SAFEGUARDING CHILDREN IN COMMUNITY RESIDENCES AND CHILD SUPPORT CENTRES IN TRINIDAD AND TOBAGO

REPORT BY THE INDEPENDENT INVESTIGATION TEAM APPOINTED BY THE CABINET OF THE REPUBLIC OF TRINIDAD AND TOBAGO TO INVESTIGATE REPORTS OF CHILD ABUSE AT CHILDREN'S HOMES.

DECEMBER 2021

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Overview

DOCUMENT	Report by the Independent Investigation Team appointed by the Cabinet of Republic of Trinidad and Tobago to investigate reports of child abuse at Children's Homes.
TITLE	**SAFEGUARDING CHILDREN IN COMMUNITY RESIDENCES AND CHILD SUPPORT CENTRES IN TRINIDAD AND TOBAGO**
DEVELOPED BY	The Independent Investigation Team appointed by the Cabinet of the Republic of Trinidad and Tobago to conduct an independent investigation into child abuse at Community Residences and other institutions providing residential care for children and incidents of absconding from such institutions.
DATE	14th December, 2021
SUBMITTED TO	The Honourable Ayanna Webster-Roy Minister in the Office of the Prime Minister, Gender and Child Affairs The Republic of Trinidad and Tobago

Executive Summary

The treatment of children in residential care institutions has often garnered the attention of the public of Trinidad and Tobago, with particular emphasis on the incidence of abuse and the wellbeing of the child.

The Republic of Trinidad and Tobago ratified the United Nations Convention on the Rights of the Child (CRC) on December 5th, 1991, thereby accepting responsibilities without reservations to uphold children's rights.

The CRC is a complete Statement on children's rights, ensuring that the Member States safeguard children's rights. Article 19 requires States to

> "take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child."

Article 20 refers to the provision of alternative care for children by the State and

Article 25 provides for the recognition by States of the right of a child who has been placed

> "by the competent authorities for the purposes of care, protection or treatment of his or her physical or mental health, to a periodic review of the treatment provided to the child and all other circumstances relevant to his or her placement."

In June 2021, the Cabinet of the Republic of Trinidad and Tobago, noting its responsibility "associated with the care, protection and supervision of children as enshrined in the Convention on the Rights of the Child," and recognising that "[t]here is an expectation that all children placed at Children's Homes will be cared for and protected from all forms of abuse and violence," appointed an Investigation Team ("Investigation Team") to conduct an independent investigation into child abuse at residential care institutions for children as well as incidents of absconding from such institutions.

By the terms of reference, the aims of the investigation were to:

- To provide an independent report on the abuse of children at Children's Homes, Rehabilitation Centres and other institutions providing residential care for children, the analysis of the issues surrounding abuse and recommendations to eradicate this problem at all such institutions housing children.
- To investigate the incidents of abuse reported in the media at the St Jude's, St Dominic's, St Mary's, the Child Support Centres, and other Private Children's Homes being mentioned in the media; and
- To investigate the incident(s) or situations of children absconding and, in particular, the incident which led to the five boys absconding from a Child Support Centre and the allegations of abuse of children placed at that Centre which may have led to absconding and the resulting death of two boys.

This report reflects a five-and-a-half-month-long investigation into the issues of abuse and absconding of residents in Community Residences and Child Support Centres. This investigation involved

- the conduct of site visits at Community Residences and Child Support Centres;
- interviews with key stakeholders including but not limited to; The Authority, key personnel at Community Residences, current and former residents, medical and professional personnel and other care providers within the system;
- review key legislation, case law, international conventions and standards, The Authority's draft policies, internal reports on critical incidents and quality control forms.

As a result, the Investigation Team examined the issues of absconding and abuse within the context of safeguarding children. Child safeguarding is the responsibility of organisations to ensure that their staff, operations, and programmes cause no harm to children with whom they come into contact and to take proactive measures to understand and affirm child rights.

The purpose of child safeguarding is to prevent exposure of children to the risk of harm and abuse, and that any concerns that children, the service provider, communities, or caregivers' have regarding children's safety within the communities in which they work or live are reported to the appropriate authorities and managed as a priority.

Key Findings

- There is a failure to safeguard children in residential care institutions.
- There is inadequate and ineffective State coordination and collaboration.
- The Children's Community Residences, Foster Care and Nurseries Act, remains ineffective until the mandatory licensing provisions of Sections 3 (1) and (2), and 17 have been proclaimed and adequate provision made for enforcement under the Act.
- Several Children's Homes are operating without licences, and The Authority has demonstrated no will, intention, or mechanism to shut down the operations of unlicensed homes that continue to put children at risk in Trinidad and Tobago.
- The Authority is not adequately or efficiently fulfilling its statutory mandate.
- Child Support Centres are operating outside of their statutory scope.
- The placement of children in need of supervision (CHiNS) into the Community Residences and Child Support Centres and the resultant mixing of Children for Care and Protection and CHiNS increases the risk to the safety and security of the residents and staff.
- The childcare system is poorly structured, inadequately monitored, inconsistently regulated. Additionally, the lack of accountability promotes an environment for abuse and absconding.
- There is no effective mechanism for children to complain of abuse within the current care system.
- Several key security, oversight, and monitoring failures contributed to the act of absconding by the five boys from the Valsayn Child Support Centre.

Recommendations

- Section 3 (1) and (2), and 17 of the Children's Community Residences, Foster Care and Nurseries Act must be proclaimed.
- A standard risk assessment framework for operations of Children's Homes must be immediately established in line with the licensing requirements, and clear timelines for compliance must be outlined and followed.
- The current methods of enforcing the provisions of the Community Residences, Foster Care and Nurseries Act must be improved.
- Facilities for children with a high risk of harm to others must be established with more intense supervision and auditing systems.
- Child Support Centres must operate within the confines of the law.
- The Office of the Children's Commissioner, a publicly funded, independent institution, be established for:
  - the receipt of complaints made by and on behalf of children in residential care
  - the Licensing and inspection of Children's Homes
  - the monitoring of the operations of The Authority and the Child Support Centres
  - reporting and making recommendations to Parliament
- The act of safeguarding must be a national response in which all agencies and ministries which have a role in providing care and protection of children must collaborate, share information and best practices to ensure a coordinated approach. The process must include children in Community Residences and Child Support Centres.
- An age-appropriate and child-friendly complaints mechanism must be established and disseminated amongst children in residential care institutions.
- Child Support Centres that are fit for the purpose of providing care and protection to children must be established by The Authority.

The Report demands re-evaluation and re-organisation of the childcare system as a matter of urgency. This Document emphasises the need for (a) critical restructuring of organisations that provide such care and protection and (b) calls for the consolidation of the legislation and proclamation of important sections of the Children's Community Residences Foster Care and Nurseries Act Ch 46:06. The Report further identifies the systemic challenges which can provide a fertile ground for child abuse and the need for inter-agency and inter-ministerial collaboration. With a sustained commitment and will, it can be possible for the health and wellbeing of children in residential institutions to be safeguarded throughout their journey and the experiences and concerns of children to be taken seriously.

This investigation was fortunate to have a team of dedicated professionals from a wide range of expertise and qualifications. It was an honour for this Investigation Team to serve the children of Trinidad and Tobago.

The Investigation Team is fully appreciative and grateful to those who voluntarily contributed to this investigation.

Chapter 1 - Introduction

"No violence against children is justifiable; children should never receive less protection than adults; all violence against children is preventable."[1]

While children are the future, they exist in the present. Therefore, the care and protection of children affect the future of this beloved country.

Over the last five decades, our society has experienced major changes in our social, economic, and political landscape. These changes have significantly impacted the primary family structure and care for children. Childhood represents a developmental stage that is posed with increased vulnerabilities. As such, our children have experienced considerable adverse outcomes. There has been a monumental increase in children presenting with behavioural, emotional, and social issues with greater intensities. The COVID pandemic has exacerbated the negative impacts on our children and especially those in our childcare services setting. Consequently, there is a need to recognise, as never before, the urgency to plan the social landscape in our developing country.

In June 2021, noting its responsibility "associated with the care, protection and supervision of children as enshrined in the Convention on the Rights of the Child" and recognising that "[t]here is an expectation that all children placed at Children's Homes will be cared for and protected from all forms of abuse and violence," the Cabinet of the Government of the Republic of Trinidad and Tobago (GORTT) appointed an Independent Investigation Team ("Investigation Team") to conduct an independent investigation into child abuse at Community Residences and other institutions providing residential care for children and incidents of absconding from such institutions.

By the terms of reference, the aims of the investigation are to:

- To provide an independent report on the abuse of children at Children's Homes, Rehabilitation Centres and other institutions providing residential care for children, the analysis of the issues surrounding abuse and recommendations to eradicate this problem at all such institutions housing children.
- To investigate the incidents of abuse reported in the media at the St Jude's, St Dominic's, St Mary's, the Child Support Centres, and other Private Children's Homes being mentioned in the media; and
- To investigate the incident/s or situations of children absconding and in particular, the incident which led to the five boys absconding from a Child Support Centre and the allegations of abuse of children placed at that Centre which may have led to absconding and the resulting death of two boys.

[1] Report of the independent expert for the United Nations study on violence against children, United Nations general Assembly, sixty-first session August 2006 A/61/294 paragraph 93.

The terms of reference provided that in the conduct of work, the Investigation Team would be required to:

- Review official reports from the Board of Management of the Children's Authority of Trinidad and Tobago, other relevant reports, or other documents as well as newspaper articles on the allegations of abuse of children.
- Identify and document the abuse with a view to identifying concrete solutions to prevent and eliminate all forms of abuse.
- Compile a chronology of events leading to absconding by some residents of Children's Homes and Child Support Centres.
- Review policies and procedures which should guide children into appropriate care, identifying gaps where necessary.
- Review the appropriateness of the treatment, care, protection, and supervision of children while in the care of the Children's Homes. Assess the adequacy of its findings and compliance with the law; and
- Make recommendations to ensure that adequate policies and procedures are in place for the treatment of children and the prevention of abuse.

The members of the Investigation Team are:

- Retired Appeal Court Judge, Justice Judith Jones (Chair)
- Mr Lawrence J. Arjoon, Child/Youth NGO Representative
- Lt Cdr Lorenzo P. Chariandy ret., National Male Transition Homes
- Ms Aisha Corbie, Clinical Psychologist
- Dr Mona Dillon, Social Worker
- Mr Aaron George, Youth Representative
- Ms Claire E. Gittens, Rt. Social Worker
- Ms Aleisha Holder, Child and Youth Development Specialist
- Mr Marcus V. Kissoon, Researcher, Gender and Development
- Mr Keshan Latchman, Clinical Psychologist
- Dr Stacy-Ann Phillip, Child Psychiatrist

This investigation seeks to answer specific questions on child abuse and absconding. The focus is on the risks and responses to absconding and abuse (specifically sexual and physical) of children in the care of the State. The target population included children housed in Community Residences and Child Support Centres or in private Children's Homes in Trinidad and Tobago. This report aims not to establish the truth of the allegations of abuse, but to acknowledge the allegations, examine the system that facilitates a failure to safeguard children in these spaces and provide recommendations for improvements.

A large part of this investigation and several of the recommendations presented to address the concept of child safeguarding. Child safeguarding is the responsibility of organisations to ensure that their staff, operations, and programmes cause no harm to children with whom they come into contact and to take proactive measures to understand and affirm child rights.

The purpose of child safeguarding is to prevent children's exposure to the risk of harm and abuse. Further, safeguarding promotes the principle that any concerns of children, service providers, communities, or caregivers' regarding children's safety within the communities where children work or live, are reported to the appropriate authorities and managed as a priority. The primary focus of safeguarding is the consideration of children's well-being- and the use of such deliberations as a guide for providing children services in meeting the statutory requirements.

Community Residences and Child Support Centres mainly provide residential care in Trinidad and Tobago. Community Residences comprise Children Homes and Rehabilitation Centres. Information provided to the Investigation Team by the Children's Authority of Trinidad and Tobago ("The Authority") identified thirty-nine (39) Children's Homes operating in Trinidad and Tobago – thirty-six (36) in Trinidad and three (3) in Tobago - two (2) Rehabilitation Centres and four (4) Child Support Centres. From the information received from The Authority, the population in these homes and centres is fluid, but records are as follows:

- As at July 2021, Children's Homes housed 620 children.
- As at September 2021, the Rehabilitation Centres housed 50 children.
- As at April 2021, Child Support Centres housed 44 children.

Statistics provided by the Crime and Problem Analysis (CaPA) Branch of the Trinidad and Tobago Police Service (TTPS) show that between March 21, 2015, to 31st July 2021, there were sixty-nine (69) reports recorded at Police Stations across Trinidad and Tobago of child abuse at Community Residences. The incidents reported were of sexual abuse and physical assault. These figures only represent reports that have been made to the police.

(Appendix 1: Reports of Offences made Against Children 2015 - 2021)

In this investigation, the Investigation Team examined six-hundred and two (602) Critical Incident Reports submitted to The Authority between 2015 – 2021 from forty-three (43) Community Residences and Child Support Centres. A table identifying the number of critical incidents reports, the Community Residences from which they emanate, and the classification used by the reporter are in **Appendix 2.**

(Appendix 2: Critical Incident Reports)

This investigation was triggered by an incident of absconding with tragic consequences. On March 20 2021, five boys whose ages ranged between 15 and 16 years absconded from a Child Support Centre run by The Authority. The five boys had been placed into the care of The Authority by the Children Court. Four of these boys had been brought to the Court by a parent who alleged that they were unable to control the child and that he was in need of supervision. The fifth boy had been brought to the attention of The Authority by a concerned person as being a child in need of care and protection. In all five cases the Court determined that the boys were in need of care and protection.

These boys had all been removed from the care of their parents and placed in the care and protection of The Authority because a Court determined that it was in their best interests. The Convention of the Rights of the Child by Article 3 treats with the best interests of the child and in this regard requires the State to

> "ensure that the institutions, services and facilities responsible for the protection of children shall conform with the standards established by competent authorities, particularly in the area of safety, health, in the number and suitability of their staff as well as competent supervision."

With respect to this incident, there are two obvious questions to be answered by this investigation: did the institutions set up by the State to protect these boys and to act in their best interests fail to do so and, if so, did this result in the death of the two boys.

This was not the first occasion of children absconding from Community Residences or Child Support Centres, but it was the first with such devastating consequences. Indeed, it is not unusual to see public service announcements in the daily press and on social media asking for the public's assistance in locating children who have absconded from these residences. A list provided to us by the Children's Authority reveals that over the period 2018 to March 2021, there had been 104 instances of children absconding from Community Residences and Child Support Centres throughout Trinidad and Tobago. A copy of that list is attached in Appendix 3. An examination of the list reveals that some Residences seem to be more prone to children absconding from those Facilities than others. However, the list does not reveal that it was the same children absconding more than once in a number of instances. In other words, some of the children could be considered to be serial absconders.

(Appendix 3: List of Absconding from Community Residences and Child Support Centres)

Subsequent to his absconding, one of the five boys published a Facebook post alleging physical abuse by security guards at the Child Support Centre. The account also makes reference to abuse as a result of his sexual orientation. According to his account, boys were taken into a bedroom that was not under camera surveillance and their heads were banged against the walls. He alleged that he was choked and suffered from breathing problems as a result. In another media report, the mother of one of the deceased boys stated that he had called her on February 24th, claiming that he was being abused. In the same report, the mother of another one of the boys who had absconded also claimed that her son was being abused while at the Centre.

As with incidents of absconding, allegations of abuse made by children living in Community Residences are not new. Our research unearthed that during the period July 2014 – May 2021, there were at least 44 reports in the media alleging incidents of absconding and abuse of children residing at Children's Homes and Child Support Centres.

In the printed press alone, some of the headlines run were:

"Boys House of Horrors" (July 2014) with reference to St. Michael's Home for boys; "St. Mary's Board to meet on sex abuse claims".(November 217) "Children's Authority investigating child's death"(June 2017) this was a reference to the suicide of a boy at a Child support Centre run by the Children's Authority; "Cyril Ross Nursery under watch" (March 2019)"Verbal abuse and corporal punishment"(June 2019) this dealt with allegations of abuse made by residents of Cyril Ross Nursery;

“Children at St.Jude’s being abused?” (August 2019); Children at St. Dominic’s caught in a bind”(February 2020); “Police Children’s Authority probe alleged abuse at Lady Hochoy Home”(August 2020); “Archdiocese probes alleged abuse at shelter”(September 2020) the article referred to allegations made by a resident with respect to a home for teenage mothers in South Trinidad; “Young: I hope guard is charged for child rape” (December 2020) this was with reference to a report of the rape of a child by a security guard in a safe house. As is to be expected, all of these articles spurred numerous social media comments.

Some of these reports detail incidents that are the subject of police investigations. Some of them were the subject of investigations by The Authority, presumably acting in accordance with its statutory duty to investigate reports of mistreatment of children. In response to a request for copies of the reports made by the various homes with respect to the incidents in question and the Authorities’ investigations and conclusions concerning each, The Authority response is contained in Appendix 4.

(Appendix 4: Response to Media Reports by The Authority)

Another report headlined: “Sexually and physically abused as a ward of State awarded $2M.” reported on a judgment delivered in the case of JM (a Minor by his kin and next friend) Nicola Mitchell v the Attorney- General and others CV 2017-03522 in July 2019 by the High Court. The judgement deals with the abuse suffered by a child in care and highlights the responsibility of the State in providing suitable residential accommodation for children in its care. By a judgement delivered this year, the Court of Appeal subsequently reduced the award to $844,650.00.

This is not the first time that allegations of child abuse have sparked public outcry, highlighting the State's failure in its duty to protect our children, leading to investigations of one kind or another. The death of Amy Annamunthodo in 2006 led to an investigation into “the systems operated by Government agencies which may have failed to prevent the death of four-year-old Amy Annamunthodo.”

The facts as found by the enquiry were these. In 2002, Amy Annamunthodo was born to a 14-year-old mother. Amy’s mother was herself a child at risk. Amy’s mother had her first child at age 12, had spent two years at the St. Jude’s home and was, as she admitted, involved in an abusive relationship. At age 2 years, Amy was admitted to the hospital with multiple injuries allegedly inflicted by her stepfather. Three months later, she was released into the care of her grandmother. The following year she was readmitted to hospital, having fallen from some steps and unable to walk. She was again released from the hospital into the care of her grandmother. Two months later, Amy was found by the police abandoned. Her body bore multiple scars. After being hospitalised, Amy was discharged in September 2005 into the care of the Mother’s Union Home. In January 2006, upon the application of her mother supported by the medical social worker assigned to her case, the Court released Amy into her mother’s care. In June 2006, Amy was brought into the San Fernando General Hospital and pronounced dead on arrival. This time her body bore evidence of sexual abuse. Amy was then four years old.

The enquiry, established by the Government and conducted by Justice Monica Barnes, concluded that the Police Service and the Medical Social Workers Department of the San Fernando General Hospital had failed Amy. Among its recommendations was the urgent establishment of the Children’s Authority. The enquiry also recommended the establishment of the office of a Children’s Ombudsman.

In 2010, a Committee was appointed by the Minister of the People and Social Development to investigate allegations of abuse at the St. Mary's Home. The Committee found that there was no substantive evidence to support the allegations of physical, sexual or emotional abuse or neglect. Despite these findings, among the recommendations made was the need for additional, appropriately qualified staff, psychometric testing and background checks to be conducted on all proposed employees and assessment of all children coming into the home.

In December 2013, a Child Protection Task Force, chaired by Dianna Mahabir-Wyatt, was established by the Government with a mandate to review the existing policies, legislation and protocols in place to protect the nation's children and to identify the steps necessary to operationalise the Children's Authority fully. The Task force published three reports. One of the recommendations was the proclamation of various pieces of legislation now commonly referred to as the package of children's legislation and the operationalisation of the Children's Authority.

Another of the recommendations of the Task Force was the establishment of a branch of the Police Service dedicated to the protection of children. From this recommendation, the Child Protection Unit of the Police Service (CPU) was created. The Unit was established in 2015 specifically to address child protection issues and provide support to The Authority.

Similar to the Barnes enquiry, the Task Force also recommended the establishment of a Children's Ombudsman.

By letters dated 17 June 2021 and 15 July, 2021 the members of the Investigation Team were advised of their appointment. The letters advised that the investigation was to be completed within four months of July 1 2021. The Investigation Team began its work on July 1, 2021. By an email dated September 28 2021, the Investigation Team sought and was granted an extension of six weeks to complete its task.

Like the State, the Investigation Team adheres to the principles espoused in the preamble to the Convention and the other international treaties establishing and upholding the right of every child to fair and equitable treatment. The Investigation Team, like the State, recognises that in Trinidad and Tobago, as in all countries in the world, children are living in exceptionally difficult conditions and that such children need special consideration. Accordingly, in this report, as far as is practically possible and taking into account the traditions and cultural values of our people, sought to incorporate into our recommendations the guidance given in these treaties and the Convention on the Rights of the Child endorsed by the State of Trinidad and Tobago.

Ultimately the task of the Investigation Team is to examine the role of The Authority in meeting the State's responsibilities for the protection of children received into its care, comment on the adequacy and effectiveness of the systems put in place to discharge these responsibilities, and where appropriate, make recommendations for change. This requires us to critically examine the role and performance of The Authority in this regard. In considering this report and recommendations, it is important to bear in mind that the operations of The Authority are guided by the legislation and is mainly funded from money allocated by Parliament. Any failure by The Authority to properly discharge its obligations given to it under the legislation as a result of inadequate resources must therefore be seen as a failure by the State to provide the necessary resources in this regard.

In embarking on the task entrusted on us, the Investigation Team can do no better than to adopt the words of the Honorable Justice Avason Quinlan-Williams in the case of JM v the Attorney-General of Trinidad and Tobago referred to above:

> "Trinidad and Tobago's State of development cannot be measured on economic indicators only. There must be other indicators that are illustrative of the values that are important to us all. One such indicator must be society's ability to protect vulnerable citizens, those born different, senior citizens and children especially those children who do not have a fit or able parent or guardian to care for them."

Chapter 2 - Background

The Existing System

In Trinidad and Tobago, Residential care for children is provided mainly by Community Residences.

The term "Community Residences" is the generic term used in the legislation to describe Children's Homes and Rehabilitation Centres. A Children's Home is defined to mean a Community Residence for the care and nurturing of children. A Rehabilitation Centre is a Community Residence for the rehabilitation of

(a) child offenders who have been convicted and committed to serving a custodial sentence or are remanded in custody pending sentence or

(b) children who have been charged with an offence and are in custody pending a hearing.

Some limited residential care is also provided by Child Support Centres maintained by the Children's Authority. 'Child Support Centre' is the name used by The Authority to refer to the Reception Centres required to be maintained by them under the Children's Authority Act, Section 14.

The legislation, as well, provides for the establishment of Hostels. Under the Children's Authority Act, section 35, Hostel is defined as a voluntary residence for persons up to the age of 21 on payment of a fee. There are no Hostels in Trinidad and Tobago within this definition.

Table 1: Identifies the Children's Homes in Trinidad and Tobago, their status, that is, whether licensed or not, and their capacity and occupancy as of July 2021, as provided by The Authority.

NO.	NAME OF CHILDREN'S HOME	LOCATION	LICENSING STATUS	POPULATION CAPACITY	OCCUPANCY JULY 2021
1.	Amica House	13 Hillview Terrace, Curepe	Licensed	▪ 20 Girls only ▪ From new-borns to age 17	▪ 20 ▪ 18 girls, aged 2 -14years ▪ 2 young women aged 19 & 18
2.	Cecilia's Children's Foundation	38 Maypole Drive, Crossings, Arima	Licensed	▪ 10 Children	▪
3.	Christ Child Convalescent Home	Church Street, Diego Martin	Licensed	▪ 20: ▪ 10 boys and 10 girls ▪ Age Range: age 3 to 16	▪ 18: ▪ 9 girls and 9 boys ▪ Age Range: 7- 14
4.	Community Residence in Lambeau	Carnbee Appendage No. 2, Lambeau, Tobago	Licensed	▪ 12 ▪ 8 boys and 4 girls ▪ Age Range: 0 - 17	▪ 7 ▪ 3 girls and 4 boys ▪ Age Range: 7- 14
5.	Couva Children's Home and Crisis Nursery	CQ 15, Government Quarters, Campden, Couva	Licensed	▪ 20 ▪ 10 boys and 10 girls ▪ Age Range: 0 - 18	▪ 18 ▪ 11 girls and 7 boys ▪ Age Range: 1-13
6.	Dar ul Aman Freeport Children's Home	Lp 71 Rajkumar Trace, Mission Road, Freeport	Licensed	▪ 12 ▪ 2 boys and 10 girls ▪ Age range 6-17	▪ 9 ▪ 2 boys and 7 girls ▪ Age range 6-17
7.	El Shaddai Restoration Home	14 Restore Road, Bonne Aventure, Gasparillo	Licensed	▪ 18 ▪ 8 boys and 10 girls ▪ Age Range: 4-18	▪ 15 ▪ 8 boys and 7 girls ▪ Age Range: 8-16
8.	Haven of Hope	Lp 139/2 Pluck Road, Woodland, San Fancique, Penal	Licensed	▪ 15 ▪ 6 boys and 9 girls ▪ Age Range: 3-15 years	▪ 14 ▪ 6 boys and 8 girls ▪ Age Range: 9-17
9.	Hope Centre	47-53 Point-a-Pierre Road, San Fernando	Licensed	▪ 15 ▪ 5 boys and 10 girls ▪ Age range 3-11	▪ 15 ▪ 5 boys and 10 girls ▪ Age range 4-15
10.	Islamic Home for Children Inc.	Rahaman Drive, Bonne Aventure Road, Gasparillo	Licensed	▪ 18 ▪ 9 boys and 9 girls ▪ Age Range 3-17	▪ 16 ▪ 8 boys and 8 girls ▪ Age range 9-17
11.	Joshua Home for Boys	22 Cherry Tree Circle, Santa Rosa Heights, Arima	Licensed	▪ 10 males only ▪ Age Range: 3 – 18	▪ 10 boys ▪ Age Range: 6-17

NO.	NAME OF CHILDREN'S HOME	LOCATION	LICENSING STATUS	POPULATION CAPACITY	OCCUPANCY JULY 2021
12.	Mother's Union Children's Home	2 Pouchet Street, San Fernando	Licensed	▪ 12 ▪ 6 boys and 6 girls ▪ Age Range: 3-11 ▪	▪ 12 ▪ 6 girls and 6 boys ▪ Age Range: 4-13
13.	Our Lady of the Wayside	11 Jerningham Ave, Belmont, Port of Spain	Licensed	▪ 18 ▪ 15 boys and 3 girls. ▪ Age Range - 0 – 10 years	▪ 18 ▪ 15 boys and 3 girls ▪ Age range 5-10
14.	Division of Health, Wellness and Family Development - Probation Hostel	Kilgwyn Road, Stumpy By-Pass, Tobago	Licensed	▪ 10 ▪ 4 boys and 6 girls ▪ Age Range 10 -17 years	▪ 9 ▪ 4 boys and 5 girls ▪ Age Range: 13-17
15.	Rainbow Rescue	2 Saddle Road, Maraval	Licensed	▪ 14 males only ▪ Age range- 10-18	▪ 14 boys ▪ Age Range: 10-16
16.	Sophia House	2-4 Park and Piccadilly Streets, Port of Spain	Licensed	▪ 16 females only ▪ Age Range: 10-17	▪ 14 girls ▪ Age Range: 13-17
17.	Sri Jaya Lakshmi Children's Home	55 – 57 Alexander Street, Longdenville, Chaguanas	Licensed	▪ 15 ▪ Age range 5-17	▪ 13 ▪ 10 girls and 3 boys ▪ Age range 6-17
18.	St. Dominic's Children's Home – Plainview Homestead	Calvary Hill, Arima	Licensed (conditional)	▪ 8 boys only ▪ Age Range: 10-14	▪ 7 boys ▪ Age Range: 10-14
19.	St. Dominic's Children's Home - Sunny Hill Homestead	Sixth Avenue, Malick, Barataria	Licensed (conditional)	▪ 4 males only ▪ Age Range: 13-18	▪ 4 ▪ 3 boys ▪ aged 15-16 and one young man
20.	St. Dominic's Children's Home- Belmont	34B Belmont Circular Road, Belmont, Port of Spain	Licensed (conditional)	▪ 42 ▪ 22 boys and 20 girls	▪ 26 ▪ 12 girls and 12 boys ▪ One young man and one young woman ▪ Age Range: 9-17
21.	Vishok Bhavan (SWAHA)	196 Mohess Road, Penal	Licensed	▪ 13 girls ▪ Age Range: 5 to 17 years	▪ 9 ▪ 7 girls, ▪ One young man and one young woman
22.	Allison's Children's Home	51 McDonald Street, Curepe	Not Licensed	▪ 9 ▪ 6 boys 3 girls ▪ Age Range: 5 - 17	▪ 2 girls ▪ Age Range: 8yrs and 15yrs
23.	Bridge of Hope	Lp 1021 EMR, James Smart Village, Sangre Chiquito, San Grande	Not Licensed	▪ 32 ▪ 16 boys 16 girls ▪ Age Range:0-7	▪ 37: ▪ 21 boys and 16 girls ▪ Age range: 7months – 10 years
24.	Chickland Children's Home	92 Chickland Village, Upper Carapichima	Not Licensed	▪ 16 ▪ 8 boys 8 girls ▪ Age Range: 2 - 17	▪ 14 ▪ 4 boys and 9 girls ▪ One young woman (19 years) ▪ Age range: 2 -13yrs
25.	Mary Care Centre -North	43 Gallus Ave, Woodbrook, Port of Spain	Not Licensed	▪ 14 ▪ 7 adolescent girls and 7 babies/ toddlers	▪ 5 adolescent girls
26.	Mary Care Centre - South	46-48 Fyzabad Oropouche Road, Harris Village	Not Licensed	▪ 12 adolescents and 12 babies/ toddlers	▪ 14 ▪ 10 adolescent girls and 4 babies/ toddlers
27.	Sylphil Home in Love Tobago	Upper Pascal Extension, Lambeau, Tobago	Not Licensed	▪ 12 ▪ 4 boys and 8 girl ▪ Age Range: 0 - 17 years	▪ 12 ▪ 4 boys and 6 girls, aged 3 - 17 ▪ Two young women both aged 19
28.	Casa De Corazon	1 Coronation Road, Upper Sangre Grande	Not Licensed	▪ 17	▪ 15 ▪ 12 boys, 3 girls
29	CREDO Drop In & Residential Development Centre- (Boys)	24 Nelson Street, Port of Spain	Not Licensed	▪ 16 boys ▪ Age Range: 10 -18	▪ 10 boys ▪ Age Range: 10-14
30.	Cyril Ross Nursery	7 El Dorado Road, Tunapuna	Not Licensed	▪ 30 ▪ 15 boys 15 girls ▪ Age 0 - 17	▪ 13: ▪ 3 boys, 7 girls ▪ one young man 18 and ▪ two young women 18 and 22 ▪ Age range: 0 – 17yrs

NO.	NAME OF CHILDREN'S HOME	LOCATION	LICENSING STATUS	POPULATION CAPACITY	OCCUPANCY JULY 2021
31.	Ezekiel Home for Abandoned Children	134 Sesame Street, Preysal Village	Not Licensed	▪ 22 ▪ 12 boys and 10 girls ▪ Age Range: new born -18	▪ 22 ▪ 12 boys, 8 girls ▪ Age Range: 5-16yrs ▪ 2 young women aged 19 and 23years
32.	Lady Hochoy Home	Harding Place, Cocorite	Not Licensed	▪ 20 ▪ 10 boys and 10 girls ▪ Age Range: new born- 18	▪ 13 ▪ 9 boys and 4 girls ▪ Ages 4-17
33.	Jairah /Raffa House	Lot 23 Dahalia Court, La Florissante South, Dabadie, Arima	Not Licensed	▪ 14 ▪ 6 boys 8 girls ▪ Age: 7 -18	▪ 15 ▪ 5 boys, 5 girls (Age Range: 8-17) ▪ 4 young women (Ages 18, 18, 19,21) ▪ 1 young man (Age 18)
34.	Marian House	156 Henry Street, Port of Spain	Not Licensed	▪ 20 males only ▪ Age Range: 14-18	▪ 7 ▪ 6 boys ▪ one young man aged 18 ▪ Age range 16-18
35.	Ferndean's Place Children's Home	10 Hillcrest Drive, Harriman Park	Not Licensed	▪ 14 ▪ 8 boys 6 girls ▪ Age Range: 0-16	▪ 11 ▪ 7 boys, 3 girls ▪ one young woman (18 years) ▪ Age Range: 9-16years
36.	Margaret Kistow Children's Home	Lp 54 Ackbarali Street, West Malabar, Arima	Not Licensed	▪ 35 ▪ 16 boys & 19 girls ▪ Ages: 3 - 17	▪ 40 ▪ 17 boys, 21 girls ▪ 2 young men (19 and 20yrs ▪ Age Range: 3-17years
37.	Operation Smile Home for Children	10 Sonnyram Avenue, Morne Roache Quarry Road, Williamsville, Gasparillo	Not Licensed	▪ 10 ▪ 5 boys & 5 girls ▪ Age: 6- 18	▪ 6: ▪ 2 boys, 1 girl ▪ 2 young men (18 yrs.) & 1 young woman (18 yrs.) ▪ Age range: 7-16 years
38	St. Jude's School for Girls	34B Belmont Circular Road, Belmont	Not Licensed	▪ 65 ▪ Age: 13-17	▪ 56 girls ▪ Age Range: 13 – 17 years
39.	St. Mary's Children's Home	Eastern Main Road, Tacarigua	Not Licensed	▪ 50 ▪ 16 girls & 33 boys	▪ 50 ▪ 16 girls & 33 boys ▪ Age Range: 4 – 16 years

Of these homes, one (1), Allison's Children's Home, has closed. Four of these Children's Homes: the St. Jude's Home for Girls; the St. Mary's Home; St. Dominic's Home and the Lady Hochoy Home are solely funded by the State. The Lady Hochoy Home falls within the definition of a Children's Home but also houses adults with disabilities and mental illnesses. This latter category comprises the majority of its residents.

Except for the Lady Hochoy Home, the State-funded homes are all Statutory Authorities under the ambit of the Statutory Authority Act Chap 24:01 and are subject to the jurisdiction of the Statutory Authority Services Commission (SASC). The SASC is responsible for the appointment, promotion, dismissal and discipline of all persons employed by Statutory Authorities. Over the years, some members of staff of these Homes who were under the purview of the Commission have slowly been replaced by employees who the Homes have contracted. All three homes are now staffed by a combination of contract staff and staff appointed by the SASC. Disciplinary control, promotion and dismissal of staff employed in these Homes, therefore, vests with two bodies: the Homes themselves with respect to those employees under contract and the SASC with respect to the other employees. As a result of difficulties associated with the discipline and control of staff under the purview of the SASC and running conflicts between these individuals and contract staff, St. Dominic's Home is in the final stage of separation from the SASC.

Of these State-funded Homes only one, St. Dominic's Home, has been issued a residence license by The Authority, that is, a license permitting the Home to provide care and accommodation for children. The license issued to St. Dominic's is a conditional residence license. The Home has met all conditions for a residence license except the requirement that it provide police certificates of character for all its staff and food badges for those members of staff whose functions involve the handling or preparation of food for consumption. On the advice of their union, those members of staff under the purview of the SASC have refused to comply with these two requirements.

The position taken by staff at St. Dominic's is the same at St. Jude's and St. Mary's. However, both of these Homes have more fundamental difficulties that need to be resolved before they achieve residence licence status. According to information provided by The Authority, as of July 2021, St. Jude's had achieved 50% readiness for a residence licence, St. Mary's 60% readiness and Lady Hochoy Home 60% readiness.

A note on St. Michael's Home for Boys

This Home was closed in May 2018. This Home was also fully funded by the State and, as with similar to St. Jude's, St. Mary's and St. Dominic's Children's Hoes, operated under the jurisdiction of the SASC. At the time of its closure, St. Michael's had the capacity to house 70 boys. The official reason given at the time for the closure of the School was its low population number as a result of the establishment of Rehabilitation Centres to house boys in conflict with the law. At the time of its closure St. Michael's housed only 4 boys. However, the reality was that for several years the St. Michael's Home for Boys had been plagued with allegations of abuse of children resident at the Home, mismanagement, and financial impropriety.

Given the focus of this investigation, information about St. Michael's Home is important to this investigation. Specifically, it is not enough to acknowledge the causes of the Home being shut down or the effect of the loss of residential places for 70 children on the system but also to highlight the difficulty faced by Children's Homes in the discipline of members of staff who fall under the jurisdiction of the SASC. A case in point is that of DA who was employed with St. Michael's as a Boys Supervisor 1. He was an employee who came under the jurisdiction of the SASC. In 2016, two disciplinary charges were proffered against him by the SASC for hitting a resident with a shovel and hitting another resident with a piece of wood. Both incidents occurred in March 2016. In July 2020, two years after the Home had been closed, the SASC found him guilty of both charges and fined him $5,000.00 to be deducted from his salary in monthly instalments of $1,000.00.

There are plans to re-open the St. Michael's Home, around October 2022, on the same site. The intention is for the Home to be used to house boys who have been deemed children in need of supervision between the ages of 10- 18 years. The Facility will accommodate 75 boys and be run by the Trinidad and Tobago Defence Force.

Except for the Probation Hostel and the Community Residence Lambeau, both situated in Tobago and run by the Tobago House of Assembly through its Division of Health, Wellness and Family Development, the other Children's Homes are all privately run. In most cases, these private homes are managed through the auspices of a Board. The degree of responsibility adopted by the Board for the operations of the Children's Homes varies from Home to Home. While the method of funding of these private homes differs, they each receive a stipend from the State for each child in their care.

In addition, upon the advent of The Authority, these Homes became entitled and received a "one-off" payment to assist them in meeting the licencing requirements of The Authority.

The Table of Children's Homes shown above reveals that in a number of homes, there are residents who are over the age of 18 years. These are residents who, on attaining 18 years, had nowhere else to go. This is not an unusual or surprising occurrence exacerbated by the lack of Hostels as conceived by the Children's Authority Act. In one Home, the investigations revealed that three past residents were squatting at the back of the premises.

A report submitted to the Investigation Team prepared by the Nina Young Women's Leadership Foundation highlights some of the difficulties experienced by past residents of St. Jude's Home in transitioning from residential care back into the Community.

(Appendix 5: The NiNa Report - THE TRANSITION JOURNEY)

The Authority runs Child Support Centres at secret locations utilising persons The Authority employs. Child Support Centres do not fall within the definition of a Community Residence and are not subject to the regulations that prescribe standards of care or those applicable to premises that house children.

Table 2: identifies the Child Support Centres in Trinidad and Tobago and their capacity and occupancy at 31 March 2021.

NAME OF CENTRE	TYPE OF CARE PROVIDED	REALITY
CSC East **Capacity - 19** **Currently - 19**	Care and Protection – Girls up to age 18 and Boys up to age 12	Care and Protection, male CHiNS under 12 years of age, female CHiNS , pregnant teens and Psychiatric cases
CSC South **Capacity - 6** **Currently - 6**	Low-risk Care and Protection – Girls up to age 18 and Boys up to age 12	Maintains designation
CSC North **Capacity - 11** **Currently - 11**	Care and Protection cases – Boys aged 12 to 18	Male CHiNS - ages 12 to 18 and psychiatric cases
CSC Tobago **Capacity - 12** **Currently - 8**	Care and Protection cases – Male and female up until 18 years of age	Combination of care and protection cases as well as CHiNS of both sexes and all age groups

The Authority planned to use three of the four Child Support Centres to house a specific category of child given what The Authority terms as "the placement crisis". However, this is no longer the position. In reality, The Authority places children in Child Support Centres and Children's Homes wherever there is space and, in many instances, even where there is no space. This has resulted in the comingling of children with different levels of risk and severe overcrowding of both CSCs and Children's Homes.

By orders made under the Child Rehabilitation Centre Act, three places have been designated as Rehabilitation Centres. These are:

0. The North-East portion of the St Jude's School for Girls
0. The Youth Transformation and Rehabilitation Centre (YTRC) male at Golden Grove which houses male child offenders
1. The Youth Transformation and Rehabilitation Centre (YTRC) female at Golden Grove houses female child offenders.

The only two Rehabilitation Centres now in operation are the YTRC male and the YTRC female. St. Jude's no longer comprises a Rehabilitation Centre. Both of these Rehabilitation Centres are funded by the State and run by the Prison Service through the auspices of the Ministry of National Security. The Commissioner of Prisons is deemed to be the licensee of both premises. The Commissioner is responsible for making policies regarding strategies for rehabilitation and the reduction of recidivism of the residents, implementing training programmes for the residents and the officers, and other matters relating to the management, maintenance or operations of a Rehabilitation Centre and the protection of the residents.[2] A multidisciplinary Child Advisory Board assists the Commissioner of Prisons in this regard. The capacity of YTRC (male) is 156, and as of September 6, there were 48 residents. The Capacity of YTRC (female) is 12 and as of September 6, 2021 there were 2 residents.

The State's Responsibility Under International Treaty

The responsibility for the safeguarding, care, and protection of children acknowledged by the Government of Trinidad and Tobago in our terms of reference is embodied in the United Nations (UN) Convention on the Rights of the Child[3]; the preamble to which States:

> "The States Parties to the present Convention, Considering that, in accordance with the principles proclaimed in the Charter of the United Nations, recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world,
>
> Bearing in mind that the peoples of the United Nations have, in the Charter, reaffirmed their faith in fundamental human rights and in the dignity and worth of the human person, and have determined to promote social progress and better standards of life in larger freedom,
>
> Recognising that the United Nations has, in the Universal Declaration of Human Rights and the International Covenants on Human Rights, proclaimed and agreed that everyone is entitled to all the rights and freedoms set forth therein, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinions, national or social origin, property, birth or other status,

[2] Section 2A of the Child Rehabilitation Centres Act
[3] United Nations Convention on the Rights of the Child: https://www.ohchr.org/en/professionalinterest/pages/crc.aspx

Recalling that, in the Universal Declaration of Human Rights, the United Nations has proclaimed that childhood is entitled to special care and assistance,

Convinced that the family, as the fundamental group of society and the natural environment for the growth and well-being of all its members and particularly children, should be afforded the necessary protection and assistance so that it can fully assume its responsibilities within the community,

Recognizing that the child, for the full and harmonious development of his or her personality, should grow up in a family environment, in an atmosphere of happiness, love and understanding,

Considering that the child should be fully prepared to live an individual life in society, and brought up in the spirit of the ideals proclaimed in the Charter of the United Nations, and in particular in the spirit of peace, dignity, tolerance, freedom, equality and solidarity,

Bearing in mind that the need to extend particular care to the child has been Stated in the Geneva Declaration of the Rights of the Child of 1924 and in the Declaration of the Rights of the Child adopted by the General Assembly on 20 November 1959 and recognized in the Universal Declaration of Human Rights, in the International Covenant on Civil and Political Rights (in particular in articles 23 and 24), in the International Covenant on Economic, Social and Cultural Rights (in particular in article 10) and in the statutes and relevant instruments of specialized agencies and international organisations concerned with the welfare of children,

Bearing in mind that, as indicated in the Declaration of the Rights of the Child, "the child, by reason of his physical and mental immaturity, needs special safeguards and care, including appropriate legal protection, before as well as after birth",

Recalling the provisions of the Declaration on Social and Legal Principles relating to the Protection and Welfare of Children, with Special Reference to Foster Placement and Adoption Nationally and Internationally; the United Nations Standard Minimum Rules for the Administration of Juvenile Justice (The Beijing Rules); and the Declaration on the Protection of Women and Children in Emergency and Armed Conflict, Recognizing that, in all countries in the world, there are children living in exceptionally difficult conditions, and that such children need special consideration,

Taking due account of the importance of the traditions and cultural values of each people for the protection and harmonious development of the child, Recognizing the importance of international co-operation for improving the living conditions of children in every country, in particular in the developing countries,

Have agreed as follows: ....."

Trinidad and Tobago ratified the Convention on the Rights of the Child (CRC) in December 1991 without reservation and in 2000 enacted a suite of Children's legislation intended to bring our system of child care in line with the provisions of the Convention. This suite of legislation included the Children's Authority Act 2000 and the Children's Community Residences, Foster care and Nurseries Act 2000. In 2008 the Children's Authority Act was amended to specifically include, as one of its

objects, compliance with "certain obligations under the United Nations Convention of the Rights of the Child." However, the Acts comprising the suite of Children's legislation were not effectively proclaimed until 2015, and even then, only partially proclaimed.

The Legislation

With respect to the provision of residential care the relevant legislation is:

- The Children's Authority Act Chap 46:10 ;
- The Children's Community Residences, Foster Care and Nurseries Act Chap 46:04 and the Children's Community Residences (Children's Homes) Regulations and the Children's Homes Community residences (Rehabilitation Centres) Regulations both made pursuant to the Act;
- The Children Act Chap 46:01;
- The Child Rehabilitation Centre Chap 13:05, and
- The amendments made to these Acts by the Family and Children Division Act No.6 of 2016 and the Miscellaneous Provisions (Supreme Court of Judicature and Children) Act No 15 of 2018.

A major problem faced in examining the legislation is that it is extremely difficult to navigate. All the Acts comprising the suite of children's legislation came into effect by proclamation. Sections of the Acts were proclaimed at different times. Some, up to today, have not as yet been proclaimed. In 2016 and 2018 further changes were made to the Acts. These changes were achieved in two ways: by adding substantial amendments to the Family and Children Division Act and by an omnibus amendment Act, the Miscellaneous Provisions (Supreme Court of Judicature and Children) Act. The short titles of these two amending Acts bear no reference to the Acts being amended and also contain amendments to a number of other pieces of legislation. An amendment to the Young Offenders Detention Act rendered by Act No.6 of 2016, for example, not only made substantial amendments to that Act but also changed its name to the Child Rehabilitation Centre Act. That change of name has not been reflected in the latest consolidation of legislation done by the Law Commission.

Further, some of the amendments made by Act No. 6 of 2016 were themselves amended by Act No 15 of 2018. In addition, both of these amending Acts also came into effect by proclamation and once again the proclamation of various parts of the Acts were staggered. Therefore, as the legislation stands it is very difficult for persons providing residential care for children to identify and understand their responsibilities which the legislation mandates.

At the hub of the legislation is the Children's Authority Act 2000 establishing The Authority. The Authority was not made operational until May 2015 when the Act, its amendments and the Regulations made pursuant to the Act were effectively proclaimed.

The Stated objectives of the Children's Authority Act is to promote the well-being of all children in Trinidad and Tobago, provide care and protection for vulnerable children and comply with certain obligations under the United Nations Convention on the Rights of the Child.[4]

[4] Section 3A

In addition to its responsibilities in respect of foster care and the adoption of children the Act requires The Authority to:

- Provide care, protection and rehabilitation of children in accordance with its provisions
- Investigate complaints made by any person with respect of any child in the care of a Community Residence that the residence failed to comply with the requisite standards prescribed under the Children's Community Residences, Foster Care and Nurseries Act, 2000 and any incident of mistreatment of children in such place;
- Investigate complaints or reports of mistreatment of children and monitor community residences, foster homes and nurseries and conduct periodic reviews to determine their compliance with such requirements as may be prescribed; and
- Issue, suspend and revoke licences of community residences and nurseries as provided under the Children's Community Residences, Foster Care and Nurseries Act, 2000.[5]

The Act mandates The Authority to promote the well-being of the child and take all reasonable steps to:

(i) Provide accommodation for the child necessary for compliance with the Act,

(ii) Ensure the availability of staff required for proper implementation of the Act, inclusive of programmes for training and

(iii) Prevent children from suffering ill-treatment or neglect.[6]

In accordance with the State's international responsibilities, the Act, therefore, ensures that through the medium of a Children's Authority, all children in residential care are ultimately the responsibility of the State. The legislation provides two methods by which The Authority is to meet its responsibilities to these children through a rehabilitation process geared to ensure each child's individual development. One strategy is via the reintegration of that child into the community. The second method involves the licencing and monitoring process, which ensures that all Community Residences comply with established standards of care.

The responsibility for the administration of the Act is placed on a Board of Management of The Authority. By the Act, the Board is required to be multidisciplinary and includes the Director of The Authority as an ex-officio member. The responsibility for the placement of children into Community Residences by The Authority vests in the Board. The Director is responsible for the day to day running of The Authority and is the Coordinator of all units of The Authority. The operational work of The Authority is divided among 8 units: They are the:

1. Legal Unit
2. Investigation and Intervention Unit

[5] Section 5
[6] Section 6

3. Emergency Response Unit
4. Child Justice Unit
5. Child Support Centres
6. Licencing and Monitoring Unit
7. Registry or Intake Unit and
8. Assessment Unit.

Mode of admission into residential care

Under the legislative scheme, there are several avenues by which children can be brought into residential care and the care of The Authority. These are:

A. Section 22 of the Children's Authority Act
B. Section 50A of the Children Act (CHiNS)
C. Children who were resident in Children's Homes prior to 2015
D. Children received into a Children's Home subsequent to 2015
E. Children in conflict with the law
F. Children left in a place of safety pursuant to section 45 of the Children's Act and
G. Child victims of human trafficking

By Section 22 of the Act, The Authority is mandated to intervene where it is of the opinion that a child is in need of care and protection and that intervention is in the best interest of the child. Once The Authority deems that intervention is in the best interest of the child, The Authority must investigate the matter and, where appropriate, receive the child into its care. Receipt into care does not necessarily mean receipt into residential care but may include residential care. Under this section, a child can also be referred to The Authority by a person having reasonable grounds for believing that a child is in need of care and protection. The section identifies a number of circumstances whereby a child can be deemed to be a child in need of care and protection. These circumstances include where a child is in need of supervision.

Section 50A of the Children Act introduced the term 'a child in need of supervision' to replace the previous term 'beyond control'. By this section a person with responsibility for a child can apply to the Court for an order that the child be deemed to be a child in need of supervision. Upon submission of such an application, the Court is required to notify The Authority and may thereafter

(i) refer that child to The Authority for appropriate intervention or

(ii) deem the child in need of care and protection and make an appropriate order pursuant to section 25 of the Children's Authority Act or

(iii) may itself make an order for the care and placement of the child and then refer the child to The Authority.

Under the Children's Authority Act therefore, there are two distinct pathways for a child to be received into the care of The Authority after 2015, via section 22 of the Children's Authority Act or via section 50A of the Children's Act. Once under the care of The Authority, the Act makes no distinction with respect to the treatment to be afforded to these two categories of children. Both categories are considered to be children in need of care and protection and received into the care of The Authority under section 22 of the Act. With respect to these children, access to Residential care is through the intervention of the Court by virtue of orders made under section 25 of the Children's Authority Act or by way of emergency placed under section 45 of the Children's Act.

A child may also come into the care of The Authority, where that child was a resident of a Children's Home prior to 2015. In such a case, in accordance with section 25 of the Children's Community Residences Foster Care and Nurseries Act, within a fixed period of the Act coming into force, that is, May 18 2015, the Manager of each Home was required to provide The Authority with information, including a treatment plan, with respect to each child resident in the Home. In accordance with this Act, upon receiving the information, The Authority shall "as soon as practicable" evaluate the child and the suitability of the placement of the child. Where The Authority is of the opinion that the Community Residence is not suitable, it is required to submit an application to the Court for an order under section 25 of the Act. However, the Act does not specifically require The Authority to take steps to bring under its umbrella of care a child who in its opinion is properly placed.

With respect to children admitted to a Children's Home after 2015, other than through the Court or by emergency placing by The Authority, section 26 of the Children's Community Residences, Foster Care and Nurseries Act require the Manager of the Children's Home to inform The Authority within 24 hours of receiving a child without a Care Order. The Authority shall then record the reception and deal with the child in accordance with section 22 of the Act.

Children in conflict with the law refer to a child who has come into contact with the justice system due to having been suspected or accused of an offence and includes a child who has been charged or convicted of a crime. In accordance with the Children's Act, a child who has been held by the Police or charged with an offence and not released on bail is required to be kept in a Community Residence. Children under 10 years of age are to be placed in a Children's Home. Where the Child is over 10 years of age the child is to be placed in a Rehabilitation Centre[7].

While an order for the child to be placed in residential care must be made by the Court, there are various ways by which this can be achieved. Where a child is convicted of an offence or is liable to imprisonment a Court may order that the child be placed in a named Community Residence or deem the child to be in need of care and protection and refer the child to The Authority[8] Where the child is referred to The Authority it shall investigate and seek any appropriate order from the Court. Except where the Court has specifically deemed a convicted child to be a child in need of supervision and has referred that child to The Authority, it is given no specific responsibility towards children in conflict with the law.

The Children Act by Sections 45 and 46 also allows for a child to be taken to a place of safety. By the Act, a place of safety is defined as a reception centre, community residence or any place appointed

[7] Section 54 of the Children Act
[8] . iSection 60(2) Children Act

by The Authority to be a place of safety. Under section 45, a police officer, a government employee with qualifications or experience in social work or a person authorised by the Court may take a child to a place of safety where an offence under the Children's Act has been committed or is likely to be committed with respect to that child.

The Act provides that the person taking the child to a place of safety must notify The Authority. The child may remain in the place of safety unless The Authority advises otherwise or the child is brought to the Court. In addition, under Section 46 the Court is mandated to bring a child to the attention of The Authority where a person having responsibility for the child has been charged, committed or bound over to keep the peace with respect to an offence with respect to that child. Unfortunately, the Act does not mandate The Authority to apply the provisions of section 22 of the Children's Authority Act to a child who has been taken to a place of safety.

The State's responsibilities are specific regarding the United Nations Protocol to Prevent, Supress and Punishing Trafficking in Persons especially Women and Children the Trafficking in Persons Act. Accordingly, the State must provide reasonable protection for victims to prevent recapture and to secure them from threats, reprisals and intimidation by traffickers and associates[9]. By this Act, non-nationals are entitled to social benefits including "appropriate housing, education and training opportunities, psychological counselling and medical assistance."[10] Further, the Act mandates the Counter Trafficking Unit to liaise with the Children's Authority to provide child victims with services which may include privacy, housing, care, and appropriate support and understanding of their rights.[11] In accordance with this mandate a memorandum of understanding was signed in August 2018 between the Counter Trafficking Unit and the Children's Authority. The memorandum acknowledges the ability of a police officer of the counter-trafficking unit to take a child victim of human trafficking to a place of safety as defined by the Children's Act. By the memorandum, The Authority also undertakes to provide suitable placement for child victims. To date, placement has been in Children's Homes. Neither the Act not the memorandum of understanding requires The Authority to take specific actions with respect to these children once they have been placed in a Children's Home.

Therefore, under the legislation The Authority is not required to treat a child in accordance with the procedure set out in section 22 where (a) the child has been delivered into a place of safety and remains there without being brought to court or The Authority removing that child; (b) where the child is in conflict with the law unless the court makes a specific referral to The Authority; (c) a child is a victim of human trafficking; and (d) where The Authority determines that a child admitted to a Children's Home prior to 2015 has been properly placed.

The legislation highlights that a large number of children in Community Residences fall directly under the jurisdiction of The Authority exercised through orders of the Court. However, there are children in Children's Homes who, although still under the care of The Authority, do not have the benefit of the services specifically provided by the orders identified in section 25 of the Children's Authority Act. For these children, these services are therefore solely within the discretion of The Authority. The largest of these categories are children admitted to Children's Homes prior to 2015. According to

[9] Section 32(b) of the Trafficking in Persons Act.
[10] Section 37(1)
[11] Section 44(2) of the Trafficking in Persons Act

The Authority, there are 160 children in residential care that fall into this category who have not as yet been assimilated into The Authority's care system.

Care of Children

Part III of the Children's Authority Act outlines The Authority's responsibilities with regard to rehabilitation and integration into the community of children in their care. Once a child is deemed by the Court to be in need of care and protection under Section 22, the Act requires The Authority to apply to the Court for various orders specified by Section 25 of the Act. Orders under Section 25 include a Care Order, that is, an order placing the child under the care of The Authority or a community residence. The Section also identifies a child Assessment Order, that is, an order for the assessment of the child made where the Court is satisfied that there is reasonable cause to suspect that the child is suffering or is likely to suffer physical, emotional, mental or psychological harm and it is unlikely that such an assessment would be made unless such an order is made. Section 25 also pinpoints a secure Accommodation Order restricting the liberty of the child, an Emergency Protection Order which may authorise the removal of the child at any place or the detention of the child at a community residence and a Recovery Order requiring the retrieval of the child.

In order to meet its responsibilities to the rehabilitation of children in its care The Authority is required to maintain two types of centres: Assessment and Support Centres and Reception Centres.[12] The Assessment and Support Centres are responsible "for the initial assessment and referral of children coming to the attention of The Authority". Although the centres are responsible for assessment of children coming to the attention of The Authority the Act does not mandate The Authority to provide an assessment for every child coming to its attention. In practice, assessments are done only when mandated by the Court or on the recommendation of The Authority's Investigation and Intervention Unit. This unit is staffed by persons including social workers, medical personnel and psychologists and is responsible for providing a psychosocial assessment for each child coming to the attention of The Authority.

