February, he told Victor Whiteside that he would not return. George's place at Eden Grove had not been lost and it would have made no sense for Ms Morrison to tell George that it been. Neither Kathryn Green nor Jacqueline Entwhistle refer in their police witness statements in 2002 to what Ms Morrison was alleged to have said about the loss of the place at Eden Grove [413].

12.108 Responsibility lay with social services management to assure itself that a proper plan and arrangements for implementing the plan were in place.

Planning for leaving care

12.109 Planning for George's care after June 2002 had not progressed very far by the time of his death in February 2002 [414]. Mr Coates accepted that there was no clear strategic plan as to how to manage George's links with the Island so that in the event of his return to the Island in summer 2002 (or indeed later), it could be done in a way that did not inevitably lead to George returning to a delinquent lifestyle [415].

12.110 The Inquiry considers the issue of leaving care and moving to independent living in Part 2.

MFS records

12.111 Richard Kneen stated that there are MFS records missing since George's file was handed to the police after the murder [416]. The police have provided to the Inquiry what they say is the full extent of the file given to them. Richard Kneen told the Inquiry that the MFS records had been given to the police and to social services through Alec Merchant [417]. When he was recalled to give evidence later in the Inquiry, he indicated that the police MFS file was not the full extent of George's file: the police took some documents and social services took the remainder [418]. He also said that the police file did not contain George Green's log book [419]; but later he voluntarily amended his evidence to accept that there was no log book and to confirm Mr Whiteside's evidence that recordings were made on separate sheets [420]. Mr

[411] Kathryn Green Day 10:75; Jacqueline Entwhistle Day 22:12
[412] Day 4:103-104
[413] Day 22:17-19
[414] Ed Coates Day 11: 157-159
[415] Day 12:19-20
[416] See below
[417] Day 8:172
[418] Day 25:44-45
[419] Day 25:47 – 49
[420] Day 25:60

Kneen indicated that MFS were asked by social services sometime in 2005 to go through and see if there were any other documents on George Green and MFS handed other documents over; the receipt for the documents given to MFS showed the documents were actually handed over in December 2003 [421].

12.112 Victor Whiteside was adamant that when MFS were looking after George

> "there was a record kept of what happened when he was dropped off somewhere, when he went to see his mum, when he was picked up, if he went missing, when he went missing…" [422].

He indicated that he had given George's entire MFS file to the police days after the murders. The file was only one paper folder [423].

Management of George's case

12.113 Throughout the period from 1998 to 2002 Sylvia Morrison was George's social worker [424]. She was a member of the Long Term Team (now Care Management Team) of which Ed Coates was the Principal Social Worker. Mr Coates had supervisory responsibility for George's case. He initially chaired some In Care Review Meetings regarding George but this was taken over by Bryan Morris, the Division's Child Care Co-ordinator, shortly after George's move to Eden Grove. Mr Coates told the Inquiry that at this stage Mr Morris also took on some of the management of George's case [425]; he said that this was "not ideal" [426]

12.114 Mr Coates accepted that there was a significant gap in the supervision of Sylvia Morrison from 6 August 2001 to the beginning of 2002 [427]. This was a time when important decisions were being made about George and Mr Coates accepted that this state of affairs and the supervision policy that existed then was 'not good enough' [428]. He accepted that, as Ms Morrison had earlier told the Inquiry, it was a disadvantage to Ms Morrison [429].

12.115 The management input during this crucial period was shared in practice and was not sufficiently clear. Importantly Ms Morrison did not receive appropriate supervision. For example, Ms Morrison was not receiving supervision around the time of making the difficult decision to allow George to return for Christmas [430]. She did have informal conversations with Ed Coates, who did not disagree with the decision. The matter was discussed at an in-care review, chaired by Bryan Morris, on 26 November 2001 [431].

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[421] Day 25:46 and Day 25: 61
[422] Day 9:23
[423] Day 9:27
[424] Ms Morrison had become George's social worker in October 1997: Day 4: 2
[425] Day 11:38
[426] Day 11:41
[427] Day 11: 36 - 40
[428] Day 11: 39:23-40:11
[429] Day 11: 42
[430] Ed Coates confirmed this
[431] 4:70:6. Ms Morrison stated that while Mr Morris provided management input by virtue of his role in meetings as reviewing officer, he did not take over her supervision or act as her line manager:

12.116 The Inquiry concludes that Ms Morrison was left insufficiently supported by management and that management was not firmly in control in making clear plans and taking decisions about George and, when George was first back on the Island for Christmas 2001, in the monitoring of what was actually happening in George's life. The social worker on the ground should not be left to shoulder alone important decisions.

12.117 Mr Noden frankly accepted that, following the change of plan on 21/22 December whereby George was permitted to stay at his mother's throughout, there should have been a professionals meeting and that discussion at the Resource Allocation Panel on 28 December was not a sufficient substitute [432].

12.118 The absence, in turn, of proper management supervision of Mr Coates is considered below in chapter 17.

12.119 Mr Noden was the line manager of Mr Coates. Mr Noden told the Inquiry that he knew of the plan to return for Christmas 2001, but not its detail, and that he approved the extra funding involved [433]. He told the Inquiry that he was "very anxious indeed" about George's return for Christmas 2001[434] but was guided by the views of those who knew George's case best [435].

[432] Day 20:49-52
[433] Day 20:40
[434] Day 20:43:4
[435] Day 20:42-43; see also Day 20:40

CHAPTER 13

EDUCATION FOR SAMANTHA AND GEORGE

Samantha

13.1 Samantha was educated at St Mary's School, Douglas between September 1992, when she was aged eight, and the summer 1996, when she was aged 11. On 3 September 1996, aged eleven, she moved up to St Ninian's High School. She did not return to St Ninian's after summer 1997 and her name was removed from the school roll.

13.2 Meanwhile on 10 March 1997 Samantha had been suspended from St Ninian's because of what her headmaster described in his statement to the Inquiry as "her extreme behaviours – bullying, assaults, verbal abuse and outright defiance". The actual incident leading to her suspension on 10 March involved defiance, not violence. At that time, St Ninian's supported children with behavioural and emotional difficulties within school through a sheltered group (a special class with a specialist teacher) and the special needs teacher [436].

13.3 Apart from 6 days remanded in the Juvenile Justice wing of the prison, Samantha was living at Cummal Shee between March and 28 July 1997. She received no education either at school or away from school during this period.

13.4 The Headmaster of St Ninian's was not prepared to send staff to Cummal Shee to teach Samantha because of concerns for their safety. At this time, Samantha was facing charges for assaults on staff at Cummal Shee. The minutes of the Governor's meeting of 7 April 1997, attended by Samantha's social worker Mrs. Bithell, record that the Headteacher suggested she attend the School's Shelter group escorted by a staff member of Cummal Shee but that the Cummal Shee manager could not spare the staff member. The then Director of Education joined the meeting and "agreed that unless the Governors were reasonably confident that Samantha could behave, she could not come back into School. The Governors agreed to further extend Samantha's exclusion from School." On 10 June 1997, Samantha was released from prison and was on remand at Cummal Shee. The Minutes of the Governor's Meeting of 11 July record that:

> "Mr. Cowley explained that when Samantha had been released there had been a request for her to receive one-hour-a-day tuition at Cummal Shee The Headteacher advised that he would not allow his staff to teach in that environment as he would be concerned for their safety. He pointed out that Samantha was attending a course of assessment in England and her education could be reviewed when that assessment had been completed. … It was recommended that the School await the outcome of the assessment but that the Headteacher must ensure the health and safety of staff and other students received priority."

[436] John Cain Day 17: 176:6-24

13.5 Between July 1997 and 2 November 1998, Samantha was placed in Wales and Gloucester. These were placements arranged by social services. Education was part of the package arranged for and paid for by social services.

13.6 Upon her return, aged 13, from Gloucester on 2 November 1998, the intention of social services was that Samantha would be living on the Island and her social worker wrote to St Ninian's asking that Samantha be re-enrolled. A pithy reply came back by letter dated 3 November 1998: the Headmaster was "astounded" at the "crass, insensitive and inappropriate" request. The clear implication was that he would not enroll her. The letter stated that a copy had been sent to the Director of Education and to the Special Needs Service, Glencrutchery School. The Inquiry was told that neither the Director nor the Special Needs Service received the letter. On 1 December 1998, Angela Oldroyd wrote to the Director of Education to request that Samantha be registered on the Include Programme for those not receiving education at school and that "you will be able to help Samantha with a future education plan". The Director replied on 7 December 1998 advising that the department "may consider" a placement at Include only after Samantha was properly and formally registered at a secondary school. No further steps seem to have been taken by social services or by the Department of Education to arrange, or provide, for Samantha's education.

13.7 On 3 February 1999, Samantha was placed at St Catherine's Centre, St Helen's where she remained until February 2001; again education was part of the package arranged for and paid for by social services.

13.8 On 27 February 2001, now aged 15, Samantha returned to live on the Island. She was not enrolled at any school on the Island on her return. No steps were taken by either social services or the Department of Education to arrange or provide for education for Samantha either in mainstream school or other forms of education. Her social worker told the Inquiry that she was concentrating on finding accommodation for Samantha and anyway she believed that if a school place had been arranged, Samantha would not have attended [437]. Nor did she take any steps to offer her vocational training stating that there was little such training available on the Island[438]. She did however take her to the job centre and arranged a few job interviews.

13.9 The Child in Care Review held on 26 November 2001 includes in its Action Plan "explore employment/training and support". The focus seems to have been on finding employment and Samantha was expected to attend the job centre. At one stage, Samantha attempted to gain employment at a hairdressing salon, but was unable to attend on the first day because of a problem with toothache; and she did not renew the attempt when the problem resolved.

13.10 The Inquiry was told by John Cain, the Director of Education that, although no documentary evidence appears to exist, it is the recollection of the department's Careers Officer that two appointments were offered and made for Samantha but neither was taken up.

Conclusions

13.11 In its closing submission in Part 1, the DHSS drew attention to the crucial importance of education for looked after children.

[437] Day 3: 192-194
[438] Day 3: 195

> "The effect early school exclusion of looked after children has on both the children themselves and their care providers should not be underestimated. It disconnects looked after children from the possibility of building positive relationships with their entire peer group rather than just those whom they are in care with, a most important part of education in its wider sense. It also removes any structure from their day, something which places an increased burden on care provider staff and, more importantly, something which the child becomes used to and even enjoys so future attempts to engage them in education, training or even employment become more difficult."

The Inquiry agrees.

13.12 During this period, there was no policy for ensuring that proper education was made available for looked after children. This deficiency was highlighted by the Ofsted Report in 2002 and since then a Policy has been drawn up.

13.13 In the absence of a policy, the ad hoc arrangements were inadequate. A range of witnesses from social services, including Mrs Clare Christian, MLC, the former Minister of Health and Social Security [439] and David Cooke, the Director of Social Services, expressed their concern about educational arrangements for looked after children. Mrs Christian referred to "friction" in 2001- 2002 concerning the amount of education being offered to looked after children. The Minutes of a Resources Co-ordinating Group Meeting held on 12 November 2001 refer to there needing to be an improvement in the unsatisfactory level of education for those in care.

13.14 The Inquiry has concluded that the provision of education for Samantha on the Island from March 1997 to February 1999 was seriously deficient.

13.15 In the period March to July 1997, there were practical difficulties in seeking to arrange out of school education which did not unreasonably expose teachers to risk of injury. There seems to have been no real effort by either social services or the Department of Education, working together or alone, to overcome them, for example by providing extra staff to enable Samantha to attend the Shelter Group or providing other educational support.

13.16 The period November 1998 to February 1999 reveals starkly how, when different agencies of government fail to communicate with each other or to work together, there is a likelihood that attempts to provide services (in this case education) are ineffective. The Department of Education told the Inquiry that neither the Director nor the Special Needs Service received a copy of the 3 November 1998 letter. This may be so and reveals a failure of internal communication within the Department of Education about a serious matter. However, when the department received the 1 December 1998 letter from Angela Olroyd, it would have been reasonable for the department to enquire why Samantha, aged only 13 and well known to the department, was not on a school roll and what steps were being taken to ensure she received education 440. When social services received the letter dated 7 December from the department, the Inquiry has been told of no steps taken by social services to break the impasse: a seeming refusal to enrol Samantha at St Ninian's and an inability to access out of school education unless she was enrolled.

[439] See, for example, Day 22:45
[440] See also Day 17:186:18

13.17 If either the Department of Education or social services had sought to communicate with each other, it is likely that the impasse would have been resolved. The current Director told the Inquiry that, at that time, the Headmaster did not have the authority to refuse to enrol a pupil in the manner of the 3 November letter [441].

13.18 The Inquiry will consider the effectiveness of the current arrangements for education for looked after children in Part 2.

13.19 The Inquiry concludes that, between February 2001 and February 2002, there was no proper plan nor arrangements made to offer Samantha different forms of education or vocational training or other preparation for employment. To a large extent, social services acknowledged this shortcoming [442]. This was a serious deficiency in the care and support for a young person who was soon to be leaving care and who needed as much help as possible to move towards independence.

13.20 In Part 2, the Inquiry will consider whether the current support for such children and young people is any more effective.

13.21 The current Director of Education, John Cain, told the Inquiry that in the period 1997 to 2002, the Education Act 1949 did not, in so many words, impose a legal duty on the department to provide an education for all children (whether of compulsory school age or not). It had a general duty under section 33 of the Act to provide primary, secondary and further education, and a more specific duty under s.34 to provide sufficient schools. Nowhere was there an express duty to provide every child with an education in all circumstances. The only specific duty to educate an individual child of compulsory school age was that laid on the parent by section 66, and it is a duty "to cause him to receive efficient full-time education suitable to his age, ability and aptitude, either by regular attendance at school or otherwise". The statutory duty therefore appears to be with the parent.

13.22 The Director told the Inquiry that the Department of Education had no responsibility for Samantha after she was made subject to the care order in October 1997 because she was no longer on the roll:

> 'the responsibility for ensuring she was educated … lay on the parent' [443].

Once off the roll of the school, he did not think the department had any corporate responsibility towards a child with the onus shifting totally onto the child's parents or the statutory parent, the DHSS [444]. He added that once a request is made for a child to be educated, there is then a requirement to take him or her onto the roll.

13.23 The Director told the Inquiry that the department provided no education from February 2001 onwards because no request was made to it [445].

13.24 It is not the role of the Inquiry to consider whether the submissions of the Department of Education as to their duties to Samantha are correct in law. However, a Department of Education which does not contribute to arrangements for the education of a child such as happened in Samantha's case cannot be said to have been making

[441] Day 17: 183
[442] DHSS Closing Submission Part 1, para 77.
[443] Day 17: 180:1-3
[444] Day 17: 180:7-12
[445] Day 17: 190

an effective contribution to her educational support. Trevor Noden and Ed Coates from social services told the Inquiry that the Department of Education did what was required by law and no more[446]. In Part 2, the Inquiry considers whether there should be an explicit duty on the department to provide education for the Island's children. The Inquiry concludes that the department was not effective in providing, or at least offering to provide, education to Samantha either in school or out of school, or vocational training or careers advice or preparation.

13.25 The records held by the department itself or in the Island's schools relating Samantha's education prior to 1998 are very thin [447]. George's records are much fuller. There are no records for Samantha after 1998. There is no duty on the department to keep records on a child unless he or she receives special educational provision. While the nature of the records which should be kept by the department needs to be considered carefully, Mr Cain believed that it would be helpful if there were a duty on the department to keep specific records. Furthermore there should be consistency in record keeping by schools.

George

13.26 George was educated at Ballaquayle Infants School between 1990, when he was aged 4, and 1993, when he was aged 7; and at Murray's Road Junior School from 1993, when he was aged 7, and summer 1997, when he was aged 11. On 1 September 1997, he joined the roll of Ballakermeen High School and remained on it until 10 March 2000, when he was aged 14.

13.27 Problems at school began to emerge when he arrived Ballakermeen High School in September 1997. He had a good start to his first high school year but suffered a deterioration in his behaviour after Christmas. George demonstrated unruly behaviours and by January 1998 George was being monitored by the Behaviour Support Teacher, Mrs Evans. In March 1998, George had to be isolated from his classmates. By June of 1998 it was agreed with his mother, Mrs Green, that he would receive a modified timetable. This had limited success and eventually George had to be taught off-site.

13.28 The school requested that George be seen by an educational psychologist and he was examined by Mrs Jenny Corkill, of the Special Needs and Psychology Service, in October 1998. Mrs Corkhill reported that he had a full value IQ measured at 90, at the lower end of the average range and that he had special educational needs. She recommended that he receive a programme monitored and supervised by the EBD co-ordinator and with an individual programme in addition to the national curriculum and that he would benefit from a structured behaviour programme.

13.29 Mrs Burnett, then the Deputy Head of Ballakermeen, told the Inquiry that it proved impossible to persuade George to attend education off-site regularly and that when he was present, he was challenging and difficult. Mrs Burnett told the Inquiry that in 1999 the school decided to require a member of staff from Cummal Shee, where George was placed, to be in attendance when he received tuition. Ms Morrison arranged this.

[446] Day 20:127:23
[447] Day 17: 192

13.30 On 29 April 1999 there was a major incident when George was extremely abusive and threatened to hit Mrs Evans. The evidence suggests that the school suspended George at this stage.

13.31 Ed Coates told the Inquiry that George was not referred to Include. Social services wanted George to be referred to Include. However, the school said that it would not refer George to Include as he did not fit the remit presented in school by Include and also George had refused to consider attending school [448].

13.32 It is also unclear on the evidence precisely what level of education George received and for how long George received no education after April 1999: different documents, statements and witnesses paint different pictures. George spent a period in Cummal Shee in May 1999 [449] but then returned home before returning to Cummal Shee in November. It appears tolerably clear that from November 1999, he was taught off-site for an hour a day, accompanied by Cummal Shee staff. His attendance was mixed. Ms Morrison told the Inquiry that because George's education had become so inadequate and remedying this was in the forefront of her mind [450] and eventually Eden Grove was chosen.

13.33 On 23 March 2000, George was placed at Eden Grove. Eden Grove provided education directly to the children, on site, and by supporting them in various college and vocational placements. George experienced college, on-site and vocational education in his time at Eden Grove. It is clear that Eden Grove was chosen in good part because of its educational provision. It is equally clear that prior to attending Eden Grove, George was receiving a bare minimum of education.

13.34 The cost of Eden Grove was wholly funded by social services. An informal conversation was had between social services and John Kermode and he had indicated that funding would not be forthcoming from the Department of Education. This was in line with social services' experiences. No formal approach was made. Although there is no written policy to the effect, the Department of Education does not pay for children to be educated outside the jurisdiction, with the exception of two bursaries for high achievers. In his oral evidence, the Director of Education defended this decision. The DHSS strongly attacked it.

Conclusions

13.35 The evidence given to the Inquiry suggests that Ballakermeen High School tried hard to cater to George's needs in school despite his aggression and violence. Over the coming years, George was offered a limited timetable, after-school teaching, one-on-one teaching, off-site teaching, support from the Behavioural Support teacher and an assessment by an educational psychologist. However, the evidence from the numerous sources is not always clear as to the exact dates for the provision of these services.

[448] Letter 23 July 1999 from Ballakermeen High School to Bryan Morris, principal social worker. In her statement to the Inquiry, Mrs Burnett said that the school referred George to Include; however, the Inquiry finds that she is mistaken.
[449] See chapter 10
[450] Day 4:23

13.36 From April 1999, when George was 13, the level of education he was receiving was minimal and was not meeting his education needs. In Part 2, the Inquiry will consider what level of education should be available for those suspended from school.

13.37 Eden Grove provided George with excellent educational provision (see chapter 11 above). Social services are to be commended for choosing and for funding George's placement at Eden Grove. It was in marked contrast to that provided for him in the months prior to March 2000. George was unable to attend full time education on the Isle of Man, whereas he did achieve that in Eden Grove, even attending Carlisle College for a few months. This disparity in achievement itself suggests that the on-Island educational provision was neither appropriate nor sufficient for George.

13.38 The Inquiry has already considered the response by social services to George's refusal to return to Eden Grove at the beginning of 2002. The Inquiry notes that plans were being made for George should he not return to Eden Grove and that, commendably, social services and the Careers Service were working together to plan to arrange vocational training for George through the college or a training centre [451]. Furthermore the Inquiry notes that earlier in 2001, when considering what plans should be made for his return in June 2002, commendably consideration was being given to George attending the Include Bridge Programme.

13.39 The Inquiry was told by the Department of Education that children could not be "excluded" from school. However, it very much appears that, whatever it was called, the effect in practice was that both George and Samantha were "excluded" from their respective schools by indefinite suspension. In Samantha's case, she received no educational provision from the Isle of Man Government from the age of 11 years and 10 months and the records relating to her education are scant. Indeed Ruth Bithell, Samantha's social worker in 1997, in her report for the Douglas Juvenile Court dated 16 October 1997 says

> "… as her behaviour deteriorated she was suspended for periods and eventually excluded".

13.40 As for children with emotional and behavioural difficulties, the Director of Education said that the department was able to provide for all behaviourally difficult children on the Island, even those with severe difficulties, but qualified this by saying the child needed to be able to engage with the education offered:

> "What we can do, and are willing to do, is to try to educate any child who can sustain engagement with the educational programme and cooperate without assaulting staff or being abusive to them in a fairly reasonable way" [452].

13.41 Both young people presented their teachers on the Island with great difficulties, displaying aggression and even violence and an unwillingness to engage with school. Nonetheless, after each was suspended from school, the net result was the same: neither Samantha nor George received any further adequate education until they left the Island and entered UK placements.

13.42 There has been an informal, though somewhat rigid, policy in place that the Department of Education would not pay for overseas education save for two bursaries for high achievers. The policy to fund bursaries stemmed from the thoroughly

[451] See meeting 21 January 2002.
[452] Day 17:206:11

laudable aim of providing appropriate education on-island to all children and in the Director of Education s' words in order to:

> " compensate to some extent for the fact that we cannot provide that type of education at all on the Isle of Man"[453].

13.43 In Part 1 of the Inquiry, Mr Cain said that that he thought that if the department was persuaded "clearly and convincingly", that "we genuinely could not, by hook or by crook, cater for a child with that particular type of needs", then the department would certainly "consider" contributing to the cost of education [454]. But he confirmed that the chances of funding being granted were very, very slim: although there was no official written policy against sending children to be educated abroad, it had been the practice for many, many years not to do so.

13.44 Mr Coates, Mr Noden and Mr Cooke each told the Inquiry that they had raised with individuals in the Department of Education the desirability of Education sharing both the responsibility and the cost of educating children with emotional and behavioural difficulties off-Island.

13.45 In Part 2, the Inquiry considers this informal policy.

13.46 13.46 After they were suspended from mainstream school, the educational provision on the Island for Samantha and George was not satisfactory. The evidence relating to the provision of education for Samantha and George remains somewhat unclear. As a whole, in relation to these two children it appears to give support to the allegations by the DHSS that 'looked after children' did not always receive the adequate educational provision from the Department of Education and that the department had not, in that period, learnt to act as corporate parents [455].

13.47 Mr Cain, when discussing engaging Samantha and George in education, told the Inquiry:

> "The question is, did we do enough? I suspect the answer to that has to be: no. There may well have been something else we could have done, should have done. There could have been a person who ignited a spark, calmed one of them down when they were aerated, formed a relationship with et cetera" [456].

13.48 While the evidence that Samantha made any progress educationally while in her English placements is less clear, George's progress at Eden Grove shows that with suitable provision he could benefit from education. This supports the argument that it is realistic to seek suitable educational provision for even the most difficult children.

[453] Day 17:205:13
[454] Day 17:208-209
[455] See also Mr Cain, oral evidence, Day 17:213-214; Mr Coates Day 11:182-183
[456] Day 17:223: 1 ff

CHAPTER 14

HEALTH SERVICES FOR SAMANTHA AND GEORGE

Samantha

Hearing

14.1 Samantha's family and friends told the Inquiry that she had significant hearing loss in her left ear that embarrassed and frustrated her [457]; and that she hid it from people. Although Angela Gilman, her social worker from 1999 to 2002 indicated that Samantha's hearing had only been discussed at her final Review in 2001 [458], it is clear it was an issue that social services were alive to when she was young. She was taken for a number of hearing tests and refused to attend others. It appears that it was an issue that became lost over the years, no doubt partly because Samantha herself hid the problem. It is to be noted that a hearing test carried out in 1996 recorded that hearing on the left was within normal limits and on the right was either normal or borderline normal.

General practitioner

14.2 Witnesses who were employed by Nugent Care at the Leece Lodge campus told the Inquiry that insufficient efforts had been made by Angela Gilman to register Samantha with a general practitioner. Samantha had been removed from a doctor's list while she was at Derby Road [459]. The Inquiry was told that, unfortunately, there were difficulties in registering Sam because some doctors were reluctant to accept her on their books because of her reputation. When he gave evidence Dr Dunne, the consultant forensic psychiatrist who examined Samantha in 2001, was particularly critical of medical practitioners for allowing this situation to arise. The Inquiry has not examined where responsibility lies for the fact that it was not until late 2001 that Samantha was again accepted on to the list of a general practitioner.

14.3 It was the efforts of Liz Dickson, Samantha's keyworker from November 2001, which secured Samantha a general practitioner. Ms Dickson made this a priority because she was concerned that Sam did in fact have a number of medical needs, albeit none of them grave, that required a doctor's attention. It is not satisfactory that a young person in public care should not have a general practitioner. Ms Dickson is to be commended for taking the matter in hand and obtaining a general practitioner for Samantha.

Misuse of alcohol and drugs

14.4 During her time at Leece Lodge there were innumerable references in the logs to Samantha's involvement with illegal drugs [460]. For example, there was a reference on 19 January 2002 to suspicion of her supplying drugs. The Inquiry has concluded that it was generally known on the Leece Lodge campus that Samantha was taking illegal

[457] See, for example, Lyndsey Barton Day 10: 103 and Young Person 1 Day 10: 143
[458] Day 2: 34
[459] Angela Gilman Day 3: 86
[460] See generally chapter 9

drugs. Damian Bradley told the Inquiry that it was the working assumption that she was taking drugs [461]. On 20 January 2002, a parent of another young person said that she was concerned at the time the young person was spending at Samantha's at Leece Lodge 2 because of its reputation as a "drug den".

14.5 Prior to Leece Lodge, Samantha was a regular user of softer drugs and had smoked cannabis in front of her mother [462]. On 29 August 2001, she had been arrested for allowing her premises, namely Derby Road, to be used for the purposes of consuming illegal drugs. She had used ecstasy, a particularly dangerous drug when used by children and young people. She had suffered drug-induced psychosis when at St Catherine's. Her friends told the Inquiry that Derby Road and Leece Lodge were used to take drugs and drink alcohol.

14.6 The dangers to the health, social functioning, physical safety and general wellbeing of a young person from involvement with illegal drugs are too well known to need rehearsing.

14.7 From the records of the Drug and Alcohol Team, it seems that Samantha first attended the Drug and Alcohol Team office on 29 August 2001 referred by Mark Hoswell, her worker at Derby Road, and was seen by Steve Chell. A letter was sent to Samantha confirming an appointment for an initial assessment for 10 September 2001. Samantha was seen on 10 September 2001 with her social worker Angela Gilman by Dr Andrew Keane, a locum; the comments following that assessment were that there was no evidence of drug dependency, that she was what DAT termed a 'harmful user' and therefore no replacement therapy or detox was required. It was left for follow up by the social worker and for a social report. An appointment was made for 27 September 2001 for Samantha to see Dr Keane but this had to be cancelled because Samantha rang and said that she could not attend at the appointed time and the social worker was unavailable at the re-arranged time. A number of other appointments were made for Samantha but were not kept.

14.8 Samantha's case was discussed at a DAT meeting on 8 November and again on 22 November 2001 on which occasion a decision to discharge her was made for not keeping appointments. On 23 November 2001 a letter was sent to Angela Gilman informing her that Samantha had been discharged. The fact that Samantha was discussed at the DAT meeting on 8 November was indicative of the concern the team had for her [463].

14.9 On 14 December 2001 Samantha made a self-referral at the DAT office and she was offered an initial assessment for 8 January 2002. In fact, Samantha came to the office without an appointment on 7 January 2002 and was seen by Thea Ozenturk, who made an assessment; Samantha stated that she had used heroin for the first time the previous week. Samantha was offered an appointment with Karen Lemonidis for 21 January 2002. At first, Samantha was allocated Thea Ozenturk as her key worker but this was changed to Karen Lemonidis because DAT's policy in respect of key workers was not to allow the same key worker for members of the same family in order to avoid any confidentiality issues and Thea Ozenturk was Lyndsey's key worker.

[461] Day 18: 16-17
[462] Day 16:70
[463] Day 3: 158:12

14.10 On 21 January 2002 Samantha arrived half an hour late for her appointment and was seen by Karen Lemonidis. On 31 January 2002 Samantha attended at the office without appointment in company with another young person; Samantha wished to change her key worker to Thea Ozenturk and spoke with Judith Stephen. The matter was discussed at a Team Meeting later that day and it was decided that such a change was inappropriate. Helen Richards was allocated to be the key worker for Samantha.

14.11 On 1 February 2002 Samantha again attended the DAT office without an appointment and was seen by Steve Chell. Samantha was seeking valium and was demanding to see Dr Wafer. On 4 February 2002 a letter was sent to Samantha confirming an appointment with Helen Richards for 12 February 2002.

Conclusions

14.12 The Inquiry recognises the great difficulty which anyone would have in seeking to help a young person, such as Samantha, misusing drugs, particularly as self-motivation is recognised as the key element. Furthermore, the Inquiry recognises that it is not only young people in care who misuse drugs; a significant number of young people who are not in care misuse drugs [464]. Nevertheless it remains necessary to consider how effective was the care and support for Samantha in respect of her misuse of drugs.

14.13 Could more have been done by DAT to help Samantha ? The period in late 2001 was in the early days of DAT. The Team was still in the process of setting up its services and the priority at that time was drug and alcohol dependent adults; less than 3% of the Team's work was with younger people under 18. There was at that time no dedicated under 18 worker at DAT. Dr Wafer told the Inquiry that if DAT had had an outreach worker, that worker could have gone out in order to try to find and engage with Samantha. The Inquiry believes that adds weight to the argument for an outreach worker at DAT; this is a lesson for the future [465].

14.14 There was no link between CAMHS and DAT at that time [466]. Such a link is important. In 2001-2002, DAT was part of Adult Mental Health Services and of the Health Division [467]. Since that time, it has come within the Social Services Division.

14.15 DAT was a new service. Through no fault of its own or of those working there, it was not able to offer Samantha as effective support as it could have done if it had been fully geared towards the needs of young people.

14.16 The disclosure on 7 January 2002 by Samantha that amongst other things she had used heroin for the first time the previous week was significant and Dr Wafer accepted that there were no DAT records to suggest this information was shared with social services. She properly accepted that it should have been [468]. Plainly, for the future DAT needs to be able to liaise speedily with social services about matters of concern.

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[464] See evidence of Ed Coates relating to European School Survey Project for Alcohol and Other Drugs (Esspad) 2003: Day 12:95-96
[465] See chapter 25
[466] Dr Wafer Day 3: 153
[467] Day 3: 173
[468] Day 3: 166-167

14.17 Could more have been done by Samantha's social worker or keyworker at Leece Lodge ? Dr Wafer told the Inquiry [469] that it would be good practice for social workers and others working with a young person to try and to keep trying to encourage the young person to address the issues; opportunities need to be seized in daily life to reinforce this encouragement. However, it must be recognised that if the young person does not wish to attend an appointment, there is very little that those working with young people can do[470].

14.18 Ms Gilman attended DAT with Samantha on 10 September 2001. Samantha failed appointments after this. There were four attempts by DAT to contact Ms Gilman during October [471]. Although Ms Gilman disputed that messages had been left and not answered by her on her return from leave, the Inquiry accepts that the contemporaneous DAT records are accurate. The Inquiry has concluded from the evidence given by Ms Gilman and DAT that Ms Gilman did not take Samantha's referral to DAT as an opportunity, albeit slight, to work with Samantha to stabilise, reduce or eliminate her drug use as seriously as she should have done. Ms Gilman told the Inquiry that she was keen for Samantha to engage with the service but had reservations that Samantha wanted to obtain a valium prescription in order to sell it on; she thought Samantha was not interested in engaging. She accepted that she did not do much to encourage SB to go to the DAT because she doubted her motives[472].

14.19 Ms Gilman spent little time with Samantha and therefore had little opportunity to attempt the sort of encouragement suggested by Dr Wafer in her evidence.

14.20 Liz Dickson was Samantha's outreach key worker. She was inexperienced in dealing with such a difficult case as that of Samantha. Not surprisingly given her general non-confrontational approach to her work with Samantha, Liz Dickson was not proactive in seeking to address her drug use [473]. She told the Inquiry that she suspected Samantha took drugs. Indeed on one occasion she saw her in a pub doorway with an older man, suspected that she was drug dealing and telephoned the police. Ms Dickson did not confront her on the issue of drugs or discuss it directly, despite taking her twice to the DAT office (in connection with appointments for Lyndsey), preferring to give her indirect advice referable to her sister [474] .

14.21 Given the serious consequences of drug and alcohol misuse for the young person and for the community generally, the Inquiry believes that the key worker working with Samantha and others working closely with Samantha should have had some experience of working with young people misusing drugs or at least some training in this field.

14.22 Furthermore, the fact that Samantha was using drugs should have been an argument for keeping a closer watch on her, not because of the criminal nature of the conduct but because of the dangers involved. Supervision and regular monitoring of her wellbeing were required.

[469] Day 3: 154
[470] Day 3: 155: 12-20
[471] DAT records
[472] Day 3: 73-77
[473] Damian Bradley Day 18: 16-17
[474] Day 9: 131-136

14.23 Social services acknowledge [475] that there was on occasion a lack of communication with the Drug and Alcohol Team: a full description of the incident at St Catherine's - using the terminology 'psychotic episode' – may not have been given to Dr Keane when he first assessed Samantha on 10 September, 2001.

Psychiatric health

14.24 Samantha was seen by a consultant psychiatrist and a psychologist in Dublin in 1991 and 1992 [476]. When on the Island, Samantha was seen by an educational psychologist in 1995 and by a consultant psychiatrist in prison in June 1997. When in Wales, she was seen by Dr Ubeysekara, consultant psychiatrist, later in 1997. Samantha was last assessed by Dr Dunne in December 2001 in relation to a criminal charge. This psychiatric assessment confirmed the conclusions of those that preceded it: Samantha had no treatable psychiatric condition. Mental ill health could not account for her behaviour.

14.25 However, the Inquiry concludes that her difficult and troubled behaviour may have been assisted by specialist child psychiatric, therapeutic or general counselling services.

14.26 Throughout the time that Samantha and George were in care, there were no specific health or mental health services set aside on the Island to meet the needs of looked after children. Samantha and George would have access to the normal services provided for any child on the Isle of Man. CAMHS was only in its infancy by the time of their deaths. Neither was referred to it.

14.27 As at February 2002, the provision of specialist child psychiatric, therapeutic or general counselling services was not adequate. Much progress needed to be made.

George

General health

14.28 No health assessments took place before October 1998, when George was seen by an educational psychologist [477]. He was identified as having special educational needs. George did not appear to have obvious health problems outside of his behavioural problems. There appeared to be no issue relating to George's general practitioner.

Psychiatric health provision

14.29 There are several references in the contemporary documents attesting to George "needing help". One example is: following the incident when George was angry and abusive and threatened Mrs Evans, his teacher at Kensington Road Youth Centre, on 29 April 1999 [478], Mrs Evans made a formal complaint to the police. The

[475] DHSS closing submissions, para 88
[476] See chapter 3
[477] See chapter 10
[478] See chapter 13

investigating police officer sought the advice of Inspector D R Bell, who advised that George be cautioned and added "This young man needs help".

14.30 Despite displaying deeply disturbed behaviour on occasion at Cummal Shee, including fire-setting and storing his faeces in bottles, the Inquiry has not been told of any psychiatric assessment or examination being arranged[479].

14.31 George was fully assessed upon entering Eden Grove in March 2000. Assessments took place by Terry Bruce, consultant psychiatrist, on 17 April 2000 and by Janet Dickinson, Eden Grove's educational psychologist, on 5 April 2000. Alongside these assessments, there was the more general assessment by the staff. George also had access to the school's counsellor, Sue Fox, and regularly visited her.

Misuse of alcohol and drugs

14.32 There is no record indicating George was under the influence of drugs or alcohol whilst at Eden Grove – although he was found trying to purchase drugs on at least one occasion. However, he referred to his drug misuse on the Island in his initial assessment at Eden Grove [480] . It remained apparent to the staff at Eden Grove – both from his words and demeanour upon return from contact – that George was using illicit substances while on the Isle of Man for contact. As detailed in chapter 12 above, concerns about George's behaviour whilst on Island were raised frequently with social services. While at Eden Grove, he received counselling about drug misuse [481].

14.33 Sylvia Morrison told the Inquiry that George's drug use was worse on the Island than at Eden Grove [482]. She did not refer George to DAT on the Island, thinking that they would not get involved if a person did not self-refer [483]. Nevertheless she stated that she would have referred him had he remained on the Island.

14.34 During his visit on the Island for Christmas 2001, there is firm evidence that he was misusing drugs. On 16 January 2002, George attended DAT for the first and only time [484]. He arrived with Samantha and despite declaring that he "wanted to sort his head out and save money", after a brief assessment Noel Gibney, a member of DAT staff, got the impression that he was seeking a free supply of valium and that the concept of detoxing was quite novel to him. George was given an appointment for 12 February 2002 [485].

14.35 At the meeting on 21 January 2001 to discuss George's refusal to return to Eden Grove [486], Mrs Green told the meeting that she suspected that drugs were being used at her house.

14.36 On the morning of 31 January 2002, George attended at social services at Hillary House in the company of Samantha and both appeared to be "high".

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[479] see generally chapter 10
[480] Sylvia Morrison Day 4:64
[481] Sylvia Morrison Day 4:64
[482] Sylvia Morrison Day 4:64:23
[483] Day 4 4:65
[484] Dr Kirsten Wafer statement W4.
[485] letter 5 February 2002: Dr Kirsten Wafer statement W4, appendix KW2
[486] see chapter 12

14.37 Later on 31 January 2002, George was arrested for shoplifting. His sister Jennifer Charles, who attended the police station as the appropriate adult, told the Inquiry that George was "clearly off his head" and that he had taken some form of drug [487]. George admitted stealing £125 worth of clothes in order to repay a debt of £100 to people he refused to name. It is reasonable to infer that it was in connection with drugs given his "high" state and the threats made by the unnamed people.

Conclusions

14.38 The Inquiry has already noted that there was absence of early and proper assessment of George's needs as a child displaying emotional and behavioural problems [488], coming from a family where emotional and behavioural problems were displayed by an older child. Therefore, no health service provision to meet such needs was made available.

14.39 In Part 2, the Inquiry considers Early Years assessment and intervention.

14.40 While at Eden Grove, George's health needs (including those relating to his emotional and behavioural difficulties) were appropriately met.

14.41 The Inquiry accepts that while George was placed at Eden Grove, Ms Morrison was justified in not seeking a referral to DAT on the Island. However, the Inquiry notes that, as in Samantha's case, the knowledge that George was misusing drugs and the obvious inference that he was mixing with others misusing drugs or other substances strengthened the urgent need for George to be returned to Eden Grove and to be properly supervised while on the Island.

[487] See chapter 12
[488] See chapter 10

CHAPTER 15

PETER NEWBERY

Introduction

15.1 Peter Newbery was born on 8 December 1980. He was aged 21 at the time of the murders. He was brought up in Douglas. He went to St Ninian's School but was suspended in September 1996 after a series of violent incidents. In October 1996, he was received into voluntary care and placed at Cummal Shee. On 28 May 1997, he left Cummal Shee and was placed in David Gray House, a bail hostel, despite being under age for admission. On 17 June 1997, Peter Newbery, aged 16, was placed by social services in bed and breakfast accommodation, where, the DHSS informed the Inquiry, Newbery lived "independently" [489]. The last Review of his case was held by social services in May 1997.

15.2 He had a large number of criminal convictions, commencing in 1996, mainly relating to offences of violence. On 24 March 2000, following his conviction for possession of Class A and B drugs and for use of threatening words and behaviour, he was made subject to a two year probation order. He breached the probation order and it was revoked in September 2000. In July 2000, the police had received what they considered to be reliable evidence that Peter Newbery, aged 19, was dealing in drugs. The Inquiry was told by the police in correspondence that it was, and is, not known to whom he was dealing [490] .

15.3 In November 2001, he was arrested for the rape of a 14 year old female who was in care. What was not known by all agencies was that in 1997 he had been arrested for an offence of unlawful sexual intercourse with a 13 year old girl. The police had been aware of this information in 1997, but in 2001 this information was not immediately available in police records.

15.4 A number of issues arise in connection with Peter Newbery.

What relationship was there between Samantha and Peter Newbery in 1997?

15.5 Peter Newbery and Samantha resided together at Cummal Shee for a period in 1997. He was 16; she was 12. Peter Newbery was moved from Cummal Shee to David Gray House on 28 May 1997, despite being below the usual admission age. Hilary Erani [491] had been a project worker at David Gray House since 1994. David Gray House was a hostel for people over seventeen years of age and was run by the Probation Service. She told the Inquiry:

> "During my time at David Gray House I was involved with the decision to allow Peter Newbery to reside at David Gray House. My understanding at the time was that this was an absolute last resort and that the DHSS approached David Gray House to request that Peter Newbery reside there

[489] Letter Simcocks 26.7.05
[490] Letter from Dickinson Cruickshank 14.7.05
[491] Ms Erani is now a probation officer, becoming one approximately three years ago.

> because they had no alternative accommodation for him at that time. During this time I liaised with Tim Norton of the DHSS. … [T]he concerns, which were discussed at the time between us, which concerned the fact that Peter Newbery was forced to leave Cummal Shee because it was believed he was having relations with Samantha Barton, who was 12 years old at the time. … It is my clear understanding and recollection of events, that the DHSS approached David Gray House … because of concerns that Peter Newbery was having a relationship with Samantha Barton."

15.6 The Inquiry was told that since that occasion, the exceptional course of placing Newbery at David Gray House has not been repeated for any other person aged below eighteen [492].

15.7 Since 1995,Tim Norton had been the principal social worker for the long-term team in Children and Families and managed seven social workers, including Ruth Bithell, who was Samantha Barton's social worker, and Angela Oldroyd, who was Peter Newbery's social worker[493]. Trevor Noden was his line manager. In August 1997, Mr Norton was transferred to his current position, social worker for Older People (the over-65s), because his managers lacked confidence in his capacity as a principal social worker and felt he was better suited as a social worker [494]. Mr Norton told the Inquiry that he "was not aware of any [sexual] relationship between Peter Newbery and Samantha Barton that was happening at that time and have no recollections of such." His current recollection of events involving Peter Newbery and Samantha was "very vague, almost non-existent".

15.8 However, there is documentary evidence - namely the records of the time from David Gray House and Cummal Shee - to suggest that Samantha and Peter Newbery *may* have had some sort of sexual relationship at Cummal Shee. It is not clear from those records exactly what form that relationship took. The documentary evidence from the time suggests that on at least one occasion they were in close physical proximity to each other and Newbery was sexually aroused [495].

15.9 Moreover, the documentary evidence from that time seems to establish that Peter Newbery was moved from Cummal Shee because of investigations into some sort of sexual relationship he was having with a 12 year old girl – Samantha - who he had taken advantage of. The Minutes of the Referral Interview on 28 May 1997 by Ray Johnstone, Project Worker at David Gray House, state that Newbery had been at Cummal Shee but was bailed to David Gray House and that " … due to other reasons, they could not take him back". Mr Norton is reported to have told the staff that "an incident had occurred in which Peter had allegedly taken "advantage of someone". … Peter is not aware of any possible investigation ". On 30 May 1997 Hilary Erani met Tim Norton. Ms Erani's note of the meeting states:

> "Tim clarified why Peter was not allowed to return to Cummal Shee. There are investigations currently in progress relating to Peter's relationship with a twelve year old girl, a resident of Cummal Shee. These investigations are of a sexual nature…

[492] DHA Closing submissions on behalf of Probation Division
[493] Statement W93
[494] Tim Norton: Day 21: 164: 3-5
[495] Cummal Shee Daily Observations for 25 May 1997. and also Daily Observation for 27 May 1997: "Peter up early left unit with Sam (12), [child C] (14), [child G] (15) … absconding with younger people from the unit will not help your case"

When Peter joined us it was strongly emphasised that he would be reported to the Police if he is seen in the company of Samantha Barton, the 12 year old girl he is to stay away from."

15.10 A statement provided in Newbery's criminal trial by Mary Lordan, a residential social worker at Cummal Shee, indicates that staff at Cummal Shee were concerned about the nature of Samantha's relationship with Newbery based on more than one observation of sexually provocative behaviour [496]. Ms Lordan describes two incidents: the first where Samantha was watching TV while bouncing up and down on Newbery's lap and the second when Samantha was in the pool room and rubbing Newbery's erect penis, both were fully clothed at the time.

15.11 There were rumours at the time that the relationship was a fully sexual one. Victor Whiteside, who was an outreach youth justice worker at NCH at the time, told the Inquiry that a client had told him that he believed Newbery was having a sexual relationship with Samantha [497]; the client had heard the rumour. Mr Whiteside told Richard Kneen, who was second in charge of the NCH outreach team [498] and told a manager at Cummal Shee, whose identity he could not now remember [499]; but he did not tell social services directly [500]. Mr Whiteside told the Inquiry that he thought there was quite a strong possibility that this client was telling him the truth [501].

15.12 At this distance in time, there is a limit to what can be stated with any degree of certainty. Peter Newbery gave oral evidence to the Inquiry. He said that Samantha and he "were kind of seeing each other", "like boyfriend/girlfriend type of thing" whilst at Cummal Shee. But he did not specify what that meant and it would be unsafe to rely on his evidence about this aspect. The Inquiry concludes that the documentary evidence at the time establishes that Newbery and Samantha were showing sexual interest in each other while at Cummal Shee. It cannot be concluded, on the basis of the above evidence, that Samantha and Peter Newbery were having a sexual relationship in the form of sexual intercourse. However, there was a suspicion at the time that their relationship had gone beyond sexual arousal or might do so.

15.13 The fact of the sexual interest and the suspicions of more developed sexual activity do not appear in social service case records of either Samantha or Newbery. It has not proved practicable to reach a conclusion as to precisely why this did not happen. But the Inquiry is clear that these matters should have been recorded in each young person's case records as information relevant to their future care and protection.

15.14 There was sufficient evidence for social services to have been alerted to the need for at least a strategy meeting and an investigation. This is particularly the case given that the previous month, April 1997, there had been concerns that Samantha was sexually active with another Cummal Shee resident, and a child protection meeting had been called as a result. Although Tim Norton suggested otherwise in his evidence, the clear meaning of the contemporaneous documents show that he did know about the concerns that led to Peter Newbery leaving Cummal Shee, albeit that they were not specific, and that Mr Norton knew enough to call such a meeting or instigate such an investigation.

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[496] also criminal statements by J. Crawley and R. Kneen.
[497] Day 9: 28
[498] Day 8:30-31. Mr Kneen had heard similar rumours from other sources.
[499] He named one person as "possibly" the person
[500] Day 9: 29-30.
[501] Day 9: 34

Were Samantha or George associating with Peter Newbery before their murders?

15.15 The only direct evidence that they were associating comes from Peter Newbery who said in his statement for this Inquiry and in oral evidence to the Inquiry that from September 2001 he had been seeing Samantha and George regularly for the purposes of selling her drugs, namely cannabis, ecstasy and speed; and that he used to hang out with Lyndsey Barton. At his criminal trial, Peter Newbery denied murdering Samantha or George and was disbelieved by the jury. The Inquiry believes his evidence should not be relied upon unless, at least, it is corroborated by other trustworthy evidence. It is not. On the contrary, Lyndsey Barton disputed that Peter Newbery was Samantha's supplier or that she or Samantha hung around with Newbery [502]. Lyndsey said that Samantha got drugs from one of his friends [503]. A witness known as "Young Person 1" said that Newbery had not been known to him and his friends.

15.16 It should be remembered however that Samantha and Peter Newbery did have a shared history in care and so would have known each other from there.

15.17 Charles Buist, a residential social worker at the Leece Lodge campus, told the Inquiry that probably in January 2002, maybe December 2001, he saw Peter Newbery approaching Leece Lodge; Newbery was walking on the pavement towards the house, a few metres away from the entrance. Mr Buist did not tell anyone at the time because he did not know who Newbery was; and that he did not see a photograph of Newbery until much later [504]. He said had he been told of the Nov 2001 allegation he would have phoned the police [505].

15.18 As the advocate for the families pointed out in his closing submission, precisely when and why Peter Newbery murdered Samantha and George remains unknown. Equally the Inquiry has concluded that there is insufficient evidence that they were associating before the murders; and that the extent and nature of the association between Samantha and George and Newbery in the months preceding the murders remains unknown.

15.19 In any event, it appears from the evidence that no one took a particular interest in or questioned either Samantha or George as to with whom she or he was associating [506].

Should Peter Newbery have been charged with a criminal offence following the November 2001 rape allegation and, if so, when?

Release without charge on police bail in November 2001

15.20 On 18 November 2001, the friend of a young person ("XY") in the care of social services reported to the care staff at Priory House, Tromode, that XY had told her that she had been raped by Peter Newbery. The care staff informed the police. The Police interviewed the friend and later that day interviewed the victim XY. The alleged circumstances were as follows. The victim XY was a 14 year old girl. She was in the care of social services and was placed at Priory House, Tromode. On 17

[502] Day 10:114-116
[503] Day 10:116:2
[504] Day 14: 145-148
[505] Day 14: 149
[506] See chapters 9 and 12

November 2001, XY, two friends from Priory House and Peter Newbery had, unknown to the staff, gone on an overnight camping trip; Newbery had raped the victim and threatened her with a knife, he had also cut her jeans, he had tied her hands with ripped clothing and gagged her. It was a very serious incident.

15.21 The Inquiry has considered whether the police, an agency of the government, should have charged Newbery with any offence arising from the rape allegation in order to discover whether he could have been remanded in custody in November or December 2001 or January 2002. The profound effect of that is clear: in custody, he would not have had the opportunity to commit the murders.

15.22 Between October 1999 and January 2003 Richard Power [507] was a Detective Sergeant in the Family Protection Unit (FPU) of the Isle of Man Constabulary, based at Police Headquarters in Douglas. His principal role was operational: to oversee the work of the FPU in accordance with its terms of reference and in partnership with the Social Services Division. Inspector Power told the Inquiry that the friend of XY was interviewed by police on 18 November. He described what she said:

> " … all four went camping and … during the night the victim and Newbery left the tent and returned sometime later. She stated that all of them had smoked cannabis during the evening. She then said that when the victim returned to the tent no mention of what had happened was made by her. It was only on their way back to Priory House that the victim told her what had happened. In this account she says that Newbery had sex with her and that he had threatened her with a knife. The witness referred to a pair of jeans that had been cut by Newbery."

15.23 Later on 18 November, XY was interviewed. Inspector Power described what happened:

> "In this interview she describes the camping trip and gave a partial account of what happened with Newbery. She said that he told her he had a friend that was being held captive in a nearby house and that if she screamed he would kill her. He threatened her with a knife. He told her that she needed to act like his girlfriend. She willingly went along with this. She then states that he tied her hands and legs with his ripped clothing, she then said that Newbery had "done stuff" to her. She was unable to verbalise what this phrase actually meant. She told DC Burrows that he gagged her with some of his clothing and that she told him to stop but he didn't and that she cried and screamed. In her interview she said that he got his knife out and cut off some of her clothing, throwing them into the river. She put her jeans back on and he gave her a grey top that belonged to him. They both then walked back to the tent together and nothing more occurred. She said that Newbery supplied cannabis to the other three children. …
> At no stage does she describe sexual intercourse with Newbery although she does describe that he touched her all over when she was naked and that she did not want this to happen."

15.24 XY was examined by the Police Forensic Medical Examiner but she refused to have any internal examination and declined to provide a urine sample. The doctor recorded minor knife cuts on her hands. The consequence of this examination was that there was no evidence of penile penetration by Newbery. On subsequent days the victim

[507] Now Inspector

was re-interviewed on a further four occasions but was unwilling or unable to state that Newbery had performed sexual intercourse with her. On the last occasion she brought the interview to a close and declined to discuss the incident any further.

15.25 On 18 November 2001, Peter Newbery was arrested on suspicion of rape [508] and subsequently interviewed. He admitted possession of cannabis but totally denied rape. He stated that he went to a hay barn with the young people where they smoked cannabis. He denied going for a walk with the victim, threatening her, tying her up or ever having any sexual contact. He stated that he thought that she was 16 years of age.

15.26 Peter Newbery was not charged with any offence and on 20 November 2001 he was released on police bail with a requirement to return to the police station on 20 February 2002. Inspector Power told the Inquiry:

> " … during the early hours of Tuesday 20 November 2001 I contacted by telephone Mr Montgomerie, Senior Prosecutor, at H. M. Attorney General's Chambers. The circumstances of the incident were relayed to Mr Montgomerie. Given the inability to prove penile penetration by Newbery and that neither the victim nor Newbery would confirm that intercourse had taken place, it was felt that there was insufficient evidence to charge Peter Newbery at this stage. There was no forensic corroboration that an offence had taken place, there was only a partial account given by the victim and the identity of the offender was still an issue. The victim was unwilling to assist in any identification procedures that would have assisted the investigation. This meant that we had insufficient evidence at that time to charge Newbery with rape, unlawful sexual intercourse or indecent assault. He was therefore police bailed pending further enquiries. … These further enquiries consisted of forensic examination of exhibits, further interviews with witnesses and the victim."

15.27 Inspector Power said in his oral evidence that the evidence disclosed by the victim XY revealed an offence of (at least) indecent assault [509]. The Inquiry notes that this is the offence with which Newbery was eventually charged after he was re-arrested on 9 February 2002. In November 2001, Newbery was not charged, on the advice of the Attorney-General's Chambers, because of the victim's assessed reluctance to give evidence [510].

15.28 The November allegation of rape was brought to the Chief Constable's attention at "the Monday operational briefing"[511], which would have been on either 19 or 26 November.

15.29 On 20 November 2001, Inspector Power carried out a full risk assessment of Newbery. His written assessment in the Intelligence Report [512] stated:

> "Peter Newbery is currently on Police Bail for rape – the circumstances are such that Peter Newbery is a high risk to women. His M.O. involves acting out a fantasy whereby he attacked the victim with a knife, bound and gagged her and then raped her." (emphasis added)

[508] Confirmed to Inquiry in letter 4.7.05 from Attorney-General's chambers
[509] Day 5: 128: 11-15
[510] Day 5: 129-130
[511] Day 17:42:25
[512] Day 5:132-133; Day 6:25:23 – 26:3

15.30 Inspector Power explained, that in the context of sexual crimes against children on the Island, the November allegation was a "serious offence" and "in that context unusual"[513].

15.31 Inspector Power told the Inquiry that, when he sought legal advice, he could not recollect informing the lawyer of his own assessment that Newbery was a 'very high risk to women'; he told the lawyer all the circumstances so that he would draw his own conclusion [514]. He accepted that if he had said that, the lawyer "may well" have said that there were grounds for seeking a remand in custody from the court.

15.32 The Inquiry has reservations about the decision not to charge Newbery with, at least, unlawful sexual intercourse with a girl under 16. The circumstances disclosed a very serious event. The police assessment rightly identified Newbery as a high risk to women.

15.33 In 2001, the Isle of Man followed informally the Code for Crown Prosecutors applying in England and Wales. This provided a test to be passed before a suspect could be charged. In 2004, a further test, the Threshold Test was added to the England and Wales Crown Prosecution Service Code for Crown Prosecutors. It permits a prosecutor to charge a person if there is at least a reasonable suspicion that the suspect has committed an offence and, if there is, it is in the public interest to charge the suspect. The Threshold Test applies to cases in which it would not be appropriate to release the suspect on bail after charge, but the evidence to apply the normal test is not yet available. However, this test did not apply to the Isle of Man at the time (and indeed did not apply in England and Wales at that time). If the Threshold Test had applied in the Isle of Man in 2001, it may have provided an opportunity for Peter Newbery to have been charged and detained in custody [515].

15.34 The Chief Constable told the Inquiry that formal adoption of the threshold test is now being considered at Force managerial level in consultation with H.M Attorney General.

15.35 Inspector Power argued:

> "Even if Newbery had been charged with an offence in relation to the allegation I was investigating, namely Indecent Assault or Unlawful Sexual Intercourse with a girl under 16 years, there would have been no grounds to detain him in custody, to be brought before the next available Court, under Section 41 of the Police Powers and Procedures Act 1998. In particular:
>
> - His name and address were known
> - There were no known risks to his protection. The victim was considered to be safe as she had been returned to Priory House who were charged with her care. There was no specific risk to any other person.
> - There was no evidence to suggest that he was about to commit further offences.
> - There were no fears that he would fail to return on bail or that his release would hinder the investigation of the offence.

[513] Day 6: 6:22-25
[514] Day 5: 149-150
[515] Closing submissions on behalf of Department of Home Affairs

- These allegations did not constitute a serious arrestable offence according to the Act."

15.36 A charge of unlawful sexual intercourse with a girl under 16 would have been a serious arrestable offence if it had caused impairment of her mental condition or was likely to lead to that occurring. Inspector Power said that he did not think that XY had suffered serious mental harm. The Inspector said that the examining doctor did not say the victim was subject to any significant rape trauma-type mental harm; "it was only in the months after that it became apparent that her behaviour had deteriorated" [516]. He said that he "was guided by the doctor's observations".

15.37 The Inquiry again has reservations about the evidence of Inspector Power that he did not believe that, even if charged, there were grounds to seek a remand in custody from the court.

15.38 In her closing submissions, the Advocate for the DHA accepted that Newbery could have been charged with unlawful sexual intercourse and the court asked to remand Newbery in custody[517]. In the Inquiry's view, it would be reasonable to infer that a fourteen year old girl would have suffered serious injury in that her mental wellbeing would be harmed by what had occurred: threatening with a knife, ripping of clothing, gagging of the victim and sexual intercourse. The fact that she was judged by the police doctor to be fit to be interviewed does not preclude such an inference being drawn.

15.39 The Inquiry was told that the Force Prosecution Policy applied and indicates that a police officer is entitled to seek advice from and consult with the Attorney General's Chambers; and that if advice is sought from, or given by, the Attorney General's Chambers, the police must abide by such advice. The Attorney-General's Chambers confirmed to the Inquiry that the police were required to follow the advice from the Attorney-General's chambers on whether or not to charge Newbery. Accordingly, in this case the police were required to follow the advice received and no criticism of the police in not pursuing the matter at that stage can be made.

Allegation in 1997 of unlawful sexual intercourse

15.40 While in custody between 18 and 20 November 2001, the police ran a check against its police information system. The check did not reveal that Newbery, then aged 16, had been investigated in 1997 for an offence of unlawful sexual intercourse with a 13 year old girl. In fact, the information was on the system, but was not accessed on that occasion [518].

15.41 The information had initially been recorded in the police "Cardboard" system. In 1998, the original system was superseded by a system called Force Records Enquiry Database (Fred), but when information was transferred, names of people who had not been convicted or cautioned (such as the investigation of Newbery in 1997) were recorded in a different field (the "other persons" field) to those convicted or cautioned. There was no electronic link to the other persons field when a normal search was made. This was the position when a search was run against Newbery's name in 2001. It was possible for an advance search to be made, which would have searched the

[516] Day 6:67 -68
[517] Day 27:153-154
[518] Michael Culverhouse Day 17:46 - 49

other persons field. However, it was not the normal practice for an advance search to be made in such circumstances. No advance search was made in November 2001. The Chief Constable frankly accepted that given that there was no automatic link between the two fields, the normal practice should have been to do an advanced search, that is, to search both fields [519].

15.42 The Chief Constable informed the Inquiry that, as a result of these events, the system[520] has now been modified and all information about a person is available on a search [521]. While it cannot be disguised that the information retrieval system in 2001 was flawed in this respect, the Chief Constable is to be commended for remedying the position now that it has been brought to his attention.

15.43 What difference did the lack of knowledge of the 1997 investigation make? In his statement to the Inquiry, Inspector Power said that he did not believe that this would have altered the decision not to charge at that stage. Inspector Power pointed out in oral evidence that given the circumstances in 1997 (Newbery was sixteen and the girl was thirteen and force had not been used), it had at that time been treated as a child protection issue rather that a matter that should go before the courts. However, he added that had he known about it, he would have had a discussion with social services about the offence and that may have added to the risk assessment of both the police and social services [522].

The decision not to re-arrest and re-interview Newbery in January 2002

15.44 Inspector Power explained in his statement:

> "23. The focus of the forensic examination was initially to determine if a sexual offence had occurred and if Newbery was the offender. Following consultation with Force Forensic officers, it was agreed that the victim's jeans and supporting exhibits would afford the best opportunity of achieving the necessary evidence by way of Newbery's DNA profile being identified in semen deposits on her jeans. These items were despatched to the Forensic Science Service Laboratory at Chorley on the 28th November 2001. These items were not sent to the laboratory for 'Fast Track' examination, however, offences involving child victims of sexual abuse are given a preferential service and this was noted on the forensic submission form. The items were not sent using the 'Fast Track' method as the potential offender was identified and the victim was not known to be at any further risk from him. It was felt that the additional costs of 'Fast Tracking' items would not have benefited this investigation because Newbery was bailed to the 20th February 2002 and it was expected that the results would be known by then.
>
> 24. In his statement dated 12th January 2002 Thomas Draycott, Forensic Scientist, states that Newbery's semen was found in the crutch area of the victims jeans. This was indicative of sexual activity involving Newbery but did not prove penile penetration of the victim and did not prove rape. There is no written record of when I received the statement from Mr Dracott. To the best of my knowledge I can recollect that this was received by the Isle of Man Constabulary on either the 21st, 24th or 25th of January 2002. Following written confirmation of the forensic

[519] Day 17:49:14ff
[520] Since 2002, the Mentor system
[521] Day 17:45
[522] Day 5: 138- 139; and Day 6:18

> results being received I then made further forensic submissions. However, the results of these submissions were never obtained because of the short time frame between their submission and the murders taking place. Such was the volume of evidence in the murder investigation that a decision was taken not to carry out any further forensic examination of exhibits in relation to the indecent assault charge until the murder investigation had been completed. …"

15.45 Although the Inquiry recognises that offences involving child victims of sexual abuse are given a preferential service, the Inquiry remains surprised that the forensic items were not sent under the "Fast Track" procedure given the serious nature of the offence and the police's own risk assessment of Newbery. The forensic results took almost nine weeks to be returned. The Inquiry also notes that there was no system in place in 2002 for recording the exact date of receipt by the police and that there should have been one. The Chief Constable told the Inquiry that a system had now been put in place to date stamp forensic results when they arrive [523].

15.46 More seriously, Inspector Power decided not to re-arrest Newbery at this stage. He explained in his statement:

> "At the time that the results of the initial forensic results on the jeans were received a decision was made that Newbery would not be re-arrested for the initial offence. The forensic results were not 'new evidence' in the terms required under Section 50(2) of the Police Powers and Procedures Act 1998. At that time the victim was known to be in the care of Social Services. I was not aware that Newbery presented any greater risk to the public at that time compared to when he was released from police custody in November 2001. There were no reasons to re-arrest Newbery prior to the 20th February 2002, when he was due to answer police bail."

15.47 On the first day of his oral evidence, Inspector Power re-iterated his view that the evidence that Newbery's semen was on the victim's jeans was not 'new evidence' for the purposes of the Police Powers and Procedures Act 1998 [524]. On the second day of his evidence, Inspector Power told the Inquiry that although the police had believed it was not "new evidence", when they sought the advice of the Attorney-General's Chambers on 10 February 2002, the legal advice given was that it was new evidence [525]. Inspector Power accepted that his view that it was not "new evidence" had been incorrect. The Chief Constable conceded that Inspector Power's understanding of "new evidence" was flawed and that once the semen on the jeans had been identified as belonging to Newbery, there was new evidence [526].

15.48 The Inquiry was told in closing submissions by the Police that, to avoid any further misunderstanding within the Force in relation to "new evidence", a memorandum has now been issued, which clarifies the present law and that since the law on "new evidence" is still evolving, further memoranda will be issued to keep pace with developments.

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[523] Day 17:60:4
[524] Day 5: 146-147
[525] Day 6:19-20; but the Attorney-General's Chambers informed the Inquiry by letter dated 1.9.05 that, to his recollection, Mr Montgomerie, the Chief Prosecutor, was not asked about the meaning of "new evidence".
[526] Day 17:59:13

15.49 Inspector Power said that, on the basis that the semen evidence was new evidence, Newbery could have been re-interviewed in late January 2002, before the murders. The presence of Newbery's semen on the victim's jeans exposed his earlier denial of any sexual contact as a lie. Inspector Power maintained his view that in late January 2002, even with the forensic evidence of Newbery's semen, there was insufficient evidence to charge Newbery with indecent assault [527]. The Chief Constable accepted that re-arresting Newbery following the receipt of the jeans evidence was "certainly an option". However, he pointed out that had he been re-interviewed at that stage, he would most likely have proffered consent as a defence at this stage and would have probably been released on police bail while that was investigated [528]. He stood by the decision not to charge him having received the first DNA evidence proving that Newbery had lied to the police [529].

15.50 Although supporting his officer's decision not to charge Newbery, the Chief Constable in his evidence said that "there is a sound case to review the decision making in this case"[530]. The Inquiry concludes that Newbery should have been re-interviewed in late January 2002 [531], given the seriousness of the events and the police risk assessment of Newbery. The Inquiry also believes that there was sufficient evidence in late January 2002 to charge Newbery with indecent assault. The semen proved a fundamental lie by Newbery (that no sexual activity took place). This would have presented the police with an opportunity to ask the court for a remand in custody [532]. The decision would have been for the court.

15.51 Newbery's motivation in murdering Samantha and George is not known. It would be only speculation to argue that by re-arresting and re-interviewing Newbery, he would have known that he was being watched and would be less likely to murder [533].

15.52 On 9 or 10 February 2002, while Newbery was in custody in connection with the murders, the Attorney-General's Chambers were informed about the semen evidence and advised that Newbery be re-arrested[534]. He was re-arrested and later charged with indecent assault. Following his conviction and sentence for murder, the indecent assault was adjourned to lie on file, not to be proceeded with, without the permission of the court.

Sharing information about Peter Newbery

15.53 While some information was appropriately shared, there were a number of breakdowns in the proper sharing of information. As Alec Merchant, currently manager of the Referral and Assessment Team of Children and Families and in 2001 social services' contact with the Family Protection Unit, said the system for sharing information "failed" [535].

[527] Day 6:23-24
[528] Day 17:58
[529] Day 17:58:21
[530] Day 17:55:15
[531] Even though further forensic results were awaited
[532] As to detaining Newbery in custody, see above
[533] 17:60:19
[534] The Attorney-General's Chambers letter to the Inquiry dated 1.9.05
[535] Day 5: 59

The reason for leaving Cummal Shee in May 1997

15.54 As has already been noted, the reason for Newbery leaving Cummal Shee, and the link with Samantha, was recorded on neither Newbery's social work file nor Samantha's social work file. It should have been [536]. Accordingly, social services were not in a position to tell anyone about this information at a later stage.

The investigation for unlawful sexual intercourse with a 13 year old in 1997

15.55 As has already been noted, this information was not retrieved from the police information system until after the murders.

Sharing the information of the November 2001 allegation within the police

15.56 Inspector Power is to be commended for taking appropriate steps to share the November 2001 allegation and, more importantly, his risk assessment of Newbery within the police force. The Chief Constable said [537]:

> " … [i]t was wholly appropriate in the circumstances, that Inspector Power did tell the whole Police about Peter Newbery's arrest, did suggest to the whole Police that he was a danger by putting an item on the Police log. He acted very reasonably indeed, by bringing it to the attention of everybody. And then every time a Police Officer did see Mr. Newbery on the street or in the car, at least they were aware of his danger and could have put in some intervention… so armed with that information an Officer on patrol saw Mr. Newbery outside of a care establishment or talking to young people, then I would expect that Police Officer to go out and put some intervention in place, and satisfy themselves that whatever interaction was going on was legitimate and report that sighting onto our intelligence system".

The police inform social services of the November 2001 allegation against Newbery

15.57 Inspector Power informed Ed Coates, principal social worker for children and families, of the allegation against Newbery at a meeting on 21 November, which he described as a strategy meeting. Inspector Power told the Inquiry in his statement that he "fully appraised those present with the incident involving the victim and the dangers that he posed". In his police notebook, he referred to it as "strategy meeting Ed Coates re [XY]". In his supplemental statement to the Inquiry, he said:

> "By my liaising with both Ed Coates and Alec Merchant [538], the DHSS were kept fully informed of the investigation, including its progress and details of Peter Newbery and the particular circumstances of the offence. In informing the DHSS of the full facts of the incident, I believe I communicated my risk assessment of Peter Newbery to Social Services"

[536] Ed Coates Day 12: 63
[537] Day 17: 61
[538] See below

The Inquiry has not been told of any contemporaneous note made by the police of this meeting [539].