The Reception Centres (Child Support Centres) are for the temporary care of children. In accordance with the Act children shall not be housed in the Reception Centres for longer that 12 weeks. Each Reception Centre is required to have available qualified staff including social workers, a child psychologist, child psychiatrist and medical personnel who are required to carry out initial medical examinations, diagnostic assessments and formulate treatment plans. Placement of children by the Board is required to be done in accordance with the recommendations made by these experts. The experts are also responsible for the implementation of plans in respect of any child in the care of the reception centre.

Insofar as the Reception Centres are authorised by the Act to provide temporary accommodation for children, The Authority is not authorised to maintain residential facilities for children. Instead, the Act provides that The Authority discharge its functions of providing for the accommodation of children

[12] Section 14 of the Children's Authority Act

in its care by making arrangements with private bodies for the accommodation of such children as identified by the Children's Community Residences, Foster Care and Nurseries Act.[13] The Act also directs The Authority to ensure accommodation in Hostels for children who are over 16 years of age and have no place to reside. These Hostels are to accommodate residents between the ages of 16 to 21 years.

Licencing and Monitoring Functions of The Authority

The Authority's responsibility with respect to Community Residences is limited to the licencing of Children's Home and the monitoring of Community Centres. It is through this medium that The Authority maintains general oversight of children placed in residential care and in particular discharges its statutory responsibility to:

- Investigate complaints made by any person with respect of any child in the care of a Community Residence that the residence failed to comply with the requisite standards prescribed under the Children's Community Residences, Foster Care and Nurseries Act and any incident of mistreatment of children in such place;
- Investigate complaints or reports of mistreatment of children and monitor community residences, foster homes and nurseries and conduct periodic reviews to determine their compliance with such requirements as may be prescribed; and
- Issue, suspend and revoke licences of community residences and nurseries as provided under the Children's Community Residences, Foster Care and Nurseries Act.

The prerequisites for the establishment and operation of Children's Homes are addressed by the Children's Community Residences, Foster Care and Nurseries Act and the Children's Community Residences, (Children Homes) Regulations 2018. In similar fashion the Child Rehabilitation Centre Act and the Children's Community Residences (Rehabilitation Centres) Regulations prescribe the prerequisites for the establishment and operation of Rehabilitation Centres. Both these Acts and the Regulations bind the State.

The licencing exercise to be engaged by The Authority ensures that no Children's Home is permitted to provide residential care for children unless it meets certain minimum standards. These are standards established by The Authority. The Authority's monitoring function ensures that those standards are maintained and the children in the care of Community Residences are safeguarded from harm.

Section 3(1) and (2) of the Children's Community Residences, Foster Care and Nurseries Act requires a Children's Home to be licenced and mandates that no child shall be cared for and provided with accommodation in a Children's Home unless a residence licence has been issued. Section 17 of the Community Residences Act makes it an offence to manage a Children's Home without a residence licence. These sections are still to be proclaimed. The effect of the failure to proclaim these sections is that some 21 years after the passage of the legislation there are Children's Homes that have not met the standards required for the issue of a licence but continue to operate. As of July 2021 out of

[13] Section 34 of the Act as amended by the Family and Children Division Act

a population of 620 children 225 of those children resided in Children's Homes which did not meet the basic standards set by The Authority for licensing and 37 children resided in Children's Homes that were only conditionally licensed. While the issue of a residence licence does not of itself ensure the safeguarding of children in the care of the Home from abuse, what is does is ensure that certain minimum standards necessary for their care and protection are preserved.

The Act mandates The Authority to issue a residence licence only when it is satisfied that there has been compliance with the prescribed requirements and makes provision for the revocation of such licence and for an appeal of any decision to revoke a licence first to the Minister and then to the High Court. The prescribed requirements are contained, for the most part, in the Regulations applicable to Children's Homes and Rehabilitation Centres. Among other things, The Authority's monitoring functions ensures that the Community Residences maintain the standards set by the Regulations.

The scheme adopted by the Regulations is slightly different dependant on whether the Community residence is a Children's Home or a Rehabilitation Centre. The Children's Homes Regulations places responsibility for different aspects of the Regulations on either the Licensee or the Manager. As a general rule, the responsibility for the operations and maintenance of the Home is placed on the Manager and for the building and provision of plant and equipment on the Licensee. Therefore, with respect to Children's Homes, the post of Manager is crucial to the efficient running of the Home. Accordingly, the Act and the Regulations establish the minimum qualifications and training for the post of Manager.

The Rehabilitation Centre Regulations are structured slightly differently. The requirements set out in the Regulation are more general with respect to vesting responsibility. Except for the keeping of records, the document does not identify the person with responsibility for the various components. The Regulations identify the records that must be kept and place the responsibility for them on the Commissioner. Unlike the Children's Homes Regulations, the Rehabilitation Centre Regulations provide for the continuous training of staff. Like the Children's Homes Regulations, the Rehabilitation Centre Regulations provide for the minimum standards to be applied to the Rehabilitation Centres.

Offences and Enforceability

The Community Residences Act creates certain offences which are punishable by a fine and imprisonment. Under the Act It is an offence for any person to subject a child in a Children's Home to corporal punishment. It is also an offence to use restraint or force, reduction or change of diet or restriction or denial of contact with family as a form of punishment. A similar provision is contained in the Child Rehabilitation Centre Act Chap 13.05 with respect to Rehabilitation Centres. However, this Act permits the restraining of children on order of the Superintendent under certain limited circumstances and only under supervision and for no longer than necessary.

Both the Children's Community Residence, Foster Care and Nurseries Act and the Child Rehabilitation Centre Act provide very limited methods for the enforcement of its provisions or those contained in the Regulations. For Children's Homes the main method of enforcement is through by way of a, refusal to grant a licence or by the revocation of the licence granted. In this regard, The Authority may revoke a licence where (a) there is a breach of provision of Part 1 of the Act or any term or condition of the residence licence or, (b) where The Authority is dissatisfied with the conditions,

rules, management or superintendence of Children's Home and the Licensee or Manager fails to take corrective measures in accordance with a notice served to that effect. Given the policy of The Authority with respect to permitting Children's Homes to continue to operate without a licence this sanction is of no or little effect.

With respect to Rehabilitation Centres the position is as tenuous. Where The Authority is dissatisfied with the conditions, rules, management or superintendence of a Rehabilitation Centre and the Licensee or Manager fails to take corrective measures the only recourse open to The Authority is to submit a report to the Minister responsible who shall lay the report in Parliament. No direction is given by the Act as to the steps that are to be taken thereafter.

Section 17B of the Children's Community Residences, Foster Care and Nurseries Act is an attempt to provide for the enforcement of the provisions of the Act and the Regulations. The section provides that "any contravention against the Act or its regulations with respect to Community Centres for which no penalty is prescribed is punishable by a fine of ten Thousand dollars and in the case of a continuous offence to a fine of five hundred dollars for each day the offence continues." The Act, by section 17B(2) disapplies section 63 of the Interpretation Act Chap 3:01 to the Act and the Regulations.

Where an Act confers a power to make any statutory instrument, in this case the power to make regulations conferred on The Authority by section 53 of the Act, Section 63 of the Interpretation Act allows for the imposition, by way of summary conviction, of a fine not exceeding $500.00 for the breach that statutory instrument. Section 17B therefore is an attempt to impose a larger fine than identified by section 63 for any breaches of the Regulations.

There are a number of difficulties with section 17B. In the first place, with respect to Children's Homes, the penalty of revoking the residence licence already exists. It is unclear therefore whether in those circumstances this section is available to enforce breaches of the Regulations. More fundamentally, there is the issue of the legitimacy of the Section insofar as it seeks to create offences and impose penalties. Section 63 of the Interpretation Act does more than just impose a fine. It gives statutory approval to the creation of an offence by implication and identifies the method of prosecution. By disapplying section 63 that statutory cover is removed.

In addition, the Section is vague and provides no information regarding exact contraventions that would attract such a fine. Neither does it suggest who is to be held responsible for these contraventions or who is to be responsible for the prosecution of these offences. Additionally, the Section does not identify the procedure when imposing the fine. Moreover, when the Section is considered in the light of the imprecise and subjective language used in the Regulations it is difficult to conceptualise the steps for enforcing most of the Regulations. Any attempt to impose the penalty prescribed by section 17B therefore runs the risk of being declared unenforceable by a court.

Pronouncements Made by The Court On The Existing Legislation And The Responsibility Of The State

There are three cases in which our Courts have made pronouncements on the role of The Authority and the responsibility of the State to children in residential care. These cases are: The Commissioner of Prisons v Seepersad and another [2021] UKPC 13; The Attorney-General v JM (a minor by his next friend NM) and others CAS302 of 2019; The Children's Authority v the Ministry of Health v North West Regional Health Authority Case No C-North AP2879 of 2020.

The Commissioner of Prisons v Seepersad and another [2021] UKPC 13

In January 2014 Sasha Seepersad, ("Sasha") aged 16, and Brian Singh, ("Brian") aged 13, (collectively called "the Children") were remanded into custody charged with robbery and murder. Sasha was remanded to the Women's Prison and Brian to the Youth Training Centre("YTC"). In December 2015 Sasha was transferred to the St. Jude's Home for Girls, which had been made a temporary rehabilitation centre for this purpose, and in January 2016, upon attaining the age of 18 years, to the Women's Prison. In 2016 Brian was transferred from YTC to the St. Michael's Home for Boys.

In proceedings brought by the Children against the decision of the Magistrate to commit them to the Women's Prison and YTC respectively the High Court found that the orders of the Magistrate were unlawful as they contravened sections 54 and 60(1) of the Children's Act. Section 54(1) of the Children's Act mandates that children be committed to Community Residences while Section 60(1) prevents the detention of a child in an adult prison. The High Court also held that the failure of the State to provide the children with accommodation compliant with the Children's Community Residences, Foster Care and Nurseries Act ("the Community Residences Act") breached their constitutional rights. The Court of Appeal upheld the High Court with respect to the unlawfulness of the Magistrate's decision but overturned the decision that the failure to provide accommodation compliant with the Community Residences Act was in breach of the Children's constitutional rights. The Children appealed this part of the decision to the Judicial Board of the Privy Council ("the Board").

Despite the failure of the State to proclaim the Sections of the Community Residences Act requiring mandatory licencing of Community Residences the Board concluded that, in accordance with the law, the State was required to provide licensed community residences suitable to accommodate the Children and had not done so. The simple issue for determination was whether this failure was in breach of the Children's constitutional rights to due process and the protection of the law. The Board determined that the Children's right to due process had not been breached but that that their right to the protection of the law guaranteed to them under the Constitution had been violated. Accordingly, it declared "that their unlawful remands to, respectively, (as regards Sasha) the Women's Prison and the St. Jude's Home for Girls and (as regards Brian) the YTC and the St. Michael's Home for boys had violated the right to the protection of the law guaranteed them under the Constitution.

In coming to the conclusion that the Children's right to due process had not been breached however the Board recognised "that there were undeniable failings of significant dimensions on the part of the State throughout the relevant period…….one of its consequences was plainly detrimental to both

appellants as they found themselves accommodated in institutions which were not suited to their ages and needs."

The Board summarised the failings of the State in this way:

> "Fundamentally, the executive brought into operation the material provisions of the Children Act without having first put in place the arrangements necessary to give effect to their mandatory requirements, in a context where the intended beneficiary cohort of these measures, namely children, had been identified by both international law and domestic law as deserving of special protection. This had a series of substantial consequences: the operation of several interrelated provisions of primary legislation was rendered impotent during a protracted period; the aforementioned cohort was deprived of the benefits and protections prescribed by the legislature; international norms were violated; the [Children] were thereby exposed to conditions, environments and influences which the frustrated legislative provisions were designed to avoid; the Chief Magistrate was compelled to make a series of unlawful remand orders; the [Children] were deprived of their liberty pursuant to such orders; and the legal system of Trinidad and Tobago did not provide them with timeous and efficacious remedies. Finally the executive has failed to offer any explanation of, much less any justification for, its acts and omissions. Taking into account all of the foregoing, the Board considers that the exercise by the executive of its legal powers was arbitrary…"

The position taken by Board in Seepersad was adopted in the two other cases under consideration.

The Attorney-General v JM (a minor by his next friend NM)and others CA S302 of 2019

In September 2012, at aged 9 JM was placed into the care of the State after his mother was charged, and subsequently convicted, of wilful abandonment and neglect. He spent 8 days in two private children's homes before being remanded to St. Michael's Home for Boys. JM had severe behavioural issues and both Homes had complained that they were unable to care for him. In March 2013 while at St. Michaels Home JM was diagnosed with Prader-Willi Syndrome. This diagnosis explained his behavioural issues.

In July 2015, The Authority conducted a multidisciplinary assessment of JM pursuant to section 25 of the Children's Community Residences, Foster Care and Nurseries Act 2000 ("Community Residences Act"). The assessment of JM revealed that the poor knowledge and understanding of JM's medical condition resulted in inadequate management and care for him; the caregiver ratio at St. Michael's did not allow for suitable supervision and St. Michael's was not conducive to ensuring the success of the interventions or the provisions of long-term care and management of JM's diagnosis. It also found that JM's association with peers who taunted him and encouraged his maladaptive behaviours caused St. Michael's to be determined an unsuitable environment for his growth and development. In October 2016 JM was removed from St. Michael's Home and placed "temporarily" at the St. Ann's Psychiatric Hospital where he remained until his court ordered removal in October 2017. The Court found that while he was resident at both St. Michael's Home and St. Ann's Institutions JM was a victim of repeated physical, sexual, mental and emotional abuse from both residents and staff.

Pursuant to an order of the High Court JM was removed from St. Ann Hospital and was then placed in a Child Support Centre run by The Authority. Here he exclusively occupied the ground floor of the

building. Twelve nurses were employed to look after him at a cost of $108,000.00 per month. This continued until JM attained the age of 18 years. JM was thereafter transferred to another facility.

Both the High Court and the Court of Appeal found that JM's detention at St. Michael was unlawful. They found that upon the proclamation of the new Children's Act there was a duty on the State to provide Community Residences or equivalent places of safety available to house JM accordingly his right to the protection of the law had been breached and he was entitled to damages for its breach. The Court also found that there was a duty on the State to protect JM from harm from the other residents and from the staff. It found that the State could not escape liability. According to the Judge: "apart from the legislative framework it provided funding for St. Michael's and employed its staff the State had overall supervisory responsibility for St. Michael's it therefore could not claim ignorance of or deny responsibility for conditions there. Further, there had been reports made by the Inspector of Orphanages on investigations into attacks on JM the State therefore had actual knowledge of JM's situation via the reports made to the Inspector."

According to the Judge:

> "an analysis of i. the circumstances in which JM came to be detained, ii. his condition, iii. the evidence of the demonstrated unsuitability of St. Michael's for JM, iv. obligations of this State under international conventions, and v. the legislative framework introduced under the Children Act and associated legislation, on May 18, 2015, all necessarily lead to the conclusion that the law that came into existence on May 18, 2015 provided for JM to be housed in a safe environment. Therefore, failure to provide it amounted, as in ***Seepersad***, to a breach of the protection of the law in relation to him."

With respect to JM's right to the security of the person the Judge Stated:

> "There can be no doubt that both the frequency and severity of the abuse that JM had to endure and the failure to prevent such abuse contributed both to actual physical harm and the likelihood of constant fear of such harm. This would be sufficient to establish a breach of JMs right to security of the person. This is because the State both directly in its supervisory and regulatory role and through its paid employees at St. Michael's, was in a position to end this and did not.

The Children's Authority v the Ministry of Health v North West Regional Health Authority Case No C-North AP2879 of 2020.

This was a decision of the Children Court on an application by the Children's Authority to have the Minister appoint any part of a general hospital as a psychiatric ward for the reception of a child. The issue in this case was whether the Minister was mandated to provide for the establishment of an appropriate facility or ward that is specially designated for the inpatient care of children who are in need of care and treatment for mental illness.

In 2012, at aged 6 HS and his younger brother were left at a doctor's office by his mother who subsequently attempted to commit suicide by running into the path of a car. HS was placed first at the Mother's Union Home and then, because of his behaviour, at the Lady Hochoy Home. In 2018 he was diagnosed with Pervasive Development Disorder, Intellectual Disability and Autism Spectrum

Disorder with Intellectual Impairment, Attention Deficit/Hyperactivity Disorder and Conduct Disorder with Limited prosocial emotions. Based on these findings, The Authority recommended that HS be placed at a long-term in-patient specialist facility for mental illness.

In 2019, Lady Hochoy Home applied to the Court for HS to be deemed a child in need of supervision. The Court made the order and requested that The Authority provide it with options for HS' long-term care. An order was made placing HS in the care of The Authority. In the absence of facilities for the long-term care for children at St.Anns Medical Hospital the Hospital recommended that he be placed in an adult ward with adult patients with a mental age of 12.

Justice Bansee determined

> "that given the suite of children legislation which embodies the provisions of the UNCRC and UNCRPD with regards to the best interests of the child at its core, the State and State Agencies have a responsibility to ensure that the best interests of the child are preserved and that positive actions are taken to protect the rights of the child. The issue is appropriate accommodation based on the child's need. It is neither the scope nor the duty of the Rehabilitation Centres or Children Homes to provide treatment for persons diagnosed with mental illness. It is wholly improper to place a child requiring treatment for mental illness at either a Rehabilitation Centre or Children Home as these Intuitions have not been outfitted with the facilities and trained staff to provide the requisite treatment to children afflicted with mental illness."

The Judge found that on the construction of sections 4 and 5 of the Mental Health Act, the Minister of Health was obliged to provide a place for the care and treatment of mentally ill persons in Trinidad and Tobago but that it was in the discretion of the Minister to determine whether it would take the form of a ward at a general hospital under section 5 or a separate facility under section 4.

The Judge ordered that the Minister within three (3) months appoint the whole or any part of a building, house or other place or any part of a general hospital as a Psychiatric Hospital or Ward respectively designated for the placement, care and treatment of HS and any other child diagnosed with mental impairment and in need of an inpatient facility;

It is clear, therefore, that the Courts are increasingly prepared to penalise the State for failing to meet its statutory and, when accepted into our domestic law, international obligations. The effect of these decisions is that failure of the State to give effect to the mandatory licencing of Children's Homes as envisaged by the Community Residences Act and the failure of the State to ensure that Community Residences to provide the facilities and maintain the standards prescribed by the Regulations and International Conventions ratified by the State may render the State open to similar claims.

Chapter 3 - Methodology

The process of this investigation began with the establishment of the Team.

Subsequently, the Investigation Team reviewed several documents (critical incident reports, media reports, police reports, international conventions, CATT's policies, Acts) requested from the relevant Agencies. Following the review of documents, the Investigation Team established a management structure that included the creation of sub-committees and the direction of the investigation.

The Investigation Team collected primary and secondary data of the experiences of the risks and vulnerabilities of children regarding absconding and abuse and the system's effectiveness in safeguarding children in the care of the State.

The Investigation Team utilised several investigation methods and strategies to scrutinise the delivery of care and protection by the Authority, the Community residences and ultimately the State.

The findings in this report are based on a large quantity of raw data, derived from a variety of different sources, obtained by and provided to the Investigation Team. The main sources were:

- Site Visits to Children's Homes, Child Support Centres and Rehabilitation Centres
- Interviews with the staff at Community Residences, The Authority's Staff, Residents (children), former residents of the facilities, former and current employees of Children's Authority
- A Document Review which included the examination of Incident reports, laws, case law, The Authority's polices and quality control forms, conventions, police reports, newspaper articles and online commentary; international standards and conventions, internal audit reports as well as policies of some Community Residences
- Feedback Forms for professionals who worked in the field of child protection and forms submitted to Community Residences.

As part of its process, the Investigation Team focussed on areas of safeguarding as well as sexual and physical abuse and identified the following definitions to guide its investigations:

Safeguarding

Child safeguarding is the responsibility of organisations to ensure that their staff, operations, and programmes cause no harm to children with whom they come into contact and to take proactive measures to understand and affirm child rights.

The purpose of child safeguarding is to prevent exposure of children to the risk of harm and abuse, and that any concerns that children, the service provider, communities, or caregivers' have regarding children's safety within the communities in which they work or live are reported to the appropriate authorities and managed as a priority.

Abuse

The Investigation Team used the definition utilised by The Authority for child abuse together with the Children's Act to guide its interpretation of sexual and physical abuse. The Authority defines abuse as "physical, sexual or emotional maltreatment of a child under the age of eighteen which can result in harm, the potential to cause harm or the threat of harm." 'Harm' is defined as including physical, sexual or mental abuse under section 50 (14) of the Children's Act.

Child Sexual Abuse

Child Sexual Abuse (CSA) is an umbrella term encompassing many acts which can range from sexual penetration of a child, to sexual grooming and sexual touching. Part V-VI of the Children's Act outlines abuse of children through prostitution as well as the sexual offences against a child which are punishable by law. We can further understand child sexual abuse as, any activity between a child before the legal age of consent (18 years) and an older, more powerful adult, or substantially older child, in which the child is used for sexual or erotic purpose. (Break the Silence, 2017)[14]

Physical Abuse

The Authority [15] defined Physical abuse as including the punching, beating, kicking, biting, shaking, throwing, stabbing, choking, hitting (with a hand, stick, strap, or other object), burning, or other forms of harm to a child, that is inflicted by a person, whether an adult or older child, causing non-accidental physical injury, ranging from minor bruises to severe fractures or death.

Site Visits

During this investigation the Team conducted at twenty-one (21) site visits to Community Residences and Child Support Centres to determine the current state of premises and the health and safety of such residences.

The site visits assisted the Investigation Team in ascertaining the actual functioning and organisation of the community residences and centres and provided a comparative analysis to the formal documentation which was requested by the Team.

The selection criteria for choosing the homes and centres were purposeful and sought to balance the following;

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[14] Break The Silence Teacher Toolkit: Raising Awareness About Gender, Child Sexual Abuse And Implications For HIV In Trinidad And Tobago, 2017, https://sta.uwi.edu/igds/breakthesilence/documents/BTS_Toolkit_complete_AS13JUNE2017.pdf

[15] https://ttchildren.org/what-is-child-abuse/physical-abuse

- Community residences from each geographical location within Trinidad and all homes and centres within Tobago
- Community residences located within rural and urban areas
- Community residences which featured prominently in the media
- Community residences which had a high incidence of critical incident reports regarding absconding as well as abuse
- Community residences and Child Support centres which had been identified in the Team's mandate

Twenty-Three (23) residential care institutions were selected using the set criteria which were further ranked by low, medium or high priority.

The Investigation Team desired to have a sample size regarding site selection which would provide diversity within the selection. The final choice of which homes were selected was made by the Investigation Team and were made in light of the limitations which have been later in this section.

The design of the site visit form drew on the laws of Trinidad and Tobago, the OSH Act, the policies of The Authority and international standards regarding the rights of the child and safeguarding of children and health and safety.

The form was designed to elicit the following information:

- The State of the premises
- Information from and knowledge of the key actors within the community residence regarding laws, processes, procedures, policies and provision of care to the residents
- Identification of persons (both staff and residents) for the interview stage

The site visits further permitted the Investigation team to meet with senior management & staff and to observe the children in their settings. The initial site visits allowed the Investigation Team to collect information on the personalities, professionals, and culture of care within these spaces. In some instances, multiple site visits were conducted on one site to ensure accuracy of information and for further observations.

The site visits formed the basis of the next step in the Investigation Team's approach which were semi structured interviews which allowed for the exploration of the interviewees' subjective interpretation of the laws, policies and roles they play within the context of safeguarding children, as well as understanding any ambiguities, complexities, contradictions and processes which would assist the Investigation Team in fulfilling their mandate.

Interviews

The Investigation Team recognised that different techniques and considerations would be required for the interviewing of children and adults, and as a result, two interview teams were created:

i. The Adult Interview Investigation Team

ii. The Child Interview Investigation Team

The Adult Interview Investigation Team

All members of the Investigation Team were involved in interviewing adults, which included:

- The Authority's staff and Board Members
- Staff of the children's homes and rehabilitation centres
- Other adult persons who wished to be interviewed by the Investigation Team

Interviews were done in person or online with no less than two Investigation Team members present for the interview.

Based on findings from document reviews and the site visits, the Investigation Team created a list of key persons deemed as important or of interest to the investigation and follow up interviews were scheduled. The follow-up interviews were usually with persons directly linked to a critical incident (absconding, accidents or reports of physical and sexual abuse of a child) and /or a person in senior management either at the homes and centres or at The Authority.

All interviews were documented, and, in some cases, the ones done virtually were audio-recorded and transcribed, and field notes and transcripts were thematically coded and analysed.

Interviews of Children

A main focus of the investigation was to centre the children's experiences and voice. It was imperative that children not only give their account and lived experience from being placed in residential care institutions of being in the homes but should participate in the creation of the recommendations in this investigation and report.

A special sub-committee was established to work with children or non-Sui Juris (minors) in the care of these community residences and child support centres. This children's interview Investigation Team comprised psycho-social care and medical professionals who followed a code of ethics which the Investigation Team created. Interviews were documented and were thematically coded and analysed.

Investigation Guidelines and Ethics

The Investigation Team developed a laborious ethical practice that had many layers of scrutiny. A number of ethical considerations were carefully managed and measures were put in place to ensure the safety of research participants and researchers. These included but were not limited to:

- ensuring that interviewers had a practice of do no harm;
- having two researchers or more present for all interviews;
- Having an observer present at interviews with the residents
- Ensuring a disclosure protocol was in place should any concerns arise during interviews.
- Informed consent was collected from all participants and agencies where required.

(Appendix 6: General Ethics Guideline)

Interviewee Selection

Convenience sampling was used in interviewee selection, as there were very specific persons who were named and highlighted as persons who were important to the Investigation.

This method allowed for samples to be selected from the population only because they were available and specific to the investigation. In the selection of staff members of both the Authority and the Community Residences, individuals from a range of professional backgrounds, at different grades, and with varying lengths of service were chosen. This allowed the Investigation Team to document information, gather the Statements of a cross-section of staff and to appreciate the multidisciplinary roles involved in different aspects of safeguarding practice.

Overall, Forty-Six (46) interviews were conducted by the Investigation Team as follows:

- 17 residents/ children
- 4 former residents
- 5 staff members at community residences
- 12 members of staff of The Authority
- the Board of The Authority
- 7 persons who expressed interest in providing information to the Investigation Team

(Appendix 7: Interview, Meetings, and Written Submissions)

Analysis

A sub-committee, namely the Analysis Investigation Team, was established to analyse the findings from the overall data including the review of documents, site visits and interviews. The Analysis Investigation Team established a coding model that would facilitate identifying, analysing, and interpreting trends or patterns in complex evidence collected. The analysis of the source, its information, and the evidence that was drawn from it, was collated and used in the formulation of the Investigation Team's conclusions and recommendations. This process was repeated numerous times throughout the investigation as new information was presented.

The final findings, recommendations and conclusions were then reviewed by the entire Investigation team.

Limitations

There were a number of limitations to the investigation. Firstly, the Covid-19 pandemic posed several challenges. During the course of the investigation, some residences were subject to quarantine orders and, as such limited the Investigation Team's access to the premises and its residents, resulting in delays to the Investigation Team's schedule. When the Investigation Team could attend these institutions, the number of persons having access to the homes and centres at any given time was limited to two or three members of the Investigation Team.

Secondly, the sample criteria and access to children and staff restrictions meant the sample was not representative of the wider population across the residents (children) and with a small sample, our investigation findings are not generalisable. The Investigation Team was often unable to locate residents as some residents had aged out and were no longer in the care of the community residence.

The time allotted by State was short and the Investigation Team had limited authority and power to summon persons to participate in the process; the Investigation Team was a coram non judice. Given the short time, and the inability to build relationships with children, it is also likely, that this could have acted as a barrier to disclosing physical or sexual abuse and that children may not have felt able to openly discuss any issues or raise concerns with the Investigation Team.

As a result of the specific population (children currently in resident care) that this investigation focused on, this report is unable to provide an analysis, critiques, and recommendations of the systems and practices for responding to non-residential child abuse reports.

Further, the Investigation Team experienced some considerable delay in getting resources to conduct its affairs and required additional support for the preparation of this report.

Data Management

The Microsoft Enterprise Suite was utilised to support the coordination and delivery of this investigation in the following areas:

- SharePoint: for Secured Cloud Storage with Robust Access Management and User Authentication.
- Microsoft Forms: for Centralised Digital Feedback and Optimised Monitoring.
- Microsoft Investigation Teams: for streamlined communication and meetings.

The secured Microsoft environment functioned with robust security measures to ensure that only authorised persons had access to the information related to this investigation. The Suite's threat detection and anti-malware functions were essential for ensuring the safety of confidential information related to children in particular.

Given that the Investigation Team operated from various locations, authorised persons could store all the files related to the investigation in the Microsoft cloud and access information on any device from any location with an internet connection.

All data collected in the investigation will be digitally transferred to the Office of the Prime Minister upon completion. Hard copies of all the data collected during the investigation will also be handed over to the Office of the Prime Minister.

Chapter 4 - Absconding at the Child Rehabilitation Centres and Children's Homes

Introduction

Absconding is the unauthorised departure from a facility to which children have been assigned by the judiciary or their legal parents/guardians. The period of absence can be measured in minutes to forever. Attorney at Law Mr Baig indicated that one of his clients said they absconded from St Michaels as he was hungry and there was nothing to eat" as opposed to cases like the resident who absconded in February from Valsayn and who still has not be found.

The NiNa report on girls, states that the children who abscond are at a higher risk due to vulnerability. It also states that the risk is exacerbated by the presence of a high crime rate and the human trafficking rings that exist in this country. This is supported by the recent unfortunate events involving five residents absconding from Valsayn and going to a high crime area where two residents were fatally shot.

Security is a lowering of threats that are identified by risk assessments in order to maintain sustainable operations and avoid losses. There are a lot of common factors between security and safety and there are a lot of mutually exclusive issues in both areas as well for example safety may require a facility to have unrestricted use of all exits and entrances while security measures may mandate the need to have strict control of movement to prevent egress.

Security provision is comprised of three areas; the environmental element, the procedural element and the culture of the psychological element. Failure in any one or in a combination of any of these factors allows a child to abscond from a facility.

Situational Analysis of Absconding at Valsayn Child Support Centre, St Jude's and the Youth Transformation and Rehabilitation Centre

Children can be placed in the Child Support Centres by the judiciary in response to many factors including the parents and guardians' inability to cope with particular types of behaviours from the child. These children, formerly designated, 'Children beyond control' are now termed Child In Need Of Supervision (CHiNS).

Prior to 2018 (Interview with Ms. Celestine former DDLRS) CHiNS would have been placed at St Michael's Boys or St Jude's Girls. Both homes at that point were mandated to provide supervision for children beyond control/CHiNS. St Jude's has since been changed from a rehabilitation home and St Michael's has been closed.

Both of the aforementioned homes were plagued with allegations and instances of impropriety in the operations and staff at the institutions. The placement of the boys has since been relegated to the Child Support Centres for ultimate placement within the Community Residences and the Girls have been placed at the Child Support Centre, but often end up dependent on space in St Jude's.

The Child Support Centres and St Jude's have had residents moved from these facilities to the Youth Training and Rehabilitation Centres (male and female) when the children commit criminal acts at the Child Support Centres or children's homes.

Our investigation revealed that the closure of St Michaels home has had a major impact on the Community residences and Child Support Centres. It has resulted in

1. that commingling of children in need of care and protection and children in need of supervision
2. An increase in the risk profile for the children's homes and child support centres
3. Staff and residents being fearful for their safety and security
4. Placement of CHiNS in facilities not designed for the placement of children with a higher security risk profile

The placement of CHiNS into the same environment as the children who have been placed for 'care and protection' creates a challenging and tumultuous environment. The challenges include gender issues, gang recruitment, criminal influencing, violent internal incidents, violent external threats and staff action in protest of increased risks.

Further the influence of these children on those with a lower risk profile for antisocial behaviours and absconding was noted by all Investigation Team Leads (see interviews with Investigation Team Lead Valsayn, Tacarigua and South) and the clinicians nurse attached to St Jude's who were interviewed.

An element that cannot be discounted is the threat to the staff and the effect that this has had on the staff at the Child Support Centres and the Community Residences. Incidents involving threats by residents to staff members were outlined by DDLRS and Staff members at Valsayn. This caused a fear among the staff who then allowed security staff to deal with minor to major infractions as they became afraid for their lives. The effect of which was that untrained personnel in the restraint of children were permitted to interact on a physical basis with the residents who have noted that the security personnel use this excuse of restraint to abuse them. (See interviews with resident's form Valsayn, and St Jude's.

The differences in the facilities are shown in the table below.

ST JUDE'S	VALSAYN	YTRC M/F
Placement by The Authority, or by the Board's recommendation. (interview with Ms. Celstine, manager of St Jude's and deputy manager St Jude's)	Placement by The Authority or Emergency response unit. (Investigation Team Lead, Ms. Lewis DDLRS, Ms. Celestine)	Placed by Court by virtue of warrant. (site visit and briefing by the management of YTRC)
The staff is not trained to handle rehabilitation in girls in policy or response methods in their manuals, The staff are not trained to deal with the extreme behaviours. There are clinicians assigned. (site visit to St Jude's and interviews with manager and nurse assigned to the facility). Records are one sided and subjective towards the staff version of incidents.	The threats by a former resident has caused the staff to adopt hands off approach towards the residents and using the security guards for control and at time discipline. Records are one sided and subjective towards the staff version of incidents.	The staff are trained to deal with the children with a high risk profile. The strict control on use of force and designated duties is maintained. The children are allowed to have access to clinicians regularly and they are subjected to oversight from Prison Command, The Authority and the courts.

ST JUDE'S	VALSAYN	YTRC M/F
Education and other basic rights are subjected to the management's favour. There were times in the past when it was withheld based on the resident's assessment by the staff. (interview with former residents if the facility) Recordings of the used decisions not included in many reports or logs.	Education and other basic rights are subjected to the management's favour. There were times in the past when it was withheld based on the resident's assessment by the staff. (interview with former residents if the facility) Recordings of the used decisions not included in many reports or logs.	Education and other basic rights such as medical strictly enforced. The recording of interaction between residents and staff on a shift basis allows for examination of any shortcoming in the rights of the child.
Physical abuse, sexual abuse and mental abuse have been carried out at the facility. (Interview with former residents, interview with the manager and deputy manager who admitted to such abuse as 'themed beatings' and the use of derogatory language by staff to the residents and sexual involvement of the security personnel with under aged residents.)	Physical abuse, and mental abuse have been carried out at the facility. Removal of the right of the child to recreate also occurs here. (interviews with current residents, a former care giver, the Investigation Team lead who admitted that when they are at high alert the boys are limited to the living room to live and sleep)	Any incident of contact with residents is investigated with a thorough system. Multiple layers of security compartmentalizes the residents so that any abuse is easily tracked, the surveillance in the high risk dormitories is thorough. The regular visits by external medical practitioners prevents abuses that are not reported from going undetected. Education of vocational and academic natures is available.

(Appendix 8: Abuse Findings)

Gaps in the Security Systems

In order for a child to abscond there must b a failure in the security system or systems. The gaps will be examined in the three categories of the security area and is displayed in the table below.

FACILITY	ENVIRONMENTAL	PROCEDURAL	PSYCHOLOGICAL	FINDINGS	RECOMMENDATIONS
CRC (Valsayn)	Facility too small for the amount of children. The perimeter is easily breached. The risk assessment that the security manager claims was carried out, was carried out by using a resident that did not present with the same risk profile as the CHiNS . The surveillance systems are adequate for the facility.	Boys were not watched in accordance with the Absconding watch guidelines. Near miss and incident register not kept. Lessons learnt sessions not held. Drills not carried out. The surveillance was useless as the guards had no access to the feed after hours and on weekends. The guard do not have assigned posts that	The security measures as laid out in the SOP manual is not followed in accordance with the Investigation Team lead interview where he said there is no manual to follow. The security head is more concerned with covering mistakes than addressing them and improving the system. (Interview with Mr. Thomas who	The mitigation method measures are outdated. There will be continued incidents of breaches in security. unless a near miss register is started and studied. Lessons learnt must also be tabled with staff.	Curriculum development must occur based on the gaps an the guards and staff trained and certified in these areas. Unity of command must be accomplished with one line of authority instead of multiple lines. The camera feed must be available 24/7 and be used. On established task for that post must

FACILITY	ENVIRONMENTAL	PROCEDURAL	PSYCHOLOGICAL	FINDINGS	RECOMMENDATIONS
	The burglar proof was oversized and was not reduced even when this was discovered to be the egress method for other absconding cases (the attempted absconding 28th March 2 days prior to the five boys)	they maintain until relief. The guards are not held accountable under the discipline system of the facility, but rather by their company. Worst action against the guard is removal from the post. The guards do not report to the facility personnel but back to their private companies. The guards put on post may be new and untrained.(The guard watching the five boys was new in accordance with the Statement of the Investigation Team lead.) The guards restrain the children even though they do not have training in restraining minors.	indicated that there were a number of processes used including table tops, emergency drills and near miss registers which records have since proven to be false. The external security guards do not look at the Investigation Team lead as their superior and hence do not report to him. The Investigation Team lead must wait for their reports to go through their companies and then The Authority then to him. This dissuades the Investigation Team lead from attempting to take charge and solve issues.		be a perimeter guard. Criminal charges are required against officer who abuses the children. The simple moving from post to post does not solve the problem nor provide a sound example of the consequences of such an act.
CR St Jude's	The perimeter is large and weakened beyond use in some places. The lighting requires revisiting. The dilapidation of the structural integrity of the buildings allow for areas to be used to egress. The area surrounding the facility is a high risk high crime area. The surrounding area is on that is easy to get	The procedures to receive packages for the residents and secure them have gaps that allows misappropriation of property. There is a framework of selling snacks that is unaudited and a possible avenue for fraud. There are no cameras on the facility. The deputy Manager Mr. Sookdeo was a staff member at St Michaels and he was incidentally the one to order the use of	The Residents State they feel like they are in prison. One resident who was exposed to St Judes and YTRC indicated that the YTRC was better living conditions. There are psychological misgiving about the security by the girls as evidenced by most of the interviews with residents or former residents. All except one	There is sufficient evidence at this home to cause a police investigation. The Deputy Manager is using his PSC status to hide behind union regulation. He runs an unauthorised sale of snacks to the residents with no way to account for the spending of the funds nor guarantee the items are of	The security should be assigned after a training course and recertified every two years. Criminal sanctions should be attached to any staff members ordering or tolerating the use of excessive force or illegal implements.

FACILITY	ENVIRONMENTAL	PROCEDURAL	PSYCHOLOGICAL	FINDINGS	RECOMMENDATIONS
	transport to anywhere in Trinidad.	handcuffs on a resident. He was inconsistent with his Statements on procedures at the facility when interviewed.	resident have claimed that MS Meyers and her daughter and son were involved in sexual and physical abuse of the residents and that 'no one can touch her'.	the same value as the expended currency. Themed beatings has also been laid on his doorstep by former residents.	
YTRC Male and female	Layers of security. Isolated facility with killing grounds and unrestricted views on all sides of the compound. The use of wire wall in the definition and hardening of the perimeter is ideal as it allows clear view and at the same time does not afford purchase by the resident who is attempting to circumvent it.	Thorough integrated system of administration and strategic operational and tactical levels of records and auditing. Regulations and laws support the efficient response to absconding. Ratio of the supervision never falls below the recommended limit.	The staff and any supporting staff have been inculcated by basic training and intense theoretical studies on rights of prisoners to include children and detainees such as refugees.(visit to RYTC by the military group researching methods for operationalizing of CHiNS in St Michaels.	Absconding is rare and controllable. The recovery rate of absconders is high as there is an active search utilizing the history and intelligence gathered on the residents.	YTRC should formulate curriculum based on their successes that staff and security guards assigned to any children's home must take and pass prior to being placed on any such post.
Margret Kistow	there is no surveillance system. There are no security guards. The perimeter is easily breached. There is a lack of supervision at the ratio approved by cat. The home is located in a high crime area.	There is an absence of procedure. There are no logs to record movement a new fixed movement control plan. drills are not carried out and there is no risk register. None of the staff are trained in safety and security.	There is no sense of security among the staff except when it concerns the questioning home staff and children. There is an aqseptence of regular absconding. It was casually mentioned by the owner of the home that the residents absconder to buy marijuana .	The home has no deterrence two absconding. It is possibly motivated by the by the conditions of the home.	It is recommended that this facilaty be closed with immediate effect. there has been in number of near misses doctrine dictates portends catastrophic event that will have high losses.
Casade Corazon	16 cameras and an electronic monitoring systems for the doors after hours. The doors	There is established procedures for the control of movement find the recording of potions who visit the	There is an acceptance of security procedures buy the staff who	The security is adequate at this home.	This is the level at which security at cr's should be pitched. It can be augmented buy a

FACILITY	ENVIRONMENTAL	PROCEDURAL	PSYCHOLOGICAL	FINDINGS	RECOMMENDATIONS
	are solid an dteh locks modern. The fence has breeches in its integrity and allows easy access and egress onto the compound.	home. Drills are carried out and important incidents are logged which facilitates investigations	follows the example of the chairman of the board.	The infrequent absconding is resultant from this tight security.	24/7 security guard patrolling the perimeter hello.

Valsayn Detailed Assessment

Security

1. The Authority's security works daylight and the external security provider works during the night. The risk is understood to be higher during the night and hence the most competent person should be on duty.
2. The surveillance is not monitored 24/7 in a way that allows response to threats detected. (There was no one monitoring the surveillance during the absconding of the boys from Valsayn on in March.)
3. There was no external response until the superior authorities were notified. (The Investigation Team Lead Stated that the cameras are monitored off site)
4. There is no section of the visitors' log where a National Picture Identification can be logged.
5. Many times the visitor is not logged offsite but only onsite.
6. There was no standardised response to distraction, particularly the distraction that the boys in the home carried out in order for the other boys to escape. If there were, One guard should have responded whilst the other two guards continued monitoring duties at the surveillance room and the outside perimeter. It is apparent that the three officers that are claimed to be present at all times were not at that strength.
7. There is a practice to allow the visitor to sign in the premises. This allows fraudulent representation of the visitor's ID to be perpetrated. It therefore increases the risk to the facility, staff and children.
8. The lack of surveillance at night and the offsite monitoring did not prevent the absconding. The records are kept only for investigative purposes and are not used to determine trends and patterns and lessons learnt. The Investigation Team lead is reported as forwarding all incidents of abuse to The Authority. It means that there is no initial investigation.

Safety

1. No drills conducted in accordance with the Investigation Team Lead's Statement.
2. Valsayn, South and Tacarigua Investigation Team leads have no idea that in accordance with the SOPs they are responsible for the emergency plans. They have all said that they are awaiting the The Authority to give them a plan.
3. The manual mandates that the Investigation Team Lead has knowledge of the emergency plans and carry out drills at a regular period, but the Investigation Team Lead at Valsayn has

reported he did not know the level of knowledge of the staff in emergencies. Further, he Stated that he is not aware of any drills conducted since he has been there. The South Child Support Centre , Tacarigua Child Support Centre Investigation Team Lead and the Valsayn Investigation Team lead both believe that the person responsible for drills is the The Authority HSSE Manager.

Findings

A sense of compromise was detected in the standards of security at the Monitoring and Evaluating unit of the The Authority. This compromise was found to be present in the executive of the authority as well as the staff at the Child Support Centres.

In addition to major security failures, the Investigation Team through its interviews has found that the following are some reasons why residents abscond from these facilities:

1. The discipline meted out to the residents is subjective and, in some cases, unorthodox.
2. The lack of structured and educational activities has been complained about by residents who have openly stated that they miss their classes while at these facilities and they want to get an education.
3. Complaints made by residents are not being taken seriously by those in authority
4. The residents miss their families and in some instances the stay longer than first anticipated at the facilities.

It was further determined that the security plan for recovery of a child who absconds is passive by the Authority which relies on the TTPS and other entities to bring information on the absent child or the child or the child's family members to return the child to the care of The Authority (see interview with DDLRS, Ms. Celestine, and the Investigation Team lead Valsayn.)

Recommendations

Ultimately Child Support Centres and Community residences require greater monitoring and oversight of their operations. The following recommendations for the overall improvement of the Security profiles at the Child Support Centres and the Community Residences have been made: -

1. Recommendations Placement must be accompanied by a risk profile on the child. Currently little to no history on the child and the treatment plans are provided.
2. Training must be developed in conjunction with the Prison Service utilizing the lessons learnt from the Youth Transformation and Rehabilitation Centres. The main difference is the level of supervision and the enforcement of regulations and standards at the Child Support Centres and the Youth Transformation and Rehabilitation centre. A resident who has experienced both systems has stated that the Youth Transformation and Rehabilitation centres is the better organisation with the exception of the confining element. This speaks volumes as to the effectiveness of the Child Support centres and the Community Residences the strict enforcement by the management and staff at the YTRC can be copied at the Child Support centres and Community Residences.

3. The measures that exist at the various homes presently comply with a variety of directions and philosophies. One such example is in rainbow rescue which eschews security as they want to have a 'family environment'. This is negligent and should there be a case of home invasion or any other situation that security is required, the management and board will be hard pressed to explain absence of such resources in the face of the responsibility to safeguard and protect the residents. There is a need to standardise security measures at the homes under The Authority. The measures that are required must adhere to a risk assessment that is carried out by an independent body that is separate from The Authority as the Authority is responsible for placements of the children and the operations of the CRCs.
4. Risk registers for near misses and incidents must be maintained and studied for lessons learnt to be used in improving the system and preventing malpractices.
5. Licenses that are not issued to Community Residences based on the lack of a fire or public health approval, should not function under any circumstances.
6. An active absconding recovery and emergency Investigation Team should be formulated with the ability to access the resident's history and use it as a backdrop to predict the movements and increase the probability of recovery.
7. The security force is a hybrid of external providers and internal personnel. The best practice based on the specialized training required in this form of security provision is for the entire force to be internal. Should this not be implemented or if there is more than three months in the implementation of this measure, the contracts with the security providers must be revised to ensure the guards report to the Investigation Team lead, the security guards at the location adhere to the requirements for reporting to the line of command at the facility and the discipline of the guards who contravene the regulations at the facility is under the The Authority and not the private company.
8. The force that should be employed at the homes should be a mature force that is over 40 years in age.
9. The use of reserves from the Defence Force as in the Transition Home Model should be considered as the standard of processing ability and suasion that is available in that pool of human resources will almost instantaneously halt absconding or reduce the level to that of YTRC.
10. It its strongly recommended that a separate facility to treat with CHiNS be provided. Such facility must have more intense supervision and auditing systems.

Chronology of Events Leading to the Absconding of the five boys from the Valsayn Child Support Centre

The absconding of the five boys from Valsayn CRC on the 20th March 2021 resulted in losses including loss of life. Two of the five boys who absconded were gunned down in Laventille. The chronological events that led to this occurrence can be recited from numerous reports concerning the day itself.

This instantaneous 'snap shot' of abscondings appeared to be the general method applied by The Authority when reporting on absconding and attempts to abscond. The Authority's reporting included a time line of only two weeks preceding the event. This approach must be ended as it is a shallow approach that does not deal with the root cause of the incident and hence corrective action cannot be taken to prevent similar incidents from occurring in the future.

The Investigation Team was called upon to provide a chronology of events which led up to the absconding of the five boys on March 20th 2021. The findings of the Investigation Team revealed that the Valsayn Centre has had numerous absconding events and attempts to abscond. The section on absconding has already defined the act and the numerous failures in the security systems that allowed these incidents to not only take place, but to be repeated.

Event of March 20th 2021

The absconding which took place on 20th March 2021 resulted from a chain of occurrences in an environment conducive to absconding. The chain of events must be tracked to the closing of St Michaels. The Investigation Team was told by the Investigation Team lead, the former Deputy Director – Legal and Regulatory Services (DDLRS) and the present DDLRS that the closure of this institution in 2018 removed approximately 70 spaces from the child care environment. Further, it stated that these spaces were specialized spaces that provided treatment and care for CHiNS and served the secondary function of ensuring there was no mixing between Care and Protection children and CHiNS who typically had a higher risk profile .

The CHiNS at that time and presently have no place to be treated and hence they are placed in the Child Support Centres. The other clients of the Child Support Centres still exist and are still placed there alongside CHiNS. The placement of CHiNS into the same environment as the care and protection children introduces a tumultuous environment. The challenges include, gender issues, gang recruitment, criminal influencing, violent internal incidents, violent external threats and staff action in protest of increased risks.

The acknowledgement of the situation and the apprehension of the staff came in the form of a red notice letter to the Director and Board of The Authority indicating that the staff were threatened by a particular resident and felt fearful for their lives.

The security guards were mandated by policy (FAHSSE Security SOP) to assist the staff when called upon to do so - to control the situation at the centre. It must be noted that the security guards comprise of both external security providers and internal personnel of The Authority. It is claimed that the external providers received similar training to that of the internal security staff of The Authority and the management of The Authority including the Head of Safety and Security.

This was found to be erroneous and a substantial departure from the reality. The security guards from the external providers were in fact not trained to deal with children and some of them were noted to be abusing the residents under the guise of restraining them. Further from studying the critical incidents it was noted that the staff actually permitted the external security force to discipline the children and in some instances, it was also found that some guards were verbally degrading the residents based on their sexual orientation in contravention of The Authority's guide regarding the use of external security providers.

An environment of abuse and uncomfortable interactions with adults pause formed and no intervention to correct it was taken except in sporadic incidents. it was also found that some nurses were also culpable of abuse to the residents by performing such acts as bashing the residents' heads against solid objects.

Such an environment was exacerbated by the shortage of caregivers which resulted in poor supervision of the facility and the reduced likelihood that the harmful interactions would be detected reported and halted. The shortage of the care givers on the day itself resulted in the five boys being left unsupervised as the guard who was asked to keep an eye on them was on his first day and was not trained in the intense supervision required for residents with a high-risk profile. One of the residents who absconded on that day described the above conditions and this was corroborated by Statements from other residents as well as the analysis of critical incident reports.

The second area that must be examined to understand the root cause of this incident and other similar incidents is the history of the five boys who absconded. Upon examination of those histories the risk of absconding was noted to be high in the case of four of the five boys and in the observed interactions of these boys, the intent to abscond was documented in a number of critical incidents. The availability of these histories and critical incidents indicating intent and capacity should have been noticed by the case workers, if the management case conferences were taking place. Further in the examination of the events, the residents were only awaiting opportunity to abscond. The fact that the residents were in the care of the State and specifically the Child Support Centre makes the failure to analyse the files of the boys in a coordinated manner, negligence which resulted in the death of two of the residents.

The complicity of the external persons in the assistance of the boys to remain outside the care of the State, namely the lady who supplied them with food and a place to stay as well as the other adults who interacted with the boys at that location, must also be noted. The recommendation is for a communication campaign the be initiated by The Authority to the Public explaining the known risks to the residents who leave the care of their legal guardians.

The table below represents the chronology of the events leading to the boys absconding from Valsayn centre on the 20th March 2021.

DTG	Fact	Support	Finding
1	St Michaels Boys Home Closed Down	Site visits to CSCs and Community Residences and interviews with Investigation Team Leads	The placing of CHiNS into the CRs and the resultant mixing of Children for Care and Protection and CHiNS has resulted in many challenges and confrontations. It also introduced risk to the residents and staff at the CSCs or CRs.

DTG	Fact	Support	Finding
2	Valsayn CSC established at Ashland Drive for reception and assessment of care and protection cases. Further established for a period of twelve weeks maximum. When the five residents absconded on the 20th March 2021, the CSC had 16 residents.	Jameer Barcoo's IA Final Report into the Operations of The Authority's Child Support Centers with Special Emphasis On Valsayn. Section 5, ss5.3.	Valsayn CSC was not designed to : 1. Hold children who are determined to abscond. 2. To hold more than 11 residents. 3. To keep the resident more than 12 weeks. 4. Effectively supervise the residents with a ratio of more than 7:1
041200Q Dec20	Ricardo Thompson enters CSC when ordered by the court in response to an application from his mother. He did not want to go and was promised that he would be released into his mother's care after his bout with COVID in December 20. He had major issues with the residents opinion of his alternate gender orientation at the CSC. He was slapped by a resident for his beliefs.	CSC Report in Ricardo Thompson December 2020 – July 2021.	
061200Q Jan21	Stephan Nicholas entered the CSC as a consequence of absconding from his home. He had a marijuana drug habit and he had gang affiliations. He was observed showing signs that he did not want to be in the CSC by pulling his hair out during his first week in quarantine. His gang affiliation and his grooming by the gang showed itself with the 3 fights that he was took part in whilst at the centre and he was attacked by another unnamed resident in an incident related to his gang activities. It is claimed by SO Ramnath that Stephen Antoine another resident with an obvious violent predisposition from his life experiences tackled Mr Nicholas purposefully resulting in a fractured wrist. He stole a lock to allow a resident from the bottom floor to attack a resident on the top floor indicating that he still had organized criminal tendencies. The progress report done on the 4th March 2021 could not have been thorough as it did not detect his intention to abscond. His motivation to use drugs was not treated with in accordance with the courts as there was no initiation of contact by the drug treatment professionals whilst the resident was at the CSC.	Progress report by Dana Noel on the 4th March 2021. Critical Incident report by SO Ramnath dd 28th Jan, 2021.	
011200Q Jul20	Stephen Antoine entered the center on 1st July 2020 and was in the centres care since. He had a violent mother who beat him and a stepfather who allegations were made concerning the abuse of his younger brother. He is defiant to authority and has been described as not listening to instructions adults gave him. His upbringing has led him to be highly sexual in his activities and several claims have been made about him with female CSC staff. It can be easily understood that he would attempt to escape the structured environment of the CSC. Stephen Antoine claimed that there were rumours about his sexual orientation. He claimed that he was lifted and his head banged on the wall by a staff member	Progress Report on Stephen Antoine by TL RitCHiNS dd 6th July 2021. LMD Monitoring Form dd 23rd Sep 20	1. Stephen Antoine follows the violent method of solving issues as demonstrated by his mother. 2. He is defiant to authority 3. He has a highly sexual character. 4. He continues to display antisocial behaviour. 5. His motivation for leaving was mainly the structured environment of the CSC

DTG	Fact	Support	Finding
221200Q Jan21	Antonio Francois entered the CSC as a result of altercations, (mainly verbal) with his mother over his risky behaviour of hanging out with the 'wrong type' of persons and the use of marijuana. The first two caused him to arrive home at late hours and worried his mother. He was able to stop his use for a month in accordance with his mother and his behaviour improved. He demonstrated the desire to return home. He was described by Dr Bobb as not a candidate for long term inpatient care.	Psychiatric Evaluation: case # C- North – CH – 3072 – 2020 – 1 dated 22/1/21	
251200Q Jan21	Semion Daniel was admitted to the CSC due to his deteriorating behaviour in the community and at his home. The behaviour was being driven by his marijuana habit. He began to steal and he was engaging in sexual relationships. He was from an environment of freedom to pursue his desires with little resistance. The CSC would have been a very structured environment and hence both the drive to smoke marijuana and the desire to do his own thing would have acted as a motivation	Investigation Report – Simeon Daniel – C – South – CH – 2925 – 2020 – 1 (December 2020) by Cezane Wilson - Clement	
301925Q Jan21	Ravi Dwarika Absconds; Prior on the 23rd September 2020 he expressed his frustration with the lockdown and Stated that he wanted to go back to his family to Carolin Skerrit Weekes. Critical Incident Report did not specify the method the resident used to get out of the facility. Discussions between Ravi and JD (past resident with gang affiliations) were observed, where they were heard talking on social media about "going to buy bread" which is the street code for buying marijuana.	RMF – 23.09.20 – Carolyn Skerritt Weekes.	
Week ending 13th Mar21.	Residents were posting pictures of themselves and having unsupervised conversations on devices. All devices were taken away		
17UKQM Mar21 171700Q Mar21	NB was viewing a photo with guns on it and that page is believed to be the Instagram account of Joshua Douglas.The Investigation Team lead discovered that as Instagram accounts were created their messages could be read and even voice notes intercepted. The fact that conversations between RD and JD were monitored suggesting they were going to buy marijuana. (RD absconded in February and this is the first reports stating this, that the committee was given.It is claimed that the offer of aid in absconding was made by JD to NB. (NB was not a part of the five boys who absconded.)A search was carried out by the security Investigation Team. The concrete in which the burglar proofing was embedded was being chipped away. (The exact location was not given) 6. Further packed bags were found with "all of the residents'" clothing and makeshift weapons. (the exact residents were not named)	Critical Incident Preliminary Report Summary; re: CSC VALSAYN – Plan to abscond and Absconding on Saturday 20th March, 2021; dd 20th March 2021 fm M. Celestine to N Harvey Mitchelle.	
181925Q Mar21	Semion Daniel and RolandoJohn attempts to abscond:	CI dd 18th Mach 2021 by Pauline Gittens - Maloney	1. No Guard was assigned to perimeter duty.

DTG	Fact	Support	Finding
	1. SO Hillaire detected. 2. Suspicious noise from the boys alerted the SO on duty on the second floor. 3. Hillaire realised the boys were missing and raised and alarm. 4. Hillaire found the boys outside when he went to search and called them back. 5. SO Birchwood, Mcintyre and Hillare, along with one Care giver Gittens Maloney, and one Nurse Von Degannes on duty. 6. The ratio of residents to supervisory staff was 16 :1. 7. The recommended ratio 8. Review of the footage showed the boys escaping. 9. The bars on the window was loosened prior in the week. 10. Bags of clothes were already packed 7. This occurred 47 days after Ravi Dwarika absconded	CI Attempted Absconding filled out on a HSSE Investigation Form 1 by RitCHiNS . Jameer Barcoo's IA Final Report into the Operations of The Authority's Child Support Centers with Special Emphasis On Valsayn.	2. No guard was using the surveillance footage. 3. The either two guards did not respond to the alarm. Hillare detected their absence and Hillaire found them in the act of escaping. 4. There was no detection of the packed bags. 5. The caregivers were not supervising the boys in accordance with the SOPs for the installation, "no children shall be left unsupervised in the dormitories." 6. Lessons were not leant from the Ravi Dwarika incident. 7. Indicates that the Ravi Dwarika incident was not analysed and used as a case study. 5. The security infrastructure is not a usual thing that is checked, (bars loosened in the week earlier as Stated.
201147Q Mar21	Stephen Antoine, Stephan Nicholas, Ricardo Thompson Semion Daniel, and Antonio Francois absconded from Valsayn CSC. They were observed in the week ending 13th March 2021 using social media to look at guns and contact former resident Joshua Douglas. They breached the internal security by passing through the burglar proof of the room they were in, on the ground floor of the building. The used the kennels to gain access to the top of the western wall and passed over it. They were unsupervised at the time. The surveillance system was not being observed. Two care givers were on duty. Four guards were on duty. One nurse was on duty. An alert was raised when they were missed. DDLRS was informed by the Investigation Team Lead. The Director was informed on the same day in writing by the DDLRS.	Jameer Barcoo's IA Final Report into the Operations of The Authority's Child Support Centers with Special Emphasis On Valsayn. Critical Incident Reporting Form; dd 20th March 2021, re: Absconding; fm. Ayana Bailey Critical Incident Preliminary Report Summary; re: CSC VALSAYN – Plan to abscond and Absconding on Saturday 20th March, 2021; dd 20th March 2021 fm. M. Celestine to N Harvey Mitchelle. Interview with Ms Celestine (DDLRS). Interview with Mohammed Shabazz. Children's Act 12 0f 2012, Part II, Section 47, (2b).	The residents planned their escape. They qualified for extra observation in accordance with the the Safety Protocol Document referred to by Jameer Barcoo. The residents gave clear signs of their impending escape. The security guards were not deployed for the most efficient coverage. The burglar proofing was bot checked even though it was found to be the access for residents in the recent past. The boys who escaped were in the bedroom during the day contrary to the policy of the CSC in "Absconding Watch'. The security guard assigned to watch the boys was outside of the bedroom without a clear line of sight. The security guard was on his first day of duty at that location. No training was given to him on the SOPs.

DTG	Fact	Support	Finding
	The St Joseph Police station was informed, 9877 PC Benjamin, 21025 PC Hinds and another officer whose identity was lost in the copying of the source document.		Two caregivers to 16 residents was under the ratio recommended.
	The residents proceeded to an abandoned house in Picton, Laventille. The residents were harboured illegally by a woman in the area contrary to the Children' Act. The Director informed a "Community Leader" from Laventille Shabaz Mohammed. Shabazz indicated that he called around asking about the residents. One of the persons he called was "community leader", Bombay. It was Bombay's area (turf) in which the boys were hiding.		

Chapter 5 - Vulnerabilities and Risk of Child Sexual Abuse at Children's Homes and Child Support Centres

Introduction

Child Sexual Abuse (CSA) is an all-encompassing term to describe the many acts that constitute the issue. These acts can range from sexual penetration of a child, to sexual grooming and sexual touching. Part V-VI of the Children's Act outlines abuse of children including prostitution as well as the sexual offences against a child which are punishable by law. We can further understand child sexual abuse as any activity between a child, before the legal age of consent (18 years) and an older, more powerful adult, or substantially older child, in which the child is used for the sexual or erotic purpose (Break the Silence, 2017).

The act of grooming is usually harder to detect and therefore goes unnoticed in most situations. Grooming is a process in which a person prepares a child (including key adults with charge of care and protection of the child) older children and the environment for abuse. The event can occur anywhere and children in care of the State are particularly vulnerable to grooming.

An effective tool for disarming grooming occurs through ensuring environmental safety as well as educating the potential victims on sexual health and rights. This education (Health and Family Life Education - HFLE) provides children with information regarding their body, their rights and a safe space to communicate their confusions about sexual behaviours.

Sexual abuse also includes transactional sex. This can be defined as, adults with the resources that are attractive to children exchanging those resources for sexual favours. This is prominent in the case of children in economic distress.

Situation

Children continue to enter the care system of the State via the Courts and through the intervention of Children's Authority because they have experienced or are at risk of experiencing significant harm, including abuse within their family. Child survivors of sexual abuse include those who have been traumatized by intra familial rape or incest. These children's experiences are usually generated by problems rooted in poverty, poor housing and general lethargy to reports on ongoing cases of incest or intra-familial rape. The fact that this type of abuse also occurs in the State system is inexcusable in the face of the responsibility of the State to provide a safe and secure environment.

This investigation considered Section 20 of the Sexual Offences Act, known as the Romeo clause, when making recommendation. Trinidad and Tobago's statutory rape law is violated when a perpetrator has sexual intercourse with a minor. However, if two residents engage in intercourse whereby one individual believes that the other is 18 years or older and one of the parties is no more than 3 years older, this is not classified as statutory rape. Although no charges will be laid, it is necessary that the State provides relevant intervention.

The investigation has identified inaction regarding reported instances of sexual abuse. The laws (Sexual Offences Act, Section 31) of Trinidad and Tobago mandates that anyone with legal responsibility of care and protection to a child must report any suspicion of child abuse or child sexual abuse to a police office. The Investigation Team detected some instances when persons did not adhere to the law. The Investigation Team also found some cases that failed to identify the relationship between the perpetrator and the victims, these situations inferred inadequate supervision, poor record keeping and lack of auditing. This failure resulted in the ongoing perpetration of these heinous acts.

Effective detection and investigation of these incidents is required specific intervention strategies which includes the use of multiple communication aids and access to varied professionals are needed. Disclosure of abuse may be additionally difficult for some children and it is the responsibility of the system to facilitate alternative mechanisms and safe spaces that encourage open discourse.

Child sexual abuse investigations must include a forensic assessment and detailed scrutiny of evidence. It is also crucial that police officers are trained to consider the wider picture and to engage in comprehensive risk assessment. Additionally, it is essential that persons with legal responsibility be held accountable and culpable for reporting all information concerning child abuse.

Furthermore, investigations into incidents of sexual abuse, physical abuse or any other crime against a child must include a safe space for the victim and child witnesses to prevent prejudice and influence on the victim or witness.

Both boys and girls experience sexual abuse. The practice of the silencing children who experience sexual abuse is gendered. Girls' silence is a result of narratives claiming that her body is to blamed along with a lack of morality, low power relations etc. Boys are silenced due to ideas and perceptions of having lost power or seen as weak and the shame associated with same sex orientation. These social factors become barriers to disclosure.

Identification of Vulnerabilities and Risk of Child Sexual Abuse And Recommendations

The Investigation team reviewed critical incident reports and conducted interviews regarding child sexual abuse and the following able below outlines the findings of the Investigation Team as it pertains to systemic gaps and failures which provide opportunities for Child Sexual Abuse.

Serial	Homes	Findings	Recommendations
1	Margaret Kistow	There is a lapse in conducting the necessary background checks resulting in the employment of a person who has prior allegations of sexual abuse at the Margaret Kistow Home despite the Home having knowledge of the allegations. The current situation increases the probability of sexual abuse. The level of alarm is set at allegations of sexual abuse because the burden of proof is low. The Manager indicated that he invites boys who age out to live with him. Manager (Xerxes).	The Authority should immediately conduct necessary investigation and evaluation of all staff, especially Mr. Seales and PCOCs must be required for all employees on an annual basis. The Authority should suspend the Home's operations and conduct an investigation.

Serial	Homes	Findings	Recommendations
		Three boys currently reside with the Manager. According to the Manager, "nothing wrong with this. I doing this for years because they have nowhere else to go." Upon enquiry, neighbours confirmed to the Investigation Team that they saw boys frequenting the Home of the Manager. The residents' supervision/monitoring system at Margaret Kistow is inadequate. There is insufficient attention paid to hiring adequate numbers of staff. There is no demand by The Authority for proper investigations into incidents such as sexual interaction between children. The Authority does not always follow up on reports of sexual interaction between children after being notified. The investigation at the Home is not followed through to corrective measures. Statements from the Manager indicated that residents often leave the Home to purchase marijuana and return to smoke it on the compound. This increases the probability of child abuse in the form of transactional sex. The Home allows children to spend weekends in Mayaro with individuals who are not the children's legal guardians/parents and the information is logged in a special book. This practice contravenes The Authority's policy. The situation puts at risk. The Margaret Kistow Home engages in practice that facilitates resident to resident sexual interaction through the practice of children sharing beds.	The Authority must be informed of instances of residents' transitioning into staff's private Homes. Further, The Authority should request of the TTPS in conjunction with Social Workers at National Family Services Division for a period of two (2) years. The Home should hire staff to ensure best practices regarding staff to resident ratio. Ensuring that relevant counselling is implemented for child-to-child sexual interaction, including sexual health education. Additionally, any report of inappropriate sexual activity must require a medical examination from the District Medical Officer (DMO) or other State facility. Also, medical personnel should be equipped and conduct regular screening of residents in accordance with best practices for indicators of abuse. The Facility must increase its security measures to prevent the absconding in accordance with this Investigation's section on absconding. The practice of sending out children should immediately cease. The Facility must meet standards of Regulation regarding one bed per child. The Authority should suspend the Facility's operations until situation is regularized.
2	St Jude's	Frequent sexual activity occur among residents, including situations that residents described as "gang rape". The allegation of "gang rape" was found to be part of a hazing process. Sexual interaction and grooming occur between residents and staff and security personnel. Habitual for the Myers family to be sexually involved with residents. Security guards have been found complicit in supplying psychotropic substances and other unregulated drugs to residents. The situation increases the children's vulnerability regarding sexual abuse. Additionally, the practice contravenes the Dangerous Drugs Act, Section 7. Security has failed to report an incident of absconding that resulted in a resident's possible engagement in sexual relations with an adult.	Increased monitoring of the residents should be enacted. Hire enough Caregivers to enable the recommended ratio of supervision to be maintained. Health and Family Life education should be included in residents' programme. All data concerning the inappropriate activities of the Myers family should be handed over to the CPU for investigation. Facilities should be upgraded to enable the installation of remote surveillance. Management should report suspicions to the CPU and The Authority issues regarding any person bringing illegal contraband into the Facility. Management must be held accountable to report to CPU, any knowledge of activities of a sexual nature contrary to the laws of

Serial	Homes	Findings	Recommendations
		There is a pattern of gross negligence on the part of Management in the use of Security Guards for the supervision of the girls. Further, the event align with offences under the Children's Act. Residents' vulnerability increase due to their migration/refugee status.	sexual abuse against children and to report any person suspected of withholding such knowledge. Management should be held accountable for failing to safeguard the residents by utilizing untrained persons contrary to the The Authority's Policy. No child should be placed in a situation where effective communication cannot occur between the child and Caregivers because of language and other barriers.
3	St Dominic's	Staff at St Dominic's sometimes fail to identify and protect residents from grooming and thus sexual abuse.	Health and Family Life education should be included in residents' programme and staff training.
4	St Mary's	Incident reports are not fully capturing the extent of sexual abuse occurring at St Mary's Home. Information from Children Victims Folder (Crime and Problem Analysis Branch - Reports of offences made against Children 2015-2021 (21/7/2021) indicate that multiple reports of sexual abuse from St Mary's Home and does not match number of incident reports. This increases the probability of sexual abuse occurrence. The situation can account for the under estimation of the number of sexual abuse cases that exists.	Independent auditors should conduct frequent interactions with the residents. The Authority must review and sign off on all reports.
5	Casa de Corazon	Management identified a female staff member who was found to be having inappropriate interactions with a resident at odd hours.	Initial assessment by relevant personnel is vital in understanding children with trauma and implementing the needed intervention. The State must take responsibility for assessing and protecting this population. Staff must read and sign off on guidelines for code of conduct. Inappropriate behaviour must be thoroughly investigated and action must be taken against perpetrators

(Appendix 8: Abuse Findings)

Chapter 6 - Analysis of Physical Abuse

Introduction

Physical abuse includes the punching, beating, kicking, biting, shaking, throwing, stabbing, choking, hitting (with a hand, stick, strap, or other objects), burning, or other forms of harm to a child; that is inflicted by a person, whether an adult or older child, causing non-accidental physical injury ranging from minor bruises to severe fractures or death.

Children's Homes/ residential centres should provide children with an out-of-familial-home setting; a secure and safe environment; therapeutic services, and a rehabilitative experience. Although there may be inherent limitations to public care for children in general, there is an expectation that a residential home provides out-of-home care that will protect children from maltreatment. The Authority received a number of complaints from residents over the last three years. The investigation found several instances of physical abuse in the various Community Residences and Child Support Centres. The different categories of abuse comprised of: resident to resident, staff to resident and resident to staff. For instance, incident reports described instances such as: residents heads being bashed against walls, hitting with objects (a lock, ruler) and biting.

The reports of physical abuse were treated in accordance with the procedure of The Authority that The Authority termed as critical incidents. The efficiency and effectiveness of this approach is arguable as suggested by the many critical incident reports received by the Corporate Services.

Situation

The child care system inclusive of the Child Support Centres and Community Residences have undergone a number of changes within the last three years. As mentioned previously the St Michael's Home for Boys which housed children with high risk profiles was closed in 2018. which resulted in the commingling of residents with different needs.

Further, The Authority's staff was not sufficiently trained to manage these children and it compounded staff shortages. The resultant environment can be described as one where the staff is apprehensive to carry out their duties in the face of conflict. Therefore, they have been authorized to request assistance from security guards to quell situations which they perceive as uncontrollable.

The mixing of these categories and the relegation of behavioural management to security guards introduced a situation of subjective determination in dealing with conflict situations. Accordingly, the security guards dealt with the situation based on varying levels of knowledge and experience instead of standardised procedures and training. This approach resulted in instances of physical abuse of residents by staff. The investigation recognised this type of abuse in the CRs, which used traditional methods of disciplining children.

Furthermore, the investigation uncovered resident to resident violence within institutional care. This type of violence occurred due to several factors, such as territorial power relations, violent aggression towards migrants, routine fighting due to poor conflict management and bullying that contributed to violent expressions. The Investigation Team also found that staff facilitated resident to resident

violence as a way to punish other residents. In some cases staff instigated violence to retaliate against a child's actions that could not utilize punitive measures in accordance with the Regulations. Additionally, Children in Homes live in large groups within an environment of complex relationship dynamics. These dynamics are polarized into children in need of protection and children in need of supervision with severe problem behaviours. The investigation found that this distinction contributed to an increased the risk of physical abuse.

Staff to resident physical abuse in residential care is complex due to the unequal power relations between staff and residents. Children with adverse experiential backgrounds and serious social and behavioural difficulties place many residents at high risk of becoming victims of abuse as staff utilizes punishment subjectively to manage children.

The staff's approach is a retaliation mechanism rather than developmental. The power relations between staff and residents continue to be an underestimated factor that contributes to how power is used towards children. The themed beatings mentioned above can also be considered as an abuse by staff to residents..

The staff's inability to manage the CHiNS resulted in some residents perceiving staff's interaction as preferential treatment. As such, some residents who perceived staff's interaction as victimization, became violent towards staff. Further, the Investigation Team noted that residents who expressed continual intent to abscond, resented attempts to prevent the activity and this resulted in violent expressions. The mismanagement of children's problematic behaviours also triggered children's aggressive response.

Findings And Recommendations– Physical Abuse

Serial	Homes	Findings	Recommendations
1	St Mary's	Incident reports are not fully capturing the extent of physical abuse occurring at St Mary's Home. Information from Children Victims Folder (Crime and Problem Analysis Branch - Reports of offences made against Children 2015-2021 (21/7/2021) indicate that multiple reports of physical abuse from St Mary's Home. However these are not supported by critical incident reports to The Authority. Lack of proper supervision facilitates physical abuse among residents at St Mary's Home. Residents sometimes take the opportunity to engage in fights when there is minimal supervision. Staff used inappropriate de-escalation measures with a child. On more than one occasion, a member of staff engaged in altercations with a resident who required alternative placement, intense therapeutic service, and a controlled environment. The staff has challenges in managing difficult	Independent auditors should conduct frequent interactions with the residents. The Authority must review and sign off on all reports. Electronic surveillance requires augmenting in conjunction with procedures and drills for rapid response to such situations. Children should engage in mandatory conflict resolution sessions. Independent monitoring (auditing) of Children's Homes should be carried out by a separate Agency from The Authority. The Authority and the Home should provide appropriate training (especially in the areas of de-escalation and behavior management), prior to on-boarding and should be completed within 3months of employment. Additionally, annual/biennial reviews should attend to staff's behaviours regarding interaction with the children.

Serial	Homes	Findings	Recommendations
		behaviors. The home does not enforce the staff code of conduct and staff disciplinary actions. Staff training requires reviewing and mandatory sessions to deal with children with problematic behaviours. L & M compromises on enforcement of the Regulations and standards.	
2	St Jude's	At St Jude's staff promote a culture that encourages abuse among residents. Ms., Millington and a past resident indicated that was common for staff to instigate themed beatings such as "House or Compound cut-ass". The Management is aware of these beatings and the staff who are instigators. There are still implements such as hand cuffs and batons being used in the Home. The Deputy Manager admitted to directing the hand cuffing of a resident as well as admitted to knowing that it was against the law. Security were found guilty of abusing residents. In a signed Statement, the Head of Security (Ms. Myers) admitted to abusing a resident by pushing them. Based on a brief from the Homes' staff there was an incident when the TTPS used excessive force without the girls presenting a threat or resistance. A past resident alleged that Mr. Edwards (a TTPS officer) beat her. The resident indicated that YTRC was much better than ST Jude's in terms of staff's management of children's behaviours.	The Home should enforce a 'staff code of conduct' for staff and residents that aligns with the requirements in the Children's Act and Community Regulations. The Authority needs to provide training in the area of managing children with troublesome behaviours to ensure compliance with the Act. No implements that are debarred by law or best practices should be allowed on the compound. Allegations of staff's inappropriate behaviour must be addressed using appropriate guidelines and where necessary reported to the Police. Any person in a position of power who is knowledgeable about these situations should report the matter to the Police Complaints Bureau to facilitate an independent investigation.
3	Valsayn	Physical abuse occur frequently at this house. The inclusion of children in need of supervision has exposed the staff two child offenders. The staff is not trained to deal with this form of behaviour. It resulted in policy decisions being made to allow the staff to request assistance from the security guards. The guards, especially the external guards, are not trained to deal with children. Their level of education is low and they tend to introduce subjectivity in the methods used to deal with children. The security guards along with the few nurses use the act of restraining as cover to bash the heads of the residents against a solid object. Further, the mix of different types of residents causes resident to resident abuse.	It is recommended that an intrinsic force of security guards be established and trained by the YTRC in collaboration with The Authority. These individuals should also undergo a formal test at which they must be successful before being assigned to a post. An industry scan followed by a gap analysis must carried out on the performance of the security guards to facilitate curriculum development. This curriculum will be mandated for any person holding a security position in any of the Children Homes or Centres. Monitoring and evaluation should be carried out on the CRC by an independent body to ensure transparent and effective detection of malpractices which should then feed into lessons learned and the eventual cessation of physical abuse.

Serial	Homes	Findings	Recommendations
		Investigations found that there were instances of resident to staff physical abuse which included a resident biting staff and wrestling with caregiver.	
4	YTRC	Physical abuse occurs very rarely. There is a plethora of regulations and layers of oversight that makes the use of excessive force difficult to go undetected. Further a robust handover procedure exist that ensures that new staff is briefed on all incidents and only takes over after engaging the residents in conversation. Resident or resident abuse is also strictly monitored with action being taken to prevent or quickly stop any incidents of this nature. Regular medical screening also occurs which is an additional layer of probable detection of excessive use of force.	This system should be modified and codified to form educational courses that can be implemented in other community residences. YTRC has the systems and overlapping layers of security. Further, the records act in combination with the training of the staff to reduce or eliminate physical abuse. Proper funding should be allocated to effectively implementing all social programmes.

(Appendix 8: Abuse Findings)

Chapter 7 - Review: The Appropriateness of Treatment, Safeguarding, Care and Protection of children in Children's Homes; Assessment of Adequacy and Compliance with the Law

This section presents a review of the appropriateness and adequacy of treatment, care and protection of children in residential care and its compliance with the law. This requires a review of the existing treatment and an examination of whether the existing treatment accords with the policies and laws. It acknowledges whether the changes can be accomplished via the proposed policies and whether these changes are adequate/ appropriate given the present conditions.

Evaluation of The Children's Community Residences (Children's Homes) Compliance with Regulations

The Regulations regarding the operation of homes covers several main areas of housing and children's overall welfare and set parameters for:

- Maintaining premises,
- Ensuring children's welfare,
- Submitting reports to Licensee and The Authority,
- Facilitating visitors,
- Ensuring the children's safety and security,
- Maintaining proper records,
- Addressing children's complaints,
- Providing The Authority with relevant notifications,
- Executing relevant notices

In keeping with the overall focus of the report, it is useful to understand how the Regulations targeted the areas of interest as well as the extent to which Children's Homes met the requirements. This is important because the proper implementation of clear directives can reduce the likelihood of absconding and children's abuse as well as promote safeguarding measures.

Notably, the Regulatory document seemed to have provided broad guidelines for which The Authority may have been expected to fill gaps in the parameters' specificity.

Child Abuse

One of the areas of concern is child abuse which includes physical/sexual abuse occurring either resident to resident or staff to resident. Relatedly, the following areas of the Regulations directly address the issue under Parts 111, IV, V, V111, IX, X and XI.

Part 111-(Premises)

- Children's sleeping arrangements 10 (1, a); 10 (2))
- Toilet/bathroom facilities 11 a
- Therapeutic Intervention Space 11 e

Adherence to these guidelines can assist in preventing abuse (e.g. resident to resident). Research suggests that 40% of children who experience sexual abuse result from an association with an older child (Finkelhor, 2012). Accordingly, it is important to establish appropriate boundaries when children interact.

Of the twenty-one (21) Homes visited, twenty (20) possessed adequate arrangements in terms of children sleeping in separate beds. However, concerns remain regarding the situation at the Margaret Kistow Children's Home where children shared beds and dormitories accommodated children of mixed age- ranges such as 4-year-old children are grouped with 15-year-old children. The scenario can heighten the probability for inappropriate mingling among the residents.

However, the number of persons in a room, as well as the capacity to separate children with particular behaviours, are significant. For instance, the Investigation Team Lead at the Child Support Centre in Tobago raised concerns about having to place two sisters in the same room despite the possibility that the individuals could engage in sexual interactions with each other because of their reported family history.

The overall space also seemed to be small, and one boy was required to sleep on a mattress on the floor. Also, in overcrowded Homes, more children may be crammed into a room, thereby facilitating opportunities for inappropriate behaviours.

Further, the Regulation notes that bathroom facilities should offer privacy to children. The Merriam Webster dictionary definition of privacy is 'the quality or State of being apart from company or observation. Therefore, privacy includes a physical space and being alone in that area. For the most part, the Homes seemed to have met this criterion. However, some Facilities have reported sexual abuse occurring among residents, with the bathrooms being a venue for such activities.

Also, addressing abuse includes providing clinical intervention. Having the appropriate space is important so that children can feel safe and thereby be encouraged to explore and deal with their issues. The Investigation Team notes that adequate therapeutic spaces are not available in some Homes.

Part IV (Children's Welfare)

- Written Admission Procedure 15 (b)
- Dissemination /understanding policies 15 c
- Procedures for enforcing rules 15 e
- Written Behavior Management Policy (BMP) 15 (g)
- Staff's Knowledge of BMP 15 (h)
- Revision of BMP 15 (i)
- Safeguarding Policy 15 (j)

Documenting procedures can assist in ensuring that stakeholders are clear about details regarding admission. The approach reduces the chances of children being inadvertently placed in unsuitable Facilities. Alongside documentation, the underlying message is adherence to the admission criteria. These parameters are significant because inappropriate placement of children can potentially lead to sexual abuse/physical abuse among residents as children with difficult behaviours bully others. Additionally, staff (especially untrained), who do not have the capacity to manage children with difficult behaviours can resort to unwholesome measures in an attempt to curb unruly behaviours.

Generally, during interviews and discussions at site visits the Homes denounced The Authority's method of mixing different categories of children in the placement process. The Institutions suggested that such actions violated licensed admission standards and severely challenged the staff's ability to adequately manage the residents. One example is the situation at Margaret Kistow, where children continue to be placed, at the very least, ignoring the Home's allotted numbers and staff's training levels. Incident reports across the Homes highlighted hostile behaviour among residents, residents touching staff inappropriately, staff/resident altercations and staff's challenges in managing residents' difficult behaviours. Also, the Investigation Teams' review of and certain documents as well as the discussions during particular interviewees pointed to allegations of staff abuse which occurred in attempts to deescalate situations.

Further, interviews with The Authority's personnel highlighted a crisis due to limited Facilities and thus significant challenges with proper placement. Overall, the Homes complained about The Authority's tendency to defy existing guidelines, sometimes bordering on coercion.

Alongside placement, staff should share information in a manner that children can grasp, considering the age and developmental status of the child. Further, there should be measures to ensure that staff understands and abides by the relevant policies that target proper management of children's behaviours.

Homes identified a system for communicating policies to children which included, signing a code of conduct document, verbal explanations, periodic reminders and posting information on walls. Further investigation is necessary to determine (1) if the process occurs within the standard timeline of seven (7 days) upon admission and (2) whether the materials were age and developmentally appropriate. Additionally, questions arise concerning the Homes' use of The Authority's designed Behaviour Management Policy. Some persons identified a draft document, and others indicated giving verbal guidelines and, in some cases, it was simply unclear regarding the knowledge about the document

and its use within the Facility. Even so, The Authority's document is yet to be approved by the Board., after six years of operations. The varied implementations and absence of a sanctioned document leaves room for too much flexibility in managing problematic behaviours. Without specific directives, children's discipline can be left to staff's subjective leanings, including antiquated disciplinary strategies. Of significance, in response to the Investigation Team's enquiries, The Authority noted that one of the challenges is getting Homes to adhere to the 'no corporal punishment' policy.

Part V (Report to Licensee)

- Manager's Monthly Reporting 16 (1)
- Manager's Report of Critical Incidents 16 (2).

The Regulation stipulates that the Manager must send monthly reports to the Licensee in a format that The Authority approves and submit a copy of the same to The Authority. Submission of the identified reports can facilitate proper oversight regarding implementation of appropriate mitigating measures. Questions remain as to whether Managers submit the requisite monthly reports. In fact, during the site visit, the Manager of the Probation Hostel admitted to defaulting on this issue and the Psychologist at St Jude's indicated that she sends a monthly report to OPM and an officer from The Authority's Liaison collects information when she visits the Home. In corroboration, the interview with the Deputy Director, Legal and Regulatory Services noted that The Authority collects the information through monitoring visits and the Homes send a monthly report to OPM to facilitate the Ministry's monitoring process. In other words, there is no system in place that mandates Homes to submit a monthly report to The Authority. Notably, discussions with The Authority's personnel underscored The Authority's inability to monitor effectively due to its staff shortage. Such gaps in monitoring were evident in Homes with under-reported incidents and Facilities with tolerated procedural lapse.

Part VIII (Records)

- Journal - Significant Event 19 (1, b)
- Disciplinary Log 19 (1, c)
- Filing - Serious Incident 19 (1, d)
- Visitor's log 19 (1, e)
- Complaint's Log 19 (1, f)
- File - Child's History 19 (2)
- Procedures re: Child's Death 19 (3)
- Keeping & Maintaining Records 19 (4)
- Storage (register, books, records) 19 (5).

Similar to timely report submission, maintaining proper reports is an important tool for monitoring the adherence to standards. Proper records are a valuable source of information regarding the occurrence, frequency and intervention for abuse. Yet, Homes were not completely upholding the particular practices. Thus, Homes selectively maintained logs and were not consistent with the standards. In one case, (Margaret Kistow), information was hurriedly entered into logs to satisfy the enquiry of the visiting Investigation Team, and the children's files were stored at the private residence of the Assistant Chief Executive Officer. Further enquiries are needed regarding the Homes' maintenance of a filing system for serious incidents. The DDLS admitted that there are problems with Homes adherence to these procedures but the visits by L & M personnel should address this issue. However, the continued widespread existence of the problem suggests gaps in The Authority's monitoring mechanism.

Part IX (Complaints)

- Written Complaints Policy 21 (a)
- Handling of Complaints (against adults & residents).

These guidelines indicate significant ways to facilitate adults' and children's report of abuse. In this case, adults including parents and other interested persons, must have access to a reporting mechanism. The Investigation Team did not unearth any clear policy to guide parents, although review of documents indicated staff's regular reports against residents. Further, the Homes rely on children reporting through an adult. In fact, The Authority's personnel indicated that children have several methods of reporting including writing in a complaints book, informing the therapist and alerting the Child Service Associate. However, all the strategies seem to necessitate the involvement of an adult. Some Homes rely on the adults' observations. In cases of children with developmental issues, details were vague concerning the particular mechanisms for reporting considering the vulnerability of this population. Generally, the system is inadequate for children's report of abuse, especially considering that the children may fear retaliation by staff. Thus, children's voices can be easily lost in current processes. During an interview, the Board indicated recent initiatives of (1) installation of boxes for children to lodge complaints and (2) the creation of, a complaints policy to help address the issue. However, this yet to be implemented.

Part X (Immediate Notifications to Children's Authority)

- Threat/abuse of child 22 (d)
- Death of child 22 (e)
- Any serious injury to a Child 22 (f)
- Injury or illness requiring hospitalization (Child) 22 (i)
- Any other critical incident 22 (l)

There is no doubt that Homes have been submitting critical incident reports. However, concerns remain as to whether the process occurs in a timely manner and whether the Homes are underreporting events. The decision to report seemed dependent on a lack of knowledge and

deliberate choice. For example, the Tobago Probation Hostel Manager indicated requiring further guidelines from The Authority and often using personal judgement. In fact, comparison of discussion during site visits with the filed documents suggest unreported critical incidents for at least four Homes (Lambeau Community Residence, Margaret Kistow, St Judes, Probation Hostel). During interviews, The Authority's personnel indicated that training has been provided to all relevant persons regarding the types of critical incidents and the reporting process. Although the recency of such training as well as the controls to ensure that reports follow standard formats is arguable. To illustrate, review of reports indicates several instances of the incorrect form and there is no evidence of consistent follow-up. Timely reporting and meaningful responses can trigger the required support for children and staff.

Part XI (Notices regarding corrective measures)

- Revoking license;
- Other Notices

De-licensing is crucial to prevent abuse in cases where it is evident or if there is potential for such practices to occur. Currently none of the Homes under review have received instructions to close. However, The Authority's documents point to at least sixteen (16) Homes that are operating under not licenced. During dialogue, The Authority's personnel have indicated working with these homes to bring them to licensing status and noted several challenges including missing documents (Medicals, Police Certificate of Character, Fire Certificate, psychiatric assessment, Public Health clearance, food badges). The Authority indicated that some of the difficulties were related to certifying Agencies' limited operations during the COVID 19 pandemic. The inability of some Homes to meet the costs of necessary structural repairs was also topical. Of concern, is the timelines for meeting the required standards and amount of monitoring and support provided in the interim. Further, The Authority admitted heightened concern with at least the functioning of the Margaret Kistow Home. However, the Board and other managerial personnel highlighted the existence of limited Homes to meet present demands and the need to carefully consider all the ramifications of strictly shutting down Facilities. Also of significance is the non-proclamation of the law (Act 46:04, Section 3) regarding licensing of Homes.

Absconding

Absconding is dangerous and puts the children at varied risks including engagement in crime (ref) sexual exploitation, abuse, violence and death. A child who absconds once is in as much danger as the frequent absconder. Additionally, Homes with inadequate amenities to meet the child's needs can create sufficient discomfort that triggers absconding. In fact, The Authority's document on absconding for the period 2019-2021 identifies 'avoiding difficult relationships with staff and peers as well as boredom as two of the major reasons for absconding Key areas in the Regulation that point to absconding are evident in Parts 111, IV, V, V111 and X.

Part 111 (Premises)

- Fencing - 9 (1, f)

Inadequate fencing and inappropriate burglar proofing create opportunities for potential absconders to easily exit the Facilities. Of the Homes visited, at least ten (10), including the Homes with the most frequent absconding incidents had walls and fences that residents can comfortably scale or had some form of compromised perimeter.

Part IV (Children's Welfare)

- Dissemination /understanding policies 15 c
- Procedures re: leaving premises 15 d
- Structure 9 (1, d);
- Therapeutic Intervention Space 11 e

The child's physical environment as well as access to relevant information and services contribute to processes which mitigate absconding. In this regard, the building should not make it easy for residents to leave undetected. The Investigation Team noted that at least two Homes (Lady Hochoy and Cyril Ross) indicated parts of the structure that were in disrepair and which residents previously used to abscond. Such repairs remain undone. The Investigation Team was also informed that delay in permission from the owner of the Valsayn property was also a factor in hindering repairs.

Further, an important part of managing absconding is the clinical intervention after the child's retrieval. Accordingly, the existence of an appropriate therapeutic environment can provide the space to safely explore the psychosocial factors that trigger absconding and establish future management strategies. At Valsayn, an environment with high risk of absconding, personnel complained about inadequate space and hence the inability to conduct sessions regularly. Other Homes, particularly those that relied on external sources for counselling, did not identify a place.

Part V (Report to Licensee)

- Manager's Monthly Reporting 16 (1);
- Manager's Report of Critical Incidents 16 (2)

Similar to the case of abuse, timely report submission is necessary to facilitate proper oversight. Generally, absconding reports seem to have been submitted in a timely fashion. However, detection of the incident may hamper the process as in the case of Valsayn resulting in gaps in the reporting procedures.

Part VIII (Records)

- File (child's history 19 (2)
- Keeping & Maintaining Records 19 (4)
- Storage (register, books, records) 19 (5)

Maintaining records, particularly the child's personal file is paramount. Records should contain significant information about the child's risk for absconding. Thus, to neglect this activity makes it difficult to effectively manage the issues of children running away from Residential Homes.

Notably, all the Homes seem to maintain children's records. However, due to the Investigation Team's reporting timelines, it was not possible to evaluate the quality and quantity of its contents. Nevertheless, discussions with the Managers indicated that the requisite assessments from The Authority are often not done in a timely manner and some children exit the Homes before the process is completed. Additionally, personnel at the Homes noted that Children's Authority often placed children without providing necessary background information. Further, interviews with the Board and Assessment Manager revealed that a treatment plan can take as much as three months to complete, requiring Board approval. However, Homes informed that there were many instances that Assessments for children placed remained outstanding for over a year after child's placement. Dialogue with different persons point to insufficient communication between The Authority and the Homes regarding children's status and progress. The foregoing suggests that there are gaps in record-keeping and hence the existence of particular administrative factors that contribute to absconding.

Equally important, is the storage of residents' documents. All the Homes, except one (Margaret Kistow) identified suitable mechanisms. In Margaret Kistow's case, documents were stored at the CEO's home. Despite the assurance of protected access to the records, the storage method is not in line with best practice. The CEO noted the lack of space at the Facility

Part X (Immediate Notifications to Children's Authority)

- Absence/absconding/missing child 22 (b)

Timely reporting is crucial in finding absconders and hence reducing the child's exposure to particular risks. Generally, absconding reports seem to have been submitted in a timely fashion. However, detection of the incident will hamper the process, as in the case of Valsayn. However, triggers such the inability of staff to manage behaviours, poor supervision, overcrowding and faulty structures must also be fully addressed.

Safeguarding

In essence, the Regulation points to safeguarding the child and ensuring the child's best interest. Safeguarding is a broad concept that captures strategies which seek to protect children from abuse, prevent harm to health, mitigate developmental risks and ensure individuals' access to safe and effective care. However, the idea of ensuring the child's best interest can be ambiguous as it hinges on making informed decisions based on expert knowledge about a child's specific circumstances (Skivenes & Sørsdal, 2018). The approach can result in varied interpretations. Overall, safeguarding and the principle of 'the child's best interests' build on promoting children's rights. The Regulation identities the two areas under Part IV as:

- Serving Child's Best Interest 15 (f);
- Safeguarding Policy 15 (j)

Of significance, The Authority's documents did not describe a particular safeguarding policy, neither a particular definition regarding the principle of the child's best interest. Therefore, The Authority seems to be guided by a universal understanding of the concepts and the wide meaning encapsulated in the Laws. Notwithstanding the broad guidelines, the Investigation Team noted the following areas that also addressed issues of 'safeguarding' as well as 'children's best interest' and ultimately related to ensuring children's basic rights. Of interest are some sections under Parts 111, IV,and VII.

Part 111 (Premises)

- Sleeping arrangements
- Place of Study 10 (1, c);
- Recreational Materials/Facilities 11 (d);
- Adaptation re: Physical Disability

Part IV (Children's Welfare)

- Academic & Vocational Training 15 (a, iii);
- Access to Physical & Recreational
- Activities 15 (a, iv);
- Access to medical care 15 (a, v);

The children in most Homes were accessing schooling including the required online versions, whether through primary, secondary or vocational levels. However, there was concern that at Margaret Kistow, children were not enrolled in classes or were not receiving classes from certified teachers. Also, St Jude's residents who were not part of the traditional school system had access to limited available schooling choices. Additionally, the designated place for studying was unsatisfactory in some cases. For instance, at Tobago's Child Support Centre there was no assigned room, only a reading corner and children often used the administrative area located upstairs. In Mary Care North, the space was a classroom to the back of the office which contained non-functional computers and also served as storage area for cribs.

Equally important is the current situation at Child Support Centres where the system is not designed to house children for more than 12 weeks, which poses specific challenges. These children are currently accessing online schooling. However, understanding the operational guidelines of the 'safe house' concept, there are some children who may not have full access to schooling when full face to face classes resume, unless an alternative viable option exists. However in an interview the Board identified an initiative to lure volunteer tutors to fill the gap of providing schooling for children under The Authority's care.

Furthermore, recreation and its associated activities raised concerns. Specifically, there seems to be adequate space for conducting physical activities in some Homes and other facilities sometimes used nearby parks and playing fields when necessary. However, there is need for further investigation to

ensure resources (including the quantity and quality of materials) align with the age and developmental needs of the children.

In terms of physical disabilities, one Home (Lady Hochoy) was specifically adapted to accommodate persons with disability, because of its targeted population. Tobago's Child Support Centre identified a self-contained bedroom on the ground floor with special ramp access. Other Homes did not indicate relevant modifications despite not currently having such children at the facility. Therefore, there can be future challenges for placing children with particular physical disabilities.

Part VII (Safety & Security)

- Implementing Evacuation Plan 18 (a);
- Adjusting Evacuation Plan (when necessary) 18 (b)
- Staff & Residents' Knowledge of Evacuation Plan 18 (c)
- Recording Number & Frequency of
- Evacuation Drills 18 (d)

Properly executed emergency evacuations can mean the difference between life and death. This is a major problem, with missing Fire plans and limited or infrequent drills. This is of additional concern where there are children with cognitive and physical disabilities such as Lady Hochoy and Child Support Centre South. Five Homes (Mary Care South, Mary Care North, St Dominic's, Credo, Joshua Boys and SWAHA) identified a system. However, the updating plans was not occurring and some homes did not know about the muster points. Additionally, it is unclear whether the dissemination of information caters for the children's understanding. However, this information is at variance with the information provided by the Investigation Team Leads at the particular facilities. At Valsayn, staff were not even aware of the Muster Points. There are gaps in addressing these particular issues related to ensuring the children's safety and security.

The Investigation Team found that while the Community residences and Child Support Centres were compliant in some areas there were still gaps that need to be addressed.

Resources

Findor, D (2012). Characteristics of crimes against juveniles. Durham, NH: Crimes Against Children Research Centre.

Skivenes, M., Sorsdal L. M. (2018). The child's best interest principle cross child protection jurisdictions. In Falch-Eriksen A., Backe-Hansen E. (eds). Human rights in child protection. Palgrave Macmillian, Cham. Https//doi.org/10.007/978-3-319-94800-3 4.

Evaluation of Rehabilitation Centres' Compliance with Regulations

Synopsis

The Trinidad and Tobago Defence Force (TTDF) was mandated by the Ministry of National Security (MNS) to manage the rehabilitation and follow-on operations of the facility for CHiNS in Diego Martin, formerly known as St Michael's Home for boys. The TTDF has tasked the TTDFR battalion to lead this mission and the Trinidad and Tobago Defence Force Reserves has remitted the operations to its Specialised Youth Service Programmes umbrella to carry out the activities associated with the mission.

Pursuant to the above, the Specialised Youth Service Programmes management visited the Youth Transformation and Rehabilitation Centres on the captioned date to ascertain the methodology at an established CHiNS acility. It was observed that the facility is a fully funded State institution that is for remanded children or those who have been found guilty of a criminal offence. It is separated into two overarching facilities that are gender-based. The female Youth Transformation and Rehabilitation Centre is on the same grounds as the Male Youth Transformation and Rehabilitation Centre. The male YTRC is well secured with five separate layers of security that is heavy on human input. The entry to exit of the residents is standardised and well documented. Systems are in place to prevent abuse and mistreatment of the residents. The staff are audited and screened on entry and exit. Staff who are found to be guilty of transgressions are dealt with in a structured, standardised manner.

The State of the facility is a mixture of old and new. Areas as a project for the conversion of the accommodation and support systems are underway. The COVID 19 pandemic has stalled this effort and it is continuing slowly with the majority of the structural work being carried out by the Prisons Project Department and the residents themselves.

Educational programmes and vocational programmes are in place for the development of the residents and a recreational and sport programme is also in place for the health of the residents.

The facility was found to be safe and secure with standardised systems in place for care, protection, health, education and discipline of the residents. The female YTC, a converted dwelling house was similar in systems, but the girls' institution requires some development to allow autonomy from the boys' programmes.

Security

The Youth Transformation and Rehabilitation Centre compound is fenced and compartmentalized. Visitors and staff are not allowed to enter with cell phones or other electronic devices and are searched prior to entry on the outside of the gate. Records of visitors verified by picture ID is practiced and any legal firearm must be lodged at the security booth. The compound is compartmentalized by physical fences and procedures to access the areas. Surveillance is mainly human in the lower risk zones and electronic and human in the capital offences and high-risk zones. There is a resettlement area for residents with six months and less remaining on their sentence. Remand residents are separate from those residents found guilty of a crime from the Court. All residents with the exception of the resettlement zone are escorted anytime they have cause to leave their zone. All zones have a

staff member present at all times and the dormitories are designed in an open style that allows continuous observation of the residents and their activities.

Services

The Youth Transformation and Rehabilitation Centre (male and female) offers education, vocational classes, physical development, psychosocial treatment, residential support, medical intervention, administrative services, including virtual Court appearances, and protection of the residents.

The institutions are registered schools and hence examinations can be carried out under the MOE, whilst vocational classes are parallel to the national vocational programmes. Qualified Teachers are assigned to carry out classes for the residents with the view of preparing them for examinations such as 14 plus, CSEC or vocational audits. Their challenges are the length of time of the resident at the institution, the variations of educational standards of the new residents, the COVID 19 challenges and psycho / social issues that may prevent learning.

Care plans are done by The Authority and the staff and are monitored and managed towards rehabilitation of the resident. This effort is supported by professionals that are allowed to visit with the residents.

Certified medics are present at all times and a doctor has been dedicated to the facility. This doctor makes visits to the YTRC and is available via call out when deemed necessary by the medics. Only the doctor is allowed to order a resident off the compound and States which medical facility the resident should be visiting. There is an isolated infirmary that allows stabilisation and separation of contagious residents.

Procedures

The standardisation of procedures and the records have emanated from the experience of the Trinidad and Tobago Prisons Service with the penal system. The entry process is very strict. No entry is allowed without a warrant from the Courts ordering the custody of the minor and all special circumstances that the Court has decided will accompany the warrant. When the warrant expires, a new one must be issued concurrently or prior to the expiry date. All accompanying case files and history can follow, but if it does not, the administrative arm of the institution begins to follow it for delivery. The resident must be handed over by a Police Officer who has to sign the documentation that the resident was handed over at a specific time and date and to whom. There is a dedicated receiving officer on all shifts as well as a Warrants Officer that ensures the paperwork is correct prior to accepting the resident. The area for reception is separated and private. The resident is issued with toiletries, uniforms bedding and a bunk and locker.

The resident is then moved into the appropriate zone. Newly remanded residents are kept in a high surveillance dormitory where they are constantly monitored. Residents found guilty of a crime are kept in a separate dormitory for newly convicted residents.

Upon the assessment that the residents are safe, they are transferred to a dormitory either for remand, conviction or capital and serious offences. All residents are reported on every day, in terms

of conduct and achievements towards their specific Care Plans. This information is collated by the administrative staff and interventions are made where necessary.

All residents are given a Handbook clearly explaining what is expected of them and what actions will be taken in instances where they do not meet expectations. The staff are also in possession of a staff Handbook that has a discipline matrix and well-established procedures to include police intervention and court appearances. When an instance of abuse is alleged, an Investigation Team from the facility deals with it providing recommendations on any liability and culpability to rectify the issue. No weapons of any type are allowed into the facility and even batons are not kept on the guards at the various dormitories. A special response Investigation Team is on standby to quell any disturbances in the institution.

Discipline is achieved by a mixture of rewards for good behaviour, counselling when minor infractions occur and punitive measures for large infractions. There is a reward system where points are accumulated from each shift supervisor's records and collated at the end of each week. These points are then exchanged for time in the recreation room. This room contains video games, football and other attractions that appeal to the children. When serious infractions occur, the children are separated into single compartments in a special dormitory. These compartments are approximately 12' by 8' and contains a bunk, toilet and in modern versions a desk. The rooms are closed in with heavy reinforced steel and can be observed from the corridor outside the room. Seven days are the maximum amount of days that is allowed in accordance with prison regulations.

The physical fitness programme provides physical training to include boxing, weight lifting, football and basketball. A certified physical instructor provides the training and the residents have taken part in national competitions in the past.

The education is accomplished by certified teachers that teach the boys in the morning and the girls in the evening. There is an IT lab that is used to prepare the residents with the audited capacity for examinations in this area. The teacher uses innovative measures to tailor the programme for each resident's length of time in the institution.

Summary

The Prisons Service based on its mandate to rehabilitate and its experience holding in a secure manner on behalf of the courts, persons of all ages, has developed a successful system for children. The main points of the children's Convention are met. The layers of supervision and strict recording measures have added to the absence or rarity of abuse to the children. Many methods can be adopted by homes in Trinidad and Tobago.

The areas of improvement will be the separation accommodation of the children, the old dormitories with regard to the flow of air and lighting and the addition to the physical programme with disciplines such as dancing and martial arts.

It is recommended the Prison Service combine with the Audit department of The Authority to ensure that homes are maintained at an acceptable standard.

Special Note on Child Support Centres

Child Support Centres represent models for Residential Homes and, therefore should closely align with all aspect of the Laws. Accordingly, Child Support Centres should demonstrate best practice regarding physical structure and the capacity of staff to promote overall children's welfare. The following are concerns Parts 111 to X, excluding VI (which addresses visitors).

Part 111 (Premises)

The building of two of the Child Support Centres need repairs. For example, Valsayn's Child Support Centre has mouldy walls resulting from a leak as well as broken doors; The Tobago Child Support Centre has a damaged wall that a child punched. Overall, the Tobago Child Support Centre is small and cramped making it difficult to provide effective overall services, including separating children with problematic behaviours. In the case of Child Support Centre South, spaces within the burglar proofing are too wide. Children have used creative means to leverage gaps in security at all centres. For instance, residents used a mango tree at the Tobago Child Support Centre to aid in scaling the 4ft fence at the front of the property. At Valsayn, individuals capitalized on a dog kennel's location to execute their plan. In Valsayn's case, lapse in detection also impacted the security's response.

Part IV (Welfare of Children)

As mentioned above, children's access to education is paramount and there must be sufficient engaging activities for the residents. As admitted in The Authority's report, boredom can trigger absconding, but it can also contribute to other behavioural issues. Of significance is the placement crisis that has inevitably included the Child Support Centres resulting in residents' extended stay at the facilities. The situation violates admission criteria and impacts particular services such as schooling. Within this context operates staff who were not trained to deal with particular behaviours. A strength of the Child Support Centres is the children's access to The Authority's doctors. However, the mixing of different categories of children, undertrained/untrained staff (especially caregivers), limited access to psychological services (e.g. Valsayn, South) and prolonged sojourn compromise children's behavioural progress.

Additionally, like the Children's Homes, children's reporting mechanisms for child abuse does not sufficiently capture the Child's voices; they are not child friendly. The fact that the Child Support Centre South was found to have children with low cognitive functioning makes it even more imperative for the development of reporting mechanisms for children to report abuse.

Part V11 (Safety & Security) & Part VIII (Records)

A major blunder is the non-implementation of regular evacuation procedures, including drills, knowledge of plans, understanding the plans and periodic evaluation of plans. Neglecting these procedures suggests the absence of particular records, which can create problems.

Chapter 8 - Review of Policies and Procedures that should guide Children's Residential Care

As part of its process, the Investigation Team undertook a review of the policies and procedures developed by The Authority, which guide the provision of care to children who are placed in Community Residences and Child Support Centres.

Policies and procedures form an important part of any organisation as they are meant to:

- guide the organisation and members of staff in its day-to-day operations
- streamline processes and approaches
- provide guidance for decision making and emergency responses
- ensure compliance with laws and regulations and
- affect the culture of an organisation and promote accountability

The Authority's Board has indicated that they have undertaken an accelerated policy drive with eight (8) new policies focussed on handling crises, absconding and the improvement of The Authority. However, it should be noted that several of the policies remain in draft form. The Board further referred to an approved Risk Management Plan. This document and several others were provided to the Investigation Team one day before submitting this report and so could not be reviewed.

The policies were reviewed, taking into consideration the site visits and interviews conducted by the Investigation Team. This approach allowed the Investigation Team to compare the processes and procedures as set out by the policies to the actual operations of the Child Support Centres and Community Residences where applicable.

Failure to effectively implement policies and procedures will likely result in:

- inefficient use of resources
- the contravention of the laws and regulations which guide The Authority and the residential care institutions
- poor delivery of services by The Authority to the residents
- increased risk and exposure to an already vulnerable population and liability of The Authority and
- opportunities for breaches in safety and security

The Investigation Team noted the following:

- Several policies have been developed for facilities operated by The Authority and are not applicable to Community Residences. This means that there are divergent practices amongst the forty-three (43) Community Residences.
- Policies and their prescribed procedures were not always adhered to in reality (reference is made to the Health and Safety Standard Operating Procedure for Incident Reporting which was deviated from by staff)

- In many instances, staff members were not fully aware of the contents of the policies nor of their respective duties contained therein.
- The proper implementation of policies requires a full complement of staff who are to be well trained in their respective duties with ab understanding of the legal and regulatory framework in which they work. If staffing is inadequate, the Investigation Team noted that certain policies would be difficult to implement successfully (See Suicide Watch/Self-harm Policy)
- Policies require more detailed processes and procedures to ensure transparency and effective implementation (See Caregivers Code of Conduct).

The Investigation Team therefore recommends:

- The Authority should develop standards and policies to be adhered to by The Authority, its Child Support Centres as well as Community Residences
- Policies must be reviewed, finalized and approved by the Board of The Authority forthwith
- The approved policies must be shared with all members of staff and Community Residences
- All persons implementing the policies must be trained prior to interfacing with residents and should receive continual follow-up training and be tested to ascertain the level of knowledge and understanding
- Enforcement of policies should be a high priority for The Authority, and noncompliance should attract disciplinary action
- A regular review and audit of all policies should be conducted, taking into account best practices, changing standards, regulations and laws, as well as organisational changes

In the following section, the Investigation Team examined the existing policies and procedures and the following structure was applied to maintain consistency in the review: -

- a short description of what the policy is meant to achieve,
- gaps and instances where policies were deviated from based on observations from site visits & interviews
- comparative analysis to any international /regional/professional /local standards and
- recommendations on how the policies could be improved

The following policies have been reviewed to date:

- Suicide Watch /Self Harm Policy
- FAHSSE- Escape and Abscond Policy
- Policy Absconding Watch Guidelines
- FAHSSE Policy Statement
- Child Support Centre Behaviour Management Policy
- Child Support Centre: Caregivers' Code of Conduct
- Child Support Centre-Security, Admissions, Orientation and Discharge Processes

- Standard Operating Procedure for Incident Reporting
- Framework For the Investigation of Complaints About a Community Residence
- FAHSSE Security Manual Standard Operating Procedures
- Guidelines on the Use of the Security Personnel from Private Security Companies
- Place of Safety

The following policies were not reviewed as they did not directly pertain to/impact the mandate of the Investigation Team:

- FAHSSE Voice Procedure and Handset Discipline
- Ligature Point Management Policy and Guidelines
- Motor Vehicle Policy
- Management Of External Transport Service Providers Policy
- Policy and Guidelines Energy Conservation Management
- Janitorial Services – Scope of Services and Standards of Performance
- Infection Prevention and Control Policy
- Handheld Metal Detector Standard Operating Procedures
- CCTV Policy Draft
- Electronic Device Policy
- Policy and Guidelines safety and Security of Staff on the Intervention of cases

The Authority's Suicide Watch/ Self Harm Policy

Overview

The Suicide Watch/Self Harm Guidelines were developed by The Authority. The contents are designed to assist staff in managing some degree of risk among residents.

Description

The Suicide Watch/ Self-Harm Policy provides guidelines on the following areas:

- Warning signs or red flags of suicidal ideation and self-harm
- Safety-proofing the space
- Monitoring and supervision
- Assessment and referral

Gaps and Recommendations

- The Guidelines do not State whether they are applicable to both Child Support Centres as well as Community Residences.
- The monitoring and supervision guidelines which referenced "one person being assigned on each shift to ensure close monitoring of child" while helpful, this presents some concerns in practicality where there may be more than one child presenting self-harm or suicidal ideation at the same time
- The Staffing observed at the homes during recent site visits ranged from 7:1 to 5:1 thereby presenting noted challenges for this policy to be implemented to provide the required monitoring and supervision for enhanced care for children at risk.
- The bathroom monitoring guideline speaks to calling "out to the resident every minute and ensure they answer". Given the ratio of staff available to oversee the residents, when actioned this guideline would result in a large number of children afforded limited supervision
- The Assessment and Referral guideline requires immediate reporting of all reports of suicide intention or self-harm however, the guidelines would benefit from including a referral to a mental health practitioner to accompany these intents prior to an actual episode or suicide attempt as noted.
- The policy is void of treatment approaches to address the presenting issues of self-harm and suicidality
- The Policy can be further reinforced by ensuring there is tailored and periodic training and retraining of staff on the guidelines of the policy, the implementation, management approaches, innovative methods and new advances in the area of Suicide and Self Harm among Children
- Given that self-harm is often a means of communicating emotional distress it is key for staff to have strategies to attend to the distress being communicated. The absence of such a response would often lead to self-injurious behaviour being repeated. The policy should

provide a framework for staff to assist residents in developing healthy alternatives to address the needs met previously through self-harm

- The impact of these incidents on both staff and residents should be considered with adequate debriefings and training for the various categories of affected persons.
- To enhance the assessment and care delivered to children with a history of chronic or ongoing self-harming behaviours, a self-harm management plan should be explored the following plan was extracted from https://www.proceduresonline.com/caldecott
  - A self-harm management plan for chronic self-injurious behaviours would include:
    - A summary of any incidents of actual or threatened self-harm;
    - Identification of any themes and patterns of the behaviours, for example; time of day, location, staff involved etc.;
    - Identifying the antecedents and triggers that indicate when an episode of self-harm has been or is more likely;
    - The current frequency and duration of incidents;
    - Identification of strategies currently employed and an evaluation of their effectiveness;
    - If necessary, develop additional strategies to further reduce, prevent, or avoid self-harming behaviours;
    - Formulation of an action plan, including recommendations and a review date.

These items should be examined in tandem with the possible triggers of a specific event or the child's current psychological functioning.

Escape and Abscond Procedure

Overview

This Policy Statement is established by The Authority to provide guidance to staff to treat with children with high risk of escaping and absconding as well as to respond effectively to those children who actually escape and/or abscond.

Description

The policy Statement provides the preventative measures to implement in the case of a resident with a high risk of absconding or escaping and the steps to take in the event of an actual escape or absconding. It gives a layered response to each case and it resides at the tactical level of the operation. The policy has an entry about staff safety that may distract from the actual purpose of the publication.

Aim: To ensure effective response by responsible parties to children with a high risk of, or who actually, escapes and absconds by the provision of practical guidelines and requirements.

Objectives

- Assigning specific responsibilities to each stratum of The Authority's operation.
- Creates a communication plan to achieve the prevention of escape and absconding and the response to any cases who carries out the aforementioned.
- Record information on all events of absconding to include near misses.
- Analyze the data recorded on absconding and escape to help prevent its reoccurrence.
- Provide steps to follow up the incident on an individual basis to include the adjustment of the care plan and risk profile of each child.
- Provide all resources for the effective implementation of the plan.
- Provide training in use of force when dealing with children who abscond or who are known to have a high tendency to abscond.