15.58 Ed Coates' minute of the meeting of 21 November, which he called a strategy meeting[540], sets out an update of XY's care and an update of police actions. It continues "RP summarised [XY's] story: …"[541]. The minute goes on to describe the events. There is no reference to the internal police risk assessment. Ed Coates could not remember at the meeting having been told formally of the police risk assessment or of an assessed risk to young women or teenagers in care, but he accepted he could not fail to be conscious of the risks given the alleged circumstances [542].

15.59 Inspector Power also informed Alec Merchant, who was managing the Referral and Assessment Team of Children and Families, at their regular weekly meeting in connection with the Family Protection Unit on 23 and 30 November. He was right to do so. However, in the Inquiry's view, these meetings on themselves were not a satisfactory means by which a decision whether to share and any actual sharing could happen. Alec Merchant told the Inquiry that Inspector Power did not expect him to do anything with the information [543]. The effect of what Mr Merchant told the Inquiry was that he, Mr Merchant, had no responsibility to do anything with the information as the relevant people already knew and would be acting on it [544]. He said he did not know with whom the information had been shared but he would be surprised if the other service providers were not made aware of this information, through either resource panels or partnership meetings. He described a system, which to the Inquiry can best be described as "ad hoc", relying for example on the information "surfacing" at a resource panel meeting [545].

15.60 Mr Coates told the Inquiry that he had a number of meetings with the police but there was no formal child protection strategy meeting [546]. Mr Coates accepted that there should have been a child protection strategy meeting to decide, among other matters, how widely within social services and service providers to share the information [547]. He suggested the meeting should have comprised social services, the police and probably the victim's care provider. He told the Inquiry that his discussions with the police were not concerned with deciding who should be informed of the information [548]. He was not sure such information should have been shared with all service providers but said there should have been a strategy meeting held with the police to discuss the issues arising from the allegation [549].

15.61 Mr Coates said that did not happen because at the time, there did not exist "really agreed structures for managing those sort of child protection investigations" [550]. He suggested that such structures were not always followed in every case even now [551].

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[539] Apart from the entry in Inspector Power's police notebook
[540] But not a formal child protection strategy meeting
[541] This note was produced to the Inquiry only after the close of the oral evidence hearings. Accordingly the Inquiry takes into account that, while having the opportunity to make submissions about it, Inspector Power was not asked about it in his oral evidence
[542] 12:84. See also Day 12:59.
[543] Day 5: 48
[544] Day 5: 48 - 52
[545] Day 5: 52:21
[546] Day 12:50
[547] Day 12: 52-56
[548] Day 12:50 - 51
[549] Day 12: 53: 1-3; 54: 5-25 – 55: 6; 58: 15-19
[550] Day 12: 61: 21-24

15.62 The Chief Constable accepted that no child protection strategy meeting was called and that one should have been called; the police lead on this would be taken by the FPU [552]. The Chief Constable argued that it was social services' primary responsibility to call a meeting but conceded that when they failed to do so, the onus fell upon the FPU [553]. Mr Coates said that "at that time, and in fact subsequently, there were still issues around who leads on strategy discussions and child protection. … My inclination is to say that the police led on that and they decided how to conduct the investigation" [554].

15.63 Plainly, there was no clear policy as to the calling of child protection strategy meetings where both police and social services were involved with a child. This led to a failure to call such a meeting. There was no formal meeting to decide who needed to know of the allegation made by XY and the police risk assessment of Newbery.

15.64 The Chief Constable told the Inquiry that, in his view, the information about Newbery should have been shared with the service providers caring for children and young people on the Island [555]. He said that in 2001-2002 there was a structured, though not written, policy about sharing information on dangerous people [556]. He said that now there are structures in place to ensure there is a record of who is being told what and by whom; but this structure was not in place in 2001-2002 and he was not aware of who beyond social services and the victim's service provider knew [557]. There was heavy reliance on the UK Working Together guidance [558].

15.65 The Chief Constable explained that information-sharing is now more structured and formal. There is now an Information Sharing Protocol [559]. However, at the date of giving his evidence, 6 July 2005, he said that neither the Social Services Division, nor the Health Division nor the Department of Education had signed the Protocol [560]. When Trevor Noden gave evidence on 12 July, it emerged that the DHSS had signed the Information Sharing Protocol "within the last two weeks". It had been developed following a seminar in October 2004 and was ready for signing in about January 2005; he could not explain why the officials, more senior than him, had delayed six months before signing [561]. Mr Noden added that until the procedure is signed the policy does not exist [562].

15.66 The Chief Constable also said that there was now a multi-agency public protection panel [563]. David Sellick, the Chief Probation Officer, said that if it had existed at the time, a meeting should have been held, in order that there could have been a multi-agency assessment of Newbery's risk [564].

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[551] Day 12: 62: 1-3
[552] Day 17:50:15
[553] Day 17: 50-51
[554] Day 12: 55-56
[555] Day 17:63:6
[556] Day 17:86
[557] Day 17:63-65
[558] Day 17:91
[559] Day 17:87-88
[560] Day 17:91-92
[561] Day 20:159:23; 161: 10-11
[562] Day 20:162:11-12
[563] 17:87-88
[564] Day 10:45-46. See also below.

Should it have been known to Samantha's service provider- Nugent Care, who ran Leece Lodge - that Peter Newbery was dangerous?

(a) to Nugent and other service providers caring for teenage girls

15.67 Priory Care, as the victim's care provider, knew of the alleged circumstance. As has already been noted, there was no strategy meeting held at which to decide, among other matters, how widely within social services and service providers to share the information [565]. The Inquiry concludes that there should have been a strategy meeting.

15.68 Mr Coates told the Inquiry that he did not formally inform the service providers about the alleged incident, but he thought they would have learnt of it through discussion at the Resource Panel [566]. In fact, the Resource Panel meetings of 28 November and 28 December 2001 and 9 January 2002 refer to XY making no mention of the alleged incident. There appears to have been no positive decision, one way or the other, whether to share this information among social services and service providers generally.

15.69 The decision whether and with whom to share the information about Newbery would not have been straightforward. On the one hand, Newbery had not been charged with any offence. Also XY was being treated unpleasantly by some of the boys resident at Priory. How widely should the information have been shared ? On the other hand, the alleged events involving XY were very serious. There was a clear police risk assessment. Appropriate sharing of the information would have provided Nugent and other service providers with the opportunity to warn the children in their care, in particular teenage girls in their care, at least to be careful who they were associating with. It would also have given the opportunity for carers to be extra vigilant about unidentified young men who might attend at any of the care homes.

15.70 The difficulty at the time was that there was no clear policy or protocol on sharing information on potentially dangerous people. On balance, the Inquiry is inclined to think that the information about Newbery's risk should have been shared more widely. Most importantly, the Inquiry is clear that a meeting should have been called to decide whether and with whom to share the information.

(b) to Nugent as a carer of XY

15.71 On 17 December 2001, XY, the victim, moved to White Hoe residential home run by Nugent Care. Plainly, Nugent should have been given this information as necessary for their care and support of XY.

15.72 The evidence is unclear and unsatisfactory as to whether Nugent Care staff who took over the care of XY were told about the alleged rape by Newbery.

15.73 Nugent Care told the Inquiry that they were not told specifically about the rape allegation.

[565] Day 12: 52-56
[566] Day 12: 51: 14

15.74 The DHSS accepted [567] that responsibility for passing on the information lay with the social worker.

15.75 None of the Nugent Care management or Leece Lodge staff who gave evidence said they were aware of the allegation until after the murders. Christopher Lever, a Nugent Care team leader at White Hoe, said in oral evidence that he had no recollection of knowing about this allegation and the connection with Peter Newbery until after the murders [568]. In his criminal statement, Mr Lever had said "[XY] mentioned to a member of staff [at White Hoe] that she was sexually assaulted by a male called Peter Newbery… Helen Moore … will know more…".

15.76 Diane Toher was XY's key worker at White Hoe Residential Unit from 19 December 2001. In her statement, she recalls the file being passed over by Priory to Nugent but she does not recall anything in the file about the alleged assault by Newbery. She can recall nothing being communicated to her at the time of transfer about XY's allegation; and she says in terms that Helen Moore "did not tell me anything about the alleged assault on [XY]". She says that "Katie Buchanan may have known more about XY's recent history" and "this may not have been communicated to me". This seems unlikely to the Inquiry, given Ms Toher's role as key worker; and Helen Moore, XY's social worker, refers in her statement to this piece of information being "key" to those charged with responsibility for XY. Ms Toher recalls, however, that a few weeks later (but before the murders) XY mentioned the alleged assault and a couple of weeks later that it was by Newbery. She says that she told her line manager Katie Buchanan and that she knew that Katie Buchanan [569] had spoken to XY's social worker Helen Moore.

15.77 It seems to be common ground between Nugent and the DHSS that Nugent staff knew of the alleged rape at some stage in January 2002.

15.78 Helen Moore was XY's social worker. In her statement, she said that on 10 December 2001, she and the victim met Katie Buchanan at White Hoe, where the victim was to move to, and discussed the allegation and mentioned Peter Newbery's name. Later in the introduction process, she met Diane Toher. XY was told she could talk about the allegation with Ms Buchanan or Ms Toher, both of whom "were fully aware of the situation". She added that on 11 December 2001, she arranged for Ann Duff of Priory to liaise with Christopher Lever of Nugent regarding the introductory process.

15.79 The Inquiry was told that Ed Coates met Francis Charlton on 6 December to discuss XY's possible move to White Hoe. Francis Charlton told the Inquiry that he could not recall being told of the allegation of rape. Damian Bradley told the Inquiry that he had no recollection of an alleged rape at the time of transfer; but recollected Francis Charlton saying in January 2002 that XY was about to make a disclosure concerning "sexual abuse" [570]

15.80 This confused and contradictory picture of what may or may not have happened reinforces the importance of accurate contemporaneous record keeping.

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[567] In correspondence with the Inquiry dated 3 August 2005

[568] Day 24:68-69

[569] At the request of the Inquiry, the DHSS attempted trace Katie Buchanan but were unsuccessful and there is no evidence from her: Simcocks letter 16.12.05. DHSS also lost contact with Mike Joughin before he could sign a statement.

570 Day 18: 30-32

15.81 The Inquiry was informed by DHSS [571] that there is no express reference on XY's file that Helen Moore clearly informed Christopher Lever of the allegations but that XY's social work file records that at the time of XY moving to White Hoe there were "discussions" about XY's history and situation with Nugent; but there is no specific reference to the alleged incident. Given the poor record keeping in social services, the absence of a record may be because of poor record keeping or it may be no specific reference was made. Plainly, there should have been a clear written record of what Nugent were told about XY and her history.

15.82 The Inquiry was informed by Nugent [572] that the only reference to Newbery on Nugent's XY files is one reference on 15 March 2002. Significantly in the Inquiry's view, there was "no formal handover report from DHSS or any other party on the file and the reports provided to Nugent Care did not refer to the indecent assault at all let alone Peter Newbery as perpetrator". Trevor Noden could not point to a document which expressly told Nugent of the rape allegation and rightly agreed that was a failing in the system [573]. Trevor Noden said:

> "my expectation would be that the information Priory Care had, presumably on file, would follow that young person to the next placement. … my understanding of those files is that they belong to us. Certainly that is the situation now with care providers, that when young people leave, care providers agree to return their files to us" [574].

15.83 Mike Borland was Project Director for Priory Services for Young People (IOM) Limited at the time. He told the Inquiry in his statement that Helen Moore, as XY's social worker, was the focal point for XY and disclosure of her personal details. "It would not have been usual for Priory staff to independently notify Nugent staff of the particular allegation. … Priory would not have disclosed details of the allegation directly as this was information which would have been passed on by social services".

15.84 It appears to the Inquiry that there was lack of clarity at that time as to who should be writing transfer summaries and as to what should be in them.

Should Samantha have been warned that Peter Newbery was dangerous ?

15.85 Because the events of 1997 were not on her file, there was no known connection between Newbery and Samantha. There was no close watch kept on whom Samantha was associating with. There was no evidence that Samantha was associating with Newbery in 2001-2002. There was no specific reason to warn Samantha against Newbery, beyond any general warning which might have been given to those in care homes or to those caring for teenagers in residential care [575].

15.86 Samantha was unsupervised and largely left to her own devices at Leece Lodge 2. Newbery's motive for murder and the circumstances in which it occurred remain unknown. Even if she had become aware of a general warning about Newbery, it cannot be known whether it would have been effective to protect her from him.

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571 Letter Simcocks to Inquiry dated 3 August 2005
572 Letter Quinn Kneale to Inquiry 21 June 2006
573 Day 20:159: 13
574 Day 20:193-194
575 See above.

Information about Peter Newbery known to Probation

15.87 Alec Merchant was the juvenile court officer for DHSS and Peter Newbery was allocated to Mr Merchant from July 1996 to April 1997. He accepted that he did not carry out a formal risk assessment but formed the view that Newbery was a "very troubled young man" who represented a "significant risk"[576].

15.88 At the age of sixteen, Newbery was sentenced to community service following conviction for assault occasioning actual bodily harm. The Probation Division ran the community service scheme. Probation continued to be involved with Peter Newbery throughout 1997. On 23 June 1997, he breached his Community Service Order, and was given a further 120 hours Community Service which he also subsequently breached. He was returned to Court as a result of this breach on 1 October 1997 and Probation had no further involvement with Peter Newbery until March 2000.

15.89 The Probation Service first had direct responsibility for Newbery in 2000. On 25 February 2000, the court requested a social enquiry report. Margaret Dunne wrote a Probation Report dated 1 March 2000. Ms Dunne's report, presciently, assessed the public to be at risk of harm from "a continuous string of assaults":

> "It is my view that unless Peter Newbery is offered professional intervention, his future is likely to continue on a downward spiral. Without assistance he will almost certainly continue to mismanage his emotions and as a result place the public at risk of harm from the continuous stream of assaults".

Ms. Dunne stated in her witness statement to the Inquiry that she believed:

> "Peter Newbery posed a medium risk of harm – to himself, based on his substance misuse and to the public given his previous violent behaviour".

15.90 In her report, Ms Dunne recommended one-to-one in depth counselling to address his violence and drug misuse. On 24 March 2000, Newbery was placed on probation for two years, until 24 March 2002. Ms Dunne produced a Supervision Plan for Newbery which identified lack of control and inability to manage emotional stress. She referred Newbery to the Anger and Stress Management programme to address his anger and stress [577]. He was required to complete the Offender Behaviour Programme. This did not occur simply because Newbery did not attend either the Programme or meetings with his probation officer [578]. Proper efforts were made to encourage Newbery to comply with his order. Because of his refusal to comply, Newbery was brought back to court for breach of his probation and on 20 September 2000 the probation order was revoked and he was sentenced to 30 days imprisonment.

15.91 Newbery was recognised as a risk to the public unless he received help. He failed, in breach of his probation order, to attend his course. Mr Sellick said:

[576] Day 5: 6: 15-16, 19-25; 7: 1-6
[577] David Sellick Day 10: 32:22-33:13
[578] Day 10: 33:13

> "After reflection on the matter I am still not able to suggest any strategy which would lawfully compel the likes of Peter Newbery to undergo treatment for anger management or the like in a secure environment. As can be seen Newbery did not engage with the Division whilst on probation and it seems probable that he would have been equally unlikely to attend for therapy or treatment unless such requirement was coupled with Court sanctions. Even then, as is the case of the Probation Order, the sanction for flouting the conditions of Probation Order is revocation of the Order, thus putting Newbery beyond the help of the Division".

Mr Sellick said there was no policy at the time (or now) for sharing the fact of breach of a probation order with other agencies [579].

15.92 Neither in 1997 nor in 2001 was there a Probation policy on the sharing of information on potentially dangerous people, although there was an expectation that such information would be passed on; nor was there a policy on what information generally should be shared with other agencies [580].

15.93 Since 2002, there is now the Information Sharing Protocol [581] and Probation have adopted the UK practice of Multi Agency Public Protection Panels (MAPPPs) for those individuals who are deemed to be high risk.

[579] Day 10: 41
[580] David Sellick Day 10: 10: 1-2; 17: 9-10
[581] See above

CHAPTER 16

THE FAMILIES

16.1 This Inquiry is not an inquiry into the care and support given to Samantha and George by their families. However, the level and effectiveness of the care and support given by others to Samantha and George has to be assessed in the context in which the care is given. Thus, it is necessary to consider to what extent the level and effectiveness of the care and support provided by the Government and its agencies was influenced or affected by the attitudes and conduct of the families.

16.2 Neither Samantha nor George's parents had been able to care adequately for their daughter and son. Much as they loved Samantha and George, they were unable to offer stability, impose boundaries or exercise control over their children. They sought the help of social services.

Samantha

16.3 Mr Crabtree on behalf of the families accepted that Mrs Burnell was a mother who was unable to parent through her own ill-health. Her ill-health did not always incapacitate her physically but it did incapacitate her functionally. By the time Mrs Burnell requested in 1995 that Samantha be received into voluntary care for the last time, it is likely that Samantha's emotional and behavourial difficulties were well formed. Steve Miller, the Director of Care and qualified psychologist from Marlowe Child and Family Services who assessed Samantha in 1997 stated in his conclusion:

> "I believe Samantha's difficulties are a direct consequence of poor childhood experiences exacerbated by poor social learning".

It is to her credit that Mrs Burnell recognised her frailties and in due course had asked that social services care for Samantha. In 1997, she did not oppose the making of the care order.

16.4 The Inquiry has heard and read a great deal of evidence suggesting that at times Mrs Burnell had a disruptive influence on Samantha's care plans and placements in early period of social services involvement [582]. Much of this disruption was undoubtedly due to Mrs Burnell's own frailties and mental ill health. Ed Coates in his written statement said:

> "Work with the family was not dissimilar to work with Samantha and it was characterised by unpredictability. …
> Work with Mrs Burnell was more frequently characterised by aggressive or angry responses and I, and the social workers, experienced her as focusing on her own needs, and rarely able to act or think particularly in the children's interests. Despite efforts in the early days by the social workers, increasingly very little co-operative work took place."

[582] This was not the case in the period from February 2001

16.5 Mr Kneen criticised Samantha's mother as "particularly difficult. She constantly undermined the work that everybody was trying to do" [583]. He gave an example of an occasion when Sam, Lyndsey, Rose Burnell and a young person were all drinking in Mrs Burnell's flat and when Mr Kneen went to try and collect the girl, Mrs Burnell told her she did not have to do as she was told. Mr Kneen indicated that: "our work was made almost intolerable by Rose Burnell"[584].

16.6 The relationships with certain social workers were difficult. Ed Coates said [585]:

> "Mrs Burnell … had a very difficult time, and had a particular view of Samantha, which would be that, I guess, although she loved her very much, she saw her as needing in some way making right; it was Samantha's problem. I don't think Mrs Burnell had a view that there were things that she could have done differently that might have helped Samantha and so I never ever saw a lot of evidence that she was taking responsibility for doing anything differently herself…I know Mrs Burnell experienced mental health problem; I know she had problem with alcohol and anger herself. I think there were some issues that got in the way of us working with her".

16.7 Mrs Burnell found it difficult to control or set boundaries for Samantha. Mrs Burnell said that from when Samantha was aged 14, she was smoking cannabis and that she allowed Samantha to smoke cannabis in front of her on a couple of occasions, thinking that she would only "smoke it on the streets anyway" [586].

16.8 Mr Coates readily accepted that it was necessary to take into account her health when analysing Mrs Burnell's ability to work with social services and that it was difficult to know how much her health had affected that ability to work in tandem with social services [587].

16.9 The evidence shows that, if anything, and because of Samantha's age and Mrs Burnell's infrequent visits, Samantha's mother was less of a disruption to the care and support offered to Samantha while in Leece Lodge than in other periods of Samantha's life.

16.10 Given the decision to return Samantha to the Island in 2001 and given the inevitability that Samantha and her mother would be able to meet freely, it was known that this might not assist the stability of any placement on the Island. Undoubtedly the difficult relationship between social workers at all levels and Mrs Burnell made Samantha's case more difficult to manage. The Inquiry does not underestimate the difficult task faced by social workers in seeking to work with Mrs Burnell. However, the Inquiry concludes that in the period after February 2001 the level and effectiveness of the care given to Samantha by others was not affected adversely to a material extent by Mrs Burnell.

16.11 Samantha and her sister Lyndsey had a loving and close, if tempestuous at times, relationship. Lyndsey herself was a vulnerable young woman misusing heroin and crack cocaine [588] and she could not have been expected to act as a positive role model

[583] Day 8:84:15
[584] Day 8:86
[585] Day 12: 34-35
[586] Day 16:71
[587] Day 12:36
[588] Day 10: 108

for her sister after Samantha's return to the Island in 2001. Her continued involvement in Samantha's life was accepted by social services and at one time it was planned by social services that they would live together despite the obvious risks [589].

16.12 Theresa Barton was Samantha's aunt. Ed Coates said:

> "Samantha's aunt, Theresa, was always supportive and co-operative. In my view she had Samantha's best interests at heart but ultimately was not able to meet her needs partly because she had to protect her own family. I believe she may feel upset that she was not able to continue looking after Samantha during the time that she did but she should not criticise herself – she probably made the only decision she could."

George

16.13 Although it is clear that George's parents cared for their children, they, and his mother in particular, have said frankly throughout the Inquiry that they were unable to impose sufficient and consistent boundaries or otherwise control him. Mrs Green clearly loved her son but was unable to impose the sort of boundaries needed to ensure her son grew up safe and secure into a well-rounded individual. She had freely admitted this for many years and conceded this at the Inquiry. Mrs Green made the point that she was aware of her inability and, as a result, placed George in voluntary care.

16.14 Mrs Green, through her Advocate, accepted that there were probably times when she did let her heart rule her head. However, Mrs Green did everything that she could to steer George through his childhood and wished like any mother that she had not needed to turn to corporate parents to help. That she realised her limitations and the difficult circumstances in which she found herself, is to her credit.

16.15 George spent the last weeks of his life living at his mother's, despite her making it abundantly clear that she could not control him. George was indeed out of control during this last contact, engaging in criminal activity, taking drugs and alcohol, staying out late and often refusing to return at all. Social services were aware that George was likely to behave in this way – both because of Mrs Green's warning and because his behaviour merely reflected that which had gone before. The Inquiry has already expressed its conclusions on this period in chapter 12.

16.16 There was some dispute between the evidence of social services' witnesses and the Greens themselves as to the degree to which the family supported the return to Eden Grove. Ed Coates accepted there was a possibility of the family being confused as to the stance of social services in respect of George returning to Eden Grove because the lines of communication with George and the family were not always clear [590]. He also accepted that further confusion could have arisen from the meeting on 21 January 2002 at which there was no social services manager present [591]. However, he accused the family of giving George mixed messages after 7 January and of indicating that he could stay on the Island [592].

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[589] See chapter 6.
[590] Day 11:169
[591] Day 11:171
[592] Day11:170

16.17 The Inquiry concluded in chapter 12 that Mrs Green realised that George should return to Eden Grove. But she had long been unable effectively to set boundaries or instil proper behaviour in George [593]. It is likely that she was able to make no impact in persuading George of the necessity of his returning to Eden Grove and was unable to stand up to his wish to remain.

16.18 Mrs Green told the Inquiry that while the family did not want George to go, as such, they did want what was best for him and the family thought that was to return to Eden Grove and finish his education [594]. Mrs Green said that George's father had said "he would support him whatever he wanted to do" but that Mr Green had also said that he thought George should go back; and he would, if George wanted, get a flat in Cumbria if George wanted to settle there after he had finished school [595].

16.19 Edric Green said that George was beyond his control because he was not allowed to physically chastise him; he said that this was the only way of controlling a wayward teenager [596].

16.20 Mr Green accepted [597] that he was "clearly a man with a strong sense of right and wrong who does not always express himself as well as he could and may be perceived by those he disagrees with to be aggressive". He told the Inquiry that because he got frustrated and angry with social services, he could be threatening [598]. It was said by the Advocate for the families that with such acceptance must come an acknowledgment that those experiencing his wrath may have felt intimidated and that those working in the very difficult and complex area of child care ought not to have to experience such intimidation. The Inquiry agrees.

16.21 Sadly the Inquiry heard evidence of Mr Green's aggressive and frightening attitude to some, but not all, of those seeking to work with him in George's best interests. Ed Coates said that on occasions Mr Green could show a degree of foresight and insight but that these occasions "were the exception not the norm, and the norm was rather more aggressive, angry, very often drunk and abusive and very threatening, and those were very, very difficult conversations to deal with"[599]. He recounted an incident when Mr Green phoned him in late January 2002. Mr Green was "very drunk and very, very abusive and very, very threatening, saying things like he knew where my family lived, he knew where my children lived, he was going to get them"[600]. Mr Green told the Inquiry that he would not have threatened his children, but he might have threatened Mr Coates. The Inquiry accepts Mr Coates' evidence about this incident: it is unlikely that Mr Green, when very drunk and very angry, can remember what he has or has not said. Mr Coates said that conversations with Mr Green often had an unpleasant air about them but this one was unusual in that it ended with a positive outcome [601]. Mr Coates also said that threats had been made to Mrs Morrison [602].

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[593] And to her credit, she had realised this and had sought social services' assistance in looking after George as a consequence. See also Anne Seed Day 7:36
[594] Day 22:55
[595] Day 22:56
[596] Day 22:93:10
[597] Through the Advocate for the families in his closing submission
[598] Day 22:128
[599] Day 12:39:9
[600] Day 12:40
[601] Day12:80-81
[602] Day 12:81

16.22 Mr Green's behaviour made working with him and the family very difficult. His behaviour was at times unacceptable, as was accepted by his Advocate. However, the Inquiry does not believe that in 2001- 2002, this had any material impact on the effectiveness of the care and support being given to George.

16.23 The Inquiry has considered separately the consequence of the events at the ferry terminal on 7 January 2002 in chapter 12 and chapter 22.

CHAPTER 17

SOCIAL SERVICES DIVISION: SYSTEMS AND STRUCTURES

Introduction

17.1 In order to assess the level and effectiveness of the care and support provided to Samantha and George, it is necessary to consider the systems and structures within the Social Services Division at the relevant time.

17.2 The Inquiry recognises that the Social Services Division grew rapidly from its creation in 1989. The pace of development and growth in personnel, services and budget was unremitting. During 2000, a new tendering process and award of contracts for Children's Services was instigated (service providers), a Child Protection Training Officer appointed, a Child Psychologist post created and appointed (only part time) and a permanent weekend duty social worker (children's) appointed [603]. In 2001 and 2002, there was a review of the division's structure and part of the new structure and posts were introduced during 2002.

17.3 This growth occurred without the necessary administration, support, systems and structures always being put in place [604] or, if in place, being complied with.

17.4 The evidence presented in Part 1 of the Inquiry has revealed that the rapid growth in social services and its contracted out services meant that sometimes, in the words of Trevor Noden, Assistant Director, and David Cooke, the Director of Social Services, "the foundation stones of polices and procedures" were not put into place as quickly as the development of the services [605]. He thought this lack affected the services offered to some extent [606].

Policies and procedures

17.5 It was apparent that, during the period considered in Part 1, there was either an absence of policies or, where policies existed, they were not complied with. This latter feature is a telling reflection on the ineffectiveness of management at all levels.

17.6 There was a policy at the time in relation to supervision (1997) and recording (1999) but neither was followed consistently. There were no policies in relation to care planning and assessment. There was no policy in relation to the compilation of chronologies for social work files and the Director of Social Services is to be commended for his introduction of such a policy during the course of, and as a result of, Part 1 of the Inquiry.

17.7 As well as those areas noted above, there were no policies in a number of other important areas. David Cooke told the Inquiry that although there was not a policy to keep children on the Island rather than place them in the UK, it was thought better to keep children with or near their families and easier to social work the case if they

[603] See Overview of History of Social Services given by David Cooke, Director of Social Services (in letter to the Inquiry 19 January 2005) in Appendix 7
[604] See Alec Merchant Day 5: 62: 9-24
[605] Day 21: 5:4
[606] Day 21: 7:8-9

were on Island. UK placements generally were also expensive though the cost of replicating them on the Island would have been greater. He agreed given the overspend in the division's budget and the nature of the job that there was always financial pressure to limit costs but said that never affected the department's view on overseas placements.

17.8 Surprisingly, Trevor Noden conceded that there was no written policy or procedure at the relevant time in relation to assessment of extended families as a possible placement for looked after children. He said that good practice indicated all options should be explored. Consideration was given to placement of Samantha with her aunt. Mr Noden was unable to shed any light on why the extended family of George was not explored.

17.9 Policies and procedures are indeed "foundation stones" of a social services organisation and they exist to assist practitioners in their social work. In particular, to assist them in focusing on important issues which have to be dealt with in the life of the child for whom they are responsible.

Care planning

17.10 At the relevant time, social services did not have any policy in relation to care planning. There was no policy that care plans had to be written for each case. It was not even necessarily considered best practice to have written care plans. In Part 1, some social workers wrote care plans, such as Ms Morrison, and others did not, such as Ms Gilman. Even where they were written, such as in George's case, it was accepted in evidence that the care plans were basic and lacking in sufficient detail. Adrian Venn, an experienced social worker, told the Inquiry that at the time the majority of cases on the Island did not have a care plan [607].

17.11 Without such a policy and without written detailed care plans, it was very difficult to have in place an effect system of care planning. That is not to say that the plans for a child were not discussed at formal and informal social work meetings. The evidence suggests they were but, it would seem, in an unfocussed and unstructured way. For example, the DHSS accepted that the lack of written clarity regarding roles and responsibilities was in part to blame for misunderstandings that seem to arise between social services and service providers regarding their requirements, particularly in relation to Samantha Barton [608]. By way of further example, Mr Noden not only accepted that social services struggled to meet Samantha's care plan objectives but also seemed unclear as to what the specific details of her care plan were [609].

17.12 David Cooke said that in the relevant period the division had some way to go in the two key areas of care planning, which he described as 'patchy', and assessments, which could have been done better.

17.13 The Inquiry has already commented unfavourably on the ineffective care planning in both George's case and Samantha's case. In Part 2, the Inquiry considers the effectiveness of the present care planning.

[607] Day 13:21
[608] DHSS Closing Submissions
[609] Day 19: 60

Assessment

17.14 Linked to the care planning is assessment. There was a lack of a policy regarding formal assessments of children. David Cooke described the lack of a formal risk policy as "unacceptable".

17.15 The Inquiry has highlighted in earlier chapters the failure to carry out necessary assessments at a number of stages in Samantha's life and in George's life and its contribution to ineffective care and support. By way of example, Ed Coates accepted that lack of assessment led to Samantha remaining with her family for too long. He also said that there should have been better and earlier assessment of George's parents ability to parent him; and that there was a lack of an assessment whether, and a strategy or plan how, to return George to his community.

17.16 Mr Coates also said that social services had not achieved stability in Samantha's care planning and agreed that there was no formal risk assessment of the pros and cons of her returns to the Island in 1998 and 2001.

17.17 David Cooke said:

> "No formal risk assessments were carried out as far as I can see. However, risk is one of the key areas of the social worker role whose job, it could be said, is to manage risk. Therefore, social work assessments should reflect risk issues and supervision, reviews and conferences should identify risk and plan how to minimise or overcome it. … This is a basic element of the job."

Reviews

17.18 At the time there was no statutory requirement for statutory reviews to take place. However the department considered that the English Children Act 1989 provisions reflected best practice and strove to operate in that way. There was no formal policy regarding reviews of looked after children. Ed Coates told the Inquiry that he drew attention to the deficiencies in a paper he wrote in 1999 and that

> "within the Care Management Team I made it clear and the expectation was accepted that all children looked after should have reviews in the following order. 1. Planning Meeting to be held within 1 week of coming into care (or a change of placement/plan); 2. Review within one month; 3. Review within a further three months; 4. Subsequent reviews to be held at a minimum of six monthly intervals. … I developed a new record/spreadsheet of all looked after children that noted key information including Review Dates that I used to monitor compliance with this standard. I was not able to set this up with 100% accuracy for a number of reasons but the system helped keep track of basic information about looked after children."

17.19 However, there was a gap in the Reviews in Samantha's case between July 2000 and November 2001 [610]. It was accepted that social services should have been more proactive in the situation with a greater management input.

17.20 In George's case, whilst planning meetings were taking place and there was generally good communication between social services and Eden Grove [611], there was a gap in Reviews between October 2000 and June 2001.

Supervision

17.21 A policy as to supervision of social workers was introduced in 1997 and updated in 2000. Ed Coates explained that as civil servants social work staff were appraised using the Civil Service Appraisal Scheme operational at the time [612]. David Cooke said in his statement that appraisal was the responsibility of each line manager; that supervision was again the responsibility of each line manager, working within the Supervision Policy of the division; and that the principle was that the social worker discussed cases with their principal social worker who discussed them with the service manager in supervision sessions, and that, in addition, there was upward briefing from the service manager when and where necessary on an individual case basis.

17.22 The evidence given to the Inquiry suggests that despite this supervision policy being in place, formal supervision at all levels simply did not occur sufficiently in accordance with either the letter or the spirit of the policy.

17.23 David Gibson, Deputy Director of Social Services, stated [613] that he had no records of formal supervision of Trevor Noden taking place between January 2001 and autumn 2002. Trevor Noden stated [614] he had no records of formal supervision of Ed Coates for 2001 to 2002; but he stated that he had a close working relationship with him and did have many informal contacts with him.

17.24 Ed Coates was responsible for the supervision of Angela Gilman and Sylvia Morrison. He accepted that there was a significant gap in his supervision of Sylvia Morrison from 6 August 2001 to the beginning of 2002, a time when important decisions were being made about George and accepted that this state of affairs and the supervision policy that existed then was 'not good enough.' Trevor Noden told the Inquiry that he was unaware that there were gaps in Ed Coates' supervision of his social worker, which is not surprising if he was not supervising Mr Coates as he should have been.

17.25 Given the importance of supervision to effective social work practice[615], these failings are unacceptable.

17.26 The Inquiry considers these issues in Part 2.

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[610] It is to be noted that in December 2000 and January - February 2001, reviews were held by the English authorities pursuant to her Detention and Training Order

[611] See chapter 11

[612] Mr Coates' practice was that this would normally be done as a supervision session (sometimes two meetings) set aside for the purpose

[613] Letter to the Inquiry dated 29.7.05

[614] Letter to the Inquiry dated 25.07.05

[615] The report of the Victoria Climbie Inquiry refers to supervision as "the corner stone of safe social work practice"

Recording and file management

17.27 A case recording policy was introduced in 1999[616].

17.28 Ed Coates confirmed his written statement to the Inquiry that during the relevant period standards of recording varied greatly and that it was not the norm for chronologies to be prepared.

17.29 Ed Coates accepted that the state of Samantha's and George's files was not satisfactory. He said in oral evidence that because he did not check the files, he did not know at the time what their state was. He agreed that the state of Angela Gilman's files could have been much better, they were disorganised, not in chronological order and it was very difficult to find the key information; he agreed he should have checked them. He said Sylvia Morrison's files were also not of good enough quality, they were not detailed enough, they were not organised well and that he was not aware of their state at the time.

17.30 David Cooke said he was 'quite appalled' by the state of the files. He could not explain why two, in his view, relatively competent social workers did not comply with the recording policy. Mr Cooke accepted that in these two cases there were two issues: not only the quality of recording but also file management and these files were very difficult to follow. The Inquiry was very concerned to learn from Mr Cooke that, even by the time he gave evidence to the Inquiry three or four years on, he had not asked either of the two social workers why their files were in such a state. He agreed that he should have done so and he could not explain why he had not [617].

17.31 The proper recording of information in social work files and the proper organisation of the case file are essential to the proper conduct of a looked after child's case. They are essential for proper decision making and for the discharge of the division's responsibility for the children it is looking after.

17.32 In the Inquiry's view, the files fell well below an acceptable standard. It is fair to note that while both sets of files are as disorganised as the other, there appears to be more information missing from Samantha's and less sign of active social work in the final few months.

17.33 When decisions were made, they were not always properly recorded: setting out the decision made and the reasons [618]. This is unacceptable [619]. The audit trail of decision making in the two cases is difficult to follow.

17.34 Another practical consequence of the poor recording and file management is that the Inquiry team had great difficulty in analysing the files of both George and Samantha. Their disorganisation caused most confusion, making it impossible to see in any logical, chronological fashion what was happening to these two young people at any one time. This made the task of the Inquiry more difficult and time consuming and, as a consequence, increasing the cost of the Inquiry.

[616] It was subsequently updated in 2004
[617] Day 21:22
[618] For example, the very important decision as to the plan on Samantha's return to the Island in February 2001
[619] DHSS Closing submissions, para 141

Management

17.35 The evidence suggests that there was a lack of clarity as to who was managing Samantha's case in July and August 2001: Ed Coates suggested there was an informal agreement whereby Julia Gilbert managed; Julia Gilbert agreed she chaired reviews in that period [620] but did not accept that she had managerial responsibility. Each thought the other was managing the case: thus, apart from chairing meetings, no one appears to have had effective managerial control for this period. Trevor Noden said he was not aware that Julia Gilbert had managed some of Samantha's reviews; he was not aware of any informal agreement that Julia Gilbert manage Samantha's case.

17.36 Similarly, there was some sharing of management of George's case[621]. This coincided with a time of important decisions needing to be made and with a period of time when Sylvia Morrison was not receiving supervision from Ed Coates.

17.37 The Inquiry has concluded that managers were not sufficiently involved in, or aware of, what was happening in Samantha's case at important stages, for example during her placement at Leece Lodge 2 [622]. This was also the situation with George's case in the run up to, and during, his Christmas visit 2001 [623].

17.38 Ed Coates accepted that there was no formal system in place at the time for the inspection of files and records by management, nor any formal scheme to monitor the performance of social work input. He accepted that social work files should have been audited more thoroughly. He made the important point that, in his view, he and other managers simply did not have the time to check files. Trevor Noden said there was a restructuring in the division in 2001-2002 creating a new tier of senior social workers to deal with the perceived problem of recording and supervision [624].

17.39 An external case file audit was commissioned from a consultant Himu Gupta in 2000. The inquiry was told that there had been an internal case file audit in 1997/1998.

17.40 In trying to explain why a number of important polices had not been implemented, Trevor Noden accepted there was a problem in the division with implementation of policies: putting them into practice. Moreover, the Inquiry has been struck by the evidence of persistent failure to comply with existing policies. These were, and remain, matters for management to attend to.

17.41 It should be clearly understood that senior managers remain accountable for making sure that the care and support of children in care is effective and appropriate.

17.42 In the light of these failures in effective management of the care and support for Samantha and George, management practice is considered in Part 2.

Resources

17.43 The issue of the adequacy of resources is relevant. Time and again, when asked questions about why either George or Samantha were placed in what appeared to be

[620] See chapter 9
[621] See chapter 10
[622] See chapter 9
[623] See chapter 12
[624] Day 20:171:1-3

less than appropriate placements, witnesses told the Inquiry that they agreed but that there had been no other options on the Islands.

17.44 When considering the placement decision making process in Samantha's and George's cases, the Inquiry bears in mind the population size of the Isle of Man and the consequence that it is not reasonable to expect to have on Island every type of resource for every type of child in care. By way of analogy one would not expect the Isle of Man hospital necessarily to have all the most advanced and specialist medical treatments; but one would reasonably expect an Isle of Man resident to have access to off-Island resources for medical treatment if it was considered to be needed.

17.45 As to childcare resources, the issue is not only that there were insufficient resources on-Island. The Inquiry has concluded that at times social services gave insufficient prominence in its decision making for Samantha and George to the possibility of placing off-Island. The Inquiry believes that there is some truth in the suggestion at the time that there was an inbuilt presumption against UK placements and this worked to prevent a properly balanced assessment being carried out of the advantages and disadvantages of placements.

17.46 Witnesses, such as Angela Gilman, agreed with the April 2001 briefing for the departmental meeting that:

> "Samantha Barton and her sister are once again stretching the resources of the department and their behaviour is highlighting problems within the system."[625]

David Cooke agreed that the division found it difficult to provide specialist care for those with very specialist needs [626] given the size of the population, the fact of being an Island and the numbers presenting with such difficulties[627].

17.47 The Inquiry concludes that there was no suitable on-Island placement for Samantha on her return to the Island from February 2001 onwards. In the absence of such a placement, greater thought should have been given to whether a placement could have been found off-Island[628]. Nevertheless, the Inquiry recognises that Samantha had historically been placed off-Island. The Inquiry has expressed its concern that Cummal Shee could not be expected to cater for all the varied needs of the disparate group of children placed there. There was a need for more and varied placement resources, so as to avoid placing looked after children with conflicting needs in the same unit[629].

17.48 In 2001- 2002, the Social Services Division was developing its childcare resources. It still did not have sufficient resources on-Island to meet the needs of Samantha and George. Ed Coates recognised in his statement that:

> " ultimately a greater range of services would have greatly enhanced our ability to look after Samantha and George safely and appropriately".

[625] Day 2:98-99
[626] Day 21: 8:15-18
[627] Day 21:10:15-25
[628] See chapters 6 to 9
[629] Day 12: 70

17.49 The evidence shows that there was a lack of specialist foster carers, a lack of specialist therapeutic residential placements, a lack of residential educational placements, and a lack of secure accommodation. Each of those resources would have been suitable to either Samantha or George at one time or another.

17.50 The care and support for Samantha from February 2001 was not adequate. There was no project to deal with a young person leaving care and/or moving towards independence[630].

17.51 During Samantha and George's early years a fostering service, with skilled and experienced carers, would have been invaluable in providing them with the opportunity to experience stable and secure family life. There was also need for family centre assessments and services to intervene earlier in Samantha's and George's lives in order to provide family assistance, assess the wisdom in their remaining with their parents and, if necessary, to enable planning for more stable long term permanent homes outside the family.

Secure accommodation

17.52 The Inquiry was told by David Cooke that the present secure unit was opened in February 2003. The Inquiry considers this first-rate facility in Part 2.

17.53 Mr Cooke told the Inquiry that agreement for the building of the secure unit was obtained in December 1998[631]. The legislation enabling secure accommodation to be used on welfare grounds had been passed in 1993. However, that did not allow young persons to be placed in off-Island secure units; nor did the UK legislation allow for Isle of Man children to be placed in UK secure units based on their behaviour on the Island. In 1994, a Juvenile wing was opened at the Isle of Man prison. The Inquiry was told that Deemster Corin, in a judgment in 1997, had said that the secure unit in the prison should only be used for very serious offenders[632]. Rightly, it was not suggested to the Inquiry that either Samantha or George should have been placed in the Juvenile wing as part of a secure accommodation order.

17.54 David Cooke agreed that the ten years between the legislation first being passed and the unit being opened in 2003 were very important ones for Samantha and George but he said that the situation was very complicated[633]. Following agreement for building the secure unit, the start of building was delayed. Mrs Clare Christian, Minister for the DHSS at the time of the murders, agreed that with hindsight that it took too long to get started on the building[634]. The Inquiry heard evidence about the delay between agreement to build in 1998 and the opening of the secure unit in 2003.

17.55 The evidence from many professionals who had cared for Samantha was that she should have been placed in a 'therapeutic' secure unit. Moreover the evidence suggested that the mere availability of such a unit provided social workers with a valuable tool to use to help them modify young people's behaviour. In effect, it was

[630] The Inquiry recognises that one was being planned for 2002.

[631] He agreed with a 1991 Report that given the small numbers of young persons involved (5 to 6 per annum), it had been appropriate to use the prison: Day 21:131:1-3
[632] Day 21: 132:5-11
[633] Day 21: 140:15-24
[634] Day 22: 51: 1

said that having a secure unit on the Island would have given the social workers a real sanction when trying to impose boundaries on them. Ed Coates explained that such a home "underpins the care in the rest of the system" so that young people understand that no mean no and yes means yes.

17.56 The evidence presented to the Inquiry has made it plain that at certain key times during her time in care, Samantha would have benefited from being placed in secure accommodation. Most notably in the period leading up to the ending of the St Catherine's placement and her imprisonment; in the period after Samantha's return to the Island when placed at Maple Avenue and at Derby Road; and at times during her time at Leece Lodge 2.

17.57 Had secure accommodation been available on the Island at the time, its use is likely to have been of benefit during the time George was refusing to return to Eden Grove and was preferring to indulge in delinquent behaviour putting himself or others at risk; a short order could have been used to re-impose some control in George's life.

17.58 The existence of secure accommodation, whether used or not, could have underpinned a firmer management approach to both Samantha's and George's care.

Performance management

17.59 Regular inspections of the division did not take place during the relevant period.

17.60 There were no regular external inspections. Mr Cooke referred to there having been three or four ad hoc external inspections [635]. Mr Noden and Mr Cooke both referred to an ad hoc external inspection of the division by Himu Gupta in 2000 [636]. However, Mr Noden said that the recommendation for external audits every three years [637] had not been implemented[638]. Mr Cooke explained that despite efforts by him it had not been possible to arrange for the English Social Services Inspectorate to inspect services on the Isle of Man because difficulties within English legislation as to how the SSI would be funded[639] .

17.61 However, the English legislation changed in 2003 and this now permits the Commission for Social Care Inspection to inspect the Island's Social Services Division; but Mr Cooke said that "to make this absolutely watertight", Isle of Man legislation needed to be introduced. At the time of giving evidence, the necessary changes were included in a draft Social Services Bill [640].

17.62 Mr Cooke said that regular and effective external inspection of the division is an important and needed element in the performance managing of the division[641]. The Inquiry agrees that it is essential.

17.63 There was no effective system of regular internal audits during the relevant period. Mr Noden seemed hesitant as to whether managers do sample checks on social

[635] Day 21:108ff
[636] Trevor Noden Day 20:181 and statement W10, exhibit TN2
[637] In para 14 on page 9 of the Himu Gupta report
[638] Day 20:185:22-23
[639] Day 21: 112:1-3
[640] Day 21: 113-115
[641] Day 21:117:1

worker's work [642]. The Himu Gupta report in 2000 had recommended six monthly internal audits of the whole of the division by a core group of auditors; but Mr Noden said that it had been decided not to implement this recommendation[643]. Mr Cooke told the Inquiry that there existed a system of "team self audit" and that around 2000 an internal quality manager was appointed[644]. The Inquiry observes that the evidence in Part 1 of the Inquiry did not indicate how "team self audit" had improved practice or ensured compliance with policies.

17.64 During the relevant period, the system for managing the performance of the division was not effective.

17.65 The Inquiry will consider current performance management in Part 2.

[642] Day 20:184:13ff
[643] Day 20:185:10-11
[644] Day 21:117-118

CHAPTER 18

SERVICE PROVIDERS

18.1 The Social Services Division has, for many years, relied heavily on service providers. In the light of the Government "head count" policy, the proportion of contracted out services has grown as social services provision has grown. This has occurred, despite the fact that many within the division have, for some years, wanted to take direct control of more of the services. Direct control is proposed so that the division has the actual responsibility and the authority for the services which are run in its name and for which it retains ultimate responsibility and also because of reservations about the quality of services provided by external providers [645]. Ken Tomlinson, the Chief Executive of the DHSS at the time, told the Inquiry that he had not thought it worthwhile to carry out a detailed costs-benefits analysis of the financial and welfare advantages/disadvantages of bringing more services under the direct control of the division given Government policy [646]. David Killip, the current Chief Executive, said he would endorse a proper cost-benefits analysis of the services provided by service providers as soon as possible [647].

18.2 However, social services were, in Trevor Noden's words, "desperate for service provision". The need to provide services meant that during the relevant period services were being commissioned from external providers in advance of any effective system for commissioning and monitoring the external service providers. In addition, the Inquiry has already noted that Nugent Care was asked to take on the care of Samantha before it had fully established its services on the Island [648].

18.3 The evidence revealed a number of troubling features. The Inquiry heard evidence that:

a. strict [649] and consistent procedures for commissioning services did not exist;
b. some service level agreements were not signed;
c. some service level agreements for specific placements or services did not exist; and
d. an adequate system for monitoring the performance of service providers did not exist.

18.4 At the relevant time, the decision to award a contract to a service provider was made by David Gibson, the Deputy Director of DHSS, and Trevor Noden [650]. Trevor Noden told the Inquiry that there were no standard written procedures for the commissioning process [651]; and that in 2000 - 2002, the division did not carry out any kind of best value approach to determine the cost and quality of providers [652]. It

[645] Ken Tomlinson, Day 26:15-16; Trevor Noden Day 20:76-81. See further chapter 24.
[646] Although Trevor Noden submitted a paper on bringing more services in-house in November 2002: Day 20:76
[647] Day 26:64
[648] See chapter 9
[649] David Cooke Day 21:79
[650] Day 20:70
[651] Trevor Noden Day 20:67
[652] Day 20:129

appears from the evidence that no consistent practice was followed. Nugent Care were awarded the contract in October 2000 after a competition with about four other service providers [653] and after interviewing Nugent senior management in the UK [654]. MFS had been providing some services under spot contracts since 1998. It was awarded a full contract to provide a range of services in April 2001. Mr Noden said that it did not have to compete with other service providers or provide references; it was more a "consolidation" of existing work [655].

Service level agreements

18.5 The Inquiry was told that care services were supplied by the providers under service level agreements. However, to the Inquiry's surprise, it emerged in evidence that in fact most of the relevant agreements were never signed. Trevor Noden said that the agreement with Nugent Care was never signed and that this was because the Chief Executive advised that it should not be signed[656]. Mr Ken Tomlinson said that it was because the "technical content" was unsatisfactory; he accepted that he shared responsibility for not making certain that the contracts were signed[657]. The service level agreement with MFS was also never signed[658] .

18.6 Moreover, it emerged [659] that there was no written agreement, even in draft, for care and supervision provided by MFS to George during his Christmas 2001 visit to the Island [660]. Given MFS's prominent role in practice during that period, this is all the more surprising. There was no written agreement, even in draft, for care and supervision provided by MFS for Samantha's stay at Derby Road [661].

18.7 In short, the care provided by Nugent at Leece Lodge 2 and Derby Road was provided under a service level agreement which the division never signed. There was no written contract or service level agreement, even in draft, for the care and supervision provided by MFS to George during his Christmas 2001 visit to the Island or by MFS for Samantha at Derby Road.

Monitoring the performance of service providers

18.8 The evidence heard by this Inquiry indicated major weaknesses, in particular, in the following:

a. the lack of a system of objective monitoring of the service providers; and
b. the system of communication between social services and the service providers [662].

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[653] Of which MFS was one: David Cooke Day 21:80-81
[654] Day 20:67-68
[655] Day 20:69
[656] Day 20:81. Trevor Noden said that he received legal advice that the arrangement was binding nevertheless: Day 20:82
[657] Ken Tomlinson Day 26:18-22
[658] Noden Day 20:85; Day 20:86:13; 88:15; Richard Kneen Day 8:41ff
[659] Trevor Noden Day 20:93-98. See also Richard Kneen Day 8:41ff
[660] Although there was an unsigned agreement for contact on the Island in early 2001
[661] Trevor Noden Day 20:93-98
[662] Which has been discussed in earlier chapters

18.9 The Inquiry was told that in the relevant period service providers were monitored in a number of ways [663]: by reference to the service level agreements, albeit that they were unsigned [664] and needed developing and made more detailed [665]; by partnership meetings; and by informal feedback from social workers [666]. Ed Coates accepted that the partnership meetings did not provide an objective way to assess how the young people were doing and that informal feedback from social workers depended on them being given and obtaining the right information: and that therefore the system was flawed and incomplete[667] . He agreed that the division had no proper objective way to monitor the performance of the service providers[668].

18.10 With hindsight, Trevor Noden said candidly that perhaps the relationship between MFS and the division had become "too close" and that the closeness was something that they "needed to think about"[669]. The division had come to rely on MFS to provide care for difficult children when other providers were not able to do so. He believed that they retained "an element of professionalism". Richard Kneen said that his relationship with social services was entirely professional[670].

18.11 At the relevant time, there was no inspector of children's homes [671]. Thus, Samantha's placements in Maple Avenue, Derby Road and Leece Lodge 2 were not formally inspected as they should have been.

18.12 Mr Cooke explained that the "difficulties coping with contracts" has lead to the division subsequently appointing a contracts manager [672].

Manx Family Services

18.13 Trevor Noden arranged an external inspection of MFS' single occupancy residential projects for young people in late 2001[673]. A report was produced in March 2002 . It concluded that there was "a major lack in professional standards of practice" that arose because there was no person "within the organisation who had appropriate experience or expertise to enable" the development of such standards. It reported:

> "We have concerns about MFS, and consider that they lay themselves open to events which place young people and those that care for them at significant risk.
> However, we believe that they offer a valuable service to the island as a community, and to young people in their care. Our concern is that current arrangements have important gaps in safeguards/quality assurance. Consequently our recommendations are based on what would need to happen if they are to develop in a way that ensures the safe care of young people and the protection of staff".

[663] Ed Coates Day 12:22-27;
[664] Which Ed Coates accepted was indicative of the lack of procedures that existed at the time
[665] Day 12:26-27
[666] David Cooke also referred to "informal" inspections by social work managers
[667] Day 12: 27-28; see also Trevor Noden Day 20:103
[668] Day 12:28:22; see also Damian Bradley Day 15:21
[669] Day 20: 90-92
[670] Day 25:82
[671] Trevor Noden Day 20:103ff
[672] Day 21:82-83
[673] Day 20:104; Report by Centre for Social Care Studies, De Montford University (carried out by the Bordesley Institute Birmingham)

18.14 Ed Coates said that having heard the evidence given at the Inquiry, he had a number of concerns about MFS: poor communication; poor record-keeping; protocols or lack of them; training; awareness of roles; judgment and understanding[674]. Trevor Noden was "quite shocked", "moved" and "anxious" as a result of some of the evidence about MFS from the criminal trial and from the Inquiry[675]. Indeed Mr Noden told the Inquiry during his evidence that he would be looking at the MFS contract and intended to set up an independent review [676].

18.15 In the light of the evidence which it has read and heard in Part 1, the Inquiry believes that such an independent review was urgently required. It welcomes the decision to set up the review [677], which is due to report in 2006. The Inquiry believes that its report should be made public.

Nugent Care Society

18.16 The Nugent Care Society is a charitable organisation providing care and assistance to people with special needs throughout the North-West of England. It employs over 850 staff and provides facilities for children including both residential and day care, as well as providing facilities and support for the elderly and less able and providing services in respect of fostering and adoption.

18.17 In 2001 – 2002, Trevor Noden did not commission an external inspection of Nugent Care because they were audited by Nugent Care Liverpool[678]. That audit was carried out in 2001 and found a number of concerns[679]. Nugent Isle of Man had a number of managerial and organisational difficulties in 2001 -2002[680].

18.18 Nugent Care no longer runs any facilities or employs any staff on the Isle of Man, but it does maintain a link in regard to both adoption services and the provision of experts to assist the Manx Courts and protect the interests of children in various proceedings.

Admission of children to facilities run by service providers

18.19 Francis Charlton, the project manager of Nugent, thought that Nugent had no option but to accept Samantha being placed with them at Leece Lodge 2.

18.20 Trevor Noden told the Inquiry that there was an expectation on service providers to provide a service[681] . In theory they could refuse to accept a placement [682] . However, he explained that if service providers were free to refuse a placement Social Services would struggle to place children and young people [683]. He accepted that if a service provider refused a referral on welfare grounds it would be better to look elsewhere rather than insist on the service providers accepting the placement [684]. He said:

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[674] Day 12:30
[675] Day 20:114: 10
[676] Day 20: 116-119
[677] See further chapter 24
[678] Day 20:105 – 106
[679] Day 15:97-98; Day 15:174 ; See also Day 18:38-48; and Gill Owen. Day 18: 156-158. See chapter 9.
[680] See chapter 9
[681] Day 19:146:16-18
[682] Day 19:147:9
[683] Day 19:148:20-21
[684] Day 19:149:12

"A… I was trying to allude to the difficulties of contracting out services before. There is a dynamic there, it seems to me, between the provider and the purchaser. As purchaser, particularly a purchaser in an island where you can't just drive down a motorway and buy services from the surrounding authorities, the dynamic there is that we expect providers to provide the service that we ask for. And the provider dynamic, I guess is somewhat different to that.

Q…Do you expect them to provide a service even if it is not an appropriate one and even if they think on welfare grounds they shouldn't?

A…I think if we reached a position where we were told by the provider that this would simply not be viable at all, that we would look elsewhere. We tried to set up our contracts to create that kind of flexibility that allows us to meet as many needs for the children in the island as we possibly can. That's where the single occupancy contract with Manx Family Services came from. Some youngsters who struggle in one project may well do reasonably well in another, and so what we have tried to do is create as many options as possible, to try and combat that problem of not having a placement.

Q..You say contractually, in theory, they are allowed to say no.

A…Yes.

Q…Do you think they should be allowed to say "no" more freely on welfare grounds?

A…If I were sitting on the provider side of the fence, I guess I would answer that question "yes". The difficulty for Social Services is when we need a placement, we usually need it now, and we want it on the island as far as possible.

…

A…I think if we had total freedom, then we would struggle to place children in the island, quite frankly Do I think they should have freedom when welfare of children is threatened, I think the answer would be "yes". But I would add the rider to that that if they said that they were unable—if the provider said, "We are unable to provide for the children that Social Services are presenting", we would be in grave difficulty in terms of placing children.

Q…Forgive me for stating the obvious, but the welfare of every individual child is the paramount consideration?

A…Absolutely, yes.

Q…And if a provider on the island is saying "we can't provide for that child", isn't it better that you look elsewhere and attempt to find somewhere that can, rather than simply placing because it is the only one available?

A…Yes…"

18.21 Samantha had been placed at Leece Lodge 2 without going through the normal admission procedures[685]. Nugent's Statement of Purpose and Function set out the appropriate procedure for assessment and admission to the unit. There was no assessment by Nugent of Samantha and her needs after the placement, such as might happen from time to time when failure to complete the pre-admission procedure is unavoidable. Moreover, Samantha did not have the kind of individualised programme envisaged in the Statement of Purpose and Function. Francis Charlton accepted in his evidence that all this placed Nugent in a vulnerable position; but said that Nugent were contracted to provide a service and the circumstances of the Island at the time were unique[686]. Importantly, the Inquiry concludes that this only added to the likelihood that the placement would prove to be unsuitable; a proper application of the admission procedures would have focused minds, at all levels, on the mismatch of Samantha's needs and the actual provision for her at Leece Lodge 2.

Conclusions

18.22 Trevor Noden told the Inquiry about the dynamic existing between social services and service providers and the difficulties of running child care services on the Island and with great reliance placed on contracting out services.

18.23 The Inquiry recognises that the child care for looked after children on the Island is unique and that there can be a desire to expect service providers to be flexible and accommodating as to when and in what circumstances they will accept a placement of a child or young person.

18.24 However, admission procedures must be adhered to. Service providers must not allow themselves to be put under pressure to accept a placement which is contrary to their accepted procedures and social services must not seek to have a child or young person placed outside recognised admission procedures. Where it is plain that a placement is contrary to a child's welfare, that uncomfortable fact must be accepted and another placement found even if it means that it has to be found off-Island.

18.25 The Inquiry considers this question further in chapter 24.

18.26 The system for commissioning and monitoring care services was, and remains, at the heart of the work of social services on the Isle of Man. In the relevant period, the system was not effective. The effectiveness of the current system for commissioning and monitoring care services is considered further in Part 2.

[685] Francis Charlton Day 15: 85-86
[686] Day 15: 103: 21 – 104:3

CHAPTER 19

THE POLICE

Introduction

19.1. Evidence provided by the Police's legal representatives indicates that there are 32.5 police officers per 10,000 head of the population. This compares favourably with the United Kingdom but the UK police figures do not include Community Safety Officers or the higher number of civil service support staff employed in the UK. The Chief Constable uses Jersey as a more obvious comparison to the Isle of Man but points out that, on Jersey, all police operations are run from one police station and they have almost double the number of support staff that are available in the Isle of Man.

19.2. The Chief Constable urged the Inquiry to reject simple comparisons with the UK figures. He pointed out that despite the Isle of Man's small size, it is required to run non-community based departments such as Special Branch and a Financial Crime Unit. These steer resources away from local policing. Because of the Island's small size, these units have a disproportionate impact on the numbers of officers available for "normal" policing.

Relationship with social services and care providers

19.3. The police accept that the Family Protection Unit was under-resourced but put this in the context of an under-resourced force rather than a lack of commitment to the FPU itself. During the relevant period, the evidence seems to suggest a reasonable working relationship between actual individuals involved with the FPU, Detective Sergeant Power [687] and Alec Merchant, from social services.

19.4. But the FPU's remit was limited. The Home Office Circular 18/1984 in respect of cautioning of juvenile offenders provides guidance with regards to juvenile offenders and states that it is often desirable for the police to liaise with local statutory and voluntary agencies about the ways in which assistance might be offered to juveniles and their families to prevent re-offending. In line with this principle, during the relevant time, the FPU would undertake this function. Cases that went to the Juvenile Court were referred to social services via the court system. In cases where a young person was a persistent offender it was agreed with custody sergeants that a decision whether to charge them with an offence or not would be based on the evidence alone and there would be no reason to refer the file to the unit other than for statistical purposes. Nevertheless, approximately 200 to 500 files per year were being referred to the FPU. The Inquiry was told that this area was often seen as low priority due to the prioritisation of resources towards other areas of the FPU's terms of reference.

[687] Now Inspector

19.5. The Chief Constable said its limited resources were taken up with investigating child sexual abuse offences and there were insufficient resources at the time to deploy to the FPU to enable it to do the sort of work carried out by a Youth Justice Team[688].

19.6. The Youth Justice Team has now been set up and has significantly improved the police response to this area of work.

19.7. The Inquiry has been aware that there were a number of difficulties in the relationship between police and care providers and social services. Each side suggested that the other was not taking delinquent behaviour by children in care seriously. Between 2 January 2001 and 11 March 2002, Inspector Peter Young was the Acting Inspector in charge of Policing B Division, which covers Douglas, Braddan and Onchan [689]. Chief Inspector Young said:

> "Although I cannot evidence it, it was the feeling of many officers during my time as Acting Inspector in charge of Policing B Division that the care workers simply abrogated all responsibility for the young people and used the missing from home system to do this. …"

In oral evidence, he said this allegation applied to all service providers in 2001 and 2002 [690]. He informed the now Inspector Power of his concern understanding that this would then be conveyed to social services[691].

19.8. Chief Inspector Young also said:

> "In or around the time of the murders I tried to hold a problem solving session at Hillary House with Mr Trevor Noden and others in relation to the theft of vehicles. A number of young people in care were stealing cars and crashing them. In my opinion it was only going to be a matter of time before either one of the young people, a member of the public or a police officer was seriously injured as a result. The meeting was unproductive because the attitude of the DHSS was that children in care would steal cars, and that was something that simply had to be accepted."

He accepted that he did not have a written contemporaneous record of the meeting[692]. Trevor Noden said that he had no recollection or record of a meeting with Inspector Young to discuss youth car crime and he firmly denied Inspector Young's suggestion that he was uninterested in this issue[693]. He did not believe that such a meeting took place. He remembered a meeting about car crime which he had with two other senior police officers which he took very seriously.

19.9. Inspector Power said that he was not "particularly impressed by the way [the DHSS] thought about youth offending in 2001- 2002"[694].

19.10. On the other hand, the Inquiry heard evidence that staff in care homes thought that the police were unsympathetic to the difficulties of caring for children and young

[688] Day 17: 19
[689] He is now Acting Chief Inspector, currently attached to the Professional Standards Department at Police Headquarters, Douglas.
[690] Day 5:73;18-19
[691] Day 5:76:18-24
[692] Day 5: 90-92
[693] Day 20:147- 149
[694] Day 6: 52

people with emotional and behavioural problems. However, the Chief Constable in his evidence recognised the real difficulties faced by care staff. He said:

> "… this is a very difficult scenario, one has to say, and I have sympathy for care providers who are dealing with extremely problematic people.[695]"

19.11. Francis Charlton said in his statement that the police were "in my experience, not generally helpful". Damian Bradley said that the relationship with the police was at times "not generally helpful"; they did not understand the complexities of the care providers' task and sometimes the care workers did not understand the police's task [696]. Donna Lever could not remember any particular difficulties with the police whilst working for Nugent[697]. Christopher Lever said it depended upon the individual officer[698].

19.12. Ed Coates [699] said that the relationship between the DHSS and the Family Protection Unit was quite close at the time [700] but that the Social Services Division and the police generally had differing agendas; the police viewed young people in care running away as "an irritant and a nuisance rather than a group of young people in need" [701]. Trevor Noden said there was a lack of corporate parenting by the police in respect of looked after children; that on the Island there was a culture of criticism and blame with children in care being seen simply as the responsibility of the Social Services Division[702]. He said there was a 'silo mentality', i.e. each Government department competing for a slice of the cake[703]. He thought social services and police had different agendas: social services had the difficulty of looking after challenging young people without a secure unit on the Island, whilst the police were believed that they were spending an inordinate amount of time on recovering missing young people [704].

19.13. Mrs Claire Christian, who was Minster for Health and Social Security during the relevant period told the Inquiry that there were "some frictions" between DHSS and the police concerning the approach of some police officers to young people in care; essentially the police did not consider or respond to looked after children in the same way as they did other children[705]. However, steps were being taken to improve cross departmental workings via the Children and Young Persons Strategy Group.

19.14. In chapter 15 on Peter Newbery, the Inquiry has already noted difficulties at the relevant time in multi-agency working in areas of child protection and information sharing leading to less than adequate actions.

19.15. While the Family Protection Unit worked reasonably well within its limited remit, the wider working relationship between police and social services/ care providers had much room for improvement before it could be said to be fully effective. In his

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[695] Day 17:54
[696] Day 18:21 - 23
[697] Day 24: 60
[698] Day 24: 90
[699] Trevor Noden spoke of a very good and close relationship with the Family Protection Unit: Day 20:147
[700] Day 12:67
[701] Day 12: 67
[702] Day 20:137 - 138
[703] Day 20:139
[704] Day 20:143
[705] Day 23: 46

evidence to the Inquiry, the Chief Constable drew attention to the great improvement in co-operative working between police and social services since 2002. The current position is considered further in Part 2.

Offending by Samantha and George

19.16. The police played a significant role in the life of both Samantha and George by virtue of their criminal and delinquent activity. The Chief Constable helpfully annexed a chronologies of their police involvement to his statement and they are set out in the Appendix 13 and 14 of this Report.

19.17. Looking back, the Chief Constable readily conceded in evidence that the prolific offending of Samantha and George would have merited a specific case based strategy to address the criminal activity of each of them. He did not suggest this at the time. The Youth Justice Team was not in existence and the FPU was overstretched and under-resourced[706].

Samantha

19.18. The only link between the death of Samantha and the police is their part in defining and containing the risk posed by Peter Newbery. This is discussed in chapter 15.

George

19.19. The only relevant link between the death of George and the police is their part in the failure to effect his return from the Island to Eden Grove following 7 January 2002. This is discussed in chapter 12.

[706] Day17:15-16

CHAPTER 20

THE ROLE OF POLITICIANS

Introduction

20.1 The involvement of politicians in the decisions to place Samantha at Derby Road and Leece Lodge 2 has already been discussed in chapters 8 and 9. Two major issues have emerged. First, to what extent, if at all, should the Minister of the DHSS or the political member for the Social Services Division be involved in taking decisions about individual children? Secondly, in what manner should a MHK or MLC (who is neither the Minister nor a political member within the department) make representations about decisions or matters concerning individual looked after children?

The role of the Minister and the political member for the Social Services Division in decisions about individual children

20.2 Clare Christian, MLC, has great experience in Government and a close knowledge of health and social services issues. She was the Minister for the Department of Health and Social Security from 1996 to 2004. She had served as a member of the DHSS with responsibility for health matters from 18 November 1994 to 1996; prior to that she had been the member of the DHSS with responsibility for Social Services matters from 24 May 1993 to 18 November 1994. Previously she had served as Chairman of the Board of Social Security (a predecessor of the DHSS) from 1982 to 1985 and had been a member of that Board from 1980 to 1982. She had also been a member of the Health Services Board (another predecessor of the DHSS) from 1983 to 1985.

20.3 Mrs Christian was aware of Samantha's case but had no professional involvement in her case. She was unaware of George's case until after his death.

20.4 Mr Geoff Cannell was the political member for the Social Services Division from October 1999 to November 2001, when he was not re-elected in the general election. John Houghton MHK was the political member from 1996 to 1999.

20.5 There are nine departments of Government[707]; each consists of a Minister and one or two members who are Members of Tynwald[708]. A member of a department is appointed by the Governor in Council[709]. The Minister may authorise any member or officer of the department to exercise any of functions of the department in his place (either jointly or alone) [710] and a member so authorised may authorise any officer to exercise any of the functions in his place[711].

[707] See generally Report of Commission of Inquiry into Development Matters at Mount Murray, Ch 7
[708] Government Departments Act 1987, s 1(2)
[709] GDA 1987, s 2
[710] GDA 1987, s 3(2)
[711] GDA 1987, s 3(3)

20.6 In the words of Mrs Christian:

> "The Member functions within the parameters of the delegated responsibilities as stated in the delegation instrument made pursuant to Section 3(2) of Government Departments Act 1987. … In general, I consider that the Member for Social Services should have a close involvement with the workings of the Social Services Division. The Member monitors from a political perspective the work of the Division which endeavours to deliver the services expected of that Division in line with Tynwald's provision of resources"

20.7 As to whether a political member has the power to make decisions about the placement of an individual child or about other operational matters, Mrs Christian said:

> "[set out para 4(c) (i)] On a literal interpretation of the Government Departments Act 1987 and the relevant instrument of delegation this may be the case as a matter of legal theory. However, as a matter of good practice it would be highly unusual for a Member to become involved in placement decisions about individual children. Decisions regarding individual children were not normally political decisions and such decisions were for the professionals such as social workers to make. The Member would usually only become involved if asked for guidance by the professionals for example on the question of availability of additional resources. I believe the general position on this subject is accurately set out in a letter which I wrote to Mr John Houghton MHK dated 17 March 1998 in response to his of 9 March 1998."

20.8 The role and powers of the departmental member arose in connection with Mr John Houghton MHK when he questioned the delegated authority to intervene when the member does not agree with an action taken by an officer [712]. She set out the position in the letter written to John Houghton on 17 March 1998, referred to above:

> "I have taken legal advice on this issue and essentially it endorses the view that day-today decisions about the appropriate care of children and young persons placed in the charge of the Department should rest with the properly qualified social workers acting within the overall direction of the Director of Social Services. It would be inappropriate for such decisions to be taken by either the Minister or any Member of the Department. I accept that view.
> You ask what is the real meaning of your delegated responsibilities. I hope the following may help with that understanding.
> It is the responsibility of the Department to determine policy and strategy for the services for which it is responsible and to oversee and monitor how those policies and strategies are being implemented by the executive arm of the Department. Furthermore, because the political arm is ultimately accountable for those services, it has the right <u>at all times</u> to question means and methods of implementation and, <u>depending upon the circumstances</u>, to instruct alternatives.
> But questioning is one thing; instructing is quite another. The point at which the political arm should restrict itself to the 'questioning role' and avoid

[712] Letter from John Houghton MHK to Mrs Christian 9.3.98, set out in Appendices

stepping into the 'instructing role' will depend very much upon the circumstances of the particular issue under consideration.

Where, for example, the issue requires, of necessity, trained professional judgements to be brought to bear – and those judgements are critical to the most appropriate decisions being taken – the political arm of a Department should respect the fact and do no more than bring a layman's contribution to the judgemental process. Indeed unless the political arm respects the professional judgements on issues requiring such input then it would beg the questions as to why the political arm is bothering to commit the public purse in the engagement of the professionals.

If, of course, actions (or inactions) of the professional in the day-to-day decision making processes cause concern to the political arm then there are avenues within the Department of those concerns to be aired. If necessary arrangements can be made for the independent peer evaluations to be undertaken. There has been very recent experience of this in relation to the School Dental Service.

Some decisions on means and methods of implementation of policies or strategies are, of course, statutorily reserved for officers of the Department. I am thinking here, in particular, of decisions on claims for social security benefits. Officers (called 'Adjudication Officers') are appointed under the law governing the administration of benefits and thereafter such an officer – and no-one else – has the duty or responsibility for arriving at decisions on benefit claims. This role of the Adjudication Officers is subject only to the right of a claimant to appeal any decision to independent appeal authorities. Again neither the Minister nor Members of the Department have any status in an appeal process.

Other decisions on means and methods of implementation of policies or strategies will, of course, be more generalist in nature. An example might be the decision on the location of the Department's second adolescent unit. The political arm having set the policy that there should be a second unit and having laid down the criteria about its functions and locality (the policy and criteria having been informed by professional advice), it should then be for the executive arm to identify a suitable location. They did so (many months ago) but, in exercising your right to questions means and methods of implementing policy decisions, you made it perfectly clear that you were not content with the location identified (White Hoe). The executive had to respect and respond to that view because the location issue was not one which trained professional judgement could be said to be critical to the proper decision being arrived at (other than in the very technical sense of land and building development).

In summary therefore the role of a Member through the form of delegated responsibilities applying in this Department is

- To assist the Department in the determination of policy and strategy for the delivery of services in the area specified and generally
- To act for the Department in the monitoring and supervision of the implementation of policies and strategies for the services area specified
- To question means and methods of implementation by the executive and, depending upon the circumstances, to instruct alternatives

Although there are clear distinctions in the basis for the political and executive arms of the Department it is nevertheless of fundamental importance to the effective functioning of the Department that each of the

> arms dovetails as a whole team promoting integrity, objectivity, openness, professionalism and mutual respect.
> The political arm may not always agree with some of the day-to-day decisions of the executive. But there are very few issues in this life where there is an absolutely right or absolutely wrong way of doing things. There are often professional judgements to be made and risks to be taken and so long as the executive decisions clearly relate to policies and strategies which the political arm has laid down and clearly reflect statutory and administrative law and processes then those decisions should be supported consistently by the political arm. Nothing will be more undermining of the confidence of the executive – and thus disruptive and potentially destructive of the effective delivery of services – than for the political arm to be jumping inconsistently and irregularly into the executive decision-making processes. Of course, bringing objectivity, openness and mutual respect to bear, this does not mean that the executive decisions cannot be questioned and it has always been my experience that, indeed, the executive welcome such interest. On the other hand the executive arm may not always agree with the policies and strategies determined by the political arm. In such instances it is the executive's duty to say so openly (but internally only) with objective reasons. But once finally determined (and assuming consistency with the law and Government policy) it is the absolute duty of the executive to give effect to Department policies and strategies in the most effective and efficient manner possible. …" (emphasis in the original)

20.9 In her oral evidence, Mrs Christian re-iterated that this remained her view of the proper extent of the exercise of a political member's powers [713]. It would not be appropriate for a political member to instruct an officer of the department to place a child where the officer's professional advice is that it is not in the child's welfare to do so [714].

20.10 Mrs Christian said that the position set out in her letter dated 17 March 1998 also applied, in her view, to Ministers[715] . She explained her own role as Minister: she never issued orders or made decisions about placement of individual children, unless asked for support by professionals such as the Director of Social Services.

> " … I made no decisions regarding the placement of individual children. For example, if the Director wanted an endorsement of an expensive UK placement, he may have asked for my support but I would not have made the decisions regarding whether the placement should happen or not."

20.11 During the relevant period of the care and support of Samantha and George, there existed the document "Notes for Ministers" which was issued with the authority of the Council of Ministers. It sets out, among other things, the Ministerial Code and the relationship between ministers and civil servants. It was formally issued in November 1996 and again in November 2001 with identical content [716]. Notes of Ministers 2001 sets out in paragraph 36 that "Each Department will have one or more Members appointed to it to assist the Minister and to whom the Minister may delegate functions. …" . Paragraph 35 deals with Management within Departments:

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[713] Day 23:26-27
[714] Day 23: 32-33
[715] Day 23:30
[716] Information given to Inquiry by Chief Secretary's Office letter 12 May 2005

"35. In January, 1992, a guidance note was issued with the authority of the Council of Ministers which set out the Council's understanding of the respective responsibilities of Ministers and Civil Servants and of the nature of the relationship between Ministers and Civil Servants. A copy of this guidance note is attached as Appendix 5."

20.12 The Duties and Responsibilities of Ministers and Civil Servants were set out in Appendix 5. Paragraph 3.1 states that "Ministers are expected to give fair consideration and due weight to informed and impartial advice from civil servants as well as to other considerations and advice in reaching policy decisions; to refrain from asking or instructing civil servants to do things they should not do; …". Paragraph 3.4 sets out that policy is for ministers to decide; that civil servants are to advise without fear or favour; and that civil servants must carry out the policy.

20.13 Paragraph 6.2 stated:

"Civil servants should always recall that it is Ministers, and not they, who bear political responsibility. A civil servant should not decline to take, or abstain from taking, an action because to do so would conflict with his or her personal opinions on matters of political choice or judgement between alternative or competing objectives and benefits. However, there may exceptionally be circumstances in which a civil servant considers that he or she is being asked to act in a manner which appears to him or her to be:-

(a) Either improper, unethical or in breach of constitutional conventions, or to involve possible maladministration, or to be otherwise inconsistent with normal standards of conduct. In such a case he or she should report the matter to the Department's Chef Officer or the Chief Secretary
(b) Or directly contrary to deeply held personal conviction on a fundamental issue of conscience."

20.14 Paragraph 8 deals with "Some Practical Aspects":

"8.1 The purist model of the Minister being concerned with policy and the civil service being responsible for the management and delivery of services in accordance with policy, whilst unassailable in principle is subject to certain qualifications in practice.

i. The distinction between policy and management is not always clear and implementation of a policy may involve the Minister getting into some details, particularly if the policy is relevant to service delivery or the way the Department functions, for example:
   Setting targets;
   Monitoring performance;
   Distributing resources;
   Assessing managerial arrangements.
   All these functions may be part political and part managerial. For the Minister to stand back totally on these issues would be to surrender the policy element involved to the Civil Service.
ii. The scale of operations and the accessibility of Ministers coupled with the small size of some Departments can tend to draw the Ministers into questions or detailed administration, and there remains some expectation within Tynwald that this should be so.

iii. It must also be recognised that managerial decisions can cause controversy and raise political issues. A Minister does have a right, as the defender of individual interests, to raise constituency or small issues and this may involve him in procedural and managerial details.

iv. Conversely the purist model makes no allowance for the civil servant to contribute to the policy debate apart from tendering advice. The very fact that it is difficult to distinguish in any absolute way at the margin between what is policy and what is management means that the senior civil servant may be involved in decision making which has a policy element. …"

20.15 It will be apparent that the statement of applicable principles set out so clearly by Mrs Christian in her letter dated 19 March 1998 and re-iterated in her oral evidence to the Inquiry is absent from the guidance in "Notes for Ministers". It is regrettable that this clear statement of principles and their practical application in the Social Services Division should not have been known to political members and officers alike. The misunderstanding and lack of clarity in the practical and proper extent of the role of political member and departmental officer in connection with Samantha's placements was unacceptable, involving as it did the welfare of a young person for whom the DHSS had a statutory responsibility.

20.16 The present position is considered in Part 2, in chapter 30.

Interventions by constituency MHKs

20.17 In chapter 9, the Inquiry has considered the representations made by Mrs Brenda Cannell MHK, as member for the constituency of East Douglas in respect of Samantha's placement within her constituency at Derby Road.

20.18 The Inquiry heard evidence of other representations being made to social services.

20.19 Speaking generally[717], Mrs Clare Christian said that in the years 2000 -2002 there was resistance from some MHKs and some communities to the placing of children or young people with problems in their areas, so much so that it became practice to advise MHKs in advance if such a placement was to take place [718]. She explained [719]:

> "There were a small number of Members of Tynwald who were quite aggressive in their approach to the issue. By and large, the majority of Members were more balanced in their approach, and whilst, naturally, they were concerned that if difficult and troubled young people were to be placed in their constituencies, with the possible consequence of difficulties for their communities and neighbours, they wanted to be aware, not necessarily with a view to opposing such a placement, but simply knowing that the children were going to be there."

[717] And not specifically referring to Mrs Cannell
[718] Day 23:15 - 16
[719] Day 23: 18

20.20 Mrs Christian went on to describe the generally intolerant attitude towards looked after children felt widely in the community at that time:

> "It also reflected a degree of general intolerance in our community, which was engendered to some degree by the press coverage at the time, towards young people who had difficulties[720]."

20.21 Constituents have made and continue to make representations to their MHKs about looked after children placed in their area. Naturally MHKs have to have regard to the views of their constituents. When asked what a constituency MHK should do when he or she or the constituents have a concern about a child care issue affecting the constituency, Mrs Christian said [721]:

> "In my view, they should approach it at a political level, through the political Members of the Department. I don't believe it is their role to summon professionals or to interview professionals in the matter, although, in a community as small as ours, we sometimes do know people who are involved in various situations. But I do think the appropriate approach is from politician to politician."

20.22 There is no specific guidance for Members of Tynwald on how they should make representations to departments about policy and about decisions in individual cases. Essentially, the conduct of Members of Tynwald in their non-Government capacity is governed only by the Standing Orders of Tynwald and the Standing Orders of the House of Keys as appropriate. These rules are mainly concerned with Members' activities within the Branches or within Parliamentary Committees [722].

20.23 The Direction given by the Council of Ministers on the Provision of Information to Members of Tynwald [723] provides that as a general principle:

> "Subject to any limitations imposed by the Minister or by the general interest of the Government, officers should provide such information regarding their department and the discharge of its functions as a Member of Tynwald may reasonably require".

20.24 The Inquiry is aware of the potential for pressure being brought on officials by Members of Tynwald. MHKs will have legitimate constituency enquiries and concerns. Where there is public disquiet about an issue there is the potential for officials, particularly junior officials, to feel that unfair pressure is brought. The DHSS told the Inquiry that it continues to receive political pressure from time to time[724].

20.25 The Government Direction makes provision for the Minister to give instructions about the provision of information by officials. The Inquiry notes Mrs Christian's suggestion that contact should be "politician to politician". The Inquiry believes that non-member MHKs play an important part in the overall governance of the Isle of Man. However, political pressure, whether it be express or implicit, should not be put on junior members of staff in connection with decisions made about a child or young

[720] Day 23:21:12-15
[721] Day 23: 22-23
[722] Information given to Inquiry by Chief Secretary's Office letter 12 May 2005
[723] Government Circular No 18/93 10 June 1993
[724] DHSS Closing submissions, Part 1, para 178

person with emotional or behavioural problems. To do so, risks a decision being made for other than welfare reasons. Accordingly, the Inquiry believes that the appropriate route for political enquiries of any kind is, if not to the departmental member, to the Assistant Director or above. A protocol should be put in place to ensure that this route is followed in all save exceptional circumstances.

20.26 The Inquiry considers this further in Part 2, in chapter 30.

CHAPTER 21

ISSUES ACROSS GOVERNMENT

Corporate responsibility and corporate parenting

21.1 Samantha and George both had considerable emotional and behavioural difficulties. Providing care and support for them was a very hard task. The evidence in Part 1 showed that all areas of Government viewed the task as primarily one to be performed by the DHSS on its own. There was little evidence that other departments or agencies believed that they had a corporate parenting role to play.

21.2 The term "corporate parent" was defined by David Cooke, the Director of Social Services, as meaning that everyone accepts that they have a role to play in the development and care of a child [725]. Therefore individuals and organisations within Government must accept individual responsibility for the well-being of looked after children. It requires an understanding that looked after children are not in care through any fault of their own but through the inability of their parents to care for them and the failure of society – and all of us within it – to have aided or assisted that family or to have intervened earlier in order to ensure that child did not continue to suffer. That failure – our failure – imposes upon the state, as our representatives, the obligation to step in and act as the parent of that child.

21.3 In the period leading up to the murders in February 2002, the concept of corporate parenting was largely unknown, or if known, was neither understood nor followed in practice. This is not surprising. In 2002, it was a new concept. In England and Wales too, it was neither widely known nor implemented.

21.4 The Inquiry heard from a number of witnesses on the question of corporate responsibility and corporate parenting. None took issue with the view of the DHSS as expressed by David Cooke. David Cooke said that the notion of "corporate parenting" was a very difficult thing to achieve and, indeed, still had not been achieved[726]. He said many agencies thought that responsibility for providing childcare services was with social services and no one else.

21.5 He said there had been an enormous improvement in the Social Service Division's relationship with the police and Department of Education since 2002 and there was now much more of an understanding of the term[727]. He had a reservation in that he went on to say that the Department of Education still did not recognise their role fully, as shown by their continuing failure to pay for children's education off-Island. Mr Cooke said that it appeared to him that where a looked after child was not attending school, the Department of Education behaved as if it was not its problem [728]. As a whole – and in relation to these two children, see chapter 13 – the evidence heard in Part 1 gives support to the suggestion by the DHSS that 'looked after children' did not always receive the best provision from the Department of Education and that the department had not, in that period, learnt to act as corporate parents.

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[725] Day 21:119
[726] Day 21:119:13-17
[727] Day 21: 120
[728] Day 21: 123

21.6 Ed Coates thought the police and social services had a different understanding of the concept of corporate parenting of looked after children[729].

21.7 The Chief Constable was clear that while there was in 2002 some momentum in dealing with difficult issues by producing policies and working cooperatively, there were still problems and gaps. He sought to reassure the Inquiry that changes had now been made[730]. The Chief Constable accepted that in 2001 – 2002 he did not pick up the phone and discuss the issue of hard-core young offenders with the Director of Social Services. With hindsight, he would have done but he said it was done at a lower level [731]. He expressed frustration at the lack of mandatory partnership arrangements and the lack of political appetite to implement them[732].

21.8 Richard Kneen indicated that:

> "the vast majority of the police are excellent, caring and understanding. But there is an element within the police force who don't see children as part of society, or not a part that they want to belong to"[733].

David Cooke also thought that there was still a certain degree of "demonising" of looked after children among the police[734].

21.9 Mr Cooke thought there was a link between the resistance of some agencies to being corporate parents and the Manx public's intolerance of looked after children[735]. However, he could point to no evidence to support his view that there had been a gradual change in relation to accepting the notion of corporate parenting.

21.10 Ken Tomlinson, Chief Executive of the DHSS during the relevant period but now retired, said that he had never heard of the term "corporate parenting"[736]. David Killip, the current Chief Executive, had heard of the term but only recently[737].

21.11 Claire Christian, MLC, said that in 2000 she proposed the establishment of a joint Ministerial Group of those departments concerned with children. From this came the formation of the Children and Young Persons Strategy Group. This involved, among others, Social Services, Health Services, Education and Home Affairs. Unfortunately, progress was slow and they were for a time diverted from their purpose of developing a children's strategy by having to respond to a Tynwald Motion on absenting children. She said in her oral evidence that the understanding in Government of the notion of corporate parenting was weak and the department was striving to develop it.

21.12 A corporate parent approach by all agencies and departments would have improved the effectiveness of the care and support given to Samantha and George. However, it is unrealistic to have expected such a developed approach in 2000- 2002.

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[729] Day 12:68:1-4
[730] Day 17:68
[731] Day 17:71
[732] Day 17:81
[733] Day 8:151
[734] Day 21: 120
[735] Day 21: 120
[736] Day 26:30:11
[737] Day 26:66:22

21.13 In Part 2, the Inquiry will consider whether corporate parenting is yet effective on the Island for children with emotional and behavioural problems.

The attitude to looked after children

21.14 As noted in chapter 20, the Inquiry has been told repeatedly that there has been and to some extent, there continues to be an atmosphere hostile to looked after children. It led to politicians feeling under pressure and in turn seeking to exert pressure.

21.15 Mr John Houghton MHK told the Inquiry that there was a negative attitude from the public towards young people because "the public feel let down"[738]. He disagreed that the publicity which he had given to the small minority (about 10 %) of looked after children causing difficulties had a negative effect in the public's perception of the other 190 looked after children. He said that he believed that the public understood that only a small number of looked after children were causing difficulties[739].

21.16 However, the Chief Constable said that in 2001-2002 some politicians

> "recklessly were casting doubts on all young people … I think it a matter of regret that certain politicians didn't act with a little bit more responsibility than they did" [740].

21.17 A number of other witnesses were scathing about what they saw as the Island's attitude towards children in care. A telling example was given by Richard Kneen in relation to the difficulties he and MFS had in opening a small home in Kirkmichael for three young people with learning difficulties, where objections were raised to his doing so[741]. Professionals gave numerous examples of public disapproval at the opening of care homes. The press were blamed for only reporting the bad news and presenting children in care as troublesome, per se.

21.18 Senior managers in social services were concerned about the negative perception of looked after children apparently held by the public. David Cooke believed that the public were and remained "very intolerant" of looked after children[742]. From his discussions with directors of social services in other jurisdictions, he believed this intolerance was more acute in the Isle of Man.

21.19 Mrs Christian thought the public mood had become more understanding over time. Recently, there had been less reaction to the behaviour and difficulties of looked after children[743].

21.20 In his statement to the Inquiry, Ed Coates gave telling evidence to the Inquiry:

> "The care of young people on the Island is viewed as a 'problem' and at times in the most negative of terms. The atmosphere and environment was and to a large extent remains one in which culturally we do not particularly value our children. Recent conferences on citizenship here on the Island

[738] Day 24:191:17
[739] Day 24: 193
[740] Day 17:69
[741] Day 25: 66-69
[742] Day 21: 120 -121
[743] Day 23: 23

> have highlighted a political dimension in which children are often still viewed as needing to be 'seen and not heard' and where control is an issue. Groups of young people are feared rather than valued.
> This view of young people is heightened when adding the 'care dimension'. The press, public and politicians of the Isle of Man have contributed to a particularly negative and critical view of young people in care. Immediately after the murders on 13 February 2002 I wrote and shared [a document entitled "Children in Care – A Plea for Dignity"] with colleagues here in the Department. I don't believe these comments were shared more widely.
> Furthermore, the level of political questions to the Department about children in care are almost always about their behaviours, and relate to complaints about their management. In my experience there have been no questions asked about how Tynwald, the Isle of Man generally or other parts of Government can contribute to the provision of a better environment and better arrangements for looking after this group of young people. I believe there is a need to review our perspectives in the way that the community work with a more understanding and inclusive way to meet the needs of this group. In addition there are MHK's who react to and resist the idea that young people may need to be looked after within their own community. This is most apparent when projects are being set up. I have experienced first hand MHK's who have expressed very negative views about this group.
> In other words the political atmosphere is not an entirely supportive one and I believe that both the Minister and political members as well as senior officers in this Department are frequently put on the defensive to the detriment of a developing service."

21.21 "Children in Care – A Plea for Dignity" is a thoughtful document which deserved to have been read more widely. It points out that those children who are looked after by the DHSS form a diverse group of children who come from a wide range of backgrounds and who have relatively few things in common. The most significant common thread is not their criminality or delinquency (indeed most do not behave in a criminal or delinquent way) but the fact that they are children who have a need to be looked after through no fault of their own. Mr Coates wrote in 2002:

> "On the Isle of Man there are approximately 130 such young people being "Looked After" each week. Some of these situations last for a few days some for the entire duration of the child's formative years. In a single year in the region of 200 children are looked after – that is the equivalent of a medium sized primary school. Many of these children go to school – several are currently studying GCSE's and some are doing A levels. Some of them are children with special needs whose parents require respite care in order to get a nights sleep. Some of them are Children who have great talents. Others are babies and toddlers who need someone simply to love them. Others are troubled teenagers – often feeling very angry and let down by the adults in their lives. It is true that some of these children have been subjected to abusive experiences and have witnessed or experienced extremes of physical, sexual or emotional harm – and then they cannot live or in some cases bear to live in their own families. Many, no most of them are perfectly normal children – they are people like you and me with the exceptions that they haven't necessarily had the best start in life. They are above all people with feelings."

He pointed out that in the aftermath of the murders, looked after children were in need of sensitive responses and thoughtful comments made with knowledge, care and understanding. He continued:

> "They need all of us to remember that some of them are scared or bewildered at this time whilst others feel outraged and offended by the belittling way in which they are often referred to as "children in care" with all the attendant baggage that this phrase seems to have acquired. They need us all to look out for them as if they are our own children because they are – they are yours, ours, they are Manx."

The full text of the document is set out in Appendix 6 to this Report.

21.22 In his oral evidence to the Inquiry, Mr Coates accepted that there were "positive" stories about looked after children in the press; but because they were in the context of the overall problem, the stories did not come over as positives[744].

21.23 It is clear from the evidence that the placement decisions about Samantha in 2001 were made against the backdrop of the public attitude to looked after children. Samantha's case was particularly difficult because she was indeed at times behaving in a manner likely to cause concern to other residents: for example late night gatherings of unsupervised looked after children, using drugs and alcohol and making a great deal of noise.

21.24 Nevertheless, the Inquiry is clear that the views about looked after children ascribed to the public in 2001 and 2002 were unfair to the vast majority of looked after children. The points made in Mr Coates' paper are well made. The public has much to celebrate in their children, whether looked after or living at home. The welfare of looked after children is not promoted if there is a widespread atmosphere of intolerance towards looked after children. Social workers and those working for care providers are caring for such children on behalf of the Government and people of the Isle of Man. Their task is a difficult one and is made more difficult if their morale is sapped by such an intolerant attitude.

[744] Day 11: 190-191

CHAPTER 22

RELEVANCE TO THE CIRCUMSTANCES SURROUNDING AND LEADING TO THE DEATHS

22.1 In the preceding chapters, the Inquiry has considered the level and effectiveness of the care and support provided to Samantha and George, particularly in the twelve months or so before their murders. It has considered their lives in the period leading up to the murders.

22.2 The Terms of Reference, in paragraph 1, also require the Inquiry:

> "to determine whether [the level and effectiveness of the care and support provided to Samantha and George] had any relevance to the circumstances surrounding and leading to their deaths."

22.3 Precisely when and why Peter Newbery murdered Samantha and George remains unknown. Equally the extent and nature of the association (if any) between Samantha and George and Peter Newbery in the months preceding the murders remains unknown [745].

22.4 Peter Newbery was responsible for, and stands convicted of, the murders of Samantha and George. The Inquiry is clear that none of the actions or failures of the departments or agencies of the Government led directly to the deaths of these young people. Where a person has the mentality to commit the murder of children, such a person will take the opportunity to do so, despite the very best endeavours of all those involved in the care of children. Whilst procedures, policies and strategies can be put in place to minimise the risks posed by such a person, absolute protection of all children at all times is impossible.

22.5 The Inquiry, whilst highly critical at the lack of effective care and support for Samantha at many different levels in different organisations, also recognises that she had been an emotionally and behaviourally challenging young person since she was a small child. The Inquiry therefore recognises the difficulty that any social service authority would have had in managing her behaviour. Whilst the Inquiry believes she should have been offered a great deal more care and support, it finds itself unable to draw a direct link between this lack of care and support and her death.

22.6 Nevertheless, both before and after Samantha's return to the Island in 2001, there was no proper assessment of her needs and no proper planning for her future. Her placements at Maple Avenue, Derby Road and Leece Lodge were not preceded by a risk assessment, by any proper planning or any proper assessment of what she needed in the placement. Thus, Samantha was largely unsupervised and the life arranged for her was mostly unstructured, undirected and aimless. She had little care and support. She was left to her own devices. She was involved in drugs, alcohol and criminality. Given Samantha's emotional and behavioural problems, this left her more vulnerable than she would otherwise have been. She was plainly at risk.

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[745] See chapter 15

22.7 Would events have turned out differently if Samantha had been warned that Peter Newbery was a danger to women? Samantha and Peter Newbery were both placed in Cummal Shee for a period in 1997. They had a relationship of some kind (see chapter 15). The relationship was not recorded on her social work file. There was no evidence that Samantha was associating with Newbery in 2001-2002. There was, therefore, no known connection between Newbery and Samantha. There was no specific reason to warn Samantha against Newbery, beyond any general warning which might have been given to those in care homes or to those caring for teenagers in residential care. Furthermore, there was no close watch kept on whom Samantha was associating with. Samantha was unsupervised and largely left to her own devices. Newbery's motive for murder, and the precise circumstances in which it occurred, remain unknown. Even if she had become aware of a general warning about Newbery, it cannot be known whether it would have been effective to protect her from him.

22.8 George returned to the Island on 21 December 2001 for Christmas but failed to return to Eden Grove on 7 January 2002. While he remained on the Island after 7 January, he was unsupervised and he too was largely left to his own devices. Given his activities during previous contact visits, he too was vulnerable and at risk.

22.9 The Inquiry has noted that attempts to effect George's return to Eden Grove were flawed[746]. George was arrested on a number of occasions. These arrests presented opportunities to seek to effect George's return to Eden Grove but they were not taken[747]. Had they been taken, there is a reasonable chance that George would not have been on the Island on 8 or 9 February 2002.

22.10 The Inquiry has already noted that it is likely that he would have left the Island on the ferry on the night of 7 January 2002 had it not been for the intervention of his father at the ferry terminal[748].

22.11 Peter Newbery was arrested in November 2001. He was assessed to be "a high risk to women"[749]. Had he been charged and remanded in custody, he would not have been at liberty in February 2002. The Inquiry has considered in chapter 15 whether he should have been charged in November 2001. In January 2002, the police received the results of a forensic examination of the clothing of the alleged victim of the November sexual assault. The Inquiry has concluded[750] that, on receipt of this new evidence in late January 2002, there was sufficient evidence to charge Newbery and that there was an opportunity to ask the court to remand Newbery in custody. The decision whether to remand in custody would have been for the court to make.

[746] See chapter 12
[747] See chapter 12
[748] See chapter 12
[749] See chapter 15, para 15.29
[750] See chapter 15, para 15.50

CHAPTER 23

VISITS AND SEMINARS

23.1 Part 2 of the Inquiry looked at the current services for children and young people with emotional and behavioural difficulties and also looked forward with a view to making wide-ranging recommendations to assist such children and young people and to avoid, so far as is possible, further tragedies similar to those that befell Samantha Barton and George Green.

23.2 To this end, it was decided that the structure of Part 2 should differ substantially from that of Part 1. I specifically looked for a format that would facilitate wide-ranging debate and discussion between individuals and between departments and would allow young people to have a voice. It was decided that seminars designed around themes of safety, health, offending, young people's voice and strategy would best allow all the relevant evidence and ideas to be explored.

23.3 I thought it important that both I and Mr Hutchinson, the expert assessor, should visit resources on the Island to speak to the staff, service users and see first hand how they worked.

Visits

23.4 The following establishments, individuals and/or teams were visited prior to the commencement of the Part 2 seminars:

- Social workers (various teams), Department of Health and Social Security, Social Services Division, Hillary House (10 October 2005)
- Detached youth workers, Department of Education, St George's Court (10 October 2005)
- Youth Justice Team, Victory House (10 October 2005)
- Health service managers, Department of Health, Crookall House (11 October 2005)
- Manx Family Services, 31b Derby Road (11 October 2005)
- Isle of Man Children's Centre, 92 Woodbourne Road (11 October 2005)
- The Chief Minister and Children & Young People's Strategy Coordinator, Government Buildings (11 October 2005)
- Secure Unit, Old Castletown Road (13 October 2005)
- White Hoe residential unit, Old Castletown Rd (13 October 2005)
- Tromode House residential unit, Ballafletcher Road (13 October 2005)
- Ynnid Whallid secondary referral centre, Glencrutchery Road (13 October 2005)
- Director of Policy, Chief Secretary's Office, Government Buildings (14 October 2005)
- The Chief Secretary Chief Secretary's Office, Government Buildings

23.5 The majority of the establishments visited were chosen because they were considered to be representative of the range of services available on the Island. I obviously wanted to visit residential units, a children's centre and meet members of the various social work teams and service providers. I also felt it was important to visit the more specialist facilities on the Island, including the secure unit, which is a relatively

recently built facility and accounts for approximately £1 million of taxpayers' money per annum, and Ynnid Whallid.

23.6 The format of the visits was left very much to the establishments themselves with the sole proviso that time was made both for viewing the establishment and asking questions of staff and residents.

23.7 The detached youth workers have a unique perspective on children and young people on the Isle of Man, formed very much by their more informal role working alongside them in positions lacking formal authority. It therefore seemed important that I had the opportunity to discuss matters with them. I also very much wanted to meet members of the Youth Justice Team.

23.8 Given the wide ranging policy implications of the Terms of Reference, I thought it vital to have meetings with the Director of Policy, the Chief Secretary, Children and Young People's Strategy Coordinator and, of course, the Chief Minister.

23.9 During each visit, I took care to meet a range of people involved in the provision of care to children and young people. The Secretariat contacted the organisations ahead of the visit and they requested that staff members were available to answer my and Mr Hutchinson's questions and show us around their facilities.

23.10 The full list of all those individuals who made themselves available on the visits can be found at Appendix 8.

23.11 I would like to extend my thanks to all the staff and young people who suffered the disruption of my visit but still gave up their time to help me better understand the services and facilities on the Island. Their help was invaluable and their comments and explanations have been instrumental in the formulation of a number of the recommendations in this report.

Seminars

23.12 Our aim in the seminars was to cover areas that could influence our inquiries. Of course, the topics are interlinked and inevitably overlap and it was sometimes a challenge during the seminars not to duplicate discussions that had already taken place in other seminars.

23.13 The themes chosen were:

- Safety
- Education and Learning
- Health
- Youth Offending
- Voice of the Young People
- Strategy

23.14 I ensured that a wide range of on-Island professionals were invited and that professionals from different disciplines attended each seminar. The seminars on safety, education and learning, health and youth offending were held in public and individuals from the following departments and organisations attended:

- Department of Health and Social Security
- Department of Education

- Department of Home Affairs
- Manx Family Services
- St Christopher's Fellowship
- Isle of Man Children's Centre
- Drug and Alcohol Team
- Children and Adolescent Mental Health Service
- The Alcohol Advisory Service
- Gelling Johnson Farrant
- Foster Plus

The Inquiry heard from the following:

- Departmental civil servants
- Social workers and their managers
- Probation officers and their managers
- Police officers
- Teachers
- School governors
- Staff and managers from the DoE
- Youth workers
- Doctors and nurses
- Psychologists
- Health visitors
- Other health workers
- Managers from Health Services
- Prison officers and their managers
- Church leaders
- Foster parents
- Child care lawyers

23.15 The seminars on Strategy and the Voice of Young People were approached differently. The young people's seminar was facilitated by Investing in Children who did an excellent job in supporting the young people as they told us of their experiences of living on the Isle of Man and gave suggestions for how their lives could be improved. The seminar presented the Inquiry with some thoughtful ideas from a fresh, and different, perspective. I was particularly impressed that Mr Steve Rodan MHK, Minister for the DHSS, as well as senior social services managers, made time to come and hear what the young people had to say.

23.16 The strategy seminar took place over half a day and involved the members and Ministers from the Department of Health and Social Security, Department of Education, Department of Home Affairs as well as the Chief Minister and senior departmental officers. I am only too aware of the busy professional lives led by the Island's politicians and would wish to record both my gratitude and my admiration that each made the time to attend the seminar. The Inquiry learned a lot from it and my impression was that those who attended had felt it to be useful and worthwhile.

23.17 The dates and attendees for each seminar can be found at appendix 9.

23.18 I also invited a number of off-Island experts to join the seminar discussions and were requested to submit papers to the Inquiry. I thought this would be a unique opportunity for the on-Island professionals to not just hear the views and expertise of those from outside the jurisdiction but to test their thoughts and interact with other professionals. The Inquiry was honoured that so many renowned experts in their field agreed to fly to the Island to take part in the seminars. That they did so is thanks

to Mr Hutchinson, the expert assessor, whose knowledge of the foremost experts of the day was matched only by his and the Inquiry Secretariat's tenacity in pursuing them until they agreed to participate.

23.19 The details of the off-Island experts attending the seminars can be found at appendix 9.

23.20 All attendees to the seminars were invited to provide written submissions tailored towards sections 2 and 3 of the Terms of Reference. Most did so and I found the resulting submissions illuminating and instrumental in setting the direction of each seminar. Following the seminars, a number of the off-Island experts wrote to the Inquiry to offer their thoughts on what had been discussed. I also found these submissions extremely helpful.

23.21 In order that I and Mr Hutchinson could concentrate on the responses of attendees, I delegated the task of chairing the seminars to Mr Verdan, although I and Mr Hutchinson did ask questions in the seminars as and when the need arose. Mr Verdan faced the task of ensuring that every attendee had their say whilst simultaneously ensuring that all topics were covered within the time available. Suffice to say, this difficult task was made to look easy and I am grateful to him for the skill with which he chaired each seminar.

23.22 The seminars, with the exception of that for Strategy, were held over a whole day and time was specifically included for lunch and coffee to give all attendees a chance to mingle and informally share problems, solutions and ideas. It was gratifying to see so many professionals – from both on and off Island – use this opportunity so enthusiastically. Interestingly, some of the feedback received from those attending mentioned how helpful they had found this time: many had particularly used the period to talk to professionals outside their area of expertise and had formed new professional contacts and connections.

CHAPTER 24

SAFEGUARDING OF CHILDREN AND YOUNG PEOPLE

Introduction

24.1 The term safeguarding is one which extends the old definition of child protection - with its criteria of physical, emotional, sexual abuse and neglect - to a wider concept of well-being for children. It includes, for example, road traffic accidents that involve children and accidents in the home.

24.2 Children and young people should be kept safe. This applies particularly to children and young people whose emotional and behavioural problems add to their vulnerability and for whom the state has specific responsibility.

24.3 This chapter will address the effectiveness of the care system, the complex agency relationships that support looked after children, the legislation and policies that provide the framework for children's care services, the quality of management, leadership and accountability, and the Island Child Protection Committee.

24.4 The Inquiry has heard from a number of sources of the impact which the murders and the subsequent Inquiry have had on public confidence in the Social Services Division and on the morale of staff. The Inquiry wishes to make it plain that it has been impressed at the picture revealed during its visits to a variety of front line staff and at the seminars. In particular, the Inquiry has been persuaded by the enthusiasm, committment and skill among of many of the staff it met.

24.5 The Isle of Man has much to be proud of in the achievements of its children and young people. It appears that real progress has been made in improving the quality of many of the services to children with emotional and behavioural problems since the deaths of Samantha and George. Further, the Inquiry recognises that the Isle of Man is not alone in experiencing the sort of difficulties revealed throughout the Inquiry's investigation.

24.6 However, the Inquiry believes the Isle of Man has some distance to go before its citizens can be confident that children with emotional and behavioural difficulties will receive a consistent and high quality service from all the agencies that should be working together to provide it. Some of the improvements needed will require new resources. Others will require a new way of looking at the problems and may not be resource intensive. The Inquiry recognises that the potential demand for new resources could be never-ending and strongly recommends that the search for resources should not divert attention from the opportunities for identifying efficiencies within and between services, as well as income generating options. There may be incentives which can be described as "spend to save", which can reduce and control expenditure over an agreed period of time.

24.7 Clare Christian MLC said in her statement to the Inquiry that the division should always be examinig current practice to see if care is being delivered most cost effectively. The Inquiry agrees. It understands that the challenge of finding efficiencies is often resisted particularly where there is perceived to be an overall lack of resources. It also recognises that a "top down" identification of potential areas for efficiencies is invariably less effective than departments themselves identifying from where the efficiencies should best come. The Inquiry is therefore reluctant to identify where it thinks efficiencies should be made, but it believes that departments should be required to look at the effectiveness of their service and identify potential efficiencies.

These can then be invested in the priorities of the Children and Young People's Strategy. One way that this process could be undertaken, for example, is to require appropriate departments to identify efficiencies amounting to a small percentage of their annual budget. The sum of these efficiencies could then contribute to the implementation of the Children and Young People's Strategy based on the priorities set by the Council of Ministers.

Services

24.8 The Social Services Division was created in 1989, having formerly been part of the Education Division. At that time, the budget for the division was £4.4 million. Children and Family Services was created in 1994 consisting of the Service Manager, seven social workers and a budget of £3 million. In a comparatively short time the division and within it Children and Family Services have grown both in responsibilities and resources. The budget for the division as a whole in 2004 was £44.26 million. The Inquiry was told that there are now 22 social workers, three family advisors, a children's advocate, a senior clinical psychologist and a looked after children's therapist, in addition to over 200 staff provided through contracted out services. There are also some 14 staff employed in the area of the Resource Centre for Disabled Children, with a further 14 posts planned for October 2005 with the opening of a second, new resource centre in Douglas. The Children and Family Services' budget now stands at approximately £11.5 million, with a projected overspend of approximately £1 million; the overspend has existed for a number of years. In view of the longstanding nature of the overspend, the Inquiry believes that it is more realistic to consolidate this figure into the base budget.

24.9 The Minister for the Department of Health and Social Security holds responsibility for the Divisions of Health, Social Security and Social Services and is supported by a Member for each Division. The department, in terms of both financial and staffing resources, is significantly larger than other departments of Government.

24.10 The Director of Social Services reports to the Chief Executive of the Department of Health and Social Security, and is supported by a Deputy Director and Assistant Directors for Children and Families and for Adults' Services.

24.11 The Government has since 1990 followed a policy of restricting the total number of Government employees. The Personnel Control Mechanism is locally referred to as 'the headcount'. It has been established partly for financial reasons - in particular because of the significant implications of providing Government pensions - and partly to ensure that there should not be an imbalance between public and private sectors within the economy.

24.12 The Inquiry understands the purpose of this policy, but it has resulted in the Social Services Division having to rely on external providers in order to keep within its headcount allocation. In order to do this well, a department must have expertise in the tendering, selection and monitoring processes of external providers. The consequences of the division not having that expertise has been made clear in Part 1[751], and will be further dealt with later in this chapter. The Inquiry has also read the reasoned submission made by Trevor Noden in May 2002, which suggested that it would be more efficient for the Department of Health and Social Security to manage directly some of the currently externally provided services, saving approximately £420,000.

[751] See in particular chapter 18

24.13 The range of services which social services provide directly (alone or with other departments), commission from external providers or grant aid is set out in a summary prepared by the DHSS and appears at Appendix 15. The Inquiry notes that a number of these services have been created since the deaths of Samantha and George. This reflects well on managers, officials and politicians in their determination to improve services.

24.14 In addition, the Inquiry believes that it is both encouraging and significant that the Director of Social Services has replaced previous providers of some services with new ones. This must indicate that some scrutiny has been taking place of external providers.

Performance Management

24.15 The Inquiry has heard and read evidence of the systems for assessing the performance of the Division and the Children and Families Services in particular. There are different ways in which performance can be assessed: these include complaints, internal and external inspections and quantitative and qualitative data.

Culture

24.16 There appears to the Inquiry to be no established culture of managing performance through regular monitoring and review in either the Department of Health and Social Security or the Social Services Division. Regular monitoring of performance should take place at all levels, at political, chief executive, chief officer, head of service, team manager, head of residential home and practitioner levels. There needs to be a determination to assess regularly whether the services being provided on behalf of the public of the Isle of Man are effective. This determination must derive initially from Ministers, Chief Executives and Chief Officers. The Inquiry believes that, without such monitoring and review of data, the effectiveness of care and support for children and young people including those with emotional and behavioural problems is reduced.

24.17 A written submission by social services with regard to performance monitoring - produced at the request of the Inquiry - revealed:

> "we do not at this stage submit performance data to the Chief Executive, however we are examining with the Chief Executive what his requirements are…..".

Ministerial and member oversight

24.18 With regard to political oversight of performance, the submission went on to say: "this would similarly apply to the Member for Social Services and Minister …..". The submission, however, does indicate that the Social Policy Committee is "receiving reports … under the Children and Young People's Strategy" and the Chief Secretary's Office is working with a member of Social Services' staff "to produce a core set of data". The Inquiry was surprised and concerned to learn of the limited extent to which performance data is evaluated and used.

24.19 The Inquiry is unable to determine service effectiveness by comparison to other similar areas/jurisdictions because the Island does not, as a rule, regularly produce the qualitative and quantitative data that would allow such comparison. Similarly, senior officers and politicians on the Isle of Man are unable to determine objectively the effectiveness of their services or the consequent decisions on priorities, investment, policies or changes in legislation, that might be necessary.

24.20 At the Strategy seminar, the Chief Minister stated that he could assess performance by whether he was receiving any complaints. Whilst complaints are a valid factor in assessing performance, it is only the tip of the iceberg in terms of the wide range of data that Ministers, Members, officials and indeed the public should be aware of.

24.21 The Inquiry acknowledges that there are senior officials and Ministers who are striving to introduce a culture of performance management to Government. To do this will require sustained training, support, encouragement and monitoring if it is to take root. The Inquiry welcomes the start made by the proposal in the Strategy that key data be reported to the Chief Minister's Committee.

Recommendation 1

The Inquiry recommends that the Chief Minister requires that a report be submitted to him by officials addressing the issue of performance management in all departments involved with young people with emotional and behavioural difficulties and addressing the training and support required to develop and sustain it.

Qualitative and quantitative data

24.22 Performance management can be quantitative – "how much is being done?" - or qualitative – "how well are we doing it?" The social services data is largely quantitative. This is not without its merits. For example, the child protection data which was supplied to the Inquiry shows a range of information that could be skillfully used to assess the effectiveness of current child protection arrangements. For example, the geographical distribution of child protection referrals indicates an uneven pattern in three different parts of the Island: this could lead to the allocation of resources in a different way.

24.23 Since the Children and Young People's Strategy is based on five outcomes sought for children and young people, performance management should be focussed on whether individual and collective services are making a difference to the lives of children and young people. Although the Inquiry commends the Government for its Strategy, which is "outcomes"-based, it believes that the key performance indicators considered by officials and Ministers should focus less on quantitative data and more on qualitative data. This will better inform the public and their representatives whether the services are effective. For example, politicians and officials will not only want to know the absolute numbers of children on the Child Protection Register, or whether the numbers of looked after children are rising or falling, they will also need information on whether the outcomes and well-being for those children, particularly concerning their health, safety and education, are improving or deteriorating.

24.24 The Chief Executive of the DHSS told the Inquiry that there were no performance indicators in the 2005 business plan relating to young people with emotional or behavioural problems. The Children and Young People's Strategy stated that "some information appeared unreliable/unsubstantiated and not directly applicable to other jurisdictions or has never been measured in order to provide a baseline". Throughout

the Children and Young People's Strategy attention is drawn to the inadequacy of the data currently available. In summary, it states that there is "a significant deficieincy in quantity, consistency and quality of information".

24.25 To be more effective in serving the needs of young people with emotional and behavioural problems, the division must improve the range and quality of the key performance data which is collected and recorded. Furthermore, the range and quality of these indicators must be regularly reviewed and, if necessary, changed. Performance data must be sent to and considered on a regular basis by the Chief Executive and the Director of Social Services and also by the Minister for the DHSS and the Member for Social Services.

Recommendation 2

The Inquiry recommends that the Chief Executive of the Department of Health and Social Security and the Director of Social Services jointly review and determine the key performance indicators against which the effectiveness of the Social Services Division should be measured and determine the frequency with which they are monitored.

Recommendation 3

The Inquiry recommends that key performance indicators are regularly sent to and reviewed by the Chief Executive of the DHSS, the Director of Social Services and by the Minister of DHSS and the member for the Social Services Division so that they can assess measures of effectiveness and efficiency.

External Inspection

24.26 There is an inconsistent pattern of external inspections of public services on the Isle of Man. The Inquiry believes that external inspections allow individual services, or parts of them, to compare themselves with the best and worst of similar services in other jurisdictions. The Inquiry is of the firm view that external inspection is a prerequisite for an efficient and effective service.

24.27 In chapter 17, the Inquiry has referred to the attempts by the Director of Social Services to engage the Social Services Inspectorate from England in the inspection of his Division. It is regrettable that the Department of Health in England was not able to agree to inspect, not least becaue other Inspectorates, such as Ofsted and Her Majesty's Inspectorates of Police and Probation, have been able to inspect relevant services on the Island. The Inquiry welcomes the evidence given by the new Chief Executive of the DHSS during Part I of the Inquiry that he wished to put in place external inspection of Social Services in the same way as police and probation have been inspected.

24.28 The Director has commissioned a number of ad-hoc reports into different aspects of his services from both voluntary organisations (most recently, the NSPCC) and from UK universities. Whilst these efforts to establish an independent overview must be applauded, they are not, in the Inquiry's view, a substitute for systematic inspection from an external government organisation that has been tried and tested on many occasions.

24.29 The Inquiry was told of legislative changes in England and Wales and proposed changes in the Isle of Man which will remove any perceived obstacle to external inspection by the English inspectorate[752]. The Inquiry believes that the DHSS through the Chief Executive and the Director of Social Services should renew its efforts to arrange for regular inspection of the Division by an external Government inspectorate.

24.30 Reports of such inspections should be made public. The Inquiry has been made aware of the view held by many that there is much ill-informed comment about social services and children and young people cared for by social services. By making reports public, children, young people and their families and the wider public are able better to judge the work of social services.

Recommendation 4

The Inquiry recommends that the Department invite an external and independent government body to inspect the Social Services Division.

Recommendation 5

The Inquiry recommends that all inspection reports are published and publicised so that children, young people and their families and the wider public are properly informed of the results.

24.31 The Inquiry believes that all relevant Government departments should have an external inspection from another jurisdiction, be that England and Wales, Scotland, Northern Ireland or Ireland, at regular and sensible intervals[753].

Internal Inspection

24.32 The Inquiry welcomes the steps that the Director has taken during 2004 and 2005 to put on a formal basis the internal departmental inspection of residential homes. An inspector was appointed during the summer of 2005, to report directly to the Director of Social Services. Sensibly, these reports also go to the Assistant Director, Children and Families and to the Care and Contracts Manager. Given the important role which the Care and Contracts Manager plays in the division's relationship with its service providers, the Inquiry welcomes the fact that she receives the reports as a matter of course. It was suggested to the Inquiry that there was a delay in these reports reaching these senior officials. The Inquiry has been told that the delay has been remedied. However, the Inquiry suggests that the Director reviews the question of delay in distribution of these reports in twelve months time and reports his findings to the Chief Executive. The Inquiry believes given the ease of modern communication that there can be no justifiable reason for any delay in these reports being distributed to these senior officers. The Inquiry suggests that the Director keeps this matter under review. The Inquiry has read and heard evidence of the early observations and conclusions of the Government's Children Homes Inspector (see below).

24.33 In addition, social services reacted positively to the initiative of St Christopher's in appointing an inspector of their homes on the Island. The division has now placed this form of inspection on a statutory footing under section 55 of the Children and Young Persons Act 2001, Standard 32 of the Minimum Standards, which is similar to the Children's Homes Regulations 2001 (Regulation 33) inspections in England. Due to the small number of residential units on the Island falling within present criteria for

[752] Chapter 17
[753] See chapter 30

inspection (a matter to which the Inquiry will return below) the service providers decided to pool this function into one individual post and each part-fund his work. The Standard 32 inspector's reports are placed on file in the unit and are available for review by the Government inspector.

24.34 These two posts are an important development in the inspection and monitoring of the establishments who care for the most vulnerable children in society. These children and young people are open to intentional and unintentional harm or neglect in establishments which can be poorly led, employ staff with low levels of training or qualifications and lack clarity of purpose. Regular departmental inspections and the inspection and support from "provider inspections" will reduce the likelihood of harm and optimise the likelihood of children overcoming their difficulties. Although only recently established, on present form these developments appear to be working well.

Service Level Agreements

24.35 The Inquiry was profoundly concerned by the evidence received in Part 1 about the lack of clarity on policies, responsibilities, roles, communication and monitoring between the Social Services Division and the providers of services[754]. An effective service cannot be run unless each party is clear what service it is they should be running and the division is able to reassure itself of the quality of service it has commissioned for the children and young people for whom it remains responsible.

24.36 The framework of the business relationship between those commissioning a service and those providing it is the Service Level Agreement. The Inquiry has read a number of Service Level Agreements, which vary in quality and format. A number were not even signed. Tendering and contracting is an area in which social services, in the child care field, are only beginning to develop expertise.

24.37 In Part 1, the lack of clarity led to providers, in some cases, assuming roles and making decisions that were not theirs to make. There has, in Part 2, been evidence to suggest that providers feel "left holding the baby" without sufficient support from the division. The Service Level Agreements should make it clear what roles each professional should play. Not all of the Service Level Agreements are clear even now. Some are more akin to a job description and would make it difficult to assess the success and performance of the jobholder. An effective Service Level Agreement needs to include

- the respective roles of the "purchaser" and the "provider"
- specific objectives which can be used by the division to monitor compliance
- information required from the provider to inform evaluation and future planning
- a mechanism and frequency for monitoring and evaluating the service
- contingencies when the service does not meet the required standard

24.38 The Inquiry recognises that the division has invested in a Contracts Manager post and that expertise is developing. It also heard from providers that the work of the current postholder has been welcomed by them. However, a Service Level Agreement represents the framework for determining the quantity and quality of the provision for vulnerable children and young people, as well as the basis for determining its

[754] See chapter 18

effectiveness. At present the Service Level Agreements cannot be said to be fully satisfactory. Therefore the progress that is being achieved by the new Care and Contracts Manager needs to be sustained and built on.

24.39 The content and scope of Service Level Agreements needs to be improved when they come up for renewal or re-tendering. The external expert Christine Davies, who is the Corporate Director for Children and Young People for Telford and Wrekin Council, gave examples to the Inquiry of what an effective Service Level Agreement might include. The Inquiry is aware that expertise in contracting out children's services is a new and developing area throughout the United Kingdom. The Division should seek advice from other authorities in the United Kingdom in order to share advances in learning in commissioning and contracting.

Recommendation 6

The Inquiry recommends that Service Level Agreements between the division and providers continue to be reviewed in order to ensure that the providers' performance in terms of outcomes for children and young people can be measured.

Recommendation 7

The Inquiry recommends that the division seeks advice from other social service authorities in other jurisdictions in order to share advances in learning in the commissioning and monitoring of services.

Looked after children

24.40 There are, as of November 2005, 86 looked after children in the Isle of Man. This has reduced from 96 in April 2005. The monthly numbers have remained within about 10% of each other throughout 2005. There are approximately the same number of boys as girls looked after. Of the 86 children, 34 are placed with foster parents, 11 are with relatives, 39 are in residential care on the Island, 4 are "off island". Nine children are aged under 5 years, eight are aged 5-10 years, five are aged 10-12 years, five are aged 12-15 years and eight are aged 15 years+.

Fostering services: accommodation strategy for looked after children

24.41 The proportion of children fostered is approximately 39%; the percentage in residential care is approximately 45%. This profile is one of great concern to the Inquiry and there was considerable discussion about it at the seminar on Safeguarding, as well as a great deal of written evidence submitted on this subject. This profile is similar to one of the worst performing authorities in the UK. Most English local authorities would expect to be placing between 69%-80% in foster placements. Children in residential establishments would vary between 8%-19%.

24.42 The Inquiry received oral and written evidence from Foster Plus and foster parents on the difficulty of recruiting foster carers in the Isle of Man: it was said that full employment and the fact that both parents usually worked made recruitment particularly difficult, especially where fostering children under five years of age was concerned. However, as only nine looked after children (about 12%) are under 5, and there are no children under 5 years in residential care, this would not seem to be the age-group which has most shortage of foster carers. It was also said that the number of carers employed by providers had, in effect, saturated the market for those willing to care for children and young people.

24.43 The Inquiry received the advice of an external expert, Mr Wes Cuell, Director of Services for Children and Young People at NSPCC. He said that "these were not uncommon challenges, which could be overcome". He made it clear that similar obstacles were cited by many local authorities in England and Wales seekng to recruit more foster parents. He believed, however, that with the right strategy, they could be overcome.

24.44 The question of foster carer rates was discussed and the Inquiry heard that the Isle of Man paid above the National Foster Care Association recommended rate. This is still, of course, significantly less than it costs to maintain a child in a residential placement. The foster parents who gave written and oral evidence to the Inquiry believed payment to be one "important factor", but not the only important factor in the recruitment and retention of foster carers .

24.45 The Inquiry heard from another external expert, Professor Ian Sinclair, Professor of Social Work at the University of York and the author of Fostering Now: Messages from Research (London: Jessica Kingsley 2005), on the comparison of costs between foster carers and residential placements. There was also a reference at the seminar to "professional" foster parents, by which is meant those who are paid a salary as well as allowances. In a written submission from a social worker, the Inquiry heard of the need for respite care fostering. Although this referred to the provision of respite care for children with disabilities, it did raise the importance of there being a fully costed strategy for the accommodation of looked after children.

24.46 The Inquiry was not able to determine whether such a strategy existed which would incorporate the demand and costs of placements of children in different settings, including fostering, kinship placements[755], different forms of residential placements, and supported housing for children leaving fostering or residential care.

24.47 It is clear to the Inquiry that renewed and determined efforts are needed to increase the number of looked after children placed with foster parents. None of those giving evidence departed from this view. Financially there would be a significant cost saving if the number of residential places were reduced by children being placed in foster homes. This saving would be apparent if even only a few children could be moved into foster care. The difference between the unit costs of a residential placement and an age appropriate fostering allowance would be such that consideration could be given to paying foster parents a salary as opposed to providing an allowance.

24.48 The Inquiry has therefore concluded that the service, Foster Plus, commissioned by social services could become more effective if the Family Placement Strategy was developed within the framework of a re-designed accommodation strategy for looked after children. The submissions from Foster Plus contain recommendations for different types of support and payment depending on the age of the child and the circumstances of the foster parent. A proposal was made in the submission to attract residential social workers into foster care. It was acknowledged that this would require attractive recruitment packages to be agreed including the payment of salaries. Carers of children with emotional and behavioural problems are likely to need support in caring for such children. In particular, carers of school-age children with emotional and behavioural problems can work and foster at the same time only if formal support is quickly and easily available for foster parents. The Inquiry believes that the Family Placement Strategy must include provision of formal support for

[755] Placement with relatives

foster parents of children with emotional and behavioural problems. The Inquiry welcomes the proposal advanced by Foster Plus.

24.49 It is clear that the present imbalance between fostering and residential cannot be allowed to continue. New ideas for recruitment and retention are required. The Inquiry is more inclined to accept the view of Mr Cuell, the external expert, that many local authorities experience difficulties in recruitment but overcome them, rather than the view that nothing more can be done.

Recommendation 8

The Inquiry recommends that an accommodation strategy for looked after children, to include foster care, kinship care, residential, secure care and after care, be drawn up with unit costs and a costed implementation plan, so as to increase the proportion of children living in foster care and kinship care.

24.50 The Inquiry suggests that the department discusses the special challenges on the Isle of Man in recruiting and retaining foster carers with external organisations and local authorities, including the British Association for Adoption and Fostering.

Strategy for residential provision

24.51 Mr Hutchinson and I visited two children's homes, White Hoe and Tromode House, as well as the Secure Unit. We also heard evidence in Part 1 and Part 2 from young people in large and small children's homes. The Inquiry also received a number of submissions from staff of the Social Services Division and from all current provider organisations on the subject of residential care.

24.52 There are two five-bedded homes run by St Christopher's, Tromode and White Hoe, and eleven smaller homes run by Manx Family Services (eight homes, thirteen beds) and Isle of Man Children's Centre (three homes, six beds). St Christopher's provide further accommodation on a spot basis, as the need arises. St Christopher's run the Secure Unit for five children with an extra bed for emergencies.

24.53 Just as the Inquiry has noted that there is no overall accommodation strategy for looked after children, which sets out objectives for the balance of provision between foster care, residential care and other forms of care, it also was surprised to see no strategy for the way in which its residential homes should be used. For example, the Inquiry would have expected to see a plan for the type of accommodation that was needed for children and young people who required a short period in care and for those who required residential care for a lengthy period. Instead there appeared to be only general residential provision, without taking into account that different settings, staff skills or size of establishment might be more or less appropriate for individual children.

Recommendation 9

The Inquiry recommends that a residential strategy should be drawn up listing the purpose and function of its residential homes and residential provision.

24.54 A willingness to find solutions to problems where no other solutions appeared to exist, similar to the approach shown by Manx Family Services, struck the Inquiry as a recurring theme on the Island, for which staff in both the voluntary and statutory sectors should be commended. The Inquiry would not wish to see this imaginative and creative approach disappear but believes it should not be a substitute for drawing

up coherent and thought-through strategies. Relying on an organisation or an individual "to sort something out" is a seductive, but in the long-term, an unreliable way of developing and managing services. The Inquiry believes that the provision of large numbers of unrelated unconnected services will eventually produce poor outcomes through a lack of efficiency. The Inquiry is clear that the lack of an accommodation strategy for looked after children and a residential strategy undermine the effectiveness of the division's current services. These services, whilst improving in focus and professionalism, still appear to lack an overall design or vision for the range of children's accommodation and residential services to which the Isle of Man aspires.

Small homes

24.55 Among the existing range of provision are so called small homes. On the one hand they provide accommodation and support for young people, which is not currently available within other residential or fostering placements. On the other hand children and young people are often placed on an individual basis and/or on an emergency basis. For example MFS had responded on a number of occasions to providing placements in accommodation when no other existing fostering or residential resources were available. These placements, sometimes described as projects, enable children to be placed, often singly, in existing MFS properties.

24.56 The Inquiry is concerned at the over reliance on this type of emergency or ad hoc provision. It lays such children and young people open to lack of proper supervision, potential isolation and, where care planning is ineffective, the potential for a young person to be left to their own devices yet again. Professor Sinclair expressed concern about these smaller residential units. He believed that not only are the unit costs likely to be very high compared to other residential provision, but also the potential isolation of the young people lays them open to lack of contact with other young people as well as there being a lack of oversight and scrutiny, which can provide the opportunity for abuse. In Part 1, the Inquiry was concerned about the quality of accommodation, care and support offered to Samantha by Nugent Care and MFS in Maple Avenue and Derby Road and by Nugent Care in Leece Lodge 2.

24.57 There is no requirement to register as a children's home a home for three or fewer children. These homes are not technically subject to the Guidance on Children's Homes and, therefore, there is no statutory requirement of inspection. The Inquiry has been informed that Manx Family Services has voluntarily agreed that their small homes should be inspected in the same way as other homes. Manx Family Services are to be commended for giving their agreement to this.

24.58 There is currently a proposal to set out in regulations the standards for small homes in identical terms the existing guidance on standards for larger homes. However, the Inquiry shares the view of two Isle of Man advocates, Angela Crapper and Paula Butterworth, that "the proposed regulations would have no enforcement powers and only a change in the primary legislation to change the definition of children's homes or to add in small homes would create a fundamental difference". The Inquiry is of the firm view that regulation and enforcement legislation for small homes should be the same as for "children's homes". Given the large number of small homes, it is not satisfactory that the regulatory and enforcement system is less stringent than for children's homes.

24.59 For the avoidance of doubt, the Inquiry states unequivocally that where a service provider is accommodating a child (other than in foster care where the placement is subject to regulatory safeguards) the placement must be subject to the inspection,

regulatory and enforcement requirements of a "children's home". Thus, all small homes or projects or accommodation however described will be inspected. Anything less is unacceptable.

Recommendation 10

The Inquiry recommends that primary legislation is changed to ensure small homes are made subject to the same regulatory and enforcement requirements as "children's homes".

Manx Family Services

24.60 The Inquiry has heard contradictory evidence from young people as to the effectiveness of small children's homes. Written evidence from two young people who were in MFS accommodation stated that they had been helped by the placements. Some young people in Part 1 of the Inquiry and a young person interviewed by the Inquiry during their visits, expressed anger and resentment towards the care they received within Manx Family Services. A number of senior staff in social services have acknowledged the willingness of Manx Family Services to find and staff placements where none other have existed, in many cases for children whose challenging behaviour has made them difficult to place. This flexibility and ability to respond in emergency situations gained praise from a number of social workers.

24.61 The Inquiry is conscious of the need to balance the need for flexibility of provision, particularly in a small jurisdiction without a range of resources, with the need to avoid the greater evil of operating in a "knee jerk" way (to use the evidence from one written submission) to a particular problem.

24.62 The Inquiry believes that the Inspector will eventually develop a view of the quality of small homes. It believes the Inspector should initially focus his work on the small homes in the Isle of Man to determine the quality and outcomes of this particular provision. At the same time the department needs to establish what part the small homes play in an overall accommodation strategy for looked after children and how the unit costs and quality of outcomes compare with other forms of provision.

24.63 The Inquiry remains concerned by the evidence it heard in Part 1[756]. It does not believe that the new inspection arrangements or Service Level Agreements, and overall monitoring have been able to demonstrate progress by Manx Family Services as an organisation with proper procedures or professional standards.

24.64 The Inquiry believes that there is a place for a limited number of small homes in a jigsaw of provision for looked after children on the Isle of Man. It welcomes that the Bordesley Institute has been engaged to review the quality of the service that Manx Family Services provides. The Inquiry hopes that this will offer the kind of detailed scrutiny of MFS in general, and small homes in particular, that is required.

24.65 Since the ending of the Inquiry hearings and seminars the Inquiry has become aware of the death of a young person in care who was accommodated in MFS accommodation and of the setting up of a special inquiry into the circumstances similar to a Part 8 Inquiry in England and Wales. The Inquiry itself has not investigated the circumstances of this death. However, it believes that the Report of the Special Inquiry needs to be taken into account when the recommendations of the present Inquiry are being considered.

[756] See chapter 8 and 18

24.66 The number of children placed in small homes is extremely high in comparison to UK authorities. The Social Services Division needs to urgently review the balance and range of placements required, the current provision and the way in which a new accommodation strategy can be developed which has family placement and kinship care at its centre. The Inquiry remains concerned about the large number of small homes run by MFS and the unit cost and effectiveness of this kind of provision. The importance of this issue means that it should be dealt with at ministerial level.

Recommendation 11

The Inquiry recommends that the Minister for the DHSS require that the Report of the review being undertaken by the Bordesley Institute and the Special Inquiry Report are submitted and considered by him and the Member for Social Services when each is completed.

St Christopher's

24.67 Mr Hutchinson and I visited White Hoe, Tromode House and the Secure Unit all run by St Christopher's. The Inquiry was impressed by the written and oral evidence received from a range of staff from St Christopher's and by what it saw on the visits. The Inquiry believes that the rigour and emphasis St Christopher's gives to the basic requirements of running a children's residential establishment reflected very well upon the staff as individuals and upon St Christopher's as an organisation.

Generally

24.68 Professor Sinclair, in his written submission, outlined four criteria for achieving successful outcomes in a children's home based on his research.

> "A good children's home has four main characteristics. First the young people are safe and not behaving in ways that have longer-term bad consequences for themselves or others. Second, they are happy and feel that others care for them. Thirdly they feel that there is a purpose to the place. Fourth, gains they make in the home are carried through when they leave it".

The last characteristic, stated Professor Sinclair, was more difficult to achieve than the other three. It depended on effective follow up by social workers and others when they left the children's home. Professor Sinclair had a number of recommendations:

> (1) Create clarity of procedures, for example on what constitutes a care plan, leading to clarity over whether a social worker is implementing, developing or challenging one.
> (2) A more rigorous exposure to outside ideas for example by arranging for inspectors by English, Scottish or Irish Inspectors, benchmarking performance with external authorities, and seconding social workers to work overseas.
> (3) Collecting statistics on a comparable basis to those in England in order to make those comparisons easier.
> (4) A drastic shift from residential to foster care included well-supported care by relatives.

The Inquiry endorses these recommendations and has addressed them at different points within this chapter.

24.69 The Inquiry received evidence from the Inspector that inappropriate placements of children were being made, possibly because so many placements were made as emergencies. This led to children being placed or moved against the wishes of providers who felt that they were more in touch with the needs of the children than social workers. It was strongly alleged by a number of people that there was a lack of liaison pre-placement and post-placement between social services staff and those in provider units when in many cases little information was passed to care homes by the department. These are failings in social work practice and should be addressed by proper supervision of the allocated social worker[757].

Secure Unit

24.70 The history of the development of the Secure Unit is a long one[758]. For some time, professionals and politicians recognised the need for secure accommodation to accommodate those children who were at risk to themselves or others and to avoid the need for young people to be remanded into custody at Victoria Road, as indeed happened to both George and Samantha.

24.71 The Inquiry commends those who supported the setting up of the Secure Unit. The Inquiry was greatly impressed with most aspects of the Secure Unit, the only exception being the limited amount of opportunity for outside exercise. In particular, the Inquiry was impressed by the attitude of staff and the range of the clear procedures and practice which existed and were evidently adhered to.

24.72 The occupancy of the unit during the last 18 months has been just below 50%. The Secure Unit is for five children with an emergency bed provided if necessary. When the Inquiry visited there was one young person in residence and over the previous three months, only one other young person had needed admission. No young person had been admitted on criminal grounds for the previous eighteen months.

24.73 The Unit costs, if fully occupied, are £200,000 per place. As the Inquiry understands it, costs do not decrease with a reduction in occupancy. This means that when one person is in residence the per annum cost for the unit as a whole remains £1 million. This is a significant amount of money to expend on unoccupied beds. The situation is clearly unsustainable. The Inquiry has heard that there is legislation shortly to go before Tynwald to enable young people up aged 17 years, who are currently remanded into custody, to be placed in the Secure Unit. This is a progressive strategy. However, in his oral evidence, the Deputy Governor of Victoria Road Prison indicated that there were never more than two young people aged 17 years in prison at any one time who could be transferred to the Secure Unit. If this pattern of usage continues, then it is clear that the staff and building at the secure unit are being significantly under-used.

24.74 The Inquiry was very impressed with the Secure Unit. It is plainly a first class facility. It is valuable for those young people who are sent there and is valuable as a backup to control the behaviour of those young people with emotional and behavioural difficulties who might believe, unwisely, that they are beyond control. It is a facility which should remain in place on the Island. The Inquiry regrets that it

[757] See below
[758] See chapter 17

was not available to assist in the care of both Samantha and George[759]. However, it occupancy rates in the recent past have been very low.