Gaps and Examples:

- The document attempts to lay out standard procedures for response at a tactical level to the aforementioned situations. It spends an inordinate amount of time in Section 4 making the case that the staff needs protecting in accordance with the OSH act. This appears to be out of place, and even though it is accepted that the staff needs to be protected in order to carry out their duties, this may not be the appropriate document to outline how that protection or why that protection is achieved.
- Commonalities with other policies of The Authority such as inadequate adherence by the Investigation Team leads at the Child Support Centres and the lack of knowledge of the staff at the Child Support Centres are found in the realities of the Child Support Centres. There is also a major shortcoming as it indicates that there are instances when the TTPS should be informed in the case of Absconding, when the TTPS should be the first call made and then internal supervisors.

- There is also a major shortcoming in that even though the policy claims that the use of force is dealt with in Appendix A, it is not even mentioned.

Deviations from Reality

When the case of the boys absconding from Valsayn is examined, it is apparent that the constant monitoring of children who have a high risk of absconding was not carried out. It is recommended that the policy be reviewed in context of the TTPS' role and the policy should communicate to the Investigation Team Leads in detail. The responses of the Investigation Team Leads at the Valsayn, South and Tacarigua Child Support Centre do not support the effective communication of this mandate to all areas under the ambit of The Authority.

Further the action to be taken in response to an absconding was not initiated by the Investigation Team lead at Valsayn, but rather he passed it on to the Deputy Director and awaited direction. At St Jude's, a Community Residence,an employee informed the Security Officer who was off duty prior to reacting. Casa de Corazon does not inform the TTPS at all until the Board of Directors mandates this action. The policy points out the high risk of the situation of absconding, yet it does not seem to be enforced in the operations of The Authority.

It is clear that the policy is not adhered to in reality at the Child Support Centres as the person driving the implementation of the training and the actual plan is the Investigation Team lead - and in all three Child Support Centres examined, the Investigation Team Lead did not know that this responsibility resided in them. Further in the case of Valsayn, a Statement from a former care giver indicated that the only training he received was provided by an on-the-job arrangement under a more experienced worker. The follow up procedure in the case of the resident in St Jude's ('Aliyah') was not as thorough as described in the policy.

In the case of homes which view themselves as family homes (such as Margaret Kistow and the Sylphil Home) protocols for absconding residents were not adhered to. In the case of Sylphil it was the police who contacted The Authority to notify them of a child who absconded from the home and not the home's manager.

Recommendations for the Policy

- The two categories of workers with the main responsibility for prevention of escaping and absconding are the caregivers and the security personnel. They should change shifts at staggered times.
- The carrying out of the preventative measures is supposed to be logged in accordance with the policy. Failure to do this should attract sanctions or disciplinary action from The Authority.
- Measures such as "wear Safe' technology that allows the location of the child to be tracked should be examined.
- Security measures such as the 24/7 monitoring of the cameras should be mandated.

Absconding Watch Guidelines

Description

This document has no ratification or signatory authority attached to it. It is unknown if this is draft or an approved document for The Authority. It does not give applicability and one has to assume it applies to all the CSCs and to the community residences as a guideline as well. Once that assumption is valid, it can be analysed as very intensive in its application and most probably not sustainable.

Aim: To ensure that all responsible parties at the CSCs, understand their duties with regard to children with a high risk of absconding in order to prevent this event from occurring.

Objectives

- Identify the person who can designate a child as high risk.
- Outline preventative measures for the caregiver.
- Specify the duties for the Security Personnel.
- Place a procedure to minimize risk of handover/takeover of staff.
- Strives to post security at strategic positions during outdoor and indoor activities.

Gaps and Deviations

- The structure provided for in the policy is untenable. In the case of Margaret Kistow Home, where the children are largely unsupervised due to their ratio of staff to residents and the layout of the structure, this will definitely not be effective.
- The policy speaks to the removal of the children's valuables. This is a good idea in theory, but it must be accompanied with the accountability of the items and the custodian who is responsible for the safe keeping of the items. This is important in light of the allegations made by a resident of St Jude's regarding the unauthorised taking of personal property by the staff and the redistribution of the items.
- The policy should also take into account scenarios such as a distraction by the other residents to allow for the integrity of the compound to be breached.
- In the case of the Probation Hostel in Tobago, the Manager reported that on several occasions where residents have absconded, the security failed to intervene and the residents left the premises.

Recommendations for the Policy

- The guidelines for the caregivers require more detail to ensure transparency and accountability for the property of the children.
- The children not having resources might also be at high risk as it may cause them to have to earn their way in the world without finances.
- There technology that can detect if a child has left the perimeter and to track them

- The use of force doctrine to prevent them from leaving should be spelt out using Rules of Engagement for the Security Guards.

FAHSSE – Policy Statement

Overview

The Policy Statement of The Authority states that the focus is on all children especially those who are at risk and vulnerable in order to safeguard them from harm. The policy is however not applicable to the children's homes by its Statement that it ensures all The Authority's operations are in compliance with the aforementioned goals.

Aim: To ensure all activities with regards to the authority of The Authority is undertaken in a manner that complies with the national legislation in HSSE and best practices for the industry.

Objectives

- Abide by the legislative requirements of the State and any other instruments of HSSE as ratified by the State.
- Ensure all stakeholders and contractors abide by the same requirements
- Empower stakeholders to refuse to work in unsafe conditions.
- Provide all resources for the effective HSSE.
- Provide training to the employees in HSSE.
- Carry out audits towards detection of threats in order to plan for the reduction of potential losses.
- Register all near misses and analyse them for root causes.
- Carry out periodic drills
- Enhance emergency plans
- Respond to all accidents and incidents
- Investigate all accidents and incidents.
- Periodically review HSSE Plans using data collected in the aforementioned activities.

Gaps

- The policy Statement provides the general aim of The Authority on HSSE and then attempts to give the objective goals that will aid in meeting that aim. The document can be effective if the objectives were actually met, but in most cases, they are not and as a result the risk profile of The Authority is high with potential losses being imminent with the passage of time and inaction to correct this State of affairs.
- The policy Statement mentions the stakeholders and continuous liaison with those categories of persons to achieve the effect with regard to all their areas, but it does not give actions to follow its Statement in reality.

- The policy encompasses all the legislation and principles that can bring the environment for children into compliance with the necessary standard, but it appears that the major failing of The Authority in this area and others is its enforcement capability.
- The Child Support Centres and Reception Centres of the authority do not comply with this policy Statement. The responsibility for HSSE has been delegated to posts pursuant to the policy Statement however the post holders in the Child Support Centres do not appear to know of their responsibilities.
- Furter there is no sign of a risk or near-miss register at the Child Support Centres or community homes. Some homes are operating without emergency plans and allowed to continue by The Authority. This is not surprising since at the three Child Support Centres there are no emergency plans and the Investigation Team leads do not know that they are to create one.

Safety

- The manual mandates that the Investigation Team Lead has knowledge of the emergency plans and carry out drills at a regular period, but the Investigation Team Lead at Valsayn has reported he does not know the level of knowledge of the staff in emergencies. Further, he Stated that he is not aware of any drills conducted since he has been there. The South CSC, Tacarigua CSC Investigation Team Lead and the Valsayn Investigation Team lead both believe that the person responsible for drills is The Authority's HSSE Manager.
- No drills are conducted in accordance with the Investigation Team Lead's Statement.
- Valsayn, South and Tacarigua Investigation Team leads have no idea that in accordance with the SOPs they are responsible for the emergency plans. They have all said that they are awaiting The Authority to give them a plan.
- At Casa De Corazon, whilst there were drills in place the Manager appeared not have an emergency plan for emergencies which fall outside the realm of natural disasters. Further there were Safety risk on the children's playground as the railings had been damaged and in need of repair.

Health

- Many homes have no sick bay or capacity to administer first aid to the children
- St Jude's has been reported by former residents as not allowing medical attention in response to ailments of injuries when they are caused by abuse of the staff.
- St Dominic's has been reported for making residents sleep on the steps as a disciplinary measure.
- The Margaret Kistow house is filthy and a fire trap.
- Many of the homes are reactive in their treatment of children.
- Homes such as Casa De Corazon, Margret Kistow, and other community houses do not have special education requirements that are needed by some of the residents.
- Margret Kistow home does not have the sufficient space 6'x6' indoors and 10'x10' outdoors for its 36 residents and the management at the home claims that the THE AUTHORITY called them to take in two more residents which they had to turn down.

Environment

- The committee did not possess the equipment to carry out environmental tests of the homes. This is an area the is required urgently as a follow up to this committee's work.

Recommendations for the Policy

- The policy requires implementation at the operational and tactical levels before it can be enforced.
- All homes and facilities must be legislatively brought under the authority of The Authority for the purpose of HSSE.
- The licensing and operating requirements must be made as a result of achieving the HSSE measures.
- No home or facility must be allowed to operate in the absence of the above, the consequences of the potential losses is too large to allow.
- Immediate training must be given to the FAHSSE department on safety and health requirements as they are apparently without this knowledge at best (as evidenced by the high risk profiles the children are subjected to presently) or they have the knowledge and are negligent in the performance of tehri duties.
- This monitoring for HSSE requirements as it concerns children should be extended to all schools and institutions that care for children in a concentrated grouping.
- The policy is not in place at the Child Support Centres of The Authority and many of the homes were found to be in non-compliance with basic health and safety requirements. It is therefore recommended that the OSH Authority of Trinidad and Tobago carries out independent audits bi-annually to back up the audits that are intended to be conducted by The Authority. This layered approach will capture threats to the health and safety of the children and mitigate against potential losses in this regard.

Child Support Centre -Behaviour Management Policy Overview

The document acknowledges that Trinidad and Tobago ratified the United Nation's Convention on the Right of the Child in 1991 with effect from January 1992. The four general principles (non-discrimination, the best interest of the child, the right to life, survival and development; and the views of children were underscored and have been regarded as essential components in setting the foundation for the implementation of the Behaviour Management Policy at Child Support Centres. This is consistent with international standards. The policy is designed to be a guide for managing the transitions, behavioural challenges and psychosocial difficulties that inevitably surface while children are in the care of The Authority.

Gaps, Deviations and Recommendations

- The document encourages staff to build a relationship with children to catalyse positive behavioural change. Theoretically, this appears effective, however, there is no clear matrix for dealing with dynamic issues such as substance abuse, grief, aggression, or stress among residents in care facilities.
- No structured programme seems to be in place for training staff/caregivers on the implementation of the Behavioural Management Policy. For instance, the document provides a list of non-verbal behaviours that caregivers should practice (nodding and maintaining eye-contact for examples), but this does not effectively promote patience, critical thinking and emotional regulation in adverse situations (fights between residents that lead to serious injury).
- The reward schemes that have been set up for caregivers to utilize are limited and demotivating. Caregivers are encouraged to praise or smile with children as a reward for good behaviour. With consideration given to the circumstances surrounding this vulnerable population, it would seem proactive for such behaviours to form part of the socialization experience at State care facilities. In cases where rewards such as toys can be provided, the question of the person responsible for financing this is raised. Site visits have not demonstrated that a budget is allocated for reward systems.
- Monitoring and evaluation systems regarding the implementation and effectiveness of policy are lacking in many homes.
- The document provides a tabulated guide of possible consequences that can be used for specific offences by residents. While useful, the consequences suggested do not consider more aggressive situations that may arise. The policy seems to assume that all children respond to verbal instructions from every caregiver. For instance, the consequence for a 1–3-year-old fighting is to say, "not nice," but what if the child continues hitting? No direction is given in this circumstance, thus leaving it to the caregiver's discretion.
- Members of staff are encouraged to familiarize themselves with the history of the children. This raises the question of access to children's files and confidential information. Should caregivers need in-depth access to children's records, the recruitment, training and appraisal systems should consistently be managed.
- The Disciplinary Logbook mentioned on page 19 seems to be underutilised at many of the State facilities for children.

- Overall, the Behavioural Management Policy provides a fair foundation for managing the behaviour of children and it is consistent with international standards. The implementation of the policy, the training of staff to use the policy and the monitoring of children's progress in conjunction with the management policy are major gaps that should be addressed.

Child Support Centre: Caregivers' Code of Conduct

Overview

Aim:

The document seeks to provide a guide to caregivers as to the standards of conduct expected in the delivery of care at the Child Support Centres.

Objectives:

Employees are provided with a central guide and reference to manage day-to-day operations at the standard required by the organisation.

Description:

The Child Support Centre: Caregivers' Code of Conduct outlines the requirements for employees to operate within each Child Support Centre. It is divided into fourteen sections that cover important guidelines to ensure the safety of staff, the wards in care and the organisation.

Sections 1-4 focuses on the required conduct for all employees. This covers the hours of work, punctuality and absenteeism, personal appearance, the general standards of conduct and disciplinary guidelines. Employees are given the tools required to manage themselves while employed and the necessary steps to address issues that may arise that may affect their performance.

Sections 5-7 outlines the guidelines for managing the children/wards in the employees' care. The employees conduct towards children highlighted in this section is in tandem to the principles of the Children's Authority as well as the United Nations Convention on the Rights of the Child. Behaviours and interactions that align with the organisation's goals are explained and unacceptable behaviours are emphasized.

Section 7 emphasizes Health and Safety for employees and children as the organisation focuses on risk mitigation.

Sections 8-14 provides the guiding principles for decision making as the ethical guidelines for operations within the organisation are highlighted. These sections serve as a valuable reference to help employees prevent ethical misconduct through empowerment and the provision of support in the decision-making process.

Gaps

- The standard ratio of caregiver to children required to maintain the well-being and safety of the child residents is not noted in this policy.
- The commitment of the Children's Authority to provide adequately experienced and qualified caregivers to deliver the necessary care to the child residents is not noted. As such what constitutes the minimum requirements of such caregivers is not contained therein.

- The requirement of continuous capacity building and training activities in a bid to maintain the adequate level of skills and training necessary to effectively care for the child residents is also excluded. Such continuous learning is critical for organisational efficacy in various business types and is paramount to the work of residential child care.
- The availability of the required staff to ensure the smooth flow of day-to-day activities, with special focus the mental health professionals is not assured. Furthermore, the steps to be taken when these resources are not available are not outlined.
- The document does not address the steps for an employee to report any form of assault from another member of staff or from a child in care.
- The document does not clearly outline the steps to report infractions by a supervisor or superior officers whether the act was toward a child or a member of staff.
- While the policy speaks against using corporal punishment towards a child, making threats of violence or engaging in acts of violence, there is need for further police investigation into acts of violence that are allegedly meted out to child residents. Information received from interviews of multiple children resident at the Valsayn Child Support Centre at the time of this investigation revealed that boys in the care of this CSC have been disciplined for behavioral matters by being physically beaten by security guards in rooms known to be void of surveillance. This presents a significant gap in operations and a breach of national laws.
- This Caregivers' Code of Conduct is void of any reference to a discipline matrix to guide staff disciplinary activities towards the residents. Such a matrix ought to be included or referenced within this policy for caregivers.
- Section 5d outlines that staff are required to create a healthy, nurturing and safe environment for the children in their care. However male residents at the Valsayn Child Support Centre revealed that there are little or no structured activities to engage the residents. This presents a risk and neglect towards the development of the children.
- The ability to report incidents of child abuse, neglect or mistreatment is a significant and meaningful clause toward the overall safety of the residents, however, interviews revealed that instances of physical assaults and abusive language reported by child residents are not always documented and are rarely addressed.
-

Recommendations:

The Code of Conduct may benefit from the addition of:

- Section 3: Standard of Conduct: the inclusion of:
  - The Statement "Employees are prohibited from allowing unauthorised personnel into the centre".
- Section 6: Physical Contact with Children in Care
  - The term "sexual grooming of a child" to be listed in prohibited behaviours.
- Where possible the inclusion of the available mental health support for employees.

- Caregivers' Code of Conduct should include The Authority's position on continuous development of caregivers and the mechanisms implemented to promote the periodic capacity building of caregivers to ensure caregivers are tooled and adequately skilled to attend to the evolving needs of the children in their care while mitigating future harm.
- Children presenting behavioural challenges should be managed through a behaviour management framework that is comprehensive and adaptive to the dynamic needs of children at the CSCs. Failure to adhere to the guidelines prescribed therein should result in documented disciplinary actions towards the caregivers found to be engaging in same. Furthermore, where the disciplinary methods used constitutes physical abuse, threats or maltreatment of a child that is inconsistent with current national laws and policies, there must be documented records of same and the necessary reports made to the police for all such actions to be addressed by law enforcement agencies.
- There must be mandatory reporting to the police of all forms of abuse and maltreatment meted out to residents at CSCs. Interviews within this investigation revealed that instances of alleged physical abuse were not reported to the police and an instance of alleged sexual abuse was also not reported to the police until days after. Further, a parent indicated being chastised by staff of The Authority for reporting such an occurrence to the police.
- There must be an established standard ratio of child to caregiver fixed according to the age, development and differing abilities of the children being cared for at the CSCs. This is required to ensure the delivery of adequate care and protection to the vulnerable children within the CSC at any point in time. Site visits and interviews conducted with staff and children assigned to the CSCs at Tacarigua and Valsayn revealed that the ratio of caregiver to child at times averaged one caregiver to seven adolescent children and children that are differently-abled or hold mental health diagnoses are included within these general ratios. Systems to address the unforeseen decline in the standard caregiver to child ratio must be implemented to mitigate risks to the children in care.

Child Support Centre- Security, Admissions, Orientation and Discharge Processes

Aim

To address processes of admissions, orientation, discharge and security at the CSC aimed at ensuring the most appropriate approach to treating the specific needs of the child in care is determined and adopted.

Objectives

The document outlines the core components of the admission, orientation, discharge and security processes and provides a standardised framework for these activities.

Description

The document stipulates the steps to be taken when a child is brought to the Child Support Centre, the information required and the assessments to be completed. The security guidelines specific to these processes are stated and provision is made for intakes done after regular working hours. The orientations process emphasizes the role of the CSA and psychologist towards acclimatizing the child, conducting initial interviews and assessing the child to determine care. The discharge process outlines the guidelines towards transitioning the departing child as well as the remaining children.

Gaps

- The document references enquiries to be made by the CSC Investigation Team Lead for the impending arrival of children with specific mention of a medical examination and a description of the circumstances leading to admission. It is noted from Site visits to the Valsayn and Tacarigua CSCs that multiple children arrived without medical examinations conducted. This resulted in the CSC staff initiating further arrangements. Furthermore, a psychosocial history is needed to effectively assess the general presentation and specific needs of the child being admitted. These segments of pertinent information are reportedly sourced often days or weeks after admission as revealed through interviews with children and staff at the mentioned CSCs.
- Interviews conducted with child residents and staff of the Children's Authority in this investigation revealed that the stipulated duration of stay at the Child Support Centers is a maximum of twelve (12) weeks for detailed assessment and placement plans to be conducted. However, in practice children were found to be placed at the CSC in excess of eight (8) or even twelve (12) months which presents a significant risk and disadvantage to the well-being of the children as the CSCs' operations which are not designed for such lengthy time of care.

Recommendations

- Each child should be admitted with a psychosocial history and for emergency admissions this history should be made available within 48hours as such information is critical to determine placement at the said Child Support Centre. Along with the psychosocial history, known trauma history, previous situations of care and protection as per the records of law enforcement agencies and a history of conflict with the law should form part of this initial screening aimed at determining the most appropriate approach to treat with the specific needs of children at the Child Support Centre. Failure to provide such information results in risks and harm as children are inappropriately placed with insufficient information at admission. An observed

example of this is where children with care and protection situations, along with developmental challenges, are placed with children who are in need of supervision, thus presenting divergent needs and care management approaches.

- The situations contributing to the extended length of stay beyond the twelve (12) week residency at the Child Support Centres must be addressed. Children that continue to be resident at the Child Support Centres for such lengthy periods are being housed without consistent structured activities for their development and healthy functioning which further jeopardises their emotional and social functioning and wellbeing. The requirement of the law must be strictly adhered.

Standard Operating Procedure for Incident Reporting

Overview

The purpose of this Standard Operating Procedure is to set out the requirements for the reporting, notification and recording of all incidents that occur at the Children's Authority of Trinidad and Tobago's facilities and during the conduct of The Authority's business. The policy therefore appears to only apply to The Authority's Child Support Centres.

The document applies to all employees, contractors, clients, visitors, and employee representatives while in the work environment.

Incidents are listed to include, but are not limited to the following:

- Occupational injuries and illnesses
- First aid treatment
- Lost-time injury/illness
- Illness or injury for which an employee receives/seeks medical attention
- Critical injury/illness
- Occupational disease
- Fatality
- Fire
- Environmental release
- Explosions
- Exposures to biological,
- Chemical or physical agents
- Vehicular accidents
- Security incidents
- Quality issues
- Near Misses

The policy notes that the minimum requirements are as follows:

"An employee who has been involved in an incident or near-misses shall report same as soon as practical to his/ her immediate Supervisor. Either the employee or his/ her immediate Supervisor shall also report the incident to the FAHSSE Unit as soon as possible. All incidents and actions shall be documented within three business days. Recordable injuries shall be added to the facility's OSHA Log immediately upon learning about an incident."

The policy includes two prescribed Forms the HSSE Incident Report Form and Form 2 to be completed for all incidents.

Limitations

The Investigation Team was not provided with the HSSE Forms for the Child Support Centres except in the case of the attempted Valsayn absconding.

Gaps and Deviations

- The Policy requires upward and horizontal lines of reporting of all incidents and prescribes two forms, namely the HSSE Incident Report Form 1 and Form 2. Form 1 is to be completed by the employee and Form 2 to be completed by the employee's immediate supervisor. In the case of CSC Valsayn and the attempted absconding which took place on 18th March 2021, a Form 1 was completed however it is unclear whether the Form 2 was also completed as it was not provided. Form 2 provides for the identification of root causes and corrective action and is essential in preventing further incidents from occurring and therefore should be completed as required.
- For the 20th March 2021 incident the Investigation Team was provided with a Facilities Administration and HSSE Department Security Report which was completed and not the Forms 1 and 2 as stipulated in the SOP.
- Further to interview with the FHSSE Manager of the Children's Authority, the procedure prescribed for Incident reporting in the policy is not adhered to by the FHSSE Department. The FHSSE department uses an alternative reporting mechanism.

Recommendations

- That the definition of 'security incidents' expressly includes absconding as a type of incident that should attract the attention of the HSSE Unit.
- That the prescribed forms be utilized when an incident occurs to ensure that the information collected is relevant and standardised. The prescribed forms require root causes to be identified and for reviews to be conducted by the administration Investigation Team and the HSSE committee. Deviation from prescribed forms could mean that salient information may not be captured for the purposes of reviews, audits, investigations and further actions.

FRAMEWORK FOR THE INVESTIGATION OF COMPLAINTS ABOUT A COMMUNITY RESIDENCE

Overview

The purpose of this Framework document is to provide the Children's Authority with guidance on the design and implementation of an efficient and effective process for investigating complaints about a community residence. The Framework document outlines Section 5 of the Children's Authority Act which grants them the power to investigate any complaints against community residences and any incident of mistreatment in such places. The framework document further refers to Regulation 19 which requires The Authority to investigate all such complaints brought to its attention and to take appropriate action.

What can be complained about, as per The Framework document is defined broadly and includes but is not limited to

3.1.1 Concerns about the quality or appropriateness of the service provided by the community residence

3.1.2 Delay in decision-making or provision of services

3.1.3 Delivery or non-delivery of services

3.1.4 Attitude or behaviour of staff and residents

3.1.5 Case management and case reviews

Examples of complaints are set out in 3.3 of the Framework document as follows:

Non –conformance issues (about the residence)

- Financial impropriety – Manager using money given to the operations of the residence for personal use
- Residents not supervised/insufficient staff
- Inadequate – food (no variation, no alternatives, served expired items); dirty drinking water; snacks (children denied snacks/something to eat when they return from school) and clothing (ill-fitting school uniforms)
- Poor infrastructure
- Children feeling victimized by staff - telling the residents demeaning things (and in the presence of other residents)
- Residents not provided with sufficient money to obtain transport to and from school

Issues of abuse (about the child)

- Physical abuse (including corporal punishment)
- Sexual abuse

Gaps and Deviations

- Section 4.2 of the of the framework states that each community residence should design a complaints procedure that is accessible and child friendly. The framework does not provide any further information on the complaints procedure nor does it provide any basic standards for the residences to adhere to in creating such a procedure except that it should be readily accessible and, in a user-friendly format for children. In several of the community residences visited it was evident that a structured complaints procedure did not exist. The reality at the residences differed
  - At the community residence in Tobago, the complaints procedure was a written one although the residents ranged from ages 0-13 years. In practice a complaint of a child was noted during a group therapy session.
  - At Margaret Kistow a resident complained via text to the Manager and Manager indicated residents had opportunities to complain at 'House' meetings or to their assigned CSA's.
  - At Casa De Corazon, a resident complained directly to The Authority via an email.
- The Framework refers to complaints log as well as the complaints procedure being prominently displayed and, in a child, friendly format. Several of the homes visited did not have such procedures displayed nor were there complaint logs.
- The Framework prescribed that The Authority ensures all steps are taken to resolve complaints and Section 8.5 States that The Authority shall visit the community residence to investigate a complaint immediately or within 72 hours of receipt of the complaint. This appeared not be the reality
  - At the Probation Hostel in Tobago, a matter involving a complaint by a female resident against two male staff members remained unresolved at The Authority level and interim measures have been put in place by the Manager to ensure the situation would not further occur. According to the Manager, due to lack of response from The Authority and Police which advised that there was not enough evidence to lay charges, the Manager conducted his own internal investigations and made the recommendation for the staff members to return to work with provisions being made for them to not enter premises of the female hostel building.

Recommendations

- There should be a prescribed and standardised complaints procedure developed by The Authority for the community residences taking into consideration the age of the residents, literacy levels and safe mechanisms in which children and third parties could report any incidents of abuse. Complaint procedures must take into account mechanisms through which residents could complain about the members of Staff including the Manager or Investigation Team Lead confidentially.
- The development of complaints procedures should be in accordance with the CRC and the Guidelines for the Alternative Care of Children as adopted by the general Assembly of the UN in 2010. Section 99 of the guidelines States

- Children in care should have access to a known, effective and impartial mechanism whereby they can notify complaints or concerns regarding their treatment or conditions of placement. Such mechanisms should include initial consultation, feedback, implementation and further consultation. Young people with previous care experience should be involved in this process, due weight being given to their opinions. This process should be conducted by competent persons trained to work with children and young people.
- Ongoing Training must be done for community residence Investigation Team leads and personnel on developing appropriate complaints procedures as well as on conducting internal investigations and advancing complaints through the reporting systems
- Prominently displayed Child Appropriate Messaging should form part of the requirements for licensing of a home and HSSE requirements.
- A Disciplinary Matrix is recommended for Community Residences that have continual non-conformances or complaints of a serious nature against them. Further a process through which certain homes could be flagged for mistreatment of children is strongly recommended.
- Terminology such as “violence” as used in the CRC could be helpful to encapsulate the wide range of acts against children which should be complained about, issues such as mental/emotional abuse, neglect, trafficking/prostitution of children are not expressly included as reportable incidents under the complaint procedure.
- Investigations must be conducted in child-sensitive ways and should have tangible outcomes which could be monitored and evaluated. In the case of A. Miller at St Jude’s where it was found that the child had been handcuffed, THE AUTHORITY did not address this finding specifically in its recommendations except to say that the use of security firm should be reconsidered. Any complaints made which constitute violence against a child should have firm consequences and should be investigated thoroughly by The Authority and the police.

Security Manual - Standard Operating Procedures

Overview

The security manual, 'Standard Operating Procedures' are formulated and promulgated to allow for the standardisation of response, preservation and protection in the facilities of The Authority. It is reasonable to understand that the act of absconding can only take place with the failure of the security system resulting in the breach of integrity of the perimeter of a facility. The root cause of the absconding is not being considered in this document. The effect of failure in security systems will allow children to access the outside world without supervision.

The NiNa report on girls, States that the children who abscond are at a higher risk due to vulnerability. It also States that the risk is exacerbated by the presence of a high crime rate and the human trafficking rings that exist within this country.

Upon analysis of the existing reality as opposed to the ideal that the manual proposes, a number of GAPS have been identified. Further it is reasonable to expect that the Reception Centres and Assessment Centres of The Authority which receive children with a high-risk profile, do not change that profile in the short time that they are expected to stay at that facility. This translates into a transfer of the risk to the facility of community home to which the high-risk child is transferred. This is an issue as the manual only covers the security personnel of The Authority and the Child Support Centres and does not extend to the community residences that the children occupy. This results in widely varying standards of security and safety at Community Residences.

Introduction

Security is a lowering of threats that are identified by risk assessments in order to maintain sustainable operations. There are a lot of common factors between security and safety and there are a lot of mutually exclusive issues in both areas as well. Common factors include increased efficiency in evaluation of measures through recordings and the correction of shortcomings through 'lessons learnt' methodology. The exclusion items are such issues as, in safety all exits and entrances must be easily used without restrictions and in security there is a need to have strict movement control to include egress.

Security provision is comprised of three areas; the environmental element, the procedural element and the culture of the psychological element. These areas feed into the effectiveness of the security system of a facility or organisation and hence will be used to analyse the security policies of The Authority.

Aim: Assist the Security Unit of The Authority in the performance of the duty of Responding to Emergencies, Protecting Life and Protecting Property

Objectives

- Standardising the performance of the Security Unit.
- Assigning duties to the security representative of The Authority attached to the CRs
- Maintaining records of activities at the Centres
- Enforcing the rules and regulations of the facility
- Protecting the staff and children at the facilities
- Mandating the use of force commensurate with the threat
- Promoting the professionalism of the authority
- Maintaining a presence to act as a deterrent
- Intervening in the case of escalation of events beyond the CSAs and Caregivers
- Maintaining surveillance of the facilities
- Responding to children who abscond
- Promotion of safety standards in accordance with OSH and ratified international instruments as appropriate.

Description

The SOP manual is a series of themed/grouped guidance support documents to the security personnel and Investigation Team/Leads assigned mainly to the CRs.

The document highlights the overarching mandate of The Authority for preservation, response and protection, that impacts upon the aforementioned establishments. It gives the security officer, senior and junior officer, the code of dress, conduct and mandates to ensure effective recording and monitoring of the facility. Further, it squarely puts the responsibility of safety in accordance with the OSH act on the representative of the security department.

During the discharge of the duties, the manual obligates the security personnel to conform with all laws of Trinidad and Tobago. The performance of acts in response to requests from the staff is addressed and it gives the security personnel the additional mandate of assisting where they can.

The work ethics such as the use of the phone on duty and demeanour is also addressed.

Gaps and examples:

The Child Support Centres and Reception Centres of The Authority do not comply with this Standard Operating Procedure with regard to security and in some instances safety.

GAPS in their compliance as follows:

Security

- The Authority's security work during the day while the external security provider works at night. The risk is understood to be higher during the night and hence the most competent person should be on duty.
- The surveillance is not monitored 24/7 in a way that allows response to threats detected. In the case of the Valsayn Child Support Centre, there was no one monitoring the surveillance during the absconding of the boys in March 2021 and there was no external response until the superior authorities were notified. (The Investigation Team Lead Stated that the cameras are monitored off site).
- There was obviously no standardised response to the distraction that the boys in the home carried out in order for the other boys to escape. If there were, one guard should have responded whilst the other two guards continued monitoring duties at the surveillance room and the outside perimeter. It is apparent that the three officers that are claimed to be present at all times were not at that strength.
- The lack of surveillance at night and the fact that whatever party monitoring offsite never prevented the absconding, represents an issue of fool's gold. The records that are reported as maintained are apparently kept only for investigative purposes and are not used to determine trends and patterns and lessons learnt. The Investigation Team lead is reported as forwarding all incidents of abuse to The Authority. It means that there is no initial investigation.
- There is no section of the visitors' log where a National Picture Identification can be logged and often times a visitor would be logged in only upon entry and is not logged out. Further our investigation revealed that there is a practice to allow the visitor to sign in the premises. This allows fraudulent representation of the visitor's ID to be perpetrated. It therefore increases the risk to the facility, staff and children.

Safety

- No drills conducted in accordance with the Investigation Team Lead's Statement.
- Valsayn, South and Tacarigua Investigation Team leads were unaware that in accordance with the SOPs they are responsible for emergency plans. They have all said that they are awaiting The Authority to give them a plan.
- The manual mandates that the Investigation Team Lead has knowledge of the emergency plans and carry out drills at a regular period, but the Investigation Team Lead at Valsayn has reported he does not know the level of knowledge of the staff in emergencies. Further, he Stated that he is not aware of any drills conducted since he has been there. The South CSC, Tacarigua CSC Investigation Team Lead and the Valsayn Investigation Team lead both believe that the person responsible for drills is the The Authority's HSSE Manager.

Recommendations

- The measures that exist in the manual require revision in an effort to standardise measures and address essential issues such as rules of engagement and use of force. When it is revised, it requires enforcement at the CSCs.

- Compromise in the degree of enforcement by the Licensing and Monitoring Associates should be part of a standardised policy that uses the risk appetite as the basis. Presently it appears to be a matter of subjectivity and it has allowed for children to be placed in unsecure facilities (See site visit analysis of Valsayn, St Jude's, Margret Kistow and Casa de Corazon)
- The manual addresses the Child Support Centres only, but the regulations for Community Residences are not complete or thorough, therefore there are no measures for addressing standards at these facilities. The manual for Child Support Centres should be extended to apply to the Community Residences.
- The manual requires systems for duties, routines, and specifics of the facility risk assessment to be conducted both by The Authority's security officers as well as external security officers. The recording of tasks for the security guards deployed on the posts should be mandated to ensure supervision of performance and mitigation of losses. Special note must be made to highlight the lack of access to the surveillance feed to the security guards who are on duty at the Child Support Centres after hours and on weekends. Further the feed should be sent to phone of the Manager.
- The manual should outline conditions in security and safety that have to be met in order for the facility to operate. Failure to do so should carry sanctions (criminal) in the form of fines or incarceration for anyone operating without this license. No facility should not be operating without the conditions of the revised manual met.
- The use of the Licensing and Monitoring Associates to monitor and evaluate the facilities, as well as to manage placement of the children at the Community Residences and Child Support Centres is not ideal. It is recommended that independent auditors from The Authority should conduct bi annual assessments of all residential care institutions. These independent auditors should also be supported by the DDLRS and the Board of Management.
- The security force is a hybrid of external providers and internal personnel. The best practice based on the specialized training required in this form of security provision is for the entire force to be internal. Should this not be implemented or if the implementation of this measure is expected to take more than three months, it is strongly recommended that the contracts with the security providers must be revised
    - to ensure the guards report to the Investigation Team lead,
    - the security guards at the location adhere to the requirements for reporting to the line of command at the facility and
    - The Authority be the body responsible for disciplining the guards who contravene the regulations at the facility.

Guidelines on the Use of the Security Personnel from Private Security Companies

Overview

The purpose of the document is to set out guidelines for Private Security Companies and to establish a foundation to translate these guidelines into oversight mechanisms. The guidelines are meant to articulate principles applicable to the actions of the PSC while performing Security Services at The Authority's facilities;

The use of private security in Child Support Centres and Community Residences is fairly widespread in the children care system. The Authority's Manual on this topic espouses many valid principles and concepts but in reality, there are many times the personnel contravene the principles therein.

Gaps and Deviations

It is recognised that absconding occurs only when there is a failure of security systems it is also absconding can be motived by abuse at the facility. It was revealed that in some instance the persons perpetrating the abuse was the security guards.

Examples can be seen in the sexual and abuse relationships carried out by a security guard at St. Jude's in direct contravention to the guidance manual. Further this abuse continued and a security company delayed in their action (see interview with Ms. Millington, and Manager at St Jude's).

Another example can be seen in Valsayn where security guards barraged the residents with derogatory terms based on their sexual orientation (see interviews with Valsayn residents). This contravenes the guidelines regarding no use of cruel treatment towards the residents. The Investigation Team found that there were instances of security guards using the excuse of restraint to abuse the boys by bashing their heads against wall and furniture at the Valsayn Child Support Centre. It is noted that the guards involved in these activities are from external companies.

The oversight of external companies falls to the Licensing & Monitoring Unit however reports on incidents from the private security guards are not given to the Licensing & Monitoring Unit nor to any other department within The Authority but rather reports are made to the management of the private security companies. The Authority is then forces to wait for the private security companies to supply them with the report (Interview with Ms. Celestine and Mr. Thomas).

The use of the external personnel also shows the disparity in the training and processing ability of the external guards compared to The Authority's personnel. It is recognized that the minimum level of training often no longer than one week in duration is given to these external security guards.

The manual further indicated that the external security guards operate within the laws of Trinidad and Tobago. However further to interviews and information provided it is clear that in most instances the external security guards are not aware of the laws and requirements. An example of this was seen in St Jude's when the security guard in response to instructions from the Deputy Manager used handcuffs to restrain the residents and, in another instance, used batons in response to a personal affront with one of the guards (Interview with Ms. Millington and former residents of St Jude's and Manager).

Recommendations

This policy like many others espouses the correct concepts but falls short on implementation and enforcement.

- It is strongly recommended that the standard of external security guards must be increased and that external security guards must receive training from the Youth Training and Rehabilitation Centre Staff and The Authority's clinicians. This training must be recertified every two years and audited with failures.
- Further private security companies are to ensure that only the personnel trained in accordance with item 1 above are to be used in The Authority's facilities and must not be replaced with untrained personnel.
- The reporting lines of the guards on the facilities to include disciplinary measures must be put in the hands of the manager of the facility. The current security force at The Authority's facilities is a hybrid of external providers and internal personnel. The best practice based on the specialized training required in this form of security provision is for the entire force to be internal. Should this not be implemented or if the implementation of this measure is expected to take more than three months, it is strongly recommended that the contracts with the security providers must be revised
  - to ensure the guards report to the Investigation Team lead,
  - the security guards at the location adhere to the requirements for reporting to the line of command at the facility and
  - The Authority be the body responsible for disciplining the guards who contravene the regulations at the facility.

Place of Safety Protocol

Overview

A place of Safety is defined as a place that adequately provides and cares for children requiring emergency accommodation. In the local context, Community Residences and Emergency Foster Care providers will function as Place of Safety. The Policy outlines section 45 of the Children's Act which permits placement of a child to a place of safety.

Place of Safety was established to serve as an emergency and short-term placement to facilitate the instantaneous removal of children to a location that is secure, child-friendly and professionally staffed. Interim care is intended to be provided at this location while children are being assessed at the Assessment Centre.

Objectives

The main objectives of the protocol are to:

- provide standards and guidelines for the safeguarding, care, and protection of children at the Place of Safety;
- provide guidelines for the operations of the Place of Safety;
- ensure that professionals functioning at the Place of Safety process are aware of their responsibilities;

Gaps and Deviations

- The policy prescribes the documentation which should be provided at the time of placement. This procedure is not strictly adhered to in practice, noting that several Community Residences have complained of not receiving documentation in a timely manner.
- The policy prescribes the ratio of caregivers to residents based on age groups. This requirement is not strictly adhered to a Child Support Centres and Community Residences are usually understaffed. In the case of the Valsayn CSC, at the time of the absconding on 20th March, there were two caregivers assigned to 16 residents. Additionally, the ratio prescribed under this policy differs from The Authority's submission to the Joint Select Committee; consistency and standardisation of ratios for caregiving must be established.
- Notably, the Audit report on the absconding of the five boys noted that there was non-compliance of several sections of the Place of Safety Policy.
- The policy refers to an initial critical incident report form to be completed within 24 hours of the critical incident as well as a Final Critical Incident report form which is to be completed no more than 90 days after the incident and should provide an in-depth account of the incident and the investigation. The Investigation Team was not provided with any Final Critical Incident report and in unaware of whether this process is followed.

Recommendations

- Caregiver ratios must be clearly defined across all policies of The Authority and must be strictly adhered to all times; the ratio must take into account the child's risk profile, the age and developmental needs of the child. Understaffing issues should be resolved.
- It is strongly recommended that the process for submission of Final Critical Incident reporting should be adhered to. The Final Critical Incident Report form will provide an in-depth account of the events which took place and any findings found from the investigation. This process will allow for closure of matters and resolutions to any issues found throughout the investigations.

Chapter 9 - General Findings

The following are general findings identified from the investigation completed. They all identify issues related to a failure to safeguard children in need of care and protection in Trinidad and Tobago.

Legislation Guiding the Safeguarding, Care, And Protection of Children is confusing and ineffective with respect to enforcement of its provisions and the creation of offences

The legislation comprising the suite of Children's legislation together with the amendments rendered by the Family and Children Division Act on the Acts and the Miscellaneous Provisions (Supreme Court of Judicature and Children Act Regulations) is confusing and makes it difficult for a practitioner in the field to ascertain the state of the law in the area.

The following should be noted:

- Section 3 (1) and (2) The Children's Community Residences, Foster Care and Nurseries Act provide that no person shall manage a community residence without a licence and no child shall be cared for and accommodated at a community residence without a licence. Failure to adhere to these sections would result in the imposition of a fine pursuant to section 17 of the Act. Neither of these sections of the Act have been proclaimed. Our investigation has revealed that several children's homes continue to operate without licences and continue to provide care for and accommodation to children in the absence of same. Where Children's Homes do not qualify for licensing, the Authority has no power to shut down these homes. As a result, the Act lacks adequate enforcement mechanisms to be used when a Children's Home fails to qualify for licensing but is still allowed to provide care and accommodation for children.
- The offences and penalties under the Children's Community Residences, Foster Care and Nurseries Act are inadequate to effectively combat abuse and provide for the safeguarding of children in residential care. Section 17 (which remains un-proclaimed to date) provides for a fine of $10,000.00 and in the case of a continuing offence to a fine of five hundred dollars for each day the offence continues. The Act does not provide for the closure of such homes which are in contravention of the Act.
- Section 17A of the Act is limited to use of the prohibited behaviour "as a form of punishment" while that is in accordance with the wording adopted in the Convention on the rights of the Child the behaviour on the whole should be prohibited. The qualifying words may serve to provide and defence and cover for the prohibited behaviour.
- Section 17B may be considered by a court to be vague and offend against the principle of legal certainty
- There are no regulations and standards provided for the operation and management of Child Support Centres. The Authority with the approval of the Minister has established standards and regulations for Community residences, however by definition Child Support Centres are not considered Community Residences and as such there are no detailed guidelines for its

operations. The absence of prescribed standards for Child Support Centres has resulted in sub-standard care being provided to children in the Child Support Centres

- Further while there are regulations which establish the prescribed standards for Community Residences, these regulations are in fact imprecise, poorly defined and subjective.

The legislation facilitates the unequal treatment of children in Community Residences

- The legislation facilitates a hybrid system of care for children resident in Children's Homes children who have the benefit of orders from the Court with respect of whom the Authority is mandated to provide care and treatment and children who do not thereby creating an unequal system of care.

Unwillingness To Enforce Licensing Requirements for Children's Homes

There is no will, intention, or mechanism to shut down the operations of unlicensed homes that continue to put children at risk in Trinidad and Tobago. Currently, unlicensed homes receive recommendations for complying with the license requirements, but delivery timelines to address risk areas and ensure compliance are not identified or managed, and there are no penalties, consequences, or implications to operations for not complying with the standards required for licensing. These include operating facilities that have not received compliance certification such as from the Trinidad and Tobago Fire Services (TTFS).

- The State by refusing to enforce the mandatory provisions for licencing continues to place children at risk by facilitating Children's Homes being permitted to provide residential care without meeting the standards prescribed by law to obtain a licence.

There is a conflict between the licencing function of The Authority and need for it to place children in Children's Homes. The challenge noted by all levels within The Authority is there "there is nowhere else to place children if they close down homes." This leads to the conclusion that placing children in situations that pose a severe risk to their health, safety, and lives is acceptable over implementing changes to and funding the required changes needed to ensure that the safeguarding, care, and protection of children are delivered to the highest standard.

Public Financing for Safeguarding, Care, and Protection of Children is Inadequate

Funding for safeguarding, care, and protection of children in Trinidad and Tobago does not match the demand for the services and facilities needed.

The number of children in need of licensed Children's Homes, Community Residences, and Hostels is greater than the current capacity.

All existing facilities are understaffed and under-resourced for the number of children in their care or cannot operate at capacity. Children are placed at risk in under-regulated, under-resourced, and poorly-managed facilities that do not have standardised operating and safeguarding systems.

Compensation for professional services focused on children is generally low, and social services within and external to the care and protection system are typically stretched beyond capacity, and the need for these services is increasing.

Inadequate and Ineffective State Coordination and Collaboration

There appears to be varied understandings of the role, responsibilities, and functions of The Authority, and the intersecting responsibility of other Ministries and State Entities in the provision of care and protection of children.

The management and staff of the Authority noted on several occasions that there was a lack of support from Ministries and other agencies such as the lack of support from the Ministry of Health to provide a psychiatric facility for children with mental health challenges as was evident in the case The Children's Authority v the Ministry of Health v North West Regional Health Authority Case No C-North AP2879 of 2020.

The Authority has failed to meet its Statutory Mandate

It is clear from an examination of the Critical Incident Reports, site visits, and interviews that the Children's Authority is failing to meet its statutory mandate as required by Section 5 of the Children's Authority Act, specifically, its mandate to: -

- provide care, protection and rehabilitation of children
- investigate complaints of a failure to comply with the requisite standards prescribed under the Children's Community Residences, Foster Care and Nurseries Act, 2000 and any incident of mistreatment of children in such places;
- investigate complaints or reports of mistreatment of children;
- monitor community residences, foster homes and nurseries and conduct periodic reviews to determine their compliance with such requirements as may be prescribed;

- issue, suspend and revoke licences of Children's Homes and nurseries as provided under the Children's Community Residences, Foster Care and Nurseries Act, 2000;
- do all such things as may be necessary or expedient for the proper performance of its duties.

This investigation highlighted that the most critical risk facing The Authority is that it is not structured and staffed to deliver the mandate outlined in the legislation. This was noted from all interviews across the organisation. The ineffective organisational capacity directly impacts upon The Authority's ability to fulfil its mandate to provide care, protection and rehabilitation of children, and questions its ability to manage risks.

Work has been started by The Authority on assessing organisational capacity, developing a competency framework, and redesigning the organisation to deliver on its mandate. This process must be prioritised as a key action to responding to the other risks identified by The Authority.

The Board of Management of The Authority noted the following as the top risks currently being managed:

1. Risk of absconding;
2. Risk of harm, and injury to children - to which they have implemented a Crisis Communication Plan;
3. Reputational risk to the organisation;
4. Risk of litigation.

The Authority does not have a standardised Risk Management System in place across the organisation. A Risk Management Plan was approved by the Board in 2021, along with a roadmap towards implementing that plan. This is expected to be completed in 2022.

The Authority is responsible for monitoring community residences, foster homes and nurseries and conducting periodic reviews to determine their compliance with such requirements as may be prescribed. Although these reviews are conducted the process does not seemed to be linked to any improvement in poor systems or negligent or even the prevention of abuse. Proper monitoring would have revealed numerous incidents which ought to have caused The Authority to remove children from Homes, conduct more rigorous investigations into reports of mistreatment, and stop placing children in Homes that are not licensed.

It was also found that child abuse and absconding are generally treated as isolated incidents, with a focus on the child as the cause, as opposed to problems that are facilitated by an inefficient system.

The Authority and its operations are currently being guided by policies which have not been approved by the Board of Management.

The Authority does not have a standardised Risk Management System in place across the organisation.

The Authority's position on caregiver to child ratio is unclear and conflicting in its Place of Safety Policy and its submission to the Joint Select Committee.

Placement Crisis

There is a placement crisis for children. There are not enough Children's Homes to meet the need and demand for placement nor are the assessments upon which placements are determined, are done in a timely manner. This crisis has resulted in the placement of children in residential care institutions which unsuitable and which fail to take into consideration the needs and best interests of the child.

As a result of the lack of homes to meet the demand for placement, the Authority is forced to:

- use the Child Support Centres (CSC) to provide long term care for the children, in contravention of the Children's Authority Act and
- place children wherever there is space rather than in homes that would be well suited for the child in accordance with his/her age, developmental needs and security risk profile
- utilise unlicensed homes
- facilitate the overcrowding of Children's Homes and CSCs.

By law, Child Support Centres are for temporary placement and for a period of not more than twelve (12) weeks. Currently children are placed in Child Support Centres for periods far exceeding twelve (12) weeks despite such centres not being equipped for long term care. Child Support Centres are meant to have a child psychologist who would make recommendations to the Board for the child's placement, it is not meant to act as a community residence.

During interviews, Management of the Homes reported being pressured by The Authority to place children despite the lack of adequate resources to manage them. This has led to overcrowding and the mixing of different categories of children that is, children in need of care and protection as well as children in need of supervision (CHiNS). Management of the Homes shared that this has led to poor supervision of children with behavioural problems which has resulted in their absconding, self-harming or harming other children or staff members. One obvious case demonstrating the dangers of mixing the different categories of children in facilities which are not equipped to deal with this has been observed at Valsayn Child Support Centre. This is a case of one resident who was initially categorized as a child in need of care and protection, and was housed at the Child Support Centre with children of varying categorizations. This resident was mentioned in several critical incident reports as having been physically assaulted by staff and other residents. In one such critical incident report, he was sodomized with a broom handle by another resident. This resident also inflicted bodily harm on another resident when he bit off piece of the peers' ear lobe. The resident was a member of the 5 boys who absconded from the Valsayn Child Support Centre, which ended in the death of 2 of the boys.

Placement of Children with behavioural problems or who are at high risk of causing hard in facilities ill-equipped to manage their needs have resulted in increasing instances for absconding.

Management of the Homes also reported that children are dropped-off at the homes by the Authority without medical examinations being completed and insufficient documentation to identify their needs and their possible risks, such as trauma, aggression or running away.

It is imperative to acknowledge that a resident's legal categorisation does not equate with their risks of harm to self or to others. Each child should be afforded a risk assessment, and consideration be

given to recategorizing children based on risk rather than legal status. Priority must be given to placing children in facilities that are equipped to mitigate their risks. This is further discussed in the recommendations section, under "Recommendations on Prioritising Risk Assessment and Placement"

In addition to the lack of residential care institutions, the placement crisis is exacerbated by the Authority's failure to deliver diagnostic assessments and treatment plans for children in a timely manner. The timeframe noted for complete assessments varied, and ranged between three (3) to at least 12 months and in some cases children left residential care without ever having received an assessment or treatment plan.

The responsibility for the approval of a child's placement and that of treatment plans vests in the Board, which is essentially an operational function vested in an oversight entity. The Board meets monthly to review and approve the placement and treatment plans. Which notably would cause delays in treatment and assessment of the adequacy of the placement.

The Annual Treatment Plans Tracker provided by the Board only identifies the total number of treatment plans assumed to be reviewed by the Board monthly and lacks any information to gauge the efficiency of the process against any established KPIs.

(Appendix 9: Annual Treatment Plan Tracker)

Failure to Uphold the United Nations Convention on the Rights of the Child

Under the terms of the United Nations Convention on the Rights of the Child, governments are required to meet children's basic needs and help them reach their full potential. These include the fundamental right to:

- Life, survival, and development
- Protection from violence, abuse or neglect
- An education that enables children to fulfil their potential
- Be raised by, or have a relationship with, their parents
- Express their opinions and be listened to.

From this investigation, it was found that

Provision of Education – there is no standardised system for the education of children across Community Residences and Child Support Centres. Some children are not provided with adequate resources and opportunities to access education, and many exit Community Residences with little to no academic qualifications after their stay. One teacher supports two Child Support Centres comprising 19 children at varying levels of ability, including learning disabilities.

Medical care provision for children in Community Residences is not standardised. Two Child Support Centres share one (1) nurse. Provision of care for children who contract COVID-19 is challenging given the operations of Residences.

The Child Care System is Poorly Structured, Monitored, and Regulated.

Several failures have been identified within the operations of the child care system. These are itemised below.

Failure to report cases of abuse to the police

Interviews within this investigation revealed several instances of alleged physical abuse, particularly those of abuse of children by staff, which were never reported to the Trinidad and Tobago Police Service (TTPS). It was also found that in several cases, reports were made weeks after the incidents occurred. Additionally, where cases were reported to the TTPS by children, it was noted that feedback for the commencement of an investigation took several months. In two (2) cases of note, both children were contacted about their interest in proceeding with an investigation after they turned eighteen (18) and were no longer at the residence.

Additionally, an instance of alleged sexual abuse was also not reported to the TTPS until days after. Further, a parent indicated being chastised by the staff of The Authority for reporting such an occurrence to the TTPS.

Security Concerns and Risks

Security at Children's Homes and Child Support Centres is provided by either private security firms, security officers employed by The Authority, or in some cases, both. These security providers all monitor and evaluate themselves. There is no independent agency to monitor, evaluate and hold security providers and security personnel accountable.

There is no standard security risk assessment framework in place for safely managing and monitoring the security needs and functions at Children's Homes in accordance with the regulations and associated international standards.

There is no standardisation of security training and operating practices.

Inconsistency in Critical Incident Reporting

There are two types of critical incident reporting forms based on the requirements of The Authority. There are also no clear guidelines on Critical Incident identification and reporting. The review of the six hundred and two (602) Critical Incidents revealed that there were one-hundred and sixty-five (165) different critical incident identification descriptions.

Management of Homes were often unclear as to what constituted critical incidents and in some cases used their own subjective understandings to determine wh

Staffing and Management of Staff at Children's Homes

The Boards St. Mary's, St. Jude's, and St. Dominic's not have the power to manage, dismiss, and replace all members of staff. Some members of staff are under the auspices of the Statutory Authorities Service Commission who is responsible for the transfer, promotion and disciplinary of a number of their staff. There is often conflict between these members of staff and contracted staff at these institutions. Additionally, permanent staff that are deemed problematic or inefficient at residences are either asked to not perform duties, or are rotated into other residences, facilitating the problem of staff shortages.

Management reported that the unionised staff at these homes refuse to comply with guidelines and regulations established by The Authority and on occasion to follow instructions from contract workers

Standards for Operations and Training

Standards in the regulations for operating a Children's Home are subjective, non-specific and lack minimum requirements for compliance.

There are also no standardised job descriptions or competency requirements for operating and managing a facility for the care and protection of children.

In the absence of a licensing system, there is no way of enforcing standards.

Based on the investigation, it was found that the training provided to ensure compliance with the regulations has been inadequate and ineffective.

Although some training has been provided to the Children's Homes by the Authority on the requirement of the legislation and care-related topics, this training is not mandatory and sporadically offered. Interviews with persons at Community Residents and Rehabilitation Centres revealed that most persons did not receive training or thorough guidelines on transitioning the existing systems to meet the new requirements.

There is no standardised screening process for persons hired to work in Community Residences and Child Support Centres.

Failure to Share Information

Several instances have emerged, where children's medical and mental health treatment were delayed due to the lack of information shared with persons caring for the child in a residential care facility by The Authority. Children's home personnel complained that when they asked for pertinent information on admission of the child, of which The Authority was in possession of, regarding a child's health, mental health and trauma history, they were told that the information was confidential and therefore could not be shared. Sharing a child's mental health diagnosis is necessary for continued monitoring by their guardians/caregivers in order for observations to be shared with their doctor for medication and therapeutic management. Monitoring children's use of medication is also important to safeguard children from misusing the medication which can be detrimental to their health. In addition, when

caregivers are unaware of the side effects of medication, there can be further harm experienced from the major side effects due to the limited information available.

There have been instances where children's absconding history was not shared. Sharing such information may have assisted in preventing further absconding when placed in care and protection type facilities. Additional security measures are necessary for environments with children with histories of absconding. The absence of this information increases the risk of future successful absconding attempts.

In order for children to access the appropriate care and services they require, it is necessary to share pertinent information with the person/ persons responsible for safeguarding the child. It is also essential to ensure that the child's privacy is respected.

This creates a delicate path that needs to be navigated. While the child's information needs to be kept confidential, withholding pertinent information such as medical, developmental and mental health information puts the child in danger when they are unable to access timely and appropriate services or medication.

Inadequate Facilities for Mental Health Care

Every child entering the care of Children's Homes and State enter with a varying level of Psychological Trauma. Traumatic situations ranged from neglect and abandonment to psychological, physical and sexual abuse. In addition to Trauma, these children all suffer from grief through the experience of "loss" of their family. These adverse psychological experiences create a platform of intense stress which results in varying levels of cognitive, behavioural and emotional dysregulation.

Children with unstable mental health disorders placed in residential care settings have encountered many challenges in accessing effective treatment required for stabilisation and management. There are currently no children's homes equipped to provide effective and efficient treatment of children with mental health disorders.

According to the meeting summary from 2017 Joint Select Committee on Social Services and Public Administration (Including Education, Health, Gender, Tourism, Public Administration, Labour, Culture, Community Development and other Social Services): An inquiry into the State of mental health services and facilities in Trinidad and Tobago[i]; it States that "over the past two and a half years The Authority has conducted intervention plans for 360 children of which 137 children presented some sort of mental illness."

Many children's homes did not have access to appropriately trained psychologists and social workers. Children placed into homes by The Authority had inconsistent access to a social worker and counselling through The Authority. Children placed prior to the inception of The Authority had no access to the necessary psychological interventions or social work advocacy. In an attempt to fill the gap in psychological treatment Homes sought out the limited counselling services provided by NGO's and in the public health sector. This led to significant delays in psychological treatment and resultant critical incidents of harm to self and others.