24.75 The Inquiry recommends as a matter of urgency that a review is undertaken of the Secure Unit to ensure that its range of excellent resources are used to their maximum effect. The Inquiry is firm in its conviction that it would be wrong and counter-productive to lower the thresholds for admitting a young person to secure accommodation in order to increase occupancy. On the contrary, the current low occupancy rates are to be welcomed in the sense they reflect the use of successful and earlier intervention. There are alternatives to the current situation which include considering the use of staff for outreach purposes with young people in the community, selling a bed to another jurisdiction to generate income for new initiatives or alternative use of the existing facilities. One alternative might include using teachers or residential social workers, who were not needed at the Secure Unit, to support either the education or care of looked after children in foster homes or residential care.

Recommendation 12

The Inquiry recommends that the role and use of the Secure Unit and its staff be reviewed as quickly as possible by the Director of Social Services in conjunction with other appropriate agencies with a view to ensuring that it is being used efficiently and effectively and that a report be submitted to the Social Policy Committee.

24.76 The Inquiry recognises some of the advantages and disadvantages of each of these courses of action, but continuing to pay such a significant proportion of scarce resources for so few young people is unsustainable. Using the resources of the Audit Department of the Treasury to advice on these issues, as well as using a range of internal and external experts to determine options, may represent a way forward.

24.77 The Inquiry is particularly interested in additional tasks which the education staff in the Secure Unit could perform. There is potential for staff to offer individual support for those children attempting to return to mainstream education after periods in the Referral Unit or suspended from school. Alternatively, the staff could in other ways augment the specialist services of the Department of Education for looked after children or for children with special educational needs, who are not able to be placed at the Secondary Referral Unit. It is of some surprise to the Inquiry that the teachers in the Secure Unit are funded not by the Department of Education, but by the Social Services Department. Once again, the Inquiry wishes to emphasise the notion of corporate responsibility. It is, in the Inquiry's view, surprising that the costs of education within the secure unit are not at least in part borne by the Department of Education.

Leaving Care

Supported Housing

24.78 The Inquiry received oral and written evidence on the housing needs of looked after children and other vulnerable groups. There is a lack of proper housing for children and young people with emotional and behavioural problems who are moving towards independent living. As the Children and Young People's Strategy points out "As they leave care, [looked after children] need to be able to live where there is supervision where they can get to work easily".

[759] See chapter 17

24.79 There is a lack of public supported housing generally. The Inquiry welcomes the review of public sector housing of which "Public Sector Housing – A Discussion Document, April 2004" is an early stage. Its purpose is to stimulate debate about national provision, management, maintenance and funding of public sector housing. The housing needs of young people leaving care and those with emotional and behavioural problems must be borne in mind in this review. The Assistant Director, Adult Services, is representing the Social Services Department on housing issues for young people as well as adults and has given a fresh impetus to this work with special needs. In view of the many issues involved in being in transition between children and adults services, the allocation of responsibility to the Assistant Director, Adult Services, for accommodation and housing for young people with behavioural and emotional difficulties seems to the Inquiry to be a sensible allocation of responsibilities between the respective sectors of Children and Families' Services and Adult Services.

24.80 The deficiency in suitable and available accommodation has a significant impact on children in this vulnerable group who are leaving care. Any progress which may have been made towards stabilising such children is immediately put at risk by the dearth of appropriate housing as they move onto the next stage in their lives. Failure to deal with this aspect of their lives at the same time risks undermining other measures being taken to assist them to move towards a constructive adult life. As the Magistrates' Association rightly emphasised in their submission to the Inquiry

> " … for offenders in the upper range ie 16 to 21, the Association sees the lack of housing provision as being a particular problem. Poor bed-sit accommodation in the private sector is seen as a contributing factor to the general trend of feelings of low self worth amongst persistent young offenders. The provision of public sector housing for such individuals should be prioritised".

24.81 The Inquiry recognises the shortage of public housing on the Island and the many demands placed upon the housing stock. The solutions are not obvious, but the Inquiry is clear that the Social Services Department should not act as a quasi-housing authority. The way forward requires a new partnership between those who understand and are professionals in managing the housing stock, and those who provide care and support when required. Under the Strategy, social services and the Department of Local Government and the Environment are to prepare recommendations during 2006 on the future housing of looked after children. The Inquiry believes that they should report to the Social Policy Committee, by the end of 2006, on their recommendations.

Recommendation 13

The Inquiry recommends that the housing needs of children and young people with emotional and behavioural problems must be clearly stated and met in the Review of Public Sector Housing.

After care support

24.82 After care support for young people who have left care is critical to maintaining the progress that has been made whilst the young person has been in care. There is often an expectation that a young person can leave a foster home or residential care when they reach their school leaving age of 16 years. This expectation can be shared by both the young person and the staff who care for them. The Inquiry heard that this is no longer the view on the Isle of Man and young people can remain in care so long as

they need or want to. Unfortunately many young people want to leave care, which they regard as an unwelcome control over their lives. This puts pressure on their carers to look for alternative accommodation, but also to provide them with support, which is often unwanted or even rejected by the young people.

24.83 Mr Hutchinson and I visited the Manx Family Service After-Care Team, who worked with a number of young people in this category. The Inquiry, whilst recognising the difficulty of working with young people who are reluctant to co-operate with the help being offered, strongly believe that there should be a range of after care services offered, and repeatedly offered, to care leavers. Even young people with a stable and secure family background would struggle if left to manage on their own before they were 18. Care leavers have none of the advantages of a stable family relationship to sustain them and it is in no way surprising that they often struggle more.

24.84 In Part 1, the Inquiry has already commented unfavourably on the inadequacy of, and failings in, the care and support offered to Samantha as part of her move to independence. In the case of some children, the absence of proper after care support, which includes accommodation, education, training and employment, will mean that there is a high likelihood that progress made in the young person's life while in care, is undone in the immediate period after leaving care. The Inquiry believes that sufficient progress has not been made to enable it to be said that the provsion of after care services is adequate or effective. The Inquiry is of the firm view that provision of adequate after care services is an integral part of the care and support for looked after children and must be recognised as such.

Recommendation 14

The Inquiry recommends that the Director of Social Services draws up a strategy for the after care for looked after children with particular attention being given to the transitional arrangements of young people from children's to adults' services.

Care planning and assessment

Common assessment framework

24.85 The Inquiry learnt that the Social Services Division had adopted, in principle, the same common assessment framework that exists in England. It appears that the common assessment is used in some cases but not in others. Where it is used the assessment process is a thorough one. There is, however, no guidance available as to when to use the common assessment framework. There is no formal check to see when it is used. No one suggested this situation should or could continue. It is expected that the relevant guidance will follow when the Integrated Children's System is implemented.

24.86 There is no standard pro-forma assessment for schools to complete when they refer a child about whom they may have concerns to social services, although school nurses do have a pro-forma for referral to social services, which includes some assessment of the child.

24.87 A sub-committee of the Island Child Protection Committee agreed that a proposal to adopt formally the common assessment framework[760] across agencies should go to the Island Child Protection Committee. The ICPC gave its formal approval. The common assessment framework due to be introduced through the Polices and Procedures Sub-Group following its meeting on 27 March 2006. However, it appears that there has been no or little discussion about it outside the members of the sub-committee. This does not bode well.

Recommendation 15

The Inquiry recommends that a Common Assessment Framework is adopted by all relevant agencies, a fully costed implementation plan is submitted to the ICPC and a multi-agency training programme is established.

24.88 The Inquiry believes that this approach to introducing the common assessment framework reflects the way in which many developments have occurred. A worthy objective is undermined by the foundations of the policy being inadequately thought through, the policy coming from one part of government without the full involvement of other key partners, or the policy being introduced piecemeal without proper guidance or training, and its success therefore relying not on a coherent pan-agency approach, but in the hope that custom and practice will eventually lead to general implementation.

24.89 The Inquiry recognises the particular problems the Island faces, and in particular the shortage of staff at senior level to manage services, develop new legislation and oversee implementation of new initiatives. Whilst the Inquiry has sympathy with this situation, it nevertheless believes that managers and practitioners need to develop an approach to its services, which is effective and efficient, properly thought through and carefully implemented.

Integrated Children's Systems

24.90 The Integrated Children's System relates not just to assessment, but to new ways of planning and reviewing children. The Inquiry welcomes the fact that these important tasks have been reviewed and will be re-launched in due course. The task of implementing such an integrated children's system is an ambitious and commendable one. The new system will also organise the data which is held by different agencies. The Inquiry does not believe this task can be achieved quickly, easily or cheaply. Many local authorities in England are struggling with similar challenges. The costs of such a system are likely to be significant and the Inquiry strongly recommends that a financial business plan is set alongside the project plan, to determine whether a system such as this is capable of being implemented in practice.

Recommendation 16

The Inquiry recommends that the current Integrated Children's System be properly costed before being submitted to Ministers for approval.

[760] Known as a Multi-Agency Assessment and Referral Form

Initial and Core Assessment

24.91 The Inquiry welcomes the evidence that the initial and core assessment process will be implemented in advance of the more complicated Integrated Children's System. The Inquiry recognises that there has been an inconsistency of implementation and that the initial and core assessments have been adopted more in the Social Services Department than in other agencies.

24.92 The Inquiry notes the intention to introduce the common assessment framework under the auspices of the Island Child Protection Committee. The Inquiry welcomes the proposal as it will improve the quality of assessments of children in need and reaffirm the need for schools, health services and social services to be working and planning together.

24.93 One of the issues highlighted in Part 1 of the Inquiry was the failure to carry out proper assessments of Samantha and George. The critical need for a proper assessment of a child is the precursor to determining what support the child requires.

24.94 The Inquiry does not believe that assessments of children in need are sufficiently robust and cannot be considered effective as they stand. The objectives for improvement are understood by some social services staff, but not all, and certainly not within the majority of the other agencies. If children and their families are to be assisted in any way, the core of that help will depend on a proper assessment. The more complicated the situation, the more the effectiveness of the assessment will depend on a multi-disciplinary approach. The need to create and deliver a new system must rate highly on any list of priorities within the Isle of Man Children and Young People's Strategy.

Care Plans

24.95 The Inquiry concluded in Part 1 that the care planning for Samantha and George was unrealistic and ineffective. As recently as the summer 2005, the NSPCC, in their interim report, stated that inadequacies remained in care planning. The Inquiry will return to the role of management in resolving this serious deficiency in due course. At present it cannot be said that care planning, which is an essential part of the care and support provided to children with emotional and behavioural difficulties, is effective.

Review of Care Plans

24.96 The Inquiry was told that not all reviews were being carried out on time and also that the reviews sometimes lacked the required objectivity in that they are not chaired by an Independent Reviewing Officer or a person independent of the case. A number of submissions said the system for reviewing looked after children is not adequate. As the inadequacies revealed by the evidence in Part 1 showed, care planning and the review of care plans carried out on a regular basis, is the formal opportunity to assess whether the way in which the child or young person is being supported is effective or not. If it is not, it can be changed. Any failings in this practice, which threatens to undermine the opportunity for any objective re-evaluation of the child's life, should be put right.

Recommendation 17

The Inquiry recommends that an administrative system is set up to ensure that reviews are conducted at the statutorily required frequencies and that they be undertaken by independent Reviewing Officers or by managers not responsible for the case.

Recommendation 18

The Inquiry recommends that senior managers are supplied, on a monthly basis, with a list of completed and uncompleted reviews of looked after children and children on the child protection register.

Recording and file management

24.97 In Part I the overall state of Samantha's and George's social work files was unacceptable. The Inquiry discussed this important failure in chapter 17. The Inquiry read many file entries which were undated and unsigned. This is plainly unacceptable. To understand the major events in a child's life, it is necessary to have a chronology at the front of every child's file and the Inquiry is pleased that, since the oral hearings in Part 1, manuscript chronologies are being introduced. The Inquiry believes that care files should be monitored regularly by managers to ensure that the policy on care files is properly maintained.

Recommendation 19

The Inquiry recommends that all departments' documents be signed and dated.

Recommendation 20

The Inquiry recommends that every case file have an up to date chronology which is maintained regularly.

Recommendation 21

The Inquiry recommends that monthly spot audits be conducted on records and record keeping and the results reported to the Director of Social Services.

Island Child Protection Committee

24.98 The Island Child Protection Committee (ICPC) was created in 1989, but at that time had few procedures and apparently met irregularly. The ICPC now has the status of an advisory body established by agreement between the departments of Health and Social Security, Education and Home Affairs. The principal tasks are "to monitor and review inter-agency procedures, promote inter-agency training, identify issues from the handling of cases and to ensure proper public awareness of child protection issues".

24.99 The Inquiry notes that within the description of tasks, there is no mention of the requirement to promote policies which prevent abuse, nor is there any requirement to oversee and direct the performance of agencies which have responsibility for child protection. In the examples that the Inquiry has been sent, data on child protection is

available, but this is quantitative data and the Inquiry could not determine how this data informed the ICPC of any action that needed to be taken as a result. An effective Child Protection Committee should be able to demonstrate how it reviews and monitors information and then takes action to resolve or improve the issue which has been identified.

24.100 The Inquiry heard evidence that social services staff generally felt that they were left with the ultimate responsibility for child protection. Evidence tended to support this suggestion. However, the Inquiry has been impressed by the introduction of a post of designated nurse for safeguarding children by the Health Division and the way she has undertaken her responsibilities. The establishment of a safeguarding team within Health and the priority that Health has given to child protection is to be commended.

24.101 The designated nurse said that she is satisfied that children in special circumstances are correctly identified, through midwifery, health visiting and the Accident and Emergency Department but she remains concerned that subsequent intervention in the lives of these children and their families is not as co-ordinated or effective as it should be.

24.102 The Inquiry supports her view that direct access to the Child Protection Register for key health and education staff should be implemented quickly. At the Health seminar, the Inquiry heard that access to the Child Protection Register excluded medical staff at the Accident and Emergency Department. The Inquiry believes this is unwise.

Recommendation 22

The Inquiry recommends that access to the Child Protection Register be immediately reviewed and immediate access given to a named person in the Accident and Emergency Department; and that other departments should identify named individuals who can access the Register.

24.103 At the seminar on Safety, an imaginary, though typical, child protection scenario was described and delegates from schools, social services and health were asked how they would respond. What emerged were different practices, thresholds, expectations and responses by those who gave evidence. Wes Cuell of the NSPCC was critical of the responses and the lack of consistency which he believed should have existed. He described the situation as having "a number of cracks through which a child could fall". The Inquiry concurs with his view.

24.104 There was concern expressed by some delegates about how neglect and referrals about potential neglect might not be properly recognised and responded to. Some teaching staff stated they were worried about reporting child protection concerns because of possible repercussions on them and there appeared to be a lack of consistent Island Child Protection Committee policies setting out child protection standards in relation to recording, referring and information sharing.

24.105 Mr Cuell stated that the existing Yellow Book, which contains procedures on child protection, needs to be reviewed and relaunched so that Isle of Man procedures and guidance and training can be properly and consistently implemented.

Recommendation 23

The Inquiry recommends that all schools have the same policies and procedures for referring Children in Need to Social Services.

Recommendation 24

The Inquiry recommends that named social workers should be established as link officers to secondary schools.

Recommendation 25

The Inquiry recommends that the Island Child Protection Committee reviews and relaunches its procedural guidance and ensures there is a proper implementation plan established, with a requirement that all relevant staff attend multi-agency training.

24.106 The Inquiry was impressed with the current work of the Family Protection Unit within the Isle of Man Constabulary and the commitment which the Chief Constable and his staff have given to more co-ordinated working. Whilst the Inquiry has received clear evidence that some police officers have not always understood the complex role of social services[761], it is nonetheless clear that the Constabulary has the benefit of excellent leadership willing to engage with other agencies. Under the leadership of the Chief Constable, the Inquiry expects the Constabulary to develop a culture that both understands and values each agency's distinctive role and responsibilities, but also works together to deliver the outcomes identified by the Children and Young People's Strategy.

24.107 In Part 1 the need for an effective mechanism for deciding what information to share on dangerous people, and how to share it, was identified. The Police had their own internal arrangements for sharing this information. At that time Multi Agency Public Protection Panels, or their equivalent, did not exist. Now that these have been introduced, it is essential that all concerned understand the role of that Panel and the need to work together to protect both individuals and the general public from potentially dangerous people. Furthermore the accountability for leading, co-ordinating conferences and arranging training needs to be clarified.

Recommendation 26

The Inquiry recommends that training an information sessions on the implications, policy and practice of Multi Agency Public Protection Panels be arranged.

24.108 The ICPC is chaired by the Deputy Director of Social Services. He referred in his evidence to the need to consider the new "Safeguarding" agenda, as opposed to simply child protection responsibilities. The Inquiry believes that this may be the opportunity for a root and branch review of the ICPC. It may well be that this work requires external advice and support. The Inquiry believes that rather than a new Safeguarding Board developing incrementally (the Health Service are already using this term in a job title), the ICPC should set up a sub-committee to produce proposals on the implementation of a new Safeguarding Board.

Recommendation 27

The Inquiry recommends that the ICPC establish a sub-committee to examine the implications of replacing the ICPC by a Safeguarding Board.

24.109 The ICPC can do much to further improve its current effectiveness but it has already made progress on a number of areas. The Inquiry was, for example, impressed that

[761] See chapter 19

the ICPC now reports to Ministers within the Social Policy Committee. This goes some way to establishing political accountability for the safety of children on the Isle of Man. However, in the Inquiry's view, it does not go far enough. A committee cannot be responsible for such an important issue. Where accountability is not made clear, there is the potential - as has been seen in Part 1 of this Inquiry and in public inquiries in other jurisdictions - for responsibilities to be unclear and active leadership absent. The Inquiry believes that an individual Minister should be given the responsibility for not only the safety of children but also the outcomes and well-being of children on the Isle of Man. This matter is dealt with in the chapter on Strategy.

24.110 On a practical level, the Inquiry welcomes the comprehensive Isle of Man Parenting Handbook. However, it is clear that the ICPC needs to become more strategic in focussing the delivery of services in a more co-ordinated fashion on the children and their families whose well-being and safety is most at risk. The Inquiry believes that the need for this development has been recognised as necessary by many, though not all, senior officers.

Recommendation 28

The Inquiry recommends that the political and officer accountability for child protection be individually established.

Recommendation 29

The Inquiry recommends that primary legislation place the Island Child Protection Committee on a statutory basis.

24.111 The Inquiry has welcomed the establishment of a sub-group of the ICPC - the Inter-Agency Review Group – that focuses on comparing the different outcomes for looked after children between different local authorities and the Isle of Man. The sub-group is primarily made up of deputy chief officers of a range of services, including education, social services, health and the police. The Inquiry believes that this demonstrates the importance that all departments are giving to this issue.

24.112 Whilst it is appropriate for senior officers to collaborate on issues such as this, the Inquiry notes that the initiative has come from the Island Child Protection Committee. It may be that comparing the outcomes of looked after children is seen as primarily having a child protection focus, though it would seem that the issues being benchmarked are wider than this. This reinforces the Inquiry's view that a review of the ICPC should be undertaken so that it is clear what its roles and responsibilities are. Is it the forum for considering the outcomes of all children on the Isle of Man or is its focus child protection and safeguarding?

24.113 The Inquiry believes it should be the latter. If this is the case, the responsibility for monitoring, reviewing and taking action on the outcomes within the Children and Young People's Strategy needs to be clarified and agreed at officer level.

Recommendation 30

The Inquiry recommends that a proposal be drawn up which identifies how the "Outcomes" of the Strategy will be monitored and reviewed at a senior officer level and on an inter-departmental basis.

Training

24.114 The Inquiry recognises, as have all other public inquiries into the death or ill treatment of children that an effective child protection system relies on effective communication and relevant professionals working in a co-ordinated manner. It also requires each agency to have the skills and training to deliver their own unique role in keeping children safe. The Inquiry has read the Island Child Protection Committee training plans for 2004/2005 and 2005/2006. The Inquiry welcomes the range of courses and the variety of contributors, including off-Island experts from Alder Hey Children's Hospital and the Bridge Consultancy.

24.115 It was not possible to determine precisely the take-up of these courses, though evidence was heard at the Safeguarding seminar that some teachers never attended. The Inquiry further understands that training on the Information Sharing Protocol was optional. The Inquiry also notes that many of the courses set out in the training plans were for specific groups, such as education staff or child minders. The Inquiry was disappointed to note from the Children and Families Management Team response to the NSPCC Report dated February 2006 that Working Together training was delivered to operational managers from key agencies on 13 and 14 February 2006 but that "the Education Department failed to take up their three allocated places".

24.116 In the future the Inquiry believes that, wherever possible, training should be provided on a multi-agency basis, thus enabling attendees to develop an understanding of the roles of staff from different services. A number of suggestions were made to the Inquiry.

24.117 The Inquiry particularly welcomed the training programme's inclusion of the voluntary sector and church groups. The Inquiry could not identify if there was any general training offered to politicians on child care issues of a strategic nature. Such training is important.

24.118 The Inquiry would expect the information regarding attendance on child protection training to be reviewed and maintained by the Island Child Protection Committee (ICPC).

24.119 The Inquiry is aware that staff often fail to attend training courses as a result of the pressure of other work. The Inquiry believes this is misguided. Training courses are an important method of learning new skills and further developing as a professional worker. The Inquiry suggests that managers in all departments of government do all they can to ensure that staff are able, and are encouraged, to attend the training courses and programmes which have been identified as necessary or useful to them.

Recommendation 31

The Inquiry recommends that the ICPC approves the annual training plan and monitors and reviews the take up of the training being provided.

Management and practice

24.120 The Inquiry became aware during Part 1 that the Director of Social Services had commissioned the NSPCC to assist with the backlog of unallocated cases. It is understood that the NSPCC were also asked to audit social services during their time with the division.

24.121 The NSPCC audited 47 cases and drew conclusions about the quality of referrals, adherence to child protection procedures, files, care planning, schools and staff training. The NSPCC produced an interim briefing paper dated 29 June 2005 for a meeting on 30 June 2005 with social services managers, as an interim review of their work. The NSPCC produced an Overview Report dated 17 January 2006. The Children and Families Management Team response to the NSPCC Report was produced in February 2006. The interim briefing paper and the Overview Report make uncomfortable reading. For example, recalling the chaotic and inadequate nature of the case files examined in Part 1 of the Inquiry[762], the results of the NSPCC audit of files suggests little progress had been made in this area since the deaths of Samantha and George.

24.122 The NSPCC Report identified a number of areas of serious concerns. It concluded that some families were not aware that referrals were being made about them. Information contained on the referrals and files was scant, which made it difficult to decide how to respond and prioritise cases. The report found that the existing child protection procedures and systems were unclear and the purpose of various meetings that were held was unclear and unspecific. The files lacked "a sense of flow", were not always in chronological order, reports and diary entries were not always signed and dated, basic details were not recorded. There was no evidence of formal assessments, though the narrative contained some assessment. Recording of stategy meetings, decisions and review arrangements needed improving. The report stated that there was little evidence of 'children in need' plans or packages of support for them; this reflected poorly on care planning. In addition, there was a lack of clarity about the roles and responsibilities of the Care Management Team and the Referral and Assessment Team.

24.123 This is a devastating report by an external agency. It indicates a continuation of the same dire problems that were seen during Part 1: poor records and record-keeping, few formal assessments, limited care plans and poor management oversight.

24.124 The Inquiry notes the Management Team reponse to the NSPCC Report and the actions proposed in the light of the NSPCC recommendations. Whilst the Inquiry welcomes these actions it cannot understand why issues that were raised in the interim briefing paper dated 29 June 2005, and which had been revealed in evidence in the Inquiry, have not been effectively addressed earlier. For example, both the Inquiry and the interim briefing paper exposed the poor file recording and file management, yet the response states that the action proposed to remedy these deficiencies has been an internal working group "to look at" file management. The first meeting of that group was to be held on 8 March 2006, nearly nine months after the first interim briefing paper dated 29 June 2005[763]. It is this lack of urgency that undermines the Inquiry's confidence in the effectiveness of senior management of the division and in their expressed determination to produce a service of high quality and efficiency.

24.125 The Inquiry is mindful of one of the primary conclusions reached by Lord Laming in the Victoria Climbié Public Inquiry:

> "The answer lies in doing relatively straightforward things well".

[762] See chapter 17

[763] The Inquiry recalls that, at the time he gave evidence in Part 1, the Director of Social Services had not asked either Samantha or George's social workers why the state of the social work files, by which in his words he had been "appalled", were so inadequate: see chapter 17.

Many of the issues identified by the NSPCC report are not complex tasks; they are simple things that should easily be undertaken correctly.

24.126 At the Safeguarding seminar, one social worker suggested that it was more important to make a visit than complete a record. The Inquiry states unequivocally that this is a mistaken view.

24.127 The Inquiry also recalls the inadequacies identified in the two Audit Division reports on the provision of Children and Family Services[764].

24.128 The failure to improve the quality of the records, record keeping and care planning is a reflection on all those up and down the management chain. The Inquiry finds it difficult to understand why, after the tragic deaths of Samantha and George, all aspects of the management of the two children were not vigorously reviewed. The Inquiry was made aware of a policy on record keeping, but it would seem that it was neither monitored nor adhered to adequately. Notwithstanding the political decision to set up a public Inquiry, the Inquiry would have expected that senior managers and politicians would have ensured that an effective internal analysis of any shortcomings was carried out and a plan to put them right devised and implemented. The Inquiry would have expected the highest priority would have been given to putting matters right wherever necessary. This would have included ensuring new policies were drawn up, guidance was issued, training was provided, supervision was given and these and many other areas were regularly monitored and reviewed to ensure compliance.

24.129 The Inquiry is sympathetic to the argument about senior staff having to carry out an excessive range of duties. However, it does not regard this as a sufficient justification for the apparent lack of management oversight of basic professional performance in cases which the NSPCC audited, referred to above, which directly replicates management's failure to ensure simple policies and procedures were implemented in relation to the care and support of Samantha and George.

24.130 The NSPCC Report also calls into question the determination, commitment and ability of those senior managers responsible for children's services to deliver in the future the changes that are required.

Compliance

24.131 The NSPCC Report refers to "a resource rich service experiencing major compliance issues". Ensuring compliance with policies and procedures is of the utmost importance in the protection and support of children with emotional and behavioural difficulties. The Inquiry has been told that in some cases it is difficult to ensure that staff comply with these policies and procedures. The Inquiry is of the view that managers should tackle any lack of compliance with the utmost firmness. The Inquiry believes that managers should be expected to ensure that policies and procedures are followed, and that no one should be left in doubt that failure to comply with policies and procedures can (and will) lead to disciplinary action. The Inquiry has concluded, as a result of what it heard in evidence in Part 1 and has read in the NSPCC Report, that there is a casual attitude to policies such as recording, care planning and the like, all of which potentially undermine the safety and well-being of

[764] See chapter 30

children. This cannot be allowed to continue and it requires management action to ensure that it does not.

24.132 The Inquiry makes no recommendations at any stage of its report about disciplinary action to be taken at any level. That is a matter for Ministers and senior managers to decide. Nevertheless it is clear to the Inquiry that poor practice from top to bottom cannot be allowed to continue without redress. A determination to improve the performance of management and professioinal practice lies at the heart of the future of Children and Families services on the Island[765].

Supervision

24.133 Part 1 of the Inquiry has revealed a failure to adhere to the policy and practice of regular supervision of social work staff[766]. One consequence of this was that staff were left unsupported and isolated and that decision making was poor. The report of the Victoria Climbie Inquiry called supervision:

> "the corner stone of safe social work practice".

The Inquiry believes that steps must be taken to ensure that supervision takes place regularly and its quality is maintained. The Inquiry agrees with the submission that refresher training and supervision should be included among the training available for those in a management role.

Recommendation 32

The Inquiry recommends that the supervisory requirements of its management staff be reviewed and refresher courses be provided to them.

Recommendation 33

The Inquiry recommends that the implementation of supervision sessions in Social Services be monitored and monthly reports provided to the Assistant Directors.

24.134 The Inquiry is driven to conclude that in a number of significant areas senior management has proved, and contiues to prove, to be ineffective in providing care and support for young people with emotional and behavioural difficulties.

Work force reform

24.135 The recruitment of appropriately trained and qualified professionals in the public sector throughout the United Kingdom is a challenge to the education service, social services, health and the police service to name but a few. The Inquiry heard of specific problems of recruitment on the Island with regard to specialist health posts and more generally social work staff. The Island is said to have its own inherent difficulties in attracting suitably qualified staff from off-Island. The Director of Social Services in written evidence stated that within the current child care complement there was a shortfall of a further two social workers.

[765] The issue of leadership is addressed in chapter 30.
[766] Chapter 17

24.136 The shortage of social workers has a number of adverse consequences. Firstly, it contributes to delay in disposing of applications for care orders. Such delay is inimical to the welfare of those children and often adds to the difficulty of seeking to repair the damaged lives of emotionally and behaviourally damaged children. The effect of the shortage of social workers is magnified by the lack of proper contingency plans in the event of the all too frequent illness or moving on of staff.

24.137 Secondly, the Inquiry was told that such shortages led to senior social workers and others in management positions, having to undertake front line casework duties, thereby being unable to fulfil properly their management functions. This then impacts on their important role in supervision and reviewing of care plans.

24.138 Thirdly, in addition, social workers having to fill in for colleagues are less inclined towards proper record keeping and are more likely to postpone opportunities for training.

24.139 The Inquiry received written and oral evidence of the comparatively low thresholds of intervention by social workers. This means that staff were able to work with a lower level of problem or need than in other jurisdictions. In many respects, this is to be welcomed but if there are insufficient social work staff to provide an effective service to the most needy, then the balance and level of intervention should be reviewed so that work is focussed on those who are most in need.

Recommendation 34

The Inquiry recommends that the thresholds for intervening in families be reviewed with a view to focussing the resources of the division on those most in need and that the threshold for intervention should be agreed by the Island Child Protection Committee following consultation with appropriate professionals.

24.140 The Inquiry recognises the special circumstances and challenges of recruiting suitable staff on the Isle of Man. It is of vital importance that the service can recruit and retain its best staff. The quality of the service depends upon this. It believes that a strategy is required which lays out options for responding to this challenge. These could include higher pay, recruitment of graduate or other trainees, recruitment of more unqualified staff and increased secondment opportunities. The strategy should be drawn up in conjunction with the Government's Human Resources Department.

Recommendation 35

The Inquiry recommends that a Recruitment and Retention Strategy for staff be drawn up for those departments working with children and young people and their families.

24.141 The Inquiry was sympathetic to and acknowledged the pressures experienced by the child care social workers. The Inquiry was told that a failure to fill vacancies, as well as long term sickness of some staff, contributed to these pressures.

24.142 The Inquiry believes that the morale of the staff of any organisation is likely to be undermined by a failure to address staff shortages or staff shortfalls. It therefore welcomed the opportunity to meet some social work staff who were so committed and positive about their work.

24.143 The Inquiry welcomes the decision by the Director of Social Services to commission the NSPCC to assist the department, in the short term, with the assessment and

management of the significant backlog of unallocated cases. Whilst it is clear to the Inquiry that this exceptional step was based primarily on the shortage of social workers, the Inquiry believes that the department has some way to go in demonstrating it is an efficient department using its resources to the optimum levels.

24.144 The Inquiry has not made a recommendation to increase the number of social workers on the Isle of Man because it was told that social workers could not be recruited to existing vacancies. Instead the Inquiry has recommended that alternative ways be found to fill the existing complement of social workers, as well the examination of the eligibility criteria that managers use to allocate cases. When these recommendations have been implemented it should then be possible to re-evaluate the need for more social workers.

24.145 The Inquiry welcomed the recent requirement that new staff should register with the General Social Care Council and that existing staff should gradually do so. This is part of the process of improving and monitoring standards.

24.146 The Inquiry heard evidence that police checks on new staff working with vulnerable people was not a mandatory requirement of employment. It would be unwise to continue this practice and not establish whether future employees have criminal records and if so for what.

Recommendation 36

The Inquiry recommends that police checks be made on all new staff who are working with vulnerable people.

24.147 The Inquiry was told in Part 1 of the threats of violence and aggressive behaviour with which both field and residential staff were faced. The Inquiry has nothing but admiration for the courage that social workers show in continuing to fulfil their responsibilities in the face of such threatening and dangerous behaviour. The Inquiry believes as much support, assistance, training and where necessary counselling should be given to staff who are required to work in potentially dangerous and threatening situations. The Inquiry recognises that this also applies to staff in education, the police force, youth services and the health service.

Recommendation 37

The Inquiry recommends that a strategy be drawn up which provides training and support for staff who have to manage difficult, aggressive and threatening behaviour.

Inter-agency working: corporate parenting and co-operation between departments

24.148 The expression “corporate parenting” has been used on many occasions during the course of this Inquiry. Although understood by social services, it does not appear to be a concept which is well-known outside of the division. Corporate parenting requires all parts of Government to recognise their general responsibility for improving the well-being of looked after children, a group with poor outcomes. It requires an understanding that looked after children are not just the responsibility of social services. The Inquiry believes that the principle of corporate parenting is one that the Government should embrace and has made recommendations to this effect in chapter 30 below.

24.149 Effective inter-agency working is at the heart of achieving better outcomes for children and young people with behavioural and emotional difficulties. The introduction of the Safeguarding Children Inter-Agency Review Group is an important recent intitiative and it must be sustained. There are some examples of successful inter-agency working, but not enough. The Inquiry has recommended in chapter 30 that legislation is introduced to place a statutory duty on all departments of Government to co-operate with each other in safeguarding and promoting the interests of looked after children and in delivering the outcomes for all children identified in the Children and Young People's Strategy.

The voice of children and young people

24.150 The Inquiry has been told that prior to the Children and Young People's Strategy being completed, a number of events were held that were designed to draw on the views of children and young people. Useful material was recorded which is now part of the Children and Young People's Strategy. The Inquiry was told that there was, until recently, a Young People's Council in Douglas although this appears to have atrophied and is no longer active.

24.151 The Inquiry heard evidence from a range of young people at their own seminar, which is discussed in chapter 29.

24.152 The Inquiry heard from one looked after young person that a member of staff from social services is visiting all looked after children to enquire as to their well-being. This clearly impressed the young person.

24.153 The Inquiry heard evidence about school councils and their usefulness and limitations; and in chapter 25, the Inquiry refers to the need for the Health Division to find ways of consulting young people, including those with behavioural and emotional difficulties.

24.154 The Inquiry appreciates it is not easy to set up structures which are sufficiently responsible and flexible to young people, particularly in the light of a changing population. Nevertheless, whilst there have been some commendable individual attempts to establish consultation with children and young people, including within the Children and Young People's Strategy, the Inquiry believes that further work is required to establish a framework for hearing the views of children and young people, particularly those with emotional and behavioural difficulties on the issues about which they are concerned.

24.155 It is necessary that children and young people should be consulted about any matters which concern them. This means that it should be accepted in every relevant department of Government that children's views should be sought and listened to. It does not mean that their views should always prevail but their views should play a part in the decision making process.

24.156 Looked after children can need particular encouragement in expressing their views about issues that are relevant to them. The Inquiry recommends that the Director of Social Services ensures that there are proper arrangements in place to enable children and young people who are looked after to express their views. It is equally important for the Director, senior officers and relevant politicians to ensure that they personally meet with these young people and hear their views from them directly. In respect, the Inquiry welcomes the proposals in the Children and Young People's Strategy that members of the Chief Ministers Strategy Committee and of the Children and Young People's Delivery Group meet with young people.

Recommendation 38

The Inquiry recommends that the Director of Social Services sets up proper arrangements to consult and hear the views of children and young people who are looked after children.

Recommendation 39

The Inquiry recommends that an annual programme of visits should be arranged for the appropriate Members and Minister to visit children and young people who are looked after children.

Recommendations in chapter 24:

Recommendation 1 **para 24.21**

The Inquiry recommends that the Chief Minister requires that a report be submitted to him by officials addressing the issue of performance management in all departments involved with young people with emotional and behavioural difficulties and addressing the training and support required to develop and sustain it.

Recommendation 2 **para 24.25**

The Inquiry recommends that the Chief Executive of the Department of Health and Social Security and the Director of Social Services jointly review and determine the key performance indicators against which the effectiveness of the Social Services Division should be measured and determine the frequency with which they are monitored.

Recommendation 3 **para 24.25**

The Inquiry recommends that key performance indicators are regularly sent to and reviewed by the Chief Executive of the DHSS, the Director of Social Services and by the Minister of DHSS and the member for the Social Services Division so that they can assess measures of effectiveness and efficiency.

Recommendation 4 **para 24.30**

The Inquiry recommends that the Department invite an external and independent government body to inspect the Social Services Division.

Recommendation 5 **para 24.30**

The Inquiry recommends that all inspection Reports are published and publicised so that children, young people and their families and the wider public are properly informed of the results.

Recommendation 6 **para 24.39**

The Inquiry recommends that Service Level Agreements between the Division and providers continue to be reviewed in order to ensure that the providers' performance in terms of outcomes for children and young people can be measured.

Recommendation 7 **para 24.39**

The Inquiry recommends that the Division seeks advice from other social service authorities in other jurisdictions in order to share advances in learning in the commissioning and monitoring of services.

Recommendation 8 **para 24.49**

The Inquiry recommends that an accommodation strategy for looked after children, to include foster care, kinship care, residential, secure care and after care, be drawn up with unit costs and a costed implementation plan, so as to increase the proportion of children living in foster care and kinship care.

Recommendation 9 **para 24.53**

The Inquiry recommends that a residential strategy should be drawn up listing the purpose and function of its residential homes and residential provision.

Recommendation 10 **para 24.59**

The Inquiry recommends that primary legislation is changed to ensure small homes are made subject to the same regulatory and enforcement requirements as "children's homes".

Recommendation 11 **para24.66**

The Inquiry recommends that the Minister for the DHSS require that the Report of the review being undertaken by the Bordesley Institute and the Special Inquiry Report are submitted and considered by him and the Member for Social Services when each is completed.

Recommendation 12 **para 24.75**

The Inquiry recommends that the role and use of the Secure Unit and its staff be reviewed as quickly as possible by the Director of Social Services in conjunction with other appropriate agencies with a view to ensuring that it is being used efficiently and effectively and that a report be submitted to the Social Policy Committee.

Recommendation 13 **para 24.81**

The Inquiry recommends that the housing needs of children and young people with emotional and behavioural problems must be clearly stated and met in the Review of Public Sector Housing.

Recommendation 14 **para 24.84**

The Inquiry recommends that the Director of Social Services draws up a strategy for the after care for looked after children with particular attention being given to the transitional arrangements of young people from children's to adults' services.

Recommendation 15 **para 24.87**

The Inquiry recommends that a Common Assessment Framework is adopted by all relevant agencies, a fully costed implementation plan is submitted to the ICPC and a multi-agency training programme is established.

Recommendation 16 **para 24.90**

The Inquiry recommends that the current Integrated Children's System be properly costed before being submitted to Ministers for approval.

Recommendation 17 **para 24.96**

The Inquiry recommends that an administrative system is set up to ensure that reviews are conducted at the statutorily required frequencies and that they be undertaken by independent Reviewing Officers or by managers not responsible for the case.

Recommendation 18 **para 24.96**

The Inquiry recommends that senior managers are supplied, on a monthly basis, with a list of completed and uncompleted reviews of looked after children and children on the child protection register.

Recommendation 19 **para 24.97**

The Inquiry recommends that all departments' documents be signed and dated.

Recommendation 20 **para 24.97**

The Inquiry recommends that every case file have an up to date chronology which is maintained regularly.

Recommendation 21 **para 24.97**

The Inquiry recommends that monthly spot audits be conducted on records and record keeping and the results reported to the Director of Social Services.

Recommendation 22 **para 24.102**

The Inquiry recommends that access to the Child Protection Register be immediately reviewed and immediate access given to a named person in the Accident and Emergency Department; and that other departments should identify named individuals who can access the Register.

Recommendation 23 **para 24.105**

The Inquiry recommends that all schools have the same policies and procedures for referring Children in Need to Social Services.

Recommendation 24 **para 24.105**

The Inquiry recommends that named social workers should be established as link officers to secondary schools.

Recommendation 25 **para 24.105**

The Inquiry recommends that the Island Child Protection Committee reviews and relaunches its procedural guidance and ensures there is a proper implementation plan established, with a requirement that all relevant staff attend multi-agency training.

Recommendation 26 **para 24.107**

The Inquiry recommends that training an information sessions on the implications, policy and practice of Multi Agency Public Protection Panels be arranged.

Recommendation 27 **para 24.108**

The Inquiry recommends that the ICPC establish a sub-committee to examine the implications of replacing the ICPC by a Safeguarding Board.

Recommendation 28 **para 24.110**

The Inquiry recommends that the political and officer accountability for child protection be individually established.

Recommendation 29 **para 24.110**

The Inquiry recommends that primary legislation place the Island Child Protection Committee on a statutory basis.

Recommendation 30 **para 24.113**

The Inquiry recommends that a proposal be drawn up which identifies how the "outcomes" of the Strategy will be monitored and reviewed at a senior officer level and on an inter-departmental basis.

Recommendation 31 **para 24.119**

The Inquiry recommends that the ICPC approves the annual training plan and monitors and reviews the take up of the training being provided.

Recommendation 32 **para 24.133**

The Inquiry recommends that the supervisory requirements of its management staff be reviewed and refresher courses be provided to them.

Recommendation 33 **para 24.133**

The Inquiry recommends that the implementation of supervision sessions in Social Services be monitored and monthly reports provided to the Assistant Directors.

Recommendation 34 **para 24.139**

The Inquiry recommends that the thresholds for intervening in families be reviewed with a view to focussing the resources of the Division on those most in need and that the threshold for intervention should be agreed by the Island Child Protection Committee following consultation with appropriate professionals.

Recommendation 35 **para 24.140**

The Inquiry recommends that a Recruitment and Retention Strategy for staff be drawn up for those departments working with children and young people and their families.

Recommendation 36 **para 24.146**

The Inquiry recommends that police checks be made on all new staff who are working with vulnerable people.

Recommendation 37 **para 24.147**

The Inquiry recommends that a strategy be drawn up which provides training and support for staff who have to manage difficult, aggressive and threatening behaviour.

Recommendation 38 **para 24.156**

The Inquiry recommends that the Director of Social Services sets up proper arrangements to consult and hear the views of children and young people who are looked after children.

Recommendation 39 **para 24.156**

The Inquiry recommends that an annual programme of visits should be arranged for the appropriate Members and Minister to visit children and young people who are looked after children.

CHAPTER 25

HEALTH OF CHILDREN AND YOUNG PEOPLE WITH EMOTIONAL AND BEHAVIOURAL PROBLEMS

Introduction

25.1 In assessing the effectiveness of young people with emotional and behavioural problems, the Inquiry has taken account of a range of health factors. These include physical health, emotional and sexual health, mental health, dental health and health issues that are affected by substance misuse and poor nutrition.

25.2 The Health Strategy (2002) correctly concluded that the Health Service alone could not deliver good health to the Island and it set out an ambitious plan to deliver better health to its patients and residents. In the Seminar on Health, through the written submissions to the Inquiry and in other evidence, it has become clear that despite some good policies, the failure to carry out key parts of the Health Strategy has resulted in an overall failure to deliver its general objectives and specific targets.

25.3 The lack of relevant data, standards, performance indicators and monitoring of children's services in general, has made it difficult for politicians and senior officers to use evidence and data in making informed decisions.

25.4 Specific initiatives such as the Drugs and Alcohol Strategy, provided that implementation is managed successfully, are a model of an inter-agency approach to policy making. The Inquiry believes that the new leadership of the Health Division is committed to new integrated ways of working, but the Health Service has some way to go before it can be seen to have a co-ordinated and strategic service for improving the health of children and young people with emotional and behavioural difficulties.

Policy

Health Strategy

25.5 In 2002, the Health Service produced "A Strategy of the Health of the Isle of Man", which was approved by Tynwald. Services for children and young people were identified and targets set. The strategic objective was stated to be "to provide the best possible life chances for children and young people on the Island".

25.6 This was to be achieved by:-

1. Improving the health of families and young people
2. Maintaining the health of well children
3. Improving support for children and adolescents with special needs
4. Tackling substance misuse problems
5. Ensuring the effective provision of vaccination and immunisation programmes, and
6. Developing oral health by pursuing the National Oral Health Strategy.

25.7 In addition, the Strategy aimed to refocus Health, Education and Social Services policies and sought to meet the local need to reduce teenage pregnancies and address the needs of teenage parents.

25.8 Specific targets were set. These included:-

- To reduce the infant mortality rate (a three year rolling average) in the Isle of Man by 25% by 2015
- To reduce the DMF in 5 year olds by 25% by 2015 (DMF score is the average number of teeth of a 5 year old which have decayed, were missing or filled)
- To achieve a 25% reduction in teenage pregnancy rate by 2006, and
- To reduce the sickness absence rate amongst school children aged 5-14 by 25% by 2015

25.9 The Health Strategy as it relates to children and young people is to be welcomed. The Inquiry is impressed by the Strategy and believes that is a sound basis for the future. However, the Inquiry learned the Strategy is not being systematically implemented. What the Inquiry would have expected to have seen was an implementation plan, including a financial plan, for the Strategy. Instead, individual elements of individual strategies appear without obvious reference to the overall framework of the original Strategy.

Recommendation 40

The Inquiry recommends that the Health Strategy (2002) is reviewed, updated and resubmitted to the Social Policy Committee with a costed implementation plan.

25.10 Although the Strategy emphasised that its success depended on the contributions of other Government departments and gave useful examples of how this could be achieved, the Inquiry was concerned that other departments were not giving the Health Strategy the priority it required, nor were they working together as they should. An example of this was that the Department of Education and the Department of Health were each developing an Early Years agenda, without reference to each other or indeed to any other Government or non-governmental agency.

25.11 The Inquiry believes that the Health Strategy is another example of a sensible way forward being prepared without the rigour of an effective implementation plan or the discipline of regular monitoring to determine its effectiveness.

Health Services

25.12 The Health Division is part of the Department of Health and Social Security (DHSS) and is led by the Director of Health Strategy and Performance. He in turn, reports to the member for Health and the Chief Executive of the Department of DHSS. The member is responsible to the Minister, Stephen Rodan MHK.

25.13 The Health Division is responsible for the full range of health services on the Isle of Man.

25.14 Children with emotional and behavioural difficulties require both routine, universal health services and specialist services that can support them in meeting their particular needs. These include Child and Adolescent Mental Health Services,

Educational Psychology Services or Social Services. The Inquiry heard that young people with special needs find it difficult to access universal health services through lack of confidence, alienation to formal services, or for other reasons.

25.15 Health Service specialist staff are very much involved with children with special needs usually as part of multi-disciplinary teams. In particular, Health Services provide the following support for children with emotional and behavioural problems:-

- Designated Nurse for Safeguarding
- Health Worker for looked after children
- School Nurse for Children with Special Needs
- Services for young people in prison via contact with a GP Practice
- Paediatric Liaison Service
- Universal Services including Primary Care Services, Secondary Care, School Nursing and Health Visiting.

25.16 There is also a service provided to prevent teenage pregnancy and to improve sexual health. Both the Health Strategy (2002) and the Children and Young People's Strategy (2005-2010) give high priority to public health indicators such as smoking, sexually transmitted infections and teenage pregnancy.

25.17 The Department of Health and Department of Education funded a full time post, the Tobacco and Sexual Health Co-ordinator, on a two-year contract, which expired in April 2005. The post and funding were reviewed and extended for a further three years until 2008. The Inquiry welcomes this decision as it recognises that the significant levels of teenage pregnancies and sexually transmitted infections needs to be addressed as a priority.

25.18 The Drugs and Alcohol Strategy is of a great significance for a number of reasons. Firstly, it recognises the seriousness of the abuse of drugs and alcohol by young people on the Isle of Man, a fact that was confirmed during Part 1 of this Inquiry. Young people and professionals told the Inquiry about the easy access that young people had to drugs and alcohol. Professionals from education, police, health, social services and the youth service all faced the implications of young people abusing drugs and alcohol and there was an urgent need to co-ordinate their responses.

25.19 The Inquiry had been impressed in Part 1 by the evidence of Dr Kirsten Wafer, of the Drugs and Alcohol Team, in which she frankly described the slow beginnings of her team's response to the needs of young people[767]. She told the Inquiry that the use of the service for young people under 18 years had increased from 3% to around 18% and described the service for young people as a "developing one".

25.20 A second point of significance is that the committee responsible for drawing up the Drugs and Alcohol Strategy, chaired by the Chief Minister, required all relevant departments to plan together, fund together and deliver together. In many ways, this provided a model of a properly integrated strategy across Government.

25.21 The Drugs and Alcohol Strategy now has one worker who dedicates 15 hours per week to treatment provision and service development for children. Although a good start, more resources and co-ordination are required to further develop the Drug and Alcohol Strategy and the Team.

[767] See chapter 14

25.22 The Public Health and Health Promotion Service is located within the Health Division. Other services relevant to the special needs of young people are commissioned from voluntary organisations such as the Alcohol Advisory Service.

Management

25.23 The Inquiry was informed that management consultants (Tribal Consultants) had reviewed the management arrangements in the Health Division, following the retirement of the previous Director. It had recommended that the new job title reflect an increased emphasis on strategy and performance and reduced role in operational, day to day management.

25.24 The Inquiry welcomes the new role for the Director of the Health Strategy and Performance and believes it will lead to a fresh examination of services for children with emotional and behavioural difficulties. The Inquiry also welcomes the approach of the newly appointed Director, Norman McGregor Edwards, which reflected his understanding of the importance of the contribution that the Health Division could make in supporting the well-being of this group of young people.

National Service Framework

25.25 The Inquiry could see no evidence of the DHSS having formally committed itself to the approach of using National Service Frameworks. Although the intent to borrow and appropriately apply the United Kingdom National Service Frameworks was proposed in the Health Strategy, this has not been implemented. Had it been implemented, it would have provided a framework against which quality of services and care could be evaluated. The absence of these standards means that staff, politicians and the public have great difficulty in determining the effectiveness of their health services.

Public Health Policy

25.26 The Health Strategy analyses the factors that contribute to ill health and sets them out in a clear and accessible manner. However, since 2002, the Inquiry - supported by the evidence of Dr Paul Emmerson, Consultant Public Health Physician – has concluded that there appears to have been little progress in obtaining "population data" on the public health of the residents of the Isle of Man. Without an investment in the collection of data it is all but impossible to make a co-ordinated and prioritised plan to improve the health of residents who may be at risk. In particular, identifying areas of high need is essential for a strategic approach to health improvement.

25.27 It is therefore difficult, in the absence of data or monitoring, for the Inquiry to determine any level of service effectiveness in the public health arena. The Inquiry regrets this as the Health Strategy lays out what it considers is an informed analysis of what is required to overcome the inequalities in health in the resident population.

Performance Management

Health Data

25.28 The Inquiry asked for and received evidence of information that was routinely reviewed by the Senior Management Team of the Health Division. This information related mostly to what was happening in secondary care, that is within what can broadly be described as a hospital setting. The information was mostly quantitative rather than qualitative [768]. The Senior Management Team receives monthly performance data from the secondary care sector. This includes information from the Women's and Children's Directorate regarding occupancy rates on paediatric wards, as well as financial monitoring of expenditure on paediatrics.

25.29 In the periods examined by the Inquiry (1st April 2004 to the 31st August 2004) there was an average of 31% occupancy in the paediatric wards. The Inquiry was not able to determine whether this level of occupancy was a matter of concern for the senior management team and if so what action was taken to use the available surplus resources. Whilst the Inquiry understands that this is only a snapshot of the occupancy levels, which may ebb and flow, nonetheless in assessing effectiveness and performance, it does raise the question as to whether these resources are being used as effectively as possible. The Inquiry has in mind that these highly trained staff could play a role in supporting, for example, young families in other settings, if there was an insufficient demand for their expertise on the wards. The Inquiry therefore raises the possibility of a new flexible workforce being developed not only in Health, but also in other departments.

25.30 Whilst this would require the production of a carefully thought out workforce strategy, it would start to recognise the overlap in skills, training and delivery of services by staff working across the children's sector.

25.31 Monthly performance data is received about certain areas of primary care by the senior management team. However, this does not appear to include any data on the following areas: child protection, children's accidents, teenage pregnancy, sexual health, child and adolescent mental health or children's dental health. In addition, information and data does not seem to be collated on a regional basis, in other words, there appears to be an absence of comparative data between different parts of the Island. Even if data does exist, it is not being monitored or evaluated on a routine basis.

25.32 There have been recent health surveys completed which indicates that some groups of children on the Isle of Man are less healthy, both physically and mentally, than their United Kingdom counterparts. The Inquiry was told however, that this information is neither routinely collected nor evaluated. In particular, geographically based information of the health status of children and young people would be particularly helpful in developing strategic preventative plans and this is currently not available in this form. In some of these areas, the Inquiry has heard that the information is not available in a form that would be useful to the Health Service. The absence of a "population needs" analysis discourages an approach which is based on need rather than on existing provision. It also disadvantages those who wish to bring a strategic patient-led approach to services

[768] See also chapter 24

25.33 The Inquiry welcomes the fact that such performance data that exists is submitted to the Minister, Member and Chief Executive on a monthly basis, but re-emphasises that without any information being submitted on children's and young people's health, then inevitably the focus of all those accountable for public health on the Isle of Man will be on ill health and secondary care, rather than on primary care and public health measures[769].

25.34 The Inquiry recognises that health data has also been submitted to the Chief Minister's Children and Young People's Strategy Committee. However, regular oversight and monitoring of appropriate data by both politicians and officials is essential. At present such oversight and monitoring is insufficient.

Recommendation 41

The Inquiry recommends that the Director of Health Strategy and Performance regularly reviews, monitors and takes appropriate action on data relating to child protection, teenage pregnancy, dental health, sexual health and young people who misuse drugs and alcohol.

25.35 The Inquiry believes that keeping staff and the public informed about the improvements in the health of the residents of the Isle of Man is a useful way forward. It not only gives factual information on a regular basis of what is being done to improve health on a range of issues, but by doing so it will encourage the public to take action themselves to improve the health of themselves and their families. The Inquiry proposes that the Health Division considers publishing a "report card" on the health of the children on the Island on a regular, annual or bi-annual basis.

Recommendation 42

The Inquiry recommends that the Health Division considers producing a report on children's health on an annual or bi-annual basis which would be made available to the public and health staff.

External Inspection

25.36 The Inquiry was told of a number of ad hoc external inspections of specific areas within the Health Service which include a recent management consultant's report (Tribal) that focused on the management arrangements for the Health Division, an inspection of the paediatric ward in 2004, and an announcement of a review and inspection of Nobles Hospital in October 2005. However, the Inquiry could see no evidence of a programme of regular external inspections of health services.

25.37 The Inquiry has welcomed the increased emphasis that has been placed on the need for strategic development in the Health Division, a recommendation that has now been implemented by the appointment of the new Director for Health Strategy and Performance whose remit is, as the title suggests, strategy and performance.

25.38 However, the assessment of health services available to patients generally, and children and young people in particular, needs regular external validation and comparison with other similar health organisations to ensure that the quality of

[769] As to the need for joint key performance indicators, see chapter 26, para 26.19

services are appropriately maintained and delivered. The Inquiry is mindful that its terms of reference relate to children and young people with emotional and behavioural problems. It therefore has framed its recommendations specifically in relation to that group of children; however it also recognises that within a universal service it is necessary to look at the health needs of all children and young people to determine the effectiveness of a specific group of young people. The recommendation therefore has been drawn up in a general way to enable it to focus on this in particular.

Recommendation 43

The Inquiry recommends that the Health Service invites external inspections of the health services on at least a three-year basis to evaluate the services that are being provided on the Isle of Man for children and young people, particularly those who have emotional and behavioural problems.

Monitoring by other agencies of health outcomes

25.39 As important as it is for the Health Division to take the lead in identifying and monitoring key health outcomes for children and young people, it is equally important for other services to be aware of these outcomes and how they can contribute to them.

25.40 In particular, the Inquiry would have expected to have seen evidence of social services monitoring the health outcomes of looked after children on a regular basis. The Health Division have funded a half time post which is designed to ensure that looked after children receive medical checks at appropriate intervals. The Inquiry welcomes the introduction of this post. The health of looked after children is an important issue, but where children have multiple moves of placement, moves away from their home area or have had little priority placed on health, it is easy to lose sight of the many large and small health issues that effect all children and young people. This post ensures that children are properly registered with a family practitioner and where appropriate medically reviewed on a regular basis. There is a Service Level Agreement that supports the post and which sets out the requirements of the post holder.

25.41 However, without a regular system of reporting and scrutiny at officer and political levels it is difficult to envisage how the health of looked after children can be assessed and, where necessary, appropriate action taken. The Inquiry was not told that any such scrutiny takes place.

Recommendation 44

The Inquiry recommends that the Social Services Management Team and the Minister and Member for Social Services regularly consider the health data of looked after children and take appropriate action where necessary.

25.42 Similarly, the Inquiry would have expected to have seen evidence that schools and the Department of Education were aware of and monitored the health of school age children.

Recommendation 45

The Inquiry recommends that the Senior Management Team of the Department of Education, Member and Minister regularly consider the health data of school age children and take appropriate action where necessary.

25.43 The Inquiry could find no evidence to suggest that an Island-wide "healthy schools" programme had been put in place. Without it, it is difficult to see how schools or the Department of Education could contribute in a systematic and co-ordinated way to the improvement of child health in schools.

25.44 The Inquiry heard evidence from the Young People's Seminar about the different steps schools were taking to introduce healthy eating. Although the Inquiry supports the implementation of strategies being undertaken in the way most appropriate to the school's individual requirements and skills, it could not identify a centrally co-ordinated healthy schools initiative, which had been politically approved and where targets had been set. A 'healthy schools' policy is a way in which a range of health inequalities can start to be overcome.

25.45 Without the framework of a national strategy for child health the many excellent projects that relate to health run the risk of developing in a piecemeal way, without the co-ordination and focus that is required to achieve change. It also runs the risk of not using resources to their best effect since overlaps in provision or a lack of knowledge about what other services can provide inevitably occur.

25.46 The Inquiry heard evidence during the Health seminar of this occurring in relation to the promotion of sexual health. Schools follow different policies and practices in giving information to young people on sexual health and family planning.

25.47 School nurses also contribute to children's health in schools, but more consistency and sensible guidance on their roles needs to be established across all schools.

Recommendations 46

The Inquiry recommends that the Department of Education and schools agree clear minimum standards for schools to follow in providing information on sexual health, including information on the availability and access to contraception, and on substance misuse.

Recommendation 47

The Inquiry recommends that the Department of Education and Health Division set out the duties, roles and responsibilities of school nurses, generally and in relation to children and young people with emotional and behavioural difficulties.

Recommendation 48

The Inquiry recommends that the Department of Education draws up a "Healthy Schools" policy and implements it consistently in all the Island's schools.

Inter-agency working: corporate parenting and co-operation between departments

Corporate parenting

25.48 The notions of the corporate parent and corporate responsibility requires a range of services to accept their responsibilities for improving the five outcomes identified in the Chief Minister's Children and Young People's Strategy. This means that services, other than health, should regularly monitor health outcomes and identify what action could be taken by their own department to improve a health outcome.

25.49 The notion of corporate parent is not well known throughout the Health Division. The Inquiry heard from a number of seminar participants, including a general practitioner, health visitor and school nurse, that they were unaware of the term.

25.50 Whilst it is true that the concept is not enshrined in legislation, it is increasingly being adopted in the UK as an approach which gives corporate responsibility for the welfare of looked after children to all departments. It therefore requires other departments to assist and support the Health Division in delivering effective services which promote the health of looked after children.

25.51 It is a concern to the Inquiry that the concept of corporate parenting has not been discussed or cascaded down the Health Service.

25.52 A regular consideration of the Island Child Protection Committee minutes and action points should be undertaken by senior managers in the Health Division. As the new wider safeguarding agenda is implemented, the safety of children will extend to children involved in accidents in the home and in the street, and bullying as well as the specific categories of emotional physical and sexual abuse and neglect of children. It is likely that the work of family practitioners, health visitors, A&E and paediatric nurses and doctors will be improved by this child protection data being available to them and their managers. At the very least, it will enable them to be aware of the demand for their services and to monitor the effectiveness of their services in relation to children with emotional and behavioural problems.

25.53 Whilst the Health Division is not alone in failing to monitor child protection data at senior level, until there is agreement that specific key outcomes are a corporate responsibility, child protection in its broadest sense on the Island will not be as co-ordinated or effective as it could be.

Co-operation between departments

25.54 The Health Division's contribution to integrated inter agency working has been impressive. The Inquiry was impressed that the Health Division had funded and appointed a safeguarding nurse to lead on child protection matters as well as fund the other half of the post (health adviser for looked after children) to promote the health of looked after children. In addition, the Health Division had funded a half time health post to work in the Youth Justice Team. The Inquiry was also told that a second paediatrician had been appointed for child protection and safeguarding. He is responsible, together with the designated safeguarding nurse, for producing relevant safeguarding strategies and policies.

25.55 The Inquiry heard from the new Director for Health Strategy and Performance about some of the factors he believed contributed to effective inter-agency working. He advocated the pooling or merging of budgets, or the parts of budgets, where

departmental responsibilities coincided or overlapped. He supported the co-location of staff from different agencies in appropriate circumstances, but stressed it was principally a joint determination by the Heads of Service to make joint, integrated working successful that was at the heart of successful change.

25.56 There are some examples where inter-agency working has been insufficiently effective. The Inquiry was told at the Health seminar that many health workers do not have access to policies relating to looked after children, which disadvantages the staff in their understanding of the specialist services these children require.

25.57 Another example is that although the paediatric consultant was aware of the named social worker from Social Services who regularly visits the paediatric ward, there is no named social worker for similar liaison purposes for the Accident and Emergency Unit.

25.58 The Inquiry believes that there are a number of other areas where health input to the outcomes identified in the Children and Young People's Strategy (such as safeguarding, prevention or enjoying and achieving) or where the input by other agencies to the health outcomes could be improved by developing joint working. These could include the Intake and Assessment Team, currently located within and staffed solely by Social Services, an Integrated Safeguarding Team, the Paediatric Service and the Therapeutic Care and Child and Adolescent Mental Health Teams.

25.59 The Inquiry believes inter-agency working, including pooling of budgets and co-location of multi-agency staff, is likely to be helpful in producing outcomes sought for children with multiple needs.

Recommendation 49

The Inquiry recommends that no proposal is submitted to the Children's and Young People's Strategy Committee or the Social Policy Committee, unless it includes a consideration of whether staff from different departments should be co-located or whether budgets should be pooled.

Listening to children

25.60 At the Young People's Seminar, the Inquiry was told that many agencies, including Health, did not seek out the views of young people about how services might be developed.

25.61 The Inquiry concluded that young people felt stigmatised by the way some services were delivered to them and by the fact that their parents' views were often sought on their health issues and not their own. The Inquiry believes that the effectiveness of the Health Service in relation to children's services can be improved by establishing a system for listening to young people about their views of the effectiveness of the services they receive. The Inquiry does not underestimate the difficulties for those seeking out the views of children and young people with behavioural and emotional difficulties, but nonetheless believe it is important and essential to do so.

Recommendation 50

The Inquiry recommends that the Health Service establish a system for listening to the views of children and young people on the effectiveness of the services they use and in particular those services for young people with emotional and behavioural difficulties.

Information sharing

25.62 The Inquiry heard evidence about the recently introduced Information Sharing Protocol. It has already expressed its concern at the wide range of staff, including senior staff in some departments, who were not aware of the existence of the Protocol.

25.63 In the chapter on Strategic Issues, the Inquiry has recommended that Chief Officers produce an Information Sharing Protocol implementation plan and require all relevant staff to attend the information and training events being provided. Where possible the Inquiry believes these events should be provided on a multi-agency basis.

25.64 The success of the Information Sharing Protocol will depend on the determination of managers in each department to ensue that staff understand and implement the Protocol. A failure to ensure staff attend the training and information events will undermine the aim to improve communication between staff in different agencies at all levels.

25.65 Many staff in the Social Services Division and the Department of Education have their own e-mail addresses on the Government system, but the Inquiry was told that this was not the case for health visitors and family practitioners. Inter-agency working and independent sharing is made easier by use of modern integrated communication systems. It is important for health professionals and other agencies to communicate easily with each other.

Recommendation 51

The Inquiry recommends that the Health Division review the IT requirements of its staff and in particular health visitors and family practitioners in order to be able to send and receive information through the Government IT network.

Child and adolescent mental health

Child and Adolescent Mental Health Team

25.66 The establishment of the Child and Adolescent Mental Health Team is widely considered to be a successful initiative, albeit that the cut off age of 16 years is regretted by all concerned. This is as a result of a shortage of resources. All the evidence suggests that despite the unsuitable location, the staff have tried to be responsive to the mental health needs of young people up to 16 years of age.

25.67 The Inquiry heard evidence that there are sixty young people waiting to be seen who will wait for an average of six weeks before assessment by a member of the CAMHS team. The longest that young people have to wait is three months. The Inquiry was told that over the last four years there has been an increase in the referral rate of 42%.

25.68 The location of the CAMHS Team at Nobles Hospital was a matter of concern as it is difficult to access and could be associated with other adult mental health services. The Inquiry were impressed by the efforts that staff took to see young people in different places around the Island but were concerned to hear that most of these locations were unsuitable for young people.

25.69 The Inquiry heard evidence at the Health seminar of the development of the CAMHS team over the last five years. Initially, it only consisted of a consultant psychiatrist and a community psychiatric nurse. The written evidence submitted by Dr Warren Levine, Consultant Child and Adolescent Psychiatrist, and his team laid out its vision for the next five to ten years, which was to provide a service for 0-18 year olds. It was argued that to extend the service would require a further twelve staff. The current service is under significant pressure and there is currently a twelve week delay from referral to an initial appointment for assessment.

25.70 The Inquiry heard that looked after children are five times more likely to have mental health disorders than their peers. The head of the Careers Service emphasised the lack of continuity of care that arose from CAMHS not treating young people over the age of 16 years and the impact on their ability to find and then remain in occupation.

25.71 The Inquiry was impressed with what they heard and read about the CAMHS services. It is a service which, like many others, has a greater demand for its services than it can meet. Dr Levine told the Inquiry that the CAMHS service is drawn into too low level work and it may be that drawing clearer lines of accountability for accessing it services, could allow it to focus on children and young people with the most serious mental health problems.

25.72 However, the Inquiry is clear that it is not acceptable for children and young people up to 16 years and those over 18 years to receive a mental health service, but for no service to be provided for those relatively small members of young people aged 16-18. The Inquiry accepts that the current CAMHS team will need an increase in staff to cope with this extra age group, but is sceptical that it would need an extra twelve staff to do so. It recommends that this figure is reviewed.

Others who provide mental health and therapeutic provision for young people

25.73 The Inquiry heard the Assistant Director and a team manager from social services meet on a monthly basis to assess the therapeutic needs of looked after children. The Inquiry welcomes both the formation of this group and also that it considers the needs of newly looked after children and reviews their needs on a six monthly basis.

25.74 The Inquiry makes no recommendations about this group but it hopes that the links between and roles of the group and CAMHS will continue to grow, to ensure that scarce and valuable resources are appropriately allocated.

25.75 The Inquiry was told that part of the remit of the Children and Families Support Team included the provision of therapeutic work with children and young people. Since the formation of this team in 1999, a variety of interventions have been provided by the team. In 2004 a therapist was appointed as a joint member of this team and CAMHS, with a specific remit to consider the emotional needs of looked after children. The Inquiry welcomed both the creation of the post as well as the fact that it is joint funded.

25.76 The Inquiry has noted the submission from the Chair of the Youth Counselling Committee and believes that the therapeutic needs of the looked after children Group should consider the extent to which use can be made of the counselling services provided by voluntary organisations.

25.77 Although his submissions deals primarily with a counselling service for all children, the Inquiry nevertheless believes that it might have resources for looked after children as well as a possible referral service for children and young people for whom CAMHS is unable to provide a service.

25.78 In short, the Inquiry believes that all those concerned with offering counselling to children and young people need to work together to ensure that each of their services is aware of what the other has to offer.

Recommendation 52

The Inquiry recommends that the Child and Adolescent Mental Health Team be incrementally funded over the next 5 years so that it can provide for children and young people up to 18 years.

Recommendation 53

The Inquiry recommends that the location of the Child and Adolescent Mental Health Team is reviewed so as to give young people easier access to its services.

Sexual Health

25.79 The Inquiry welcomes the continuation in funding of the Tobacco and Sexual Health Co-ordinator post. Conversely, the Inquiry has been told that the Sexual Health Strategy (2002) has no additional funding. Inevitably this means the effectiveness of attempts to safeguard sexual health of its young people is seriously compromised. In particular, the Inquiry notes the evidence stating that attempts to provide adequate and consistent sexual health information to school children has been limited by the lack of resources.

25.80 This is another example of a strategy being approved without a financial plan being attached to the implementation plan.

25.81 In addition, the Inquiry heard that the successful implementation of the Sexual Health Strategy relied on all services giving sufficient priority to this policy. Because of other internal priorities, this had not happened.

25.82 Concern was expressed at the high incidence of syphilis, chlamydia and teenage pregnancy which were similar to, though slightly higher than, UK rates. The Inquiry was told of a lack of consistency of the promotion of sexual health initiatives across the Isle of Man. In a survey conducted by Public Health about half of school children aged 14 and 15 were not aware of condoms.

25.83 The Inquiry heard evidence that all the children from 11 years of age have a minimum of 50 minutes per week on personal and social education. This was thought by the participants at the Health seminar to be too little.

25.84 The Inquiry was told that young people have difficulty accessing services, and in particular that the GUM Clinic (Genito-Urinary Medical Clinic) was too difficult to access for family planning purposes. There was concern expressed by some at the Health Seminar that schools were not allowed to install condom machines. One attendee stated that she believed there had been a decline in the provision of family planning advice over the last ten years.

25.85 The Inquiry was impressed by evidence from the external expert, Elaine Sage, Assistant Director of Service Provision and lead for Children's Services, Knowlsey Primary Care Trust. She emphasised that specific shared targets, the involvement of young people, one referral process, free condoms being provided through youth services and other appropriate services and targeted provision and advice on those that needed it most, were all essentials to a successful teenage pregnancy policy. She said that it was a range of solutions that would make a difference not just one approach.

25.86 The Inquiry also heard evidence at the Strategy seminar of the different views of politicians in relation to "safe sex" and how far condoms should be made available to young people. The Inquiry has concluded that there needs to be a further discussion at political and official levels in order to clarify the policy on sexual health and create a properly costed implementation plan. Given the importance of school in a young person's life, the Department of Education must be involved in such discussion.

Recommendation 54

The Inquiry recommends that the Sexual Health Strategy is reviewed by the Health Division, in conjunction with the Department of Education and all other appropriate parties, and a properly costed implementation plan is drawn up, agreed and put before the Social Policy Committee for its consideration and approval.

Recommendation 55

The Inquiry recommends that as part of the review of Sexual Health, the Health Division should clarify its policy on family planning and the provision of contraception as it relates to young people.

Recommendation 56

The Inquiry recommends that the review ensures that proper access to information and contraception is available to young people particularly those with emotional and behavioural difficulties.

Drug and Alcohol Strategy

25.87 This strategy, personally lead by the Chief Minister, has sought to create a joint strategy based on inter-agency and cross-departmental co-operation. It is stressed that the strategy will only work effectively if based on an integrated and multi-disciplinary approach.

25.88 The inquiry welcomes this strategy as being a model of how working together at strategic, management and professional levels should operate.

25.89 The circumstances surrounding and leading to the death of Samantha highlight the importance of there being a drugs and alcohol strategy; her involvement in drugs and

the drug scene played a significant part in her life after her return to the Island in February 2001. The Inquiry recognises the great difficulty inherent in seeking to help a young person, such as Samantha, who is misusing drugs, particularly since self-motivation is recognised as the key element in recovery. In chapter 14, the Inquiry considered the ways in which Samantha's social worker and keyworker might have done more to address Samantha's drug misuse. Dr Wafer told the Inquiry that it would be good practice for social workers and others working with a young person to try, and to keep trying, to encourage the young person to address the issues: opportunities need to be seized in daily life to reinforce this encouragement.

25.90 Given the serious consequences of drug and alcohol misuse for the young person and for the community generally, the Inquiry believes that a key worker and others working with a young person who is misusing drugs should have training in how to approach the young person's drug misuse.

25.91 Dr Wafer also told the Inquiry that a DAT outreach worker might have been able to have helped in that he or she could have gone out into the community to try to find and engage with Samantha[770]. Although DAT now has a full time worker for the under eighteens, funding is awaited for an outreach worker. The Inquiry believes that there should be an outreach worker at DAT.

25.92 The Strategy focuses on both alcohol and drugs. It emphasises the importance of prevention and treatment. It also links in with community safety, economic progress, the quality of the environment and social well-being. Probably few other social factors have such an effect on so many aspects of a community's well-being, and the effects of drugs and alcohol are increasingly replicated in other countries as well as in the Isle of Man.

25.93 The Inquiry has been concerned by the reports of the scale of binge drinking by young people, and, sometimes, young children, particularly on Friday and Saturday nights.

25.94 Whilst the Isle of Man is by no means alone in facing this problem, the Inquiry encourages the Government to give this issue as much priority as it can afford. Cultures of heavy drinking and casual recreational drug taking can rapidly become entrenched in a society if strong action is not taken. It is not an easy problem to resolve but a long term, persistent commitment to change the behaviour of both young people and adults will hopefully succeed.

Recommendation 57

The Inquiry recommends that a social worker and others working with a young person who is misusing drugs attend training in how to approach the young person's drug misuse.

Recommendation 58

The Inquiry recommends that an outreach worker post be created at the Drug and Alcohol Team.

[770] see chapter 14

Recommendations in chapter 25:

Recommendation 40 **para 25.9**

The Inquiry recommends that the Health Strategy (2002) is reviewed, updated and resubmitted to the Social Policy Committee with a costed implementation plan.

Recommendation 41 **para 25.34**

The Inquiry recommends that the Director of Health Strategy and Performance regularly reviews, monitors and takes appropriate action on data relating to child protection, teenage pregnancy, dental health, sexual health and young people who misuse drugs and alcohol.

Recommendation 42 **para 25.35**

The Inquiry recommends that the Health Division considers producing a report on children's health on an annual or bi-annual basis which would be made available to the public and health staff.

Recommendation 43 **para 25.38**

The Inquiry recommends that the Health Service invites external inspections of the health services on at least a three-year basis to evaluate the services that are being provided on the Isle of Man for children and young people, particularly those who have emotional and behavioural problems.

Recommendation 44 **para 25.41**

The Inquiry recommends that the Social Services Management Team and the Minister and Member for Social Services regularly consider the health data of looked after children and take appropriate action where necessary.

Recommendation 45 **para 25.42**

The Inquiry recommends that the Senior Management Team of the Department of Education, Member and Minister regularly consider the health data of school age children and take appropriate action where necessary.

Recommendations 46 **para 25.47**

The Inquiry recommends that the Department of Education and schools agree clear minimum standards for schools to follow in providing information on sexual health, including information on the availability and access to contraception, and on substance misuse.

Recommendation 47 **para 25.47**

The Inquiry recommends that the Department of Education and Health Division set out the duties, roles and responsibilities of school nurses, generally and in relation to children and young people with emotional and behavioural difficulties.

Recommendation 48 **para 25.47**

The Inquiry recommends that the Department of Education draws up a "Healthy Schools" policy and implements it consistently in all the Island's schools.

Recommendation 49 **para 25.59**

The Inquiry recommends that no proposal is submitted to the Children's and Young People's Strategy Committee or the Social Policy Committee, unless it includes a consideration of whether staff from different departments should be co-located or whether budgets should be pooled.

Recommendation 50 **para 25.61**

The Inquiry recommends that the Health Service establish a system for listening to the views of children and young people on the effectiveness of the services they use and in particular those services for young people with emotional and behavioural difficulties.

Recommendation 51 **para 25.65**

The Inquiry recommends that the Health Division review the IT requirements of its staff and in particular health visitors and family practitioners in order to be able to send and receive information through the Government IT network.

Recommendation 52 **para 25.78**

The Inquiry recommends that the Child and Adolescent Mental Health Team be incrementally funded over the next 5 years so that it can provide for children and young people up to 18 years.

Recommendation 53 **para 25.78**

The Inquiry recommends that the location of the Child and Adolescent Mental Health Team is reviewed so as to give young people easier access to its services.

Recommendation 54 **para 25. 86**

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Recommendation 55 **para 25.86**

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Recommendation 56 **para 25.86**

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Recommendation 57 **para 25.94**

The Inquiry recommends that a social worker and others working with a young person who is misusing drugs attend training in how to approach the young person's drug misuse.

Recommendation 58 **para 25.94**

The Inquiry recommends that an outreach worker post be created at the Drug and Alcohol Team.

CHAPTER 26

EDUCATION, TRAINING AND RECREATION

Introduction

26.1 The education of young people with behavioural and emotional problems is a challenge not just to schools and educational support services but also to other agencies who offer the framework of support in which a vulnerable or demanding child can flourish. The collaboration that is required to meet the needs of the most challenging children in society is significant, but throughout the Inquiry it has become clear that, strategically, the relationship between the Department of Education and the Social Services Division in particular has been strained. In particular the difficulties seem to revolve around the responsibilities of each department for providing and funding educational placements for children with emotional and behavioural problems.

26.2 In 2002, an Ofsted Inspection of the Department of Education gave an overall judgment that "the work of the Department was weak". Much to the credit of the then Minister for Education, he accepted that criticism and asserted his determination that the department should modernise.

26.3 A review by Ofsted in 2004 of the recommendations in the 2002 Inspection found that there "has been much very satisfactory improvement". In particular, the new planning system on the Isle of Man, a new emphasis on school improvement supported by a new approach in budget setting and the ability to obtain new data, were all signs of progress.

26.4 However, in other areas there had not been progress and the review noted mixed performance in special educational needs (SEN) and in improving access to education. In particular, it was noted that full-time education had not been made available to suspended pupils and there appeared to be a lack of progress in performance management, particularly for SEN and access to education. Most importantly the review concluded

> "that successful implementation will require strong leadership from both the Department and senior officers so that the Education Service as a whole can follow the new directions which have been set in motion since the Inspection".

26.5 The Inquiry is concerned that there is not yet sufficient determination shown by senior officials in the Department of Education to deliver this new agenda.

Services

26.6 The statutory body responsible for the provision of the Education on the Isle of Man is the Department of Education. This consists of the Minister of Education, assisted by two members of Tynwald and a Director of Education supported by civil servants. The department is directly responsible for the Youth Service, the Careers Service, the Library Service and for support to thirty-five Primary Schools, five Secondary Schools and a further Education College. The school population of the Isle of Man is just over 12,000 pupils.

26.7 The Department of Education provides care and support arrangements for children and young people with emotional and behavioural difficulties through the schools, the Special Needs and Psychology Service and through the Youth and Community Service. In respect of SEN, the Department of Education states:

> "The policy of the department is that Special Education Needs should be identified and met in mainstream schools, wherever possible. The Department meets the needs of pupils and students with very significant difficulties in special units attached to mainstream schools, and with the exception of students at the Cronk Souree Unit, and suspended students, all students are currently educated in mainstream schools".

26.8 There are two special units attached to schools, Cronk Souree for children at Key Stage 1 and 2, and Ynnid Whallid for six children at Key Stage 3. This provides those children with support for children with the greatest emotional and behavioural difficulties.

26.9 In addition, there is a pre-school assessment centre that conducts assessments on children referred and provides treatment programmes for children with significant developmental difficulties.

26.10 Three out of the five secondary schools provide nurture groups. All five have delegated budgets that include the budgets formerly allocated to Include.

26.11 The Department of Education has submitted written evidence outlining a range of care and support that is made available in schools. Representatives of secondary schools who attended the Education seminar also described some of the ways they would support students. There are very many initiatives to help young people, but they do not appear to be available consistently across all schools. Understandably each school wishes to develop its own responses to individual problems within their school. The Inquiry heard at the seminars that some schools are more open than others to external support from other agencies such as the Youth Justice Team, Child and Adolescent Mental Health Team and sexual health workers.

26.12 Alternative support is available for children and young people who are suspended and is provided by the school. The minimum requirement is five hours per week. All who gave evidence considered this to be highly unsatisfactory, a view with which the Inquiry strongly concurs.

Performance management

Management information

26.13 The Inquiry was shown written evidence of a range of data and information on a range of subjects that was evaluated on a monthly, term or annual basis. This included topics such as targets achieved by children with special needs, the attendance and suspension figures for schools, attendance of looked after children and the performance of looked after children.

26.14 These reports are forwarded to the Director of Education[771], the Minister and to appropriate staff. This practice is welcomed by the Inquiry.

26.15 The Inquiry, however, could see no evidence in the written submissions that child protection figures or the health of children in schools was being monitored in this way. The Inquiry believes that such information should be collected and monitored by the department and that the Director should consider what further data should be collected and monitored.

Recommendation 59

The Inquiry recommends that the Director of Education reviews whether the range of performance management data collected and analysed by the department is adequate.

26.16 An Inter-Agency Review Group has recently been established with high-level representatives at Deputy Chief Officer level from health, police, social services and education. The group, which has met once, is piloting an analysis of looked after children through benchmarking within schools, the Youth Justice Team, social services and after-care. This should lead to all departments being informed of the outcomes of looked after children in the Isle of Man. This initiative by the Deputy Chief Officers is welcomed by the Inquiry and should be maintained.

Monitoring by other agencies

26.17 The Inquiry could not find any evidence of monitoring of key education performance data by other agencies. For example, the Inquiry would have expected social services to require information on the attendance and performance of looked after children from the Department for Education. In addition, the Youth Justice Team, the Child and Adolescent Mental Health Team and the Health Division should be asking for and considering data on suspensions and appropriate child health issues.

26.18 The above failures reinforce the Inquiry's opinion that departments have much to do to before they view their respective duties and responsibilities as inter-linked and inter-dependent.

26.19 The creation of joint key performance indicators would undoubtedly assist in bringing departments closer together. For example, in relation to looked after children or issues of child protection, every department should not only monitor the appropriate data collectively through the ICPC but also within their own individual department.

Recommendation 60

The Inquiry recommends that each of the five outcomes identified in the Children and Young People's Strategy is supported by key performance indicators and every relevant agency and in particular education, social services, health and police services, regularly monitor and review their performance in relation to the five outcomes and take appropriate action.

[771] The Chief Executive of the Department

Schools

26.20 The Department of Education, in receiving information on performance of schools, has a responsibility to challenge and improve performance through formal and informal visits. The independence of secondary schools with their own budgets should not be a barrier to a strong and constructive relationship being established between the schools and the department. The Inquiry developed an impression at the seminar that the relationship between some schools and the department was not entirely satisfactory. If this impression is correct, the Inquiry hopes that all concerned will take whatever action they can to improve the relationships.

26.21 The heads of the secondary schools play an important role in providing education for young people with emotional and behavioural problems. This role relates to the general well-being of these children and in particular is influenced by issues such as child rotation, health and the vulnerability of special groups like looked after children. While the Inquiry does not wish to burden headteachers unnecessarily, it believes that they should be provided with certain performance management data relating to these children to enable them to review the performance of their schools, against all the five outcomes identified in the Children and Young People's Strategy.

26.22 Elsewhere the Inquiry has stressed the importance of each department being aware of and monitoring the performance of not only their own, but other departments' performance. The Inquiry has recommended that this data be available to the relevant Minister and to senior officials in the Department of Education. Given the critical work of secondary heads in educating children with emotional and behavioural problems the data should also be made available to them. Some of the data currently provided to staff within the department should be provided also to the headteachers.

Recommendation 61

The Inquiry recommends that appropriate performance management data available to the Department of Education be provided on a regular basis to heads of the secondary schools.

65.1.1.1 External inspection of the Department

26.23 The Department of Education is to be commended for inviting Ofsted to inspect the department in 2002. The 2004 Review of progress in implementing the 2002 inspection recommendations is also to be welcomed.

26.24 In March 2005 a document was published entitled "School Self Review and Evaluation Framework: External Validation Framework". The rationale for this paper is stated to be:

> "the Department of Education now intends that the evaluation of education provision will be carried out through a process of school self-review and evaluation rather than through inspection….. In order to ensure that the school self-evaluation is rigorous and accurate, the Department of Education will establish a system of external validations …… If the Department of Education has concerns about the quality of education at any school …. then a review by the Department of Education or an external inspection may be carried out in order to identify the action needed to bring about achievement."

26.25 The Inquiry understands the value of self-assessment and the general wish to reduce the intrusive elements of external inspections. However, in relation to children identified as having educational and behavioural disorders, it does not consider that self-assessment alone is adequate given the current inadequate level of provision.

26.26 The Inquiry notes the Ofsted Report of 2004 that stated that there is still much to do to deliver an effective service. The Inquiry recommends that Ofsted is invited again to inspect the educational provision for children with emotional and behavioural problems. The Inquiry hopes that the Department of Education will agree a timetable of inspection with Ofsted, which can ensure that it can be evaluated and compared to other similar authorities at sensible intervals. External inspections are an important way of ensuring continual improvement, particularly if they are properly publicised to keep pupils, parents and staff properly informed of the level of service being provided.

Recommendations 62

The Inquiry recommends that the department continues to invite Ofsted or another external and independent government body to inspect the department's provision of education for children and young people with emotional and behavioural problems.

Recommendation 63

The Inquiry recommends that all Inspection Reports are published and publicised so that pupils, parents, staff and the public are properly informed of their results.

Children not receiving education

26.27 There has been a considerable amount of anecdotal evidence about the problems in obtaining consistent and effective education for those children who are challenging to themselves and others within and outside of school. The Youth Justice Team, for example, estimated that 60% of the young people with whom they were involved were experiencing problems accessing school. St Christopher's Fellowship have had to resort to seeking legal advice in an attempt to assist children in their care to obtain a proper education.

26.28 The Inquiry recognises, too, that trying to identify fault in the failure of some young people to receive education is not straightforward. The young people concerned are not only troubled, but often troublesome. Many do not want to be in school.

26.29 Nevertheless, the Inquiry firmly believes that systems in the Department of Education ought to be in place to allow officials, political members and the Minister - on a weekly basis - to know:

- which children are in or out of school
- which are suspended and for what periods
- which children are causing so many difficulties that they need urgent and immediate consideration.

26.30 Such systems seemed to be absent in the Department of Education: it took the department a lengthy period to provide this information to the Inquiry. The Inquiry wanted to know whether children are currently completely out of the education

system, as was Samantha. It is grateful to John Kermode, Assistant Education Officer (Special), for his written information detailing his exhaustive investigation as to whether any child is out of the educational system. His conclusion is that there is only one young person who can reasonably be assessed as having his schooling unresolved and that the arrangements for his education are entirely unacceptable. He goes on to say

> "with the exception of the position of child X, the only things that caused me concern (in my investigation) were examples of poor communication between the adults of different services and of these adults not being able to sustain effective, negotiated, joint working agreements between each other for the benefit of young people".

26.31 The Inquiry is inclined to accept this view.

26.32 Relationships at some levels seem at best to be fragile and at worst have broken down: this has led, in many cases, to the overall welfare of some children, particularly those with most need, and in particular their education, to have been marginalised by inter-departmental wrangles. That this should be the case is a dire reflection on the professionalism of all concerned. To overcome this state of affairs needs specific and determined action. This action should deal with agreed common objectives, joint performance indicators, pooling of resources, including budgets where appropriate and integration of staff.

Recommendation 64

The Inquiry recommends that the Director of Social Services and the Director of Education produce proposals for the Social Policy Committee on how their departments and the schools can better work together to improve the educational outcomes of children with emotional and behavioural problems.

Suspensions

Information/ data

26.33 Because of the wealth of anecdotal reports to the Inquiry that there are a number of children suspended for more than ten days, or who are entirely out of education, the Inquiry required more investigation by the Department of Education, to determine the accuracy or otherwise of these allegations and particularly as they related to looked after children. As set out above, obtaining this information proved to be difficult for the department. John Kermode and his staff spent in excess of twenty working days (by his own estimate) before he had to his satisfaction determined how many suspensions had occurred and what plans were in place to provide alternative education for them. The Children and Young People's Strategy pointed out that this data needed to be improved.

26.34 The Inquiry is grateful to him for carrying out this detailed investigation, but it is clear that it should not have been necessary. The Inquiry believes this information should have been readily available within the department and should have been collected and reviewed on a regular routine basis. As already stated, because of the importance of education to the lives of children and young people, the Inquiry believes that systems in the Department of Education ought to be in place to allow officials and Ministers - on a weekly basis - to know which children are in or out of

school, which are suspended for what periods and which children are promoting so many difficulties that they need urgent and immediate consideration.

26.35 The Inquiry was told that "tracking" suspended children was "a big problem" in education. It was stated that the department was not always told that a student was suspended, particularly if a student is repeatedly suspended from school for ten days by way of a governor vote. If this is so, the Inquiry believes it to be wholly unacceptable. The Inquiry heard from the external expert, Mr Paul Helps, Head Teacher, Hillingdon Tuition Centre, Middlesex, of the fortnightly "pupil teaching meeting" which received information, and was attended by representatives, from all relevant agencies.

Recommendation 65

The Inquiry recommends that the Director, the relevant political Member and the Minister receive monthly reports as to which children are suspended; which children are not attending full time education at school; and which children in school are receiving a modified programme; and that the Director provide to the relevant political Member and the Minister a monthly report setting out the education arrangements for each such child and whether further or different arrangements need to be made.

26.36 The Department of Education indicated that the Isle of Man suspension rate was approximately 80% of that of authorities in the United Kingdom. Education is vital for all children. Its importance for looked after children is well stated in the closing submissions on behalf of the DHSS in Part 1 and which are set out at paragraph 13.11 above. The Inquiry endorses the DHSS's statement.

26.37 The Inquiry heard from the Youth Justice Team that 60% of the young people on statutory orders that they worked with were receiving little or no education. At the Education Seminar all concerned recognised the potential of young people out of school being at risk in one way or another. The link between a child being out of standard education and offending was accepted by all.

26.38 The Inquiry was informed by the Department of Education that a suspension can sometimes be not only a welcome relief to the school, but can also be welcomed by some young people who do not want to be at school in the first place. With a lack of motivation to resolve the situation potentially existing on both sides, there is every possibility that children can remain out of school.

26.39 The Inquiry recognises the scale of difficulties with which schools are sometime faced in managing challenging behaviour. It heard examples of good practice at the seminar on education of how some secondary schools managed disruptive and aggressive behaviour.

The duty to educate

26.40 The law as it stands places the responsibility on the parent for ensuring that children receive their education. Whilst the Inquiry understands and supports the need to reinforce parental responsibility, it does not accept the fact that the Department of Education should abrogate its responsibility for being properly informed of children out of school or its role in providing flexible and imaginative support and provision for those children unable – for whatever reason – to access standard educational provision.

26.41 The Inquiry believes this is linked to the ongoing difficulties in inter-agency working and with the reluctance of the Department of Education to bear its share of corporate responsibility for the education of the Island's children. The Inquiry returns to these issues in chapter 30, which deals with strategic issues for Government.

26.42 The Inquiry is clear that the schools and the Department of Education should ensure that systems and procedures are put in place so that no child can slip through the education net. A fundamental part of the Department of Education's role is to ensure that they know what educational provision is offered to - and accepted or rejected by - each school age child on the island.

Recommendation 66

The Inquiry recommends that as well as the existing duty on a parent to educate his or her child, there be a statutory duty on the Department of Education to provide appropriate education for each child on the Island.

Recommendation 67

The Inquiry recommends that the Department of Education monitor the education of looked after children on a monthly basis, in conjunction with the Social Services Division and jointly takes whatever action is appropriate to resolve any problems.

The use of the power to suspend

26.43 The Inquiry heard evidence at both the education and young people's seminars about the inconsistent use of suspension in different schools. A fictitious case study posited in the education seminar raised the possibility of suspension as one option for dealing with an allegedly difficult child. Teachers from three different schools were asked to describe what would typically happen next. The replies indicated that suspension is used earlier and more routinely in some schools than in others and the young people in their seminar alleged it was used as a threat for both large and small misdemeanours. It is not for the Inquiry to determine the detail of the criteria for suspension, but it does believe that there should be a consistent policy throughout the Island's schools and that it should be properly monitored by the Department of Education on a regular basis.

26.44 The Inquiry believes that over the years for whatever reasons, different practices have developed for suspending and refusing the admission of children and young people. The Inquiry does not regard it as satisfactory that the Department of Education should not know on a routine basis, how many children are in or out of school and for what reasons. Equally it is not satisfactory that on an issue as important as suspension there should be different practices and standards in its five secondary schools. The Inquiry has been told that Articles of Government are in force for each of the secondary schools. It seems that, unlike the provision of special needs within schools and the provision of education for suspended children, there is at present no requirement on schools to follow "guidance" given by the department on use of the power to suspend.

Recommendation 68

The Inquiry recommends that there should be a consistent policy for suspension produced for secondary and primary schools on the Isle of Man. It should be regularly monitored and appropriate action taken if necessary.

26.45 The Inquiry was told of confusion as to how to appeal a decision to suspend. The Inquiry cannot judge whether this confusion is widespread. However, it would be useful if there were a guide on how to instigate an appeal, written in straightforward language and explaining how an appeal is begun and dealt with.

Recommendation 69

The Inquiry recommends that the current appeals procedure have appended to it a guide on how to instigate an appeal.

Education for suspended children

26.46 The Inquiry was told that the Department of Education wishes to extend the minimum educational requirement for children not in school from five to twenty five hours per week. The Inquiry understands the significant costs of achieving this but would point to the significant costs of children being out of full-time education. Reference has been made to the evidence of the Youth Justice Team that 60% of the young offenders on their caseloads have educational attendance problems. It should also be noted that there are significant costs in providing extra staff to care for looked after children who receive one hour's education per day. The Inquiry welcomes the aim of the Department of Education to provide education for twenty five hours per week as from September 2006. The Inquiry agrees that the provision of one hour's education per day is wholly unsatisfactory and that an appropriate fulltime curriculum should be available to suspended pupils.

26.47 The Inquiry is clear that the education arrangements for children suspended for more than ten days should be effective and clearly laid out. Accordingly, a written plan for the child's education should be drawn up and implemented. The Inquiry believes that the schools should take lead responsibility for drawing up the plan. If the child suspended for more than ten days is looked after, the child's personal education plan should be reviewed and altered accordingly.

Recommendation 70

The Inquiry recommends that every child suspended for more than ten days should be supplied with a "Suspended Pupil Plan".

26.48 Furthermore, the secondary schools' Articles of Government require secondary schools to follow guidance from the Department as to the arrangements made by the head teacher for teaching a young person while he is suspended. The guidance given in 2002 is currently being updated. The new guidance should contain clear guidance on minimum standards of education.

Recommendation 71

The Inquiry recommends that there should be guidance as to the minimum standard of education required. Compliance must be monitored and effectiveness tested.

Special Educational Needs

26.49 Mr Hutchinson and I visited Ynnid Whallid, a Secondary Referral Unit for six children in Key Stage 3. The staff impressed the Inquiry with their determination and professionalism in the face of a challenging lack of adequate accommodation and other resources. There are only two teachers at the Unit, including the head, and this can cause resource difficulties with children of differing educational standards.

26.50 At the Unit, during the seminars and in written evidence, the Inquiry heard of the lack of similar provision for Key Stage 4 (14-16 years). Whilst the department is to be commended for establishing Ynnid Whallid recently, the need for a similar unit for the older age group is accepted by all. When Ynnid Whallid was set up, schools were asked to refer children whom they thought might benefit from such provision. Twenty-two young people were referred but Ynnid Whallid is only able to provide places for six.

26.51 Mr Paul Helps argued that a Secondary Referral Unit was exactly the right location for a multi-agency support team, where different professionals could work with children and parents. This work could be at the Referral Unit but also at school to assist a child in re-integrating into school. The Inquiry does not think it necessary to set up a separate team at this stage. A similar effect could be achieved by different agencies working better together. It therefore suggests that relevant agencies determine how they can better contribute on a multi-agency basis to Ynnid Whallid and in due course to a Secondary referral Unit for Key Stage 4.

Recommendation 72

The Inquiry recommends that a multi agency protocol for the support of Secondary Referral Units be drawn up.

26.52 The Inquiry understands that a bid has been made for funding to develop another pupil referral unit for Key Stage 4, but that other priorities mean that it is unlikely to be implemented for at least another two years.

26.53 The Inquiry was impressed by the attempts by some secondary schools to meet the needs of very demanding children, through a range of initiatives including nurture groups in three schools. However, it is too much to expect that this is an adequate service for some children with a very high level of need. The Inquiry has concluded that, despite the best efforts of the Department of Education and the schools, the current services for children with extreme emotional and behavioural problems are not yet adequate. It is plain that there is a significant need for more support for children at Key Stage 4. The pressures on the schools to manage children with these difficulties is growing and if this group of children are not to fall out of the system altogether as Samantha did, then new resources must be found to meet these needs.

Recommendation 73

The Inquiry recommends that the Department of Education continue to give a high priority to the proposal to establish a further pupil referral unit for Key Stage 4.

26.54 The Inquiry heard of the different ways in which secondary schools were supporting children with special educational needs. In its report in 2002, Ofsted said at paragraph 166 :

> "At present, support to improve behaviour is unsatisfactory. There are some areas of effective practice but overall support is fragmented and the Department and its officers have no system for assessing the contributions made to improving behaviour of the various initiatives, nor of linking them with the various approaches to dealing with suspended pupils. As a result, neither the relative effectiveness of the various programmes, nor the value for money they offer can be assessed."

26.55 The Inquiry was told that at the time of the 2002 Ofsted inspection there was a draft behaviour support plan in place, which was due for revision. Since then, the Department of Education has produced a consultation paper, 'Supporting Good Behaviour in Schools', which was circulated in December 2004. The Inquiry notes with dismay that, four years after Osted reported that support services were "unsatisfactory", there is still no behaviour support plan in place. During approximately the same period, as the Children and Young People's Strategy pointed out in 2005, the percentage of pupils suspended in secondary schools had been increasing by around 10% per annum (averaged over the previous four years). In addition, sampling by the Department of Education itself suggested that the proportion of children with special educational needs, with a behavioural component to their difficulties, was also sharply rising.

26.56 The continued absence of a behaviour support plan is unacceptable.

26.57 The Inquiry notes the different range of services being provided in secondary schools. The Inquiry believes that there should be a departmental policy for behaviour support in schools which sets out clear expectations and minimum requirements as to the range of services which these children should be receiving. The department needs to put in place a way of measuring the effectiveness of each school's support for such children. A behaviour support plan must be put in place.

Recommendation 74

The Inquiry recommends that the Department introduce a behaviour support plan which includes standards for provision of support to be made available within schools for children with emotional and behavioural problems.

26.58 Nurture groups should be extended to the remaining two secondary schools which do not have them. In addition, the benefits of providing parenting programmes has been widely recognised and the Inquiry recommends that the Department of Education, together with other departments, should examine ways of further developing these programmes in schools and elsewhere.

Recommendation 75

The Inquiry recommends that there be a nurture group in each secondary school.

Recommendation 76

The Inquiry recommends that the Department of Education, in conjunction with other departments, examines ways of further developing parenting programmes in schools and elsewhere.

Looked after children

'The Education of Children in Public Care'

26.59 In 2002 a Joint Protocol was issued by the Department of Education and the Department of Social Security called 'The Education of Children in Public Care'. It is a detailed and comprehensive document setting out the rationale, policies and respective roles and responsibilities for meeting the educational needs of looked after children. It may have been produced as a response to the Ofsted Inspection in 2002, which found that the Department of Education had poor information on looked after children and that support for them was weak. There was at that time no formal system to identify looked after children in schools, who as a result were not always aware which children in their school were looked after. Ofsted reported that on average about one third of looked after children had special educational needs and that "urgent action" was required.

26.60 The Inquiry notes with interest that the policy document identified the concept of the corporate parent and explained its implications some three years ago. It set out a range of requirements for schools, the Department of Education and social services on issues such as sharing information and sharing responsibility between the designated teacher for looked after children and the social worker in order to ensure that each looked after child had a personal education plan. In addition, it set a requirement that "an alternative educational placement should be provided within one week of a breakdown of an education placement". The procedure for suspension was laid out clearly and unequivocally in this document.

26.61 Given the existence of this policy document, it is disappointing to the Inquiry to hear from one residential unit that five out of the six children had no personal education plan.

26.62 The Children and Young People's Strategy identifies this policy document as being important for the improvement in outcomes for looked after children. The Inquiry agrees. However, the Inquiry believes that the existence of the policy document is insufficient; the policies need to be put into practice. In the case of this policy document, it appears that a good policy is proving far less effective than it should be because of a failure to implement the policy effectively.

Recommendation 77

The Inquiry recommends that the document 'The Education of Children in Public Care' (2002) be reviewed and, if necessary, updated by the Director of Education and Director of Social Services and relaunched with appropriate publicity and training for teachers and social work staff.

26.63 An investigation has now been undertaken into the educational provision offered to every looked after child of school age[772]. The majority of looked after children are receiving a normal education and are both attending and achieving well. A number of other LACs with particular difficulties are receiving specialist education, provided in an imaginative and sensitive way that allows them to access full time appropriate education. Some of the children cited within the investigation are receiving no education because they refuse to utilise what is offered to them. Others are on limited

[772] See above

hours programmes. However, the investigation reported that there are tensions between these children's carers and their teachers that reveals a lack of joint working between professionals on the ground.

Personal education plans

26.64 The clarity of the policy relating to personal education plans (PEPs) is sadly undermined by the confusion about its implementation. At the seminar on education for example, there was confusion and uncertainty amongst those attending as to whether it was the designated teacher or the social worker who was responsible for initiating the production of a PEP. One school representative was adamant that it was the social worker who was responsible. The Inquiry, having read the procedure, understands that it is a shared responsibility.

26.65 Education is as much of an integral part of a looked after child's life as it is for a child living at home. Given the importance of education for young people with emotional and behavioural problems, the Inquiry is concerned that the clear requirement for a personal education plan is not always complied with. Ensuring compliance is the responsibility of management. Failure to comply is unacceptable.

26.66 The personal education plan should be prepared with the involvement of a wide range of people: the young person concerned, a child-carer, teacher and social worker, all of whom have a responsibility for ensuring it is implemented.

Recommendation 78

The Inquiry recommends that there be an immediate review of the PEPs of all looked after children and that in future senior managers in Social Services and in the Department of Education ensure that these are completed on a regular basis and used by schools and social services.

The role of governors

26.67 In order to signal the importance of education to a looked after child, the Inquiry suggests that a one governor on each governing body be designated to have a lead role on behalf of the governors for responsibility for looked after children in the school.

Recommendation 79

The Inquiry recommends that there be one governor on each governing body with special responsibility for looked after children.

Inter-agency working: corporate parenting and co-operation between departments

Corporate Parenting

26.68 In Part 1 and during the seminars, the Inquiry learned of the difficulties surrounding the concept of corporate parenting. The Director of Education, answering a question by the Advocate to the Inquiry in Part 1, agreed that it was "correct"…"that the minute a child is off the roll of the school, the Department of Education has no corporate responsibility towards the child".

26.69 In evidence in Part 1, the Director of Education stated that the Department of Education could not accept a system of corporate parenting until new legislation was introduced. However, at the strategy seminar he said that the Department of Education had been working to the concept of corporate parenting and would continue to do so. What is clearly needed is an agreement by all parts of the Government that that they are working towards the same ends and their policies should reflect this.

26.70 The Department of Health and Social Security have stated that unless there are legislative changes away from a system that places the onus on the parent to present a child fit for education, there will always be difficulties for those children who have problems in their family life, especially therefore those in care. It is the Government's, and specifically the Department of Education's, failure to embrace the concept of corporate parenting that has allowed the policy of one department to act against the policy of another. It is difficult to see how the current situation can be reconciled to the 'outcomes' for children identified in the Children and Young People's Strategy.

26.71 The Inquiry is aware that the notion of corporate parent, whilst being clear to those in the social services field, is not as well understood by other departments and their staff[773]. The term has been taken to mean that all those working in Government should view the outcomes for looked after children as a collective responsibility rather than one which rests on one department. In England this has led to different local authority departments, including housing, leisure, finance and human resources, outlining what contribution they can make to the general well-being of looked after children. In one authority, the Leisure Services Department have provided looked after children with a leisure card which gives them free access to leisure facilities. In another, the Finance Section has offered individual mentoring on financial matters to those young people who want advice.

26.72 The Inquiry welcomes the more recent evidence from the Director of Education because if the concept of corporate parent and a shared responsibility for looked after children is to be successfully implemented, it cannot depend solely on legislative change. Nevertheless, the Inquiry believes that the legislation needs to be amended to place the responsibility for educating a child not only on the parent but also on the Department of Education and it has therefore recommended this above.

26.73 In Part 1, the Inquiry was unconvinced by the arguments put forward by the Director of Education and the representative of the Department of Education in his closing submission for not part-funding George Green's and Samantha Barton's residential placements off-Island[774]. George's placement, in particular, was chosen primarily for educational reasons and resulted in his receiving the full time education that he was not receiving on the Island.

26.74 The reluctance to provide alternative full time education for looked after children who are suspended from school, and the continuing refusal to jointly fund off-island residential placements for looked after children, represents an inability to move forward to embrace the new agenda of shared responsibility. The failure to fund the teachers placed in the Secure Unit (where, ironically, residents do receive a full education) and the refusal thus far to fund an education worker within the Youth

[773] See chapter 30
[774] See chapter 14

Justice Team, suggests that a change in legislation is required to ensure the Department of Education works in partnership with other agencies to meet the needs of vulnerable children.

26.75 There is also a requirement for strong leadership in the Department of Education to embrace a new agenda of working together and corporate parenting, as the Inquiry discusses in the Chapter 30 on strategic issues for Government. The Inquiry is not convinced that a lack of resources in the existing budget of the department should be a barrier to new kinds of inter-agency working. Ofsted stated in its 2002 Inspection that the department was well funded compared to education authorities in the United Kingdom.

26.76 The Inquiry believes it is essential to draw up a protocol for the joint funding of looked after children who are educated off Island. Bringing together budgets for children who need special residential education or residential care, would be a major step to overcoming the competing budgetary pressures, which usually tend to undermine joint working.

Recommendation 80

The Inquiry recommends that the Director of Social Services, the Director of Education and the Director for Health Strategy and Performance produce a joint report for the Social Policy Committee on the way in which joint funding for residential placements of children and young people with emotional and behavioural problems can be established.

26.77 The Inquiry heard evidence from Christine Davies, Director of Children's Services, Telford and Wrekin, that her local authority had established a joint commissioning team between the former education and social services departments. This in effect means that those parts of the respective departmental budgets, which are responsible for educating and placing children who have special educational needs and family problems, are brought together. This then gives the team the incentive to explore the needs of the whole child and how a joint budget can be used in his or her interests, irrespective of the origins of the budget heading. For example, a joint budget might use the original social service contribution to pay for a non-teaching assistant to assist with the education of a child on the verge of suspension or, alternatively, special care arrangements, such as a foster carer, might be paid for by an original education budget heading.

26.78 The Inquiry believes that bringing budgets and staff together where appropriate, will contribute to an integrated approach to meeting the needs of children with behavioural and emotional problems.

Recommendation 81

The Inquiry recommends that the Director of Social Services and the Director of Education and the Director for Health Strategy and Performance should draw up proposals on how they can establish a Joint Commissioning Unit to integrate budgets where it is appropriate to do so and present their proposals to the Social Policy Committee.

Co-operation between departments

26.79 Much has been heard during the Inquiry of the need for different organisations to contribute to each other's objectives. This also applies to the need for other departments to contribute to the vitally important objectives of the Department of Education. Written evidence received by the Inquiry suggests that some care providers do not give sufficient weight to the educational needs of young people. One example that was given was of work being left by a teacher at a residential placement for the young person and on her return, finding the work sheets untouched in the same place they were left.

26.80 The example of education support workers given in evidence by St Christopher's is, in the Inquiry's view, a model of good practice. St Christopher's understand that the responsibility for delivering education to looked after children cannot simply rest with the schools. Looked after children need the continuing support of their carers, as other children would receive from their parents. The St Christopher's model works well in multi-occupancy residential homes such as those run by St Christopher's. The Inquiry is of the firm view that education support workers are also needed for children in smaller units such as single occupancy units. The Director of Social Services must consider, with relevant service providers, how best this provision can be established.

Recommendation 82

The Inquiry recommends that Education Support Workers should be established for all children in residential units to assist in improving the education results of looked after children.

26.81 The Inquiry heard of an unsuccessful attempt to build a multi-agency team at Ballakermeen School. At the education seminar, teachers and social workers attributed blame to each other for its failure. The Inquiry commends both for trying to work together in this way and encourages schools and social services to continue trying. At the minimum, the Inquiry believes that named social workers should be assigned to each secondary school as liaison points and to promote better communication and understanding of each other's role. The Inquiry heard evidence of St Ninian's High School and Tromode House using a range of imaginative actions to defuse difficult and challenging behaviour, without the school placement breaking down. The Inquiry believes this was as a result of the strong relationship established between key members of staff in the school and in the residential unit. It is to be commended.

Recommendation 83

The Inquiry recommends that social services provide the name of a social worker who will act as a liaison point between each secondary school and the Social Services Division.

26.82 Although it has been said that there is a new will for the Department of Education and other services to work together, there is still far to go in reaching even a minimal level where inter-agency planning at both strategic and policy level and at the front line could be described as satisfactory. The Inquiry encourages the Director of Social Services and Director of Education to work together to promote the importance of education for looked after children.

26.83 The Inquiry heard evidence from Christine Davies, Director of Children's Services, Telford and Wrekin, on the work that is required to develop and sustain the notion of corporate parenting. In particular, she spoke of the need for training of politicians and senior officers on the implications of corporate parenting and what is required in practice if the Government is to act as a corporate parent. The Inquiry endorses this advice.

26.84 Christine Davies gave examples of a range of events that contributed to the educational success of looked after children. For example, there was a special prize giving ceremony which acknowledged through the public award of prizes, not just the academic success of some looked after children, but also the way in which others had overcome great emotional difficulties to improve their behaviour, to increase their attendance at school, or simply to have tried hard in school. The prize giving ceremony was attended by senior politicians, the chief executive and other chief officers, and helped to raise the profile and priority of education for looked after children. The Inquiry would hope that initiatives along those lines could be introduced in the Isle of Man.

Recommendation 84

The Inquiry therefore recommends that training is provided to senior officials in all parts of Government on the principles, responsibilities and implications of the Government acting as a corporate parent to looked after children.

26.85 Ultimate authority on the Island lies with the Members of Tynwald. The Inquiry would hope that Members of Tynwald would want to avail themselves of the opportunity to learn more about corporate parenting and its implication for Government. Members could be invited to training seminars provided for senior officials or their training could be arranged separately.

Recommendation 85

The Inquiry recommends that information and training is made available for Members of Tynwald, including the Council of Ministers and departmental members, on the principles, responsibilities and implications of the Government acting as a corporate parent to looked after children.

Leisure and youth activities

26.86 The Inquiry heard evidence from Mike Clague, Youth and Community Advisor, and Andy Varnom, the National Sports Manager, that the Isle of Man has a wide range of high quality and varied sports facilities. Many of the young people at their seminar spoke of a number of low cost activities, which they used and welcomed. However, for children with emotional and behavioural difficulties these clubs seemed less popular.

26.87 Detached youth workers to whom the Inquiry spoke described large numbers of children and young people gathering on the streets of Douglas on Friday nights. They described as many as 150 young people congregating in Douglas on one occasion. They spoke of binge drinking often by young teenagers, a few as young as thirteen. At the Young People's seminar impassioned pleas were made for another centre for young people similar to the "Machine". The young people said that even when full as many as 100 young people would be waiting to get into the Machine. It was clear that the Machine did not suit every young person - some young people praised the

Ramsey facility, which the Inquiry understands is a similar venture based in the north of the Island. The lack of resources on the Island was raised by the young people, though a new development at a swimming pool in Peel was welcomed.

26.88 The Inquiry was impressed with the attitude and commitment of the detached youth workers and accepted their view that the majority of the young people returned home safely after a night out. However, the Inquiry remains concerned for those who do not. Young people at their seminar asked for further youth facilities. The Inquiry encourages the detached youth workers to continue to focus on those young people who do not use the more traditional youth facilities.

26.89 In Part 1, the Inquiry has noted the largely aimless and unconstructive days spent by Samantha at Derby Road and Leece Lodge. The Inquiry believes that the Leisure Department could offer specific packages for particularly needy children. At the Seminar the Inquiry heard that Mr Varnom and Mr Clague were becoming more involved in meetings relating to children's services. Constructive leisure activities have a part to play in assisting young people with emotional and behavioural problems develop. Not only could a leisure interest help to occupy constructively a young person's free time, but also a specific leisure activity could represent part of a package for a child or young person who has become alienated from education or other parts of the system.

26.90 The Inquiry welcomes the greater involvement of the Young and Community Advisor and National Sports Manager and hopes that specific named youth workers and sports officers will be allocated to groups of looked after children in residential units and foster care as well as schools.

Recommendation 86

The Inquiry recommends that a named youth worker and a sports officer should be allocated to looked after children in residential homes and foster care.

26.91 The Inquiry also received submissions recommending the establishment of mentors for young people with emotional and behavioural difficulties. Mentors can be used for a variety of principal tasks, for example working to support educational performance, befriending young people in care or helping young people with particular leisure interests such as IT or a sports activity. The Inquiry believes that volunteers, most particularly from young people's own communities, would add an important element to the range of support these young people need.

Recommendation 87

The Inquiry therefore recommends that the Director of Social Services, Director of Education, Director of Strategy and Performance (Health), Chief Probation Officer and the Chief Constable draw up proposals for the establishment of a mentoring scheme.

Information sharing

26.92 The Information Sharing Protocol was signed by all agencies towards the end of the Summer 2005. It was a concern to the Inquiry that some of the schools represented at the education seminar and the Deputy Director of Education had not heard of the Information Sharing Protocol or had misunderstood its purpose. Although the Protocol has only recently been signed and only four (voluntary) training seminars

have taken place, this did not excuse the widespread lack of knowledge of the Protocol's existence.

26.93 One head teacher at the seminar felt that at present information was effectively conveyed by education to other agencies, but without reciprocation. He believed having a named social worker allocated to each school was the way to overcome this. A social services representative agreed, but could not provide a social worker for each secondary school because of resource problems. The external expert Christine Davies stated that a named worker for each school was a necessary and important step in ensuring information was properly shared and understood.

26.94 The CAMHS representative was concerned about breaching confidentiality and therefore did not agree automatically to share any information with the school. The Inquiry was concerned to hear of this reservation, as matters of confidentiality had been made clear in the Protocol.

26.95 The conclusion from the seminar was that information-sharing was ineffective and needed improvement from all agencies.

There is now a Protocol explaining information sharing with which professionals should be familiar with and use regularly. It is apparent that all teachers have their own email addresses, as do social workers, and not only the Protocol but other key information could be routinely shared with a sizeable proportion of those staff working with children. The use of existing technology and named and developing contact points between agencies could substantially improve the situation. The production of the Information Sharing Protocol is an important achievement. It now needs to be made to work and the Inquiry has made recommendations to help to achieve this in chapter 30.

Vocational training and careers service

26.96 At the young people's seminar there were complaints about the absence of specialist careers advice.

26.97 At the education seminar the Inquiry heard that the Careers Service was under resourced; it does not have the resources to offer specific and specialist help to children with emotional and behavioural problems, who are often under qualified and emotionally immature. The Inquiry heard that the Careers Service were unable to offer an effective service to those young people who were disaffected and needed additional support.

26.98 The Careers Service indicated that special courses for 16 year olds and above with particular difficulties should have been provided since the unemployment benefit changes in 1990-91, but these had fallen by the wayside.

26.99 The Inquiry was dismayed by this evidence since with employment and the general maturing process of age, young people - even those with emotional and behavioural problems - can usually grow into productive citizens. Without help they are likely to be permanently unemployed and to remain disaffected and any other successful work done elsewhere for the young person is likely to be undermined.

Recommendation 88

The Inquiry recommends that Director of Education and the Director of Social Services commission from the Careers Service its proposals for providing specific and specialist careers and vocational training guidance to children with emotional and behavioural problems, which include a financial plan laying out how the proposals can be implemented.

26.100 The Inquiry heard from the head of the Careers Service that if looked after children were to be helped with future career and further training, that careers officers needed to be invited to reviews in time to plan well in advance of the young person leaving school or care. He went on to describe the "desperate" need for a training scheme for children with educational and behavioural needs and he drew attention to forty young people who left school 'last summer' (2005) who were still unemployed and for whom there was no relevant training and support.

Recommendation 89

The Inquiry recommends that Director of Education and the Director of Social Services draw up proposals as to how, and at what stage, a careers officer is to be involved in care planning for a looked after child.

26.101 The Inquiry heard that bids had been made for a careers officer to offer careers guidance to vulnerable young people, but that to date they had been unsuccessful. However, the Ofsted Review of 2004 had drawn attention to the failure to appoint such a post and drew attention to the implications for "the vulnerable young people who badly needed it".

Recommendation 90

The Inquiry recommends that a Careers Officer be appointed to assist in offering career guidance to vulnerable young people.

Record keeping

26.102 In Part 1 of the Inquiry the lack of adequate school records, particularly those that affected Samantha Barton, was discussed. The Director of Education agreed when giving evidence that it would be helpful for there to be a duty placed on the department to hold records, so long as it is made clear what the nature of those records should be.

26.103 The Inquiry supports this view not only because of the absence of adequate records as they related to Samantha Barton, but also because of the difficulty that the Department of Education had in accessing suspension records. Although the Inquiry recognises that specific pupil records, as they relate to the child's education, are different from keeping appropriate statistical information, it nevertheless is of the opinion that a duty on the department to keep records would give a necessary prominence and priority to record keeping.

Recommendation 91

The Inquiry recommends that there be a statutory duty on the Department of Education to maintain appropriate pupil records and that the Director of Education draws up proposals on how this can be achieved.

Recommendations in chapter 26:

Recommendation 59 **para 26.15**

The Inquiry recommends that the Director of Education reviews whether the range of performance management data collected and analysed by the Department is adequate

Recommendation 60 **para 26.19**

The Inquiry recommends that each of the five outcomes identified in the Children and Young People's Strategy is supported by key performance indicators and every relevant agency and in particular education, social services, health and police services, regularly monitor and review their performance in relation to the five outcomes and take appropriate action.

Recommendation 61 **para 26.22**

The Inquiry recommends that appropriate performance management data available to the Department of Education be provided on a regular basis to Heads of the secondary schools.

Recommendations 62 **para 26.26**

The Inquiry recommends that the Department continues to invite Ofsted or another external and independent government body to inspect the Department's provision of education for children and young people with emotional and behavioural problems.

Recommendation 63

para 26.26

The Inquiry recommends that all Inspection Reports are published and publicised so that pupils, parents, staff and the public are properly informed of their results.

Recommendation 64 **para 26.32**

The Inquiry recommends that the Director of Social Services and the Director of Education produce proposals for the Social Policy Committee on how their departments and the schools can better work together to improve the educational outcomes of children with emotional and behavioural problems.

Recommendation 65 **para 26.35**

The Inquiry recommends that the Director, the relevant political Member and the Minister receive monthly reports as to which children are suspended; which children

are not attending full time education at school; and which children in school are receiving a modified programme; and that the Director provide to the relevant political Member and the Minister a monthly report setting out the education arrangements for each such child and whether further or different arrangements need to be made.

Recommendation 66 **para 26.42**

The Inquiry recommends that as well as the existing duty on a parent to educate his or her child, there be a statutory duty on the Department of Education to provide appropriate education for each child on the Island.

Recommendation 67 **para 26.42**

The Inquiry recommends that the Department of Education monitor the education of Looked after Children on a monthly basis, in conjunction with the Social Services Division and jointly takes whatever action is appropriate to resolve any problems.

Recommendation 68 **para 26.44**

The Inquiry recommends that there should be a consistent policy for suspension produced for secondary and primary schools on the Isle of Man. It should be regularly monitored and appropriate action taken if necessary.

Recommendation 69 **para 26.45**

The Inquiry recommends that the current appeals procedure have appended to it a guide on how to instigate an appeal.

Recommendation 70 **para 26.47**

The Inquiry recommends that every child suspended for more than ten days should be supplied with a “Suspended Pupil Plan”.

Recommendation 71 **para 26.48**

The Inquiry recommends that there should be guidance as to the minimum standard of education required. Compliance must be monitored and effectiveness tested.

Recommendation 72 **para 26.51**

The Inquiry recommends that a multi agency protocol for the support of Secondary Referral Units be drawn up.

Recommendation 73 **para 26.53**

The Inquiry recommends that the Department of Education continue to give a high priority to the proposal to establish a further pupil referral unit for Key Stage 4

Recommendation 74 **para 26.57**

The Inquiry recommends that the Department introduce a behaviour support plan which includes standards for provision of support to be made available within schools for children with emotional and behavioural problems.

Recommendation 75 **para 26.58**

The Inquiry recommends that there be a nurture group in each secondary school.

Recommendation 76 **para 26.58**

The Inquiry recommends that the Department of Education, in conjunction with other departments, examines ways of further developing parenting programmes in schools and elsewhere.

Recommendation 77 **para 26.62**

The Inquiry recommends that the document 'The Education of Children in Public Care' (2002) be reviewed and, if necessary, updated by the Director of Education and Director of Social Services and relaunched with appropriate publicity and training for teachers and social work staff.

Recommendation 78 **para 26.66**

The Inquiry recommends that there be an immediate review of the PEPs of all looked after children and that in future senior managers in Social Services and in the Department of Education ensure that these are completed on a regular basis and used by schools and social services.

Recommendation 79 **para 26.67**

The Inquiry recommends that there be one governor on each governing body with special responsibility for looked after children.

Recommendation 80 **para 26.76**

The Inquiry recommends that the Director of Social Services, the Director of Education and the Director for Health Strategy and Performance produce a joint report for the Social Policy Committee on the way in which joint funding for residential placements of children and young people with emotional and behavioural problems can be established.

Recommendation 81 **para 26.78**

The Inquiry recommends that the Director of Social Services and the Director of Education and the Director for Health Strategy and Performance should draw up proposals on how they can establish a Joint Commissioning Unit to integrate budgets where it is appropriate to do so and present their proposals to the Social Policy Committee.

Recommendation 82 **para 26.80**

The Inquiry recommends that Education Support Workers should be established for all children in residential units to assist in improving the education results of looked after children.

Recommendation 83 **para 26.81**

The Inquiry recommends that Social Services provide the name of a social worker who will act as a liaison point between each secondary school and the Social Services Division.

Recommendation 84 **para 26.84**

The Inquiry therefore recommends that training is provided to senior officials in all parts of Government on the principles, responsibilities and implications of the Government acting as a corporate parent to looked after children.

Recommendation 85 **para 26.85**

The Inquiry recommends that information and training is made available for members of Tynwald, including the Council of Ministers and departmental members, on the principles, responsibilities and implications of the Government acting as a corporate parent to looked after children.

Recommendation 86 **para 26.90**

The Inquiry recommends that a named youth worker and a sports officer should be allocated to looked after children in residential homes and foster care

Recommendation 87 **para 26.91**

The Inquiry therefore recommends that the Director of Social Services, Director of Education, Director of Strategy and Performance (Health), Chief Probation Officer and the Chief Constable draw up proposals for the establishment of a mentoring scheme.

Recommendation 88 **para 26.100**

The Inquiry recommends that Director of Education and the Director of Social Services commission from the Careers Service its proposals for providing specific and specialist careers and vocational training guidance to children with emotional and behavioural problems, which include a financial plan laying out how the proposals can be implemented.

Recommendation 89 **para 26.101**

The Inquiry recommends that Director of Education and the Director of Social Services draw up proposals as to how, and at what stage, a careers officer is to be involved in care planning for a looked after child.

Recommendation 90 **para 26.102**

The Inquiry recommends that a Careers Officer be appointed to assist in offering career guidance to vulnerable young people.

Recommendation 91 **para 26.104**

The Inquiry recommends that there be a statutory duty on the Department of Education to maintain appropriate pupil records and that the Director of Education draws up proposals on how this can be achieved.

CHAPTER 27

EARLY YEARS AND PREVENTION

27.1 The Terms of Reference for the Commission are focussed on children of secondary school age or above on the Isle of Man who have behavioural and emotional problems. The Terms of Reference also require the Inquiry to take account, where considered necessary, of care and support received in their earlier years.

27.2 Speakers in Tynwald have drawn attention to the critical role that intervention at a young age, both with children and parents, can play in determining a child's outcomes. There is no doubt that the earlier the intervention, the more successful it is likely to be. The Inquiry therefore asked for written submissions on the subject, visited a family centre and invited Dame Gillian Pugh, an internationally respected expert in early years, to join the education seminar, which included a discussion on early years education, health and emotional well-being.

Services

27.3 There is a range of services available to young families through the universal services of family practitioners, health visitors and midwives. There is a pre-school assessment centre, which supports young families and offers programmes mostly linked with child health development. There are currently three family centres on the Island, two run by the Isle of Man Children's Centre and one by MFS. A further family centre will be opened in the near future. The family centres support families with parenting programmes and undertake assessment where child protection concerns exist and on behalf of the court in cases of care proceedings.

27.4 The Department of Education's aim is to make a nursery place available for every child whose parents want it by 2010. Currently there are ten nursery classes offering places to 357 children. A strategy for the development of the foundation stage has been drawn up by the Department of Education.

27.5 Both the Department of Education and Department for Social Services have a responsibility for registering and inspecting different parts of the services offered to young children. The DHSS are responsible for registering and inspecting nurseries and child minders, the Department for Education is responsible for inspecting and registering nursery classes. The Inquiry believes there would be merit in bringing those inspectors into one team, to ensure consistency and integration of all services for young children.

Recommendation 92

The Inquiry recommends that as part of the developing Government inspection strategy, consideration be given by the Director of Education and Director of Social Services to the establishment of a joint early years registration and inspection team.

Government wide strategy

27.6 Dame Gillian Pugh said at the education seminar in relation to early years education:

> "It just seems to me that we have got …… health, social care and education all developing separate strategies, and if one actually created one strategy, we might make a great deal better use of the money that is available. I think nearly everything that I would want to see in the strategy is happening somewhere, but not necessarily everywhere, and not necessarily joined up".

27.7 The Inquiry heard that the Deputy Director of Education had produced an early years strategy but other departments were not involved in its production. The Inquiry commends the Deputy Director for her initiative. However the Inquiry encourages her to ensure that no departmental strategy is published until other appropriate Government and non-government agencies are given the opportunity to contribute fully to it.

27.8 The Inquiry believes the Government should invest in an early years strategy. It has noted the comments made in the Tynwald debate on the Children and Young People Strategy to this effect. Only by making a real commitment to supporting families in need will the pattern of difficult behaviour, low educational aspirations, antisocial behaviour and poor health be turned around. There is no quick fix. An early years strategy needs to be a long-term strategy, properly financed over a number of years. The Children and Young People's Strategy makes the same points. The Inquiry believes it should be one of the Government's top children's priorities.

27.9 The Inquiry agrees with the comments and proposals made by Dame Gillian Pugh in her written evidence. In particular, it supports her recommendation that

> "it should be a high priority for the Isle of Man Government to develop a single strategy (for early years) building on the range of current developments within education, social services, health and the voluntary sector".

27.10 Accordingly the Inquiry believes that the Government should decide which department should be responsible for leading and co-ordinating the drawing up and implementation of a fully costed early years strategy. Consideration should be given to building on the work already done by the Department of Education.

Recommendation 93

The Inquiry recommends that a multi-agency early years strategy be drawn up with a fully costed implementation plan.

Some components of an early years strategy

27.11 Dame Gillian Pugh then went on to set out for the Inquiry what this strategy would include:

> i) a clear policy for the development of services for young children and their families, setting out the principles upon which services should be based, a development plan and a clear process for implementation and review. These principles should include how mainstream services can be expanded in such a way to ensure that suitable provision is provided for those in greatest need;
>
> ii) Joint funding arrangements should be created where services are to be offered free to families. In the UK two examples of this are that there is now free nursery education for 15 hours a week for all three and four year olds, and welfare benefits are provided to support the additional requirements of parents on low incomes;
>
> iii) Integrated Services: regardless of whether services are provided by statutory, voluntary or private providers, the nursery provision should always provide care and education combined;
>
> iv) An appropriate curriculum, based on sound principles and on the central importance of learning through play. The UK has developed a foundation Stage curriculum for children aged 3-5 and Birth-Three Matters for Children in settings before the age of 3. Together they provide a clear framework for practitioners working with children up to the age of 6;
>
> v) A single registration and inspection framework;
>
> vi) Sufficient funding to provide adequate training for all early childhood workers. Research supports the involvement of trained early years teachers in all settings, heads of centres to be graduate level and all other staff to be NVQ level 3 and above. There is also considerable value in multi-agency training, both within and across centres;
>
> vii) Services to be provided in partnership with parents, and ways to be found of supporting parents, particularly during the first three years of a child's life. Parents are likely to value a range of support services, from very informal drop-in centres and informal play sessions, through access to groups and adult education classes, through to more structured parenting courses;

Multi-agency

27.12 Dame Gillian Pugh's proposal for a multi-disciplinary team was supported by evidence from others. A social worker, in written evidence, told the Inquiry that there is usually no social work early years for children with special needs and she suggested there would be benefits of social work involvement in the pre-school assessment centre. The head of the pre-school assessment centre, in her submission, expressed concern about insufficient nursery places in general and the failure to prioritise nursery places for children who have educational and behavioural difficulties. She regretted the fact that children with these difficulties were not targeted for specific help in nursery (and other) early years settings.

27.13 The overwhelming and inescapable conclusion derived from a range of opinions including those from Tynwald, teachers, social workers and many others, is that more needs to be done to help children and their families as early as possible. Preventing problems from developing means identifying those children and the parents who are most at risk and offering them help and support as early as possible. Nurture groups in schools, school nursing and other terms of help, as important as they are, should be complemented by a co-ordinated strategy between agencies to support families in their early years.

27.14 The health service, with its midwives, health visitors and family practitioners, is a critical partner in any early years strategy. So are education, social services and the voluntary sector. The voluntary sector can often be accepted more willingly by some families since it is non-statutory and therefore seen as less threatening. However, all these services have a part to play in supporting and assessing families in need.

27.15 The Inquiry hopes that the development of a properly costed, fully integrated early years strategy will be given a high priority by the Isle of Man Government.

Conclusion

27.16 At present the early years strategy cannot be said to be effective, as it is not properly co-ordinated and there is no unified view about what the strategy might deliver. In addition there is no financial plan.

27.17 The Inquiry has been told of the significant costs of looking after and educating children with emotional and behavioural difficulties. It is clear to the Inquiry that there already exist a range of services available for young children and their parents. There are provided by health, education and social services as well as the voluntary sector.

27.18 The aim of Government should be to invest more in supporting families in need, in their early years, with the aim of reducing high cost expenditure on comparatively small numbers of young people as they get older. The Inquiry recommends this course of action. It believes part of the increase in investment can come from efficiencies of bringing services together, part will need new resources.

27.19 In some authorities in the United Kingdom, early years units have been created to improve communication between health, education and social services staff in particular. The Inquiry is of the opinion that this way forward should be explored.

Recommendations in chapter 27:

Recommendation 92 **para 27.5**

The Inquiry recommends that as part of the developing Government inspection strategy, consideration be given by the Director of Education and Director of Social Services to the establishment of a joint Early Years registration and inspection team.

Recommendation 93 **para 27.10**

The Inquiry recommends that a multi-agency early years strategy be drawn up with a fully costed implementation plan.

CHAPTER 28

YOUTH OFFENDING

Introduction

28.1 During Part 1 of the Inquiry, much evidence was given, both orally and in written form regarding offending behaviour by young people. In particular, the persistent offending of certain young people, often looked after children, seemed to be considerable. The Inquiry heard that Samantha Barton and George Green had been convicted of 64[775] and 49 offences respectively by the time of their deaths[776].

28.2 The Inquiry therefore considered it important to examine the effectiveness of care and support for young people with emotional and behavioural problems relating to their offending. It sought written submissions on this subject, visited the Youth Justice Team and Secure Unit and held a seminar specifically on this topic.

28.3 Inevitably many of the issues discussed at the Youth Offending seminar overlapped with issues raised at other seminars, most particularly school suspension, information sharing, inter-agency working and looked after children.

28.4 The Inquiry heard and read evidence concerning the apparent reduction in youth offending and the absolute reduction by 30% in reported crime on the Island. There has been a reduction in offending of 25% by the young people involved in the Youth Justice Team, but the Inquiry was told that specific figures on how youth crime has dropped are not possible to extrapolate from existing data, since any unsolved crime cannot be attributed to one particular group.

28.5 The Inquiry wishes to acknowledge the significant achievement inherent in a 25% reduction in offences by the young people involved with the Youth Justice Team. The Inquiry accepts the argument of experienced police officers that there is likely to have been a concomitant reduction in unsolved youth crime.

28.6 Since the Secure Unit opened in February 2003, there have been 57 admissions of 30 different young people: 17 of the young people and 29 of the admissions have been, via the welfare route, rather than the criminal route. The Unit was last used to accommodate a young person via a criminal route in August 2004, when a child was placed there on remand. The last accommodation of a young person serving a criminal sentence took place in April 2004.

28.7 Although there are fifteen places for young offenders in the Isle of Man prison at Victoria Road, no one under the age of 17 is currently placed there.

28.8 Although there has been no research on the subject, anecdotal evidence presented to the Inquiry suggests that the work of the Youth Justice Team has contributed greatly to this welcome reduction in secure and custodial disposals. Senior police officers, and others working in the field of law and order, are confident that the YJT has significantly contributed to the reduction in custodial sentencing for youths.

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[775] This figure excludes her convictions in England and Wales

[776] See chapter 19

28.9 The Inquiry believes that the creation and operation of the Youth Justice Team is a credit to those who established it and those who work within it. The Inquiry now wishes to be reassured that it is not, in the words of one person who attended the Youth Offending Seminar, "built on sand". This means substantial additions and legislative changes are required as described below.

Planning and Strategy

Collection and analysis of data

28.10 The Youth Justice Team is guided by two formative reports. "Reforming Youth Justice on the Isle of Man – A Strategy Report" was prepared by Mr A Chard in 2002 and highlighted a number of objectives and key tasks for the YJT. That report was supplemented by the "Youth Justice Business Plan 2003-2006". This is a wide-ranging strategic document, which takes account of *"Every Child Matters"*, a paper on which the English Children Act 2004 is based. It also sets out an impressive range of principles for the Youth Justice Team on the Isle of Man. Subsequently, the YJT has produced an "Interim Report 2004-2005" which provided an overview of the strategy and principles of the YJT and provided an analysis of the first collation of data relevant to its work.

28.11 The Inquiry believes the Business Plan and the Interim Report are an impressive start to identifying the main objectives of the service. They have drawn heavily on practice elsewhere, most particularly from the Youth Justice Board of England and Wales. The Inquiry commends the Youth Justice Team for this approach which has the merits of using experience elsewhere to inform planning and practice on the Island and avoids some of the start-up costs associated with new developments.

28.12 The Inquiry particularly welcomes the statistical analysis introduced in order to evaluate the team's effectiveness. The analysis shows that there has been a 28.5% reduction in offences committed whilst the young offenders were on specific orders. This is a very welcome reduction and reflects well on the efficacy of the YJT. The Inquiry commends the YJT for seeking to collect and make use of data about young people offending or at risk of offending. This practice must be continued and the collection and analysis of data must be expanded.

28.13 In particular, the Inquiry recommends that in future years further analysis is undertaken of data relating to the offending rates of looked after children. Education and Youth Service Officers believed that the offending levels of looked after children are higher for their population than for the general population. Evidence from Sergeant Hardman indicates that approximately half the young people referred to the Youth Justice Team are in care. In the Youth Justice Business Plan 2003-2006, it indicated, against 2001 figures, that 42% of the referrals were of looked after children. Given the low numbers of looked after children (approximately 90) compared with the general population of children and young people (approximately 17,000) it is clear that looked after children are more likely to experience a range of problems including offending. If this were so, it would require further specific programmes or approaches to address these issues.

Recommendation 94

The Inquiry recommends that the YJT continue to collect and analyse data relevant to offending by young people with emotional and behavioural problems and in particular, recommends that analysis is undertaken in greater depth on the offending rates of looked after children and appropriate measures implemented.

Sharing information

28.14 Another important challenge for the Youth Justice Team is to ensure that interim reports and business plans are appropriately circulated to all agencies, including the Court. Evidence was heard at the Youth Offending Seminar that the Magistrates Court was, for example, unaware of these reports. It is central to effective services across the board that all services dealing with young people with emotional and behavioural difficulties should be aware of important information relating to such children.

Recommendation 95

The Inquiry recommends that future Youth Justice Business Plans and future Youth Justice Team Interim Reports be widely publicised within other agencies who come into contact with young people with emotional and behavioural difficulties including the courts.

Planning

28.15 The Youth Justice Business Plan 2003-2006 sets out three strategic objectives for tackling youth offending:

- Protection
- Prevention and Promotion
- Participation

The Plan states that Protection relates to "protecting young offenders from re-offending and victims from the impacts of offending". Prevention and promotion relates to preventing youth crime, promoting responsible parenting, improving educational and employment opportunities for young people and promoting accessible leisure opportunities for young people. Participation refers to enabling all members of the community, including young people and young offenders, their families and victims, to have a say in the delivery of services to tackle youth offending and its causes.

28.16 The Business Plan was drawn up in April 2003 and was based on international research and seminars held on the Isle of Man. Following a helpful analysis of the data, which related to 2001, the Business Plan concluded that the analysis gave:

> "a clear indication of the links on the Isle of Man between offending by young people and family difficulties, child abuse, mental health issues and educational disadvantage."