While Lady Hochoy Home cares for children with intellectual disability and other developmental disorders, they are not equipped to provide the necessary constant supervision required for management of unstable psychiatric disorders. It was noted that some children experiencing symptoms of their diagnosis became violent damaging the infrastructure of the home, physically hurting staff, themselves and traumatizing other children. Caregivers, inadequately trained in dealing with such presentations posed risks of abuse to the children while trying to manage the situation. Children with unstable mental health disorders were also found to successfully abscond.

In the case of St Jude's, self-harming was found to be prevalent and the requisite treatment remains unavailable due to the lack of psychological support. It was further noted that in the case of one resident at the Valsayn Child Support Centre who was involved in multiple critical incidents regarding physical and sexual aggression, this resident was unable to access psychiatric assessment and thus the staff were unable to appropriately manage his behaviours. A Resident at the Tacarigua Child Support Centre required in-patient psychiatric treatment and had to be placed in the adult unit as there was no child in patient mental health facility which could accommodate her needs.

Interviews with children who had the availability of a psychologist noted that having a session with a psychologist was very helpful to them. Girls from St. Judes noted that they wished they could have regular interactions with the psychologist. However due to the case load of the single psychologist it was impossible to have regular and consistent sessions with all the girls requiring same. Some of the residential facilities also did not have a private and confidential space that is necessary for such interventions, inhibiting the professionals from providing effective services.

Failure to have Effective Child Complaint Mechanisms

The voices of children are being stifled through using child abuse reporting measures that completely rely on the services of an adult. As discussed in the Policy Review Section

- At the community residence in Tobago, the complaints procedure was a written one although the residents ranged from ages 0-13 years. In practice a complaint of a child was noted during a group therapy session.
- At Margaret Kistow a resident complained via text to the Manager and Manager indicated residents had opportunities to complain at 'House' meetings or to their assigned CSA's.
- At Casa De Corazon, a resident complained directly to The Authority via an email.

The Board advised that it was exploring the option of placing complaint boxes at facilities which children could use in the event of abuse and the creation of a complaints policy which has not yet been done.

The lack of complaint mechanisms and a standardised complaints policy for children represents a large gap in the system of care which undermines the concept of safeguarding.

The Care for Migrant Children is Inappropriate and Inadequate and may be in contravention of the State's responsibility under the Legislation and International treaties

The Investigation Team found that the Authority has not been responsive to the complaints of abuse made by child migrant victims of trafficking who had been placed at St Jude's for care and protection.

Interviews by the Investigative Team indicated that it was common for Venezuelan migrant girls

- to be verbally abused and openly labelled prostitutes by staff and local residents,
- To endure group beatings at the hands of local residents, and in one instance from as security guard, resulting in multiple physical injuries,
- To experience theft of their personal belongings provided through the Counter Trafficking Unit.

Findings revealed inadequate responses by The Authority and an overall failure to safeguard child migrant victims. The management of the St Jude's have been aware of the instances of assaults to the migrants' victims and have failed to address or prevent its reoccurrence. The premises used to house these girls are unsuited to meet the statutory and treaty requirements of appropriate housing, education and training opportunities. Security measures in the Children's Homes used to house these children are poor and there have been a number of recorded instances of absconding.

There are Inadequate Transitioning Plans in Place

Transitioning from children's homes into healthy adult functioning is a key indicator of the effectiveness and efficiency of the interventions delivered by children's homes. This is critical to mitigating risks and vulnerabilities in the resident's adult life and furthermore equipping them for family and community reintegration, and to becoming healthy contributors to society.

This Investigation has found that such transition programmes across Community Residences and Child Support Centres are woefully lacking or non-existent resulting in many residents 'aging out' of the system unprepared and ill-equipped for adult life. This will undoubtedly present greater risks for adult victimisation, further abuse and homelessness.

Multiple homes, for example Margaret Kistow, noted that the females would often become pregnant shortly after exiting the home and were financially and emotionally unprepared for the childcare responsibilities they subsequently faced. Findings revealed that upon turning eighteen 18 years some residents took up residence with the staff at their personal abodes. This was notable for the Margaret Kistow Home where multiple male residents resided at the personal residence of the Assistant Chief Executive Officer upon attaining the age of eighteen (18) while others were placed on the staff listing at the Home without any formal training or experience.

In the case of St. Jude's and Sylphil Home, Tobago residents also lived at the personal residences of staff upon attaining eighteen (18) years of age. For the Cyril Ross Children's Home, the findings indicated that children are usually admitted as toddlers and upon turning 18 were rendered homeless. Currently such children reside at the back the home on mattresses without any structures protecting

them from the environmental elements and thus presenting risks to themselves as well as the current child residents of the Home. These events indicate a significant risk as failure to provide appropriate transition facilities for children when they turn 18, which is a failure of the homes and the Authority to safeguard children within their care.

It should be noted that in the case of the Probation Hostel, Tobago, management indicated collaboration with the Division of Health, Wellness and Family Development in creating Transition plans and after care monitoring for residents who re-integrated with their families and or attained the age of eighteen (18).

The Children's Authority Act outlines the provision of hostels for children who are over the age of sixteen and up to the age of twenty-one (21), however this has not yet been operationalised.

There is one operational transition home, the National Male Transition Home, which does not function as a Hostel as defined in the legislation. This Home was found to have effective, accountable systems, and safe facilities in place to support the transition of young men. The Home however can only facilitate twelve (12) residents currently due to staffing capacity.

Overall Failure to Safeguard Children

The above findings of the Investigation Team highlight that there is an overall failure to safeguard children. The system of child care and protection is fraught with challenges which expose already vulnerable children who come into contact with the Authority, the Child Support Centres and the Community Residences to the risk of harm and abuse. Insufficient facilities, ill equipped staff, the mixing of children with differing needs and the delayed delivery of psycho/social support all contribute to a culture conducive to absconding. Poor monitoring, reporting and limited knowledge of policies and guidelines all contributed to incidences of abuse not being detected.

Chapter 10 - General Recommendations

Legislation Guiding the Safeguarding, Care, and Protection of Children

NO.	RECOMMENDATIONS	RESPONSIBILITY
1	Consolidate all the amendments to the Act.	GORTT
2	Amend Legislation to ensure a streamlining of the methods of admission into care and to ensure that each child in care has access to the facilities offered by The Authority.	GORTT
3	Sections 3 (1) and (2), and 17 of the Children's Community Residences, Foster Care and Nurseries Act must be proclaimed immediately. (Subject to the moratorium referred to under the recommendations relating to the enforcement of licencing requirements for Children's Homes) The GORTT shall amend the legislation to provide for a moratorium of not more than one year from the proclamation of sections 3(1) and (2) and section 17 of the Children's Community Residences, Foster Care and Nurseries Act to allow suitable Homes to become licence ready.	GORTT
4	The Children's Community Residences and Foster Care and Nurseries Act must be amended to ensure the effective enforcement of the provisions of the Act and Regulations. The amendment to the Act must include the removal of the words "as a form of punishment" at section 17A (1) (b)(c) and (d). Consequential amendments to be made to section 17A(3).	GORTT
5	Penalties for the Offences listed under 17 A the Children's Community Residences and Foster Care and Nurseries Act for Offences relating to prohibited forms of punishment must be increased.	GORTT
6	The Authority must redraft the Regulations for Community Residences to so that they are specific, objective, fully cover the areas addressed and enforceable.	The Authority
7	Hostels, as defined by the Children's Authority Act, are to be commissioned as a matter of urgency.	GORTT
8	The ongoing development of a National Child Protection Strategy must be prioritised, with clear and measurable standards for all persons interacting with children in Trinidad and Tobago.	GORTT

Public Financing for Safeguarding, Care, and Protection of Children

NO.	RECOMMENDATIONS	RESPONSIBILITY
9	The State, in its expenditure and assignment of resources, must prioritise investment in the child care system. Furthermore, the State must invest in sustainable early prevention of delinquency and prioritise this in the national development agenda. The following is recommended: • The Authority to conduct an audit to determine the number of child care facilities needed, the category of children to be accommodated, and the type of care required. • The audit will be used to guide the establishment of more Community Residences. • Hostels, as defined by the Children's Authority Act, to be established. The State to fund these additional Facilities. • A cadre of Staff to be immediately trained in the areas of security, counselling, behaviour management • A Risk Assessment to be undertaken to identify gaps in the child care system • Specialised Community Residences be developed to support children with physical and mental disabilities and developmental issues in accordance to the type of treatment required. • Social Services to be strengthened to assist The Authority in the provision in the more holistic services for children in residential care.	The Authority /GORTT
10	An independent publicly funded Children's Commissioner be established with the authority and power to • Issue, suspend and revoke licences of community residences and nurseries as provided under the Children's Community Residences, Ch. 46:04. Foster Care and Nurseries Act; • Oversee the operation of the Child Support Centres managed by The Authority • investigate complaints made by or on behalf of children • Inspect Child Support Centres as well as Community Residences • Monitor The Authority and its operations • enter onto the premises of all Community Residences for the purpose of inspection • Convene and establish a coalition of inter-ministerial and other child service expertise.	GORTT
11	The State must make financial provisions to ensure adequate, well run, safe, and licensed Community Residences to provide placement for children in need of care and protection in Trinidad and Tobago.	GORTT
All initiatives funded by the State must be accompanied by clear and measurable standards and performance indicators that allow for impact and effectiveness analysis. In addition, all persons receiving State funds must be able to show measurable results from work done.		

State Coordination and Collaboration

NO.	RECOMMENDATIONS	RESPONSIBILITY
12	Pollcies to be established to identify and coordinate the key roles for Ministries and State Agencies to deliver effective safeguarding, care, and protection of children An inter-agency task force to be established under the Office of the Prime Minister to coordinate the national system and integrate operations across State agencies and Ministries for the effective and timely delivery of care and protection of children in Trinidad and Tobago. The task force to include representatives from the Ministry of Health, Ministry of Education	GORTT
13	Protocols to be established with the Ministry of Education to ensure that children in Community Residences are provided with education opportunities no different to that provided for children in the regular school system. Where possible, children in Children's Homes to be enrolled in regular school with the Home providing transport to and from school. Where that is not possible, the education provided should be similar to what is available in the regular school system. Child Support Centres should have tutors attached to them to ensure that children in their temporary care are provided with age and ability appropriate classes to ensure that children do not suffer educationally while in the temporary care of the Child Support CentreCentres.	The Authority, directly supported by the Ministry of Education.
14	Protocols to be established with the Regional Health Authorities, outside of emergency care, to ensure that priority treatment is provided for residents at Health Centres and clinics. Formalisation of the system should be coordinated by The Authority and the office of the Chief Medical Officer, and the operationalisation of the process coordinated by Community Residents and Child Support Centres and the Regional Health Authority and Centres.	The Authority directly supported by the Ministry of Health.

Enforcement of Licensing And Monitoring Requirements for Children's Homes

NO.	RECOMMENDATIONS	RESPONSIBILITY
15	Responsibility for Licensing be moved from The Authority enabling it to focus on its core duty of the provision of care, protection and rehabilitation of children and the monitoring of Community Homes. The responsibility for licencing to be placed with the Children's Commissioner and the recommendations for this role have been itemised in recommendation 10.	GORTT
16	The Authority to conduct an Audit of all unlicensed Homes • to ascertain the conditions in the Home and whether the Home is fit for purpose • Children's Homes to be given a maximum of one (1) year to become compliant with the licensing requirements after the completion of the risk assessment. Risk Assessment should take no more than one (1) month to be completed. • As far as possible, the GORTT shall provide the necessary resources to ensure that the standards are met. These resources can be by way of the use of use coordinated state resources to facilitate the upgrade works: Ministry of Works and Infrastructure, CEPEP, Defence Force. • Monitoring of compliance should be done by The Authority, and Licensing should be done by the Children's Commissioner once in compliance with all requirements from all regulatory entities. Licences should itemise the number of children to be accommodated as well as the categories of children the home is authorised to provide care for.	The Authority GORTT

Operations of the Children's Authority of Trinidad and Tobago

NO.	RECOMMENDATIONS	RESPONSIBILITY
17	• The Board to conduct its organisational redesign with urgency given that effective organisational design is fundamental for the delivery of The Authority's mandate, and directly impacts upon all other risks to the organisation and children in the care of the State • The organisational structure should be supported by a risk assessment and a situational assessment of the State of children and youth in Trinidad and Tobago, including migrant children. • A competency framework to be developed that aligns the organisational structure, roles, and responsibilities to the needs assessment, situational assessment, and mandate of The Authority without the responsibility for Licensing. • A standardised enterprise risk management framework is to be established and rolled out with priority to ensure that the organisation can build capacity to identify, mitigate, and monitor risk effectively. • Job descriptions and Key Performance Indicators should be established in line with the new competency framework.	The Authority
18	The Board to review, finalise and approve all draft policies and to share same with all employees Adequate training to be conducted regarding the implementation of the policies and in line with a Management of Change plan. All policies implemented by The Authority for the provision of care and protection of children are by Regulation to become applicable to all Community Residences to ensure a standardised approach to care and protection of children. The Authority shall provide training to the staff of the Children's Homes on the existence, use and implementation of the policies	The Authority
19	Detection of Abuse: • The Authority implements a system to ensure that on the monthly visits its Licencing & Monitoring officers speak to a fixed number of children in private. While these children are to be chosen randomly the purpose of the exercise is to ensure that each child has the opportunity to speak in private with the officer over a given period. • Audio monitoring and regular rounds in the bedrooms are recommended to monitor in case of abuse by care givers or security • To ensure that clause 15(g)(h)(I) and (j) of the Children's Community Residences(Children's Homes) Regulations are complied with and that it be made a condition of the licencing of the Home	

Recommendations on Prioritising Risk Assessment and Placement

NO.	RECOMMENDATIONS	RESPONSIBILITY
20	The Authority to ensure that a standard caregiver to child ratio dependent on the child's risk and age and needs is maintained at Community Residences and Child Support Centres. The Investigation Team notes the Authorities recommendation made in their submissions to the Joint Select Committee in April 2021: • 1:5 for low-risk cases with minimal challenging behaviour • 1:3 for medium-risk cases • 1:1 for high-risk cases with extremely challenging behaviours.	The Authority
21	The responsibility for placement of children into Community Residences, and approval of treatment plans for children after assessment, to be moved from the Board and placed with the Director of The Authority. This is recommended to ensure faster approval times, and reduce the time spent by children at Child Support Centres awaiting placement. • The board will be responsible for the policy to guide r placement and treatment and provide oversight and assessment on the Key Performance Indicators associated with placement and treatment. • The efficiency of the placement and treatment plan approval systems should be assessed by, at minimum, the KPIs established for approval, the number of cases for approval monthly, the number of cases approved, the number of cases not approved and associated reasons, and the plans for support cases not approved. • The Authority to ensure that diagnostic assessments are completed for all children. An initial risk assessment should be completed upon receipt of the child into care to determine placement, and a complete diagnostic assessment should be completed within 48 hours. This would require an increase in the number of assessment centres. These diagnostic assessments must include a complete risk assessment and a physical, mental and social assessment of the child. • The use of the term Children in need of Supervision (ChiNs) should not be used to describe the type of care and treatment to be given to a child. Placement and treatment must be in accordance with the risk assessment made on the child upon receipt into care. • Upon the placement of children at a Children's Home the Homes are to be provided with the diagnostic assessment of the child and an initial care plan for the child. This care plan shall be subject to periodic review by a case worker who shall be assigned by the Authority to the child in conjunction with care providers in home.	The Authority/GORTT

Children of different risk profiles are being housed in one facility. This creates a problem in the management and support of the children. Children with a high risk of harm to others and behaviour difficulties are placed in Homes that are not able to supervise them and manage their needs. The interaction between these children and lower-risk children also creates problem situations at the residences. The inability of staff to control these situations can itself lead to further physical abuse.

The delivery of care, protection and supervision of children, should take into account each child's individual risks and associated needs. The most effective and least restrictive environment should be chosen to provide these services. As a result of this investigation, it has been noted that a major factor in directing placement is legal categorisation, i.e child in need of care and protection versus child in need of supervision (CHiNS). The degree of risk does not necessarily equate to legal category thus, each child should be afforded a risk assessment, and consideration be given to recategorizing children based on risk rather than legal status. Also noted, due to overcrowding, placement has become determined based on available space. This has led to children with varying risks being housed together in homes that are unable to provide the appropriate care, protection and supervision required, and thus provides a major risk for abuse and absconding. It is imperative that primary objectives should be to increase the number of homes and to prioritize risk assessment as the guide to placement.

The primary goal of first contact should be an initial risk assessment completed by a trained professional with primary focus on determining a safe placement. A more comprehensive assessment, formulation and management plan would continue in the safe environment. An initial risk assessment should focus on determining child's risk of harm to self, to others and from others.

These initial risks should direct placement options:

- Example (1) a child is determined to have increased risk of harm to self (in the context of self-harm/suicide), should be further screened to determine the immediate level of care needed, i.e hospitalization vs. within a care home that can provide close supervision, has a self-harm/suicide policy and the facility to implement it, and has reliable access to qualified mental health providers and easy access to emergency health services.
- Example (2) a child determined to have increased risk of harm to self (in context of absconding), child should be further screened to determine the immediate level of care needed, i.e hospitalization vs. within a care home that can provide high security measures including secure perimeter, working security cameras that are well-monitored, staffing to allow for close supervision, proximity to law enforcement.
- In cases where multiple risks are elevated, best attempts should be made for the child to be placed in a home that is equipped to mitigate all risks identified.

Inability to provide suitable accommodation for any target risk, should be well documented with a proposed alternate plan to mitigate that risk.

A documentation which at minimum outlines; the risks, placement requirements to mitigate risks, barriers to attaining suitable placement and alternate plan to mitigate risk, should accompany every child to their determined placement.

In cases where there is a barrier to conducting an initial risk assessment:

- This should be well-documented, stating reasons for barrier, and proposed plans to overcome barrier.
- The child should be accommodated in a safe space that can provide mitigations for all major risks, until the initial risk assessment can be done. The child should not be kept in this

environment for more than 7days, due to increased risk of co-housing the vulnerable and impressionable child with others who may exploit their vulnerabilities.

- The goal should always be to house the child in the most effective and least restrictive environment that can provide adequate care, protection and supervision.

(Appendix 10: Simple Initial Clinical Risk Assessment Form)

A clearly documented risk assessment facilitates communication, through a common language, amongst all involved in the child's care.

Risk is not static, but fluctuates, thus there is a need for regular reassessments. Risk reassessment and its management should be ongoing at every session with care Investigation Team or when an untoward event occurs, and updated with every critical incident. Risk assessment and management should be incorporated into the Individualized Care Plan, which should contain established and agreed upon goals and objectives identified collaboratively between child and treatment Investigation Team. This would enhance communication between care Investigation Team and child, providing the child with specific reasons for placement and specific goals and objectives to assist child to reduce their targeted risks.

The Investigation Team acknowledges, it is not possible to identify and eliminate risk entirely, however, the objective of good clinical risk management is to minimise the likelihood of an adverse outcome.

The following resources can be reference for further information:

- Subotsky, F. (2003). Clinical risk management and child mental health. *Advances in Psychiatric Treatment, 9*(5), 319-326. doi:10.1192/apt.9.5.319
- https://www.cambridge.org/core/journals/advances-in-psychiatric-treatment/article/clinical-risk-management-and-child-mental-health/D4F8A99AE7831C701790DEC503DBEEC1
- Guidelines for Clinical Risk Assessment and Management in Mental Health Services, (New Zealand) Ministry of Health in partnership with the Health Funding Authority July 1998
- https://www.moh.govt.nz/notebook/nbbooks.nsf/0/2FE380C25ED2F1B34C25668600741EBA/$file/mentalra.pdf

Operating Systems for Community Residences and Child Support Centres

NO.	RECOMMENDATIONS	RESPONSIBILITY
22	A safe system to be implemented for children to report incidents of abuse inflicted by staff members through anonymous channels (e.g. a one-way phone for children with provided numbers, systems established by the Children's Commissioner) The Authority to provide standards and guidelines to Community Residences regarding these complaint mechanisms.	The Authority
23	There must be mandatory reporting to the police of all forms of abuse of children. This is the responsibility of every single person in contact with children. Failing to report cases of physical abuse to the TTPS must also be made an offence and enforced.	GORTT
24	**SECURITY** • As far as possible the Authority to have an internal security force trained to treat with children in residential care. This security function should also extend to private children's homes. While this will be a cost to The Authority and GORTT, the returns will be in children's safety, protection, and care. • All security officers and security providers must complete a number of standardised, accredited courses which include care for children and limitations when dealing with children. Only persons who have completed this suite of courses are to be able to work on the compound. • A detailed list of training needed by security providers to be identified by The Authority. • Where external security providers are to be used, the contract agreement should made with The Authority and the security provider must be required to supply the Authority with a list of persons to be used in the homes. These persons must submit to appropriate training as a condition of the contract. • Physical security measures must be standardised for each children's home and child support centre. These include burglar proofing, recording devices (cameras in corridors and entrance to the room, and audio monitoring in rooms), lighting and barriers around the compound which can be overridden with clearance of a higher authority. • Independent, unbiased monitoring and evaluation of the security services provided is strongly recommended. The recommendation is that the Commissioner of Police be the overarching authority responsible for monitoring and evaluating any agency or person performing the security functions at centres charged with the care and protection of children, in accordance with the Supplemental Police Act specifically through the Estate Constables that the act guides. That is, use the existing regulations and structures to enable The Authority to have oversight over all security providers operating in centres charged with the care of children. Responsibility for monitoring security providers can also fall within the role of the Children's Commissioner.	The Authority

	• Security at Community Residences and Child Support Centres is important enough for The Authority to have operational responsibility across the board. • Annual table top meetings to be conducted by the FHSSE staff together with management to identify issues, root causes and solutions.	
25	One of the requirements to operate a Children's Home, in accordance with the regulations, must include security on the compound provided by The Authority, guided by a standardised security risk assessment. This assessment should include established standards for security operations.	The Authority
26	**CRITICAL INCIDENTS** • Standardised criteria for classifying and reporting critical incidents to be established and enforced. • A standard mechanism for reporting all critical incidents and a data management system to support these records to be established. • All critical incidents that include physical or sexual abuse to be reported to the TTPS, and persons should be held accountable for non-compliance with this requirement.	The Authority
27	For effective management and control, the Children's Homes must need to maintain control over staff members. The control and supervision This must not reside in the Statutory Authorities Service Commission. Any person not complying with regulations for child protection must be held accountable and charged.	GORTT
28	There should be regular auditing of all Staff members of the Authority and Children's Homes. This auditing is to include performance appraisals every six (6) months). A thorough background check must be conducted by Special Branch on all persons who are responsible for the care of chilldren whether they are employed by the Authority or the Children's Home. The licensing process must include a requirement that Psychometric testing should be administered to all employees of the Children's Home. This should be criteria for licensed homes to hire staff members.	The Authority
29	**STANDARDS** • A regional and international industry assessment should be completed to identify and establish the minimum and measurable standards for operating and managing facilities for the care and protection of children. • Standardised job descriptions and competency requirements to be established for all facilities providing care and protection of children. • Standards and Procedures established for Child Support Centres should also be the Standards and Procedures used for all Community Residences to ensure consistency in service delivery, monitoring, and evaluation.	The Authority

30	The Authority must be notified of all staff changes in Children's Homes as part of Licensing Requirements.	The Authority
31	Persons involved in the care of children must receive appropriate, adequate and standardised training, including basic first aid and CPR Staff Training should include, at a minimum: • Child Abuse Awareness Course – offered by Office of the Prime Minister – Gender and Child Affairs • Safety, Safe Spaces, Safeguarding & Child Protection • Prevention of sexual exploitation and abuse (PSEA), Psychosocial Programme, Gender-Based Violence offered by UNICEF • First Aid Staff should also have certification in relevant areas that pertain to care required by children at Community Residences and Child Support Centres.	The Authority
32	A standardised Discipline Matrix to be established for all Community Residences and Child Support Centres to limit subjectivity.	The Authority
33	Recreational areas for children to be a minimum of 10'x10' on the outside (in accordance with a standard from the United States Code of Federal Regulation.) to ensure compliance with the UNCRC as well regulations 15(a)(iv) and 11(d); Homes should provide a recreational area for children to play and engage in other physical activities.	The Authority
34	Policies and guidelines for confidentiality and information sharing by persons working in child care services to be established, noting the child's right to privacy. See section 40 of the Data Protection Act on the matter and the mandate of the Authority.	The Authority
35	**CARE FOR MIGRANT CHILDREN** Immediate action is required to provide appropriate accommodation for migrant children and victims of trafficking in accordance with international responsibilities and the Persons in Trafficking Act. All abuses, including to migrant children, must be reported by Children's Home and the Child Support Centres to the Child Protection Unit of the Trinidad and Tobago Police Service.	GORTT
36	**TRANSITION** • Transition programmes are to be incorporated across all Community Residences and Child Support Centres, as a failure to adopt these presents significant risks to residents when 'ageing out'. These increased risks can and must be reduced through an established transitioning policy and programmes implemented across all Community Residences and Child	The Authority

	Support Centres subject to a robust monitoring and evaluation mechanism with annual impact assessments and reviews. • Transition programmes should be initiated no later than age sixteen (16) across all homes with these homes held accountable for non-compliance. • Programmes should include, but not limited to, life skills, health, conflict resolution, mentoring, financial literacy, employability and family/ community reintegration.	

A Note on the Children's Commissioner

The Investigation Team recommends that a Children's Commissioner be established. The role and functions of the Commissioner would be akin to those of an Ombudsman. We note that over the years there has been a consistent call for the establishment of a such an office. This is also consistent with international best practice.

Through the fact finding, analysis process the Investigation Team determined that a conflict existed between The Authority's responsibility in providing care and protection (which includes placement of children) and their responsibility under the Act to place children in Children Homes licenced by them for that purpose. This conflict has been enhanced by "the placement crisis" As a result the Authority is conflicted between its need to licence only suitable Children's Homes and its need to find placement for Children in need of care and protection.

As a result, the Investigation Team recommends that the responsibility of issuing, suspending and revoking licences contained in section 5(1)(f) of The Children's Authority Act be removed from the Authority and placed in the hands of the Children's Commissioner.

We note that the need for a Children's Commissioner was addressed in the National Child Policy, 2020. The Policy recommends the establishment of a Children's Commissioner within the time frame of 2023-2026. The Investigation Team is of the opinion that, given its findings on abuse contained in this report, the lack of proper complaints procedures across the board and the inability of the Authority to adequately perform its function of investigation under section 5((1)(c) and (d) the time frame suggested in the National Child Policy is too long. The Commissioner shall also have oversight over the operations of the Authority to ensure that it acts within its statutory remit. The Commissioner shall also have the responsibility of ensuring that the Child Support Centres operated by the Authority meet the standards established for Children Homes and do not exceed the 12 weeks residence mandate required by the legislation.

Investigation Team therefore recommends the immediate creation of an office of an impartial and independent Children's Commissioner established by an Act of Parliament and answerable to Parliament. The Children's Commissioner powers should include:

- The power to issue, suspend and revoke licences of Children's Homes as provided under the Children's Community Residences, Ch. 46:04. Foster Care and Nurseries Act;
- Oversight of the Child Support Centres /Reception Centres operated by The Authority
- Power to investigate complaints made by or on behalf of children

- Inspect Child Support Centres/ Reception Centres as well as Community Residences
- Monitor The Authority and its operations
- The power to enter onto the premises of all Community Residences for the purpose of inspection

It must be noted that the Children's Commissioner is not intended to replace the Children's Authority's role in providing care and protection, monitoring of community residences and investigating complaints however it is envisioned that the Commissioner will ensure compliance with the Convention on the Rights of the Child, the Constitution, the laws of Trinidad and Tobago as well as any other regulations which affect children. This will promote accountability, strengthening the rule of law and where necessary make recommendations for changes to law.

A Note on Mental Health Treatment in Residential Care

According to Article 23 of The Convention on the Rights of the Child (CRC) recognises children who have mental health diagnoses as having a disability and requires the appropriate and dignified provision of services. It States,

> "1. States Parties recognise that a mentally or physically disabled child should enjoy a full and decent life, in conditions which ensure dignity, promote self-reliance and facilitate the child's active participation in the community.
>
> 2. States Parties recognise the right of the disabled child to special care and shall encourage and ensure the extension, subject to available resources, to the eligible child and those responsible for his or her care, of assistance for which application is made and which is appropriate to the child's condition and to the circumstances of the parents or others caring for the child."

In addition, Article 24 of the CRC identifies the need for States to provide quality health care for children. Children who are diagnosed with mental health conditions, sometimes require quality psychiatric health care. The CRC adds,

> "States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services."

Therefore, failure of the State to provide the required and specialised mental health facilities at all levels denies the child access to quality health care.

In the 2018/2019 6th report of the Joint Select Committee on Social Services and Public Administration: Inquiry into mental health and wellness services and facilities in Trinidad and Tobago, it was recommended that a unit or ward be created that is dedicated for children with mental

disorders. This recommendation was proposed in their medium-term plans. In addition, the committee recommended that

> "a review of the existing suite of children's legislation and the Mental Health Act be conducted to ensure that adequate provisions are made to treat with the complex legal issues which arise out of the diagnosis, treatment and accommodation of children who are mentally-ill or subnormal; and IX. That consultations with stakeholders on the proposed amendments to the Mental Health Act be initiated and the final amendments be submitted for the consideration of the Parliament by the second quarter of 2019."[ii]

In consideration of the varied stages of development of children over different ages, children with mental health disabilities require treatment while continuing with their age appropriate programmes for their cognitive, emotional, social and behavioural development. The following recommendations are made:

1. **SHORT TERM MENTAL HEALTH FACILITY**

Some children experience severe behavioural and severe emotional disturbance and may require admission to a mental health facility for the purpose of observation, assessment, diagnosis, treatment and stabilisation in order to return to daily functions. Without appropriate and effective treatment, these children struggle to develop their age-appropriate milestones required for healthy functioning which can impact on their overall development.

A child with access to early efficient diagnosis and treatment has the potential to stabilise in a shorter space of time. With stabilisation of their psychiatric disorder the child will more manageable and will have better chances of effective integrating with other children.

A mental health treatment facility specifically designed for children who require short term visits for diagnosis and stabilisation is necessary. The designated facility will require consideration for children at varying ages and developmental levels and will need to establish appropriate programmes for their development. It is necessary that the designated environment offer safety and security and yet maintain a therapeutic space to manage and treat children at varying developmental stages and varying levels of emotional and behavioural dysregulation. It will also be required to have not only medical staff (psychiatrist, paediatrician, mental health nurses) but also professionals who can stand in to facilitate the continued progression of the child's development where appropriate, for example teachers, social workers, psychologists, recreational therapist, dietician etc.

Children who are psychiatrically stable are better managed in community based residential settings.

2. **MEDIUM TO LONG TERM CARE- CHILDREN'S HOME SPECIALIZED MENTAL HEALTH RESIDENTIAL FACILITY**

Some children require longer term care for their mental health disabilities. They require trained professionals who can meet their mental health requirements. Children's Homes in Trinidad and Tobago do not have the necessary resources to manage children requiring longer term mental health care. As such this poses major risks to the other children and staff of the homes.

The child with special mental health needs should not be overlooked. As part of the recommendation for an increase in the number of children's homes, there needs to be an increase in the number of specialized homes, especially ones to accommodate those children who require increased mental health support. A specialised residential home for children with mental disabilities is necessary. Once stabilisation occurs they should be transitioned to the appropriate community residence.

Currently, there are no facilities or treatment centres to support the child whose severity of mental illness requires intensive mental health care, but does not meet the criteria for in-patient psychiatric hospitalisation. In accordance with reviewing the appropriateness of treatment, it is recommended that a facility appropriately equipped for the extended treatment of children with mental illness be developed. The criteria and principles of care for such a facility should model guidelines put forth by established international bodies such as American Academy of Child and Adolescent Psychiatry (AACAP), Principles of Care for Treatment of Children and Adolescents with Mental Illnesses in Residential Treatment Centers, June 2010.[iii] It provides a description of the program, as well as guidelines for the structure and staffing, admission, treatment and discharge planning, preventing aggressive behaviours, therapeutic services standards, special populations, educational services, and the therapeutic environment.

In general, every child requires access to adequate psychological interventions. These interventions should provide a system of care and should be trauma informed. Every home should be afforded at least one psychologist and one social worker. Ideally, an adequate child to mental health professional ratio should be considered. When children have access to therapy, they are able to develop the appropriate emotional, social and behavioural regulation skills necessary for their development. These skills assist in reducing and/or eliminating aggressive behaviours, self-harm and suicidality.

Effective trauma based clinical interventions are crucial. The psychological reaction to trauma engages the survival/"fight or flight" response. This response to trauma may trigger the child to display increased aggressive behaviour (fight) or running away (flight)/absconding triggered. All Psychologists and Social Workers should undergo mandatory periodic training in childhood trauma interventions and be supervised by a clinician experienced in trauma interventions. Such training and supervision must be incorporated into the Staff performance management system. To ensure provision of effective psychosocial treatment services, a well-designed confidential and therapeutic space should be afforded to the clinicians at all homes and Child Support Centres. This space should be uncompromised and respected.

Chapter 11 – Conclusion

Child abuse and children absconding in Community Residences and Child Support Centres continue to be a severe problem in Trinidad and Tobago.

This investigation found compelling evidence that the phenomenon is common throughout the child care and protection system. The recommendations in this report note that professional standards employed in safeguarding children need to be informed and be cognisant of the risk and vulnerabilities that contribute to the occurrence of these issues.

Essential elements for effective prevention are only part of the solution. Prevention efforts and policies must directly address children, their caregivers, and the environments in which they live to prevent abuse and deal effectively with cases of abuse and absconding that have already occurred.

Concerted and coordinated efforts of a whole range of sectors are required, and, in accordance with its international commitments, the State must take responsibility for the safeguarding of children and be accountable for any failure in this regard.

In light of the evidence found, the Investigation Team believes that placing children in Children's Homes without regard for their particular needs and without proper evaluation creates or exacerbates the systemic risk to those children.

There is also evidence to show that there is an increased risk of sexual and physical abuse to children due to being placed in Community Residences and Child Support Centres with poor or inadequate staffing and the inability to meet the minimum standards required for obtaining a residence licence for operations of a Children's Home. In addition, these Homes invariably have difficulty in effectively establishing and executing safeguarding policies.

The Investigation Team believes the evidence supports the need to review several practices at this time and that the recommendations made are keeping with a high and creditable standard of safeguarding measures to protect children from harm. Now is the opportune time to establish the office of a Children's Commissioner. It is the hope of this Investigation Team that these recommendations will be adopted by the State within the time frame suggested and will be part of the Government of the Republic of Trinidad and Tobago's child-centred planning and development.

Change to the existing system is long overdue, and for the safety of the children, the recommendations contained in the report must be put in place.

Submitted by the Investigation Team

DOCUMENT	Report by the Independent Investigation Team appointed by the Cabinet of the Republic of Trinidad and Tobago to investigate reports of child abuse at Children's Homes.
TITLE	**SAFEGUARDING CHILDREN IN COMMUNITY RESIDENCES AND CHILD SUPPORT CENTRES IN TRINIDAD AND TOBAGO**
DEVELOPED BY	The Independent Investigation Team appointed by the Cabinet of the Republic of Trinidad and Tobago to conduct an independent investigation into child abuse at Community Residences and other institutions providing residential care for children and incidents of absconding from such institutions.
DATE	14th December, 2021
SUBMITTED TO	The Honourable Ayanna Webster-Roy Minister in the Office of the Prime Minister, Gender and Child Affairs The Republic of Trinidad and Tobago

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Appendicies

- Appendix 1: Reports of Offences made Against Children 2015 - 2021
- Appendix 2: Critical Incident Reports
- Appendix 3: List of Absconding from Community Residences and Child Support Centres
- Appendix 4: Response to Media Reports by The Authority
- Appendix 5: The NiNa Report - THE TRANSITION JOURNEY
- Appendix 6: General Ethics Guideline
- Appendix 7: Interview, Meetings, and Written Submissions
- Appendix 8: Abuse Findings
- Appendix 9: Annual Treatment Plan Tracker
- Appendix 10: Simple Initial Clinical Risk Assessment Form

(Appendix 1: Reports of Offences made Against Children 2015 - 2021)

CRIME AND PROBLEM ANALYSIS BRANCH

Matco Building
#112 Henry Street, Port of Spain
REPUBLIC OF TRINIDAD AND TOBAGO

Provisional Figures 23/08/2021

Reports of Offences made Against Children 2015 - 2021 (31/07/2021)

OCCURRED DATE	STATUS	YEAR	STATION	LOCATION \HOME	OFFENCES	SEX	DOB	AGE	ETHNICITY
21/03/2015	PENDING UNDER INVESTIGATION	2015	FOUR ROADS	ST MICHAEL HOME FOR BOYS	ASSAULT & BEAT / THREATS	M	21/06/2003	11	MIXED
01/08/2015	CHARGED	2016	BELMONT	ST DOMINICS CHILDRENS HOME BELMONT CIRCULAR ROAD BELMONT	SEXUAL OFFENCE	F	23/08/2001	15	MIXED
01/08/2015	CHARGED	2016	BELMONT	ST DOMINICS CHILDRENS HOME BELMONT CIRCULAR ROAD BELMONT	SEXUAL OFFENCE	F	23/08/2001	15	EAST INDIAN
19/10/2015	PENDING UNDER INVESTIGATION	2015	BELMONT	2A ST ANNS GARDENS IMMORTAL CHILDREN CENTRE	ROBBERY	F		12	MIXED
20/10/2015	NO FURTHER POLICE ACTION	2015	FOUR ROADS	ST MICHAEL'S BOYS HOME DIEGO MARTIN	ASSAULT & BEAT / THREATS	M	16/10/2000	15	AFRICAN
02/01/2016	PENDING UNDER INVESTIGATION	2016	BELMONT	ST JUDE'S HOME FOR GIRLS	SEXUAL OFFENCE	F	02/07/2001	14	AFRICAN
31/01/2016	CHARGED	2016	FOUR ROADS	ST.MICHAEL HOME FOR BOYS DIEGO MARTIN	BREACH OF PEACE	M	16/10/2000	15	AFRICAN
31/01/2016	CHARGED	2016	FOUR ROADS	ST. MICHAEL HOME FOR BOYS DIEGO MARTIN	ASSAULT & BEAT / THREATS	M	16/10/2000	15	AFRICAN
31/01/2016	CHARGED	2016	FOUR ROADS	ST.MICHAEL HOME FOR BOYS DIEGO MARTIN	ASSAULT & BEAT / THREATS	M	16/10/2000	15	AFRICAN
17/02/2016	PENDING UNDER INVESTIGATION	2016	BELMONT	BELMONT CIR ROAD IN THE VICINITY OF ST JUDE HOME	ROBBERY	M	13/03/2002	13	MIXED
26/02/2016	PENDING UNDER INVESTIGATION	2016	ST. JAMES	LADY HOCHOY CRICULAR CCOCORITE	ASSAULT & BEAT / THREATS	F	03/03/1997	18	AFRICAN
29/05/2016	PENDING UNDER INVESTIGATION	2016	GASPARILLO	RAHAMAN'S DRIVE BONNE AVENTURE ROAD GASPARILLO ISLAMIC HOME FOR CHILDRI	LARCENY	F	02/10/2009	6	MIXED
29/06/2016	PENDING UNDER INVESTIGATION	2016	AROUCA	ST MARY'S CHILDREN'S HOME A.C. SCHOOL TACARIGUA	MISSING PERSON	M	10/12/1998	17	AFRICAN
26/09/2016	PENDING UNDER INVESTIGATION	2016	ARIMA	LADY HOCHOY SCHOLL ARIMA	SEXUAL OFFENCE	F	01/01/2006	10	AFRICAN
14/10/2016	PENDING UNDER INVESTIGATION	2016	BELMONT	30 BELMONT CIRCULAR BELMONT ST JUDE'S HOME FOR GIRLS	ASSAULT & BEAT / THREATS	F	25/01/2002	14	AFRICAN
19/10/2016	PENDING UNDER INVESTIGATION	2016	BARRACKPOSE	LENGUA ROAD PRINCES TOWN VIC ISLAMIC TML SCHOOL	KIDNAPPING	F	17/11/1991	18	EAST INDIAN
17/12/2016	NO FURTHER POLICE ACTION	2016	ST. JAMES	BLDG APT 32 LADY HOCHOY CIR ROAD COCORITE	CHILD ABUSE	M		14	MIXED
01/01/2017	PENDING UNDER INVESTIGATION	2017	AROUCA	ST MARY'S CHILDREN'S HOME	SEXUAL OFFENCE	M	02/03/2009	8	MIXED
01/01/2017	PENDING UNDER INVESTIGATION	2017	AROUCA	ST MARY'S CHILDREN'S HOME 97 EASTERN MAIN ROAD TACARIGUA	ASSAULT & BEAT / THREATS	M	13/01/2008	9	AFRICAN
01/01/2017	PENDING UNDER INVESTIGATION	2017	AROUCA	ST MARY'S CHILDREN'S HOME 97 EASTERN MAIN ROAD TACARIGUA	ASSAULT & BEAT / THREATS	M	19/11/2005	11	EAST INDIAN
01/01/2017	PENDING UNDER INVESTIGATION	2017	AROUCA	ST MARY'S CHILDREN'S HOME 97 E M R TACARIGUA	SEXUAL OFFENCE	F	21/03/2003	14	AFRICAN
01/01/2017	PENDING UNDER INVESTIGATION	2017	AROUCA	ST MART'S CHILDRENS HOME 97 E M R TACARIGUA	SEXUAL OFFENCE	F	21/03/2003	14	AFRICAN
01/01/2017	PENDING UNDER INVESTIGATION	2017	AROUCA	ST MARY'S CHILDRENS HOME 97 E M R TACARIGUA	SEXUAL OFFENCE	F	21/03/2003	14	AFRICAN
01/01/2017	PENDING UNDER INVESTIGATION	2017	ST. JOSEPH	ST MARY'S CHILDRENS HOME 97 E M R TACARIGUA	SEXUAL OFFENCE	F	21/03/2003	14	AFRICAN
01/01/2017	PENDING UNDER INVESTIGATION	2017	ST. JOSEPH	ST MARY'S CHILDREN'S HOME 97 EASTERN MAIN ROAD TACARIGUA	ASSAULT & BEAT / THREATS	F	11/03/2004	13	AFRICAN
01/01/2017	PENDING UNDER INVESTIGATION	2017	AROUCA	ST MARY'S CHILDRENS HOME 97 E M R TACARIGUA	ASSAULT & BEAT / THREATS	M	18/12/2004	12	EAST INDIAN
01/01/2017	PENDING UNDER INVESTIGATION	2017	AROUCA	ST MARY'S CHILDRENS HOME 97 E M R TACARIGUA	ASSAULT & BEAT / THREATS	F	20/07/2003	14	AFRICAN
01/01/2017	PENDING UNDER INVESTIGATION	2017	AROUCA	ST MARY'S CHILDREN'S HOME 97 E M R TACARIGUA	ASSAULT & BEAT / THREATS	F	16/08/2008	9	AFRICAN
01/01/2017	PENDING UNDER INVESTIGATION	2017	AROUCA	ST MARY'S CHILDRENS HOME 97 E M R TACARIGUA	ASSAULT & BEAT / THREATS	F	13/06/2005	12	EAST INDIAN
01/01/2017	PENDING UNDER INVESTIGATION	2017	AROUCA	ST MARY'S CHILDRENS HOME 97 EASTERN MAIN ROAD TACARIGUA	ASSAULT & BEAT / THREATS	M	27/04/2009	8	AFRICAN
01/01/2017	PENDING UNDER INVESTIGATION	2017	AROUCA	ST MARY'S CHILDEN'S HOME 97 E M R TACARIGUA	ASSAULT & BEAT / THREATS	M	19/08/2009	8	AFRICAN
01/01/2017	PENDING UNDER INVESTIGATION	2017	AROUCA	ST MARY'S CHILDRENS HOME 97 E M R TACARIGUA	ASSAULT & BEAT / THREATS	M	01/04/2005	12	AFRICAN
01/01/2017	PENDING UNDER INVESTIGATION	2017	AROUCA	ST MARY'S CHILDRENS HOME 97 E M R TACARIGUA	ASSAULT & BEAT / THREATS	M	08/12/2004	12	EAST INDIAN
01/01/2017	PENDING UNDER INVESTIGATION	2017	AROUCA	ST MARY'S CHILDRENS HOME 97 E M R TACARIGUA	ASSAULT & BEAT / THREATS	M	23/07/2007	10	AFRICAN
01/01/2017	PENDING UNDER INVESTIGATION	2017	AROUCA	ST MARY'S CHILDRENS HOME 97 E M R TACARIGUA	ASSAULT & BEAT / THREATS	M	16/03/2007	10	AFRICAN
01/01/2017	PENDING UNDER INVESTIGATION	2017	AROUCA	ST MARY'S CHLILDRENS HOME 97 E M R TACARIGUA	ASSAULT & BEAT / THREATS	M	09/06/2007	10	AFRICAN
18/05/2017	PENDING UNDER INVESTIGATION	2017	FOUR ROADS	ST MICHAELS HOME	ASSAULT & BEAT / THREATS	M	17/11/1999	17	AFRICAN
30/06/2017	NO FURTHER POLICE ACTION	2017	LONGDENVILLE	JAI LAKSHMI CHILDRENS HOME LONGDENVILLE	ASSAULT & BEAT / THREATS	M	02/02/2005	12	EAST INDIAN
30/06/2017	NO FURTHER POLICE ACTION	2017	LONGDENVILLE	JAI LAKSHMI CHILDRENS HOME LONGDENVILLE	ASSAULT & BEAT / THREATS	M	06/09/2000	16	EAST INDIAN
30/06/2017	PENDING UNDER INVESTIGATION	2017	LONGDENVILLE	JAI LAKSHMI CHILDRENS HOME LONGDENVILLE	SEXUAL OFFENCE	M	02/02/2005	12	AFRICAN
30/06/2017	PENDING UNDER INVESTIGATION	2017	LONGDENVILLE	JAI LAKSHMI CHILDRENS HOME LONGDENVILLE	ASSAULT & BEAT / THREATS	M	06/09/2000	16	AFRICAN
01/07/2017	PENDING UNDER INVESTIGATION	2017	AROUCA	ST MARY'S CHILDRENS HOME 92 E M R TACARIGUA	SEXUAL OFFENCE	F	21/03/2003	14	AFRICAN
01/07/2017	PENDING UNDER INVESTIGATION	2017	AROUCA	ST MARY'S CHILDRENS HOME 97 E M R ST TACARIGUA	SEXUAL OFFENCE	F	21/03/2003	14	AFRICAN
01/07/2017	PENDING UNDER INVESTIGATION	2017	AROUCA	ST MARY'S CHILDRENS HOME 97 E M R TACARIGUA	SEXUAL OFFENCE	F	21/03/2003	14	AFRICAN
02/11/2017	PENDING UNDER INVESTIGATION	2017	AROUCA	EASTERN MAIN ROAD TACARIGUA ST MARY CHILDREN'S HOME	ASSAULT & BEAT / THREATS	M	31/08/2002	15	MIXED
18/08/2018	NO FURTHER POLICE ACTION	2018	BELMONT	ST DOMINICS CHILDRENS HOME	ASSAULT & BEAT / THREATS	M	21/03/2009	9	MIXED
11/09/2018	CLOSED DETECTED	2018	BELMONT	ST DOMINIC'S HOME FOR CHILDREN 34B BEMONT CIRCULAR ROAD	ASSAULT & BEAT / THREATS	M	27/04/2008	10	AFRICAN

17/10/2018	PENDING UNDER INVESTIGATION	2018	BELMONT	ST JUDES HOME FOR GIRLS BELMONT CIRCULAR ROAD BELMONT	ASSAULT & BEAT / THREATS	F	28/10/2003	15	AFRICAN
30/10/2018	CLOSED DETECTED	2018	BELMONT	ST DOMINIC'S CHILDREN'S HOME	ASSAULT & BEAT / THREATS	M	22/04/2006	12	AFRICAN
30/10/2018	CLOSED DETECTED	2018	BELMONT	ST DOMINIC'S CHILDREN'S HOME	ASSAULT & BEAT / THREATS	M	02/03/2006	12	AFRICAN
22/11/2018	PENDING UNDER INVESTIGATION	2018	BELMONT	ST DOMINIC'S HOME	ASSAULT & BEAT / THREATS	F	30/05/2002	16	AFRICAN
12/12/2018	NO FURTHER POLICE ACTION	2019	BELMONT	ST DOMINIC'S CHILDREN'S HOME BELMONT	SEXUAL OFFENCE	F	19/04/2005	13	AFRICAN
12/12/2018	PENDING UNDER INVESTIGATION	2019	BELMONT	ST DOMINICS CHILDREN HOME 34B BELMONT CIRCULAR ROAD BELMONT	SEXUAL OFFENCE	F	06/05/2005	13	MIXED
13/12/2018	PENDING UNDER INVESTIGATION	2018	BELMONT	ST DOMINIC'S CHILDREN'S HOME	ASSAULT & BEAT / THREATS	M	01/01/2004	14	AFRICAN
03/04/2019	CHARGED	2019	SCARBOROUGH	CHILDREN COMMUNITY RESIDENCE	ROBBERY	F		15	AFRICAN
04/04/2019	CHARGED	2019	SCARBOROUGH	CARNBEE APPENDAGE LAMBEAU CHILDREN COMMUNITY RESIDENCE HOME	ASSAULT & BEAT / THREATS	F		17	AFRICAN
01/06/2019	PENDING UNDER INVESTIGATION	2019	BELMONT	ST JUDES HOME	ASSAULT & BEAT / THREATS	F	28/10/2002	16	AFRICAN
19/07/2019	PENDING UNDER INVESTIGATION	2019	SCARBOROUGH	DIVISION OF HEALTH AND FAMILY WELLNESS SIGNAL HILL	ASSAULT & BEAT / THREATS	M		15	AFRICAN
23/07/2019	PENDING UNDER INVESTIGATION	2019	BELMONT	ST JUDES SCHOOL FOR GIRLS 30 BELMONT CIRCULAR ROAD BELMONT	SEXUAL OFFENCE	F	29/12/2004	14	AFRICAN
14/08/2019	CHARGED	2019	BELMONT	ST JUDES HOME FOR GIRLS	ASSAULT & BEAT / THREATS	F	15/09/2002	16	MIXED
08/01/2020	PENDING UNDER INVESTIGATION	2020	BELMONT	ST DOMINIC'S CHILDRENS'S HOME 34 B BELMONT CIRCULAR ROAD BELMONT	SEXUAL OFFENCE	M	14/06/2004	15	AFRICAN
08/01/2020	PENDING UNDER INVESTIGATION	2020	BELMONT	ST DOMINICS CHILDRENS HOME 34B BELMONT CIRCULAR ROAD BELMONT	SEXUAL OFFENCE	M	01/01/2004	16	AFRICAN
07/02/2020	PENDING UNDER INVESTIGATION	2020	BELMONT	ST JUDES HOME FOR GIRLS 30 BELMONT CIRCULAR ROAD BELMONT	ASSAULT & BEAT / THREATS	F	30/05/2003	16	AFRICAN
10/05/2020	PENDING UNDER INVESTIGATION	2020	ST. JAMES	LADY HOCHOY HOME	ASSAULT & BEAT / THREATS	M			AFRICAN
19/05/2020	PENDING UNDER INVESTIGATION	2020	SCARBOROUGH	LAMBEAU VCNTY SYLPHIL HOME FOR LOVE	OTHER MINOR OFFENCES	M	17/06/2002	17	AFRICAN
30/10/2020	CHARGED	2020	BELMONT	ST DOMINICS HOME & WOODBROOK HEALTH CENTERE	SEXUAL OFFENCE	F	07/02/2006	14	AFRICAN
30/11/2020	PENDING UNDER INVESTIGATION	2020	BESSON STREET	6A EASTERN MAIN ROAD LAVENTILLE - A CITY NEW TOUCH FOR THE NEW LIFE CHILDRE	ASSAULT & BEAT / THREATS	F			AFRICAN
18/12/2020	PENDING UNDER INVESTIGATION	2020	GASPARILLO	LADY HOCHOY HOME SOUTH CIRCULAR ROAD HARMONY HALL GASPARILLO	ROBBERY	M			AFRICAN
27/12/2020	PENDING UNDER INVESTIGATION	2020	SCARBOROUGH	CHILDREN'S AUTHORITY SAFE HOUSE MT PLEASANT	SEXUAL OFFENCE	F		16	AFRICAN
03/03/2021	CHARGED	2021	SCARBOROUGH	CHILDREN'S AUTHORITY SAFE HOUSE	SEXUAL OFFENCE	M	14/08/2005	15	AFRICAN

(Appendix 2: Critical Incident Reports)

Home	Type of abuse	Date of incident
Allison's Children Home	Sexual Interaction	23.04.2020
Amica House		5.09.2016
Angel of Hope Children's Foundation (ceased operation)	Physical abuse by a resident	16.9.17-18.9.17
Angel of Hope Children's Foundation (ceased operation)	Sexual Interaction	4.09.2017
Angel of Hope Children's Foundation (ceased operation)	Sexual Interaction	10.5.2017
Angel of Hope Children's Foundation (ceased operation)	Sexual Interaction	05.10.2017
Bridge of Hope	Burglary	24.01.2019
Bridge of Hope	Death	1.7.2019
Bridge of Hope	Physical injury to child	10.07.2017
Bridge of Hope	Physical Altercation	29.12.2018
Casa de Corazon	Breaking, entering and damaging the bus	16.12.2017
Casa de Corazon	Burglary	19.07.2016
Casa de Corazon	Deviant behaviour and suicide threat	28.05.2018
Casa de Corazon	Physical Altercation	05.03.2018
Casa de Corazon	Physical Altercation	15.1.2021
Casa de Corazon	Physical injury to child	10.10.2018
Casa de Corazon	Physical injury to child	18.10.2019
Casa de Corazon	Physical injury to child	17.03.2021
Casa de Corazon	Possesion of deadly weapon with intent to injure	30.04.2021
Casa de Corazon	Self Harming	9.3.2018
Casa de Corazon	Self Harming	29.3.2018
Casa de Corazon	Self Harming	11.11.2020
Casa de Corazon	Self Harming	16.01.2021
Casa de Corazon	Sexual Interaction	29.06.2020
Casa de Corazon	Threats to staff by parent	28.02.2021
Casa de Corazon	Verbal and physical abuse	28.02.2021
Casa de Corazon	Verbal conflict externally	01.11.2020
Casa de Corazon	Verbal conflict externally	01.11.2020
Casa de Corazon	Verbal conflict with damage to personal property	6.1.2021
Cecilia's Children's Home	Absconding	18.11.2019
Cecilia's Children's Home	Seizure	22.09.2019-29.09.2021
Chickland Children's Home	Physical injury to child	02.04.2020
Chickland Children's Home	Physical injury to child	05.04.2016
Chickland Children's Home	Sexual Interaction	06.09.2019
Christ Child Convalescent	Absconding	20.11.2017
Christ Child Convalescent	absconding	25.05.2016
Christ Child Convalescent	Absconding: Pick up by parents illegally	07.09.2017
Christ Child Convalescent	Burglary	28.08.2017
Christ Child Convalescent	child contracted infectious disease	14.10.2016
Christ Child Convalescent	Medical issue	30.01.2020
Christ Child Convalescent	Medical issue	25.07.2019
Christ Child Convalescent	Medical issue	22.08.2020
Christ Child Convalescent	Misconduct by staff member	21.05.2017
Christ Child Convalescent	mixing of substance and giving to other children	08.06.2017
Christ Child Convalescent	Physical injury to child	10.04.2018
Christ Child Convalescent	Physical injury to child	17.02.2018
Christ Child Convalescent	Sexual Interaction	11.01.2018
Christ Child Convalescent	Sexual Interaction	07.04.2019
Couva Children's Home	MISSING INFORMATION	16.3.2018
Couva Children's Home and Crisis Nursery	Suspension	16.03.2018
Credo Foundation For Justice: Drop in Development Centre	Absconding	7.08.2017
Credo Foundation For Justice: Drop in Development Centre	Absconding	12.09.2019
Credo Foundation For Justice: Drop in Development Centre	Absconding	12.11.2019
Credo Foundation For Justice: Drop in Development Centre	Breach of rules	17.01.2020
Credo Foundation For Justice: Drop in Development Centre	Disrespect and Lies	22.01.2018
Credo Foundation For Justice: Drop in Development Centre	Marijuana	10.01.2019
Credo Foundation For Justice: Drop in Development Centre	Medical issues	19.01.2020