28.17 The Business Plan represented a significant step towards laying out the strategic priorities, the criteria for measuring success and specific actions that were required. The financial plan was thin and it did not make the point that many of the resources to make the plan work would be existing ones, and not new resources. It was not clear how the financial plan would be implemented.

Recommendation 96

The Inquiry recommends that the new Business Plan for the years following 2006 include a fully costed implementation plan.

Performance management

28.18 As well as receiving evidence from many experts in this field based on the Island, the Inquiry sought the advice of two experts from off-Island, both from the Youth Justice Board for England and Wales**:** Malcolm Potter, who is Regional Manager for Yorkshire and North Humberside, and Chris Wright who is a member of the Youth Justice Board and is responsible for overseeing Performance Management of the youth justice system. Both welcomed the Youth Justice Team interim report 2004-2005 and the five year Strategy for Children and Young People.

28.19 Mr Wright and Mr Potter believed there would be greater potential of achieving the outcomes sought in regard to youth crime through their inclusion within the 5 year Strategy for Children and Young People. In particular they suggested that it would be important to include specific targets that relate directly to the five key outcomes sought within the Strategy. The Inquiry accepts their advice and proposes that that targets relating to the employment, education and training status of young people in the criminal justice system, and the provision of substance misuse services are established and given greater prominence.

Recommendation 97

The Inquiry recommends that targets relating to the employment, education and training status of young people in the criminal justice system, and the provision of substance misuse services are established and given greater prominence.

28.20 The Youth Justice Team is working well at the moment. Mr Potter and Mr Wright advised that the initiatives in the field of youth justice being taken on the Island should be set within a performance management context informed by an evidence base and supported by learning and development opportunities for those staff working with children and young people either offending or at risk of offending. Their experience of the youth justice reform process in England and Wales suggested that the active monitoring of practice and performance through an external organisation has ensured an effective focus is maintained at the service delivery level. The Inquiry accepts this advice. While the Inquiry in no way seeks to play down the success of the YJT, it suggests that consideration be given to identifying a suitable external organisation to inspect and monitor the performance of the YJT. Further advice from Mr Potter and Mr Wright could be taken in this respect.

Recommendation 98

The Inquiry recommends that the Minister and civil servant given responsibility for the YJT under the legislation recommended by this Report identify a suitable external organisation to inspect and monitor the performance of the YJT.

Resources

28.21 The Youth Justice Team was set up by re-directing existing resources from current services into the new team.

28.22 The Youth Justice Team is led by a Sergeant from the Isle of Man Constabulary. It consists of two further police officers, two social services staff, a half post allocated from health, two sub-contracted youth justice posts from Manx Family Services and a part time youth worker. The Inquiry had the opportunity to meet most of the team and was greatly impressed not only with their positive approach, but also with the results that they had already achieved. The Inquiry noted that while the police, social services and health have all contributed resources, the Department of Education and the Probation Service have chosen not to transfer existing staff to the Youth Justice Team. Instead they made bids for new money to fund posts within the YJT. The Inquiry was told that these bids were originally made two years ago and were rejected. The bid from Education has now been renewed and the outcome is awaited.

28.23 Given the importance of education issues, the Inquiry is of the firm view that education is one of the essential components of the YJT. The absence of an education representative is unacceptable[777].

28.24 The Inquiry understands the pressure on departments' budgets, but has noted that some departments have not allowed the absence of new resources to stop them contributing to an important project. They have either re-organised their work priorities or made efficiencies to implement new ways of working. The Inquiry hopes that, irrespective of whether new resources are made available, both the Department of Education and the Probation Service will each find ways of funding a post (either full or half-time) to join the Youth Justice Team.

Recommendation 99

The Inquiry recommends that in the event that their renewed bid is unsuccessful, the Departments of Education and the Probation Service do each fund out of its existing budget a post (either full or half-time) to join the Youth Justice Team.

Statutory Basis for YJT and Accountability

28.25 At present the Youth Justice Team has no statutory basis in the Isle of Man. The policies it is implementing are mostly based on good practice elsewhere, particularly from the Youth Justice Board of England and Wales.

28.26 The Inquiry has been critical elsewhere of initiatives being drawn up without a strategic plan, costs or approval through the appropriate governance arrangements of Tynwald, and it is undoubtedly the case that the Youth Justice Team has been established in this way. It has, however, been a successful venture despite its lack of

[777] See further below

statutory basis. Nevertheless it not only has no legal basis upon which to operate, but it also has no funding and no proper accountability to politicians. The Inquiry sees no advantages to the YJT continuing under its current inadequate governance arrangements and believes that its success may be jeopardised by the absence of a proper statutory basis. The Magistrate's Association referred to its "tenuous foundations". The Inquiry's concern is clearly shared elsewhere since the Children and Young People's Strategy has as one of its objectives to "formalise the pilot Youth Justice Team by introducing a statutory duty for relevant departments to establish and maintain a Youth Justice Team".

28.27 When placing the YJT on a statutory basis, the opportunity should be taken to make explicit the core members of the YJT: police, health, education, social services, probation.

Recommendation 100

The Inquiry recommends that the Youth Justice Team be placed on a statutory basis and there be a statutory duty for the departments responsible for the Police, Social Services, Health, Education and Probation services to establish, maintain and resource the Youth Justice Team.

28.28 The Inquiry is concerned that not only should the Youth Justice Team be placed upon a proper statutory footing, but that accountability for the service should be made explicit. The present arrangement whereby the service is managed by committee is wholly unsatisfactory. There are a number of management options available. The Department of Home Affairs' recommendation in their closing submission suggested that the YJT become a "separate unit distinct from any department with funding direct from Central Government". This implies that it reports to the centre of Government, albeit to an unspecified person. Another alternative is for the YJT to report directly to the Chief Executive of the Department of either Home Affairs, Education or Health and Social Security. This would mirror the approach in England and Wales, where the accountability goes beyond and above the individual chief officers and rests with an officer at the top of Government.

Recommendation 101

The Inquiry recommends that the Chief Minister's Social Policy Committee identifies a specific Chief Executive or Chief Officer to be accountable for the Youth Justice Team and for delivering the Youth Justice Strategy.

Political accountability

28.29 The Inquiry believes that accountability for the Youth Justice Strategy and the Youth Justice Team cannot lie with an official. There must be political as well as official accountability. This will require a named Minister or Departmental Minister to be identified as responsible for the Youth Justice Team and the Youth Justice Strategy.

28.30 The Youth Justice Team is, in many ways, an excellent example of joint departmental working. By different departments coming together within the one team, reductions in youth offending have been achieved that would not have been possible without such co-operation. But, as explained above, the Team needs to have a named individual to report to at a governmental level to ensure that it is both evaluated and accountable. This is the consequence of cross-departmental working and developing

a new culture of multi-disciplinary, multi-agency working. One Minister or departmental member must therefore take responsibility for Youth Justice, despite it having input from a number of different departments.

Recommendation 102

The Inquiry recommends that the Council of Ministers, or its Social Policy Committee, identify a Minister or departmental member, who is accountable for Youth Justice.

Inter-agency working corporate parenting and co-operation between departments

28.31 In Chapter 30 on Strategic Issues for Government the Inquiry has recommended that there be a duty placed on appropriate Government agencies to work together in the provision of services to children and young people. However, the Inquiry will consider in the present chapter some necessary aspects of inter-agency working in relation to offending and the risk of offending.

28.32 The Chief Constable has in his evidence on many occasions stressed the importance and benefits of partnership working.

28.33 There are a number of successful partnerships which work on a voluntary basis. These include Project Centurion, Drug/Alcohol Arrest Referral Schemes and the Bradden Parish Commissioners Partnership. This latter partnership seems to be unique insofar as it is the only local authority on the Isle of Man to employ a Community Safety Worker.

28.34 In particular, the Inquiry is impressed by the way senior managers in the police and social services have driven forward the establishment of the YJT and by those in the Health Service who have understood the need for health involvement in the lives of these particular young people. The links with services such as CAMHS, the Drug and Alcohol Services, family practitioners, school nurses, are vital and such relationships are well managed by the health postholder within the YJT to the benefit of the young people concerned.

Department of Education

28.35 The Inquiry has commented on the absence of an education presence within the Youth Justice Team. Among many representations on this issue, the Magistrates Association drew attention to the absence of an education representative in the YJT.

28.36 The Inquiry believes that the links with schools are of paramount importance and the advantages of locating an education post within the Youth Justice Team are many. The postholder would understand the range of responsibilities, requirements and initiatives operating within the educational system, and would undoubtedly develop new relationships, better communications and improved ways of supporting young people when they have offended, or when they are thought to be at risk of offending. The Inquiry believes that as a member of the YJT such a postholder would assist making good working relationships with schools and with the Department of

Education. It would reflect the need to re-inforce the central importance of education, in its broadest sense, in the lives of young people with emotional and behavioural difficulties.

28.37 The Inquiry has already recommended that an education representative be appointed as part of the Youth Justice Team.

28.38 It concerns the Inquiry that there is no protocol between the Youth Justice Team and the Department of Education, or between the Youth Justice Team and the individual schools. The Inquiry recognises that not everything can be achieved immediately, but recommends that in the current absence of an education representative located within the Youth Justice Team, a protocol is even more necessary. It would assist in formalising the school, department and YJT's respective roles in relation to young offenders, aid three way communications, set out information sharing requirements and provide named points of contact.

28.39 For example, schools need to know about cautions of and offences by their pupils and the YJT need to know about suspensions of pupils from schools. As one participant said at the seminars:

> "I think it is important that we do not label children but at the same time I do not see how staff in a school can support a child and the child's parents if they do not know that there is an issue."

Another made the point from the other side:

> "If we have the statistics from England and Wales, the youth crime survey 2004, which says that young people out of education, excluded and playing truant are twice as likely to offend, then it would be very, very useful to know if they are suspended or excluded so we can put in the preventative measures as early as possible".

Recommendation 103

The Inquiry recommends that a protocol be drawn up between the Youth Justice Team and the Department of Education and the secondary schools, which includes criteria for sharing information, points of contact and their respective roles and responsibilities.

28.40 At the seminar, the Inquiry heard from school representatives that they would welcome stronger links with the Youth Justice Team. In particular, they wanted to hear if the YJT was involved with any pupil at their particular school and in turn the YJT wished to receive information automatically about all pupil suspensions. The Youth Justice Team stated it would welcome a named person in each school able to liaise with it directly.

Recommendation 104

The Inquiry recommends that each secondary school and the Youth Justice Team each nominate a member of their staff to be the respective contact points between the school and the Youth Justice Team.

28.41 The Inquiry concluded that there was sufficient good will on the part of schools and the Youth Justice Team to strengthen the communication between them. This better communication would be of great benefit to young people on the island and could be easily achieved.

Residential homes

28.42 The Inquiry heard from both the Youth Justice Team and two of the children's homes it visited about the way in which joint working between children's homes staff and the Youth Justice staff was developing. Youth Justice Workers visit children's homes, where necessary, and make important links with both young people and staff. This has helped all concerned to stay informed about any developments taking place in the young person's life.

Youth workers

28.43 The Inquiry received written evidence from the Youth and Community Adviser. He believed that it would be inappropriate for a Youth Worker to be part of the Youth Justice Team. This was because he believed that young people could begin to view youth workers as part of the YJT, and be less inclined to attend clubs and projects voluntarily and share personal issues with them. The Inquiry believes that, on balance, this view is correct and therefore does not recommend that a youth worker join the YJT. However, the Inquiry hopes and expects that the Youth Service and the YJT will maintain regular contact.

28.44 The Inquiry was impressed with the Youth Workers they met and their high level of commitment to the young people with whom they worked. The Inquiry was also reassured that the Youth Service was well aware of the boundaries of confidentiality with young people and in particular where children were at risk.

Local or central agencies responsible for housing

28.45 The Inquiry has already referred to the lack of proper housing for children and young people with emotional and behavioural problems who are moving towards independent living and has already referred to the important evidence received from the Magistrates' Association on this issue[778]. The Association suggested that as provision comes to be made for suitable housing for such young people, there should be either direct involvement or closer links put in place between housing officers within the Department of Local Government and the Environment or local government and the Youth Justice Team and the Probation Service. The Inquiry believes that suitable housing provision is an essential component of providing effective support for such young people. It also believes that links should be forged even now between the DOLGE and local government on the one hand and Youth Justice Team and the Probation Service. These links should develop as provision is made for suitable housing following the Housing Review and the implementation of the recommendations of this Report. Consideration of links should involve whether it is necessary now or in the future for a "housing representative" (depending the outcome of the Housing Review) to be on the YJT.

[778] See chapter 24

Recommendation 105

The Inquiry recommends that the Social Policy Committee ensures through the Children and Young People's Strategy that the accommodation needs of vulnerable young people, including those at risk of offending or re-offending, are met, through discussion with and provision by appropriate housing agencies in the public, voluntary and private sectors.

Secure accommodation, custody and persistent offenders

28.46 In the Introduction to this chapter attention was drawn to the evidence given to the Inquiry which suggested that the impact of the Youth Justice Team has been to reduce the number of custodial sentences and remands received by young people, both in the prison and in the secure unit. The Inquiry is not aware of any analysis that has been undertaken to determine if this trend is likely to continue. However, the Inquiry is clear that it would not wish to see a de-commissioning of the Secure Unit.

28.47 Nevertheless, given the substantial cost of running the unit, the role of the building and its staff needs to be reviewed.

28.48 The Inquiry believes this should be done in conjunction with the Governor of Victoria Road Prison. The Inquiry heard evidence from the Deputy Governor that there was no effective rehabilitation programme for young people in prison, although another delegate at the seminar stated that the education budget within the Prison had been increased threefold and this would begin to have an impact in the next year. In his evidence, the Deputy Governor indicated that he did not think that there had ever been more than two young people up to the age of 17 years in prison at any one time.

28.49 The Inquiry considers that there may be resources available to both the prison and the secure unit, which could, if considered together, improve the care, support and rehabilitation of young people.

28.50 The Inquiry understands it is proposed to amend the legislation to extend the age of young people to 17, for those who are remanded or sentenced to be placed in the Secure Unit. The Inquiry welcomes this.

Recommendation 106

The Inquiry recommends that the Prison Governor, or his representative, the Head of the Secure Unit and the Manager of the Youth Justice Team, report to the Social Policy Committee on the implications for all the services concerned of 17 year olds being remanded to or required to serve their custodial sentence in the Secure Unit.

28.51 The Inquiry has stated already that it was very impressed with the Secure Unit[779]. However, it has noted that its occupancy rates in the recent past have been very low.

28.52 The Inquiry has proposed that a review of the Secure Unit include consideration of the very great potential for income generation[780]. Although it would require a change in legislation not only in the Island but also in the UK, the sale of a bed to another

[779] See chapter 24
[780] Chapter 24, para 24.73

jurisdiction could raise £200,000 per annum. This in turn could be used to fund the other priorities of Government for the care and support of children. The Inquiry recognises both the advantages and disadvantages of such a course of action. The process of changing legislation in the Isle of Man and England and Wales could be a lengthy one, it could reduce the options for accommodating Manx children if there was, for example, a surge of offending that required remands to secure accommodation, and it could also present problems for maintaining contact between an English child remanded to the Island and his family. The advantages are that it would reduce the unit costs per child which currently are prohibitive and thus making the Secure Unit more efficient.

28.53 In chapter 24 on Safeguarding, the Inquiry discusses possible alternative uses for the services and staff of the Secure Unit and has recommended that the role and use of the Secure Unit be reviewed as quickly as possible by the Director of Social Services with all other appropriate agencies, to ensure that it is being used efficiently and effectively.

Sentencing options

28.54 The Inquiry received written evidence from the Isle of Man Magistrates Association. It stated that it was, with the one exception, on the whole satisfied with the range of disposals it has available regarding young offenders. It stated its belief that the Youth Justice Team had improved the quality of community penalties aimed at the rehabilitation of young offenders.

28.55 The Association's submission drew attention to the importance of education:

> "From the experience of its members, the Association considers that there is a close correlation between young people who are not regularly attending mainstream education and juvenile offending."

This experience was shared by many others giving evidence.

28.56 The Magistrates' Association stated that:

> "As part of a community based penalty, the Association would like to have the option of imposing more educationally based programmes upon juvenile offenders, who were not going to school because of either suspension or exclusion. Such programme would require a relevant juvenile offender to attend some type of educational provision, possibly vocationally based, for significant periods of time during the working week as part of a community order".

The Inquiry believes this would be a valuable proposal and suggests that as a part of a community based penalty the juvenile court is given the option of imposing "through Community penalties, conditions regarding attendance upon meaningful, in terms of hours and attendance and input, educational programmes for those offenders excluded from mainstream education".

Recommendation 107

The Inquiry recommends that the juvenile court be given the power to impose as part of a community penalty, conditions requiring attendance upon effective, in terms of hours, attendance and input, educational programmes for those offenders excluded from mainstream education or otherwise not attending education

Bail conditions

28.57 Both the Families and the Department of Home Affairs in their closing submissions made recommendations to give powers to the police to permit conditions to be attached to the granting of police bail. The inquiry is aware that the ability to attach conditions to George's police bail could have assisted the police in returning George Green to his residential placement in England[781].

28.58 However, the Inquiry has been given insufficient evidence to be able to judge whether such a proposal is necessary in the support of young people with behavioural and emotional problems. Accordingly it would be unwise for the Inquiry to reach a conclusion as to whether the ability to impose conditions would be valuable in other cases or as to the wider implications of such a change.

The jurisdiction of the juvenile court

28.59 The Inquiry believes that there is a strong argument for raising of the age of young offenders appearing before the juvenile court to include 17 year olds. There is obvious logic in aligning the age a person faces adult criminal sanctions with the attainment of adult majority. On a practical level, such a change would increase the potential number of cases passing through the youth justice agencies and able to take advantage of the proven success of the YJT and the Secure Unit. This factor is given added weight if, as is recommended by the Inquiry, the YJT becomes a properly funded and fully multi-agency.

28.60 The Magistrates' Association supported such an extension of the juvenile court's jurisdiction and provided the Inquiry with figures showing that the amount of time spent by justices dealing with juvenile criminal work has reduced considerably in recent years.

Recommendation 108

The Inquiry recommends that the age of persons appearing before the juvenile court be raised to 17 years.

Anti-social behaviour protocol

28.61 The Inquiry was told of the 2004 Protocol for the management and effectiveness of Anti-Social Behaviour Orders. Mr Wright and Mr Potter, from the Youth Justice Board for England and Wales drew attention to pre-crime interventions, namely services specifically focussed on children and young people, including those below the age of criminal responsibility, who might be identified by a number of agencies as presenting a concern by virtue of their anti-social or criminal behaviour. Whilst some of the children who present this type of behaviour may come to the attention of social services, experience in England and Wales is that sometimes they fall under the threshold of need that leads to social work intervention. A pre-crime intervention team takes as its focus the impact of a child's behaviour on his community as much

[781] See chapter 12

as their identified level of need. Such a service has the potential to prevent anti-social behaviour escalating and may also serve to reassure the community that early intervention to combat anti social behaviour is taking place.

28.62 The Inquiry believes in the value of preventative initiatives, such as an Early Years Strategy[782]. Therefore the Inquiry suggests that consideration be given to linking these services or initiatives to the existing provisions for the broader management of anti-social behaviour and suggests that the Protocol is reviewed and broadened to include agreement about what preventative provision may be put in place prior to resorting to a court order. Such intervention might include a diversionary service or Acceptable Behaviour Contracts for either the child or his parents. Given the limit on the resources available the Inquiry recognises that it is not practicable to establish a separate team to undertake this pre-crime intervention. However it may be practicable to make use of an existing multi agency panel to consider such cases and to ensure that the harm and nuisance that such activities present to the public, as well as any presenting welfare need, is receiving some considered attention.

Recommendation 109

The Inquiry recommends that the Anti-Social Behaviour Protocol is reviewed and, if necessary, broadened to include agreement about what preventative provision may be put in place prior to resorting to a court order.

Comprehensive children's services directory

28.63 The Chief Constable has also made a simple, but useful, recommendation that a comprehensive children's services directory should be compiled. The Inquiry supports this proposal which will help staff from different agencies better understand each other's roles and responsibilities.

Recommendation 110

The Inquiry recommends that a comprehensive children's services directory should be established as part of the work of the Children and Young People's Strategy Committee.

Conclusion

28.64 In considering the effectiveness for young people with emotional and behavioural difficulties who are at risk of offending or re-offending, the Inquiry has generally been impressed with what it has seen and heard.

28.65 The strengths are the imaginative approach to finding solutions to specific problems when constrained by resource shortfalls, as well as finding ways of providing a service to a small number of children on the Island which quite evidently cannot provide, or access, specialist services in the same way as say a local authority in England. The weaknesses of the initiatives have tended to be that they are without a proper financial strategy or implementation plan and they are not properly monitored

[782] See chapter 27

and reviewed. There is also no legal basis for the existence of the YJT and no clear political or official accountability for Youth Justice.

28.66 It is evident that, since its formation, the YJT has had a significant impact on the level of offending by young people and the progress they have made needs both recognition and consolidation in law.

Recommendations in chapter 28:

Recommendation 94 **para 28.13**

The Inquiry recommends that the YJT continue to collect and analyse data relevant to offending by young people with emotional and behavioural problems and in particular, recommends that analysis is undertaken in greater depth on the offending rates of looked after children and appropriate measures implemented.

Recommendation 95 **para 28.14**

The Inquiry recommends that future Youth Justice Business Plans and future Youth Justice Team Interim Reports be widely publicised within other agencies who come into contact with young people with emotional and behavioural difficulties including the courts.

Recommendation 96 **para 28.17**

The Inquiry recommends that the new Business Plan for the years following 2006 include a fully costed implementation plan.

Recommendation 97 **para 28.19**

The Inquiry recommends that targets relating to the employment, education and training status of young people in the criminal justice system, and the provision of substance misuse services are established and given greater prominence.

Recommendation 98 **para 28.20**

The Inquiry recommends that the minister and civil servant given responsibility for the YJT under the legislation recommended by this Report identify a suitable external organisation to inspect and monitor the performance of the YJT.

Recommendation 99 **para 28.24**

The Inquiry recommends that in the event that their renewed bid is unsuccessful, the Departments of Education and the Probation Service do each fund out of its existing budget a post (either full or half-time) to join the Youth Justice Team.

Recommendation 100 **para 28.27**

The Inquiry recommends that the Youth Justice Team be placed on a statutory basis and there be a statutory duty for the departments responsible for the Police, Social Services, Health, Education and Probation services to establish, maintain and resource the Youth Justice Team.

Recommendation 101 **para 28.28**

The Inquiry recommends that the Chief Minister's Social Policy Committee identifies a specific Chief Executive or Chief Officer to be accountable for the Youth Justice Team and for delivering the Youth Justice Strategy.

Recommendation 102 **para 28.30**

The Inquiry recommends that the Council of Ministers, or its Social Policy Committee, identify a minister or departmental member, who is accountable for Youth Justice.

Recommendation 103 **para 28.39**

The Inquiry recommends that a protocol be drawn up between the Youth Justice Team and the Department of Education and the secondary schools, which includes criteria for sharing information, points of contact and their respective roles and responsibilities.

Recommendation 104 **para 28.40**

The Inquiry recommends that each secondary school and the Youth Justice Team each nominate a member of their staff to be the respective contact points between the school and the Youth Justice Team.

Recommendation 105 **para 28.45**

The Inquiry recommends that the Social Policy Committee ensures through the Children and Young People's Strategy that the accommodation needs of vulnerable young people, including those at risk of offending or re-offending, are met, through discussion with and provision by appropriate housing agencies in the public, voluntary and private sectors.

Recommendation 106 **para 28.50**

The Inquiry recommends that the Prison Governor, or his representative, the Head of the Secure Unit and the Manager of the Youth Justice Team, report to the Social Policy Committee on the implications for all the services concerned of 17 year olds being remanded to or required to serve their custodial sentence in the Secure Unit.

Recommendation 107 **para 28.56**

The Inquiry recommends that the juvenile court be given the power to impose as part of a community penalty, conditions requiring attendance upon effective, in terms of hours, attendance and input, educational programmes for those offenders excluded from mainstream education or otherwise not attending education

Recommendation 108 **para 28.60**

The Inquiry recommends that the age of persons appearing before the juvenile court be raised to 17 years.

Recommendation 109 **para 28.62**

The Inquiry recommends that the Anti-Social Behaviour Protocol is reviewed and, if necessary, broadened to include agreement about what preventative provision may be put in place prior to resorting to a court order.

Recommendation 110 **para 28.63**

The Inquiry recommends that a comprehensive children's services directory should be established as part of the work of the Children and Young People's Strategy Committee.

CHAPTER 29

THE VOICE OF YOUNG PEOPLE

Introduction

29.1 This Inquiry was determined to hear directly from the young people of the Isle of Man and to ensure that they had the opportunity to influence the thinking of the Inquiry, with particular emphasis on those matters which concern the care and support of young people with emotional and behavioural difficulties. The Inquiry is not aware of other public inquiries that have approached young people's involvement in this way.

29.2 The Inquiry recognised the difficulties inherent in seeking the views of young people so it resolved to frame the issues of potential concern around the five outcomes of the Children's and Young People's Strategy.

29.3 To ensure that young people were able to prepare their ideas and views, the Inquiry invited an external organisation specialising in consultation with young people to undertake the necessary preparatory work. The successful tender was made by "Investing in Children", an organisation from Durham, UK.

29.4 Investing in Children then met with two groups of young people aged 9-13 years and 13-22 years. About sixty young people discussed issues that were important to them about living on the Isle of Man. The next day, forty of these young people returned to discuss these issues in more depth and looked at how these issues might be relevant to the Inquiry. Three more meetings took place and, eventually, twenty-one young people, supported by two members of staff from "Investing in Children", gave presentations and took part in discussions with the Inquiry during the course of the Voice of Young People seminar. A number of senior officers from the Department of Health and Social Security, including the Minister, attended this public presentation and heard for themselves what the young people of the Island had to say. The ages of the young people at the seminar ranged from 12 year olds to 18 year olds. The Inquiry was particularly impressed that the Minister gave priority to attending this seminar.

29.5 The Inquiry is most appreciative of the thought, time and effort all the young people put into preparing evidence for the Inquiry.

Summary of concerns

29.6 The young people spoke passionately and in detail about what was important to them in education, leisure, transport, social services, health and about how unfairly they are perceived by the media and parts of the adult world.

29.7 Their over-riding message was that they wanted to be taken seriously, be properly listened to and be respected as individuals. One of their important recommendations, amongst many, was "having a young persons' council to relay things to the Government".

Education

29.8 The young people talked at length about education, raising issues as diverse as bullying, the need for more school clubs, school rules, suspension for allegedly trivial misdemeanours, vocational training, wanting a nicer learning environment and the ineffectiveness of most school councils.

29.9 They asked to have someone – an advocate – to talk to who was not a teacher, who listened and took their complaints seriously and got things done.

Social Services

29.10 Those young people who had experience of the care system discussed social services. Whilst they felt that social workers carried out an important job, they thought they were often too rushed and did not listen enough. They felt that young people over 16 and homeless were not considered to be the responsibility of social services, which they believed was wrong.

29.11 They believed there were too few fostering places on the Island and no one to offer young people confidential support with problems, such as mental health problems or family issues.

29.12 The young people felt there was no accessible advocacy or complaints process and that young people were not involved in any sort of ongoing discussions about the services they receive, including planning, developing or evaluating services.

Health

29.13 The young people wanted to be spoken to directly by doctors rather than via their parents. They also raised the inadequacy of sex education and their need for specific information and access to contraceptive advice. Of further concern was their not knowing where to go for general health advice. They also wished healthy eating could be further encouraged in schools.

Housing and transport

29.14 An issue of particular concern to these young people was the need for more housing for young people, particularly care leavers, and planning and development issues on the Isle of Man. They were particularly concerned over the problems of transport: citing the attitude of some bus drivers and the scheduling of evening buses.

Safety

29.15 Overwhelmingly, the young people felt safe on the Island, which they felt was entirely different to their fear of being bullied. They wanted the police to be friendlier and less suspicious and did not want to be moved on when they were simply “hanging around”.

Sports and Leisure

29.16 The young people wanted cheaper sports and leisure facilities and were keen to have another venue to go to which was similar to '*The Machine'*, a venue on Broadway. The Young People were very supportive of the way '*The Machine'* was run, but felt it could not cater for all the young people on the Island. They also welcomed the alcohol free policy of '*The Machine'*.

Communication

29.17 Lastly they spoke of the need for better communication, partly to let them know about what was happening on the Island with respect to leisure activities and partly to inform them about information such as where to obtain practical advice on access to family planning advice or other health related issues. There were different views about how this communication might be delivered.

External expert

29.18 The Inquiry was fortunate in that Ms Maria Battle, the Deputy Commissioner for Children for Wales attended the Voice of Young People seminar, as well as the Strategy seminar. She was able to confirm that the issues raised by this group of young people were broadly similar to those raised by young people in Wales.

Commissioner for children and young people

29.19 The Inquiry received advice from Ms Battle.

29.20 She described the statutory powers of the Commission for Children in Wales and how the appointment of the Commissioner for Children had arisen from the long-term abuse of children in residential care in Wales.

29.21 The Inquiry has considered a number of potential recommendations in respect of the representation of children and young people. In particular, the idea of a children's "champion" independent of Government, has been given careful thought. Those who oppose the need for a children's champion, often hypothesise that such an appointment will result in calls for champions for all other minority groups, such as older people or people with disabilities. They are, therefore, naturally wary of such a move and attempt to disqualify the proposal on cost grounds.

29.22 The Inquiry takes the view that young people on the Isle of Man need a champion, irrespective of the requirements of other groups. However, the Inquiry recognises that the role of children's champion should extend to all children in order not to disadvantage some.

29.23 The role of the Commissioner in Wales falls into two broad areas: first to obtain young people's views on issues that affect them in order to influence the direction that the Commission takes in relation to the policies of Government and other public bodies, and secondly to negotiate, mediate and intervene in individual cases to reach solutions, get results and ensure agencies work together effectively. In this latter area, the focus is, in Ms Battle's words, "to get quick and effective solutions where

services are failing children, by mediation, negotiation, advocacy and signposting. If necessary, we will use our statutory powers".

29.24 The Inquiry was impressed with the way the Commission had been established in Wales: its statutory powers, the methods by which it sought to establish the views of "the hard to reach groups" and its ability to advocate and intervene in individual cases on behalf of children and young people. The Inquiry believes that a Children's Commissioner based on this model has much to offer the Isle of Man in making its support for children and young people properly effective.

29.25 Ms Battle advised the Inquiry of the work the Commissioner for Children for Wales carries out for children excluded or not attending school in order to ensure they receive proper education; for children who are involved with social services to make sure that they receive proper support and that agencies work together; and for children who need health services.

29.26 The Inquiry believes that, in the Isle of Man, the role of the Commissioner should be first to ensure that in all settings which concern children and young people, their views should be sought and considered. This would apply equally to Government policies or the operational policy of a school, paediatric ward or children's home.

29.27 Its second role should be to receive complaints from a young person or on his or her behalf and to ensure they are properly investigated, considered and resolved.

29.28 Beyond identifying the two core roles of the Children's Commissioner, the Inquiry does not wish to be specific as how this recommendation is implemented on the Isle of Man. There are a number of options and different models throughout the United Kingdom and elsewhere in Europe upon which the setting up of a post of Commissioner for Children and Young People could be based. Options for the Island could include the commissioning of a voluntary organisation to undertake this task, a full or part time appointment reporting directly to Tynwald or the exploration of a joint enterprise with another smaller jurisdiction.

29.29 The Inquiry is mindful of the cost of establishing a Commissioner for Children and Young People. It also notes the proposal for a Children's Commissioner made by the Assistant Director Children and Families in 2003. In both Part I and Part 2, the Inquiry has identified a number of ways in which support for young people with emotional and behavioural difficulties has been and remains less effective than it should be, or, the Inquiry believes, could be. Monitoring of performance is not yet adequate to ensure effective services. Change is required.

29.30 The Inquiry believes that, if given similar powers to those held by the Commissioner in Wales, a Commissioner for Children and Young People would be able to investigate complaints from young people and families about services provided by Government departments and others. This would be an additional safeguard for young people with emotional and behavioural difficulties and an additional means by which delivery of necessary support for such young people assured. A Children's Commissioner would be an additional means by which departments could be held accountable.

29.31 Furthermore, establishing a Children's Commissioner would be to act in accordance with best up to date international practice and principles.

Recommendation 111

The Inquiry therefore recommends that the Isle of Man Government appoints a Children's Commissioner.

Youth Council

29.32 The Inquiry heard from a number of sources how a Youth Council had been set up in Douglas, but was not a success and had now lapsed. The Inquiry notes that the Children and Young People's Strategy had sought out the views of young people prior to its formulation and also presented the Strategy to young people when it was launched. The Inquiry commends these innovative steps.

29.33 To involve young people in decision-making at policy and operational levels through a Youth Council, requires a paradigm shift in approach from a wide range of individuals and agencies. Consultation and involvement of young people will, almost always, produce better solutions on issues that affect them. However, the process of involving young people needs careful planning and preparation.

29.34 Increased empowerment, involvement and responsibility for young people are among the objectives of the Children's and Young People's Strategy and the Inquiry strongly supports the Isle of Man's determination to involve young people as young citizens in issues that affect them.

29.35 The Inquiry believes a Youth Council should be re-established on the Isle of Man, and should be properly supported and funded sufficiently to enable it to fulfil its task of representing children and young people of all ages on the Isle of Man. The Social Policy Committee should identify and direct an officer to set up and liaise with the Youth Council when it is established.

29.36 Ms Maria Battle explained that the Children's Commissioner for Wales was statutorily required to communicate with children and young people in their localities, particularly those hardest to reach. The Inquiry believes that the remit of the body setting up the Youth Council should include a requirement to establish targeted programmes in order to reach "hard to reach" groups of children and young people. For example, consideration could be given to holding special events at which there are reserved places for hard to reach children: the Commissioner for Children for Wales has two events each year at which 150 places are allocated to mainstream schools and 150 places to hard to reach children.

Recommendation 112

The Inquiry therefore recommends that the Isle of Man establishes a properly funded and supported Youth Council for the Isle of Man.

Helpline

29.37 There does not appear to be a helpline for children and young people on the Isle of Man. The Inquiry believes there should be. Unless the Government wishes to establish its own helpline, the Inquiry recommends it approaches Childline to provide a service for the island's children and young people wanting confidential help and advice.

Recommendation 113

The Inquiry therefore recommends that the Government establishes a helpline for children and young people on the Isle of Man.

Communication

29.38 The Inquiry recognises the need for effective communication by and with young people. A periodic young person's newsletter written by and for young people needs to be established and the Inquiry recommends that this is set up and run either by the children's commissioner or under the auspices of a Youth Council. In addition, establishing a website for children and young people, which provides them with appropriate information, should be considered.

Recommendation 114

The Inquiry therefore recommends that the Government examines improved ways of young people receiving and giving appropriate information.

Recommendations in chapter 29:

Recommendation 111 **para 29.31**

The Inquiry recommends that the Isle of Man Government appoints a Children's Commissioner.

Recommendation 112 **para 29.36**

The Inquiry recommends that the Isle of Man establishes a properly funded and supported Youth Council for the Isle of Man.

Recommendation 113 **para 29.37**

The Inquiry recommends that the Government establishes a helpline for children and young people on the Isle of Man.

Recommendation 114 **para 29.38**

The Inquiry recommends that the Government examines improved ways of young people receiving and giving appropriate information.

CHAPTER 30

STRATEGIC ISSUES FOR GOVERNMENT

Introduction

30.1 The programme of six seminars held by this Inquiry has been a unique event. The Inquiry is not aware of there being in any other jurisdiction a public inquiry in which such senior politicians and officials have come together to consider and contribute to the deliberations of the Inquiry. This Inquiry is grateful to ministers and senior officials from all parts of the Government for making time in busy schedules. By doing so, members of the Government have aided this Inquiry immeasurably in its task of judging the effectiveness of the care and support for young people with emotional and behavioural problems.

30.2 The strategy seminar focussed on the broad cross-Government strategic issues for providing effective care and support for such children. Amongst other matters, it considered how departments work together, where accountability lies, how young people's voices can be heard and how the effectiveness of policies and services can be maintained and shown to be effective. It also dealt with resources and implementation.

30.3 The Inquiry heard from the Chief Minister that the Children and Young People's Strategy was helping to encourage departments from working less in isolation to a more corporate approach. He hoped that this would lead to more co-operation between departments.

30.4 The Inquiry heard that there had been some integration of working and was told that the Drugs and Alcohol Strategy was an example of good practice. Although a range of agencies signed up to the Drugs and Alcohol Strategy, the success of its implementation depends on inter-agency collaboration. To ensure that the progress that has been achieved thus far is sustained, it will require strong leadership, frequent evaluation and much encouragement.

Children and Young People's Strategy 2005 - 2010

30.5 The Children and Young People's Strategy is an impressive document and contains a good analysis of the issues facing the Island and contains good proposals for tackling the issues. In particular, the aim to increase preventative services with the long term aim of reducing the number of children and young people at risk is welcomed. Linda McCauley, the Strategy Co-ordinator, should be commended for the work she has done in drawing up the Strategy.

30.6 The Inquiry has considered carefully the Strategy for Children and Young People 2005-2010 laid before Tynwald on 12 July 2005. In addition, the Strategy was discussed and referred to at the Part 2 seminars. That Strategy is stated to be the result of the Government's concern to do as much as possible to support the health and well-being of the Isle of Man's children. The Government has stated it wants to make long term plans so its services could work better to meet the needs of all children and young people. Attached to this Report at Appendix 17 is the 'Summary of Framework of Actions' taken from the Strategy. This document lists the objectives of the Strategy and the actions required to fulfill those objectives. Inevitably there is a degree of

overlap between the recommendations of this Report and the actions proposed in the Strategy. However this Report and its recommendations should be seen as very much running in parallel to the Strategy. The Report does not replace it, save where there may be a difference. Both must be read together.

30.7 However, unless implemented successfully, support for young people with behavioural and emotional problems will not be improved and the population of the Island as a whole will not be assisted. The Inquiry is unaware of a costed implementation plan[783]. The Inquiry believes that there is a lack of adequate accountability for implementation of the Strategy and there is an absence of properly effective management arrangements to oversee and evaluate its progress.

Accountability and government structures

Minister for Children and Young People

30.8 The Inquiry heard of the key role that the Chief Minister plays as Chair of the Social Policy Committee. It is he who ensures that Ministers from the Department of Health and Social Security, Department of Education and Department of Home Affairs in particular, work closely together in the interests of children and young people. The current Chief Minister has considerable experience and knowledge of meeting the needs of young people, and has demonstrated his keen interest in this area over many years.

30.9 The Children and Young People's Strategy contains many features which, if implemented, would improve the level and effectiveness of care and support systems for young people with emotional and behavioural difficulties. The Inquiry has sought to highlight and strengthen these initiatives in its Report and Recommendations. However, The Chief Minister has many other responsibilities which will, of necessity, limit the time he can devote to the Children and young people's agenda. The Inquiry, whilst recognising the progress that has been achieved in moving to a more corporate approach, considers that a named Minister or Member for Children would be able to monitor, evaluate, prioritise and develop services for young people across departments in an even more productive way. The Inquiry believes that the appointment of a politician with responsibility for children and young people, reporting directly to the Chief Minister, should be made initially for the duration of the Children and Young People's Strategy 2005-2010.

30.10 The Inquiry is concerned that other strategies and policies over time have lost their impetus and therefore their effectiveness. Many worthwhile recommendations and proposals have been made but not implemented effectively. As the Chief Constable observed in his evidence in Part 1 about the Island:

> "Things take a long time to happen here in my experience"

In many areas, such as the Health Strategy, there has seemed to be an absence of effective reviews and re-assessment of the action needed to implement their recommendations. The policy document, 'The Education of Children in Public Care',

[783] See further below

was an important and necessary initiative setting out clear policies. There have been serious failings in implementing it[784].

30.11 The Inquiry believes in order to ensure that the Children and Young People's Strategy, and the proposals within it, does not lose its impetus and therefore its effectiveness, it is necessary to appoint a Minister or Member for Children. The Inquiry does not believe it is necessary to create a large infrastructure. The appointment is one which will create clear political accountability for delivering better outcomes for children and young people on the Isle of Man. The strategy requires a significant change in management and professional practice.

30.12 The Inquiry has not suggested the major structural upheaval involved in setting up a new integrated Children's Department but the scale of the changes will nevertheless demand much determination and strong leadership by senior politicians. Not identifying a named Minister or Member who will be accountable to Tynwald and the public of the Isle of Man, runs the risk of diluting the leadership that is required for achieving the requisite changes. The Inquiry believes it is a matter for Government to determine the detail of the implementation of this position in the light of the review of Government arrangements currently under discussion.

Recommendation 115

The Inquiry recommends that a post of Minister or Member for Children is created, which will report to the Chief Minister and Tynwald on the implementation of the Children and Young People's Strategy.

30.13 It follows that an official for children and young people needs to be appointed who reports to the Minister or Member for Children and whose role will be primarily a strategic and co-ordinating one between departments. This individual will also provide to the Minister or Member for Children information, which will help him/her to fulfil his/her political responsibilities. The Inquiry has resolved not to recommend a new Children's Department. It nevertheless believes that a senior official needs to be nominated to co-ordinate and implement the strategy at strategic, managerial and professional levels. The Inquiry makes no firm recommendation as to which post holder could undertake a lead responsibility for delivering the Children and Young People's Strategy, but is clear it should not be a separate new post. The Inquiry considers the options could include a Chief Executive of a Department, a Director of an existing service related to children or the Strategy Co-ordinator. Each has its merits. The litmus test of the whether the post holder is suitable will be that he/she has sufficient status and influence to ensure other senior officials embrace the substantial changes that are required to deliver the Strategy. For this reason, the Inquiry favours someone at Chief Executive level.

Recommendation 116

The Inquiry recommends that a senior officer is identified to support the Minister or Member for Children in implementation of the Children and Young People's Strategy.

[784] See chapter 26

Children's Department

30.14 The Inquiry listened carefully to the views of Ministers, professionals and the external expert witnesses on the merits or otherwise of restructuring along the recent English approach. It carefully considered whether there is a genuine commitment to corporate working throughout the Government and whether a new structure with new leaders should be established to promote this. The principal issue for the Inquiry was whether a change in the corporate culture to bring about effective working together could only be achieved by creating a new Children's Department or whether the current departmental structures could be made to work in a better way. The advantage of restructuring into one department for Children's Services is that it brings together under one chief officer the accountability and management for ensuring the delivery of the outcomes sought by the Strategy. It further enables that chief officer to manage and resolve the competing priorities of different services. A major disadvantage is that creating new structures occupy much time and divert attention in the short term from improving outcomes for children.

30.15 The Inquiry considered the advantages and disadvantages of creating a new structure. It also considered what would have to change if the current structures remained as they are. Those changes include a genuine willingness and determination to deliver the Children and Young People's Strategy on an integrated corporate basis. In particular it requires senior officers of all services to place the interests of children at the heart of their policies as opposed to the interests of their individual services. The Inquiry considered whether there was a real will and ability within the current chief officers to genuinely work in a new way. In the light of what it has heard about the past and present situations, the Inquiry cannot hide its concern about the willingness of some parts of Government, most particularly the Department of Education, to embrace new ways of working and the lack of a widespread understanding of the concept of corporate parenting. However, the Inquiry has been persuaded that the determination of the Chief Minister and the Social Policy Committee is such that they will drive the corporate approach forward. Had this not been the case, the Inquiry would have recommended a new departmental structure for Children's Services, which would have integrated into one department all those parts of departments providing services to children and young people (such as education, children and families services in the Social Services Division and relevant parts of the Health Division).

30.16 The Inquiry, in reaching its conclusion, has sought to avoid the disruption which inevitably follows large-scale reorganisations. However, it remains clear that it will require a major change of attitude and performance if the Chief Minister's objectives for more corporate working are to be successful.

30.17 However, despite the disruption caused by large scale restructuring, the Inquiry recommends that the Social Policy Committee reviews the progress of Children's and Young People's Strategy after one year from the publication of this Report. In particular, the Committee should review the corporate approach to strategy, policy, management and practice. Should progress not have been achieved at this point, the case for restructuring will have been strengthened and should be reconsidered. This would lead to the creation of a new department for children and young people with new leadership.

Recommendation 117

The Inquiry recommends that the Social Policy Committee review the progress of joint integrated working by relevant departments after one year from the publication

of the Report of the Inquiry and if adequate progress has not been achieved, it considers reorganising its Children's Services into one department.

Commissioner for Children and Young People

30.18 The Inquiry believes that a Commissioner for Children and Young People should be appointed and has recommended this in chapter 29. It is of the firm view that the Commissioner is necessary in order to ensure that services for children and young people with emotional and behavioural problems, and indeed all children, become and remain effective.

Costing implementation plans

30.19 The Inquiry has been impressed by the ambition of the Children's and Young People's Strategy and in particular that part relevant to the needs of young people with emotional and behavioural difficulties. The Inquiry was told at the Strategy Seminar that the strategy was "aspirational". The Inquiry was also told that a number of strategies have previously been put before Tynwald that have been of the same aspirational nature, and which lacked a sufficient assessment of the resources to make the full implementation of them a reality. One example given at a number of seminars was that of the sexual health strategy. Reference was made at the seminar to the impact on staff where hopes were raised by the approval of a strategy by Tynwald only to have them dashed by a conspicuous lack of implementation.

30.20 The Inquiry is concerned that the Children and Young People's Strategy was placed before Tynwald for aspirational approval only and without going on to cost the proposals and to prepare a plan which would be realistically capable of implementation. Without the means to implement the Strategy, it raises expectations unfairly and risks undermining confidence in the Government's Strategy for Children and Young People.

30.21 The Inquiry recommends that a financial implementation plan is produced for the Children and Young People's Strategy that firstly costs the various parts of the strategy and secondly identifies from where the funding will come. Strategies that extend over a number of years will inevitably lead to implementation taking place over a number of years. Whilst it is accepted that financial and other circumstances may change over time, a properly costed plan which sets out the way in which priorities will be delivered, and a time frame for delivering them, will enable the public, practitioners, managers and politicians to understand and prepare for change within the strategy. The alternative is the year-by-year budget approach which, in the main, can be disconnected from any long-term vision.

30.22 The Inquiry was told at the Strategy seminar that there was an expectation that funding for the Strategy would come from both new and existing resources. In addition, there was a discussion about the possibility of income generation. All these factors need to be put together to form a financial plan to ensure that the Children and Young People's Strategy can be delivered according to ministerial priorities.

The bidding process

30.23 The Director of Social Services explained the business planning process in his statement to the Inquiry:

> "The government clearly separates the business planning process from the estimates process. The estimates process comes first. This process begins in March/April each year when the Division collects and prioritises bids internally for submission to the Department. The Department would then draw up and approve a priority list integrating the bids submitted by Health and Social Services. That list is then forwarded to Treasury who will look at the bids and, following a meeting with the Department, submit their recommendation regarding a budget to the Council of Ministers for approval. The current arrangement looks at three years budgets together."

30.24 In earlier seminars, at the Strategy Seminar and in written submissions, reference was made to the way in which the existing bidding process undermined the potential for inter-departmental working on agreed common outcomes. The Inquiry notes the arrangements for budget bidding set out in the Strategy. The Inquiry believes that they need strengthening.

30.25 Each department inevitably focuses on its own core responsibilities as its priority. The new Social Policy Committee seeks to agree priorities for the government but the Inquiry was told only of occasional examples such as the Drug and Alcohol Strategy where Chief Officers were encouraged to submit joint proposals for funding "joined-up" services or outcomes. Whilst the Inquiry understands the many pressures on the "core business" of each department and division, it nevertheless noted carefully the Chief Minister's determination to move away from departmentalism towards corporate working. The Inquiry is clear that a new system for establishing corporate recommendations should be established. It believes that relevant Chief Officers should together draw up these recommendations, rather than submit separate bids for Minister to adjudicate upon.

30.26 The Inquiry recommends that the Chief Officers' Group should submit a properly costed implementation plan for the Social Policy Committee. The change in the process would be that the Directors would jointly make recommendations on which priorities should be considered to deliver effectively the successful implementation of the Children and Young People's Strategy. This would include financial proposals which would indicate how the priorities might be funded. The Chief Officers would not submit bids to Ministers which were not agreed as being a priority for the Strategy. This would give options and recommendations for priorities to be implemented during the course of the Strategy. The Chief Officers would make these recommendations within a financial framework agreed by Ministers. It would probably include some new resources, an agreed level of efficiency savings to be recycled into new services, opportunities to "spend to save" and proposals for income regeneration.

30.27 The Inquiry does not underestimate the challenge of Chief Officers being asked to accept that the priorities of the new agenda within the Children and Young People's Strategy might be greater than those within their core responsibilities. The changes they are being asked to accept is that the Strategy is now the framework under which all services for children and young people are considered, evaluated and prioritised.

Recommendation 118

The Inquiry recommends that Ministers from the Social Policy Committee establish a corresponding Chief Officers Group charged with making joint recommendations regarding priorities for the implementation of the Children and Young People's Strategy and putting forward the financial plans for implementing them.

Pooling of budgets

30.28 In other chapters, the Inquiry has made recommendations about the pooling of budgets where there is an overlap of responsibilities. Examples include the Youth Justice Team, funding for off Island placements, or an early years strategy. Each of these areas potentially has funding which comes from a range of departments. The Inquiry recognises the challenges of bringing budgets together from different departments but believes nevertheless, that pooled or ring-fenced budgets for specific services contribute to service effectiveness and in particular efficiencies.

Recommendation 119

The Inquiry recommends that inter-agency services which overlap in their responsibilities are identified and the pooling, merging or ring fencing of those budgets is introduced where appropriate.

Co-location

30.29 Part of the efficiencies that can take place relate to accommodation and co-location. As services gradually evolve to meet the five outcomes of the Strategy, it will become apparent that successfully changing and improving these outcomes require different services to work more closely together. For example, the Inquiry has been told that the Youth Justice Team has reduced offending rates of young people by recognising that if change in a young person's behaviour is to be achieved services need to take account of a range of his/her needs, including education, health and safety.

30.30 The Inquiry has heard from both professionals and young people that the notion of a "one-stop shop" for children is an attractive one. This would require a range of staff from different agencies to be available at one location on a full or part-time basis. The Inquiry is attracted to this proposal which it believes is child-centred and in particular expects it to be attractive to young people who find it difficult or challenging to access services. The Inquiry encourages the Government to consider the possibilities of such proposals. The Inquiry commends the attempts by the Youth Service and the Health Division to acquire a venue which would have accommodated an information and advice service and also access to health services. The Inquiry also believes that building services around communities will make them more accessible to young people. It recognises the costs of creating new centres, but also sees the possibilities of using existing resources and buildings in different ways. The role of school premises as potential locations for a range of services is attractive to the Inquiry although it makes no specific recommendation on this subject.

30.31 Where children and young people with emotional and behavioural problems are concerned, the question of easy access to advice and support becomes even more important.

Recommendation 120

The Inquiry recommends that co-location of staff from different departments be considered wherever it is thought that joint working could be improved.

Recommendation 121

The Inquiry recommends that in determining the effectiveness of its services, the Government takes into account the views of children, young people and their families about the location of their services.

Early years and preventive services

30.32 Although the Terms of Reference of the Inquiry primarily focus on children and young people of secondary school age or above, the Terms of Reference also require consideration, where considered necessary, of care and support provided in earlier years.

30.33 Dame Gillian Pugh, an international expert on Early Years, stated in her evidence:

> "… there appears to be no shortage of provision on the Island, with a considerable variety of services for children, young people and their families. What appears to be missing is sufficient attention to the needs and views of users about these services and poor co-ordination between the various providers".

30.34 The Inquiry heard that an early years strategy had been produced by the Department of Education without reference to any other department. Whilst commending the Department of Education for giving early years sufficient priority to produce a strategy, the roles of primary health care and in particular Health Visitors and Family Practitioners, as well as that of Social Services, are crucial in formulating an integrated approach to supporting young families.

30.35 The Inquiry believes that more emphasis should be given to early years if the problems that families experience in later years are to be avoided. The Inquiry therefore has set out recommendations in Chapter 27 above. While these are long term solutions, they are important and should be implemented as a matter of priority.

Voice of children and young people

30.36 The Inquiry commissioned an external organisation to seek the views of young people on matters concerning them, in particular the five outcomes identified in the Strategy. About 60 young people contributed and 21 attended the Voice of Children and Young People seminar. The Inquiry recognises and applauds the efforts made by the Government to consult young people in connection with the Strategy. However, it believes that more needs to be done, as discussed in chapter 29 above.

Performance management and external inspection

Data

30.37 At the Strategy Seminar both the Chief Minister and the Minister of the DHSS expressed frustration that current services were not properly evaluated to determine whether or not they were effective. The Inquiry noted in Part 1 that whilst there were

some examples of monitoring, Ministers, Members and Chief Executives did not receive the kind of information about performance management that they needed in order to assess the effectiveness of current service delivery and, crucially, future priorities.

30.38 The Children and Young People's Strategy, rightly in the opinion of the Inquiry, has emphasised the importance of collecting adequate data.

30.39 In the light of the five outcomes identified in the Children and Young People's Strategy and which have joint corporate objectives, it is more important than ever that there are clear indicators set out by which each service will be measured. A good example of a strategy that incorporated the need for joint working is the Health Strategy (2002). The Health Strategy identified the need for action from the Transport and Housing Departments amongst others, to make a corporate Health Strategy effective. Since the Children and Young People's Strategy reinforces the fact that most improvements to children's lives depend on specific departments working effectively together, the implementation plan needs to be precise about what it is that each department is expected to do, and how their performance should be measured. What has been lacking is the data and proper evaluation to determine how the plans are being implemented. Recommendations about the use of data have been made in each of the preceding chapters of Part 2 as the Inquiry believes data and effective performance management systems lie at the heart of determining the effectiveness of services on the Isle of Man.

Recommendation 122

The Inquiry recommends that in determining the effectiveness of the Children and Young People's Strategy, the Social Policy Committee give a high priority to the development of systems for measuring and managing performance.

External inspection of departments

30.40 The Inquiry welcomes the support given by Ministers to external independent inspection of services. Some departments have already introduced regular external inspection but others have not. The Inquiry believes that independent external inspection is an essential step for evaluating not only the effectiveness of individual services, but also the way services are working together.

30.41 This proposal was strongly supported by the evidence of two external experts, Jonathan Farrow, Chief Executive of St Christopher's Fellowship, itself a provider on the Isle of Man, and John Coughlan, Director of Children's Services for Hampshire. Mr Farrow was so concerned at the lack of any inspection of child care services on the Island when St Christopher's won the contract for some residential services that he set up his own internal inspection arrangements. Since then social services have established an internal departmental Inspection Unit which appears to be working well. This is however only a supplement rather than a substitute for independent external inspection.

30.42 The Inquiry believes that all relevant Government departments should negotiate an external inspection from another jurisdiction, such as England, Wales, Scotland, Northern Ireland or Ireland, at regular and sensible intervals, rather than on an ad hoc

basis. It has specifically recommended the introduction of external inspection of the Social Services Division[785]. It may be that the Government could offer its own staff to contribute to inspections in other jurisdictions whenever appropriate, thus both reducing costs and increasing expertise within its own service.

Recommendation 123

The Inquiry recommends that the Council of Ministers requires each relevant department and in particular the Health Division, Social Services Division, the Department of Education, Police Service and Probation Service to be inspected on a regular basis by an independent inspectorate from another jurisdiction.

Monitoring performance of service providers

30.43 The Inquiry has been greatly concerned by the absence of proper monitoring of service providers[786]. Monitoring of performance is usually undertaken through a combination of methods which include inspection of services, formal reviews of service level agreements, consideration of complaints and reports by social work practitioners. Increasingly commissioners of services are also consulting the users of services on their views. The Inquiry has been concerned at the absence of fully effective service level agreements between the Government and the non-governmental providers. It recognises that the new Inspection arrangements and a contracting officer, as discussed in Chapter 24, have started to address these issues, but the Inquiry remains concerned at how long it has taken to address these matters of profound concern which have been raised on different occasions over, in some cases, a number of years. There was for example, an audit of Manx Family Services single occupancy residential projects for young people in February 2002.

30.44 The Inquiry has seen the reports of two audits carried out by the Treasury Internal Audit Division of provision of children and families services by the DHSS. The 2002 audit report confirmed many of the impressions gained by the Inquiry during Part 1. Points arising from the Audit dated 24 December 2002 included:

- Compliance with existing requirements could not be verified because many procedures, guidelines and service level agreements only existed in draft form
- Most service level agreements were not signed, so no formal requirements existed to comply with
- There was no monitoring of performance or adherence to the terms and conditions of the agreements
- Targets needed to be established and measured to assess achievement of goals and objectives
- Supervision policy was not being adhered to
- Essential that Social Services Division made a significant improvement with regard to issuing procedures and guidelines
- There was no true and representative picture portrayed of the expenditure analysis of the department.

[785] See chapter 24
[786] See chapter 18 and chapter 24

30.45 It is a matter of concern that a review of services by the Audit Division[787] two years later found many similar shortcomings. The audit report of March 2004 included the following concerns:

- Contracts with service providers were not signed
- Concern expressed regarding contract made by one of the existing suppliers with members of the department prior to short listing
- Concerns about the comparative costs and effectiveness of placements
- The need for the Division to consider the implications and requirements of the service level agreements prior to the completion of contracts
- Efficient use of the facilities and possible savings were dependent on Division monitoring and controlling the service providers

30.46 Serious problems had persisted in Children and Families Services of the Social Services Division and in the commissioning and monitoring services.

30.47 Whilst recognising the recent improvements to both inspection and contracting, and noting that an external investigation is to be made into the Manx Family Services, the Inquiry remains greatly concerned about the problems identified in both audit reports. In particular, given the inadequate response to the 2002 report, the Inquiry seeks reassurance that the concerns outlined above will be robustly and vigorously dealt with.

Recommendation 124

The Inquiry recommends that, one year after receiving the Report of the Inquiry, the Social Policy Committee receives a joint report from the Director of Social Services and the Audit Division outlining the action which has been taken in relation to the findings of the audit reports of 2002 and 2004 and on any issues outstanding.

Placement strategy for looking after children

30.48 One of the foremost concerns of those attending the seminar was the comparatively small number of foster placements available. The Isle of Man has a low ratio of children in foster placements to residential placements. Only 39% of children looked after are placed in foster placements. This compares unfavourably with local authorities in the UK where foster placements as a proportion of all placements of looked after children, vary between 69% and 80%. A drive to recruit more foster placements last year had disappointing results.

30.49 The low unemployment rate on the Isle of Man (1%) and the small population size mean that there are particular difficulties in recruiting foster and adoptive parents. The Inquiry heard evidence from Foster Plus that in addition many of those interested in working in the caring professions were already employed in those professions. However, Wes Cuell, the external expert from the NSPCC, expressed forcefully that whilst many local authorities in England often found reasons for low recruitment, all of them made significant strides in recruitment when they made concerted efforts. He said: "there is nowhere in the UK where you cannot recruit foster carers". The

[787] The review was limited by a desire on behalf of the Audit Division not to encroach on the likely areas to be covered by the present Inquiry

Inquiry cannot see any reason why the Isle of Man should be so different to comparative areas in England, and therefore believes that greater efforts can be made to recruit more foster placements.

30.50 It is a matter of concern to the Inquiry that there should be such an imbalance between fostered children and those placed in residential care. This is discussed further in chapter 24.

30.51 The Inquiry believes there is no clear accommodation strategy for looked after children. The residential homes run by St Christopher's and the Isle of Man Children's Centre are showing improvement in focus and delivery of care. But one external expert expressed great concern from a financial and child safety point of view about the large number of small homes. The high costs and the potential isolation of young people in single occupancy homes both suggest that a cost/benefit analysis of these homes should be part of a wider examination of the way in which care is being delivered. Whilst the Inquiry has heard positive evidence from some professionals and young people about how the small homes provided by Manx Family Service fill a gap that other services cannot provide, nevertheless the Inquiry remains concerned at the number of small units and the overall proportion of young people who rely on them. The Inquiry believes significant financial savings as well as improved outcomes for children and young people can be achieved by substantially increasing fostering and reducing residential placements. When asked during the Seminar on Safety, representatives of all service providers including MFS, readily accepted they had children within their units whom they thought would benefit from fostering.

30.52 The Inquiry has recommended that an accommodation strategy for looked after children be drawn up with a view to increasing the number of children placed in foster homes as well as clarifying the specific roles played by its residential homes. Not only should the role of the existing residential provision be re-assessed, but a determined policy introduced to reduce the residential provision in favour of a significantly better paid fostering, adoptive and kinship service. The Inquiry has made a number of recommendations in relation to the priority of increasing foster placements and reviewing and reducing the reliance on residential care in Chapter 24. The Inquiry has also considered the question of the secure unit[788].

Health

30.53 A range of Health issues has been considered by the Inquiry. These include family planning, sexually transmitted infections, dental health, paediatric services and secondary and primary care. In particular, the Inquiry has considered provision relating to drugs and alcohol and child and adolescent mental health. All have been addressed in the chapter 25 on Health.

30.54 The Inquiry noted that a re–launch of the Health Strategy 2002 was being considered. The Inquiry has recommended that the Social Policy Committee considers this issue along with financial proposals on its implementation as soon as possible.

[788] See chapter 24

Education

30.55 Educational provision for children and young people with emotional and behavioural problems has some way to go before it can be said to be adequately effective. The Inquiry has considered this in chapter 26.

30.56 The Inquiry is aware that tension exists between the Department of Education and some of the secondary schools. Whilst not unique, it nevertheless potentially undermines the way in which the Government of the Isle of Man expects its schools to be run. Allowing schools autonomy within a Government framework is often a potentially difficult balance to strike. However, the Inquiry became aware of a considerable variation in the practice of suspending children and the range of pastoral and special educational support that is offered in the secondary schools. Some aspects of the practice are excellent and progressive; others are not. The Inquiry believes that the Department of Education and the head teachers need to work hard to agree on where consistency of practice is required and where flexibility is permitted, particularly in relation to children with emotional and behavioural problems.

30.57 The Inquiry recognises the recent establishment of the Secondary Referral Unit at key stage 3 for six children and was impressed by the commitment of the staff. It is apparent however, that there is a significant need for more support for children with similar problems at key stage 4. The pressures on the schools to manage children with these difficulties is growing and if this group of children are not to fall out of the system altogether as Samantha Barton did, then new resources must be found to meet these needs.

30.58 In Part 1 and in the education seminar the Inquiry was greatly concerned by the apparent absence of a sense of responsibility for meeting the education needs of looked after children by the Director of Education and his staff. The lack of commitment to joint funding of residential placements for George Green and Samantha Barton and his evidence about that issue in Part 1 was an example. The central role of education in the lives of all children, but particularly for those where the other parts of their lives are in chaos, is critical. The Inquiry did not accept the evidence given by the Director of Education that his department should not contribute to the educational costs of off-Island residential placements. The Inquiry is clear that the Department of Education should accept a responsibility for providing education for all children on the Isle of Man, and this should include a financial responsibility.

30.59 However, the Inquiry is keen to see departments move away from defending their budgets against each other and to move forward with a new approach of identifying common outcomes, shared responsibilities and pooled budgets where demonstrably children and young people require departments to work together.

30.60 The Inquiry has seen, read and heard of effective work taking place between schools, social services and health to support the well-being of children with emotional and behavioural problems. One such example involved staff from St Ninian's and Tromode House Children's Home working flexibly and effectively together to manage a young person's challenging behaviour. The Inquiry recognises that this is not an isolated incident of good practice but leadership is required to ensure that this is applied consistently across the services.

Workforce issues

30.61 In chapter 24 on safeguarding, the Inquiry outlined the range of recruitment, retention and training issues that it was told related to the Isle of Man. The Inquiry has made a number of recommendations in relation to these issues. The Inquiry has made no recommendations to change the policy on the "head count". However, it has recommended reviewing the recruitment and retention strategy for those staff working with children, particularly those with emotional and behavioural difficulties, as it believes that there are steps that can be taken to recruit and train high quality staff.

30.62 In chapter 25 on health, the Inquiry drew attention to the overlap in skills, training and delivery of services by staff working with children. It has also considered the possibility of more flexible use of staff at the Secure Unit[789].

Inter-agency working: corporate parenting and co-operation between departments

30.63 In each of the chapters relating to Part 2, the Inquiry has allocated a section to inter-agency working. In many organisations, both inside and outside of Government, there is an inclination for individuals, teams and, sometimes, whole departments to focus only on their own direct responsibilities without awareness or concern for the related responsibilities of others. From a "consumer" perspective it is important that related services are co-ordinated properly so they are not pulled in opposite directions by conflicting policies, given contrary advice or overwhelmed by "support" from different numerous professionals.

30.64 The Inquiry is firmly of the view that effective inter-agency working is at the heart of achieving better outcomes for children and young people with behavioural and emotional difficulties. There are some examples of successful inter-agency working at strategic, managerial and professional levels, but not enough. Achieving this remains a major challenge for Government.

30.65 One example of inter-agency working is in the support of the principle of corporate parenting. The expression "corporate parenting" has been used on many occasions during the course of this Inquiry[790]. It is a term which means that those individuals within central and, particularly, local government must accept individual responsibility as well as collective responsibility for the well-being of looked after children. It requires an understanding that looked after children are not in care through any fault of their own but through the inability of their parents to care for them and through the failure of society – and all of us within it – to have aided or assisted that family or to have intervened earlier in order to ensure that child did not continue to suffer. That failure – our failure – imposes upon the state, as our representatives, the obligation to step in and act as the parent of that child. But we all have a role to play in doing that. It is not simply the task of social services, nor indeed of all the other agencies of government, it is incumbent upon all of us as individuals to accept partial responsibility for parenting those children whose parents cannot or will not. It requires individuals and departments alike to make contributions to the well-being of looked after children.

[789] See chapter 24
[790] See chapter 21

30.66 As in other jurisdictions, such as England and Wales, corporate parenting is not a phrase widely known or understood outside of social services.

30.67 The Inquiry has concluded that in general it is a term which is understood by social services staff, but not by the majority of staff in other agencies, nor by a number of politicians. The Inquiry believes that it is a helpful concept which brings departments, staff and politicians together in delivering better policies and services for looked after children. It helps avoid departments working against each other, either intentionally or unintentionally. It gives a priority to a group of young people whose outcomes are usually demonstrably worse than those of other children.

30.68 The Inquiry is impressed by much of the Chief Minister's Children and Young People's Strategy, which stresses the need for all departments to work together in the interests of children and young people. The concept of "corporate parent" to looked after children supports the overall aims of the Children and Young People's Strategy in encouraging the joint responsibility by different departments of Government for the well-being of children and young people. The Inquiry recommends that the Social Policy Committee formally adopts the principle of "corporate parent". The Inquiry is clear that the term "corporate parent" will need careful explanation to politicians and staff from different departments of Government.

30.69 The Inquiry supports the Chief Minister's desire to introduce a new culture of inter-agency working in Government. In order to do this, the Inquiry believes that it is necessary to place a duty on agencies to work in partnership together, if a change of culture is to be brought about and embedded.

30.70 The Inquiry believes that the protection of the Island's most vulnerable children should be the highest priority within the Children and Young People's Strategy. To achieve a new approach requires an acceptance by a range of agencies that they have an equal responsibility in providing an effective and safe child protection service on the Isle of Man. The advocate who represents social services in child care cases in court proceedings has given evidence that she believes that inter-agency co-operation should be enforced by a change in legislation which places a duty on agencies to co-operate with each other rather than relying on best practice from the English Children Act 2004. The Inquiry agrees.

30.71 The Inquiry recognises that there are examples of successful partnership working on the Isle of Man but equally the Inquiry has seen many examples where a failure to place a duty on agencies to work together in partnership has made the approach in the particular area a hit and miss affair. Examples of such failure include the lack of understanding of corporate parenting, the lack of joined-up thinking in early years work, the refusal of some departments to place staff within the Youth Justice Team and others.

Recommendation 125

The Inquiry recommends that the Isle of Man Government adopt the principle of corporate parenting.

Recommendation 126

The Inquiry recommends that legislation is introduced to place a statutory duty on all departments of Government to co-operate with each other in safeguarding and promoting the interests of looked after children and in delivering the outcomes for all children identified in the Children and Young People's Strategy.

Information sharing

30.72 The Inquiry has considered information sharing to be an important pre-requisite for delivering effective services to children with emotional and behavioural difficulties and most chapters have references to its importance. One reason is because a common feature of many of the public inquiries held in the UK into the deaths or ill-treatment of children has been a breakdown in communication between individuals and agencies. A second reason that is that it has been told of several important policies and strategies whose effectiveness have been undermined by the fact that key individuals have not been informed about them. Ironically, one of these is the Information Sharing Protocol itself. Senior staff in several departments were unaware of its existence. In Part 1 the Inquiry took a considerable interest in how information was shared about dangerous people and what the implications were of not doing so. Information sharing is therefore critically important at a range of levels and the Inquiry has made a number of recommendation about improving communications, training, compliance, monitoring and systems.