Credo Foundation For Justice: Drop in Development Centre	Physical injury to child	05.06.2018
Credo Foundation For Justice: Drop in Development Centre	Physical injury to child	25.05.2018
Credo Foundation For Justice: Drop in Development Centre	Sexual Interaction	02.07.2018
Credo Foundation For Justice: Sophia House	Absconding	08.04.2016
Credo Foundation For Justice: Sophia House	Absconding	01.11.2016
Credo Foundation For Justice: Sophia House	Absconding	7.03.2017
Credo Foundation For Justice: Sophia House	Absconding	05.05.2017
Credo Foundation For Justice: Sophia House	Absconding	06.01.2017
Credo Foundation For Justice: Sophia House	Absconding	10.01.2017
Credo Foundation For Justice: Sophia House	Absconding	15.02.2017
Credo Foundation For Justice: Sophia House	Absconding	30.01.2018
Credo Foundation For Justice: Sophia House	Absconding	11.07.2019
Credo Foundation For Justice: Sophia House	Absconding	13.09.2019
Credo Foundation For Justice: Sophia House	Angry behaviour	09.04.2016
Credo Foundation For Justice: Sophia House	Beyond control matter	12.10.2016
Credo Foundation For Justice: Sophia House	Beyond control matter	07.11.2019
Credo Foundation For Justice: Sophia House	Breach of rules	14.02.2017
Credo Foundation For Justice: Sophia House	Breach of rules	14.02.2017
Credo Foundation For Justice: Sophia House	Court Order	24.02.2017
Credo Foundation For Justice: Sophia House	Medical issue	12.07.16
Credo Foundation For Justice: Sophia House	Medical Issue	28.09.2016
Credo Foundation For Justice: Sophia House	Medical issue	13.06.16
Credo Foundation For Justice: Sophia House	Medical issue	17.05.2016
Credo Foundation For Justice: Sophia House	Medical issues	24.03.2017
Credo Foundation For Justice: Sophia House	Parent misconduct	09.09.2015
Credo Foundation For Justice: Sophia House	Physical altercation	07.03.2020
Credo Foundation For Justice: Sophia House	Physical injury to child	04.07.2019
Credo Foundation For Justice: Sophia House	Self Harm	8.02.2017
Credo Foundation For Justice: Sophia House	Staff misconduct	12.01.2020
Credo Foundation For Justice: Sophia House	Stealing	11.08.2016
Credo Foundation For Justice: Sophia House	Threating staff	18.06.2019
Credo Foundation For Justice: Sophia House	Transferred	6.12.2017
Credo Foundation For Justice: Sophia House	Unauthorized visit	22.12.2017
Credo Foundation For Justice: Sophia House	Verbal abuse	16.06.2019
Cyril Ross Nursery	Absconding	08.02.2019
Cyril Ross Nursery	Aggressive behaviour	3.04.2016
Cyril Ross Nursery	Aggressive behaviour	12.08.2019
Cyril Ross Nursery	Breaking and entry	17.02.2016
Cyril Ross Nursery	Cigarettes found.	20.03.2016
Cyril Ross Nursery	Cigarettes found.	5.04.2016
Cyril Ross Nursery	Cigarettes found.	6.04.2016
Cyril Ross Nursery	Inappropriate behaviour	7.04.2016
Cyril Ross Nursery	Inappropriate behaviour	16.12.2019
Cyril Ross Nursery	Inappropriate behaviour	10.03.2016
Cyril Ross Nursery	Inappropriate behaviour	12.03.2016
Cyril Ross Nursery	Inappropriate behaviour	31.03.2016
Cyril Ross Nursery	Inappropriate behaviour/ Sexual Interaction	8.04.2016
Cyril Ross Nursery	Money found	05.03.2016
Cyril Ross Nursery	Physical altercation	22.03.2016
Cyril Ross Nursery	Physical altercation	14.01.2019
Cyril Ross Nursery	Physical altercation	25.03,2016
Cyril Ross Nursery	Seizure	08.08.2019
Cyril Ross Nursery	Sexual Interaction	11.03.2016
Cyril Ross Nursery	Sexual Interaction	13.03.2016
Cyril Ross Nursery	Sexual Interaction	1.04.2016
Cyril Ross Nursery	Sexual Interaction	4.04.2016
Cyril Ross Nursery	Sexual Interaction	7.04.2016
DHWFS PROBATION HOSTEL	Medical issue	29.09.2019

DHWFS PROBATION HOSTEL	Medical issue	23.11.2020
DHWFS PROBATION HOSTEL	Medical issue	13.04.2021
DHWFS PROBATION HOSTEL	Medical issue	20.02.2021
DHWFS PROBATION HOSTEL	Sexual Interaction	21.02.2021
DHWFS PROBATION HOSTEL	Sexual Interaction	05.10.2017
El Shaddi Restoration Home	Absconding	05.06.2017
Ezekiel Home for Abandoned Children	Absconding	24.03.2018
Ezekiel Home for Abandoned Children	Aggressive behaviour	04.01.2018
Ezekiel Home for Abandoned Children	Medical Issue	07.07.2019
Ezekiel Home for Abandoned Children	Medical issue/ Physical altercation	10.07.2019
Ezekiel Home for Abandoned Children	Possession of a weapon	27.06.2019
Ferndean's Place Children's Home	Absconding	21.08.2020
Ferndean's Place Children's Home	Outbreak of infectious disease	04.09.2017
Happy Home (ceased)	Absconding	19.02.2016
Islamic Home for Children	Absconding	24.05.2016
Islamic Home for Children	Threatening phone call	22.10.2020
Jairah House	Death Threats to caregiver	11.12.2019
Jairah House	Sexual Interaction	26.09.2019
Joshua Boys	Absconding	
Joshua Boys	Medical Issue	05.01.2019
Joshua Boys	Medical Issue	12.05.2019
Joshua Boys	Misbehaviour at school	27.09.2019
Joshua Boys	Stealing	09.12.2019
Joshua Boys	Student suspended	09.12.2019
Joshua Boys	Suspicious activity from a staff member	21.02.2019
Lady Hochoy	Absconding	26.06.2018
Lady Hochoy	Absconding	28.06.2018
Lady Hochoy	Absconding	09.08.2019
Lady Hochoy	Damage to property	06.01.2020
Lady Hochoy	Death	20.04.2018
Lady Hochoy	Death	15.12.2017
Lady Hochoy	Inappropriate behaviour	12.06.2018
Lady Hochoy	Inappropriate behaviour	24.06.2018
Lady Hochoy	Inappropriate behaviour	26.06.2018
Lady Hochoy	Injury to child	11.03.2020
Lady Hochoy	Injury to child	05.10.2020
Lady Hochoy	Injury to child	10.11.2020
Lady Hochoy	Medical issue	24.04.2018
Lady Hochoy	Sexual abuse	19.05.2021
Lady Hochoy	Sexual Interaction	08.06.2017
Lady Hochoy	Staff threatened resident	5.08.2019
Margaret Kistow Children's Home	Death	09.09.2017
Margaret Kistow Children's Home	Outbreak of infectious disease	Mar-Jun 2017
Margaret Kistow Children's Home	Physical altercation	05.12.2017
Margaret Kistow Children's Home	Sexual Interaction	Dec-20
Margaret Kistow Children's Home	Sexual Interaction	12.7.2021
Marion House	Absconding	15.10.2016
Mary Care North	Absconding	27.4.2020
Mary Care North	Absconding	30.10.2020
Mary Care North	Absconding	31.07.2020
Mary Care North	Absconding	29.12.2020
Mary Care North	Absconding	22.08.2020
Mary Care North	Absconding	04.07.2021
Mary Care North	Absconding	14.03.2021
Mary Care North	Absconding	4.07.2021
Mary Care North	Aggressive behaviour	16.03.2021
Mary Care South	Absconding	27.08.2020
Mary Care South	Absconding	25.08.2020

Mary Care South		17.06.2020
Mother's Union Children's Home	Absconding	7.05.2021
Mother's Union Children's Home	Aggressive behaviour	23.10.2019
Mother's Union Children's Home	Medical issue	16.06.16
Mother's Union Children's Home	Sexual Interaction	2.10.2016
Mother's Union Children's Home	Threats by parents	3.06.2018
Operation Smile	Medical issue	15.05.2020
Our lady of wayside	Medical issue	06.11.2015
Our lady of wayside	Medical issue	11.11.2015
Our lady of wayside	Medical issue	1.02.2016
Our lady of wayside	Medical issue	12.01.2021
Rainbow Rescue	Aggressive behaviour	15.03.2018
Rainbow Rescue	Assault a staff member	16.03.2018
Rainbow Rescue	Disrespect at school	18.11.19
Rainbow Rescue	Disrespect at school	21.11.2019
Rainbow Rescue	Medical issue	17.01.2018
Rainbow Rescue	Medical issue	15.02.2020
Rainbow Rescue	Medical issue	22.02.2020
Rainbow Rescue	Medical issue	30.08.2020
Rainbow Rescue	Misuse of medication	5.09.2020
Rainbow Rescue	Physical altercation	25.05.2021
Rainbow Rescue	Self Harm	2.11.2020
Rainbow Rescue	Verbal threats	17.02.2021
Sri Jaya Lakshmi Children's Home	Absconding	16.01.2020
Sri Jaya Lakshmi Children's Home	Injury to child	2.9.2019
Sri Jaya Lakshmi Children's Home	Medical issue	16.04.2021
Sri Jaya Lakshmi Children's Home	Physical altercation	30.06.2017
Sri Jaya Lakshmi Children's Home	Threatened by visitors	29.04.2018
St. Dominic's Home	Allegation of Physical Abuse	13.02.2020
St. Dominic's Home	Medical issue	04.05.2020
St. Jude's School for Girls	12,000 worth of damages by 8 residents and medication stolen.	21.04.2020
St. Jude's School for Girls	Abconding	14.09.2018
St. Jude's School for Girls	Abconding	26.07.2019
St. Jude's School for Girls	Absconding	10.03.2018
St. Jude's School for Girls	Absconding	16.05.2018
St. Jude's School for Girls	Absconding	20.07.2018
St. Jude's School for Girls	Absconding	01.10.2018
St. Jude's School for Girls	Absconding	18.10.2018
St. Jude's School for Girls	Absconding	19.10.2019
St. Jude's School for Girls	Absconding	2.8.2019
St. Jude's School for Girls	Absconding	14.08.2019
St. Jude's School for Girls	Absconding	21.05.2019
St. Jude's School for Girls	Absconding	8.12.2016
St. Jude's School for Girls	Absconding	23.10.2017
St. Jude's School for Girls	Absconding	13.07.2017
St. Jude's School for Girls	Absconding	24.06.2017
St. Jude's School for Girls	Absconding	24.10.2017
St. Jude's School for Girls	Absconding	10.3.2018
St. Jude's School for Girls	Absconding	12.04.2018
St. Jude's School for Girls	Absconding	30.07.2018
St. Jude's School for Girls	Absconding	15.05.2018
St. Jude's School for Girls	Absconding	29.10.2018
St. Jude's School for Girls	Absconding	16.08.2019
St. Jude's School for Girls	Absconding	20.07.2019
St. Jude's School for Girls	Absconding	26.08.2019
St. Jude's School for Girls	Absconding	27.07.2019
St. Jude's School for Girls	Absconding	04.02.2021

St. Jude's School for Girls	Absconding	29.01.2021
St. Jude's School for Girls	Absconding	16.09.2020
St. Jude's School for Girls	Absconding	23.10.2020
St. Jude's School for Girls	Alleged sexual abuse	28.04.2018
St. Jude's School for Girls	Altercation between resident and staff	07.05.2020
St. Jude's School for Girls	Altercation between resident and staff	07.01.2021
St. Jude's School for Girls	Physical Alteration	19.05.2020
St. Jude's School for Girls	Physical Alteration	09.01.2021
St. Jude's School for Girls	Physical Alteration	09.01.2021
St. Jude's School for Girls	Physical Alteration	09.02.2021
St. Jude's School for Girls	Physical Alteration	15.01.2021
St. Jude's School for Girls	Physical Alteration	24.01.2021
St. Jude's School for Girls	Altercation between residents.	07.02.2021
St. Jude's School for Girls	Altercation between staff/ residents	19.02.2021
St. Jude's School for Girls	Attacking staff.	25.04.2020
St. Jude's School for Girls	Attempt to abscond by lighting fire	1.05.2020
St. Jude's School for Girls	Attempt tp abscond	29.10.2018
St. Jude's School for Girls	Attempted theft	08.04.2018
St. Jude's School for Girls	Attempted to abscond	24.04.2019
St. Jude's School for Girls	Attempted to abscond and theft	02.05.2020
St. Jude's School for Girls	Caregiver slapped resident	27.08.2019
St. Jude's School for Girls	Child had difficulties breathing and was taken to hospital.	13.01.2021
St. Jude's School for Girls	Child hititng staff with object.	27.06.2019
St. Jude's School for Girls	Child was walking around naked.	13.02.2021
St. Jude's School for Girls	Damage to property	30.03.2018
St. Jude's School for Girls	Damage to property	27.10.2018
St. Jude's School for Girls	Destroyed Property	17.01.2018
St. Jude's School for Girls	Destroyed Property	29.10.2018
St. Jude's School for Girls	Destruction of property	14.01.2021
St. Jude's School for Girls	Fight between resident and staff	19.05.2019
St. Jude's School for Girls	Fighting between residents	20.05.2020
St. Jude's School for Girls	Fire setting and destruction of property	08.10.2020
St. Jude's School for Girls	Hitting staff and residents	8.7.2019
St. Jude's School for Girls	Illness to child	18.05.2020
St. Jude's School for Girls	Inappropriate behaviour	27.06.2019
St. Jude's School for Girls	Ingestion of unprescribed medication	30.04.2019
St. Jude's School for Girls	Injury to child (hit her head)	22.04.2019
St. Jude's School for Girls	Injury to child (hit her head)	17.05.2020
St. Jude's School for Girls	Injury to staff by a resident.	22.05.2017
St. Jude's School for Girls	Medical issue	5.9.2019
St. Jude's School for Girls	Medical issue	5.09.2019
St. Jude's School for Girls	Medical issue	5.9.2019
St. Jude's School for Girls	MISSING INFORMATION	11.05.2020
St. Jude's School for Girls	Nearby loud explosion	24.03.2018
St. Jude's School for Girls	Overdose of medication	12.01.2016
St. Jude's School for Girls	Overdose on medication	26.07.2019
St. Jude's School for Girls	Overdose on medication	27.9.2019
St. Jude's School for Girls	Physical altercation	14.10.2016
St. Jude's School for Girls	Physical altercation	17.01.2018
St. Jude's School for Girls	Physical altercation	17.01.2018
St. Jude's School for Girls	Physical altercation	8.04.2018
St. Jude's School for Girls	Physical altercation	17.10.2019
St. Jude's School for Girls	Physical altercation	2.8.2019
St. Jude's School for Girls	Physical altercation	2.8.2019
St. Jude's School for Girls	Physical altercation	01.06.2019
St. Jude's School for Girls	Physical altercation	01.06.2019
St. Jude's School for Girls	Physical altercation	15.06.2019

St. Jude's School for Girls	Physical altercation	16.06.2019
St. Jude's School for Girls	Physical altercation	18.08.2019
St. Jude's School for Girls	Physical altercation	20.04.2019
St. Jude's School for Girls	Physical altercation	21.04.2019
St. Jude's School for Girls	Physical altercation	26.7.2019
St. Jude's School for Girls	Physical altercation	27.07.2019
St. Jude's School for Girls	Physical altercation	7.06.2020
St. Jude's School for Girls	Physical altercation	9.02.2021
St. Jude's School for Girls	Physical altercation	01.02.2021
St. Jude's School for Girls	Physical altercation	25.02.2021
St. Jude's School for Girls	Physical altercation	26.02.2021
St. Jude's School for Girls	Physical altercation	22.08.2020
St. Jude's School for Girls	Physical Physical Alterationand violence to staff	06.02.2021
St. Jude's School for Girls	Physical altercation between staff and children.	21.09.2016
St. Jude's School for Girls	Physical assault	18.08.2019
St. Jude's School for Girls	Physical assault	21.04.2019
St. Jude's School for Girls	Physical assault	27.06.2019
St. Jude's School for Girls	Physical injury to child	12.10.2018
St. Jude's School for Girls	Physical violence between adults and children	16.09.2020
St. Jude's School for Girls	Physical altercation	7.06.2020
St. Jude's School for Girls	Physical altercation	05.07.2021
St. Jude's School for Girls	Poisonous substance	17.01.2018
St. Jude's School for Girls	Possesion of fireworks	27.06.2019
St. Jude's School for Girls	Possesion of knife	3.9.2019
St. Jude's School for Girls	Marijuana	20.03.2018
St. Jude's School for Girls	Pregnant resident reported that she was bleeding and was taken to the hospital.	15.02.2021
St. Jude's School for Girls	Pregnant resident reported that she was bleeding and was taken to the hospital.	28.12.2020
St. Jude's School for Girls	Resident had an axniety attack, elevated breathing and blood pressure	24.01.2021
St. Jude's School for Girls	Resident in possession of a weapon	13.05.2020
St. Jude's School for Girls	Resident pulled down her pants and showed her behind to staff	10.02.2021
St. Jude's School for Girls	Resident threatening staff member	5.02.2021
St. Jude's School for Girls	Resident took of clothes and showed staff private parts. Began cursing and making a scene.	24.01.2021
St. Jude's School for Girls	Resident was admitted to hospital with low blood sugar level	15.02.2021
St. Jude's School for Girls	Seizure	20.04.2019
St. Jude's School for Girls	Self Harm	09.07.2017
St. Jude's School for Girls	Self Harm	29.06.2017
St. Jude's School for Girls	Self Harm	30.07.2018
St. Jude's School for Girls	Self Harm	01.07.2018
St. Jude's School for Girls	Self Harm	03.04.2018
St. Jude's School for Girls	Self Harm	09.07.2018
St. Jude's School for Girls	Self Harm	03.07.2018
St. Jude's School for Girls	Self Harm	16.05.2018
St. Jude's School for Girls	Self Harm	16.06.2018 7 27.06.2018
St. Jude's School for Girls	Self Harm	5.05.2019
St. Jude's School for Girls	Self Harm	15.05.2019
St. Jude's School for Girls	Self Harm	17.05.2019
St. Jude's School for Girls	Self Harm	20.04.2019
St. Jude's School for Girls	Self Harm	25.01.2021
St. Jude's School for Girls	Self Harm	25.01.2021
St. Jude's School for Girls	Self Harm	25.01.2021

St. Jude's School for Girls	Self Harm	25.01.2021
St. Jude's School for Girls	Self Harm	25.01.2021
St. Jude's School for Girls	Self Harm	25.01.2021
St. Jude's School for Girls	Self Harming	13.05.2020
St. Jude's School for Girls	Self Harming	18.05.2020
St. Jude's School for Girls	Self Harming	7.02.2021
St. Jude's School for Girls	Self Harming	8.02.2021
St. Jude's School for Girls	SeLf Harming resulting in hospitalisation	8.02.2021
St. Jude's School for Girls	Self-Harm	22.01.2021
St. Jude's School for Girls	Sexual Interaction	22.09.2016
St. Jude's School for Girls	Sexual Interaction	22.06.2018
St. Jude's School for Girls	Sexual Interaction	09.06.2019
St. Jude's School for Girls	Sexual Interaction	10.9.2019
St. Jude's School for Girls	Shaving of hair.	29.07.2018
St. Jude's School for Girls	Smoking	10.8.2019
St. Jude's School for Girls	Smoking	20.07.2019
St. Jude's School for Girls	Unusal Phenomena	15.09.2017
St. Jude's School for Girls	Unusal Phenomena	02.08.2018
St. Jude's School for Girls	Vandalism	02.03.2018
St. Jude's School for Girls	Vandalism	5.11.2018
St. Jude's School for Girls	Verbal altercation	23.04.2019
St. Jude's School for Girls	Verbal altercation	15.02.2021
St. Jude's School for Girls	Violence between residents	17.06.2020
St. Mary's Home	2 residents are currently hospitalized after consuming an unknown mixture.	23.04.2021
St. Mary's Home	Absconding	17.02.2017
St. Mary's Home	Absconding	9.12.2017
St. Mary's Home	Absconding	04.05.2021
St. Mary's Home	Absconding	24.06.2021
St. Mary's Home	Absconding	23.03.2021
St. Mary's Home	Alleged poisonous substance given to residents by another resident.	22.04.2021
St. Mary's Home	Child damages staff's vehicle	11.05.2021
St. Mary's Home	Child was not feeling well.	30.07.2020
St. Mary's Home	Child was severely sick. Rushed to the hospital	2.2021
St. Mary's Home	Communication of a sexual nature via the internet	25.05.2021
St. Mary's Home	Illness/ injury to child	10.12.2017
St. Mary's Home	Illness/ injury to child	7.08.2017
St. Mary's Home	Illness/ injury to child	20.05.2020
St. Mary's Home	Illness/ injury to child	12.04.2021
St. Mary's Home	Inappropriate sexual conversation	26.05.2021
St. Mary's Home	Injury of a child not from the home	12.12.2017
St. Mary's Home	Injury to child	15.03.2020
St. Mary's Home	Injury to child	06.08.2020
St. Mary's Home	Injury to child in Football	5.9.2020
St. Mary's Home	Injury to staff by a child	22.05.2017
St. Mary's Home	Injury to staff by a child	22.05.2017
St. Mary's Home	Injury to staff by a child	9.03.2017
St. Mary's Home	Injury to staff by a child	9.03.2017
St. Mary's Home	Injury to staff member	29.03.2017
St. Mary's Home	Injury to staff members and vandalising of dorm unit	30.03.2018
St. Mary's Home	Innappropriate internet access and use.	24.05.2021
St. Mary's Home	Male resident grabbed staff member and attempted Sexual Interaction.	15.06.2021
St. Mary's Home	Medical report	28.08.2017
St. Mary's Home	Mother saw video of child kissing boy online.	17.05.2021

St. Mary's Home	Physical abuse to a child by a staff member.	17.01.2018
St. Mary's Home	Physical altercation between residents	12.04.2021
St. Mary's Home	Resident consumed dish washing liquid and had a razor blade.	19.04.2021
St. Mary's Home	Resident ingested small amt of dish washing liquid	19.04.2021
St. Mary's Home	Resident is fearful for her life.	15.04.2021
St. Mary's Home	Resident jumped off a wall	16.02.2018
St. Mary's Home	Resident reported that staff allowed them to fight in staff room.	1.04.2021
St. Mary's Home	Residents received a number of lashes to the face and body	19.03.2021
St. Mary's Home	Self Harm	30.07.2020
St. Mary's Home	Self Harm	04.08.2020
St. Mary's Home	Sexual abuse between residence	26.09.2017
St. Mary's Home	Sexual engagement	15.03.2021
St. Mary's Home	Sexual Interaction between 2 male residents	17.07.2020
St. Mary's Home	Sexual Interaction between 2 male residents	2.4.2021
St. Mary's Home	Sexual Interaction between 2 male-female residents	22.02.2021
St. Mary's Home	Suicide attempt	6.8.2018
SWAHA	Altercation between 2 residents	4.10.2020
SWAHA	Illness requiring medical attention	24.06.2017
SWAHA	Illness requiring medical attention	9.12.2018
SWAHA	Resident bit a staff memebr	16.11.2020
SWAHA	Sexual engagement	16.05.2018&23.05.2018
SWAHA	Slight injury which resulted in a visit to the hosptial	4.06.2020
Tacarigua Home	Absconding	03.02.2020
Tacarigua Home	Absconding	14.04.2021
Tacarigua Home	Oral sexual encounter	27.02.2021
Tacarigua Home	Oral sexual encounter	27.02.2020
Tacarigua Home	Physcial threats to resident.	11.12.2020
Tacarigua Home	Physcial threats to resident.	31.04.2020
Tacarigua Home	Physical altercation	09.04.2020
Tacarigua Home	Physical altercation	16.02.2020
Tacarigua Home	Physical assault by caregiver	19.04.2021
Tacarigua Home	Physical injury to child	11.05.2020
Tacarigua Home	Physical injury to child	19.01.2020
Tacarigua Home	Physical injury to child	23.08.2020
Tacarigua Home	Physical injury to child	27.02.2021
Tacarigua Home	Physical injury to child	10.06.2020
Tacarigua Home	Physical injury to child	17.03.2020
Tacarigua Home	Physical mistreatment of child	16.05.2020
Tacarigua Home	Possible food poisoning	08.03.2020
Tacarigua Home	Robbery	03.10.2020
Tacarigua Home	Self Harm	13.05.2020
Tacarigua Home	Self-Harm	01.09.2020
Tacarigua Home	Serious injury of a Caregiver	24.05.2020
Tacarigua Home	Sexual abuse	24.09.2020-22.10.2020
Tacarigua Home	Sexual abuse	25.01.2020
Tacarigua Home	Sexual abuse	24.04.2021
Tacarigua Home	Sexual assault	2.08.2020
Tacarigua Home	Sexual assault	2.08.2020
Tacarigua Home	Sexual assault	2.08.2020
Tacarigua Home	Sexual assault	2.08.2020
Tacarigua Home	Sexual assault	16.07.2020
Tacarigua Home	Sexual Interaction	20.04.2020

Tacarigua Home	Sexual Interaction	20.04.2020
Tacarigua Home	Sexual Interaction	20.04.2020
Tacarigua Home	Sexual Interaction	20.04.2020
Tacarigua Home	Sexual Interaction	20.04.2020
Tacarigua Home	Sexual Interaction	20.04.2020
Tacarigua Home	Sexual Interaction	20.04.2020
Tacarigua Home	Sexual Interaction	20.04.2020
Tacarigua Home	Sexual Interaction	20.04.2020
Tacarigua Home	Verbal Threats	16.05.2020
Valsayn Home	Absconding	30.01.2021
Valsayn Home	Absconding	20.03.2021
Valsayn Home	Aggressive behaviour	13.07.2020
Valsayn Home	Aggressive behaviour	18.7.2020
Valsayn Home	Aggressive behaviour	8.11.2020
Valsayn Home	Aggressive behaviour	13.11.2020
Valsayn Home	AGGressive behaviour	18.11.2020
Valsayn Home	Aggressive behaviour	25.11.2020
Valsayn Home	Aggressive behaviour	4.12.2020
Valsayn Home	Aggressive behaviour	4.12.2020
Valsayn Home	Aggressive behaviour	10.1.2021
Valsayn Home	AGGressive behaviour	13.01.2021
Valsayn Home	Aggressive behaviour	28.01.2021
Valsayn Home	Aggressive behaviour	08.02.2021
Valsayn Home	AGGressive behaviour	11.02.2021
Valsayn Home	Aggressive behaviour	15.02.2021
Valsayn Home	Aggressive behaviour	19.02.2021
Valsayn Home	Aggressive behaviour	22.02.2021
Valsayn Home	Aggressive behaviour	22.02.2021
Valsayn Home	Aggressive behaviour	26.02.2021
Valsayn Home	Aggressive behaviour	15.03.2021
Valsayn Home	Aggressive behaviour	20.06.2021
Valsayn Home	Aggressive behaviour	28.06.2020
Valsayn Home	Assaulted with a weapon	2.11.2020
Valsayn Home	Attempt to ascond	15.06.2020
Valsayn Home	Attempted assault	03.04.2021
Valsayn Home	Attempted suicide	25.05.2021
Valsayn Home	Breaking and entering	12.12.2020
Valsayn Home	Caught smoking cigarettes	27.02.2020
Valsayn Home	Damage to property	07.02.2021
Valsayn Home	Damaged device	6.11.2020
Valsayn Home	Damaged to property	01.12.2020
Valsayn Home	Damaged to property	27.02.2021
Valsayn Home	Destruction of property	16.06.2020
Valsayn Home	Destruction of property	17.06.2020
Valsayn Home	Inappropriate behaviour	17.11.2020
Valsayn Home	Inappropriate behaviour	26.02.2021
Valsayn Home	Inappropriate touching	19.02.2021
Valsayn Home	Injury to child	10.07.2020
Valsayn Home	Jumped the fence	17.10.2020
Valsayn Home	Jumped the fence	11.12.2020
Valsayn Home	Medical issue	28.11.2020
Valsayn Home	Money found	23.12.2020
Valsayn Home	Not listening to staff	14.08.2020
Valsayn Home	Physical altercation	11.08.2019
Valsayn Home	Physical altercation	20.09.2019
Valsayn Home	Physical altercation	12.09.2019
Valsayn Home	Physical altercation	24.10.2019
Valsayn Home	Physical altercation	28.10.2019

Valsayn Home	Physical altercation	31.10.2019
Valsayn Home	Physical altercation	27.10.2019
Valsayn Home	Physical altercation	1.11.2019
Valsayn Home	Physical altercation	7.15.2021
Valsayn Home	Physical altercation	22.06.2020
Valsayn Home	Physical altercation	29.06.2020
Valsayn Home	Physical altercation	22.07.2020
Valsayn Home	Physical altercation	3.07.2020
Valsayn Home	Physical altercation	4.7.2020
Valsayn Home	Physical altercation	7.7.2020
Valsayn Home	Physical altercation	8.07.2020
Valsayn Home	Physical altercation	12.07.2020
Valsayn Home	Physical altercation	15.07.2020
Valsayn Home	Physical altercation	19.7.2020
Valsayn Home	Physical altercation	20.7.2020
Valsayn Home	Physical altercation	26.07.2020
Valsayn Home	Physical altercation	04.08.2020
Valsayn Home	Physical altercation	4.08.2020
Valsayn Home	Physical altercation	5.08.2020
Valsayn Home	Physical altercation	6.08.2020
Valsayn Home	Physical altercation	10.08.2020
Valsayn Home	Physical altercation	10.08.2020
Valsayn Home	Physical altercation	13.08.2020
Valsayn Home	Physical altercation	16.08.2020
Valsayn Home	Physical altercation	19.08.2020
Valsayn Home	Physical altercation	26.08.2020
Valsayn Home	Physical altercation	26.08.2020
Valsayn Home	Physical altercation	02.09.2020
Valsayn Home	Physical altercation	22.09.2020
Valsayn Home	Physical altercation	3.10.2020
Valsayn Home	Physical altercation	4.10.2020
Valsayn Home	Physical altercation	22.10.2020
Valsayn Home	Physical altercation	2.11.2020
Valsayn Home	Physical altercation	23.11.2020
Valsayn Home	Physical altercation	24.11.2020
Valsayn Home	Physical altercation	25.11.2020
Valsayn Home	Physical altercation	4.12.2020
Valsayn Home	Physical altercation	06.12.2020
Valsayn Home	Physical altercation	7.12.2020
Valsayn Home	Physical altercation	11.12.2020
Valsayn Home	Physical altercation	14.12.2020
Valsayn Home	Physical altercation	15.12.2020
Valsayn Home	Physical altercation	23.12.2020
Valsayn Home	Physical altercation	25.12.2020
Valsayn Home	Physical altercation	26.12.2020
Valsayn Home	Physical altercation	26.08.2019
Valsayn Home	Physical altercation	19.01.2021
Valsayn Home	Physical altercation	10.01.2021
Valsayn Home	Physical altercation	06.02.2021
Valsayn Home	Physical altercation	11.02.2021
Valsayn Home	Physical altercation	20.02.2021
Valsayn Home	Physical altercation	02.03.2021
Valsayn Home	Physical altercation	15.03.2021
Valsayn Home	Physical altercation	6.04.2021
Valsayn Home	Physical altercation	5.03.2021
Valsayn Home	Physical altercation	26.5.2021
Valsayn Home	Physical altercation with staff	02.09.2020
Valsayn Home	Physical altercation with staff	19.01.2021

Valsayn Home	Physical altercation with staff	31.01.2021
Valsayn Home	Physical injury to child	02.12.2020
Valsayn Home	Physical injury to child	10.12.2020
Valsayn Home	Physical injury to child	20.01.2021
Valsayn Home	Physical injury to child	28.01.2021
Valsayn Home	Physical injury to child	11.04.2020
Valsayn Home	Physical injury to child	11.04.2020
Valsayn Home	Physical injury to child	02.05.2020
Valsayn Home	Physical injury to child	01.06.2020
Valsayn Home	Physical injury to child	01.09.2020
Valsayn Home	Physical injury to child	8.09.2020
Valsayn Home	Possession of a knife	6.4.2020
Valsayn Home	Possession of a weapon	15.11.2020
Valsayn Home	Possession of a weapon	24.11.2020
Valsayn Home	Self Harm	25.03.2020
Valsayn Home	Self Harm	19.08.2020
Valsayn Home	Self Harm	8.10.2020
Valsayn Home	Sexual Interaction	28.02.2020
Valsayn Home	Sexual Interaction	27.08.2020
Valsayn Home	Sexual Interaction	13.10.2020
Valsayn Home	Sexual Interaction	18.12.2020
Valsayn Home	Sexual Interaction	26.12.2020
Valsayn Home	Sexual Interaction	04.01.2021
Valsayn Home	Sexual Interaction	22.02.2021
Valsayn Home	Sexual Interaction	25.03.2021
Valsayn Home	Sexual Interaction	31.05.2021
Valsayn Home	Sexual Interaction	24.06.2021
Valsayn Home	Sleeping arrangements	19.11.2020
Valsayn Home	Stealing	19.05.2020
Valsayn Home	Verbal Threats	27.06.2020
Valsayn Home	Verbal threats to staff	18.03.2021
Valsayn Home	Verbally assaulted with cursing	18.03.2021
Valsayn Home	Verbally harassed	25.05.2021
Valsayn Home	Verbally harassed	02.07.20201
Valsayn Home	Verbally Threatened	12.02.2021
Valsayn Home	MISSING INFOMRATION	25.03.2021
YTRC FEMALE	Absconding	27.04.2019
YTRC FEMALE	Absconding	27.04.2019
YTRC FEMALE	Hospitalisation of resident	03.03.2021
YTRC MALE	5 residents absconded.	6.10.2019
YTRC MALE	Absconding	3.10.2019
YTRC MALE	Absconding of 2 residents	22.02.2019
YTRC MALE	Physical altercation	26.01.2020
YTRC MALE	Altercation between residents and staff	30.01.2020
YTRC MALE	Physical altercation	24.01.2020
YTRC MALE	Attempted suicide	17.08.2020
YTRC MALE	Hospitalisation of 4 residents	27.6.2017
YTRC MALE	Hospitalisation of 4 residents	23.06.2017
YTRC MALE	Injury to resident	16.01.2020
YTRC MALE	Injury to resident	21.01.2020
YTRC MALE	Physical altercation	21.01.2020
YTRC MALE	Possession of a weapean (stabber)	30.01.2020
YTRC MALE	Resident drank disinfectant and toilet bowl cleaner	04.12.2020
YTRC MALE	Suicidal thoughts	09.03.2021
YTRC MALE	Threats made against another resident	30.12.2019
YTRC MALE	Threats made to staff by residents	13.01.2020

YTRC MALE	Threats to life to staff with a pieces of broken toilet bowl.	29.01.2020
YTRC MALE	Violence against 1 resident by 2 residents	24.08.2019

(Appendix 3: List of Absconding from Community Residences and Child Support Centres)

CHILDREN'S AUTHORITY OF TRINIDAD AND TOBAGO

Incidences of Absconding at Community Residences

2018-2021

The table below provides information on children who have absconded from Community Residences for the period 2018 -2021. The children range from ages 11-17 years and St Jude's School for Girls have seen the highest number absconders over the years. It must be noted that estimated 95% of the children were recovered and returned to the Community Residence.

Some of the reasons noted for absconding include:

- Restriction of their freedom or autonomy (feeling that their autonomy is being stifled)
- Wanting to maintain connection with significant others outside
- Avoiding difficult relationships with staff and peers at the residence
- Poor mental health
- Boredom

Table 1. Shows a total number of 25 absconding incidents for 2018

Community Residence	# of incidents	Current Age	Status	Sex
Christ Child Convalescent	2	11 12	C&P C&P	Male Male
CREDO Boys	1	16	C&P	Male
Joshua Boys	1	17	C&P	Male
Lady Hochoy	4	15	C&P	Male
Raffa Girls	1	16	C&P	Female
Rainbow Rescue	2	17 16	C&P C&P	Male Male
Sophia House	1	15	C&P	Female
St. Jude's School for Girls	12	18 18 17 15 16 15 16 17 16 16 16 17	ChINS ChINS ChINS ChINS ChINS ChINS ChINS ChINS ChINS ChINS ChINS ChINS	Female Female Female Female Female Female Female Female Female Female Female Female
St. Mary's	1	17	ChINS	Male

Table 2. Shows a total number of 37 absconding incidents for 2019

Community Residence	# of incidents	Current Age	Status	Sex
Cecilia's Children's Home	1	15	ChINS	Female
Community Residence in Lambeau	1	10	ChINS	Male
CREDO Boys	3	16 16 16	C&P C&P (Non-National) C&P	Male Male Male
Division of Health Wellness and Family Development – Probation Hostel	1	13	ChINS	Male
Ezekiel Home	1	16	C&P	Female
Ferndean Children's Home	1	17	C&P	Male
Operation Smile	1	15	C&P	Male
Jairah House	1	17	C&P	Male
Lady Hochoy	3	15	C&P	Male
Mary Care North	1	16	C&P	Female
Sophia House	5	17 17 16 16 17	C&P C&P C&P C&P (Non-National) C&P (Non-National)	Female Female Female Female Female
Sri Jayalakshmi	1	17	C&P	Male
St. Dominic's Children's Home	1	17	C&P	Female
St. Jude's School for Girls	5	18 18 18 17 16	ChINS ChINS ChINS ChINS ChINS	Female Female Female Female Female
St. Mary's	3	16 15 15	ChINS ChINS ChINS	Male Male Male
YTC- Male	7	18 18 18 17 17 17 17	Children in Conflict with the Law	Male Male Male Male Male Male Male
YTC- Female	1	18	Children in Conflict with the Law	Female

Table 3. Shows a total number of 28 absconding incidents for 2020

Community Residence	# of incidents	Current Age	Status	Sex
CREDO	2	18 15	C&P ChINS	Male Male
Joshua Boys	2	16 14	C&P C&P	Male Male
Lady Hochoy	5	15	C&P	Male
Margarete Kistow	2	17 15	C&P C&P	Male Male
Mary Care North	3	17 16 16	C&P (Non-National) C&P ChINS	Male Male Male
Mary Care South	4	16 16 16 16	ChINS C&P ChINS C&P	Female Male Female Female
St. Jude's School for Girls	7	18 18 17 17 17 16	ChINS ChINS ChINS ChINS ChINS ChINS	Female Female Female Female Female Female
St. Mary's	2	16 16	ChINS ChINS	Male Female
The Islamic Children's Home	1	14	C&P	Male

Table 4. Shows a total number of 14 absconding incidents for 2021

Community Residence	# of incidents	Current Age	Status	Sex
Division of Health Wellness and Family Development – Probation Hostel	1	15	ChINS	Male
Marian House	1	17	C&P	Male
Mary Care North	2	16 16	ChINS C&P	Female Male
Mary Care South	1	16	ChINS	Female
Rainbow Rescue	1	17	C&P	Male
St. Jude's School for Girls	6	17 17 17 17 17	ChINS ChINS ChINS ChINS ChINS	Female Female Female Female Female

		16	ChINS	Female
St. Mary's	2	15 14	ChINS C&P	Male Male

(Appendix 4: Response to Media Reports by The Authority)

Media Report Response: August 8th 2019

Children's Authority of Trinidad and Tobago

LICENSING AND MONITORING DEPARTMENT
MONITORING FORM

ROUTINE MONITORING FORM				
SECTION 1				
Name of Community Residence	St. Jude's School for Girls	**Date and time of Visit**	23rd August 2019 @ 10:30AM	
Address of Community Residence	30 Belmont Circular Road, Belmont, Port-of-Spain	**Date of Last Visit**	26th July 2019	
Member of staff from residence and Position	Ms. Bruce- Manager Ms. Tonya Roach- Greaves- Psychologist Ms. Hannaway- Caregiver Ms. Kirton- Caregiver Ms. Simmons- Caregiver	**Licensed**	Yes ☐ No ■	Expiry Date: N/A
MONITORING OFFICERS DETAILS				
Monitoring Officer's Name and Position	Rachel Daniel-Halley- Licensing & Monitoring Associate	**Type of Visit**: (Select one or more combination)	■ Announced ☐ Weekend ☐ Unannounced ☐ Night	

DETAILS OF FOLLOW-UP VISIT		
Were follow-up and corrective actions taken on issues raised from last visit:	**If "Yes" outline action taken below**	**If "No" state reasons below:**
☐ Yes ■ No		-Critical incident reports outstanding

Outstanding Action	**Completion Date**	**Person Responsible**
Application documents	TBA	Management of St. Jude's
Repairs around the residence	TBA	Management of St. Jude's

General Comments:	Houses were doing general cleaning and throwing out old items and cleaning in cupboards. Most girls were involved in the activities.	
Licence & Application Status	☐ Status on application package to be submitted ☒ Status on letters of Omission ☐ Adherence to terms and conditions of license ☐ Inspection to be Scheduled ☐ Inspection conducted ☐ Awaiting decision from the Board	Comments: Incomplete application form. Fire has refused to certify the locations as the nuns quarters have been stated to be a fire hazard. Public Health has also refused to issue a certificate of approval.

Type of Interaction

Interactions With	Type of Interaction	Category of Personnel	
☒ Children ☒ Staff	☒ One on one interviews ☐ Focus Groups ☒ Observations	☒ Permanent ☐ Temporary ☐ Volunteers ☐ House Mothers/ Fathers ☐ Teachers	☒ Manager/ Director ☐ Facility Operator ☐ Auxiliary ☐ Nurse's Aide ☒ Other: Psychologist, Matrons, Court officer

Number of persons interviewed:	**Staff**	**Children**	
		M	**F**
	5	0	5

Age Range of Children Involved in Interviews (Check selection): →

☐ 3 - 7 Years ☒ 15 - 18 Years
☐ 7 - 10 Years ☐ Other (please specify)
☒ 11 - 14 Years

Issues Raised by Staff/ Other Personnel:	Staff were complaining of the disruptive girls on the compound and enquiring as to what is happening with them. Other than that, no major complaints were made.
Issues / Complaints Raised by Children:	Conversations were held with some of the residents individually and as groups. Some girls spoke of the discomfort on the compound with the girls that were stirring up trouble, whilst other girls indicated that they were not concerned with the trouble the girls were stirring up, they prefer to stay out of it.

AREAS CHECKED

Premises

Kitchen:	Met	Not Met
Lighting	■	☐
Ventilation	■	☐
Equipment	■	☐
Cleanliness	■	☐
Food Badges	■	☐
Garbage disposal	■	☐
Potable Water	■	☐
Food Storage	■	☐

Action Required: None

Living/ Dining Room:	Met	Not Met
Suitably furnished	■	☐
Lighting	■	☐
Ventilation	■	☐
Cleanliness	■	☐

Action Required: None

Bedrooms:	Met	Not Met
Lighting	■	☐
Ventilation	■	☐
Storage	■	☐
Cleanliness	■	☐
Individual Beds	■	☐
Railings (bunk beds)	☐	■

Action Required:

Gertrude House- Safety railings needed on upper bunks.

Toilet and Bathroom:	Met	Not Met
Toilets	☐	■
Showers	■	☐
Hand washing Basin	■	☐
Lighting	■	☐
Ventilation	■	☐
Bins	■	☐
Running potable water	■	☐
Fixtures & fittings	☐	■
Toiletries	■	☐

Action Required: Shower stall in Maria Goretti not draining properly. Extensive Work needs to be done to repair it.

Laundry:	Met	Not Met
Washer	■	☐
Dryer	■	☐
Clothes line	■	☐
Storage	■	☐
Running water	■	☐

Action Required: None

Child Friendly Spaces:	Met	Not Met
Study area	■	☐
Recreational Areas	■	☐
Recreational Equipment	■	☐

Action Required: None

Welfare of Children

Food & Nutrition:

	Met	Not Met
At least 3 meals	■	☐
Menu Plan	■	☐
Food storage	■	☐
Donated cooked food	☐ N/A	☐
Special dietary needs	■	☐

Action Required: None

Clothing:

	Met	Not Met
Storage	☐	■
Clothes	■	☐
Shoes	■	☐

Action Required: Appropriate storage needs to be installed in Carmel House B (Rehab Centre) as there are now 5 girls housed in this dorm.

Education:

	Met	Not Met
All school-aged, in school	■	☐
Programmes available	■	☐
Vocational Programmes	■	☐
Extra-Curricular Activities	■	☐

Action Required: None

Best Interest, Fair Treatment:

	Met	Not Met
Complaints system	■	☐
Reward system	■	☐
Disciplinary system	■	☐
Spaces for confidential talks	■	☐
Communication Policy	■	☐
Disability amenities	☐ N/A	☐

Action Required: Policies to be documented

Medical:

	Met	Not Met
Immunization	☐	■
Check-ups	■	☐
First aid kit	■	☐

Action Required: Residents that are on remand do not have immunization cards at the home. Request to family is made should information be required.

Orientation:

	Met	Not Met
Rules posted	■	☐
Admission records	■	☐
Orientation program	■	☐

Action Required: None

Supervision:

	Met	Not Met
Staffing	■	☐
Supervision of Children Observed	■	☐

Action Required:

Safety & Security: Met ■ Not Met ☐

Records: Met ■ Not Met ☐

Safety & Security	Area for visitors Emergency drills ☐ ■ Fire Safety Equipment ☐ ■ Fire Equipment Serviced ☐ ■ Emergency signage ■ ☐ Evacuation Plan ☐ ■ Logged Evacuation Drills ☐ ■ Perimeter Fencing ■ ☐ Entry & Exit gate ■ ☐ Action Required: Due to the client group, drills have not been conducted.		**Records**	Register of Children Journal of Significant Events ☐ ■ Disciplinary Log ☐ ■ Serious Incident Log ☐ ■ Visitors Log ■ ☐ Children's Records ■ ☐ Storage of Files ■ ☐ Complaints Handling System ■ ☐ Critical Incidents ■ ☐ Daily Log ■ ☐ Action Required: Logbooks still to be completed as stipulated by regulations	

Breach of Regulations

Premises	Welfare of Children	Records	Safety & Security	Complaints Handling	Communication
-Poor drainage in shower stall	-Missing safety railings	-Missing logbooks in some dorms	-No evacuation drills conducted or logged		
-Unusable toilet in Maria Goretti	-Insufficient beds				
-Several unusable sinks in all dorms except Gertrude House					

Recommendations	
Recommendations:	**Status** (Ongoing, Complete, Referred, etc.)
-Logbooks to be updated as required by legislation. -Critical incident reports that are outstanding to be completed and submitted as soon as possible. *At the time of the visit, a Police investigation was being conducted into the beating of Tia Villafana. Outcome to be reported to the Children's Authority as soon as possible.	

Signatures:

Community Residence Representative:

Name	Signature	Position	Date
YVETTE BRUCE	Y. Bruce	Manager Ag	23/08/2019

Licensing & Monitoring Representatives:

Name	Signature	Position	Date
Rachel Daniel-Halley	R. Halley	Licensing + Monitoring Associate	23/08/2019

Additional Information: (*If further information is required under the following sections, please input such information here***)**

Welfare of Children:

An interview was conducted with Tia in order to obtain details on the incident that resulted in her being beaten up by other residents:

Tia indicated that a number of girls were attending a camp at the St. Dominic's Belmont campus. Shekera Reid, Afiya Pierre and herself were discussing running from St. Dominic's. Tia indicated she changed her mind and told the girls "Don't ruin our opportunities; we are getting to go to school in September". It was raining; therefore, St. Jude's bus came to St. Dominic's to pick up the girls. However, when the bus came, Shekera decided to take the opportunity to run. She ran down the hill and Mr. Lutchman ran behind her. However, she could not be found once Mr. Lutchman got to the main road. The other girls were taken back to St. Jude's compound.

Tia stated that once they got back on the compound, before she went back in to her dorm, she asked to speak to Mr. Deoraj as she decided to explain what happened. Tia mentioned that Mr. Deoraj was upset with her for plotting to absconed from the compound. Shortly after Shekera came back on to the compound and she also informed Mr. Deoraj that they did plan to run, but Tia decided against it. Mr. Deoraj apologised to Tia and commended her for making the right decision.

When they got on to the compound, Tia indicated that Nicola Austin, Afiya Pierre, Ameelia Glasglow all approached her and asked her why she let down her sister. Tia stated that she informed them that if she does not want to run, she is not going to run and mess up her opportunity. At that time, Nicola punched her in her face and a fight broke out. Tia stated that at that time, Mya Hollingsworth and Miliah Arthur joined the fight and they were all beating her. She fell to the ground when Mya began stomping on her head.

Tia stated she was in a lot of pain and was taken to the doctor and then to the police to make a report.

Tia also mentioned that prior to the visit; Nicola has been sending girls to her dorm to see where she is and what she is doing. However, this morning, staff realised what was happening and sent the girls that Nicola sent to look for Tia, out of the dormitory. Tia also complained that yesterday, she was coming back to her dorm from the office and saw Mya coming towards her. She explained that she moved out of Mya's path, but Mya still decided to pass close to her and bump in to her. Tia also expressed her fear of being in the dorm as Nicola threatened her and told her "We are already getting charged for beating you up. We not going down for something so small, someone has to die here". Tia stated that she did not inform any member of staff of this threat and has been staying in her dorm to stay out of their way. Tia indicated that Nicola and her followers were calling her a snitch. Even if Nicola and the other girls are removed, the girls that are loyal to Nicola may come to attack her. She also stated that she informed her magistrate that if any girl attacks her again, she will be "fighting like a man, I aint' taking no licks from nobody again".

Tia also stated that she is unable to see out of her left eye, and blurred vision from the right eye. She also stated that she is unable to be in bright sunlight and she cannot watch television for too long.

***It should be noted that at the time of this visit, Officer Walker from the Belmont Police Station was at the residence obtaining statements from Nicole Crooks that would be used to determine whether the girls involved in beating up Tia, would be charged and removed from the residence. Also based on the statements made by Tia, alternative placement was being sought at Sophia House for Tia for her own safety.**

An interview was also conducted with Analee Balmacoonsingh who complained in court of allegedly being sexually assaulted by girls of St. Jude's as she woke up with "hickies" over her breast and chest.

Analee is placed in Gertrude House with seven other girls, namely- Shakira Neptune, Ruby Jordan, Mya Hollingsworth, Arianna Mahabir, Kassandra Gonzalez, Isabella Ramdeen, Murisha and herself.

Questions were raised regarding the incident of alleged sexual abuse in the dorm that was reported in court by her mother. Analee indicated that she is not 100% sure as to what happened. She stated that she has not been sleeping properly. She also mentioned that she is not a heavy sleeper. However, on or around the 16th/ 17th August 2019 she somehow got some sleep and must have been sleeping heavy, as she is not clear as to what happened to her. She indicated that she awoke with marks on her breast and is not sure how she got them. She also mentioned that she has sensitive skin therefore her skin marks very easily. She also stated that the marks do look like what appears to be "hickey marks".

Analee therefore indicated she cannot confirm how she received the marks on her skin.

Photo Evidence:

Red Flags for Immediate Action

Action to be taken:	**Status** (Ongoing, Complete, Referred, etc.)
*Nicola Austin, Myah Hollingsworth, Ameelia Glasglow, Afiyah Pierre, Miliah Arthur participated in physically beating Tia Villafana. Request for the removal of these girls from St. Jude's is being sought.	At approximately 6:05pm information was received that Tia had been placed at Sophia House and the girls accused of beating up Tia, were all taken to CPU North holding cells in Maracas, St. Joseph.

Senior Licensing and Monitoring Associate Review

- In agreement with recommendations made. ☐ Yes ☐ No
- Recommendations to be revised ☐ Yes ☐ No

Senior's recommendations if any:

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Referrals and Updates

Refer to:	☐ **Children and Family Department:** ☐ Referral letter completed ☐ Referral letter signed as received by CFSD (attach copy of referral to this form) ☐ Email sent to team lead Date: ☐ Phone call made to CFSD team lead	☐ **Investigation:** ☐ Referral letter completed ☐ Referral letter signed as received by Investigation (attach copy of referral to this form) ☐ Email sent to team lead. Date:	**Update**	☐ **Registry** ☐ Referral letter completed ☐ Referral letter signed as received by Registry (attach copy of referral to this form) ☐ Email sent to team lead Date: ☐ Phone call made to Registry team lead Person spoke to:	**Comments:**

	Person spoke to: Date: Time:	☐ Phone call made to Investigation team lead Person spoke to: Date: Time:		Date: Time:	

Senior Licensing and Monitoring Associate Review

- Recommendations actioned ☐ Yes ☐ No
- Follow-up completed ☐ Yes ☐ No

Licensing & Monitoring Manager Review

Comments: Privileges

Signatures:

Senior Licensing & Monitoring Associate:

Signature: _____ Date: _____

Licensing & Monitoring Manager:

Signature: _____ Date: _____

ROUTINE MONITORING FORM				
SECTION 1				
Name of Community Residence	St. Jude's School for Girls	**Date and time of Visit**	23rd September 2019 @ 10:00AM	
Address of Community Residence	30 Belmont Circular Road, Belmont, Port-of-Spain	**Date of Last Visit**	23rd August 2019	
Member of staff from residence and Position	Ms. Tonya Roach- Greaves- Psychologist	**Licensed**	Yes ☐ No ■	Expiry Date: N/A
MONITORING OFFICERS DETAILS				
Monitoring Officer's Name and Position	Rachel Daniel-Halley- Licensing & Monitoring Associate	**Type of Visit**: (Select one or more combination)	☐ Announced ☐ Weekend ■ Unannounced ☐ Night	

DETAILS OF FOLLOW-UP VISIT		
Were follow-up and corrective actions taken on issues raised from last visit:	**If "Yes" outline action taken below**	**If "No" state reasons below:**
☐ Yes ■ No		-Critical incident reports outstanding

Outstanding Action	Completion Date	Person Responsible
Application documents	TBA	Management of St. Jude's
Repairs around the residence	TBA	Management of St. Jude's

General Comments:	Residents were engaged in classes. Residents were also observed doing their charges before attending their classes.
	Residents educational information was also obtained as well as the general register updated with admissions and discharges to the residence.

Licence & Application Status	☐ Status on application package to be submitted ☐ Inspection to be Scheduled ☒ Status on letters of Omission ☐ Inspection conducted ☐ Adherence to terms and conditions of license ☐ Awaiting decision from the Board	Comments: Incomplete application form. Fire has refused to certify the locations as the nuns quarters have been stated to be a fire hazard. Public Health has also refused to issue a certificate of approval.

Type of Interaction

Interactions With	Type of Interaction	Category of Personnel	
☒ Children ☒ Staff	☒ One on one interviews ☐ Focus Groups ☒ Observations	☒ Permanent ☐ Temporary ☐ Volunteers ☐ House Mothers/ Fathers ☐ Teachers	☐ Manager/ Director ☐ Facility Operator ☐ Auxiliary ☐ Nurse's Aide ☒ Other: Psychologist

Number of persons interviewed:	Staff	Children M	Children F	Age Range of Children Involved in Interviews (Check selection): →		
	5	0	5		☐ 3 - 7 Years ☐ 7 - 10 Years ☒ 11 - 14 Years	☒ 15 - 18 Years ☐ Other (please specify)

Issues Raised by Staff/ Other Personnel:	Ms. Greaves indicated that she was working through finalising outstanding critical incidents. However, she is awaiting some reports from various
	Staff and residents in order to close off the reports.
Issues / Complaints Raised by Children:	Residents indicated that things were quiet at the residence for the moment. They did not have any complaints at the moment.

AREAS CHECKED

Premises

Kitchen:	Met	Not Met
Lighting	■	☐
Ventilation	■	☐
Equipment	■	☐
Cleanliness	■	☐
Food Badges	■	☐
Garbage disposal	■	☐
Potable Water	■	☐
Food Storage	■	☐

Action Required: None

Living/ Dining Room:	Met	Not Met
Suitably furnished	■	☐
Lighting	■	☐
Ventilation	■	☐
Cleanliness	■	☐

Action Required: None

Bedrooms:	Met	Not Met
Lighting	■	☐
Ventilation	■	☐
Storage	■	☐
Cleanliness	■	☐
Individual Beds	■	☐
Railings (bunk beds)	☐	■

Action Required:

Gertrude House- Safety railings needed on upper bunks.

Toilet and Bathroom:	Met	Not Met
Toilets	☐	■
Showers	■	☐
Hand washing Basin	■	☐
Lighting	■	☐
Ventilation	■	☐
Bins	■	☐
Running potable water	■	☐
Fixtures & fittings	☐	■
Toiletries	■	☐

Action Required: Shower stall in Maria Goretti not draining properly. Extensive

Laundry:	Met	Not Met
Washer	■	☐
Dryer	■	☐
Clothes line	■	☐
Storage	■	☐
Running water	■	☐

Action Required: None

Child Friendly Spaces:	Met	Not Met
Study area	■	☐
Recreational Areas	■	☐
Recreational Equipment	■	☐

Action Required: None

	Work needs to be done to repair it.		
Welfare of Children	**Food & Nutrition:** Met / Not Met At least 3 meals ☑ ☐ Menu Plan ☑ ☐ Food storage ☑ ☐ Donated cooked food ☐ N/A ☐ Special dietary needs ☑ ☐ Action Required: None	**Clothing:** Met / Not Met Storage ☑ ☐ Clothes ☑ ☐ Shoes ☑ ☐ Action Required: None	**Education:** Met / Not Met All school-aged, in school ☑ ☐ Programmes available ☑ ☐ Vocational Programmes ☑ ☐ Extra-Curricular Activities ☑ ☐ Action Required: None
	Best Interest, Fair Treatment: Met / Not Met Complaints system ☑ ☐ Reward system ☑ ☐ Disciplinary system ☑ ☐ Spaces for confidential talks ☑ ☐ Communication Policy ☑ ☐ Disability amenities ☐ N/A ☐ Action Required: Policies to be documented	**Medical:** Met / Not Met Immunization ☐ ☑ Check-ups ☑ ☐ First aid kit ☑ ☐ Action Required: Residents that are on remand do not have immunization cards at the home. Request to family is made should information be required.	**Orientation:** Met / Not Met Rules posted ☑ ☐ Admission records ☑ ☐ Orientation program ☑ ☐ Action Required: None
			Supervision: Met / Not Met Staffing ☑ ☐ Supervision of Children Observed ☑ ☐ Action Required:
	Safety & Security: Met ☑ / Not Met ☐		**Records:** Met ☑ / Not Met ☐

Safety & Security	Area for visitors Emergency drills ☐ ■ Fire Safety Equipment ☐ ■ Fire Equipment Serviced ☐ ■ Emergency signage ■ ☐ Evacuation Plan ☐ ■ Logged Evacuation Drills ☐ ■ Perimeter Fencing ■ ☐ Entry & Exit gate ■ ☐ Action Required: Due to the client group, drills have not been conducted.	**Records**	Register of Children Journal of Significant Events ☐ ■ Disciplinary Log ☐ ■ Serious Incident Log ☐ ■ Visitors Log ■ ☐ Children's Records ■ ☐ Storage of Files ■ ☐ Complaints Handling System ■ ☐ Critical Incidents ■ ☐ Daily Log ■ ☐ Action Required: Logbooks still to be completed as stipulated by regulations	

Breach of Regulations					
Premises	**Welfare of Children**	**Records**	**Safety & Security**	**Complaints Handling**	**Communication**
-Poor drainage in shower stall	-Missing safety railings	-Missing logbooks in some dorms	-No evacuation drills conducted or logged		

Recommendations					
Recommendations:					**Status** (Ongoing, Complete, Referred, etc.)
-Please work on updating logbooks according to legislation -Please work on submitting all outstanding incident forms as soon as possible					

Signatures:

Community Residence Representative:

Name	Signature	Position	Date
TONYA GREAVES	RSFE TG	Psychologist	23/09/2019

Licensing & Monitoring Representatives:

Name	Signature	Position	Date
Rachel Daniel-Hurley	RD Hurley	Licensing + Monitoring Associate	23/09/209

Additional Information: (*If further information is required under the following sections, please input such information here***)**

Premises:

Welfare of Children:

Records:

Safety & Security:

Complaints Handling:

Communication:

Photo Evidence:

Red Flags for Immediate Action	
Action to be taken:	**Status** (Ongoing, Complete, Referred, etc.)

Senior Licensing and Monitoring Associate Review	
• In agreement with recommendations made. ☐ Yes ☐ No • Recommendations to be revised ☐ Yes ☐ No	**Senior's recommendations if any:**

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Referrals and Updates

Refer to:	☐ **Children and Family Department:** ☐ Referral letter completed ☐ Referral letter signed as received by CFSD (attach copy of referral to this form) ☐ Email sent to team lead Date: ☐ Phone call made to CFSD team lead Person spoke to: _____ Date: Time:	☐ **Investigation:** ☐ Referral letter completed ☐ Referral letter signed as received by Investigation (attach copy of referral to this form) ☐ Email sent to team lead. Date: ☐ Phone call made to Investigation team lead Person spoke to: _____ Date: Time:	**Update**	☐ **Registry** ☐ Referral letter completed ☐ Referral letter signed as received by Registry (attach copy of referral to this form) ☐ Email sent to team lead Date: ☐ Phone call made to Registry team lead Person spoke to: _____ Date: Time:	**Comments:**

Senior Licensing and Monitoring Associate Review

- Recommendations actioned ☐ Yes ☐ No
- Follow-up completed ☐ Yes ☐ No

Licensing & Monitoring Manager Review

Comments: Privileges

Signatures:

Senior Licensing & Monitoring Associate:

Signature: _____ Date: _____

Licensing & Monitoring Manager:

Signature: _____ Date: _____

ROUTINE MONITORING FORM				
SECTION 1				
Name of Community Residence	St. Jude's School for Girls	**Date and time of Visit**	26th July 2019 @ 9:30AM	
Address of Community Residence	30 Belmont Circular Road, Belmont, Port-of-Spain	**Date of Last Visit**	25th June 2019	
Member of staff from residence and Position	Ms. Bruce- Manager Mr. Deoraj- Asst. Manager. Ms. Sullivan- Court Officer Ms. Tonya Roach- Greaves- Psychologist	**Licensed**	Yes ☐ No ■	Expiry Date: N/A
MONITORING OFFICERS DETAILS				

Monitoring Officer's Name and Position	Rachel Daniel-Halley- Licensing & Monitoring Associate	**Type of Visit**: (Select one or more combination)	☒ Announced ☐ Weekend ☐ Unannounced ☐ Night

DETAILS OF FOLLOW-UP VISIT

Were follow-up and corrective actions taken on issues raised from last visit:	**If "Yes" outline action taken below**	**If "No" state reasons below:**
☐ Yes ☒ No		-Poor drainage in 1 shower stall in Maria Goretti -1 Toilet still not working in Maria Goretti -Door not repaired in bathroom in St. Therese -Critical incident reports outstanding

Outstanding Action	**Completion Date**	**Person Responsible**
Application documents	TBA	Management of St. Jude's
Repairs around the residence	TBA	Management of St. Jude's

General Comments:	All dorms were clean and well maintained. Girls were engaged in a cricket match with the students of CCC.

Licence & Application Status	☐ Status on application package to be submitted ☒ Status on letters of Omission ☐ Adherence to terms and conditions of license ☐ Inspection to be Scheduled ☐ Inspection conducted ☐ Awaiting decision from the Board	Comments: Incomplete application form. Fire has refused to certify the locations as the nuns quarters have been stated to be a fire hazard. Public Health has also refused to issue a certificate of approval.

Type of Interaction

Interactions With	**Type of Interaction**	**Category of Personnel**	
☐ Children ☒ Staff	☒ One on one interviews ☐ Focus Groups ☒ Observations	☒ Permanent ☐ Temporary ☐ Volunteers ☐ House Mothers/ Fathers ☐	☒ Manager/ Director ☐ Facility Operator ☐ Auxiliary ☐ Nurse's Aide

		Teachers	☒ Other: Psychologist, Matrons, Court officer

Number of persons interviewed:	**Staff**	**Children**		**Age Range of Children Involved in Interviews** (Check selection): →	☐ 3 - 7 Years ☐ 7 - 10 Years ☒ 11 - 14 Years ☒ 15 - 18 Years ☐ Other (please specify)
		M	**F**		
	4				

Issues Raised by Staff/ Other Personnel:	Issues were raised regarding the placement of a resident who has been convicted, placed at St. Jude's.
Issues / Complaints Raised by Children:	Residents were observed engaged in a cricket match. They refused to be interviewed as they were cheering on their fellow residents and did not want to "miss" part of the match.

AREAS CHECKED

Premises

Kitchen:	**Met**	**Not Met**
Lighting	☒	☐
Ventilation	☒	☐
Equipment	☒	☐
Cleanliness	☒	☐
Food Badges	☒	☐
Garbage disposal	☒	☐
Potable Water	☒	☐
Food Storage	☒	☐

Action Required: None

Living/ Dining Room:	**Met**	**Not Met**
Suitably furnished	☒	☐
Lighting	☒	☐
Ventilation	☒	☐
Cleanliness	☒	☐

Action Required: None

Bedrooms:	**Met**	**Not Met**
Lighting	☒	☐
Ventilation	☒	☐
Storage	☒	☐
Cleanliness	☒	☐
Individual Beds	☒	☐
Railings (bunk beds)	☐	☒

Action Required:

Gertrude House- Safety railings needed on upper bunks.

Toilet and Bathroom:	Met	Not Met
Toilets	☐	☒
Showers	☒	☐
Hand washing Basin	☒	☐
Lighting	☒	☐
Ventilation	☒	☐
Bins	☒	☐
Running potable water	☒	☐
Fixtures & fittings	☐	☒
Toiletries	☒	☐

Action Required: Shower stall in Maria Goretti not draining properly. Extensive Work needs to be done to repair it.

Laundry:	Met	Not Met
Washer	☒	☐
Dryer	☒	☐
Clothes line	☒	☐
Storage	☒	☐
Running water	☒	☐

Action Required: None

Child Friendly Spaces:	Met	Not Met
Study area	☒	☐
Recreational Areas	☒	☐
Recreational Equipment	☒	☐

Action Required: None

Food & Nutrition:	Met	Not Met
At least 3 meals	☒	☐
Menu Plan	☒	☐
Food storage	☒	☐
Donated cooked food	☐ N/A	☐
Special dietary needs	☒	☐

Action Required: None

Clothing:	Met	Not Met
Storage	☐	☒
Clothes	☒	☐
Shoes	☒	☐

Action Required: Appropriate storage needs to be installed in Carmel House B (Rehab Centre) as there are now 5 girls housed in this dorm.

Education:	Met	Not Met
All school-aged, in school	☒	☐
Programmes available	☒	☐
Vocational Programmes	☒	☐
Extra-Curricular Activities	☒	☐

Action Required: None

Welfare of Children

Best Interest, Fair Treatment:	Met	Not Met
Complaints system	■	☐
Reward system	■	☐
Disciplinary system	■	☐
Spaces for confidential talks	■	☐
Communication Policy	■	☐
Disability amenities	☐	☐ N/A

Action Required: Policies to be documented

Medical:	Met	Not Met
Immunization	☐	■
Check-ups	■	☐
First aid kit	■	☐

Action Required: Residents that are on remand do not have immunization cards at the home. Request to family is made should information be required.

Orientation:	Met	Not Met
Rules posted	■	☐
Admission records	■	☐
Orientation program	■	☐

Action Required: None

Supervision:	Met	Not Met
Staffing	■	☐
Supervision of Children Observed	■	☐

Action Required:

Safety & Security

Safety & Security:	Met	Not Met
Area for visitors	■	☐
Emergency drills	☐	■
Fire Safety Equipment	☐	■
Fire Equipment Serviced	☐	■
Emergency signage	■	☐
Evacuation Plan	☐	■
Logged Evacuation Drills	☐	■
Perimeter Fencing	■	☐
Entry & Exit gate	■	☐

Action Required: Due to the client group, drills have not been conducted.

Records

Records:	Met	Not Met
Register of Children	■	☐
Journal of Significant Events	☐	■
Disciplinary Log	☐	■
Serious Incident Log	☐	■
Visitors Log	■	☐
Children's Records	■	☐
Storage of Files	■	☐
Complaints Handling System	■	☐
Critical Incidents	■	☐
Daily Log	■	☐

Action Required: Logbooks still to be completed as stipulated by regulations

Breach of Regulations

Premises	Welfare of Children	Records	Safety & Security	Complaints Handling	Communication
-Poor drainage in shower stall -Unusable toilet in Maria Goretti -Several unusable sinks in all dorms except Gertrude House	-Missing safety railings -Insufficient beds	-Missing logbooks in some dorms	-No evacuation drills conducted or logged		

Recommendations

Recommendations:	**Status** (Ongoing, Complete, Referred, etc.)
-Leaking shower in downstairs bathroom in Carmel House and Maria Goretti to be repaired. -Logbooks in all dorms to be filled in properly. Dorms that are missing the required logbooks to obtain them. *Well done on all dorms being clean.	

Additional Information: (*If further information is required under the following sections, please input such information here***)**

Premises:

Welfare of Children:

Records:

Safety & Security:

Complaints Handling:

Communication:

_____
_____
_____

Photo Evidence:

Red Flags for Immediate Action	
Action to be taken:	**Status** (Ongoing, Complete, Referred, etc.)

Senior Licensing and Monitoring Associate Review	
• In agreement with recommendations made. ☐ Yes ☐ No	**Senior's recommendations if any:**

• Recommendations to be revised ☐ Yes ☐ No	

FOR OFFICIAL USE

Referrals and Updates

Refer to:	☐ **Children and Family Department:** ☐ Referral letter completed ☐ Referral letter signed as received by CFSD (attach copy of referral to this form) ☐ Email sent to team lead Date: ☐ Phone call made to CFSD team lead Person spoke to: Date: Time:	☐ **Investigation:** ☐ Referral letter completed ☐ Referral letter signed as received by Investigation (attach copy of referral to this form) ☐ Email sent to team lead. Date: ☐ Phone call made to Investigation team lead Person spoke to: Date: Time:	**Update**	☐ **Registry** ☐ Referral letter completed ☐ Referral letter signed as received by Registry (attach copy of referral to this form) ☐ Email sent to team lead Date: ☐ Phone call made to Registry team lead Person spoke to: Date: Time:	**Comments:**

Senior Licensing and Monitoring Associate Review

- Recommendations actioned ☐ Yes ☐ No
- Follow-up completed ☐ Yes ☐ No

Licensing & Monitoring Manager Review

Comments: Privileges

Signatures:

Senior Licensing & Monitoring Associate:

Signature: _____ Date: _____

Licensing & Monitoring Manager:

Signature: _____ Date: _____

February 16 2020

☑ Community Residence	☐ Nursery	☐ School	Other:_____

Name of Residence	**St. Dominic's Children's Home**		
Address of Residence	**Belmont Circular Road, Belmont**		
Dates	**12 February 2020**	**Date of last visit**	**29 January 2020**
Type of Visit	**Announced** ☑ **Unannounced** ☐	**Time of Visit**	**10.30 am**
Monitoring Officer(s)	**Stephan Williams –Licensing & Monitoring Associate**		

PURPOSE OF VISIT

☐ **Non-conformance follow up (pre-inspection/Inspection)**	☑ **Received Complaint**
☐ **Routine Monitoring Visit**	☐ **Follow up on corrective action from complaint**
☐ **Emergency**	☐ **Follow up on recommendations made from last visit**
☐ **Other**	

AREAS CHECKED

☐ **Premises**	☑ **Safety & Security**	☐ **Application**
☑ **Welfare of children**	☐ **Complaints**	
☐ **Records**	☐ **Communication**	

FINDINGS

(Briefly document findings in point form)

Background

On the 12th February 2020, there was an article in the media which highlighted allegations of corporal punishment from St. Dominic's Children's Home. It was stated that two (2) residents , ages 8 and 9, were being beaten on Monday evening (10th February) by a part-time caregiver who became upset that were children were wearing the wrong pants and sneakers. Officials stated that they were beaten with a leather belt after the relief staff member learned one of them had worn a pair of pants that was not set out for him to wear. The other was beaten for wearing the wrong sneakers to school that day.

Given the nature of the report, an investigation was conducted to substantiate the claims. Residents and staff members were interviewed as well as the Household Log Books were reviewed to determine if any reports were documented.

Interviews

Ms. Meera Dookhoo- Welfare Manager

When questioned, Ms. Dookhoo, stated that she was only made aware of the allegation via the newspapers on the morning of the 12th February. She added that this allegation is very serious however she didn't receive any reports of any corporal punishment incidents. Upon arriving at the residence, she would have requested feedback from the case workers as to if they would have received any complaints from residents .During the interview, Ms. Dookhoo stated that the residence is currently experience several staffing challenges and there are mischievous employees making false accusations on the residence.

Ms. Parsanlal- Case worker

Ms. Parsanlal is the assigned case worker for the female residents that are within the ages of 8 to 9 years old. When questioned, she stated that she was only made aware of the allegation via newspapers and that she made enquires with the residents to determine if there was any truth. Ms. Parsanlal explained that none of the residents (Bethlem House) complained about receiving licks or any form of corporal punishment.

Mr. Ramirez – Case worker

Mr. Ramirez is one of the case workers who is assigned to male residents with the ages of 8 and 9 years old. When questioned, he stated that he found out about the article from Ms. Dookhoo and informed that there was no incident of corporal punishment. He added that the two (2) boys who are housed at the St. Martin's House whereby they were both given a consequence for wearing the wrong school uniform on Monday. He explained that M.L – 9 years and H.W- 8 years were sent home from school (Belmont Boys Primary) to change their school uniform because their pants and shoes violated the school's dress code. Both boys changed into the correct uniform and returned to school however, it was learnt that they concealed the prohibited clothes in their bags before return to school where they both changed.

Upon their return after school, one of the boys forgot to revert into the correct uniform and for which they were issued a consequence of chores and exercises as their punishment for being deceitful. He stated that at no time corporal punishment is used as a form of discipline.

Mr. Rodrigues – Youth Officer

Mr. Rodrigues is the Youth Officer that is assigned to the Shalom Center to conduct activities and programmes with the residents during the hours from 12.00 pm to 6.00 pm. He explained that there has been staffing problem at the

residence over the past few years which would have resulted in him adopting a double shift to supervise residents that are accommodated at the St. Martin's House from 8.00 pm to 6.00 am.

Mr. Rodrigues informed that the allegation in the newspapers was referring to him despite his name was not mentioned. He stated that everyone on the compound knew it was him and even his own family had contacted him about the situation when the allegation was made public. He explained that he neither hit nor abused any resident with his hand, leather belt or any object and the statements that were made were absolutely untrue. When asked, Mr. Rodrigues stated two (2) boys were given exercises and extra chores as their consequence for violating the rules of their school after they were sent home for deliberately wearing the wrong uniform (pants and shoes). He added that the boys were also caught being deceitful after they returned to school. He mentioned that residents at St. Dominic's are only subjected to specific consequences such as early bedtimes, extra chores or they may be banned from either games night or movie night which usual takes place on weekends.

He further added that the staffing problem at the residence is among The Statutory Authority Service Commission Employees (SASC), the Management Team of the residence and contracted employees. Mr. Rodrigues explained that most of the SASC employees are caregivers in the different Houses on the compound but those who are assigned at the St. Martin's and Bethlem Houses have been making numerous allegations about the home including statements of residents not been feed proper meals. While trying to contain his emotions, Mr. Rodrigues explained that the staffing issues are the home are very serious and at the moment the false allegations circulating in the media is slandering his name and reputation as a caregiver.

He added that these situations all have repercussions and that the residents are being used as collateral damage to fuel the rifts with employees at the home. He further added that some of the residents at the St. Martin's House are adopting defiant and uncontrollable behaviours which they do not usually exhibit. He believes there is a transference of negative energies from the staffing disputes which is affecting the residents from their daily routines including going school, participating in counselling sessions and implementation of their care plans. He acknowledged that this incident has escalated the situation at the residence and resolution needs to be urgent.

<u>Interviews of residents</u>

Nine (9) residents between the ages of 7 and 10 years old were individually interviewed regarding the allegations of residents being beaten with a leather belt. None of the residents stated that they were beaten with a belt or any other object from any staff member. When asked, all residents indicated that they do not receive licks but they receive a consequence as a form of punishment. All residents would have indicated that consequences would either be extra chores or children would get ban from movie night.

<u>Ms. Murray – Human Resources Specialist</u>

Ms. Murry explained that there is a "sit-in strike' from the SASC employees namely from the St. Martin's House and Bethlem House. She added that the employees would have cited unsafe working conditions at the home due to concerns they raised about entering and exiting the Northern gate of the compound. Additionally, the employees also complained about difficulties pertaining to a staircase and pathway that leads to their respective Houses.

Ms. Susan Grey and Ms. Ria Perez are both Juvenile House Supervisors who lodged an official complaint to Occupational, Health and Safety Authority (OSHA) for which an inspection was conducted on the 2nd February 2020. It was noted that OSHA Inspectors indicated that the Home is to be classed as an essential service and refusal to work could not be actioned in this environment. Despite, the residence obtained Certificates of Approval from both Public Health and Fire Services in November 2019, minor recommendations were highlighted by OSHA Inspectors.

As a result of strike, the residence had to hire temporary relief staff and requested contracted employees to volunteer to work extra shifts.

Additional information

- As part of the investigation, the Log Books (St. Martin and Bethlem) were reviewed to determine if there were any reports highlighting corporal punishment. It was noted that there were no entries in the Daily Logs regarding corporal punishment or any form of abuse.

- St. Dominic's Children's Home – Belmont was inspected by the Licensing and Monitoring Unit in January 2020 which involved the entire resident population being interviewed regarding their welfare. Based on the report, none of the residents disclosed that corporal punishment was being administered.

Conclusion

Based information gathered, it can be concluded that the allegations of residents being beaten by a leather belt were not substantiated.

St. Mary's Interventions for report on Nov 2017

- Report received on the 23rd October 2017, via a disclosure from an external therapist under the Authority's employ.
- November 1st, all residents were interviewed at their respective schools
- November 1st, all staff members were interviewed at the St. Mary's children's home
- November 2nd, 18 residents underwent forensic medical examinations at the Authority's Mt facility
- November 3rd, article was posted in local print based on information leaked to the media
- November 2nd to November 7th, log for the years 2016 and 2017 were reviewed for notation of abuse or evidence of sexual activity.
- November 7th, debriefing session conducted with Authority psychologists and residents at the home regarding the medicals and assessing the metal state of the residents as a result of same.
- Matter ventilated at November's and December's convening of Care Committee, (internal meeting with Board Members)
- Changes to the reporting structure were recommended to St. Mary's. Information was being lost between the Supervisors and the Supervisor III. This caused some information to not be reflected in the resident's individual files.
- November 30th letter prepared to St. Mary's Chairman regarding findings of the investigations as well as a safety plan for proper supervision of residents.
- December 11th interviews were conducted with the external counselling services hired by St. Mary's Children's Home (The Centre for Human Development). The behavior of the residents identified included
    - 'Wining' on other residents- this they believe usually peaks after the carnival seasons
    - Inappropriate touching- this behaviour was reported by the caregivers and it usually occurs during play and before bedtime. It was maintained that this occurs when the residents are fully clothed.
    - Imitation of sexual acts- there were two accounts of this, one with a resident dramatizing oral sex with a banana and the other of a resident dry humping a teddy bear, each example was done in the presence of their peers.

- December 11th, review of counselling notes for the period 2016 and 2017 for all residents at the home.
- January 16th internal team meeting regarding follow up steps with St. Mary's
- Unannounced visits to St. Mary's were conducted in the month of December 2017 to March 2018. These visits were spot checks as to the reporting procedures and practices for the home. No critical incidents revolving around hyper sexualized behaviors were found during this time.
- March 15th 2018, case conference with counselor from the Centre for Human Development, regarding handover notes for case workers in Children's Authority to ensure continuity in their interventions
- May 25th 2018, Case conference between welfare staff at St. Mary's and social workers of the Authority regarding intervention and case management of residents. This was to be done quarterly

Media Compilation: Child Abuse Investigation Team

Compiled by: Aleisha Holder, Aisha Corbie, Keshan Latchman

Updated: 05/08/2021

(CATT)

No	Date	Media	Link	Home/Center	Title	Comments	Recommendations Completed
2014							
1.	July 16 2014	Blog**	https://www.trinidadandtobagonews.com/blog/?p=8303	St Michaels	BOYS HOUSE OF HORRORS	Prior to the 2015 proclamation of the Children's package of Legislation, the home did not have a reporting duty to the Authority. The home was responsible for reporting critical incidents to the Board of the home and to the former Ministry of Gender Youth and Child Affairs.	

No	Date	Media	Link	Home/Center	Title	Comments	Recommendations Completed
2017							
7.	Nov 3 2017	Newsday	http://newsday.co.tt/2017/11/03/19-claim-sex-abuse/?fbclid=IwAR2h-KQipGP_MhAQ6IqECYfcDcZv251lQsfu2DFzx1_3U_14MIsYWUzDgiw	St. Mary's Children's Home	St. Mary's Board to meet on sex abuse claims	This report was investigated by the Authority. Findings and recommendations were outlined to management team of the home. The home was able to institute many of the recommendations.	Engage in a case conference with the CFHD, St. Marys Staff and Children's Authority regarding, proper communication amongst staff and with the Authority. Increased monitoring, inclusive of unannounced visits as well as visits outside the normative working hours. Alternative placement was sought for the resident reported the allegations. This was due to his discomfort at the home after the reporting incident.

No	Date	Media	Link	Home/Center	Title	Comments	Recommendations Completed
							Case conferences held with the newly established welfare team and the CATT case workers. To ensure proper case management information was shared between both organisations. Debriefing session conducted with residents and staff after investigative actions were taken.
9.	June 20 2017	Loop News	https://tt.loopnews.com/content/childrens-authority-investigating-childs-death Four girls from St. Dominic's children's home missing	Valsayn Child Support Centre	Children's Authority investigating child's death		

No	Date	Media	Link	Home/Center	Title	Comments	Recommendations Completed
				2018			
12.	July 9 2018	Newsday	https://newsday.co.tt/2018/07/09/mothers-questions-unanswered/	Valsayn CSC	**Mother's questions unanswered**		
				2019			
17.	Aug 8 2019	TV6 News	https://www.tv6tnt.com/news/7pmnews/children-at-st-judes-being-abused/article_3de6b442-ba3a-11e9-ba67-c337e898c629.html	St Jude's	Children at St Jude's being Abused?	Media Report did not specify which children were the subject of the complaint. However, monitoring reports for the period found physical punishment by the TTPS to residents involved in a riot on the compound.	Five residents involved in the riots were charged and placed in YTC by the TTPS via emergency court hearings. 1 resident was transferred to Sophia House.

22.	Aug 8 2019	TV6	https://www.tv6tnt.com/news/7pmnews/children-at-st-judes-being-abused/article_3de6b442-ba3a-11e9-ba67-c337e898c629.html	St Judes	CHILDREN AT ST JUDES BEING ABUSED?	Same as 17.		
2020								
23.	February 16, 2020	Newsday	https://newsday.co.tt/2020/02/16/children-at-st-dominics-caught-in-a-bind/	St Dominic's	Children at St Dominic's caught in a bind	Investigation did not substantiate report.	Meetings held with OPM regarding the funding to the home to make payments to service providers who conduct supervision in lieu of SASC staff.	The home is awaiting funding.

25.	Aug 30 , 2020	Guardian	https://www.guardian.co.tt/news/police-childrens-authority-probe-alleged-abuse-at-lady-hochoy-home-6.2.1195325.cabb3ee795	Lady Hochoy Home	Police, Children's Authority probe alleged abuse at Lady Hochoy Home	Report on critical incidents provided by home. Investigations conducted did not substantiate the allegations.	Follow up meetings were held with Management regarding administrative actions to be taken against the staff making false allegations. Interviews with staff regarding alternative measures of discipline. Residence has been a part of a number of training sessions conducted by both the OPM and the CATT.
26.	Sept 4 2020	CNC3	https://www.cnc3.co.tt/rc-archdiocese-probes-alleged-abuse-at-shelter-as/	Shelter	RC Archdiocese probes alleged abuse at shelter as…	Investigation substantiated some allegations at Mary Care Centre- South Oropouche. A meeting was held with the manager of the home. The staff member was removed from the home.	The offending staff member was removed from the home. Staff were sensitized as to the appropriate measures of discipline when dealing with children, especially pregnant residents. The shelter has since engaged in the licensure process and is in the process of implementing

							corrective measures towards receiving their residence licence The home has received assistance regarding implementation of proper complaint and inventory logs. Regarding financial assistance the home has been placed on the OPM's payment per child grant. Policy regarding the use of electronic devices has been revised, to facilitate online education during the COVID-19 pandemic.
27.	December 15 2020	Newsday	https://newsday.co.tt/2020/12/15/young-i-hope-guard-is-charged-for-child-rape/	Safe House	**Young: I hope guard is charged for child rape**		

(Appendix 5: The NiNa Report - THE TRANSITION JOURNEY)

October 2021

THE TRANSITION JOURNEY

CHALLENGES & ROADBLOCKS FACED BY YOUNG LADIES TRANSITIONING FROM STATE CARE

The NiNa Young Women's Leadership Programme

About Us

What is NiNa?

The NiNa Young Women's Leadership Programme (NiNa) provides financial literacy, entrepreneurial skills development and self management tools to build self-value in young women within the state care system and particular chosen schools in Trinidad and Tobago. NiNa has a transition programme for young ladies who leave the state care at the age of 18 to reintegrate them back into mainstream society, and has worked with girls from the St. Jude's Home for Girls to support their overall development.

Goals & Activities

NiNa goals

NiNa seeks to create a cadre of young female leaders in the Caribbean through training in life skills, leadership, self-belief, and entrepreneurship.

NiNa activities

NiNa has several activities under four streams of work –
(1) NiNa Secondary School Programme
(2) NiNa St. Jude's Home for Girls Programme
(3) NiNa Summer Programme
(4) NiNa Transition Programme

Creating quality citizens automatically lead to building a better Trinidad and Tobago.

It takes a village...The Transition Programme aims to provide resource networks, safe physical and psychological spaces, personal healing, growth and development and will facilitate education for young women ageing out of state care. The likelihood of these women disappearing, becoming statistics or perpetuating the cycles of abuse and neglect that they were exposed too is high. The aim is to support the transition.

Working hand in hand

The NiNa Programme, through its work with young ladies within care homes of the State is determined to ensure that Trinidad and Tobago have a cadre of young women who can take up the mantle of leadership, and empowered citizens to continue on the legacy left by our past leaders to make our country a better one that we found it. We continue to expand by including other students from schools such as the Belmont Secondary and Bishop Anstey and Trinity East and include mentors from university and other tertiary institutions.

Challenges & Findings

Youth who are transitioning to adulthood need to have well developed self-esteem and self-efficacy skills

The transition arm of the NiNa program emerged after having mentored young women who resided at the St Jude's Home. Upon approaching their time to leave the St Jude's Home at the age of eighteen (18), these young women began showing signs of self-sabotaging behaviour, fear, and anxiety including reversing any progress made in preparation for entering the 'real world'.
Additionally, there were cases where the young women who left St Jude's at age eighteen (18) who were part of the NiNa mentorship programme requested financial support, and resources to assist with them navigating their new lives outside the St. Jude environment. Resources requested and required included housing, employment, money, and emotional support.

Youth who are transitioning to adulthood need to have well developed self-esteem and self-efficacy skills that equip them to manage relationships in multiple contexts, including education and employment settings, as well as with friends and family members. Often, youth in the state care system have lived through multiple traumas and disruptive events by the time they begin their transition to adulthood. This can include abuse and/or neglect, lack of continuity in education, and an array of losses of relationships (e.g., friends, family, and/or siblings).

Challenges & Findings

Research on the developing brains of adolescents and young adults points to the importance of understanding the “vulnerability of teens"

Their life experiences can create additional problems resulting in mental illness, substance abuse issues, and a lack of confidence. These challenges impact their emotional and social development as they transition into adulthood.
Research points to the significance of this stage and highlights the importance of positive, supportive relationships in the context of the continuing development of the adolescent brain.

What the NiNa program has learnt over the years is that, ideally, the young women leaving St Jude’s at age eighteen should have a place to call home upon emancipation from the child welfare system, with connections to caring adults who can provide support, including helping them access necessary resources and services.
Research suggests that youth in state care who have natural mentors during adolescence have improved young adult outcomes. Connections to non-parental adults through informal mentoring is reported to enhance the outcomes of foster care youth in education/employment, psychological well-being, and physical health. Youth who had the support of a mentor also demonstrated a decreased participation in unhealthy behaviors, such as unprotected sexual activity, alcohol and substance abuse, and delinquent activities.

Challenges & Findings

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When youth "age out" of the child welfare system with limited connections or without the support of positive, caring adults, they may have an increased risk of facing the following challenges:

Challenges

1. Unstable housing or homelessness - Within the NiNa cohort of young ladies, upon turning eighteen, at least 40% of the young women had no stable place to call home. St Jude's played a role in securing housing for some of them through placement at hostels, the others who were placed in the care of relatives, after a few months, found themselves looking for a place to live due to poor adjustment to living with unfamiliar family members, being asked to leave, and getting involved in unhealthy relationships. The result is them being left without a stable place to live. Studies show a correlation between a history of state care and homelessness as well as the impact of emancipation from state care on young adults. More than one-fifth of state care youth experience homelessness for at least one day within a year of emancipation.

2. Lack of adequate elementary and secondary education. Youth emancipating from state care typically face many obstacles during their educational journeys, obstacles that can hinder their ability to graduate on time or receive CSEC passes.
Young ladies within the St. Jude's Home may have missed many days or even months of school. Participants within NiNa have been placed in programs such as Civilian Conservation Corp (CCC), Servol Life Center and MIC-IT Institute of Technology.
While these programs provide an opportunity to build skills, it has been observed that for the majority of jobs, the requirement is a full Caribbean Examination Council (CXC) certificate, bringing the young ladies to an immediate block in their search for employment or further education.

When youth "age out" of the child welfare system with limited connections or without the support of positive, caring adults, they may have an increased risk of facing the following challenges:

Challenges ctd

3. Lack of employment and job training. Former residents of state care may have limited work histories and on-the-job training opportunities. Many lack the skills required to hold a steady job, or the incentive and academic preparation to attend a university program. Ladies who do obtain employment may find only jobs with lower paying wages, which makes them vulnerable to poverty, and the inability to establish complete independence. The lack of employment, independence and limited skills also leads to being exploited usually by older men who provide a false sense of security to the young ladies leading them to vulnerable living situations including gender based violence, unsuitable housing and even exploitation via prostitution and other criminal activities.

4. Problems with physical health, behavioral health, and general well-being. Young ladies leaving state care at the age of eighteen within NiNa without support and stability have encountered health problems including hospitalization due to illness, accident, injury, drug use, or emotional problems. There have also been cases of mental health disorders including depression, social phobia, alcohol abuse, alcohol dependence, substance abuse, or substance dependence.

5. Lack of access to health care. Young ladies within the programme who are not legal residents of Trinidad and Tobago have encountered challenges in accessing health care at the hospitals and health centres.

When youth "age out" of the child welfare system with limited connections or without the support of positive, caring adults, they may have an increased risk of facing the following challenges:

Challenges ctd.

6. Justice system involvement. Youth emancipating from state care may be at greater risk of becoming involved with the criminal justice system due to lack of support networks, low employment skills, and unstable living arrangements. Within the NiNa program there have been thus far two young ladies entering the justice system post-St Jude's.

7. Lack of social connections. Permanent relationships with positive adults are a powerful protective factor against negative outcomes and can provide critical support to youth as they transition to adulthood. Youth in state care often rely on adults who have provided professional supports through their roles in the child welfare system. Although an emancipating youth may desire autonomy from adult supervision, the transition is more successful when he or she has a strong connection to a trusted adult supporter. Establishing this relationship prior to emancipation is important, albeit not easy, given that many youths have had turbulent experiences with adults in the past.

Recommendations

Many of the girls are not ready to leave the facility, however, must leave at eighteen (18) years, according to the law

At the SECOND SESSION OF THE ELEVENTH PARLIAMENT (2016/2017) on the Treatment of Child Offenders at the Youth Training Centre, St. Michael's Interim Rehabilitation Centre for Young Male Offenders and St. Jude's Interim Rehabilitation Centre for Young Female Offenders Joint Select Committee – Human Rights Equality and Diversity, the recommendations for St Jude's also touched on the importance of a transition program.

The Committee recommends that remedial teaching methods adopted by St. Jude's and YTC need to be tailored to improve and encourage the transition into other mainstream education/vocational institutions upon exit of the institution.

Many of the girls are not ready to leave the facility, however, must leave at eighteen (18) years, according to the law. Many of the girls housed at the facility do not receive visits or phone calls from their parents. Many of the young ladies cannot return to their homes upon leaving the facility. As such, the staff tries to assist by finding rooms at the Salvation Army Hostel and half way homes.

Recommendations

Many of the girls are not ready to leave the facility, however, must leave at eighteen (18) years, according to the law

NiNa Recommends:

1. Introduction of a mandatory transition programme to the young ladies who are within six to eight months of leaving state care. The program is to include life skills training: for example how to set up a bank account, how to apply and receive national identification; on the job training; and relevant social skills.

2. Linkages to safe and seamless transition spaces – spaces to include a safe and secure place to live, mentors, and peer counsellors. Different types of therapy ought to be made available and mandatory.

3. Partnerships with Government agencies such as Ministry of Social Development and Family Services, Family Planning, On the Job Training Programme, NEDCO, YTEPP, MIC Institute of Technology and other Technical Vocational Training Centres

4. Work in partnership with the Private Sector to support job training and mentorship opportunities.

5. There are many abandoned Government houses and quarters throughout Trinidad. Transition homes can be set up using these properties, particularly the ones in the areas of Trinidad that are conducive to holistic living and healing- Chaguaramas, Couva, Point A Pierre, Beach Camp.

Young adults exiting state care need emotional support as they navigate the transition to independent adulthood

Conclusion

Without the social and emotional skills to manage the stresses of emerging adulthood, youth often struggle to maximize the housing, education, and employment resources that are available to them.

Preparation in advance of leaving state care can go a long way in mitigating issues such as teenage pregnancy, falling into the judicial system, entering abusive relationships, poor jobs and housing choices and exacerbating mental health issues.

Adult mentors who stay connected with the young ladies as they transition to adulthood provide the emotional supports necessary for youth to achieve positive adult outcomes. Mentorships formed through informal connections (within the youth's life) or through formal programs will increase the likelihood of successful transitions to adulthood. Lifelong connections with positive adults are critical to success as youth begin to make decisions that affect their future.

October 2021

NINA YOUNG WOMEN'S LEADERSHIP PROGRAM

TRINIDAD & TOBAGO

NiNa - Creating the Next Generation of Young Women Leaders — www.akosuadardaineedwards.com/programmes

(Appendix 6: General Ethics Guideline)

The General Ethical Guidelines implemented in this investigation follows and is adapted from the guidelines discussed in the

CP MERG (2012), Ethical principles, dilemmas and risks in collecting data on violence against children: A review of available literature, Statistics and Monitoring Section/Division of Policy and Strategy, UNICEF, New York.

This General Ethical Guidelines will ensure adherence to the ethical principles set by the United Nations Committee on the Rights of the Child as relevant to research policy and practice

1. The best interests of the child (Article 3.1) states that the best interests of the child must be a primary consideration in all actions concerning children

2. Non-discrimination (Article 2) requires the application of all the rights in the Convention to all children at all times and identification of children who may require special measures for the full implementation of their rights

3.The right to be heard (Article 12) states that children's opinions must be sought in matters that affect them, and that their views must be given due weight.

The ethical principles implemented will also ensure the investigation upholds the ethical principles of Autonomy, Beneficence, Non-maleficence and Justice.

To fulfill the ethical principles, the committee will ensure that participants involved in this investigation are provided:

1. Disclosure: provision of accurate, comprehensive information to potential participants.

2. Understanding: participants need to understand relevant information, appreciate the situation and its consequences, and make choices.

3. Competence: participants, including vulnerable populations, must have sufficient cognitive abilities, experience and competence to understand the information.

4. Voluntariness: acting freely, without coercion, with consideration given to the influence of power dynamics, particularly on vulnerable populations.

5. Consent: provision of informed, freely given, valid consent, with the option to withdraw at any time without consequence.

6. Privacy and Confidentiality: privacy with regard to how much information the participants want to reveal or share, and with whom; allowing for privacy in the processes of information gathering/data collection and storage that allows the exchange of information to be confidential to those involved and the option of being not identifiable in the publication and dissemination of findings.

The Ethical Guideline used for the Child Interview is an adaptation from the following established guideline of The American Professional Society on the Abuse of Children:

Title: Forensic Interviewing in Cases of Suspected Child Abuse Publication

Author: APSAC Taskforce

Date: 2012

Publisher: The American Professional Society on the Abuse of Children (APSAC)

Retrieved from: https://www.apsac.org/guidelines

This Guideline encourages interviewers to "attempt to collect facts in a neutral and objective way. In keeping with the APSAC Code of Ethics, the interview should be conducted "in a manner consistent with the best interests of the child." Trauma to the child should be minimized, while considering all reasonable explanations for the allegations."

Guideline for Child Interview

Purpose of Child Interview

To elicit as much reliable information as possible from the child to help determine whether abuse occurred, risk factors that may lead to abuse, as well as risk factors that lead to the incident/s or situations of children absconding. Interviewers will attempt to elicit information about specific facts that can be verified later.

Interview Context

1. Participants

    a. Child Interviewee Selection

Children with history of absconding, and those identified in Critical Incidents reports as reporting allegations of abuse, or being involved in physical or sexual incidents involving security officers or staff members. Also interviewed were residents who may be able to provide information regarding the incident which led to the five boys absconding from the Valsayn Child Support Centre.

    b. Interviewers

Consist of professionals who have at least five years of experience engaging children with trauma backgrounds.

    c. Independent Observer

The Independent Observer's purpose will be the child's advocate and support person. Ahead of time rules of conduct and the importance of refraining from direct involvement in the interview would be established with this person. As well as establishing the rules of confidentiality via signed statement. The Independent Observer would have no employment connection to Children's Authority of Trinidad and Tobago (CATT), or to any Children's Homes, Rehabilitation Centres and other institutions providing residential care for children.

d. Neutral Qualified Interpreter

Once the interviewers are not proficient in the child's first language, a proficient and qualified interpreter will be used to provide interpretations in the language the child is most comfortable in engaging.

2. Consent to be interviewed and recorded:

Consent will be requested from Children's Authority of Trinidad and Tobago (CATT), for those children currently under the care of CATT. Consent will be requested from parents or legal guardians for those children no longer under the care of CATT. Assent will be acquired from children.

3. Location/Setting:

Office at CATT, Private Office at CSC or Community home.

An environment that is private, informal, free from distractions and affords the child comfort, familiarity-where possible, and a sense of safety. To foster a sense of safety, it will be confirmed that alleged perpetrator, is not present in the vicinity at the time of the interview.

Interview Format

Two interviewers will be present during the interview. The interview will be child-centred and trauma-informed. The interviewer will establish and maintain rapport throughout the interview.

Interviewer provides:

1. Introduction of Interviewers, Role and Purpose of the Interview
2. Information to Child about Documentation Method, Confidentiality and its limits.
3. Interview Instructions/"Ground Rules"
    a. Give permission to say "I don't know"
    b. Give permission to correct interviewer mistakes.
    c. Give permission to admit lack of understanding – 'Tell Me If You Don't Know What I Mean'
    d. Give permission to admit lack of memory – 'I Don't Remember'
    e. Convey to the child that the interviewer does not know what happened and cannot help the child answer his/her questions
    f. Elicit a promise to tell the truth
4. Use mainly open-ended, non-suggestive, age/developmentally appropriate questions, minimizing closed ended questions, to gather more information about the child, build rapport and elicit a narrative from the child regarding the incident in question. In cases where the child is deaf/hard of hearing or when not proficient in English, a neutral qualified interpreter will be acquired.

5. Closing: Prior to closing there will be a 5 minute break to process interview with team and collect any additional and clarifying questions. After break lead interviewer will
    a. Present any further questions to the child.
    b. Clarify with the child “Is there something else you want to tell me?”
    c. Shortly processing child’s feelings and expectations about the interview:
        1. How do you feel about talking with me?
        2. What do you think (caregiver, alleged perpetrator) will say/think about you talking with me today?
        3. Do you have any questions for me about what we talked about
    d. Thank child for talking with team.

(Appendix 7: Interview, Meetings, and Written Submissions)

Scheduled Interviews

DATE	Name	Org	Time	Location	Team	Status
Tuesday 7th September 2021	Ms. Michele Celestine		10:00 AM	MS Teams	**Team**	Confirmed Completed
Wednesday 29th September 2021	Ms. Latisha Millington	Former St. Jude's	PM	MS Teams	**LtCdr Chariandy JJones Mr. Keshan Latchman**	Confirmed Completed
Tuesday 5th October 2021	Senator Nakhid	-	9:00 AM	OPM	**LtCdr Chariandy JJones Ms. Corbie**	Confirmed Completed
	Ms. Miller	Relative of Resident at St. Jude's	1:00 PM	OPM	**LtCdr Chariandy JJones Ms. Corbie**	Confirmed Completed
Tuesday 12th October 2021	Mr. Deboulet	Former Employee Valsayn CSC	AM	MS Teams	**Team**	Confirmed Completed
Thursday 28th October 2021	Ms. Christopher/Jackman	Parent	AM	**OPM**	**JJones Ms. Corbie**	Confirmed Completed
	Ms. Odle	Former Resident (St. Jude's)	PM	OPM	**JJones Mr. Arjoon**	Completed Confirmed

DATE	Name	Org	Time	Location	Team	Status
Wednesday 3rd November 2021						
	Ms. Mounter + Guest (Latifa Corriea)	Former Resident (St. Jude's)	AM	OPM	**JJones Mr. Arjoon**	Completed Confirmed
Wednesday 10th November 2021	Ms. Ayana Bailey	CATT	9:00 AM	OPM	**LtCdr Chariandy JJones**	Confirmed Completed
	Ms. Anesha Blackman		10:30 AM	MS Teams	**LtCdr Chariandy JJones**	Confirmed Completed
	Mr. Stephen Williams	CATT	1:30 PM	OPM	**LtCdr Chariandy JJones**	Confirmed Completed
Thursday 11th November 2021	Interview at CTU (2 Venezuelan nationals)	CTU	1:00 PM	CTU	**JJones, Ms. Corbie**	Confirmed Completed
Friday 12th November 2021	Mr. Andrew Richins	CATT	9:00 AM	OPM	**JJones LtCdr. Chariandy**	Confirmed Completed
	Mr. Daniel Garcia	Valsayn CSC	11:00 AM	OPM	**Dr. Phillip, Ms. Holder**	Confirmed Completed
	Ms. Rachel Daniel Halley	CATT	1:30 PM	OPM	**JJones LtCdr Chariandy**	Confirmed Completed
	Interview at CTU (2 Venezuelan nationals)	CTU	1:00 PM	CTU	**JJones, Ms. Corbie**	Confirmed Completed

DATE	Name	Org	Time	Location	Team	Status
Tuesday 16th November 2021	Mr. Hanif Benjamin		10:00 AM	MS Teams	**Team**	Confirmed Completed
	Ms. Jenna Samaroo		11:30 AM	MS Teams	**Team (led by Dr. Dillon)**	Confirmed Completed
Wednesday 17th November 2021 (possible)	Ms. Patrice Jones	TAC CSC	10:00 AM	MS Teams	**JJones Dr. Dillon Ms. Gittens**	Confirmed Completed
	Mr. Derwin Henry	St. Mary's	2:30 AM	MS Teams	**Ms. Gittens**	Confirmed Completed
Thursday 18th November 2021	Ms. Reesa Hernandez	CATT	9:00 AM	MS Teams	**JJones Dr. Dillon**	Confirmed Completed
Friday 19th November 2021	Ms. Yvette Bruce	St. Jude's	9:00 AM	OPM/Virtual	**TBD**	Confirmed Completed
Tuesday 23rd November 2021	Ms. Tonya Greaves (Psychologist)	St. Jude's	10:00 AM	Virtual	**Team**	Confirmed Completed
Friday 26th November 2021	Mr. Deoraj Sookdeo	St. Jude's	(as early as possible)	In Person	**Pending**	Confirmed Completed
	Ms. Ivis Rivers (cook)	St. Mary's	11:30 AM	In Person TBD	**Team (led by Ms. Gittens)**	Confirmed Completed

DATE	Name	Org	Time	Location	Team	Status
Monday 29th November 2021	Reschedule of Interview with Richardo Thompson's mother	Valsayn CSC	10:00 AM	OPM	**TBD**	Confirmed Completed
	Reschedule of Interview with Richardo Thompson's mother	Valsayn CSC	11:00 AM	OPM	**TBD**	Confirmed Completed
Tuesday 30th November 2021	Ms. Siew Sankar Ali	CATT (Head of Assessments)	10:00 AM	MS Teams	**Team**	Confirmed Completed
	Mr. Thomas	CATT FHSSE Manager	11:30 AM	MS Teams	**Team**	Confirmed Completed
	Ms. Lewis	CATT License and Monitoring Manager	1:30 PM	MS Teams	**Team**	Confirmed Completed
	Ms. Harvey Mitchell	CATT Director	2:30 PM	MS Teams	**Team**	Confirmed Completed

DATE	Name	Org	Time	Location	Team	Status
Thursday 2nd December 2021	St. Jude's Residents	St. Jude's	9:00 AM	St. Jude's	**Ms. Corbie Mr. Latchman Neutral Observer**	Confirmed Completed
Friday 3rd December 2021	CTU	CTU	1:00 PM	CTU	**Dr. Phillip Ms. Corbie Neutral Observer**	Confirmed
Tuesday 7th December 2021	Ms. Lewis	CATT License and Monitoring Manager	12:00 PM	MS Teams	**Team**	Confirmed
	CATT Board	CATT Board	1:00 PM	MS Teams	**Team**	Confirmed

Interviews to be fixed:

Ms. Braithwaite and her attorneys

(Appendix 8: Abuse Findings)

AREAS OF INVESTIGATION (ABUSE) FINDINGS DOCUMENT

HOME / CENTRE	AREA OF INVESTIGATION (1)	AREA OF INVESTIGATION (2)	RAW DATA (FACTS)	DATA SOURCE	FINDINGS	RISK TO CHILDREN	CONCLUSION	RECOMMENDATIONS
Casa de Corazon	PHYSICAL ABUSE		Location: 5 mins drive from the center of Sangre Grande; 5 mins from police station and 15 mins from hospital. Perimeter is dilapidated, chain link on 3 sides: wall on the inner right-hand side. It's on the corner of the main road. Fairly large compound with playground to the fronts. Hazards on the playground. 5 cameras to the front, 2 to the back 2 to either side and some on the inside. Cameras only monitored during the day in the admin office. At night no one watches cameras: police have a log to the cameras which record images. The former manager hit H. with a pipe. Staff: The staff is a bit of an upheaval. Manager was dismissed (Ms. Harripersad) and 2 of the remaining staff was in position for the manager post (not by choice but by the board). They each were given the manager post for some time and now the new manager is Ms. Crystal White. Manager appears to be timid and frightened. Manager was originally the admin assistant and was thrown into the position. It seems like the manager position is not really for her. She is unaware of protocols and regulations. She did mention she want more qualified personnel. The staff are appraised once a month and employee of the month type of environment. The person who works in the kitchen wanted to say something but was uncomfortable to speak but she was just hired. Ages: 7-17 of children. Home: - 2 sections of dorms separated by common areas: living room, dining room and kitchen. Dorms are separated for girls and boys; bedrooms are huge, and 6 boys can sleep in a room at a time. have double decker bed. Construction taking place by the boys' dorms in the corridor and that has one of the exits blocked. 2 exits to the main building: one to the front and one to back. the one to the back is very stiff from disuse and takes some effort to open it. Fire extinguishers are all new. Staff appeared genuinely concerned for the children and were helping them in their schooling. Seven Day Adventist Home and they do devotions 2 a day morning and evening. Good structure put into place for the day with scheduling. Kitchen is clean enough and storeroom for food needs upgrading. Storage of food was ok. Preparation of food was being done by a new member who do not have a food badge. One child had specific dietary requirements and his food was locked away and labeled in the cupboard: home is strict on following the care procedure. The food portion was very small for the children and limited meat. There is a formal plan put into place for emergencies. Muster point is a bit far and further down the road. The Manager said the fence needs to be replaced by a wall as someone tried to enter the compound recently. No security guards. There is a security alarm with Blink security. House was fairly clean. Staff misconduct: - A staff was recently dismissed for "counseling" a young boy in her bedroom at 1	Site Visit and Onsite Interviews	current system undermines the security measures for preventing and managing absconding	HIGH	CATT not responsive or active in the home. Good daily structure and staff monthly appraisal conducted.	Need to follow up on the staff's ideologies, if there are similar to the last manager. More support required from CATT. 7 year old needs proper care for his disabilities.

HOME / CENTRE	AREA OF INVESTIGATION (1)	AREA OF INVESTIGATION (2)	RAW DATA (FACTS)	DATA SOURCE	FINDINGS	RISK TO CHILDREN	CONCLUSION	RECOMMENDATIONS
			am and that was not tolerated by the home. A caregiver (Cindy) was a bit rough with young who wanted some water and was on online school (The caregiver was hired by the last manager who got terminated). Aunties go to play outside with the children and do activities. The pastor (Ms. Tricia was fired recently) intervened and that's the same boy who was in the staff member room at 1 am who was getting "counseling". J. (a resident) reported the manager's abuse to H. to CATT via email and CATT called the manager to ask what's going on and the manager took off the internet in response. CATT: - They try not to take CHiNS or anyone with any sexual abuse history/ tendencies, it takes a few months to get the children's records from CATT. Social Worker (new) to update the care plans (outside of CATT) and about 5 children have behavioral issues and the social worker do sessions with them. All children were assessed by an external company (about 3 years ago). No support from CATT, about 5 children with no case officer from CATT: no interventions. The home is supposed to be a transitional place for the children until they can go back to their families, however the parents are supposed to attend parenting classes etc. However that is not done so the children remain at the home. CATT do not follow up. Residents: One of the CHiNS had a sexual relationship with one of the boys at the home and she is now at St. Jude's. She made an allegation against one of the boys that he raped her.					

HOME / CENTRE	AREA OF INVESTIGATION (1)	AREA OF INVESTIGATION (2)	RAW DATA (FACTS)	DATA SOURCE	FINDINGS	RISK TO CHILDREN	CONCLUSION	RECOMMENDATIONS
Community Residence at Lambeau	SEXUAL ABUSE	ABSCONDING	Number of residents, age, Location of home: Currently the Acting Manager is the Manager of the Probation Hostel (Mr. Gordon). Senior Programs Coordinator oversees both homes and was present at the time of the interview. Reported that the dogs are their security. Absconding incidents. Someone absconded and they did not see the issue to report it. Rooms in the home. No security cameras. Emergency lights. Split level house and tiny yard (no place to play). They take the kids to a playing field 3-5 mins away. Properly fenced property. Boys and girls separated and have their own beds. CATT involvement: Mr. Gordon kept repeating that there was a disconnect between CATT and the managers and insensitive to cultural differences. Mr. Gordon said that CATT places children without providing background on the children or trying to overpacked the home. "Once the children aren't warded but carried to the hospital for an incident, I don't believe in reporting it to CATT". He also has not done any monthly reports to the wellness center in a long time. Residents: A 15 year old boy there from CSC and security is provided at night for the young man. They take walk-in children (for example they took in a young man (O.D.) who scaled the wall and asked to stay with them and they took him in but he was engaging in inappropriate behavior with younger boys at the home and they reported it to CATT but now he ran away). Staff misconduct: Problem with reporting incidents and they have not sort clarity from CATT as to what should and should not be reported. Incidents have gone unreported to CATT. There was a report of staff sexual misconduct with an OJT and a resident where the child reported the incident to the therapist. HR was contacted and OJT immediately removed. SOPs were done about a week before the site visit conducted. Find that filling out critical incident report is "too much" and prefers to write it in a book. A child who used to live at the home now lives at a staff member (pastor/psychologist) house with her son and the staff member claims that the young man has mental challenges. Not keen on rules and regulations. No assessment being conducted as the "psychologist" just "talks" to them. One the first day, the staff was dishonest about the incidents that occurred at the home but were honest on the second day. No procedures put into place for reporting abuse. Covid. The Manager has covid and is at home. At the moment someone is in quarantine and two children have to share a bed at the moment.	Site Visit and Onsite Interviews	current system undermines the security measures for preventing and managing absconding. This system allows for abuse both physical and sexual. Inappropriate interactions with security personnel. Lack of security tools and emergency plans put into place.	HIGH	The current process facilitates many opportunities to abscond. Rules and reporting are not conducted. There is a disconnect between CATT and home.	Procedures and policies have to be followed according to CATT and incident reports need to be implemented. Speak to young man who is living with staff member son. Proper psychological assessments need to be conducted. Dogs may need to be removed from premise.

HOME / CENTRE	AREA OF INVESTIGATION (1)	AREA OF INVESTIGATION (2)	RAW DATA (FACTS)	DATA SOURCE	FINDINGS	RISK TO CHILDREN	CONCLUSION	RECOMMENDATIONS
CSC Tobago	ABSCONDING		Location/Home: middle of a residential setting, houses are very close together and a bar nearby (very noisy). When entering the property, it's an electronic gate controlled by security and it's the sole entrance and exit to the property. To get into the building, security has to let you in and out: electronic door. A house lot of land. There is grass walkway and space at side to do outdoor activities. Tiled bedrooms are located downstairs and are very tiny and had bunk beds (2 dorms for girls and 1 for boys: capacity-4 in a room). Had twin bed for children and realize it can be easily damage by children so now converted to bunk bed. One room has a mattress on the floor. Storage spaces are available to all children individually, but the cupboards have no doors as they said the children were damaging them whenever their behavior issues: they punch the door and walls. There is a room with disability access, but the bedroom is used now as a normal bedroom. There is a room called the orientation room for newcomers. Fencing around the building made from latis: used to have barbed wire but found it affected the way the property looked so they took it down. Admin thinks the safe house should be in another area. 1 bathroom each for the girls and staff bathroom, kitchenette upstairs separate from the children. The children do not have access to the kitchen unless they are doing laundry, which is next to the kitchen, but they need to be supervised. Very restricted environment. Security cameras in all areas except bedrooms and bathroom. Monitors were in the team lead office and assessment center (10 mins away) have access to it. No one is station there 24/7 to watch the cameras. 3 security guards (2 on the perimeter and 1 inside) on compound but they do not have access to cameras. No safety drills in a long time. Have their own doctor and psychiatric nurses are present (outsourcing so expensive). 12 caregivers present. No rounds being conducted at night. No standardized discipline policy but a consequences sheet is implemented. Residents: 13 children but the home can only accommodate 8, so over housed. CNPs and CHiNS mixed. Ages: 5-16 years. Recently got a psychologist on board to do counseling. 3 absconding incidents: They prevented 2 from leaving but 1 was able to climb the mango tree and left the yard. New rules: children are not allowed to go near the mango tree. 2 possible boys who could abscond: 2 brothers. Security is not allowed to talk to children only supposed to watch children. People in the road call out to the children to come talk to them and admin is concerned with that as it supposed to be a safe house Staff: Team Lead is very thorough and tries to do all that is necessary to take care of the children. She is from Trinidad and has a master's in social work.	Site Visit and Onsite Interviews	current system undermines the security measures for preventing and managing absconding	HIGH	Home seems well managed.	Possibly change to wall fence and remove mango tree. The security at night should have a way of communicating with assessment center in the event that there is an emergency.