30.73 The production of the Information Sharing Protocol is an important achievement. It now needs to be made to work. The Protocol needs an implementation plan if it is to be used effectively. The Inquiry would expect to see an implementation plan to include compulsory inter-agency information and training events, the use of e-mails, which teachers and social workers have access to, and the circulation of the Protocol information and leaflets to all appropriate agencies.

Recommendation 127

The Inquiry therefore recommends that an implementation plan is drawn up to publicise to all relevant staff the policy, procedures and requirements of the Information Sharing Protocol.

Leadership

30.74 This was not an area discussed at the strategy seminar except in relation to ministerial accountability for the implementation of the Children and Young People's Strategy. It was, however, an issue that was raised many times in the other Part 2 seminars and throughout the written evidence.

30.75 In chapter 24, the Inquiry has expressed concern and made a number of recommendations in relation to the findings of the NSPCC report into the poor practice of social services staff as recently as the summer of 2005. More generally, it has expressed concern at the absence of monitoring of performance by senior social services staff and the Chief Executive of the DHSS. The apparent isolation of the Department of Education in working with other departments has been referred to earlier in this Report. The seeming lack of urgency in achieving change on a range of Government policies was discussed at the strategy seminar. All of these observations reinforce the need for strong and decisive leadership in delivering effective services.

30.76 The Inquiry recognises that to administer effectively the range of services within Government is highly complex and challenging. It requires able, well-trained and hard working officials to make it work. The Chief Minister made it plain that he wishes to establish a new culture of corporate working in the way the Government's business is managed. This requires new attitudes, different perspectives and new skills.

30.77 The Inquiry believes that if the Government is to deliver a new culture within public services for children and young people, like any other organisation seeking to bring about change, it needs to assess whether it has the leaders in divisions and departments to achieve this goal. Whilst the Inquiry is particularly focussed on the support for children with emotional and behavioural problems, it believes the same principles of corporate working will apply to all the objectives of the Isle of Man Government. If a new culture is to be achieved, leaders will have to modify their behaviour and approach to their individual and collective responsibilities. The Inquiry strongly supports the Chief Minister in his determination to change the culture of public services in the Isle of Man. Poor inter-agency and inter-departmental working has been a consistent feature throughout this Inquiry. In addition, poor management oversight and practice has been a prominent feature throughout Part 1 of the Inquiry.

30.78 Without a determination to change radically the culture of the way in which Government Departments operate, the Inquiry does not believe that the required change will take place. The Inquiry believes that the Government should provide management development and training opportunities for its senior officers to prepare properly for the changes that are required and if necessary should seek external support.

30.79 The Inquiry believes that external management consultants could usefully assist in identifying changes required in management practice and behaviour and in offering training and development. They could also assist in evaluating the skills and performance of senior officers in their potential to deliver the new agenda. Depending on their conclusions it might be considered necessary to engage a small team (composed of both on-Island and off-Island members) to implement the recommendations of the Inquiry's report.

Recommendation 128

The Inquiry recommends that, to support his desire to move towards corporate working, the Chief Minister engages management consultants to work with senior officers in the Government to establish the skills and behaviour required to deliver the new agenda and to provide appropriate training.

Recommendation 129

The Inquiry recommends that the Chief Minister engages a management consultancy to evaluate and review the skills and performance of senior Government officers in their potential to deliver the new agenda for change and that the consultancy be free to recommend management changes if, after evaluation and review, they feel them to be necessary.

30.80 The successful implementation of the recommendations of this report will depend in part on determined leadership. In view of past failure to implement effectively the introduction of new policies and other changes, the Inquiry believes that, twelve months after publication of this report, there should be an external review of progress towards implementing the recommendations of the Inquiry. The Inquiry notes that in its closing submissions, the DHSS invited such an independent assessment of progress and implementation at a future date.

Recommendation 130

The Inquiry recommends that, twelve months after publication of this Report, there be an external review of the progress towards implementing the recommendations of the Inquiry.

Relationship between officials and politicians

Officials and the minister or political member

30.81 In Part 1 a number of allegations were made regarding improper political pressures placed upon a range of staff (see chapters 8, 9 and 20). The allegations were discussed in Part 1 and it became apparent that the belief that inappropriate political pressures were being put on staff was widely held by both junior and senior staff.

30.82 As has been discussed in chapter 20 above, Mrs Clare Christian, MLC, after having taken legal advice, set out in a letter dated 17 March 1998 a clear statement of the principles delineating the proper exercise of the power of the Minister and political member in the Social Services Division and their practical application. This clear understanding did not prevent, in 2001, the political member on the one hand and senior social services staff on the other from not recognising where lay the division of responsibility. The misunderstanding and lack of clarity in the practical and proper extent of the role of political member and departmental officer in connection with Samantha's placements was unacceptable, involving as it did the welfare of a young person for whom the DHSS had a statutory responsibility. It was regrettable that this clear statement of the principles was not better known to political members and officers alike.

30.83 In December 2001, the Council of Ministers commenced a review of the Notes for Ministers. By May 2005, a draft was ready to go to Members of Tynwald. This draft was amended to reflect the evidence given in Part 1of the Inquiry relating to the giving of instructions to officers by the political member[791].

30.84 The final version of the Government Code was due to be issued in late 2005. Part 4 deals with "Ministers and Civil Servants". Paragraph 4.9 states:

> "Civil Servants should always recall that it is Ministers, and not they, who bear political responsibility. A civil servant should not decline to take, or abstain from taking an action because to do so would conflict with his or her personal opinions on matters of political choice or judgement between alternative or competing objectives and benefits. However, there may exceptionally be circumstances in which a civil servant considers that he or she is being asked to act in a manner which appears to him or her to be:
>
> (a) Either improper, unethical or in breach of constitutional conventions, or to involve possible misadministration, or to be otherwise inconsistent with normal standards of conduct or professional judgment. In such a case he or she should report the matter to the Department's Chief Officer or the Chief Secretary.
>
> (b) Or directly contrary to deeply held personal conviction on a fundamental issue of conscience." (emphasis added)

[791] Information given to Inquiry by Chief Secretary's Office letter 20 October 2005

30.85 The Inquiry recognises that Part 4 of the Government Code applies to all departments of Government. It welcomes the additional words inserted in paragraph 4.9 of the Government Code, which are underlined in the text set out above. However, in the light of the evidence given in Part 1, the Inquiry remains concerned that proper exercise of powers by the Minister and political member on the one hand and the duties of officers on the other and their practical application in the Social Services Division are not sufficiently widely known or clearly understood. They need to be known and understood by political members and by officers alike. Expectations of behaviour and relationships and methods of communication between officials and politicians should be unambiguous. The Inquiry believes that there should be written guidance issued by the Minister for DHSS; it should be made available to newly appointed ministers and political members on taking up appointment and to officers in the department. It should be based on the overarching Government Code and on the principles set out in Mrs Christian's letter dated 17 March 1998.

Recommendation 131

The Inquiry recommends that the Minister for the DHSS issues on behalf of the department written guidance on the principles governing the proper exercise of the powers by the Minister and the departmental members in respect of decisions involving the welfare of individual children looked after by the department.

Officials and non-member MHKs

30.86 The Inquiry recognises the importance of transparent relations between officials and politicians. In chapter 20 above, the Inquiry considered concerns raised about the proper method by which non-member MHKs approach junior officials in the Social Service Division and whether some regularisation of the position would be beneficial. The Inquiry believes that political pressure should not be brought, directly or indirectly, on junior officials in connection with decisions made about a child or young person with emotional or behavioural problems. It believes that the appropriate route for political enquiries of any kind is, if not to the departmental member, to the Assistant Director or above. A protocol should be put in place to ensure that this route is followed.

Recommendation 132

The Inquiry recommends that the Council of Ministers discusses with the appropriate authorities in Tynwald the development of a Protocol governing contacts between non-member MHKs and officials of the Social Services Division.

Recommendations in chapter 30:

Recommendation 115 **para 30.12**

The Inquiry recommends that a post of Minister or Member for Children is created, which will report to the Chief Minister and Tynwald on the implementation of the Children and Young People's Strategy.

Recommendation 116 **para 30.13**

The Inquiry recommends that a senior officer is identified to support the Minister or Member for Children in implementation of the Children and Young People's Strategy.

Recommendation 117 **para 30.17**

The Inquiry recommends that the Social Policy Committee review the progress of joint integrated working by relevant departments after one year from the publication of the Report of the Inquiry and if adequate progress has not been achieved, it considers reorganising its Children's Services into one department.

Recommendation 118 **para 30.27**

The Inquiry recommends that Ministers from the Social Policy Committee establish a corresponding Chief Officers Group charged with making joint recommendations regarding priorities for the implementation of the Children and Young People's Strategy and putting forward the financial plans for implementing them.

Recommendation 119 **para 30.28**

The Inquiry recommends that inter-agency services which overlap in their responsibilities are identified and the pooling, merging or ring fencing of those budgets is introduced where appropriate.

Recommendation 120 **para 30.31**

The Inquiry recommends that co-location of staff from different departments be considered wherever it is thought that joint working could be improved.

Recommendation 121 **para 30.31**

The Inquiry recommends that in determining the effectiveness of its services, the Government takes into account the views of children, young people and their families about the location of their services.

Recommendation 122 **para 30.39**

The Inquiry recommends that in determining the effectiveness of the Children and Young People's Strategy, the Social Policy Committee give a high priority to the development of systems for measuring and managing performance.

Recommendation 123 **para 30.42**

The Inquiry recommends that the Council of Ministers requires each relevant department and in particular the Health Division, Social Services Division, the Department of Education, Police Service and Probation Service to be inspected on a regular basis by an independent inspectorate from another jurisdiction.

Recommendation 124 **para 30.47**

The Inquiry recommends that, one year after receiving the Report of the Inquiry, the Social Policy Committee receives a joint report from the Director of Social Services and the Audit Division outlining the action which has been taken in relation to the findings of the audit reports of 2002 and 2004 and on any issues outstanding.

Recommendation 125 **para 30.71**

The Inquiry recommends that the Isle of Man Government adopt the principle of Corporate Parenting.

Recommendation 126 **para 30.71**

The Inquiry recommends that legislation is introduced to place a statutory duty on all departments of Government to co-operate with each other in safeguarding and promoting the interests of looked after children and in delivering the outcomes for all children identified in the Children and Young People's Strategy.

Recommendation 127 **para 30.73**

The Inquiry therefore recommends that an Implementation Plan is drawn up to publicise to all relevant staff the policy, procedures and requirements of the Information Sharing Protocol.

Recommendation 128 **para 30.79**

The Inquiry recommends that, to support his desire to move towards corporate working, the Chief Minister engages management consultants to work with senior officers in the Government to establish the skills and behaviour required to deliver the new agenda and to provide appropriate training.

Recommendation 129 **para 30.79**

The Inquiry recommends that the Chief Minister engages a management consultancy to evaluate and review the skills and performance of senior Government officers in their potential to deliver the new agenda for change and that the consultancy be free to recommend management changes if, after evaluation and review, they feel them to be necessary.

Recommendation 130 **para 30.80**

The Inquiry recommends that, twelve months after publication of this Report, there be an external review of the progress towards implementing the recommendations of the Inquiry.

Recommendation 112 **para 30.85**

The Inquiry recommends that the Minister for the DHSS issues on behalf of the department written guidance on the principles governing the proper exercise of the powers by the minister and the departmental members in respect of decisions involving the welfare of individual children looked after by the department.

Recommendation 132 **para 30.86**

The Inquiry recommends that the Council of Ministers discusses with the appropriate authorities in Tynwald the development of a Protocol governing contacts between non-member MHKs and officials of the Social Services Division.

CHAPTER 31

RECOMMENDATIONS

This chapter brings together the Recommendations which are to be found in the Report. The paragraph numbers are cross-references to the paragraphs in the Report in which the recommendations can be found.

Recommendation 1 **para 24.21**

The Inquiry recommends that the Chief Minister requires that a report be submitted to him by officials addressing the issue of performance management in all departments involved with young people with emotional and behavioural difficulties and addressing the training and support required to develop and sustain it.

Recommendation 2 **para 24.25**

The Inquiry recommends that the Chief Executive of the Department of Health and Social Security and the Director of Social Services jointly review and determine the key performance indicators against which the effectiveness of the Social Services Division should be measured and determine the frequency with which they are monitored.

Recommendation 3 **para 24.25**

The Inquiry recommends that key performance indicators are regularly sent to and reviewed by the Chief Executive of the DHSS, the Director of Social Services and by the Minister of DHSS and the member for the Social Services Division so that they can assess measures of effectiveness and efficiency.

Recommendation 4 **para 24.30**

The Inquiry recommends that the Department invite an external and independent Government body to inspect the Social Services Division.

Recommendation 5 **para 24.30**

The Inquiry recommends that all inspection Reports are published and publicised so that children, young people and their families and the wider public are properly informed of the results.

Recommendation 6 **para 24.39**

The Inquiry recommends that Service Level Agreements between the Division and providers continue to be reviewed in order to ensure that the providers' performance in terms of outcomes for children and young people can be measured.

Recommendation 7 **para 24.39**

The Inquiry recommends that the Division seeks advice from other social service authorities in other jurisdictions in order to share advances in learning in the commissioning and monitoring of services.

Recommendation 8 **para 24.49**

The Inquiry recommends that an accommodation strategy for looked after children, to include foster care, kinship care, residential, secure care and after care, be drawn up with unit costs and a costed implementation plan, so as to increase the proportion of children living in foster care and kinship care.

Recommendation 9 **para 24.53**

The Inquiry recommends that a residential strategy should be drawn up listing the purpose and function of its residential homes and residential provision.

Recommendation 10 **para 24.59**

The Inquiry recommends that primary legislation is changed to ensure small homes are made subject to the same regulatory and enforcement requirements as “children’s homes”.

Recommendation 11 **para24.66**

The Inquiry recommends that the Minister for the DHSS require that the Report of the review being undertaken by the Bordesley Institute and the Special Inquiry Report are submitted and considered by him and the Member for Social Services when each is completed.

Recommendation 12 **para 24.75**

The Inquiry recommends that the role and use of the Secure Unit and its staff be reviewed as quickly as possible by the Director of Social Services in conjunction with other appropriate agencies with a view to ensuring that it is being used efficiently and effectively and that a report be submitted to the Social Policy Committee.

Recommendation 13 **para 24.81**

The Inquiry recommends that the housing needs of children and young people with emotional and behavioural problems must be clearly stated and met in the Review of Public Sector Housing.

Recommendation 14 **para 24.84**

The Inquiry recommends that the Director of Social Services draws up a strategy for the after care for looked after children with particular attention being given to the transitional arrangements of young people from children’s to adults’ services.

Recommendation 15 **para 24.87**

The Inquiry recommends that a Common Assessment Framework is adopted by all relevant agencies, a fully costed implementation plan is submitted to the ICPC and a multi-agency training programme is established.

Recommendation 16 **para 24.90**

The Inquiry recommends that the current Integrated Children's System be properly costed before being submitted to Ministers for approval.

Recommendation 17 **para 24.96**

The Inquiry recommends that an administrative system is set up to ensure that reviews are conducted at the statutorily required frequencies and that they be undertaken by independent Reviewing Officers or by managers not responsible for the case.

Recommendation 18 **para 24.96**

The Inquiry recommends that senior managers are supplied, on a monthly basis, with a list of completed and uncompleted reviews of looked after children and children on the child protection register.

Recommendation 19 **para 24.97**

The Inquiry recommends that all departments' documents be signed and dated.

Recommendation 20 **para 24.97**

The Inquiry recommends that every case file have an up to date chronology which is maintained regularly.

Recommendation 21 **para 24.97**

The Inquiry recommends that monthly spot audits be conducted on records and record keeping and the results reported to the Director of Social Services.

Recommendation 22 **para 24.102**

The Inquiry recommends that access to the Child Protection Register be immediately reviewed and immediate access given to a named person in the Accident and Emergency Department; and that other departments should identify named individuals who can access the Register.

Recommendation 23 **para 24.105**

The Inquiry recommends that all schools have the same policies and procedures for referring Children in Need to Social Services.

Recommendation 24 **para 24.105**

The Inquiry recommends that named social workers should be established as link officers to secondary schools.

Recommendation 25 **para 24.105**

The Inquiry recommends that the Island Child Protection Committee reviews and relaunches its procedural guidance and ensures there is a proper implementation plan established, with a requirement that all relevant staff attend multi-agency training.

Recommendation 26 **para 24.107**

The Inquiry recommends that training an information sessions on the implications, policy and practice of Multi Agency Public Protection Panels be arranged.

Recommendation 27 **para 24.108**

The Inquiry recommends that the ICPC establish a sub-committee to examine the implications of replacing the ICPC by a Safeguarding Board.

Recommendation 28 **para 24.110**

The Inquiry recommends that the political and officer accountability for child protection be individually established.

Recommendation 29 **para 24.110**

The Inquiry recommends that primary legislation place the Island Child Protection Committee on a statutory basis.

Recommendation 30 **para 24.113**

The Inquiry recommends that a proposal be drawn up which identifies how the “outcomes” of the Strategy will be monitored and reviewed at a senior officer level and on an inter-departmental basis.

Recommendation 31 **para 24.119**

The Inquiry recommends that the ICPC approves the annual training plan and monitors and reviews the take up of the training being provided.

Recommendation 32 **para 24.133**

The Inquiry recommends that the supervisory requirements of its management staff be reviewed and refresher courses be provided to them.

Recommendation 33 **para 24.133**

The Inquiry recommends that the implementation of supervision sessions in Social Services be monitored and monthly reports provided to the Assistant Directors.

Recommendation 34 **para 24.139**

The Inquiry recommends that the thresholds for intervening in families be reviewed with a view to focussing the resources of the Division on those most in need and that the threshold for intervention should be agreed by the Island Child Protection Committee following consultation with appropriate professionals.

Recommendation 35 **para 24.140**

The Inquiry recommends that a Recruitment and Retention Strategy for staff be drawn up for those departments working with children and young people and their families.

Recommendation 36 **para 24.146**

The Inquiry recommends that police checks be made on all new staff who are working with vulnerable people.

Recommendation 37 **para 24.147**

The Inquiry recommends that a strategy be drawn up which provides training and support for staff who have to manage difficult, aggressive and threatening behaviour.

Recommendation 38 **para 24.156**

The Inquiry recommends that the Director of Social Services sets up proper arrangements to consult and hear the views of children and young people who are looked after children.

Recommendation 39 **para 24.156**

The Inquiry recommends that an annual programme of visits should be arranged for the appropriate Members and Minister to visit children and young people who are looked after children.

Recommendation 40 **para 25.9**

The Inquiry recommends that the Health Strategy (2002) is reviewed, updated and resubmitted to the Social Policy Committee with a costed implementation plan.

Recommendation 41 **para 25.34**

The Inquiry recommends that the Director of Health Strategy and Performance regularly reviews, monitors and takes appropriate action on data relating to child protection, teenage pregnancy, dental health, sexual health and young people who misuse drugs and alcohol.

Recommendation 42 **para 25.35**

The Inquiry recommends that the Health Division considers producing a report on children's health on an annual or bi-annual basis which would be made available to the public and health staff.

Recommendation 43 **para 25.38**

The Inquiry recommends that the Health Service invites external inspections of the health services on at least a three-year basis to evaluate the services that are being provided on the Isle of Man for children and young people, particularly those who have emotional and behavioural problems.

Recommendation 44 **para 25.41**

The Inquiry recommends that the Social Services Management Team and the Minister and Member for Social Services regularly consider the health data of looked after children and take appropriate action where necessary.

Recommendation 45 **para 25.42**

The Inquiry recommends that the Senior Management Team of the Department of Education, Member and Minister regularly consider the health data of school age children and take appropriate action where necessary.

Recommendations 46 **para 25.47**

The Inquiry recommends that the Department of Education and schools agree clear minimum standards for schools to follow in providing information on sexual health, including information on the availability and access to contraception, and on substance misuse.

Recommendation 47 **para 25.47**

The Inquiry recommends that the Department of Education and Health Division set out the duties, roles and responsibilities of school nurses, generally and in relation to children and young people with emotional and behavioural difficulties.

Recommendation 48 **para 25.47**

The Inquiry recommends that the Department of Education draws up a "Healthy Schools" policy and implements it consistently in all the Island's schools.

Recommendation 49 **para 25.59**

The Inquiry recommends that no proposal is submitted to the Children's and Young People's Strategy Committee or the Social Policy Committee, unless it includes a consideration of whether staff from different departments should be co-located or whether budgets should be pooled.

Recommendation 50 **para 25.61**

The Inquiry recommends that the Health Service establish a system for listening to the views of children and young people on the effectiveness of the services they use and in particular those services for young people with emotional and behavioural difficulties.

Recommendation 51 **para 25.65**

The Inquiry recommends that the Health Division review the IT requirements of its staff and in particular health visitors and family practitioners in order to be able to send and receive information through the Government IT network.

Recommendation 52 **para 25.78**

The Inquiry recommends that the Child and Adolescent Mental Health Team be incrementally funded over the next 5 years so that it can provide for children and young people up to 18 years.

Recommendation 53 **para 25.78**

The Inquiry recommends that the location of the Child and Adolescent Mental Health Team is reviewed so as to give young people easier access to its services.

Recommendation 54 **para 25. 86**

The Inquiry recommends that the Sexual Health Strategy is reviewed by the Health Division, in conjunction with the Department of Education and all other appropriate parties, and a properly costed implementation plan is drawn up, agreed and put before the Social Policy Committee for its consideration and approval.

Recommendation 55 **para 25.86**

The Inquiry recommends that as part of the review of Sexual Health, the Health Division should clarify its policy on family planning and the provision of contraception as it relates to young people.

Recommendation 56 **para 25.86**

The Inquiry recommends that the review ensures that proper access to information and contraception is available to young people particularly those with emotional and behavioural difficulties.

Recommendation 57 **para 25.94**

The Inquiry recommends that a social worker and others working with a young person who is misusing drugs attend training in how to approach the young person's drug misuse.

Recommendation 58 **para 25.94**

The Inquiry recommends that an outreach worker post be created at the Drug and Alcohol Team.

Recommendation 59 **para 26.15**

The Inquiry recommends that the Director of Education reviews whether the range of performance management data collected and analysed by the Department is adequate

Recommendation 60 **para 26.19**

The Inquiry recommends that each of the five outcomes identified in the Children and Young People's Strategy is supported by key performance indicators and every relevant agency and in particular education, social services, health and police services, regularly monitor and review their performance in relation to the five outcomes and take appropriate action.

Recommendation 61 **para 26.22**

The Inquiry recommends that appropriate performance management data available to the Department of Education be provided on a regular basis to Heads of the secondary schools.

Recommendations 62 **para 26.26**

The Inquiry recommends that the Department continues to invite Ofsted or another external and independent government body to inspect the Department's provision of education for children and young people with emotional and behavioural problems.

Recommendation 63 **para 26.26**

The Inquiry recommends that all Inspection Reports are published and publicised so that pupils, parents, staff and the public are properly informed of their results.

Recommendation 64 **para 26.32**

The Inquiry recommends that the Director of Social Services and the Director of Education produce proposals for the Social Policy Committee on how their departments and the schools can better work together to improve the educational outcomes of children with emotional and behavioural problems.

Recommendation 65 **para 26.35**

The Inquiry recommends that the Director, the relevant political Member and the Minister receive monthly reports as to which children are suspended; which children are not attending full time education at school; and which children in school are receiving a modified programme; and that the Director provide to the relevant political Member and the Minister a monthly report setting out the education arrangements for each such child and whether further or different arrangements need to be made.

Recommendation 66 **para 26.42**

The Inquiry recommends that as well as the existing duty on a parent to educate his or her child, there be a statutory duty on the Department of Education to provide appropriate education for each child on the Island.

Recommendation 67 **para 26.42**

The Inquiry recommends that the Department of Education monitor the education of Looked after Children on a monthly basis, in conjunction with the Social Services Division and jointly takes whatever action is appropriate to resolve any problems.

Recommendation 68 **para 26.44**

The Inquiry recommends that there should be a consistent policy for suspension produced for secondary and primary schools on the Isle of Man. It should be regularly monitored and appropriate action taken if necessary.

Recommendation 69 **para 26.45**

The Inquiry recommends that the current appeals procedure have appended to it a guide on how to instigate an appeal.

Recommendation 70 **para 26.47**

The Inquiry recommends that every child suspended for more than ten days should be supplied with a “Suspended Pupil Plan”.

Recommendation 71 **para 26.48**

The Inquiry recommends that there should be guidance as to the minimum standard of education required. Compliance must be monitored and effectiveness tested.

Recommendation 72 **para 26.51**

The Inquiry recommends that a multi agency protocol for the support of Secondary Referral Units be drawn up.

Recommendation 73 **para 26.53**

The Inquiry recommends that the Department of Education continue to give a high priority to the proposal to establish a further pupil referral unit for Key Stage 4

Recommendation 74 **para 26.57**

The Inquiry recommends that the Department introduce a behaviour support plan which includes standards for provision of support to be made available within schools for children with emotional and behavioural problems.

Recommendation 75 **para 26.58**

The Inquiry recommends that there be a nurture group in each secondary school.

Recommendation 76 **para 26.58**

The Inquiry recommends that the Department of Education, in conjunction with other departments, examines ways of further developing parenting programmes in schools and elsewhere.

Recommendation 77 **para 26.62**

The Inquiry recommends that the document 'The Education of Children in Public Care' (2002) be reviewed and, if necessary, updated by the Director of Education and Director of Social Services and relaunched with appropriate publicity and training for teachers and social work staff.

Recommendation 78 **para 26.66**

The Inquiry recommends that there be an immediate review of the PEPs of all looked after children and that in future senior managers in Social Services and in the Department of Education ensure that these are completed on a regular basis and used by schools and social services.

Recommendation 79 **para 26.67**

The Inquiry recommends that there be one governor on each governing body with special responsibility for looked after children.

Recommendation 80 **para 26.76**

The Inquiry recommends that the Director of Social Services, the Director of Education and the Director for Health Strategy and Performance produce a joint report for the Social Policy Committee on the way in which joint funding for residential placements of children and young people with emotional and behavioural problems can be established.

Recommendation 81 **para 26.78**

The Inquiry recommends that the Director of Social Services and the Director of Education and the Director for Health Strategy and Performance should draw up proposals on how they can establish a Joint Commissioning Unit to integrate budgets where it is appropriate to do so and present their proposals to the Social Policy Committee.

Recommendation 82 **para 26.80**

The Inquiry recommends that Education Support Workers should be established for all children in residential units to assist in improving the education results of looked after children.

Recommendation 83 **para 26.81**

The Inquiry recommends that Social Services provide the name of a social worker who will act as a liaison point between each secondary school and the Social Services Division.

Recommendation 84 **para 26.84**

The Inquiry therefore recommends that training is provided to senior officials in all parts of Government on the principles, responsibilities and implications of the Government acting as a corporate parent to looked after children.

Recommendation 85 **para 26.85**

The Inquiry recommends that information and training is made available for members of Tynwald, including the Council of Ministers and departmental members, on the principles, responsibilities and implications of the Government acting as a corporate parent to looked after children.

Recommendation 86 **para 26.90**

The Inquiry recommends that a named youth worker and a sports officer should be allocated to looked after children in residential homes and foster care

Recommendation 87 **para 26.91**

The Inquiry therefore recommends that the Director of Social Services, Director of Education, Director of Strategy and Performance (Health), Chief Probation Officer and the Chief Constable draw up proposals for the establishment of a mentoring scheme.

Recommendation 88 **para 26.100**

The Inquiry recommends that Director of Education and the Director of Social Services commission from the Careers Service its proposals for providing specific and specialist careers and vocational training guidance to children with emotional and behavioural problems, which include a financial plan laying out how the proposals can be implemented.

Recommendation 89 **para 26.101**

The Inquiry recommends that Director of Education and the Director of Social Services draw up proposals as to how, and at what stage, a careers officer is to be involved in care planning for a looked after child.

Recommendation 90 **para 26.102**

The Inquiry recommends that a Careers Officer be appointed to assist in offering career guidance to vulnerable young people.

Recommendation 91 **para 26.104**

The Inquiry recommends that there be a statutory duty on the Department of Education to maintain appropriate pupil records and that the Director of Education draws up proposals on how this can be achieved.

Recommendation 92 **para 27.5**

The Inquiry recommends that as part of the developing Government inspection strategy, consideration be given by the Director of Education and Director of Social Services to the establishment of a joint Early Years registration and inspection team.

Recommendation 93 **para 27.10**

The Inquiry recommends that a multi-agency early years strategy be drawn up with a fully costed implementation plan.

Recommendation 94 **para 28.13**

The Inquiry recommends that the YJT continue to collect and analyse data relevant to offending by young people with emotional and behavioural problems and in particular, recommends that analysis is undertaken in greater depth on the offending rates of looked after children and appropriate measures implemented.

Recommendation 95 **papa 28.14**

The Inquiry recommends that future Youth Justice Business Plans and future Youth Justice Team Interim Reports be widely publicised within other agencies who come into contact with young people with emotional and behavioural difficulties including the courts.

Recommendation 96 **para 28.17**

The Inquiry recommends that the new Business Plan for the years following 2006 include a fully costed implementation plan.

Recommendation 97 **para 28.19**

The Inquiry recommends that targets relating to the employment, education and training status of young people in the criminal justice system, and the provision of substance misuse services are established and given greater prominence.

Recommendation 98 **para 28.20**

The Inquiry recommends that the minister and civil servant given responsibility for the YJT under the legislation recommended by this Report identify a suitable external organisation to inspect and monitor the performance of the YJT.

Recommendation 99 **para 28.24**

The Inquiry recommends that in the event that their renewed bid is unsuccessful, the Departments of Education and the Probation Service do each fund out of its existing budget a post (either full or half-time) to join the Youth Justice Team.

Recommendation 100 **para 28.27**

The Inquiry recommends that the Youth Justice Team be placed on a statutory basis and there be a statutory duty for the departments responsible for the Police, Social Services, Health, Education and Probation services to establish, maintain and resource the Youth Justice Team.

Recommendation 101 **para 28.28**

The Inquiry recommends that the Chief Minister's Social Policy Committee identifies a specific Chief Executive or Chief Officer to be accountable for the Youth Justice Team and for delivering the Youth Justice Strategy.

Recommendation 102 **para 28.30**

The Inquiry recommends that the Council of Ministers, or its Social Policy Committee, identify a minister or departmental member, who is accountable for Youth Justice.

Recommendation 103 **para 28.39**

The Inquiry recommends that a protocol be drawn up between the Youth Justice Team and the Department of Education and the secondary schools, which includes criteria for sharing information, points of contact and their respective roles and responsibilities.

Recommendation 104 **para 28.40**

The Inquiry recommends that each secondary school and the Youth Justice Team each nominate a member of their staff to be the respective contact points between the school and the Youth Justice Team.

Recommendation 105 **para 28.45**

The Inquiry recommends that the Social Policy Committee ensures through the Children and Young People's Strategy that the accommodation needs of vulnerable young people, including those at risk of offending or re-offending, are met, through discussion with and provision by appropriate housing agencies in the public, voluntary and private sectors.

Recommendation 106 **para 28.50**

The Inquiry recommends that the Prison Governor, or his representative, the Head of the Secure Unit and the Manager of the Youth Justice Team, report to the Social Policy Committee on the implications for all the services concerned of 17 year olds being remanded to or required to serve their custodial sentence in the Secure Unit.

Recommendation 107 **para 28.56**

The Inquiry recommends that the juvenile court be given the power to impose as part of a community penalty, conditions requiring attendance upon effective, in terms of hours, attendance and input, educational programmes for those offenders excluded from mainstream education or otherwise not attending education

Recommendation 108 **para 28.60**

The Inquiry recommends that the age of persons appearing before the juvenile court be raised to 17 years.

Recommendation 109 **para 28.62**

The Inquiry recommends that the Anti-Social Behaviour Protocol is reviewed and, if necessary, broadened to include agreement about what preventative provision may be put in place prior to resorting to a court order.

Recommendation 110 **para 28.63**

The Inquiry recommends that a comprehensive children's services directory should be established as part of the work of the Children and Young People's Strategy Committee.

Recommendation 111 **para 29.31**

The Inquiry recommends that the Isle of Man Government appoints a Children's Commissioner.

Recommendation 112 **para 29.36**

The Inquiry recommends that the Isle of Man establishes a properly funded and supported Youth Council for the Isle of Man.

Recommendation 113 **para 29.37**

The Inquiry recommends that the Government establishes a helpline for children and young people on the Isle of Man.

Recommendation 114 **para 29.38**

The Inquiry recommends that the Government examines improved ways of young people receiving and giving appropriate information.

Recommendation 115 **para 30.12**

The Inquiry recommends that a post of Minister or Member for Children is created, which will report to the Chief Minister and Tynwald on the implementation of the Children and Young People's Strategy.

Recommendation 116 **para 30.13**

The Inquiry recommends that a senior officer is identified to support the Minister or Member for Children in implementation of the Children and Young People's Strategy.

Recommendation 117 **para 30.17**

The Inquiry recommends that the Social Policy Committee review the progress of joint integrated working by relevant departments after one year from the publication of the Report of the Inquiry and if adequate progress has not been achieved, it considers reorganising its Children's Services into one department.

Recommendation 118 **para 30.27**

The Inquiry recommends that Ministers from the Social Policy Committee establish a corresponding Chief Officers Group charged with making joint recommendations regarding priorities for the implementation of the Children and Young People's Strategy and putting forward the financial plans for implementing them.

Recommendation 119 **para 30.28**

The Inquiry recommends that inter-agency services which overlap in their responsibilities are identified and the pooling, merging or ring fencing of those budgets is introduced where appropriate.

Recommendation 120 **para 30.31**

The Inquiry recommends that co-location of staff from different departments be considered wherever it is thought that joint working could be improved.

Recommendation 121 **para 30.31**

The Inquiry recommends that in determining the effectiveness of its services, the Government takes into account the views of children, young people and their families about the location of their services.

Recommendation 122 **para 30.39**

The Inquiry recommends that in determining the effectiveness of the Children and Young People's Strategy, the Social Policy Committee give a high priority to the development of systems for measuring and managing performance.

Recommendation 123 **para 30.42**

The Inquiry recommends that the Council of Ministers requires each relevant department and in particular the Health Division, Social Services Division, the Department of Education, Police Service and Probation Service to be inspected on a regular basis by an independent inspectorate from another jurisdiction.

Recommendation 124 **para 30.47**

The Inquiry recommends that, one year after receiving the Report of the Inquiry, the Social Policy Committee receives a joint report from the Director of Social Services and the Audit Division outlining the action which has been taken in relation to the findings of the audit reports of 2002 and 2004 and on any issues outstanding.

Recommendation 125 **para 30.71**

The Inquiry recommends that the Isle of Man Government adopt the principle of Corporate Parenting.

Recommendation 126 **para 30.71**

The Inquiry recommends that legislation is introduced to place a statutory duty on all departments of Government to co-operate with each other in safeguarding and promoting the interests of looked after children and in delivering the outcomes for all children identified in the Children and Young People's Strategy.

Recommendation 127 **para 30.73**

The Inquiry therefore recommends that an Implementation Plan is drawn up to publicise to all relevant staff the policy, procedures and requirements of the Information Sharing Protocol.

Recommendation 128 **para 30.79**

The Inquiry recommends that, to support his desire to move towards corporate working, the Chief Minister engages management consultants to work with senior officers in the Government to establish the skills and behaviour required to deliver the new agenda and to provide appropriate training.

Recommendation 129 **para 30.79**

The Inquiry recommends that the Chief Minister engages a management consultancy to evaluate and review the skills and performance of senior Government officers in their potential to deliver the new agenda for change and that the consultancy be free to recommend management changes if, after evaluation and review, they feel them to be necessary.

Recommendation 130 **para 30.80**

The Inquiry recommends that, twelve months after publication of this Report, there be an external review of the progress towards implementing the recommendations of the Inquiry.

Recommendation 112 **para 30.85**

The Inquiry recommends that the Minister for the DHSS issues on behalf of the department written guidance on the principles governing the proper exercise of the powers by the minister and the departmental members in respect of decisions involving the welfare of individual children looked after by the department.

Recommendation 132 **para 30.86**

The Inquiry recommends that the Council of Ministers discusses with the appropriate authorities in Tynwald the development of a Protocol governing contacts between non-member MHKs and officials of the Social Services Division.

APPENDICES

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APPENDIX 1

WITNESSES WHO GAVE EVIDENCE

Monday, 23rd May 2005 – DAY 1

Opening statement by Mr Verdan
Opening statement by Mr Crabtree
Opening statement by Mr Corlett
Opening statement by Ms Roberts
Opening statement by Mr Kermode
Opening statement by Ms Batson

Tuesday, 24th May 2005 – DAY 2

Ms Angela Gilman

Wednesday, 25th May 2005 – DAY 3

Ms Angela Gilman (continued)
Dr David Dunne
Dr Kirsten Wafer
Ms Angela Gilman (continued)

Thursday, 26th May 2005 – DAY 4

Ms Sylvia Mossison
Ms Angela Oldroyd

Friday, 27th May 2005 – DAY 5

Mr Alex Merchant
Inspector Young
Inspector Power

Monday, 13th June 2005 – DAY 6

Inspector Power (continued)
Ms Liz Casling
Mr Ian McReady

Tuesday, 14th June 2005 – DAY 7

Mrs Anne Seed
Mr Philip Kneen
Mr Mark Hoswell

Wednesday, 15th June 2005 – DAY 9

Mr Richard Kneen

Thursday, 16th June 2005 – DAY 9

Mr Victor Whiteside
Ms Liz Dickson

Wednesday, 22nd June 2005 – DAY 10

Peter Newbery
Mr David Sellick
Miss Kathryn Green
Miss Lyndsey Barton
Young Person 1

Thursday, 23rd June 2005 – DAY 11

Mr Ed Coates

Monday, 27th June 2005 – DAY 12

Mr Ed Coates (continued)
Mr Francis Charlton
Ms Victoria Higgins

Tuesday, 28th June 2005 – DAY 13

Mr Adrian Venn
Ms Kathleen Cooke
Ms Jackie Baker

Wednesday, 29th June 2005 – DAY 14

Ms Diane Watts
Ms Alex Cowie
Mr Charles Buist
Mr Eddie Tinsley

Thursday, 30th June 2005 – DAY 15

Ms Anne Curphy
Mr Francis Charlton
Mr Damian Bradley

Friday, 1st July 2005 – DAY 16

Ms Theresa Barton
Mrs Rose Burnell
Mr Damian Bradley (continued)

Wednesday, 6th July 2005 – DAY 17

Chief Constable Mike Culverhouse
Ms Sarah Heselwood
Chief Constable Mike Culverhouse (continued)
Ms Sarah Heselwood (continued)
Chief Constable Mike Culverhouse (recalled)
Mr John Cain

Thursday, 7th July 2005 – DAY 18

Mr Damian Bradley (continued)
Ms Gill Owen
Ms Mary Miles
Ms Gill Owen (continued)

Monday, 11th July 2005 – DAY 19

Mr Trevor Noden

Tuesday, 12th July 2005 – DAY 20

Mr Trevor Noden (continued)

Wednesday, 13th July 2005 – DAY 21

Mr David Cooke
Mr Tim Norton

Thursday, 14th July 2005 – DAY 22

Ms Jackie Entwhistle
Mrs Margaret Green
Mr Edric Green
Young Person 2

Friday, 15th July 2005 – DAY 23

Mrs Clare Christian MLC
Mrs Brenda Cannell MHK
Mr Geoff Cannell

Monday, 18th July 2005 – DAY 24

Mrs Donna Lever
Mr Christopher Lever
Mr John Houghton MHK

Tuesday, 19th July 2005 – DAY 25

Mr Graham Kneen
Mr Philip Kneen (recalled)
Mr Richard kneen (recalled
Mr Leslie Moorcroft

Wednesday, 20th July 2005 – DAY 26

Mr Ken Tomlinson
Mr David Killip

Wednesday, 14th September 2005 – DAY 27

Closing Submissions by Mr Verdan
Closing Submissions by MR Crabtree
Closing Submissions by Mr Gibson
Closing Submissions by Mr Goldie
Closing submissions by Mr Carter
Closing Submissions by Mr Corlett
Closing Submissions by Ms Roberts
Closing Submissions by Mr Kermode
Closing Submissions by Ms Pringle
Closing Submissions by Mr Coren
Reply Submissions by Mr Verdan

APPENDIX 2

INTERESTED PARTIES AND REPRESENTED WITNESSES

The Department of Health and Social Security:	Andrew Corlett. Simcocks Advocates
The Department of Education:	John Kermode. Department of Education
The Department of Home Affairs:	Sharon Roberts and Gillian Whittle Dickinson Cruickshank Advocates
The Families of Samantha Barton and George Green	Simon Crabtree and Chris Gawne. Messrs Alexander Harris
Manx Family Services	Pamela Pringle. Pamela Pringle Advocates
Nugent Care:	Kevin Goldie and Stephanie Bateson. Quinn Kneale Advocates
Priory Care:	Neal Gibson. Messrs Nabarro Nathanson
Ex employees of Nugent care & other individuals;	Pamela Pringle. Pamela Pringle Advocates
St Christopher's Fellowship:	Ms L Byrne. Mark Moroney Advocates
Mrs Brenda Cannell MHK:	Steven Coren. Paul O'Neill Advocates
Mr Geoff Cannell:	Jeremy Carter. Carters Advocates
Lesley Moorcroft:	Jeremy Carter. Carters Advocates
Peter Newbery	Paul O'Neill. Paul O'Neill Advocates
Damian Bradley:	Andrew Bridson. Andrew Bridson Advocates

APPENDIX 3

LIST OF ISSUES

RELATING TO PARAGRAPH 1 OF TERMS OF REFERENCE

	Question
1	What care and support was provided by the Government and its agencies to Samantha Barton and George Green? In particular: i) Identify the methods and means by which such care and support was provided. ii) What education was provided to Samantha and George? iii) What health and mental health services were offered to Samantha and George? iv) What policies were in place for dealing with young offenders and, in particular, repeat offenders? v) What policies were in place to deal with drug and alcohol use by young people? vi) What steps were taken to control or prevent drug and alcohol use by young people?
2	Who provided such care and support ? i) Identify the organisations and agencies that provided such care and support. ii) Identify the individuals who provided such care and support. iii) State the periods of time over which such individuals, organisations and agencies provided such care and support. iv) State the particular roles and responsibilities of each individual, organisation and agency v) Particularise the specific involvement had with Samantha Barton and George Green in the 2 years prior to their deaths.
3	How effective was the care and support provided to Samantha and George? i) What was the purpose and objective of such care and support? ii) Were the purpose and objective achieved? iii) What risk assessments and care plans and other plans were made for the care and support of Samantha and George by social services and by other agencies (including multi-agency risk assessments, care plans and other plans)? iv) What assessments were made of the needs of Samantha and George?

	v) What review/reviews were undertaken of the care and support given? What policies were in place for setting and reviewing outcomes for children in care? Who received reports or information about such reviews? vi) Were such policies operated in the cases of Samantha and George? And if so, were they effective? What action can be demonstrated as a result? vii) How were the non-Government agencies which provided care and support to Samantha and George monitored by the relevant Government Departments? viii) How were the staff who provided care and support to Samantha and George monitored by Nugent Care and Manx Family Services and the Government Departments? ix) Detail how and when the organisations and agencies that provided such care and support communicated with each other about Samantha Barton and George Green? x) What inter-agency plans were there? xi) Did the various agencies who provided care and support to Samantha Barton and George Green cooperate and share information effectively and adequately? xii) Were there, and are there now, any legal barriers to such cooperation and sharing? xiii) What systems were in place to record information about Samantha and George and the care and support given to them? Were they followed? xiv) Who monitored the performance of the Government and the DHSS and/or its partners and was/is there any independent regulation of social work practice on the Island? xv) What systems were in place for monitoring and inspecting the care the children were receiving from the Government and/or individual workers? Who was regulating/inspecting the care providers?
4	i) What further or different care and support could have been provided ? ii) Should any further or different care and support have been provided for Samantha and George ?
5	What systems or structures were in place for responsibility and accountability (including at Government Department level) in the provision of care and support to young people? In particular: i) Who in each Government Department had overall responsibility for the care and support given to Samantha and George? ii) What arrangements were in place for keeping such person informed about the care and support given to Samantha and George and its effectiveness? iii) To what extent was there a shared or multi disciplinary response to the problems being exhibited by Samantha Barton and George Green? Was there any shared ‘corporate responsibility?’

	iv) Who was responsible for taking the lead in ensuring the well-being and safety of Samantha Barton and George Green? Where did accountability stop? What steps were taken by that person/body?
6	Without prejudice to the generality of the above, in the period 2 years before their death: i) What level of education and supervision was offered to Samantha and George? ii) What systems were in place to regulate where the young people were at any given time, in particular at night? iii) What systems were in place to deal with the issue of absenting? iv) What actual steps were taken to deal with absenting? v) How often did Samantha Barton absent herself from Maple Avenue, Derby Road, and Leece Lodge? vi) What systems were in place to control the visitors to the residential unit? vii) Detail the care plans in existence for the 2 years prior to the deaths of Samantha and George. viii) In relation to the decision to place Samantha at Maple Road, Derby Road and Leece Lodge: ix) When and by whom was the decision made? x) What were the reasons for the decision? xi) Detail how and when the care and support was reviewed. xii) In relation to the visits to, or other periods spent in, the Isle of Man by George: a) When and by whom was the decision made to permit the stay in the Isle of Man? b) What were the reasons for the decision? c) What steps taken to deal with his overstaying away from his planned placements? d) Who was responsible for George's care and support and well-being while on island and who provided it? e) What steps, if any, were taken to effect the return of George to Eden Grove?
7	What were the immediate circumstances surrounding and leading to the deaths of Samantha Barton and George Green? i) Specify what you know about the movements of Samantha Barton and George Green in the 6 months prior to their deaths.

	ii) Detail all you knew about their use of drugs and alcohol iii) Detail all you know about their involvement, if any, in criminal activities iv) State all that you knew about their relationship with Peter Newbery. v) What assessments were made of the risk or danger that Peter Newbery posed? Were such assessments shared with other agencies and in particular with those responsible for the care and support of Samantha and George? vi) Was it known with whom Peter Newbery was associating; and, if not, should it have been known and by whom ?
8	What relevance, if any, did the care and support provided have to the circumstances surrounding and leading to their deaths?
9	i) What Legislation, policies, practice and guidance were put in place following (a) The McManus Report (b) The Leslie Report (c) The report by De Montfort University following the death of Mathew Crosbie (d) Other policy initiatives and strategies? ii) What steps were taken by the Government to incorporate the recommendations contained in the reports and strategies referred to above into the care and support given to Samantha and George?
10	i) To what extent was the care and support offered to Samantha Barton and George Green compromised by the families' attitudes and conduct. (ii) what contact and/or involvement did families of SB and GG have with organisations and agencies who were providing care and support to SB and GG?
11	What action was taken to ascertain the views of Samantha Barton and George Green on the care that they were receiving? Are their views and responses reported and/or recorded and if not why not?
12	What support was provided to the care providers by the Government/police/other statutory agencies?
13	i) What facilities were at the time of the deaths of Samantha and George, and are at the present time available, to accommodate children of secondary school age or above on the Isle of Man who may be thought to be in need of particular care and support? ii) What assistance was available at the time of the deaths of Samantha and George, and is available now, to children of secondary school age or above who need or might need assessment and assistance to address and improve behavioural and emotional problems which they have or might have?

APPENDIX 4

WITNESS STATEMENTS

1. Angela Gilman	43. Jonathan Kelly	85. Inspector Power
2. Sylvia Morrison	44. Philip Kneen	86. Inspector Young
3. Judith Stephen	45. Ned Guest	87. Anne Seed
4. Dr Kirsten Wafer	46. Peter Christie	88. Ian McCready
5. Alec Merchant	47. John Knight	89. R W Henderson MHK
6. Margaret Dunne	48. Richard Kneen	90. Mary Miles
7. Dr Balakrishna	49. Mark Hoswell	91. Jackie Entwhistle
8. Angela Oldroyd	50. John Cain	92. Julia Gilbert
9. Ed Coates	51. George Quayle	93. Tim Norton
10. Trevor Noden	52. Adrian Burnett	94. Keneth Best
11. David Cooke	53. Rose Burnell	95. Alex Watson
12. Mike Culverhouse	54. Lyndsey Barton	96. Daniel Corlett
13. Liz Dickson	55. Theresa Barton	97. Graham Kneen
14. Victoria Higgins	56. Margaret Green	98. Hilary Erani
15. Jacqui Baker	57 Edric Green	99. Patricia Kneen
16. Helen Giddings	58. Kathryn Green	100. S Andrew Caley
17. John Kelly	59. YP (identity withheld)	101. Ciaran Quigley
18. Maxine McBrier	60. YP (identity withheld)	102. Michelle Fletcher
19. Leanne Newbold	61. YP (identity withheld)	103. Ian MaClean
20. Alex Cowie	62. YP (identity withheld)	104. Lisa Robson
21. Eddie Tinsley	63. YP (identity withheld)	105. David Killip
22. Gary Simpson	64. YP (identity withheld)	106. Ken Tomlinson
23. Charles Buist	65. YP (identity withheld)	107. Jennifer Charles
24. Paul Brennan	66. YP (identity withheld)	108. Juan Corlett
25. Karen Bannen	67. YP (identity withheld)	109. Helen Moore
26. Kathleen Cooke	68. YP (identity withheld)	110. Mike Borland
27. James Gillespie	69. YP (identity withheld)	111. Voirrie Moore
28. Diane Watts	70. John Houghton MHK	112. Helen Kneen
29. Adrian Venn	71. YP (identity withheld)	113. Simon McCann
30. Peter Newbery	72. YP (identity withheld)	
31. Francis Charlton	73. Claire Christian MLC	
32. Mrs Gill Owen	74. Geoff Cannell	
33. Christopher Lever	75. Brenda Cannell MHK	
34. Damian Bradley	76. Sarah Heselwood	
35. John Kennedy	77. Leslie Moorcroft	
36. Terry Bruce	78. J D R Kewley	
37. Bryan Morris	79. Dr David Dunne	
38. Liz Casling	80. Liz Curphy	
39. Ian Noble	81. Victor Whiteside	
40. Pat Mackenzie	82. Eammon Moore	
41. David Sellick	83. Barbara Rains	
42. Jillian Jones	84. Donna Lever	

APPENDIX 5

SOCIAL WORK RECORD DATED 5 AUGUST 2001

SUNDAY 5TH AUGUST 2001

Called at Barton's and Rose opened the door. She was really concerned about the girls and told me that they have been out of it on drugs for the last two weeks. She invited me in as I walked in I noticed the front bedroom was an absolute mess. You couldn't see the floor. I walked into the small back bedroom and there were 8 young lads between the ages of approx 15 – 17 in there most of them wrapped in quilts asleep. Rose had tried to wake Linzi but said she had had no response (She tried while I was there). Sam seemed OK but here general hygiene is a major concern. Her skin is really bad, her lips are all chapped and cracked. She generally looked really bad. Rose then took me into the living room and kitchen to show me what a mess it was. There was an old mattress on the floor in the living room and the floor was a mess. The kitchen was flooded and a complete mess. I spoke to Rose and told her I would try to do something about this.

On returning to White Hoe I called Paul to inform him of what I saw and asked his advice on calling the duty social worker. I contacted the duty social worker (Kenny Best) to explain the situation, he told me to contact MFS and see if they could sort anything out. Ned and Phil are going to check on the girls every hour from 5pm to 11pm, and Nugent Care will be checking on them until 5pm. I contacted Kenny to inform him of this. I have suggested to all agencies that an emergency meeting should take place tomorrow and this placement should be reviewed.

I contacted PHQ to inform them that 8 young lads were at the house and it looked like they had stayed the night, they said that none of them are missing from care but it was useful information. Myself and Paul are going to go down to the Bartons at 2pm and see how things are.

MONDAY 6TH AUGUST 2001

Sam and Linzi still in bed when I arrived. Sam got up and asked for her washing and for a sim pack for her mobile as she has found it. Rose was there along with other young people (males). The house was a total mess Sam got the money for both girls and asked for milk and pop.

PM. Linzi and Sam both in with other young people staff didn't know who they were. Linzi to have washing ready for collection tomorrow morning. Both girls appeared to be under the influence of what looked like drugs.

Karen Bannon

APPENDIX 6

CHILDREN IN CARE: A PLEA FOR RESPECT AND DIGNITY

EXHIBIT "EC3" TO STATEMENT OF ED COATES DATED 13.2.02

It is almost exactly one year since there were two very similar reports in the Manx Press about Children in Care. Both of these reports were written in response to two separate mothers complaining that since coming into care their daughters behaviour had significantly worsened. Both articles talked of their children becoming out of control, taking drugs and possibly putting their lives at risk. It was interesting to note that at the time, based on the scant evidence of the parent alone the reports sought to insinuate that it was the actions of the DHSS that worsened the girls plight with quotes such as "They seem to be doing more harm than good" being typical. One year on this assertion would most certainly be found to be untrue.

At the time of one of the reports (20/2/2001) it was paired with another in which the problem of missing children was reported and in which Inspector Gary Roberts said most of the people reported missing were children in care and he admitted that the numbers were "impacting on police services". Subsequent media reports and Political campaigns have compounded the sense that children in our care are somehow bad and that the DHSS is responsible for their unruly behaviours.

In recent weeks there has been a further upsurge in bad Press for Children in Care lead by a campaign by MHK**.** The thrust of this is that it seems they are in need of firm control so that the public can carry on their lives in peace. Whilst many of us have no issue with this aspiration the problem with it is that the language being used is becoming inappropriate and sometimes intemperate and the arguments are being made from a standpoint of considerable ignorance. With the awful events of this weekend in mind this situation is now being amplified several times over with and intensely damaging effect on two groups of people – the children themselves and the small numbers of dedicated staff who work all hours facing all kinds of difficulties in order to protect children and to attempt to enhance their lives.

It is the children, however that I wish to focus on first – and not George or Sam because discussing about their situations cannot be addressed until the facts are known, but children in care as a whole. The very phrase "Children in Care" is in fact an outdated one – the phrase is referred to, and used without people understanding what or who they are talking about – and it is often used, quite offensively as shorthand for children in trouble. For example it is not unusual as has happened recently for the group to be held responsible for a whole range of societies ills. Instead of Children in Care the staff in social services now refer to the group as "Looked After" Children in an attempt to take a more neutral approach to these Children.

This is a diverse group who in fact come from a wide range of backgrounds and histories and who have relatively few things in common. The most significant thread is not their criminality but that they have needed ot be *Looked After through no fault of their own.*

On the Isle of Man there are approximately 130 such young people being "Looked After" each week. Some of these situations last for a few days some for the entire duration of the child's formative years. In a single year in the region of 200 children are looked after – that is the equivalent of a medium sized primary school. Many of these children go to school – several are currently studying GCSE's and some are doing A levels. Some of them are

children with special needs whose parents require respite care in order to get a nights sleep. Some of them are Children who have great talents. Others are babies and toddlers who need someone simply to

love them. Others are troubled teenagers – often feeling very angry and let down by the adults in their lives. It is true that some of these children have been subjected to abusive experiences and have witnessed or experienced extremes of physical, sexual or emotional harm – and then they cannot live or in some cases bear to live in their own families. Many, no most of them are perfectly normal children – they are people like you and me with the exceptions that they haven't necessarily had the best start in life. They are above all people with feelings.

In the aftermath of recent events they are people in need of sensitive responses thoughtful comments made with knowledge, care and understanding. They need all of us to remember that some of them are scared or bewildered at this time whilst others feel outraged and offended by the belittling way in which they are often referred to as "children in care" with all the attendant baggage that this phrase seems to have acquired. They need us all to look out for them as if they are our own children because they are – they are yours, ours, they are Manx.

These young people also need to be re-assured that those caring for them are competent – that they know what they are doing and indeed that they are held in high esteem by their community. There are of course important questions to ask and to be answered – but not while the police are still searching for a dangerous killer. Those in the Media or in politics asking questions need to reflect upon whether their questions are considerate of the needs of these children for whom they share a huge responsibility. Those with responsibility for the work of the DHSS need to ensure that these erroneous perceptions of social workers, care staff and the department as a whole are challenged. They owe it to their staff and the children to make a robust defence of them. They also need to be clear that full scrutiny of the facts by a Public Inquiry is something that the staff and the department would not only, not fear, but it is something that they would actively welcome.

Ed Coates
13/02/2002

APPENDIX 7

OVERVIEW OF HISTORY OF SOCIAL SERVICES

OVERVIEW OF HISTORY OF SOCIAL SERVICES given by David Cooke,

Director of Social Services (in letter to the Inquiry 19 January 2005)

I'm aware of how potentially difficult it may be for the Inquiry team to get a sense of the history of Social Services Division. This being the case I've had put together a brief, potted history of key events in the Division's short history, which I enclose for your information. Clearly each year has been filled with much more than could possibly have been included but this gives the 'highlights'.

HISTORY OF SOCIAL SERVICES DIVISION

1. 1989 Annual Budget: 4,413,510

Social Services is born, staff are moved into the Drill Hall, Tromode (sharing accommodation with the Water Board) consisting of: Director; Manager Personal Social Services; Homes Registration Officer; Principal Social Worker and Team of 6 Social Workers (there are now 20); 3 Home Care Organisers; Manager of Administration; Executive Officer; Administrative Officer and 3 secretaries.

Service Manager for Older People/Mental Health appointed later in the year.

Main areas of responsibility: Older People/Mental Health & Adult Disabilities Social Work; Running of the 4 Government Residential Homes for older people; Home Care; Registration & Inspection of Residential Homes for Older People; Orange Badge Scheme; Aids & Adaptations; Grant Aid to voluntary organisations e.g. Age Concern, Alcohol Advisory Service etc; Administration of Trust Properties (housing for older people)

2. 1990 Annual Budget: 5,505,800

Children's Social Work service becomes the responsibility of Social Services (from Dept. of Education) – based at Hill Street, Douglas with 1 Principal Social Worker (now 2 Team Managers and 5 Senior Social Workers) and team of 6 Social Workers (there are now 20 f.t.e.) and 2 secretaries (now 5.5 secretaries and 2 administrative officers)

3. 1991 Annual Budget: 7,132,700

Disabled Resettlement Officer is appointed (finding employment for disabled persons) SSI make recommendations as to future structure of the Division

4. 1992 Annual Budget: 8,486,100

Project to set up and open first two small community homes for people with learning disabilities. Since then more homes have been opened each year to a total now of 22. Old Social Services home for older people (Reayrt ny Baie) is knocked down and re-built (on the same site) – officially opening in 1993 with 48 beds with respite and day care facilities McManus Inquiry takes place

5. 1993 Annual Budget: 8,385,520

Social Services move into dedicated office accommodation at Hillary House – this enables Children's & Adult Services to be accommodated together

Deputy Director is appointed
Separate Disabilities Team (Adults) is created
Service Manager for Disabilities and Principal Social Worker are appointed

6. 1994 Annual Budget: 8,398,800

Service Manager for Children & Families is appointed
First permanent Day Duty Social Worker post created and appointed
New Structure, as recommended by SSI
Inspection is adopted with 3 service areas and an administrative 'arm'

7. 1995 Annual Budget: 8,981,400

Children's Social Workers are split into two teams – Long Term and Short Term – second Principal Social Worker is appointed

8. 1996 Annual Budget: 9,333,200

Social Services take over responsibility for Registration & Inspection of Nurseries & Childminders (from Health Services) – 2 officers are appointed for this

9. 1997 Annual Budget: 10,751,400

2nd Disability Employment Officer is appointed
The process to close Carnane & Colden Wards of Ballamona (where people with Learning Disabilities had been placed) begins (completed in 2000) – occupants moved to small homes in the community
2nd permanent Day Duty Social Worker post created and appointed
Leslie Inquiry takes place

10. 1998 Annual Budget: 13,035,000

Quality & Customer Services Manager is created and appointed
Child Care Co-ordinator post is created and appointed
New Children's Resource Centre (short breaks for disabled children) opens in Ramsey
Government wide 'Way Ahead' initiative

11. 1999 Annual Budget: 15,374,400

Domiciliary Care Manager post is created and appointed (encompassing Home Care & Meals on Wheels)
Third Children's Social Work Team is set up – Family Support Team – third Principal Social Worker appointed
Project to update computer system is set up under a Project Manager
Service Manager for Older People/Mental Health becomes Services Manager Adults now encompassing Disabilities
External review of Social Services commissioned

12. 2000 Annual Budget: 18,473,700

Tendering process and contract awards for Children's Services
Child Protection Training Officer appointed
Child Psychologist post created and appointed (part time)
Permanent Weekend Duty Social Worker Fri – Mon (children's) is appointed
New 5 bed children's home is built and opened

13. 2001 Annual Budget: 24,445,400

Following review of Divisional Structure by Himu Gupta and Phil Abbott part of identified new structure comes into effect – new posts are created (Senior SW/Ass Dir/Team Manager) – effective Sprin/Summer 2002

14. 2002 Annual Budget: 29,382,300

Care First by OLM, electronic client index system, is introduced. ICT Manager appointed
New Structure of Assistant Directors for Children & Families & Adults; Team Managers (1 Disabilities; 1 Elderly/Mental Health; 2 Children's Services) and Senior Social Workers (5 Children's Services; 2 Elderly/Mental Health; 1 Disabilities) came into force
Care & Contracts Manager (children's services) took up post
Full time Advocate/Lawyer for Children's Services is contracted (working in Hillary House)
New Secure Care Home is built – opening early in 2003
Child in Need Research by John Moores University/Veronica Wigley

15. 2003 Annual Budget: 43,425,000

Responsibility for all Mental Health Services (including DAT & CAMHS) is transferred to Social Services
Youth Justice Team is created
Executive Officer for Children & Families post created and appointed
Staff Development Manager post created and appointed
Compliance & Finance Manager post created and appointed
Children & Young Persons Act 2001 comes into force (January)
New Social Services owned and run homes for the elderly is built (Southlands – 86 beds with respite and day care facilities) to replace old home

16. 2004 Annual Budget: 44,267,900

Manager for Registration & Inspection Unit post is created and appointed. Responsibility for Registration & Inspection of nursing establishments is officially transferred to Social Services Registration & Inspection Unit
Children's Homes Inspector post created and appointed
Additional Registration & Inspection Officer for Residential/Nursing Homes is appointed LAC Therapist post created and appointed LAC/YJ Health Advisor post created and appointed
Business Relationship Manager (HR) appointed
General Manager for Learning Disabilities
(Residential & Day Care Services) post created and appointed
Tendering process/contract awards for Children's Services takes place
Work commences on implementation of Integrated Children's System
Stage One of ROSLAC Research by John Moores University/Veronica Wigley

Figures are Gross Revenue Budget and do not include Capital Budgets.

APPENDIX 8

RESOURCES VISITED FOR PART 2

Monday 10 October 2005
Department of Health & Social Security, Hillary House, Prospect Hill, Douglas

Ms Susan Coyle,	Social Worker, Family Support Team
Mr Richard Gibbs,	Social Worker, Referral & Assessment Team
Ms Tracy Power,	Senior Social Worker, Care Management Team
Ms Sue Tustain,	Senior Social Worker
Ms Stephanie Waters,	Senior Social Worker, Family Support Team
Mr John Willet,	Social Worker, Referral & Assessment Team
Ms Alex Watson,	Social Worker, Care Management Team

Monday 10 October 2005
Department of Education, St Georges Court, Upper Church Street, Douglas

Mrs Nicola Evans,	Detached Youth Worker
Mrs Jeanette Facey,	Detached Youth Worker
Mrs Jackie Fisher,	Detached Youth Worker
Mrs Joanne White,	Detached Youth Worker

Monday 10 October 2005
Youth Justice Team, Victory House, Prospect Hill, Douglas

PC David Asbridge,	
Peter Christie,	Social Worker Referral/Assessment Team
Jonathan Frost,	Youth Justice Team Worker
Det Sgt Gary Hardman,	
Neil Hay,	Office Manager, Youth Justice Team
Mrs Rosa Kennedy,	Youth Justice Team Worker
Ms Jackie Pate,	Health Adviser for Looked After Children & Youth Justice Team

Tuesday 11 October 2005
Health Services, Crookall House, Demesne Road, Douglas

Mrs Bev Critchlow,	Director of Nursing, Midwifery & Professional Development
Mr Norman McGregor Edwards,	Director of Health, Strategy and Performance

Tuesday 11 October 2005
Manx Family Services, 31b Derby Road, Douglas

Mr Carl Faragher,	Team Leader, Outreach and Aftercare
Ms Cheryl Faragher,	Outreach Support Worker
Ms Michelle Fletcher,	Outreach and Aftercare Project Worker
Mr Phil Kneen,	Aftercare Support Worker
Mrs Anne Seed,	(then) Outreach and Aftercare Manager

Tuesday 11 October 2005
Isle of Man Children's Centre, 92 Woodbourne Road, Douglas

Mrs Pam Jackson,	Senior Practitioner, Douglas Family Centre
Mrs Carrie Wade,	Family Centre Team Member

Tuesday 11 October 2005
Government Buildings, 3rd Floor, Prospect Hill, Douglas

Hon Donald James Gelling Esq CBE CLnstSMM FIMgt CP MLC
Mrs Linda McCauley MRTPI,
Children and Young People's Strategy Co-ordinator,

Thursday 13 October 2005
St Christopher's Fellowship Secure Unit, Old Castletown Road, Douglas

Mr Mike Borland,	Head of Service
Mr Ron Giddens,	Director of Children's Services
Ms Maxine McBrier,	Manager

Thursday 13 October 2005
Tromode House, Adolescent Unit, St Christopher's Fellowship, Ballafletcher Road, Tromode, Douglas

Mr Mike Borland,	Head of Service
Mr Ron Giddens,	Director of Children's Services
Ms Voirrie Moore,	Team Leader
Mr Steve Taylor,	Manager

Thursday 13 October 2005
White Hoe residential unit, St Christopher's Fellowship, Old Castletown Road, Douglas

Ms Jackie Baker,	Team Leader
Mr Mike Borland,	Head of Service
Mr Ron Giddens,	Director of Children's Services

Thursday 13 October 2005
Ynnid Whallid, Secondary Referral Centre, Glencrutchery Road, Douglas

Mr Graham Atkinson,	Head of Centre
Mrs Sue Griffiths,	Head of Curriculum
Mrs Pauline Jones,	Learning Support Assistant
Mrs Vicky Peel,	Learning Support Assistant

Friday 14 October 2005
Government Buildings, 3rd Floor Prospect Hill, Douglas

Mr Jon Callister,	Director of Policy, Chief Secretary's Office
Mrs Mary Williams	Chief Secretary, Chief Secretary's Office

APPENDIX 9

THOSE ATTENDING PART 2 SEMINARS

YOUNG PEOPLE'S SAFETY 18 OCTOBER 2005

EXTERNAL EXPERTS:

Mr Wes Cuell,	**Children's Services Director, NSPCC, London**
Professor Ian Sinclair,	**Social Work Research & Development Unit, University of York**
Mr John Bass,	Probation Officer, Probation Division, Department of Home Affairs
Ms Ann Borland,	Team Manager, Foster Plus
Mrs Margaret Britton,	Deputy Director of Education
Mr Ed Coates,	Child Care Co-ordinator, Department of Health & Social Security
Mr Peter Corrin,	Foster Parent
Mrs Carol Corrin,	Foster Parent
Ms Nicola Couling,	Social Worker, Department of Health & Social Security
Miss Helen Craster,	Looked After Children Psychotherapist, CAMHS
Mr David Gibson,	Deputy Director of Social Services
Mr Ron Giddens,	Director of Children's Services, St Christopher's Fellowship
Ms Julia Gilbert,	Fieldwork Manager, Department of Health & Social Security
Ms Pip Handsbury,	Named Nurse for Safeguarding Children, Health Services Division
Mr Chris Johns,	Senior Social Work Practitioner, Referral & Assessment, Department of Health & Social Security
Mr Bill Kelly,	Residential Worker, St Christopher's Fellowship
Mr John Kermode,	Assistant Education Officer (Special), Department of Education
Ms Lisa Kinread,	Residential Manager, Manx Family Services
Mr John McKenzie,	Practice Director, Isle of Man Children's Centre/Branch Chair Isle of Man Branch of the British Association of Social Workers
Mike Langdon	Det Chief Constable, Department of Home Affairs
Ms Maxine McBrier,	Residential Manager, Children's Secure Unit
Dr William van der Merwe,	Consultant Paediatrician, Noble's Hospital
Mr Trevor Noden,	Assistant Director of Children and Families, Social Services
Mrs Catherine Quilliam,	Designated Nurse for Safeguarding Children, Health Services
Ms Joyce Quine,	Agency Manager, Isle of Man Adoption Service
Mr Geoffrey Sugden,	Registrations & Children's Residential Care Inspections Officer, Department of Health & Social Security
Mr Andrew Swithinbank,	Assistant Director of Social Services, Adult Services
Mr Steve Taylor,	Team Manager, Tromode House, St Christopher's Fellowship
Mrs Jo Thomas,	Care Contracts Manager, Social Services Division
Det Sgt Andy Turner,	CID Reactive Team, Department of Home Affairs

YOUNG PEOPLE'S EDUCATION & LEARNING 19TH OCTOBER 2005

EXTERNAL EXPERTS:-

Ms Christine Davies, CBE,	**Corporate Director for Children and Young People, Telford & Wrekin**
Mr Paul Helps,	**Head Teacher, Hillingdon Tuition Centre, Middlesex**
Dame Gillian Pugh DBE,	**Institute of Education, University of London**
Mrs Jacqueline Baker,	Team Leader, St Christopher's Fellowship
Mr John Binns,	Deputy Head Teacher, Castle Rushen High School
Mrs Catherine Bradbury,	Deputy Head Teacher, QEII High School
Mrs Margaret Britton,	Deputy Director of Education
Mr Mike Clague,	Youth and Community Adviser, Youth Office, Department of Education
Mr Ed Coates,	Child Care Co-ordinator, Department of Health & Social Security
Rev Ian Davies,	Diocesan, Member of Governing Body of Marown School, Diocesan Director of Education
Mrs Elizabeth Mary Deans,	Chairperson, QEII Board of Governors
Ms Christine Eccles,	Asst Director for Education, Training & Employment, St Christopher's Fellowship
Dr Paul Emerson,	Consultant in Public Health Medicine, Health Services Division
Mr David Gibson,	Deputy Director Social Services
Mr Ron Giddens,	Director of Children's Services, St Christopher's Fellowship
Ms Angela Guest,	Youth Officer, Youth & Community Division, Department of Education
Sgt Gary Hardman,	Youth Justice Team
Ms Rosemarie Hedley,	School Nurse, Health Services
Mr John Kermode,	Assistant Education Officer (Special) Department of Education
Mrs Pat Kneen, B.Ed, MA,	Director, Manx Family Services
Mr John Knight,	Chief Executive, Isle of Man Children's Centre
Dr Warren Levine,	Consultant Child & Adolescent Psychiatrist, CAMHS
Ms Lyz Moore,	Tobacco and Sexual Health Co-ordinator for Schools and Isle of Man College
Mr Trevor Noden,	Assistant Director of Children and Families, Social Services
Mr Derek Norton,	Acting Assistant Education Officer (Special), Department of Education
Ms Elaine Payne,	Registrations and Inspections Officer, Department of Health & Social Security
Mr Julian Potts,	Head of Careers Services, Department of Education
Mrs Joanna Radcliffe,	Head of Pre School Assessment Centre, Pulrose Youth & Community Centre
Mr Geoffrey Sugden,	Registrations & Children's Residential Care Inspections Officer, Department of Health & Social Security
Ms Jo Thomas,	Care & Contracts Manager, Social Services Division
Mr David Trace,	Head Teacher, Ramsey Grammar School
Mr Andy Varnom,	National Sports Manager, National Sports Centre

YOUNG PEOPLE'S HEALTH 20TH OCTOBER 2005

EXTERNAL EXPERTS:

Ms Elaine Sage,	**Assistant Director of Service Provision, Head of Nursing and Lead for Children's Service, Knowsley PCT**
Ms Jane Scott,	**Regional Change Adviser for London Change for Children Programme, Department of Health (UK)**
Mr Damian Bradley,	(then) Chief Executive, Manx Family Services
Mr Grainne Burns,	Youth Worker, Play & Youth Services, Department of Education
Ms Lesley Dorward,	Director of Health Promotion, Public Health Directorate, Health Services Division
Dr Paul Emerson,	Consultant in Public Health Medicine, Health Services Division
Ms Deborah Evans,	Teacher, Ballakermeen High School
Ms Joanna Fisher,	Senior Educational Psychologist, Acting Head of Inclusion Support
Ms Julia Gilbert,	Fieldwork Manager, Department of Health & Social Security
Ms Lynne Grant,	A & E Liaison Health Visitor, Snaefell Surgery
Ms Rosemarie Hedley,	School Nurse, Health Services Division
Mrs Pat Heggs,	Clinical Nurse Specialist, Mental Health Promotion, Department of Health & Social Security
Ms J Hill,	A & E Nurse Manager, Named Nurse Child Protection, Noble's Hospital
Dr David James,	GP, Hailwood Community Centre
Mr Chris Johns,	Senior Social Worker, Department of Health & Social Security
Ms Pam Kerruish,	Social Worker, Department of Health & Social Security
Inspector Kenneth Kneale,	Lower Douglas, Police Station, Department of Home Affairs
Det Inspector Keith Kinread,	CID Proactive Team, Department of Home Affairs
Mr John Knight,	Chief Executive, Isle of Man Children's Centre
Dr Warren Levine,	Consultant Child & Adolescent Psychiatrist, CAMHS
Mrs Emma McClean,	Therapist/Manager CAMHS
Mrs Orla McGlinchey,	Drug & Alcohol Adviser, Department of Education
Mr Norman McGregor	Edwards, Director of Health Strategy and Performance, Health Services Division
Ms Lyz Moore,	Tobacco and Sexual Health Co-ordinator for Schools and Isle of Man College
Mr Michael Morrison,	Legislation Officer for Health Services Division
Mr Trevor Noden,	Assistant Director of Children and Families, Social Services
Mr Derek Norton,	Acting Assistant Education Officer (Special), Department of Education
Mrs Thea Ozenturk,	Director of Isle of Man Alcohol Advisory Service
Ms Jackie Pate,	Health Adviser for Looked After Children & Youth Justice Team
Mrs Susan Porter,	Service Manager, Health Visiting/School Nursing, Health Services Division
Hon Stephen Charles Rodan BSc MR Pharm S MHK,	Minister for Health & Social Security
Mr Maric Thorpe, FRCS, FFAEM,	Consultant A & E Department, Noble's Hospital
Mr David Trace,	Head Teacher, Ramsey Grammar School

YOUNG PEOPLE'S OFFENDING 01ST NOVEMBER 2005

EXTERNAL EXPERTS:

Mr Malcolm Potter,	**Youth Justice Board Regional Manager, Yorkshire and the Humber**
Mr Chris Wright,	**Head of Performance, Youth Justice Board, London**
Mrs Margaret Britton,	Deputy Director of Education
Mr Ken Callister,	Youth Officer, Youth & Community Division, Department of Education
Mr Steve Chell,	Manager, Drug & Alcohol Team, Department of Health & Social Security
Mr Peter Christie,	Social Worker, Department of Health & Social Security
Mr Mike Clague,	Youth and Community Adviser, Youth Office, Department of Education
Mr Robert Cowley,	Deputy Headmaster, St Ninian's High School
Ms Joanna Fisher,	Senior Educational Psychologist, Acting Head of Inclusion Support, Department of Education
Ms Michelle Fletcher,	Outreach and Aftercare Project Worker, Manx Family Services
Mr Ron Giddens,	Director of Children's Services, St Christopher's Fellowship
Mr John Gill,	Schools Division, Legal/Admin, Department of Education
Det Sgt Gary Hardman,	Youth Justice Team
Mr Trevor Hussey,	Assistant Governor, Isle of Man Prison
Ms Rosa Kennedy,	Youth Justice Worker, Youth Justice Team, Department of Health & Social Security
Ms Maxine McBrier,	Manager St Christopher's Secure Unit, The Children's Secure Care Home
Mr David McClean,	Drug & Alcohol Professional, Social Services Division
Mrs Emma McClean,	Therapist/Manager CAMHS
Ms Julie McNicholl,	Manager, Local Government
Mr Alec Merchant,	Liaison Social Services & Youth Justice Team, Team Manager, Department of Health & Social Security
Mr Michael Morrison,	Deputy Head of Health Services Division
Mr John Needham,	Legal Officer, Isle of Man Courts of Justice
Mr Trevor Noden,	Assistant Director of Children and Families, Social Services
Mr Derek Norton,	Acting Assistant Education Officer (Special) Department of Education
Ms Jackie Pate,	Health Adviser for Looked After Children & Youth Justice Team
Rev Bill Platt,	Youth Worker of the Foundry, Broadway Baptist Church
Mr David Sellick,	Chief Probation Officer, Department of Home Affairs

VOICE OF YOUNG PEOPLE 02ND NOVEMBER 2005

EXTERNAL EXPERTS:

Ms Maria Battle,	**Deputy Children's Commissioner for Wales**
Ms Felicity Shenton,	**Consultant, Investing in Children**
Ms Ashleigh Greathead,	**Consultant, Investing in Children**

Freya Bibby
Amy Corkill
Dan Corkish
Simon Cowan
Stef Cowan
Wayne Dale
Dean Ellison
Charlotte Faragher
Tara Hampson
Michelle Harrison
Shelkl Harrison
Emily Lightfoot
Sarah Mathews
Darren O'Hare
Orlaith O'Mahoney
Elizabeth Robinson
Barny Seegers
Thalia Smith
Kuba Szymanski
Andy Whittaker

STRATEGY 07TH NOVEMBER 2005

EXTERNAL EXPERTS:

Ms Maria Battle,	**Deputy Children's Commissioner for Wales**
Mr John Coughlan,	**Director of Children's Services, Hampshire**
Mr Jonathan Farrow,	**Chief Executive, St Christopher's Fellowship**

Hon David Moore Anderson, MHK, Minister for Education	
Mr John Cain,	Director of Education
Mr Jon Callister,	Director of Policy, Chief Secretary's Office
Mrs Clare Christian, BSc MLC	
Mr David Cooke,	Director of Social Services
Mrs Anne Valerie Craine, MHK	
Mrs Bev Critchlow,	Director of Nursing, Midwifery & Professional Development, Department of Health & Social Security
Mike Culverhouse,	Chief Constable IOM Constabulary
Capt Andrew Cowin Douglas, MHK	
Hon Donald James Gelling, Esq CBE CInstSMM FIMMgt CP MLC,	Chief Minister
Mr Will Greenhow,	Chief Executive Officer, Department of Home Affairs
Mrs Hazel Hannan MHK,	Member for Peel
Mr David Killip,	Chief Executive, Department of Health & Social Security
Mrs Linda McCauley,	Children and Young People's Strategy Co-ordinator, Chief Secretary's Office
Mr Norman McGregor Edwards,	Director of Health Strategy and Performance, Department of Health and Social Security
Mrs Margaret O'Reilly,	Strategy Co-ordinator, Drugs & Alcohol, Chief Secretary's Office
Mrs Sally Roberts,	Financial Management Adviser, Treasury Department
Hon Stephen Charles Rodan, BSc MR Pharm S MHK,	Minister for Health & Social Security
Mr David Sellick,	Chief Probation Officer, Department of Home Affairs
Hon John Philip Shimmin, BEd MHK,	Minister for Home Affairs
Dr Andrea Steriu,	Database & Information Manager, Department of Home Affairs
Mr Trevor Noden,	Assistant Director of Children and Families, Social Services

APPENDIX 10

WRITTEN SUBMISSIONS RECEIVED FOR PART 2

Dr Eleanor Ashton M.B	
Ms Maria Battle,	Deputy Children's Commissioner for Wales (External Expert)
Ms Jacqui Baker	Whitehoe Children's Home
Ms Ann Borland,	Team Manager Fosterplus
Mr Damian Bradley,	Chief Executive, Manx Family Services
Mrs Margaret Britton,	Deputy Director of Education
Mr Mike Clague,	Youth and Community Adviser, Youth Office, Department of Education
Mr Ed Coates,	Child Care Co-ordinator, Department of Health and Social Security
Mr and Mrs P Corrin,	Foster Parents
Mr John Coughlan,	Director of Children's Services, Hampshire (External Expert)
Mr R Cowley	Deputy Headteacher St. Ninian's High School
Mr John Craine	
Ms Angela Crapper	Advocate. [submission with Pamela Butterworth]
Mrs M Cringle, JP,	Chairman Isle of Man Magistrates' Association
Ms Bev Critchlow,	Director of Nursing, Midwifery and Professional Development, Department of Health and Social Security
Mr Wes Cuell,	Children's Services Director, NSPCC, London
Ms Christine Davies, CBE,	Corporate & Young Person's Services, Telford (External Expert)
Mr N McGregor Edwards	Director of Health Strategy and Performance. Department of Health and Social Security
Ms Michele M Edwin,	Operations Manager, Include
Dr Paul Emerson, BA, MBChB MFPHM,	Consultant Public Health Physician, Health Services Division
Families submission	Dated 2 October 2005
Mr Jonathan Farrow,	Chief Executive, St Christopher's Fellowship (External Expert)
Ms Joanna Fisher,	Senior Educational Psychologist, Acting Head of Inclusion support, Department of Education
Mr David Gibson,	Deputy Director of Social Services
Mr Ron Giddens,	Director of Children's Services, St Christopher's
Ms Julia Gilbert,	Fieldwork Team Manager, Department of Health and Social Security
Ms Ashleigh Greathead,	Investing in Children (External Expert)
Mr Paul Helps, M.Ed	Head Teacher, Hillingdon Tuition Centre, Middlesex (External Expert)
Ms Anne Kelly	
Ms Mary Kennaugh MA	Social worker and George Green's aunt
Mrs Pamela Kerruish,	Social Worker, Department of Health and Social Security
Mr John Kermode,	Assistant Education Officer (Special), Department of Education
J.D Kewley	Dickinson Cruickshank
Mrs Pat Kneen, B.Ed, MA,	Director, Manx Family Services

Mr John Knight,	Chief Executive, Isle of Man Children's Centre
Dr Annie Kurien,	Consultant Paediatrician, Noble's Hospital
Dr Warren Levine,	Consultant Child and Adolescent Psychiatrist, CAMHS
Ms Orla McGlinchey	Alcohol/Drug Education liaison Officer
Mr David McWilliam	former Local Authority Commissioner
Mr Alex Merchant	Team Manager, Referral and Assessment Team
Dr William van der Merwe,	Consultant Paediatrician, Noble's Hospital
Mr John McKenzie,	Practice Director, Isle of Man Children's Centre/Branch Chair Isle of Man Branch of the British Association of Social Workers
J B Moffatt	Transport and General workers Union
Ms Lyz Moore,	Tobacco and Sexual Health Co-ordinator for Schools and Isle of Man College
Mr Trevor Noden,	Assistant Director of Children and Families, Social Services
Rev Bill Platt,	Youth Worker of the Foundry, Broadway Baptist Church
Mrs Margaret O'Reilly,	Strategy Co-ordinator, Drugs and Alcohol, Chief Secretary's Office
Mrs Thea Ozenturk,	Director of Isle of Man Alcohol Advisory Service
Ms Julie Peel,	Lecturer, Isle of Man Business School
Rev Bill Platt	Chair of Youth Partnership Youth Counselling Committee
Mrs Susan Porter,	Service Manager Health Visiting and School Nursing, Health Services Division
Mr Malcolm Potter,	Youth Justice Board Regional Manager, Yorkshire and the Humber (External Expert)
Mr Julian Potts,	Head of Careers Service, Department of Education
Dame Gillian Pugh, DBE,	Institute of Education, University of London
Mrs Catherine Quilliam,	Designated Nurse for Safeguarding Children, Health Services
Mrs Joanna Radcliffe	Head Teacher Pre-School Assessment Centre
Residents	Osborne Grove, Richmond Grove and Windsor Road. Douglas
Jo Richardson	Anagh Coar Primary School
Ms Elaine Sage,	Assistant Director of Service Provision, Head of Nursing and Lead for Children's Service, Knowsley PCT (External Expert)
Ms Jane Scott,	Regional Change Adviser, for London Change for Children Programme (External Expert)
Mrs Anne Seed,	Chief Executive, Manx Family Services
Ms Felicity Shenton,	Investing in Children (External Expert)
Mrs J Simpson	Isle of Man Federation of Women's Institutes
Professor Ian Sinclair,	Social Work Research & Development Unit, University of York
Brian Smith	
Mr Andrew Swithinbank,	Assistant Director of Social Services (Adults)
Det Sgt Andy Turner,	CID Reactive Team, Department of Home Affairs
Mr Andy Varnom,	National Sports Manager, National Sports Centre
Mrs Sue Wadsworth,	Manager of Registrations and Inspections Unit, Social Services Division
Ms Stephanie Waters	Senior social worker. Department of Health and Social Security
Mr Chris Wright,	Head of Performance, Youth Justice Board, London (External Expert)

APPENDIX 11

CLOSING SUBMISSIONS FOR PART 1

1. Families – Alexander Harris (counsel: Simon Crabtree)
2. Department of Health and Social Security - Simcocks
3. Department of Home Affairs – Dickinson Cruickshank
4. Department of Education – John Kermode
5. Nugent Care Society – Quinn Neale
6. Former employees of Nugent Care – Pamela Pringle
7. Manx Family Services – Pamela Pringle
8. Priory Care – Nabarro Nathanson
9. Mrs Brenda Cannell MHK – Steve Coren
10. Mr Geoff Cannell – Jerry Carter
11. Damien Bradley – Andrew Bridson
12. Leslie Moorcroft – Jerry Carter
13. Adrian Venn
14. Jacqueline Baker

APPENDIX 12

NAMES/DEPARTMENTS/GENERAL PUBLIC WHO HAVE CONTACTED THE INQUIRY

DEPARTMENT OF HEALTH AND SOCIAL SECURITY

Dr Doddaballapur Balakrishna, M.B., B.S., Associate Specialist in Psychiatry	
Ms Lisa Beard,	Executive Officer, Children & Families
Mr Kenneth Best,	Social Worker
Mr Ed Coates,	Child Care Co-ordinator
Mr David Cooke,	Director of Social Services
Mr Juan Corlett,	Social Worker
Ms Bev Critchlow,	Director of Nursing, Midwifery & Professional Development
Dr Paul Emerson,	Consultant in Public Health Medicine
Mr David Gibson.	Deputy Director of Social Services
Ms Julia Gilbert,	Fieldwork Manager
Ms Pip Handsbury,	Named Nurse for Safeguarding Children
Ms Pam Kerruish,	Social Worker
Mr David Killip,	Chief Executive
Dr Annie Kurien,	Consultant Paediatrician, Noble's Hospital
Dr Warren Levine,	Consultant Child & Adolescent Psychiatrist, CAMHS
Dr Ian MacLean,	Chief Administrative Medical Officer/Director of Public Health
Mr Norman McGregor Edwards,	Director of Health Strategy and Performance
Mr Alec Merchant,	Liaison Social Services and Youth Justice Team, Team Manager
Dr Williams van der Merwe,	Consultant Paediatrician, Noble's Hospital
Ms Helen Moore,	Social Worker
Ms Lyz Moore,	Tobacco and Sexual Health Co-ordinator for Schools and Isle of Man College
Mr Brian Morris,	Manager, Children's Services
Ms Sylvia Morrison,	Social Worker
Mr Trevor Noden,	Assistant Director of Children and Families
Mr Tim Norton,	Social Worker
Ms Angela Oldroyd,	Social Worker
Mrs Susan Porter,	Service Manager Health Visiting/School Nursing
Mrs Catherine Quilliam,	Designated Nurse for Safeguarding Children
Mr Geoffrey Sugden,	Registrations & Children's Residential Care Inspections Officer
Ms Judith Stephen,	Manager of the Southern Community Mental Health Team
Mr Andrew Swithinbank,	Assistant Director of Social Services (Adults)
Mrs Jo Thomas,	Care Contracts Manager
Ms Diane Toher,	Social Worker
Mr Ken Tomlinson,	former Chief Executive DHSS
Mrs Sue Wadsworth,	Manager of Registrations and Inspection Unit
Dr Kirsten Wafer,	Consultant in charge of Drug and Alcohol Team
Ms Alex Watson,	Social Worker
Mr John Wilson,	Head of Health Services Division (retired)

DEPARTMENT OF EDUCATION

Mrs Margaret Britton,	Deputy Director of Education
Ms Adrienne Burnett,	Head Teacher, Ballakermeen High School
Mr John Cain,	Director of Education
Ms Joanna Fisher,	Senior Educational Psychologist, Acting Head of Inclusion Support
Mr John Kermode,	Assistant Education Officer (Special)
Mr Julian Potts,	Head of Careers Services
Mr George Quayle,	Head Teacher St Ninian's High School

DEPARTMENT OF HOME AFFAIRS

Mr Mike Culverhouse	Chief Constable
Mrs Rosie Crosby,	Governor, Isle of Man Prison
Ms Margaret Dunne,	Specialist Probation Officer (Drugs)
Mrs Margaret Erani,	Probation Officer
Mr Will Greenhow,	Chief Executive Officer
Sgt Gary Hardman,	Youth Justice Team
Mr Paul Hoggett	Acting Chief Inspector (Retired)
Mr Keith Kinrade,	Det Inspector CID Proactive Team
Mr Richard Power	Inspector
Mr Gary Roberts	Det Sgt
Mr David Sellick,	Chief Probation Officer
Mr Andy Turner,	Det Sgt CID Reactive Team

DEPARTMENT OF TRADE & INDUSTRY

Mr Chris Corlett,	Chief Executive
Mr Chris Woodward,	Group Manager of Training & Employment

DEPARTMENT OF LOCAL GOVERNMENT & THE ENVIRONMENT

Mr Nick Black,	Chief Health & Safety Officer
Mr Ian McCauley,	Director of Planning & Building Control
Mr Richard Senior,	Director of Estates & Housing

CHIEF SECRETARY'S OFFICE

Mr Jon Callister,	Director of Policy
Mrs Linda McCauley,	Children and Young Persons Strategy Co-ordinator
Mrs Margaret O'Reilly,	Strategy Co-ordinator, Drugs and Alcohol
Mrs Mary Williams,	Chief Secretary

ATTORNEY GENERAL'S CHAMBERS

Mr Peter Carlè,	Legal Officer, Prosecutions
Mr William Corlett,	Attorney General
Miss Michelle Norman,	Legal Officer
Mrs Linda Watts,	Senior Prosecutor

GENERAL REGISTRY

Mr Peter Corkill,	Chief Registrar
Mrs Voirrie Moore,	Clerk to Coroner of Inquests

ISLE OF MAN COURTS OF JUSTICE

Mr Michael Ball,	Chief Registrar
Mr Michael Moyle,	High Bailiff
Mr John Needham,	Legal Officer, Courts

THE TREASURY

Mr Clive McGreal,	Chief Internal Auditor
Mrs Marie Ellison,	Treasury Administration
Mrs Sally Roberts,	Financial Management Adviser

OFFICE OF CHIEF MINISTER

Mrs Pauline Pescodd,	Senior Administrator to the Chief Minister

MEMBERS OF THE LEGISLATIVE COUNCIL

Dudley BUTT Esq MLC
Mrs Clare CHRISTIAN, BSc MLC
Mrs Pamela CROWE, MLC
Hon Alexander DOWNIE Esq, FIMar EST MCMI FFB, MLC, Minister for Trade & Industry
Hon Donald GELLING, Esq, CBE ClnstSMM FIMgt, MLC, Chief Minister
Edmund LOWEY, Esq, MLC
Leonard SINGER, Esq, MR Pharm S, MLC
George WAFT, Esq, Dip, App, SS BSC (Hons), MLC

MEMBERS OF THE HOUSE OF KEYS

Hon David ANDERSON, MHK,	Minister for Education
Hon Robert BRAIDWOOD, BEng, MHK,	Minister for Transport
The Hon James BROWN, SHK	(Speaker of the House of Keys)
Hon Allan BELL, MHK,	Treasury Minister
Mrs Brenda CANNELL, MHK,	Member for Douglas East
John CANNAN, Esq, MHK,	Member for Michael
Richard CORKILL, B Pharm MR Pharm S, MHK,	Member for Onchan
Mrs Anne CRAINE, MHK,	Member for Ramsey

Hon David CRETNEY, MHK,	Minister for Tourism and Leisure
Dominic DELANEY, MHK,	Member for Douglas West
Capt Andrew DOUGLAS, MHK,	Member for Malew and Santon
Adrian DUGGAN, Esq, MHK,	Minister for Douglas South
Adrian EARNSHAW, Esq, MHK,	Member for Onchan
Hon Philip GAWNE, BSc, MHK,	Minister for Agriculture, Fisheries & Forestry
Quintin GILL, Esq, MHK,	Member for Rushen
Mrs Hazel HANNAN, MHK,	Member for Peel
Robert HENDERSON, Esq, DipMgt MCMI MIHSM RMN, MHK,	Member for Douglas North
John HOUGHTON, Esq, MHK,	Member for Douglas North
Peter KARRAN, Esq, MHK,	Member for Onchan
Malachy CORNWELL-KELLY, Esq, LLB (Hons) AKC MCMI	(Clerk of Tynwald, Secretary of the House of Keys and Counsel to the Speaker)
Hon John RIMMINGTON BA, MHK,	Minister for Local Government & The Environment
Hon Stephen RODAN, BSc MR Pharm S, MHK,	Minister for Health & Social Security
Hon John SHIMMIN, Bed, MHK,	Member for Douglas West
William TEARE, Esq, MHK,	Member for Ayre
George QUAYLE, Esq, MHK,	Member for Middle

PUBLIC RECORDS OFFICE

Ms Miriam Critchlow,	Public Records Officer
Mr Brian Roberts,	Archive Officer

INFORMATION SYSTEMS DIVISION

Mr Allan Patterson,	I.S. Director

FOSTER PLUS

Ms Ann Borland,	Team Manager

ISLE OF MAN ADOPTION SERVICES

Ms Joyce Quine,	Agency Manager

Ex-NUGENT CARE

Ms Jackie Baker,	Team Leader
Ms Karen Bannen,	Residential Social Worker
Mr Francis Charlton,	Manager
Ms Kathleen Cooke,	Key Worker
Ms Gillian Cowie,	Key Worker
Ms Liz Dickson,	Residential Social Worker
Ms Helen Giddings,	Key Worker

Mr Jimmy Gillespie,	Key Worker
Ms Sarah Heselwood,	Residential Social Worker
Ms Victoria Higgins,	Residential Social Worker
Mr Mark Hoswell,	Social Worker
Mr Jon Kelly,	Senior Residential Social Worker
Mr John Kennedy,	former Director and Chief Executive
Mr Christopher Lever,	Key worker
Ms Leanne Newbold,	Key Worker
Ms Gillian Owen,	Nugent Care (UK)
Ms Barbara Taylor,	Strategic Support Officer
Mr Eddie Tinsley,	Residential Social Worker
Mr Gary Simpson,	Residential Social Worker
Mr Adrian Venn,	Team Leader
Ms Diane Watts,	Team Leader of Outreach Department

PRIORY GROUP LIMITED

Mr Stephen Bradshaw,	Director of School Development
Ms Sarah Hunt,	Administration Officer
Dr Chai Patel,	Chief Executive

MANX FAMILY SERVICES

Mr Damian Bradley,	then Chief Executive
Ms Angela Fairburn,	Manager of Family Centre
Mr Graham Kneen,	Director
Ms Lisa Kinrade,	Residential Manager
Ms Patricia Kneen,	Director
Mr Philip Kneen,	Care Worker
Mr Richard Kneen,	Director
Mrs Anne Seed,	then Outreach and Aftercare Manager
Mr Victor Whitewside,	former Director

ST CHRISTOPHERS FELLOWSHIP

Mr Ron Giddens,	Director of Children's Services
Mr Bill Kelly,	Residential Worker
Ms Christine Eccles,	Assistant Director of Education
Mr Steve Taylor,	Manager, Tromode House
Ms Maxine McBrier,	Manager, Secure Unit
Mr Mike Borland,	Head of Service

ISLE OF MAN CHILDREN'S CENTRE

Mr John Knight,	Chief Executive
Mr John McKenzie,	Practice Director
Mrs Mandy Delaney,	Residential Manager
Mrs Carrie Wade,	Course Director
Mrs Pam Jackson,	Douglas Senior Practitioner
Mr Simon McCann,	Outreach Support Worker

GENERAL PUBLIC

Dr E A Ashton
Mr and Mrs P M Black
Dr Terry Bruce, MA, M.B, B.Chir D.P.M. F.R.C.Psych, Consultant Psychiatrist UK
J Busby
Mr Robert Matthew Campbell
Mr Geoff Cannell
Mr Steven Corkill
Mr & Mrs P Corrin, Foster Parents
Mr John Craine
Mr Dizzy Christian
Ms Pamela Crosbie
Mr E A Crowe
M Donnelly
Mr and Mrs J Eccles
P Fisher
Mr Walter Gilbey
Mr and Mrs E C Gore
Mr Hughes
Jonny Hynes
Ms Anne Kelly
Mr J D R Kewley
Ms Helen Kneen

Mr and Mrs J M McClatchey
Mr David MacWilliams
Mr D North
Mr R E Quine OBE
Ms Barbara Rains
Mr Roy Redmayne
Mrs Lisa Robson
Mr B Smith
N Smith
Sir Miles Walker
Mr Dean Whitehead

FAMILY

BARTON FAMILY

Ms Rose Burnell
Ms Theresa Barton
Ms Lyndsey Barton

GREEN FAMILY

Mrs Jennifer Charles
Mrs Anne Curphey
Mr Edric Green
Mrs Margaret Green
Ms Kathryn Green
Mrs Jackie Entwhistle

TRANSPORT & GENERAL WORKERS UNION

Mr Michael Hewer,	DHSS Convenor
Mr Bernie Moffatt,	Regional Industrial Organiser

EDEN GROVE SCHOOL

Ms Liz Casling,	Teacher
Ms Debbie Hewitt,	Senior Administrator
Mr Ian McCready,	Principal
Ms Pat MacKenzie,	Residential Care Worker
Mr Ian Noble,	Residential Care Worker

THE MARLOWE CHILD & FAMILY SERVICES

Ms Mary Miles,	Residential Social Worker

SALVATION ARMY

Mr Wayne Tomlinson

APPENDIX 13

CONVICTIONS AND CAUTIONS OF SAMANTHA BARTON

TAKEN FROM THE STATEMENT OF CHIEF CONSTABLE MIKE CULVERHOUSE

5.1 Convictions and Cautions (File 8, 001-013)

12/11/96 - Common assault (aggravated) Sally Ann Cracknell Public foyer at Police HQ, Douglas 05/03/97 - Conditional Discharge 12 months

16/01/97 - 1-2) Common assault on Voirrey Ann Moore & Robert Jonathan Jones, 05/03/97 - 1-2) Conditional Discharge 12 months each offence

25/02/97 - 1-2) Common assault on Anne Craigens Duff & Roger Woodcock 05/03/97 - 1-2) Conditional Discharge 12 months each offence

25/02/97 - Assault ABH on Sally Ann Cracknell, 05/03/97 - Conditional Discharge 12 months

16/01/97 - Assault ABH on Marjorie Richards 05/03/97 - Conditional Discharge 12 months

23/03/97 - Common assault on John Albert McKenzie, 11/06/97 - Conditional Discharge 12 months

02/05/97 - Common (aggravated) assault on Heath Lorraine Tebbut, 11/06/97 - Conditional Discharge 12 months

03/06/97 - Assault ABH on Sally Ann Cracknell, 11/06/97 - Conditional Discharge 12 months

03/06/97 - Criminal Damage to Crockery of unknown value 11/06/97 - Conditional Discharge 12 months

03/06/97 - Criminal Damage to lady's wristlet watch of unknown value, 11/06/97 - Conditional Discharge 12 months

31/03/97 - Criminal Damage to vehicle, 11/06/97 - Conditional Discharge 12 months

20/04/97 - Provoking Behaviour 11/06/97 - Conditional Discharge 12 months

12/04/97 - Raise a false fire alarm at Cummal Shee, 11/06/97 - Conditional Discharge 12 months

21/04/97 - Common assault (aggravated) on Lorraine Alex Michelle Kelly 11/06/97 - Conditional Discharge 12 months

20/04/97 - Common assault (aggravated) on Anne Craigens Duff, 11/06/97 - Conditional Discharge 12 months

12/04/97 - Common assault on Christopher John Pullen, 11/06/97 - Conditional Discharge 12 months

23/03/97 - Assault ABH on Robert James Carr 11/06/97 - Conditional Discharge 12 months

21/06/97 - Common assault (aggravated) on Voirrey Ann Moore 28/07/97 - Conditional Discharge 1 year

26/07/97 - Common assault (aggravated) on Ann Craigens Duff 28/07/97 - Conditional Discharge 1 year

11/06/97 - Breach of conditional discharge of 28/07/97 - No action

09/07/97 - 1-3) Assault PCs William Dale Moffatt, Angela Collins and Dawn Katrina Lowe in Execution of duty 28/07/97 - 1-3) Conditional Discharge 1 year

26/07/97 - Criminal Damage to fire alarm break glass at Cummal Shee 28/07/97 - Conditional Discharge 1 year

25/07/97 - 1-2) Assault WPC Dawn Michelle Murray & Helen Louise Hastie in Execution of duty 28/07/97 - 1-2) Conditional Discharge 1 year

07/08/98 - 1) Affray 2) Battery 3) Use threatening/abusive words or behaviour 4&5) TWOC 6) Interfering with vehicle 7) Criminal damage 8) Drive whilst disqualified 9) no insurance 10) criminal damage 11) battery 12) arson – 1-12) Supervision Order 12 months – conditions of residence – night restriction and education each offence also 4,5,6,8 & 9) disqualified from driving 4 years each offence

04/12/98 - Did together with ***, *** and *** use threatening unlawful violence towards David Reginald Berry and Harvey James Patterson such as would cause person to fear for own safety - 1 year probation to reside where directed by DHSS – currently with Aunt, Teresa Barton curfew 8pm – 7am unless accompanied by Aunt

04/11/98 - Did use threatening abusive insulting words or behaviour likely to cause harassment alarm or distress 04/12/98 -1 year probation concurrent

11/11/98 - Unlawfully assault Sally Ennett on or about 04/12/98 - 1 year probation concurrent

04/12/98 - 1-2) Allow self to be carried in 2 TWOC DMN 737 & CMN 709E - 1-2) 1 year probation concurrent on each

04/12/98 - Assault Harvey James Patterson occasioning actual bodily harm - 1 year probation concurrent

15/06/00 - Assault of PC Horsefield in execution of duty 10/08/00 - 12 months conditional discharge

10/08/00 - Theft of pint of milk value of 42p from Police HQ - 12 months conditional discharge concurrent

11/09/00 - Assault on PC Julie Jones, 12/09/00 - Withdrawn – Social Services escort to Liverpool

Between 12/04/01 & 18/04/01 - Criminal Damage to curtain poles, television stand, video recorder telephone etc to the value of £350 16/08/01 - 12 months conditional discharge

21/05/01 - Unlawfully assault Stephen Freeman 16/08/01 - 12 months conditional discharge concurrent

29/07/01 - Use or threaten violence toward PC Robert James Midghall such as to cause fear for personal safety 15/11/01 Section 1 public order – Withdrawn

Between 13/05/01 & 16/05/01 - Did together with *** burglary/theft of alcoholic drinks and tobacco of an unknown value 17/12/01 - 14 days imprisonment concurrent suspended 1 year. No order as to costs.

02/10/01 - Criminal Damage to information sign of unknown value 17/12/01 - 7 days imprisonment concurrent suspended 1 year

02/10/01 - Use threatening abusive words or behaviour likely to cause harassment alarm or distress 17/12/01 - No separate penalty

16/08/01 - Breach of conditional discharge of 17/12/01 - No action

24/10/01 - Assault PC Roseita Joyce in execution of her duty 17/12/01 - 28 days imprisonment suspended 1 year

24/10/01 - Possession of class A drug – ecstasy 17/12/01 - No separate penalty

24/10/01 - Possession of Class B drug – cannabis resin, 17/12/01 - No separate penalty

24/04/01- Criminal Damage to EMN 535M 17/12/01 - No separate penalty

24/07/01 - Handling stolen goods namely a Nike Sports bag and a black case 17/12/01 - No separate penalty

17/12/01 - Permit premises to be used to smoke Cannabis resin - No separate penalty

13/05/01 - Being carried in TWOC BMN 366B 17/12/01 - No separate penalty

10/12/01 - Theft of two bathrobes value £59.98 from Deal Zone Onchan 24/01/02 - 14 days imprisonment suspended 12 months

<u>Cautions</u>

16/06/96 - Common Assault – Caution
03/10/96 - 1-3) Common Assault (aggravated) on Heather Lorraine Tebbut Anne Creggans Duff & Margaret Richards 13/10/96 - 1-3) Caution
30/11/96 - Provoking behaviour 20/12/96 - Caution

APPENDIX 14

CONVICTIONS AND CAUTIONS OF GEORGE GREEN.

TAKEN FROM THE STATEMENT OF MIKE CULVERHOUSE. CHIEF CONSTABLE

02/03/99 - Use of threatening, abusive or insulting words like to cause John Steven Buttery harassment, alarm or distress 02/06/99 - 12 months probation – condition not to enter N.S.C. Complex for 3 months

15/02/99 – Use of threatening abusive words or behaviour likely to cause Barry Cox harassment alarm or distress 02/06/99 – Withdrawn

15/05/99 - Attempt to steal money from Robert Charles Lord & threatening or using force to do so 02/06/99 - 12 months probation concurrent

23/05/99 - Burglary/theft of fire extinguisher of unknown value 02.06.99 - 12 months probation concurrent

24/04/99 - Unlawfully assaulted Susan McKnight 02.06.99 - 12 months probation concurrent

Between 27/05/99 & 30/05/99 - Did together with *** & *** take conveyance K962 MAN 02/06/99 - 12 months probation concurrent

02/06/99 - Did together with *** & *** burglary/theft of unknown amount of money Marown & District Bowling Club - 12 months probation concurrent No compensation

29/04/99 - Use of threatening abusive words or behaviour towards Deborah Marie Evans likely to cause harassment alarm or distress 02/06/99 - 12 months probation concurrent

24/04/99 - Criminal damage to window of double decker bus 02/06/99 - 12 months probation concurrent No Compensation Order

15/05/99 - Assault ABH on Robert Charles Lord (aged 13 years) 02/06/99 – Withdrawn

18/04/99 - Cause harassment, alarm or distress to Dawn Michelle Murray 02/06/99 - 12 months probation concurrent

15/06/99 - Cause harassment, alarm or distress to PC 42 MacDonald 07/07/99 - 12 months conditional discharge concurrent
02/06/99 - Breach of Probation Order 07.07.99 - No action

21/06/99 - Did together with *** theft can of petrol of unknown value 07/07/99 - 12 months conditional discharge

28/06/99 - 1-2) Unlawfully assault Mark Andrew Edmonds age 8yrs & 5 months & Belinda Jane Glover 03/11/99 - 1-2) Withdrawn

27/08/99 - Criminal damage to pane of glass of unknown value 22/11/99 - 12 months probation concurrent

05/11/99 - Provoking behaviour tending to breach of the peace 22/11/99 - 12 months probation concurrent

07/07/99 - Breach of conditional discharge 22/11/99 - No action

12/07/99 - Use threatening abusive or insulting words or behaviour towards PC D Pearson likely to cause harassment alarm or distress 22/11/99 - 12 months probation

05/11/99 - Use threatening abusive words or behaviour towards Neil Saxon & Rosalin Sheridan likely to cause harassment alarm or distress 22/11/99 - 12 months probation concurrent

05/01/00 - Criminal damage to pane of glass value £10.40 13/01/00 - Care Order

07/07/99 - Breach of Conditional Discharge of 13/01/00 - No action

08/01/00 - Criminal damage to interior cage door handle of Police van EMN 267T 13/01/00 - Care Order

22/11/99 - Provoking behaviour tending to breach of the peace 13/01/00 - Care Order

02/06/99 & 22/11/99 - 1-2) Breach of probation of 13/01/00 - 1-2) no action

22/11/99 - Criminal damage to cooker panel and a garden ornament of unknown value 13/01/00 - Care Order made DHSS now legal guardian & responsible for all welfare DHSS has facility to make a Placement Order if required

19/02/00 - Breach of bail conditions - Warned as to consequences Curfew at Cummal Shee 8pm to 8am. Not to leave Cummal Shee unless supervised by staff member

15/01/00 - Did destroy by fire a length of carpet intending to destroy such property or being reckless as to whether such property would be destroyed 24/02/00 - 12 months probation

24/01/00 - Criminal damage to Perspex board of unknown value 24/02/00 - 6 months probation concurrent

02/02/00 - Did together with *** criminal damage to metal bar & wall of unknown value 24/02/00 - 6 months probation concurrent

17/02/00 - Breach of bail conditions imposed on 24/02/00 - No action

04/02/00 - Theft of Kenmore Whiskey value £15.50 24/02/00 - 12 months conditional discharge concurrent

07/02/00 - Criminal damage to window 24/02/00 - 6 months probation concurrent

02/06/99 - Breach of probation of 24/02/00 - No action

08/10/99 - Ride DMN 719C without insurance 24/02/00 - 12 months conditional discharge concurrent DLE

30/01/00 - Criminal damage to pane of reinforced glass & internal plasterboard wall value £80 24/02/00 - 6 months probation concurrent

08/10/99 – Take conveyance DMN 719C 24/02/00 - 12 months conditional discharge DLE

02/03/00 - Unlawfully assault Paul Graham MacLugash 23/03/00 - 5 days imprisonment consecutive

01/03/00 - Cause harassment alarm or distress towards PC Gorry 23/03/00 - No separate penalty

24/02/00 - Breach of Conditional Discharge of 23/03/00 - No action

24/02/00 - Breach of Probation of 23/03/00 - No action

01/03/00 - Theft of two pound coins belonging to Margaret Elizabeth Green 23/03/00 - 5 days imprisonment consecutive

06/03/00 - Arson – damage by fire a toilet seat belonging to National Children's Home Cummal Shee intending to damage such property or being reckless as to whether such property would be damaged 23/03/00 - 28 days imprisonment
11/10/01 - Criminal damage to front offside headlamp cluster and drivers door of DMN 830N of unknown value 23/10/01 - 12 months conditional discharge

10/10/01 - Section 2 Public Order – Fear or provocation of violence 23/10/01 - 12 months conditional discharge concurrent

11/10/01 - Public Order Section 2 – Fear or provocation of violence 23/10/01 - 12 months conditional discharge concurrent

Between 26/12/01 & 29/12/01 - Theft from vehicle DMN 713M of Aiwa Walkman personal stereo & headphones & a packet of cigarettes of unknown value 07/01/02 - 12 months conditional discharge

28/12/01 - Criminal damage to vehicle P604 OWW 07/01/02 - 12 months conditional discharge concurrent

29/12/01 - Theft of driving licence from vehicle DMN 993K 07/01/02 – 12 months conditional discharge

<u>Cautions</u>

30/08/99 - Harassment, alarm or distress 18/02/02 – Caution

28/12/01 - Use abusive language in the presence of PC 19 Bradley outside of the Venue Nightclub 29/12/01 – Caution

APPENDIX 15

BRIEF SUMMARY OF SOCIAL SERVICES PROVISION FOR THE CARE AND SUPPORT OF CHILDREN AND YOUNG PEOPLE WITH BEHAVIOURAL AND EMOTIONAL PROBLEMS

SERVICES PROVIDED DIRECTLY BY SOCIAL SERVICES EITHER SOLEY OR JOINTLY WITH OTHER GOVERNMENT DEPARTMENTS:

Three Social Work Teams:

- **Referral & Assessment**: for brief intervention, initial assessment and child protection investigations.
- **Care Management**: for long term cases, children in care, children on the Child Protection Register and family support programmes.
- **Family Support**: workers for children with disabilities and specialist therapy workers who work with children who are bereaved have been abused or have other emotional or behavioural problems.

Psychologist

- Working with both children and parents referred by social workers.

Looked After Child Therapist

- Psychotherapist to work directly with young people in care and offer training or support to foster carers and residential care workers. This post facilitates closer working links with CAMHS Team.

Resource Centre for Children with Disabilities (soon to be 2 as another is being built)

- This comprises both short break service and outreach support work providing support services in the family home.

Youth Justice Team (Police, Social Services and Health)

- For juveniles up to 17 years. Offending behaviour work and preventative work. All cautioning decisions taken by Team Leader. Acceptable Behaviour Contracts as diversionary strategy. The Youth Justice Business Plan 2003-2006.

Health Advisor for Looked After Children/Young People in the Youth Justice System

- Job Description for this post is at **[Ref: 82-000478-80].**

E.L.A.C. (Education of Looked Ater Children) Project

- Jointly with Education looking at the education of looked after children. Lead officers are Ed Coates from Social Services and Derek Norton from Department of Education.

C.A.M.H.S. Team (Children & Adolescent Mental Health Service)

- A team including therapists, psychologist, Consultant Psychiatrist (specialist in child psychiatry) and Psychodrama/Psychotherapist working with young people with mental and emotional health problems.

Drug & Alcohol Team

- Team of professionals including Consultant Psychiatrist (specialist in substance misuse); staff grade doctor; Consultant Psychologist; Clinical Specialist; Drug & Alcohol Professionals; Drug & Alcohol Nurse; Health Visitor; Probation Officer; Social Worker. Services of this team are available to young people where appropriate.

SERVICES CONTRACTED BY SOCIAL SERVICES FROM SERVICE PROVIDERS:

Two Outreach Teams

- One run by Manx Family Services, one by Isle of Man Children's Centre. Offering alternative to care programmes. See Service Level Agreement for full description of services on offer at **[Ref: 75-000067-71].**

Aftercare Team and Aftercare Project

- Run by Manx Family Services - workers are involved in Pathway Planning for care leavers. Young people up to the age of 21. Project to offer 'drop in' facility for young people living independently for advice and basic necessities.

Residential Projects

- Two five bed homes – Tromode House and White Hoe Residential Unit run by St Christophers Fellowship which are principally reception and assessment. Service Level Agreements for these are at **[Ref: 75-000150-154; 75-000155-159]**. There are 11 contracted smaller homes (offering 19 beds) in the community run by Isle of Man Children's Centre (contracted for 3 homes – 6 beds), St Christopher's (spot purchased only) and Manx Family Services (contracted for 8 homes – 13 beds) offering individually tailored programmes of accommodation and support **[Ref: 75-000026-30; 75-000031-36].** Additional 'spot purchased' small homes are also contracted as the need arises.

Secure Care Home

- For both welfare and criminal routes ensuring that no young people go to prison custody anymore. This facility is run by St Christopher's Fellowship – Service Level Agreement at **[Ref: 75-000144-149]**

Fostering Services

- Provided by Fosterplus who provide training for their foster carers in assisting children with differing needs, including those with emotional and behavioural problems. The services includes 24/7 support team for foster carers and social work assistants. The setting up of a Specialist Fostering Service has been included in the contract awarded last year to engage, train and manage a specialist pool of carers for children with challenging behaviour or with more specialised needs (e.g. children with disabilities). Details of the services required are found at **[Ref: 75-000001-8].**

Adoption Service

- Provided by Isle of Man Adoption Society (formerly Manx Churches Adoption & Welfare Society) – including counselling service for adopted persons. Service Level Agreement is at **[Ref: 75-000010-15].**

Three Family Centres

- Two run by Isle of Man Children's Centre and one by Manx Family Services. Situated in Ramsey, Douglas and the South with satellite services for outlying communities. Open access centres and referred work by both Social Services and Health Visitors, some families self refer. Other work is around risk assessment, parenting programmes and care proceedings.

Residential Assessment Centre

- Parent / child assessments for Court and rehabilitation programmes.

The above contracted out residential services are subject to Registration and Inspection (along with the nurseries, playgroups and childminders on the Island) by our Registration & Inspection Team. The job description of the Children's Homes Inspector (appointed October 2004) can be seen at **[Ref: 82-000469-71].** There is also the internal Quality Inspections Officer who undertakes advisory visits to all residential homes to advise on improvements required prior to inspection **[Ref: 77-000188-91].**

GRANT AID IS PROVIDED BY SOCIAL SERVICES TO THE FOLLOWING VOLUNTARY BODIES:

Alcohol Advisory Service

- This organisation will offer a service to young people under 16 where appropriate.

Relate

- Marriage guidance for prevention of family breakdown.

Women's Aid

- This organisation runs the Refuge.

Crossroads Young Carers Project

- Supporting young carers. Crossroads holiday schemes for disabled young people during school holidays for young people up to the age of 16.

D.A.S.H.

- Help line run by a voluntary agency for people with drug and alcohol problems.

MULTI AGENCY FORUMS & GROUPS:

Domestic Abuse Forum
Group researching domestic violence on the Island, a Strategy and Business Plan have been written with the aim to establish a Co-ordinator.

Island Child Protection Committee
Social Services Division provide the Chair for this Committee and the Policy & Procedures Sub-Group to update practice and protocols. There is also a Training Sub-Group to consider Child Protection Training needs. The 'yellow book' Child Protection Procedures produced under the auspices of the ICPC are at **[Ref: 87-0000070-137].**

Isle of Man Youth Partnership
Multi-disciplinary forum to assist vulnerable young people.

Disabled Children's Register
New joint initiative with Department of Education and Crossroads Caring for Carers Isle of Man (with parental involvement) to register level and type of need to enable more effective future planning of services for children with disabilities.

Anti Social Behaviour Order Strategy Group
Police led looking at ASBO's.

Mental Health Forum
Joint meetings with colleagues in Mental Health Services sharing and developing good practice and improved joint working.

Chief Minister's Strategy Group
Social Services are represented on this group which discusses strategy for young people up to 21 years. The 2005-10 Strategy developed by this group is at **[Ref: 146-000028].**

Resource Co-ordinator's Group
All Service Providers meet to share practice and set standards.

25 July 2005

APPENDIX 16

DRAMATIS PERSONAE

Where relevant, titles given are those in use at the time

The Department of Health and Social Security

Kenny Best - Duty social worker

Ruth Bithell - Samantha's social worker August 1995 – November 1998

Ed Coates – Principal social worker, line manager to Ms Gilman and Ms Morrison

David Cooke – Director of Social Services

Juan Corlett – Duty social worker

David Gibson - Deputy Director, social services

Julia Gilbert – Manager of the Care Management Team and Children and Families Support Team

Angela Gilman – Samantha's social worker September 1999-2002

Alec Merchant – Social services contact with family protection unit 2001-2002/ Peter Newbery's probation officer July 96 to April 1997

Bryan Morris – Principal social worker/Child Care Coordinator

Sylvia Morrison – George's social worker October 1997 – 2002

Trevor Noden – Service Manager Children and Families, line manager of Ed Coates and Tim Norton.

Tim Norton –Principal social worker, line manager of Ruth Bithell and Angela Oldroyd

Angela Oldroyd – Samantha Barton's social worker November 1998 – September 99.

Diane Toher – Social worker and key worker at White Hoe.

Alex Watson – Lyndsey Barton's social worker

The Department of Education

Adrienne Burnett – Deputy Head, now Head Ballakermeen High School

John Cain – Director of Education

John Kermode - Assistant Education Officer (Special)

George Quayle – Head, St Ninian's High School

The Department of Home Affairs

Mike Culverhouse – Chief Constable, Isle of Man Constabulary

Margaret Dunne – Peter Newbery's probation officer April 2000- July2001

Inspector Richard Power [Detective Sergeant Family Protection Unit 1999-2003]

David Sellick – Chief Probation Officer

Inspector Peter Young Isle of Man Constabulary

The families of Samantha Barton and George Green

Lyndsey Barton – Samantha's sister

Theresa Barton – Samantha's maternal aunt

Rose Burnell – Samantha's mother

Jennifer Charles – George's sister

Jackie Entwhistle – George's sister

Edric Green – George's father

Kathryn Green – George's sister

Margaret Green – George's mother

Manx Family Services

Ned Guest – outreach worker

Philip Kneen – outreach worker

Richard Kneen – Director

Victor Whiteside – Director

Priory Care

Mike Borland - Project Director for Priory Services

Liz Casling – Eden Grove
Carl Faragher – outreach team
Ian McCready – Head, Eden Grove
Eammon Moore – Team Leader, outreach team
Ian Noble – Eden Grove
Anne Seed – Team Manager, outreach team

Nugent Care Society

Jacqui Baker (nee Gourlay) - Residential social worker, Leece Lodge
Damian Bradley – Deputy project manager,
Charles Buist - Residential social worker, Leece Lodge
Francis Charlton – IoM project manager (until suspension 21 January 2002)
Kathleen Cooke - Residential social worker, Leece Lodge
Alex Cowie – Residential social worker, Leece Lodge
Ann Curphey – Residential social worker, Maple Ave. George's aunt
Liz Dickson – Outreach worker, Leece Lodge. Samantha's Key worker from November 2001
Jimmy Gillespie - Residential social worker, Leece Lodge
Sarah Heselwood - Residential social worker, Leece Lodge
Victoria Higgins - Residential social worker, Leece Lodge
Mark Hoswell – Outreach worker, Derby Road
Christopher Lever – Team Leader
Donna Lever – Team Leader
Maxine McBrier - Residential social worker, Leece Lodge
Leslie Moorcroft - Residential social worker, Leece Lodge
Leanne Newbold - Residential social worker, Leece Lodge
Gill Owen – Assistant Director, Children's Residential and Community Services, Liverpool
Eddie Tinsley - Residential social worker, Leece Lodge
Adrian Venn – Team Leader

Diane Watts – Team Leader Leece Lodge then with outreach

Trish Wilson, - Outreach worker, Derby Road

Politicians

Brenda Cannell MHK

Geoff Cannell MHK, Member for social services division

Clare Christian MLC, Minister for DHSS

John Houghton MHK

Other individuals of note

Dr David Dunne, - Consultant Forensic Psychiatrist

Hilary Erani – Project worker, David Gray House

Mary Miles – Residential social worker, Marlowe (Pembrokeshire)

Peter Newbery

Dr Kirsten Wafer - DAT

APPENDIX 17 Summary of Framework of Actions

Strategic Direction	Objective	Actions	Lead Dept	Time
Integrated, joint services with more local delivery and improved accountability and responsibility	**Better Working**	Chief Ministers Committee (CM's CYPSC) to remain and meet 4 times a year. Remit to implement Strategy, promote legislation, reporting structure for joint working teams on child related issues and monitor budget.	CSO	2005/06
		Establish a Safeguarding Children Review Group with roles responsibilities and funding to meet monthly to review actions and progress for active children and family Social Services cases and those suspended from education.	CSO	2005/06
	Better Delivery of Services	Launch a Pilot, Community Partnership in a local area with funding.	CSO	2005/07
		Pilot mentoring service for .young people to assist with pathways into training and employment.	DOE	2006/07
Better access to and collection of information and improved accountability and responsibility	**Collect, share and track information**	Agree protocols and a common set of information from birth to 21.	DHSS	2005/06
		Launch a secure System Index of information on children.	DHSS	2008/9
		Share core assessment information across statutory and non-statutory agencies.	DHSS	2005/07
	Easy access to information and services	Investigate the need for a dedicated information phone line open 24/7	DOE	2007/08
		Drop in youth centre in central location	DOE	2005/06
		Establish a Children and Young People Transport Group.	DOE	2005/06

	Key data to measure health and well being	Research key data, benchmark develop measurable outcomes. Build on the Health and Life style Survey in Children (HLSC), European Longitudinal Study of Pregnancy and Childhood IOM (ELSPAC) and European School Survey Project for Alcohol and Drugs (ESPAD).Appoint a 3 year contract Researcher	CSO	2006-07
Increasing preventative services with a long term aim of reducing services in high risk areas and improved accountability and responsibility	**Better support to parents**	Strengthen and build parenting programmes with health visitors/school nursing service/school nurture groups/Life Education/Family Centres providing generic and targeted services.	DHSS	2007/08
		Build community capacity by developing parenting programmes in partnership with the voluntary sector.	CSO	2005/10
		Conciliation/Mediation Service for Marital breakdown	DHSS	2006/07
	Healthy, fit children	Action plan by Public Health for joint working to deliver health objectives.	DHSS	2006
		Build on good practice of leisure provision and report on the concerns expressed in public consultation	DTL	2005 ongoing
		DOE to coordinate with DHSS and DTL the formalisation of a Healthy Schools Programme.	DOE	2006
	Extra preventative support	Sport, Arts, Youth and Community to report on children and young people not accessing their services	DTL	2006-07
		Extend range of public sector rented accommodation for young people with no alternative accommodation - long term aim.	CSO	2007-08
		Educational Inclusion Action Plan to include extended, alternative education	DOE	2005-08
		Tracking of/support for post 16s not in education, training or employment.	DOE	2006/07

		Voluntary agency Mentoring and Counselling service for children and young people	CSO	2006-07
		Improve responsiveness of Child and Adolescent Mental Health Service (CAMHS) by working towards raising the age range to 0-18years and build on the four tier system to ensure that all agencies are trained and supported.	DHSS	2006-08
		Mandatory, holistic child protection training for all who work with children.	DHSS	2005 on going
	Improved outcomes for 'looked after' children	Education for Looked after children improved	DOE/ DHSS	2005 on going
		Report on future housing provision for looked after children	CSO	2005 on going
		Agree key indicators which measure progress of looked after children and regularly review and reporting on them to Chief Minister's Committee	CSO	2005 on going
	Value all cultural backgrounds	Equity and Diversity training to all agencies who work with children.	DOE	2007-08
		English as second language support	DOE	2006/07
	Youth Justice System	Formalise and support the established Youth Justice Team.	DHA	2006-07
		Promote legislation to raise the age of children dealt with through the juvenile justice court and the place of custody for young offenders	DHA	2007/08
Involving children, young people, their	**The voice of Children and Young People**	Communication Plan for Strategy	CSO	2005
		Representatives of the Chief Ministers Strategy Committee to meet annually with children and young people.	DOE	2005/06

families and communities as service users and in partnership.		Representatives of the Children and Young people's delivery Group to meet bi-annually with young people.	DOE	2006/07
		Youth Bank established	DOE	2005 on going
	Partnerships between public/private and voluntary	Support voluntary agencies to maximise funding streams	CSO	2005 on going
		Joint training initiatives to share good practice and widen opportunities to learn from skills.	CSO	2006/10

APPENDIX 18

BIOGRAPHY OF EXPERTS

WES CUELL (NSPCC)

Wes Cuell is a qualified social worker who joined the NSPCC in August 2004 from Luton Borough Council, where he had worked since 1997 as assistant director and then as head of children and family services. He has broad experience both as a social worker and social work manager for Bedfordshire and Hertfordshire Social Services Departments.
For many years Wes has been chairperson of an Area Child Protection Committee and, as an adopted person himself, has a special interest in adoption. This has contributed to his drive in taking an active role on behalf of the Children and Families Committee of the Association of Directors of Social Services (ADSS), and previously being a member of the Adoption Standards Working Group. Wes has an active interest in social work education and a close association with the University of Luton, having been chairperson of the management board of the Luton Diploma in Social Work Course for five years before taking on the same role for a Post Qualifying Consortium.
His interests include music, running and hill walking, and in his holidays he is currently working his way across the Pyrenees from west to east. He is also chairperson of his local parish council and governor of an infants school in central Luton, through which he continues his active interest in the south Asian community and culture. A very busy man, Wes makes plenty of time for his family, including his first grandchild, a one-year old grandson living in Wisconsin. He looks forward to further additions to the family!

CHRISTINE DAVIES – BRIEF BIOGRAPHY

Educated at Bradford and Aberystwyth Universities.

Spent the past 31 years working in the education services at every level.

Taught in comprehensive schools in Manchester, Somerset and Shropshire.

Joined the Schools Psychological Service in Shropshire in the early 1980's and then had various roles in the education service with Shropshire County Council including S.E.N. Adviser and Education Officer responsibility for pre-school, admissions, exclusions, equalities and special educational needs.

Appointed Corporate Director, Education and Culture with Telford & Wrekin Council in June 1997 and is now the Corporate Director for Children and Young People.

Chair of the Children and Young People's Strategic Partnership Board for Telford.

Telford & Wrekin Council is a national trailblazer for Children's Trusts, Information-Sharing and Common Assessment. This year, the Council been awarded 'Beacon Status' for 'Integrating Children's Services'. In addition, Telford is citied as an exempla authority in the Government's papers 'Every Child Matters – Change for Children' and the recently published 'Youth Matters'. The Council is designated an 'Excellent' Council through the Comprehensive Performance Assessment process.

National Roles include:

President of the National Association of Chief Education Officers (ACEO) in 2002/03.

Since then, led the debate on the future of Children's Services on behalf of ACEO and Confed (Confederation of Education Officers) and sits on the national 'Stakeholder Board for Children and Young People', the National Steering Groups for Children's Trusts and IRT; TeachandLearn.net Advisory Board and the National Placement Forum (for children 'in care').

A Non-Executive Director of the 'Building Schools for the Future' (Partnership for Schools)

Advises the Local Government Association on Education and Children's Services.

Christine was awarded the CBE in this year's Queens Birthday Honours for 'an outstanding contribution to education'.

DR GILLIAN PUGH DBE

Gillian Pugh has recently retired as Chief Executive of Coram Family, a post she held from 1997. Established in 1739 as the Foundling Hospital, Coram Family is a leading children's charity which aims to develop and promote best practice in the care and support of very vulnerable children and their families. Gillian has been responsible for extending the range of services, and for establishing Coram's reputation as an innovative organization providing high quality services. She worked previously at the National Children's Bureau for more than 20 years where she was responsible for a broad range of work in the children's field, especially services for young children and support for parents.

Over the past 30 years Gillian has advised governments in the UK and overseas on the development of policy for children, on coordination of services, on prevention and early intervention, on curriculum, on parent education and support, and on the role of the voluntary sector in service provision. She was an advisor to the Children, Young People and Families Directorate at the Department of Education & Skills and is now working to implement the Every Child Matters agenda. Gillian was a founder member and is chair of the Parenting Education & Support Forum, is a trustee of the National Family & Parenting Institute, a member of the new Children's Workforce Development Council, and is visiting Professorial Fellow at the Institute of Education. She was awarded the DBE in 2005 for services to children and families.

October 2005.

MARIA BATTLE

Maria is a solicitor who has practised in public law and childrens rights since 1984 in Wales. She is currently the deputy children's commissioner for Wales and heads the legal and investigation department, advising and supporting individual children in Wales, undertaking investigations and public inquiries and influencing policy development.

Formerly a solicitor in two local authorites in Wales she moved into the voluntary sector working with NCH Action for Children as the manager of the guardian ad litem service and with the Children Society Cymru as head of policy and communications. Maria has been an independent childrens advocate in childrens residential homes, an independent complaints investigator and has chaired and undertaken reviews into child protection investigations, health and education of looked after children and childrens complaints procedures. She lectured in Law at the Universities of Glamorgan and Birmingham; and was the independent Chair of Carmarthenshire County Council`s Standards Committee.

Maria is a school governor responsible for special educational needs and child protection and the legal adviser to the Menevia Child Protection Commission West Wales and a member of the South Wales Family Justice Council.

PAUL HELPS

Professional Qualifications:		
Master of Education	1996	Brunel University
Certificate of Education	1973	Maria Gracey College
Advanced Diploma in Educational Management – Part 1		Open University

Present Post:		
Head teacher	The Hillingdon Tuition Centre	1988 - Present

Previous Posts:	
Consultant Head teacher	Hounslow PRU
Head of Upper School (Senior teacher)	Barnhill Comprehensive

Previous to this a range of middle management posts with responsibility for pupil progress, learning and behaviour.

At The Hillingdon Tuition Centre I have the responsibility for leading a dedicated group of professionals with the responsibility of educating pupils that have been excluded from mainstream education.

The Hillingdon Tuition Centre teaches Key Stage 2, 3 and 4 pupils. The teaching takes place in two buildings on one site.

At Key Stage 2

Pupils follow a 15 week programme and then reintegrate into mainstream or specialist educational provision.

At Key Stage 3

Pupils follow a 15 week programme and then reintegrate into mainstream or specialist educational provision.

At Key Stage 4

Pupils follow an academic programme comprising 5 GCSEs vocational courses, preparation for the world of work or further education.

MALCOLM POTTER

Current Post	Youth Justice Board Regional Manager Yorkshire and the Humber
Employment History	A range of posts in Children's Residential Services and Youth Justice Services for Sheffield City Council including the management of its residential remand unit and management of its Youth Offending Team
Higher Education Qualifications	University of Sheffield BA (Hons) Law University of London MSc. In Social Work Studies and Certificate in Qualified Social Work
Background	My career has been spent working mostly with young people in the criminal justice system and care system spanning 25 years. In this time I have worked as a practitioner and manager and have had responsibility for the operational delivery of services and more recently for strategic and policy development. In 1998 I managed one of the initial pilot sites for the introduction of multi agency Youth Offending Teams. I have served on a number of national bodies including one that developed the Persistent Young Offender fast Track pledge and have acted as an advisor to the Local Government Association and the Association of Directors of Social Services. My current post involves developing and promoting effective practice, monitoring the performance of the youth justice system in the region and includes oversight of community based services, local authority secure units and prison establishments. It also includes the reviewing of serious incidents

JONATHAN FARROW B.SC.(HONS), M.SC.(OXON), C.Q.S.W.

PROFILE:

Chief Executive with a business background, experienced in achieving change and developing and directing charitable service provision, through implementing business disciplines, building balanced teams and working with a diverse range of partners and funders in local and national government.

CAREER TO DATE:

Chief Executive **1997 - Present**

St. Christopher's Fellowship.

Registered Charity and Housing Association that employs 300 people with a turnover in excess of £12.5m, providing support to 2000+ young and homeless people in 40 locations.

- Transformed St. Christopher's into a leading, professional player in the specialist fields of residential child-care, leaving care, supported housing services, education and training for young and homeless people.
- Changed service provision to a style which is cost efficient, risk controlled, with quality services – and declared as service of choice by local authorities and government.
- Closed 40% of existing projects. Won new contracts increasing turnover from £2.9m (1997) to £12.5m (2005). Budgeting for £15m (2006).
- Introduced: service user participation in service development and delivery, project, department and organisation business plans, together with approved risk management strategies.
- Introduced board appraisal and first new Memorandum and Articles since 1936.
- Introduced integrated IT systems (controlled expenditure of £700K in last 5 years), resulting in transformation in outcome reporting and internal and external communications.
- Asked by Department of Health and London Directors of Social Services to rescue the UK's only Refuge for runaway children. Achieved, in part, by securing largest ever capital-grant from BBC Children in Need Appeal (£630K).
- Secured funding for employment training projects for disadvantaged young people from charitable trusts and statutory agencies to create a specialist employment training and education department.

Freelance Management Consultant **1991 - 97**

Contracts included:

- **Member, Community Care Support Force.** Department of Health. Invited by Minister of Health to be member of team advising Local and Health Authorities on April 1993 reforms in Community Care.
- **The Association for Children with Life-Threatening Conditions (ACT).** Devised structure for Association, which was created with Government support to be the national voice of the Children's Hospice and Palliative Care movement.

Group Director, Residential Services and Mencap Homes Foundation.

Royal Society for Mentally Handicapped Children and Adults **1987 - 91**

One of six directors, lead division responsible for ¾ of organisation's turnover.

- Increased turnover from £6.5m to £30m (in 1991).

- Developed Mencap Homes Foundation into the country's largest provider of care in the community, for people with learning disabilities.
- Opened an additional 200 homes (making 300 in total) for some 2,000 people with learning disabilities transferring people from long-stay institutions to small residences
- Managed teams of 2,000+ staff and numerous volunteers.
- Advised National Council on matters of policy. Participated in corporate management of and fund-raising for Royal Mencap.
- Contracted with more than 100 Health Authorities and local Councils, together with 40 Housing Associations.
- Supported, advised and consulted with many local voluntary Mencap Societies.
- Campaigned for better services for people with learning disabilities via the media, local and national government.

RELEVANT EXPERIENCE INCLUDES:

Cabinet Office	"Top Management Programme" 2002 (4 week residential course in leadership studies).
Past Chairman	SCA Community Care Services (450 staff, 75 volunteers, £6.5m turnover).
Immediate past Hon. Secretary	The Connaught Group of 15 child-care charity chief executives.
Past Vice-Chairman	The Hampton Trust (Support and training for young people at risk from crime).
Past Board Member	Hampshire and Isle of Wight Probation Service.
Past Board Member	New Era Housing Association and founder board member First Choice Housing Association

QUALIFICATIONS:

Oxford University:	
M.Sc. in Applied Social Studies	1984
Certificate of Qualification in Social Work	1984
Southampton University:	
B.Sc.(Hons) in Accountancy and Economics	1975

CHRIS WRIGHT

Chris Wright has worked as a practitioner, manager and policy adviser within both the child care and criminal justice systems in England and Wales for the past twenty years.

He joined the Youth Justice Board for England and Wales (YJB) as Head of Performance in May 2001. He has responsibility for overseeing the performance management of the youth justice system. Prior to joining the YJB he established and led Nottingham City's first multi-agency Youth Offending Team.

He has a first degree in Politics and Sociology from the University of East Anglia and a Masters degree in Applied Social Science from the University of Oxford. He holds a professional social work qualification.

APPENDIX 19

THE INQUIRY TEAM

CHAIRMAN

Mark Everall QC

EXPERT ASSESSOR

Rob Hutchinson CBE, BA, BSS, MA, CQSW

ADVOCATE TO THE INQUIRY

Alexander Verdan

LEGAL ASSISTANT TO THE ADVOCATE

Ceri White

LEGAL ASSISTANT TO THE INQUIRY

Laurance O'Dea