HOME / CENTRE	AREA OF INVESTIGATION (1)	AREA OF INVESTIGATION (2)	RAW DATA (FACTS)	DATA SOURCE	FINDINGS	RISK TO CHILDREN	CONCLUSION	RECOMMENDATIONS
Cyril Ross Home	ABSCONDING	FAILURE TO SAFEGUARD	Number of residents, age, Location of home: Kelly Simpsons (only one security present at a time and she was wearing scrubs) allowed them to sign book and give an introduction. The home has children ranging from toddlerhood to 18 years. The home said that the residents are currently toddlers and younger children who they believe are more "settled" than previous residents, therefore, "not many measures need to be put into place to secure the home". The home is asking for more money so that they can acquire the resources to fix the home and surrounding space. The walls to the front of the house are very low so residents can jump it as well as outsiders can jump it. Absconding incidents: There were several places where persons can abscond the building. For e.g. persons used to sneak out through the roof because there is an opening there (pictures obtained). Premise not secured: most of the cameras do not work and wall is very low and easy to climb and escape. Rooms in the home: The girls stay upstairs and there is a gate that is kind of lock. To the back on the first floor that was kind of lock together had 3 rooms. The female toddlers to the front and older boys to the back: 1 bathroom area for toddlers and older boys to use. CATT involvement: Manager have gotten children who do not have HIV at the home and had to write to the court requesting the children be removed. In the past incident reports, the children were sexually engaging with each other. When manager was asked if the home is for CNPs for CHiNS, she did not seem to know or understand the question. No policies put into place for children with mental challenges or special needs. Residents: Some of the residents will leave and go to parties and come back any time. The boys already left the home and there were no policies put into place for that. The home would have caught children watching porn and did not do anything about it because no policies were put in place. Also, there is no place to really do online class: a girl was doing it up in her room without supervision. The interactions with the children from staff was a bit harsh. For example, one boy did not want to eat with a table mat so they told him that he cannot eat any food until he decides to use the table mat. "Don't put any food in yuh mouth yuh know" the staff repeated this to the child several times. The child (around 15-16 years old) was pretty angry. The two-house mothers seem very condescending to the child not wanting to listen and in a way talking about the child in front of the child. This same child was romping around with the security guard with his hand around her neck and the guard's cards fell and the boy took them and did not want to give them back and the guard had to beg him to give it back. The shower stalls were 6 feet high with an opening at the top and there were indications that the older boys would have gone into the ceiling to move about. There were incident reports of these same boys going into the pantry and cooking food for themselves: and none of	Site Visit and Onsite Interviews	current system undermines the security measures for preventing and managing absconding	MEDIUM	the current process facilitates many opportunities to abscond and also a lack of medical needs are being met.	possible policies to be put into place for children to transition out of the home. Follow up needed on missing medical staff and resources required for the home to be functioning in a medical capacity.

HOME / CENTRE	AREA OF INVESTIGATION (1)	AREA OF INVESTIGATION (2)	RAW DATA (FACTS)	DATA SOURCE	FINDINGS	RISK TO CHILD REN	CONCLUSION	RECOMMENDATIONS
			the areas have been fixed. Staff misconduct: Inconsistencies in manager's account of information. For example, when asked about the security officer's qualifications, she said the file was by the St. Vincent de Paul's office but later in the interview when she was asked where are all of the employee's files kept, the manager said that she has all of the files. Manager seemed willing and transparent about the prescriptions, medical information and auditing files however she is not a pharmacist (they have not had one for a while). A doctor still visits (Dr. Matthew) does check-ins and prescribes medication, but manager administers the medication. No nurses on board. Poor keeping of records and poor management of children in regard to medication. The manager provides vague information on incident reports and "couldn't" find them. She did not see any issues wrong at the home. Other issues: At the back of the home on the premises, there are 3 children (ages: 16,18 & 19 yrs; 2 boys (Antonio and Matthew) & 1 girl) who were past residents of the home living on the compound on a mattress. The security mentioned that the 3 persons fight and curse a lot and have been warned not to push their hands through the windows and the security is concerned. There is a sheet on the gate to give privacy for the children to bath but they can be seen at the other side of the building if they are bathing, and children can see them. The children do not get food or medication from the home. So, there is a question on how they are being treated for their condition. Past residents sleep on the compound and come and go as they pleased.					

HOME / CENTRE	AREA OF INVESTIGATION (1)	AREA OF INVESTIGATION (2)	RAW DATA (FACTS)	DATA SOURCE	FINDINGS	RISK TO CHILDREN	CONCLUSION	RECOMMENDATIONS
Joshua Home for boys	ABSCONDING		Number of residents, age, Location of home: Home in residential area. 10 children in home ranging from 6-17 years. Ratio: 3:1. Qualifications: Don Robsinson and director (past schoolteacher) seems qualified. Records are kept in the counseling room in a closed cabinet, but the records are available to the director, manager, supervisor and resident caregivers etc. Absconding incidents: Child absconded where the child stole something from Massy Stores a few years ago.Rooms in the home: Not enough chairs for residents and no study area for children to be online or to do work. No place for sick children (quarantine). Rooms are narrow and relatively small. The corridor is the same way. Wire netting on the wall to prevent ball from going over by the neighbors. 4 bedrooms for residents and 1 self-contained bedroom for the caregiver. 1 room to the back like an office where the children do homework. The structure of the home entails, the board, the director, the director's sister is the manager and a supervisor (Don Robinson; an older gentleman with a military background), 4 care-givers. Children will have behavioral issues that resemble that of CHiNs. There are no security guards on the compound. All children are in education schooling, and they have access to virtual schooling. Do not have any psycho-social support. Dr. Joel had a prior relationship with this psychologist on 3 boys who have learning challenges, but this report wasn't passed on to school to help the boys get better help. The home said they were unaware they could have passed on the report to SSSD and instead had the report. The rooms are well kept but dark. CATT involvement: Most staff not vaccinated, and the director was upset that CATT was pushing for children to be vaccinated. Limited communication from CATT when children are referred to the home. There seems to be a disconnect between the home and CATT and following the policies. Residents: Recreation: the garden in the house. The home does not have the yard space for the children to really enjoy activities. No transition plan for aging out of the home. The boys appeared fairly happy, there were a lot of bicycles on the compounds. They have visiting hours for relatives once a month. Staff misconduct: When ask how they discipline the children, the responded "they cah do nothing based on the new rules of CATT". When an incident of abuse arises, they will simply talk to the children. Some hostility, harsh tone and resistance received originally from director. Home is not licensed. Mr. Robinson made suggestive comments that he would "deal" would the children accordingly if he has too as he would not be tolerating any bad behavior.	Site Visit and Onsite Interviews	current system undermines the security measures for preventing and managing absconding	HIGH	possible physical abuse by Mr. Robinson	Staff should be vaccinated. CATT not sure if they are responsible for vaccinating children and are following up with parents for permission. Follow up needed.

HOME / CENTRE	AREA OF INVESTIGATION (1)	AREA OF INVESTIGATION (2)	RAW DATA (FACTS)	DATA SOURCE	FINDINGS	RISK TO CHILDREN	CONCLUSION	RECOMMENDATIONS
Lady Hochoy Home	ABSCONDING	PHYSICAL ABUSE	Location: Residential home for people with intellectual disabilities. Long building (pictures obtained). High risk area where home is located. Its near to health office in St. James. Diego Martin is wellness center for disabilities in mental health. Police station is about 10 mins away. Age: 3-76 years. 62 residents in total a lot of them abandon by relatives. Final decision of who is accepted in the school is the administration personnel. 3 staff members for boys and 3 for girls. Staff:Manager (and childcare officer (Nicole: social worker). Denver Developmental Screening Schedule used to assess children in the physiotherapy dept (physiotherapist has been there 35 years: male). Security guard at the entrance (Amalgamated Security firm: not very happy with the quality of service). 2 staff per dorm at night. Staff seems qualified. Home: 8 dorms, a playroom and physio department, dining room, kitchen and living room. Boys' and girls' dorms separated, and adults and kids separated. If not, all paperwork is presented for the children, they do not accept them. They are very firm on that. Medicals and PCR test must be done before child enters home. No person in charge of HSS, they rely on fire service. No drills in a while. Everywhere in the home was clean. A lot of yard space, garden to the front and secure compound. No specific time for bedtime, around 9 on weekdays and longer on weekdays and holidays. Own school for children on compound. Entrance has been acquired to the property from the side with the squatters where persons jump the wall to get to the fruit trees. So, they cut down a lot of the fruit trees. Wall around with barbed wire to the top. Don't have enough cameras (8 cameras for dorms and 4 externally) and want more. Security guard is not allowed inside the building; there is a bathroom outside for him. They aren't licensed. Dorms have emergency lighting and there is a generator from the entire compound. AC only in admin office and physio dept. Open porch area but it is in a mess, ceiling needs fixing and is closed off to residents. Study areas and devices are only given to children for school but on weekends they may get an opportunity to use it. Kitchen garden: tomatoes, cassava and peas. Several domestic fowls and ducks on western side of building. Most of the ducks have been stolen. Funding comes from OPM and ministry of social dev and they get some donations. Residents: Only 16 children there (CNPs). 3 age out in 2021 and one in December. No counseling for children due to low functioning capacity of the children. CATT:There was a child who had mental challenges and he ran away a few times and the home challenged CATT in court to remove the child because they did not have the resources to manage the child and the home won the case and the child was sent to St. Ann's. Makes reports to CATT immediately if something happens. In the last 2 months they	Site Visit and Onsite Interviews	current system undermines the security measures for preventing and managing absconding	HIGH	Home well managed and facilties very clean. Physiotherapist doing developmental assessments of children.	CATT needs to be more aware about whats going on. Need better assessments on children. Need to follow up on the staff member who was suspended for taking pictures of child in chains.

HOME / CENTRE	AREA OF INVESTIGATION (1)	AREA OF INVESTIGATION (2)	RAW DATA (FACTS)	DATA SOURCE	FINDINGS	RISK TO CHILDREN	CONCLUSION	RECOMMENDATIONS
			had 4 different case workers from CATT and there was a disconnect where the case workers kept coming back asking for the same information. Staff misconduct:The security does not pay attention, always on the phone and watching a movie. A matter is currently in front of the court for a sexual abuse claim with the security guard and a child. The child has mental challenges and makes advances at the guard and the child walks around naked at night and the security took pictures of the child and sent it to another staff member. Previous physical abuse allegations on staff members on children where they chained a child down and sent pictures to the media. The staff member still at the home after being put on suspension.					
Maragret Kistow	SEXUAL ABUSE		Employment of Mr Seales with allegation of sexually abusing a resident with a physical disability. Police Cerificate of Character missing for staff. Residents transitioned from facility to Mr Seales' home	Site Visit and Onsite Interviews dd 19/9/21 & 22/10/21 with Assistant CEO & House Mother Confirmed by a Social Worker	There is a lapse in conducting the necessary background checks Employment of a person who has allegations of sexual abuse despite home having knowledge of the allegations of sexual abuse	HIGH	The current situation increases the probability of sexual abuse.	CATT should immediately conduct necessary investigation and evaluation of all staff, especially Mr Seales police COC must be required for all employees on an annual basis

HOME / CENTRE	AREA OF INVESTIGATION (1)	AREA OF INVESTIGATION (2)	RAW DATA (FACTS)	DATA SOURCE	FINDINGS	RISK TO CHILDREN	CONCLUSION	RECOMMENDATIONS
				who is a member of the investigative team				
Margaret Kistow	FAILURE TO SAFEGUARD	SEXUAL ABUSE	Sexual intercation btween 2 boys (EC & AG). Incident reported as sexual abuse. Report, compiled by housemother (Genieve) recommnds more staff to supervise boys. Staff not adequately qualified/trained/experienced to supervise children. Language used by interviewer when investigating the incident with the boys.	CI report dd 15/1/21 Interview transcript attached to report. Site Visit Reports 17th September and 22nd October 2021, and in accordance with (IAW) statements made by manager.	The supervision/monitoring system is inadequate as there is no monitoring and evaluation of hiring practices. The interview transcript raises concerns about the investigative proedure. Incident was reported to CATT, but no evidence of follow-up.	HIGH	There is no demand by CATT for proper investigations into incidents such as this. CATT does not always follow up on reports after being notified. The investigation at the Home is not followed through to correctve measures. There is no oversight in the hiring onf staff.	Ensuring that relevant systems are implemented for prevention of child to child sexual violence, including support for victim and perpetrator. There is a need to implement standards and oversight into the hiring practices. A Investigative Procedure to be implemented with at least minimum standards for the conduct of investigations. Any report of inappropriate sexual activity must require a medical examination from the District Medical Officer (DMO) or other state facility.

HOME / CENTRE	AREA OF INVESTIGATION (1)	AREA OF INVESTIGATION (2)	RAW DATA (FACTS)	DATA SOURCE	FINDINGS	RISK TO CHILDREN	CONCLUSION	RECOMMENDATIONS
Margaret Kistow	FAILURE TO SAFEGUARD	SEXUAL ABUSE	Girls sharing beds. Boys sleeeping in a common open area	Site Visit and Onsite Interviews with Assistant CEO & House mother dd 19/9/21	Faciliates resident to resident sexual abuse. Facilitates the transmission of contageous diseases. Facilitates a higher risk in the case of fire or natural disaster. This practice is allowed due to the number of residents and available space. Practice promotes poor hygene practices. Violates Regulation 10 (1) - every child should have its own bed.	HIGH	Residential facility does not have the space to put requisite furniture requred to comply with the regulations. THe facility is overcrowded. High risk of the spread of contageous diseases. High risk of losses in case of a fire or natural disaster.	No home should be allowed to operate without the requsite space. Punitive measures should be taken for breached of the regulations. Where situations of overcrowding exist, CATT should take immidiate action to stop the practice by appropriate actions to include relocation of the children.
Margaret Kistow	FAILURE TO SAFEGUARD		Outbreak of chicken pox during March to June 2017. Report is signed as 16/9/17. CATT's handover Memo dd 2/10/17.	CI report signed as 16/9/17, Site Visit and Interview with	Failure to report contageous outbreak. Violation of Regulations (PART X: 22 (h)) - notifying the Authority immediately in writing. Situation aggrevated by overcrowding.	HIGH	Critical incidents are not reported in a timely manner. CATT need to enforce the industry standards of space per child. There needs to be regular medical monitoring of children's homes.	In circumstances where there are no medical personnel attached to the Home, CATT must provide this monitoring. Punitive measures (fines) must be formulated and enforced against person or institutions who fail to adhere to standards and procedures. CATT should not permit the operations of any Home unless they adhere to the space requirments for residents.

HOME / CENTRE	AREA OF INVESTIGATION (1)	AREA OF INVESTIGATION (2)	RAW DATA (FACTS)	DATA SOURCE	FINDINGS	RISK TO CHILDREN	CONCLUSION	RECOMMENDATIONS
Margaret Kistow	ABSCONDING		All incidents of absconding were more frequent than reported to CATT. The facility does not have cameras and has door sensors. The facility does not have 24 hour security patrols. The person responsible for security patrol is inadequately trained and has other duties. The number of staff is inadequate and untrained.	Site Visit and Onsite Interviews with Assistant CEO & House mother dd 19/9/21. Critical incident reports.	The security measures are inadequate to prevent absconding. The procedure measure are inadequate to prevent absconding. Staff to resident ratio is inadequate to prevent absconding and ensure safety of residents. Insufficient staff to prevent behaviours that can lead to absconding.	HIGH	Failure to implement proper security measures and maintain approved staff ratios can undermine the process of mitigating absconding and overall effective monitoring.	No permission to operate should be obtained without adequate security measures being put into place in accordance with the risk assessment. Staff to children ratio should be in accordance with best practices. In a range of 3:1 to 7:1 in keeping with the draft strategic plan of CATT. Security personnel to be hired from recognized security providers in accordance with the comissioner of police.

HOME / CENTRE	AREA OF INVESTIGATION (1)	AREA OF INVESTIGATION (2)	RAW DATA (FACTS)	DATA SOURCE	FINDINGS	RISK TO CHILDREN	CONCLUSION	RECOMMENDATIONS
Margaret Kistow	PHYSICAL ABUSE	FAILURE TO SAFEGUARD	There are no adherence to job descriptions and tasks were interchangeable. Prior residents (XL, GL, CE, NG & DB) are currently staff members who are not qualified. Some residents leave the compound periodically to purcahse marijauna.Some residents smoke marijuana on the compound. Ms Kistow does not have the capacity to discipline the children in an acceptable manner. There are inappropriate resident to resident relationships at the Home. Abuse ocurs at Margaret Kistow in accordance with statement from Margaret Kistow. No disciplinary log and no discipline matrix in accordance with CATT's policy. Punishments are subjective.	Manager indicated that there was a lack of assigned duties to any one person. Interview with Manager. Site Visit and Onsite Interviews with Ms. Kistow confirmed by Mr Seales dd 19/9/21 & 22/10/21. One of the boys confessed to Team member about smoking marijauna.	Difficult to hold staff accountable to standards of performance as duties were interchangeable. Security system is either incomplete or there are breeches in the integrity of the security and recording attendance. Staff are not trained to manage children. Punishments are subjective. The current situation facilitates abuse as staff could implement inappropriate methods in the absence of proper institutional responsibility. discipline is not in keeping with accordance of CATT policy. Ms. Kistow holds to the antiquated practice of discipline.	HIGH	Abuse occurs at Margaret Kistow in accordance from statement from Margaret Kistow Manager and House mother. CATT is aware of the abuse in keeping with a statement from Ms. Hayley. Continuous development training to be implemneted by CATT in accordanace with regulations. Conflict resolution, descalation, behavioral management	CSA must maintain a consistent schedule and have contact with the child. Only the specfic personnel should be responsible for discipline. All logs need to maintained in accorandance with regualtions Ensure staff is provided with relevant training: eg. Conflict resolution, descalation, behavioural management). No permission to be given to children's home to operate without discipline matrix. Once these recommendations are reviewed- CATT should incoroproate and sign off on all draft policies. Licensing and monitoring should ensure that all children's home utilize standardized documentation to prevent subjectivity.

HOME / CENTRE	AREA OF INVESTIGATION (1)	AREA OF INVESTIGATION (2)	RAW DATA (FACTS)	DATA SOURCE	FINDINGS	RISK TO CHILDREN	CONCLUSION	RECOMMENDATIONS
Margaret Kistow	FAILURE TO SAFEGUARD		CATT not providing timely assessments, sometimes only verbal and children are aging out without having being assessed; no in-house counsellors, where necessary homes forced to rely on services available to general public.	Site Visit and Onsite Interviews with Assistant CEO & House Mother dd 19/9/21 .	Lack or delay of providing assessments makes it impossible to implement the appropriate intervenions and prevents the dessimination of relevant information to satff about how to manage children. Children are not accessing counselling as regularly as necessary.	HIGH	Children not accessing needed counselling to achieve objectives of care plan. CATT not providing relevant information to assist in management of the children. Prevents effective reintegration into the community.	CATT to ensure every child in CR receive at minimum psychosocial and medical assessment both existing residents and within 7 days upon admission into care for new residents. CATT: Treatment plan should be developed within 12weeks of admission into community residence CATT: Clear policy regarding development of Treatment and Care Plans and how they interact.
Margaret Kistow	PHYSICAL ABUSE	FAILURE TO SAFEGUARD	The Home does not comply with the requirments for the maintenane of logs according to regulations 19. CATT aware of this shortcoming. The Home does not record rounds and thus there are no 'rounds log'. Residents personal files are kept at the home of Mr Seal es.Illegible Disciplinary log entry viewed, reported to be entries made by residents, in accordance with the understanding of management. Denied by CATT	Dicussions during site visits dd 19/9/21 & 22/10/21 with Assistant CEO & House Mother Pictures from site visits dd 22/10/21 Interview with L&MA officer Rachel Daniel-Haley	Absence of particular logs Improper storage of files Management unable to properly process instructions and makes no logical sense regarding procedures. Improper maintenanace logs	HIGH	The current process undermines accountability and sabotages opportunities to report and check for abuse. Staff lacks capacity to understands directions and make decisions based on logic	CATT should enforce the regulations regarding the use of logs. CATT should define and enforce requirements for employment staff. CATT: L&M should ensure that logs are maintained and should not compromise on standards of records mainteance.

HOME / CENTRE	AREA OF INVESTIGATION (1)	AREA OF INVESTIGATION (2)	RAW DATA (FACTS)	DATA SOURCE	FINDINGS	RISK TO CHILDREN	CONCLUSION	RECOMMENDATIONS
Margaret Kistow	FAILURE TO SAFEGUARD		Upon enquiry, Ms Kistow indicated that CATT had not explained all the standards to be met in running a children's Home. Inconsistent statements by Mr Seales.	Site Visit and Onsite Interviews dd 19/9/21 with Assistant CEO & House Mother	There seems to a lack of knowledege by key personnel regarding the standards for operating a Home. Conflict between managers regarding instructions for CATT in running childens homes. Home does not maintain standards as provided by regulations (hygiene, capacity, environmental	HIGH	The current situation prevents proper safeguarding leads to abuse and to denial of children's basic rights. The home is unsafe for the care of children. Situation allows for communicable diseases	CATT should enforce standards contained in regulations and not compromise on children's health and safety.
Margaret Kistow	FAILURE TO SAFEGUARD		Place very filthy. Ms Kistow indicated that the Facility had water problems and there was often no running water, overcrowding, fire-trap	Site Visit and Onsite Interviews dd 19/9/21 &22/10/21	The home only complies with the standards set in the regulations for the provision of laundry facilities	HIGH	The Facility does not meet childen's basic needs.	Management should collaborate with CATT and relevant authorites to rectify the water issues. CATT must not allow overcrowding of facility. CATT: Home should not be allowed to operate without public health and fire approval
Margaret Kistow	FAILURE TO SAFEGUARD		During the site visit several of the children were on devices, only a few seem to be enagaged in online schooling. The housemother(Genieve Lawrence) recommended more educational support for children ages 12-18 and indicated that there was no support for children who have talents and wished to explore them.	Site Visit and Onsite Interviews dd 22/10/21 with Assistant CEO & House Mother	Some children may not be accessing the appropriate schooling. Failure to comply with regulations 15 a(iii).	HIGH	The current situation violates basic childrn rights of access to education. as well as Regulation PART IV 15:a,iii	CATT should ensure relevant evaluation of children and ensure no child be placed in a home with insufficient access to education.

HOME / CENTRE	AREA OF INVESTIGATION (1)	AREA OF INVESTIGATION (2)	RAW DATA (FACTS)	DATA SOURCE	FINDINGS	RISK TO CHILDREN	CONCLUSION	RECOMMENDATIONS
Mary Care North	ABSCONDING		Mothers stay longer than previously required. Location of the home near Arapita Avenue. No security measures. 1 caregiver at a time: 7 days on and 7 days off. 1 caregiver retired nurse. Also used as a place of safety for child victims of human trafficking. 3 incidents of child victims absconding.	Site Visit and Onsite Interviews	Lack of security measures, location of the home and the use of the premise as a place of safety for child victims of human trafficking encourages incidents of absconding.	HIGH	The use of the home for purposes other than to house pregnant mothers facilitates absconding.	CATT: Placement should not be contrary to the policy of the home. Find out why the care-giver left St. Judes. Very little follow-up from CATT. Counseling needs to be implemented immediately. CATT needs to provide better trained staff and licensing for specialised homes.
Mary Care North	FAILURE TO SAFEGUARD		Assessments and medicals not usually provided. No transitional training provided to mothers.	Site visit interviews: 8/10/2021.	Lack of psychosocial assessments and medical. No psychologist or social worker attached to the home. Home relies on expertise given by CATT. No transitional training provided to the mothers.	HIGH	CATT is not meeting its saturatory responsiblity with respect to the rehabilitation of the residents. Home has no access to social workers or psychologists for assessments of children. No transitional training provided to mothers.	CATT: Medical and psychosocial assessments must be done with respect to every child. CATT: where the home has no psychologists or social workers attached, CATT must provide same. Transitional training and interventions must be provided to mothers to minimize risk of future harm
Mary Care South			Factual position similar to Mary Care North. In addition, home operating in conjunction with Mary Care North and mothers and children sent to Mary Care South when the baby is over 3 months. Residents then await CATT approval to be discharged. House on main road; no security features except there are security cameras but not monitored on a 24 hour basis. Home in reality managed by a supervisor. Supervisor has too many responsibilities and is unaware of administrative information such as Job descriptions and admission process etc. Manager visits periodically. One recent absconding incident; mother with child walked out of the compound. No training provided for young mothers.	Site Visit and Onsite Interviews dd 01/10/2021	Absconding risk increased because of the children having to wait for CATT approval to leave. Home in reality managed by a supervisor who is unqualified to managed the home. The management of the home is being done by the supervisor.	HIGH	Better security monitoring. CATT policy of delaying release of the mother and child encourages absconding. Poor/ no transitional training provided to mothers.	Home must comply with the act and managing of the home with respect to the qualifications of the de-facto manager. Transitional training must be provided for young mothers.

HOME / CENTRE	AREA OF INVESTIGATION (1)	AREA OF INVESTIGATION (2)	RAW DATA (FACTS)	DATA SOURCE	FINDINGS	RISK TO CHILDREN	CONCLUSION	RECOMMENDATIONS
					Location of the home provides a security risk for absconding. Poor security survillance. No transitional training provided to mothers.			
St Mary's	FAILURE TO SAFEGUARD		On May , 17, 2021 Ms. Maria Villafana contacted the hotline to report that she recently saw a video involving her daughter; DV (CASE-20161212-8643) kissing a boy. Ms. Villafana said the video is no longer on social media, however the video was dated November 11, 2020. Ms. Villafana also said that she does not understand how her daughter can be engaging in this type of activity since she is at the St. Mary's Children's Home"	Email thread in CI folder-Fwd_ Case update_ DV St Marys.msg	Inproper supervision of devices and inproper relationship between residents.	MEDIUM	Lax security with respect to the use of devices. Poor security in respect to the mixing of sexes which can lead to sexual abuse.	Home should put in place policy with respect to use of devices and intermingling of the sexes.
St Mary's	SEXUAL ABUSE	PHYSICAL ABUSE	Multiple sexual abuse reports to CPU on 1/1/2017, 7/1/2017; Multiple assault/beatings/threats 1/1/2017, 11/2/2017. No critical incident reports of these incidents.	Children Victims Folder: From Crime and Problem Analysis Branch-Reports of offences made against Children 2015-2021 (21/7/2021)	Status of Investigations - All Pending. No critical incidents report in folders that correlate with these reports	HIGH	Home not reporting all critical incidents. Criminal investigations are taking too long to be completed.	CATT: home should ensure that all critical incidents are reported. CPU should ensure that investigations of sexual abuse coming from residential homes be given priority.
St Mary's	FAILURE TO SAFEGUARD		on 2/4/21 at 8:03pm- 2 male residents found in a sexual compromising position in dorm bathroom, it was recommended that two staff reassigned at night shift. On 22/2/21 at 11am - sexual engagement. Supervisor was distracted. Resident M (15y/o M) entered independent living dorm and engaged in sexual activity with D (15y/o F). During site visit interviews it was reported that - No formal staff rounds are conducted, as staff in close promixity to residents. 1 staff to 1dorm (about 11 residents)	CI reportdd 2/4/21 reported by Dominic Martin. CI reportdd 2/22/21 signed by Fitzroy Henry	Sexual interaction between residents: male/ male and female/male. Poor supervision.	HIGH	Inadequate supervision, in both ratio of staff to resident, as well as in poor monitoring, i.e. lack of staff rounds/checks, allows for	To recruit more staff recuritment. Enforcement of staff to child ratio in accordance with CATT recommendations. Home to institute policy in respect to conducting formal staff rounds.

HOME / CENTRE	AREA OF INVESTIGATION (1)	AREA OF INVESTIGATION (2)	RAW DATA (FACTS)	DATA SOURCE	FINDINGS	RISK TO CHILDREN	CONCLUSION	RECOMMENDATIONS
				Site Visit interview with Mr F. Henry-Manager(Ag)			abuse to occur.	
st Mary's	FAILURE TO SAFEGUARD		Resident ingested small quantity of diluted dishwashing liquid. No particulars given in the report.	CI report dd 19/04/21 reported by Arline Collins	inadequate supervision, allowed child to access and consume. Critical information absent in critical incident.	HIGH	Risk of severe damage to the child. Lack of supervision.	Enforcement of staff to child ratio. Home to institute policy on supervision. CATT to ensure proper training in making critical incident reports.
st Mary's	FAILURE TO SAFEGUARD	ABSCONDING	CI report indicated that resident "walked of compound", 11 residents and 1 staff member present. "boys were playing on the football field', "E walked off the compound". A number of secuirty cameras are defective. Number of ascondings per year: 2018-1; 2019-3;2020-2;2021-2. Home shares the compound with a school to which members of the public has access.	CI report dd 24/6/21 reported by Dominic Martin . Incident Report E.N. CI dd 23/3/21 . reported made by Dominic Martin. Site Vist Interview with Mr Fitzroy Henry (Manager, Ag), Absconding Lists	Inability to secure public gate, allows for children to simply walk off the compound.	HIGH	Poor supervision and inability to properly secure the premises, is the cause of an ongoing problem of absconding.	Home to recruit more staff. Home to take steps to separate public school from its premise.
st Mary's	FAILURE TO SAFEGUARD		CI report reveals that 2 residents consumed a suspected poisonous substance at 6:45 pm but were only taken to the health centre the next day. Substance was administered to them by another resident. Investigation subsequently revealed that the substance was with dishwashing liquid mixed with juice or bleach, jasol and dish washing liquid.	CI report dd 21/4/21 which was	At least caregivers on 3 shifts aware resident comsumed substance however noone	HIGH	Failure to supervise the children adequately and failure to safeguard by	Home's reporting policy must be enforced. Need for standard medical policy in such an event. Provision of

HOME / CENTRE	AREA OF INVESTIGATION (1)	AREA OF INVESTIGATION (2)	RAW DATA (FACTS)	DATA SOURCE	FINDINGS	RISK TO CHILDREN	CONCLUSION	RECOMMENDATIONS
				reported by Angela Carr on 22/4/21	reported or took action until next day.		not securing items accordingly. Failure to take the children to health center immediately.	supervision must be increased.
St Mary's	FAILURE TO SAFEGUARD		"The resident stated that he wanted to go to the toilet to wash his hands and instead of returning to his dormitory to wash his hands, he took the opportunity to visit the Staff Bathroom Facility located at the back of the Administration Building" "He observed the female staff coming out of the female staff bathroom and hugged her. She resisted, and he then grabbed at her and began to pull her towards the male staff bathroom"	CI E.S. 2021, report dd15/06/2021 made by Debra Bayack	Inappropriate touching by resident. Lack of adequate supervision.	HIGH	Inadequate supervision of residents.	Home needs to improve supervision of residents. Home needs to install functional camera security system.
st Mary's	FAILURE TO SAFEGUARD	PHYSICAL ABUSE	CI report indicates that in the absence of staff, two residents physically abused another resident. Despite the complaint, supervising staff left the children and went to the staff room and it was at this time the resident was assaulted.	Incident report BS, CI dd 19/3/21, reported by Debra Bayack	Poor supervision by staff despite warnings.	HIGH	ratio of staff to residents is inadequate to provide adequate supervision for care and protection	Enforcement of best practice guidelines and policys for supervison and safety.
St Mary's	FAILURE TO SAFEGUARD		On 3 monitoring visits, children were not interviewed.	St Mary's RMF 9/1/20, 3/10/19, 3/11/20	Children are not interviewed during every monitoring visit	MEDIUM	L&M visits are inadequate assessments due to lack of resident input	CATT: to ensure that residents are interviewed on every monitoring visit.
St Mary's	FAILURE TO SAFEGUARD		Member of staff hit in the face by a resident. CI report reveals that the resident had been prescribe an anti-psychotic medication and the dosage had been halved without medical authority.	All reports of Abuse folder - SMCH-Complaints 26/7/18 -L&M complains monitoring form visit date 18/7/18	adjusting treatment without physician advice	MEDIUM	Staff improperly adjusted residents medication. Assault most likely was a result of the unauthorized adjustment of medication.	Need to implement and enforce medical protocols.

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St Mary's	FAILURE TO SAFEGUARD	PHYSICAL ABUSE	In 2017 a recommedation by Licensing and Monitoring Dept of CATT was made for alternative residence for JS as a result of his hypersexual behaviour. Despite the recommendation and continued attacks on residents and staff by JS up to Sept 2019, alternative placement had not been found.	All reports of Abuse folder - SMCH-Complaint 12.12.17 ,Complaint 16.10.2019. Cl dd 29/1/2018. Employee Lisiting as at August 10 2021.	Resident identified as a safety threat to staff and other residents. Removal recommended but not implemented.	HIGH	Provision of Specialised care required for resident.	CATT: to ensure implementation of recommendations made by Licensing and Monitoring.
St. Judes	PHYSICAL ABUSE	FAILURE TO SAFEGUARD	Staff and security bring in contraband for the girls in the past, guards have been reported to engage in both physical and sexual assault of the girls. Staff promoted groups of resident to physically abuse other residents- termed "Compound Beatings, House beatings/cut-arse". Staff failed to intervene in a timely manner during fights between residents team beatings occur frequently. Child was handcuffed after assault incident with security guard. Nothing is done when abuse is reported. Police reports are not made when beatings occured. One of the residents of this home, left the home and went to live with one of the senior persons in the security firm (she lives nearby). Recreational activities present for the children? Qualifications of staff are unknown and pending, cannot find history of staff and their prior experience.	Interview with past residents LM and LC. L & M complaints monitoring form dd 9.01.20 critical incident reports 14.10.16 ; 17.1.18 Interview with Management Interview with Venezulean	Physical Abuse occurs in the form of corporal punishment, excessive and inappropriate force, as well as via peer on peer physical assault due to lack of staff descalation and intervention. Residents are encouraged to break law and are exposed to deterimential effects on general health and mental wellbeing, inclusing but not limited to addiction	HIGH	Incidents of physical abuse are not being reported to law enforcement. Residents do not have a confidential way of reporting abuse. Staff unable to manage difficult behaviors. CATT involvement: more staff needed. Residents Mental wellbeing of the children is possibly affected. Conditions	Establishment of an independent body to receive confidential reports from residents and staff, and has power to take action independent of CATT. L&M to speak with residents at every schueduled and unscheduled visit. CATT to reulate and monitor CR enforcement of Staff Code of Conduct or staff discipline policy CATT to ensure, through regulation and monitoring, that all staff receive descalation and behavior managemnt training as pre-employment orientation and then

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				Residents			present for abuse to take place.	with review quarterly
St. Judes	FAILURE TO SAFEGUARD	ABSCONDING	Home is located in a high crime area, with easy access to main road. Poor security: no electronic surveillance, perimeter compromised (weak wall), burglar proof not restrictive enough. Unsatisfactory safety procedures: no emergency plan established, no fire drills conducted, high possibility of injuries or loss of life in the event of a fire. Absconding incidents: When absconding, multiple times, the girls are not seen again	Site Visit and Onsite Interviews FHSSE manual and draft operations manual was shared for interviewers on site visit.	Based on the location of the home (high risk), it makes it easier to abscond. Current security system undermines measures for preventing and managing absconding. Lack of security tools and emergency plans put into place.	HIGH	Failure to ensure appropriate security measures allows for absconding to occurDue to location in a high crime area, where ogranzied crime groups frequent, there is increased risk of girls interactions with these such groups when they abscond (as well as the risk of human trafficking activities Child endangement	CATT to fianlize FHSSE manual and operations manual. CATT to ensure that all homes adhere to FHSSE and operations policies so as to mitigate risks of absconding

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							at risk of occuring due to lack of security tools and emerengcy plans	
St. Judes	PHYSICAL ABUSE		Report by Toyna Roach states that on 21.09.16 there was a physical altercation between staff and children in the courtyard. Reports attached reveal a verbal altercation between staff, Kenya Blackman and child, AL. That altercation escalated into a physical fight during which Blackman hit the child with a lock twice to her head. At least five members of staff witnessed all or parts of the incident. Blackman admitted hitting the chid with the lock but said that she was provoked and was defending herself. According to the statement of Patrice Bailey-John the situation could have been avoided by Blackman not engaging the child and behaving like an adult.	CI report dated 21.09.16 together with statements from staff and children witnesses to the incident	Blackman assaulted the child. The excuse that she was defending herself does not validate the force, as the force used was inappropriate in the circumstances. Rather than engaging with the child she ought to have de-escalated the situation. The other staff members present ought to have intervened to avoid the interaction between the member of staff and the resident intensifing.	HIGH	Blackman is primarliy accountable for the situation and resulting assualt of the child. Other staff must also be helad accountable for failure to descalate the incident so as to safeguard the parties. Staff are unable to manage difficult behavior apporpriately Staff are not held accountable for non-compliance with the	CATT to ensure periodic Training of Staff in appropriate methods of intervention and de-escalation of incidents Home and CATT should conduct an assessment of staff to ascertain whether suited to the task of child care in certain Homes Review of the qualifications and experience required of a 'caregiver' and all other posts incolved in Child care at the Home

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							established code of conduct to regulate and prevent altercations between the staff and residents.	
St. Judes	ABSCONDING		According to the CI report the incident occurred on 23.10.17 at approximately 3 am. 11 children I member of staff. Report to PS Johnson by Deputy Manager states that 6 children were found to be missing at approximately 4.30am. The back door and burgular proof gate found open. According to the letter there were inconsistencies in the statement of the relief staff who was on duty at the time and she was dismissed. The statement of one of the absconding girls reveals that one of the residents went into the matron's room and took the keys another opened the back door and took the lock off the back gate. The keys were then replaced. The girls packed their good clothes and waited for the matron to fall asleep. When she fell asleep they absconded.	CI report dated 23.10.16 letter to PS from Deputy Manager	lax security with respect to the keeping of keys; no proper security checks on doors; staff to child ratio inadequate; staff sleeping while on duty	HIGH	poor supervision in place. ratio child to staff too high. It is evident that the member of staff habitually sleeps while on duty, absonding her role of carte towards the children Inadequate security re securing of keys and checking of doors leading to the outside of building	CATT to ensure adherence to staff to resident ratio accordance to CATT regulations Home to ensure supervision of staff while on duty Home to ensure adequate security measures are in place

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St. Judes	ABSCONDING	FAILURE TO SAFEGUARD	13.07.17 child noticed to be "high" on the 12.07.17 sent for a drug test next day and returned to beauty school did not return to home at 4 pm	CI report dated 13.07.17	Child should have been identified as an absconding risk given suspected drug use.	HIGH	negligence. Even if the child was not obviously at risk of absconding once drug use was suspected proper supervision measures should have been put in place to identify the source and prevent reuse.If that had been done the absconding would have been prevented.	Proper follow through by staff where impermissable behaviour is suspected. Management practices to be reviewed

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St. Judes	FAILURE TO SAFEGUARD	FAILURE TO SAFEGUARD	Self Harm: "Numerous incidents of Self- harm. Many with a sharpener blade. Most serious the use of a broken polish bottle- earlier in day the child complained about feeling to harm herself- she had the day before ingested a safety pin- put. Child placed under supervision- incident happened during a lapse in supervision. Child broke a nail polish bottle and ate two peices of the glass and a thumb tack-	CI reports dated 29.6.17; 29.06.17 ;1.7.18; 2.07.18; 16.5.18; 16.06.18 ;27.06.1 8; Onsite intervie ws with current resident s	Self- harm amongst residents occurs regularly at St. Jude's; The absence of appropriate screening by staff of girls at risk of self harm and of items that can be used to inflict harm. Inappropriate proper supervision of those girls with reference to self-harming behaviours and trendencies	HIGH	Staff untrained to manage self-harming behaviors and recommendin g psychologocal help is not the practise. Poor supervision and screening for potentially dangerous items amongst residents	Regular risk assessments to be made on children to assess suicidal and self-harm behaviors. Children to be given appropriate psychological or psychiatric treatment and proper supervision once assessed as at risk for self harming; Residents should be provided daily structured rehabilitative and developmental activities so as to address self-harming tendences and other emotional challenges that residents present Residents must be availed appropriate psychological interventions to treat with emotional and mental health challenges consistent with international best practises to treat with such issues. The widespread and primary intervention of pharmarcological intervantion that has been observed must be revisited CATT to ensure training of staff in identifying risk of, and preventing suicide and self-

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								harm. Comprehensive inquiry needs to be commissioned as to the reasons residents of this home are particularly vulnerable to self-harm

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St. Judes	PHYSICAL ABUSE	FAILURE TO SAFEGUARD	On 18 jan 2018 phychologists called in a report to CATT of an assault of SM by 6 other residents [No CI report made until 25.01,18] According to the child starting the fight told to do so by staff. confirmation that fight premediated by another resident. Confirmation of this practice "compound or House cut arse" by LM and LC in their interveiws with Team. Also referred to in Complaint Monitoring form by Rachel Daniel-Halley as being reported by another resident. 2 Staff on duty for 9 girls. Staff did not intervene to avert or control fight just allowed it to escalate and then called police officers stationed at Home and eventually Belmont Police. One Police officer sat on the victim to "prevent her from being hit". No decision taken by Home to discipline attackers -awaiting a decision by police.	Complaint Monitoring form dd 25.1.18 by Rachel Daniel-Halley; CI report dated 25.01.18 ; typed statements of staff Alicia Padarath and Abigail Patrice(see 22 /52 and 25/52) handwritten statements from DJ (7/52) JS(12/52) AL(13/52) MM(14/52)? R(15/52) SM(16/52) AF(23/52) KM(24/52) Complaints Monitoring form dated 23 August 2018	Fight between A and S instigated by the staff as a means of controlling/ punishing girls without breaching the rule re corporal punishment. No attempts by the Staff on duty to prevent the fight escalating into a brawl. Not enough staff on duty. In accordane with CATT best practice the staff ratio should have been at least 1:3. It was in fact 1: 4.5; There was an inappropriate attempt to "sheild" S by sitting on her this may also have caused or contributed to the injuries suffered by S. Breach of reporting procedure. no attempt by CATT to insitute a proper investigation or to provide recommendtions on the use of police officers in these circumstances	HIGH	improper and ineffective supervision by staff: the use of girls to punish other girls is a circumvention of s. 4 (7A) of the Children Act prohibiting coporal punishment ; improper and dangerous and, as in this case, could lead to serious consequences to the both to victims and the attackers; ineffective and inadequate supervision: staff to child ratio and failure staff to prevent the incident from escalation; over reliance by staff on the use of police and police tactics to control girls;	the practice of instigation by staff must be stopped; ; if the legislation does not provide for this to be an offence then amendments to the Act to provide for such a situation necessary; CATT to implement policy on the use of Police Officers to control residents; Training for staff on methods of controlling children and de-escalating incidents; proper staff to children ratio to be maintained in this case 1;3; (as per JSC submission dd April 9, 2021, pg4) police intervention must not be the primary behaviour modification approach as may be needed for cases of genuine rioting; General retraining of Management and staff consistent with the policies and procedures appropriate for effective care and oversignt of vulnerable children must be expedited at St Judes within the shortest possible time. This is critical to address the ongoing

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								challenges in managing children's difficult and self-harming behaviours in a rehabiltiutative and adaptive manner. Person unable to adopt such retraining should be disengaged so as to promte the safety of the children. (serious consideration to be given to the question of whether staff capable of retraining at this stage; management style at the Home to be reviewed)

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St. Judes	PHYSICAL ABUSE		During the course of the same incident above the residents state that D, K and M were assaulted by Ms. John a security officer. All three alleged that Ms. John accused them of hitting/pushing her in the melee and began to choke each of them. At the time they all say that Ms. John had taken off her shoes and weave in order to fight with them. According to M, Ms. John also assaulted her with the weave.	see statements referred to above	In retalitation for someone hitting her, Ms. John assaulted three of the girls. The assault was unreasonable and cannot be condoned or justified. IN taking off her weave and shoes it is clear that the Security was prepared to engage in rather than prevent a brawl. This was not a proper response to the situation. Further in an attempt to "punish" who ever injured her she indiscrimately accused and attacked girls without any basis for doing so. There can be no justification for her response. Further with respect to the actions of the Security Guard the St. Jude's staff failed to stop the attacks. No or inadequate response by CATT to the issues raised.	HIGH	unjustified assault on three girls by a security guard employed by St. Jude's Security provider. failure by the caregivers to protact the children from an unjustified assa. ult; Management style at the home to be investigated; CATT's monitoring procedure inadequate	Removal of this security firm and replacement with officers properly trained in the behaviroal managemnt of children; Training to be provided to St. Judes staff and all security in descalation and developmentally approrpiate behavioral managment of children. General retraining of Management and staff consistent with the policies and procedures appropriate for effective care and oversignt of vulnerable children

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St. Judes		FAILURE TO SAFEGUARD	Marijuana use in one of the Houses discovered between 21-23 March 2018. Four girls tested positive. Disciplinary action: stern warning and chores. Claims by L M, one of the residents involved, that marijuana regularly obtaining from members of staff and security officers. Confirmed by LC in interveiw. Confirmation that marijuana use prevelent amoung the girls and that security responsible for brining it in from Manager Ag in interview with Team.	Ci report dated 21-23 march 2018interview with L M 29.09.21 and Intervei w with Latifa Correria . Intervei w with Ms. Bruce acting Manager	criminal activity re possession and trafficking of drugs; major security lapses re contraband coming into home; Failure by staff to discipline girls for its use or staff and security for bringing drugs onto the compound. No report made to the police. No steps taken by CATT to prevent its reoccurrance.	HIGH	Known use of marijuana by girls condoned and encouraged by staff; Breeches of section 35 & 36 of Children's Act 2012 Apparent breaches of the law by children, staff and security unaddressed and reported by Management and CATT. Failure to safeguard children from illicit drug use	Established zero tolereance drug use policy maintained through mandatory random drug testing for staff and residents. Disciplinary steps to be taken against both staff and girls found contravening policy; Incidents of drug use and trafficking of drugs to be reported to the police. CATT's procedures and Monitoring function must be immediately reviewed and improved so as to mitigate reoccurence. Internal periodic drug prevention education programmes must be incorporated within the general intervention packages for staff and residents

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St. Judes	FAILURE TO SAFEGUARD		Self harm: P J 1.07.18 . Prior to incident resident was heard yelling out- she was removed from the dorm but later returned to dorm removed the wire from her bra and cut forearm	CI report 1.07.18	poor reporting. negligence in not treating with the reason for her having to be removed from the dorm earlier and negligence in returing her to the dorm when situation not resolved.	HIGH	Poor supervision	Staff to be trained in identifying and preventing self-harm behaviors. Staff educated and trained in Self-harm and suicide prevention policies Once it is alleged that a child is self-harming that child should be referred to a pyschologist for assessment immediately as well as measures such as constant supervision and the removal all instruments that could cause harm put in place to prevent further harm to the child
St. Jude's	ABSCONDING	FAILURE TO SAFEGUARD	According to the Serious incident report a house discussion among the girls spiraled out of control . The girls refused to go back in the house. Absconded because staff called the police and because the opportuniity presented itself when a staff member opened the gate to enter. Millington confirms this incident.	serious incident report dated 16.10.16 (found included at the end of CI marked 22.09.16) and statement of staff Stapleton and Sobes-Norville found there. Some confirmation by LM in her	There was no attempt to de-escalate the situation before resorting to calling the police; lax security measures resulted in the opportunity being presented to the girls to abscond.	HIGH	Lax security measures resulted in the girls absconding	Staff needs to be trained in de-escalating situations Security protocols to be established and implemented to manage difficult siutations such as this, and to prevent gaps in security while managing the situation. police intervention must not be the primary behaviour modification approach but as may be needed for cases of genuine rioting;

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				interview.				

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St. Jude's	ABSCONDING		According to the CI filled four children absconded on Dec 8 between 2am and 4am. On duty at the time was one caregiver, and 2 Security Guards, Gray and Miller. The report states that the children were checked in at 2am and when checked again at 4.45am the dormitory was empty. There was damage to the dormitory including a hole on an external wall. Warrants were issued for the 4 girls and charges brought for absconding. According to the security report annexed the children were located in the West Wing prison (Rehab) According to the report on the night of Dec 6 continious pounding was heard and a hole opened up on the northern wall this allowed the girls to access the landing outside the perimeter wall on the St. Dominics playfeild. The Manager of St. Judes and Operations Manager of Security Ms. Myers were informed. Security Officers positioned themselves to monitor the situation as the children went in an out of the building onto the landing. Belmont Police arrived but advised that they were unable to arrest the children as they were legally on the premises and had not escaped legal custody. The officers left at 1.20 am and security officers continued to monitor the scene. The next day (Dec 7) the Security officers continued to monitor the hole and showed the Deputy Manager. The security officers continued to monitor the hole that day. One member of staff was detailed to take care of the girls she checked them at 2 am . Sometime after 4 am the member of staff requested Security to open the the door of the prison and they discovered the girls missing LM has a different version of the incident. According to LM they had been in the rehab for some considerable time. The conditions there were bad. they were getting juice in pinesol bottles sometimes the food was spoilt,they weren't getting phone calls and hardly getting visits. They had no TV. She says that they protested by beating the tables and singing and stuff. The police were called. One Police Officer a Mr. Edwards came he asked no questions and just began hitting and a fight ensured. In particular he attacked and choked her friend. The friend spit on him and the beating intensified. (He later pressed charges against her friend). This was done in the presence of staff members and security guards employed by St. Jude's. One of the guards was Marissa Myers. Afterwards they locked the gate and left. The girls called on them to open the gate so that they could use the toilet. No one came. The girls finally decided that they would escape. They burst a hole in the wall and ran.	CI report dated 8.12.16 and statements of the Security Guards allached . Interview with LM dd 29.09.21	On the version given by the Security Guards the absconding of the girls was a direct result of incompetence and gross negligence by security and management. Almost to the level of a deliberate facilitation of the escape to enable St. Jude's to charge the girls for escaping legal custody. Security had been alerted to the possibility of the hole by the pounding heard from the night of the 6th. They saw the hole that night and the girls moving in and out of the prison onto the landing and did nothing to stop them. They attempted to have them arrested for escaping legal custody that night but failed. Instead of containing the situation they allowed it to develop. Management was implicated as Ms. Bruce Manager was advised on the 6th and the deputy manager on Dec 7. Both the Security and the management allowed the situation to continue for at	HIGH	On any version St. Judes was complicit in the escape and negligent in allowing it to occur. There is no doubt that the breaking of the wall ought to have alerted staff/ security. For one it would have been noisy work, would have occupied the children for some time and could be seen from the outside of the building. Proper supervision and perimeter checks by security would have alerted management to the breach. The age of the incident precludes any serious investigation into the actions of the police in the physical abuse of the girls. However the use of the police to intervene in	St. Jude's staff must be trained in the proper managment of residents. General retraining of Management and staff consistent with the policies and procedures appropriate for effective care and oversight of vulnerable children must be expedited at St Judes within the shortest possible time. This is critical to address the ongoing challenges in managing children's difficult behaviours in a rehabiltiutative and adaptive manner. Persons unable to adopt such retraining should be disengaged so as to promte the safety of the children. The practice of calling the regular police to supplement poor management techniques must cease. If police officers are to be summoned only in genuine cases of riots and they must be officers in the CPU who have been trained to manage rioting children. Supervision must be

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					least 24 hours until the girls escaped on the morning of Dec 8. On the version given by LM reveals serious breaches with respect to the treatment of the children while in the Rehab. ie spoilt food, refusal to allow them visits, no school. Further physical abuse at the hands of the police with the knowledge and compliance of the staff.		the management of the residents is of serious concern, as is the use of the rehab as a prison and the treatment meted out to the girls placed in the rehab.	increased and adequate security policy and measures must be put in place.

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St. Jude's	ABSCONDING	PHYSICAL ABUSE	14.10.16 CI report treats with an assault on a resident by a group of 5 girls including LM, L, S and D. According to the report made by Toyna Roach this was in the presence of 3 members of staff and 1 security officer. However the report lists that two security guards, Ms. Gray and Ms. Myers were witnesses to the incident. The members of staff were caregivers Sobers-Norton, Kirton and Stapleton. The report states that a fight ensued over allegations of theft of make up. The victim, AL had to go to the Hospital. The "pre-report" however indicates Ms. Paul as one of the reporting staff. According to the pre-report the girls had gotten into a altercation over missing make up earlier. They went outside when asked to comeinside at 6 pm they refused to do so and at 7.45 while three security officers were escorting the victim into the West wing (rehab) she was attacked by the girls. The CI refers to a statement from the victim AL but none is attached. Report of 1.10.16 also written by Roach refers to an absconding by the same 5 girls. According to the report on duty at the time were care givers Stapleton and Sobers -Norville. The report of the caregivers states that the girls were at a meeting at Marie Gorietti house to discuss an urgent matter when tempers flared. They all left the house and went outside. When the girls were called inside the five girls refused to go into the dorm.While outside Mr. Medford ??? came to the gate According to the report "information recieved is that they all blocked the gate when he attempted to enter the tunnel and as he stepped through they all bolted through and left the compound. LM in her interview does not seperate the two incidents. She admits that she and the other girls beat up the other resident but says that the beating was as a result of instigation by a member of staff Ms. Paul. According to LM while they were beating her the staff came to pull them apart and in their haste left the gate unlocked and they ran. According to her the girl did not press charges but Management did.	CI report dated 17.10.16 and Serious Incident report dated 16.10.16 (found in file dated 22.10.16). Intervei w with LM on 29.09.21	There are inconsistencies in the version presented by St. Judes namely the presence of Ms. Paul on 14.10 and the number of security officers present on 16.10. Furhter it is difficult to accept that the girls would have atttacked Lyken while she was being escorted by 3 security officers. Further with respect to 16.10 whay would Medford open the gate when the girls had already flocked towards it. Also of concern are the dates when the reports were made. Both incidents occurred over a weekend. The CI report for 14.10 indicates that it was made by Ms. Roach on 17.Dec. The serious incident report of the 16.10 simply bears that date 16.10 and the time 5.48 which was the time of the incident. it is clear that the form could not have been filled out at that time. it is to be noted that the form itself requires that it be filled out within 12	HIGH	to await hearing from Ms. Roach. However even if the version profferred by St. Judes is to be accepted gross negligence has been shown with respect to both incidents.The intentional delays to intervene to prevent or de-escalate fights and conflicts among residence demonstrates clear negligence and failure to safeguard the children in care. The practise of staff instigaing fights amongst residents consitutes a failure to saefguard the children within care	In a bid to provide for the safety of children in care, staff found to be instigating fights among residents by committing or ommitting acts, as well as failing to prevent or descalate fights, must be held accountable for failure to safeguard and face disciplinary measures.

HOME / CENTRE	AREA OF INVESTIGATION (1)	AREA OF INVESTIGATION (2)	RAW DATA (FACTS)	DATA SOURCE	FINDINGS	RISK TO CHILDREN	CONCLUSION	RECOMMENDATIONS
					hours of the incident. (At this stage I tend to prefer the version given by Ms. M).			
Swaha			Location: off a main road, two gates before getting to the building. Low risk. Staff: Manager and house facility officer were present. Manager has a BSC in Social Work and caregivers must have at least 5 CXC passes and certificates in childcare is advisable. Residents:Ages 10-22 (past resident with mental challenges): 10 girls and 1 boy (do not usually accommodate boys but it was a family who came together). Staff to children ratio-6:1. Home:Operation for 11 years. Licensed and awaiting renewal certificate. 5 bedrooms, 3 of bedrooms have 3 beds and 2 bedrooms have 2 beds. Have external and internal security cameras (none in bathroom or bedrooms). No security. Manager monitors cameras. All checks are done at night and doors of bedrooms are left open. Well managed operations: house is very cleaned. Toilets and Baths sufficient for number of children. 4 upstairs, 2 downstairs and a separate one for the staff upstairs and downstairs.	Site Visit and Onsite Interviews		LOW	Home seems well managed.	CATT to follow up more often.

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			They have a medical kit kept in the office. Battery operated light, they are about 15 mins away from health center and private doctor close by. Yard space to the front and a play park available. No ac. Rooms are large and airy. No phones allowed and children only have devices for school. Study area is a library and a lobby. If needed the playroom can be additional space to study. Criteria to join home is female with no disabilities. Fire drill once a month. Completely vegetarian home. Children have personal files and staff have access to them. Their written policies have to be sent to investigation team. CATT: Since CATT has begun to manage the home, only 2 children have been placed there: not much interaction from CATT and no assessments conducted. Only one child has ADD and she is on medication. The home is concerned about the lack of attention from CATT on the children who were not placed there by them.					
Tacarigua Center	ABSCONDING		While at site visit the Team witnessed an attempted absconding despite the presence of the secutiry guard sitting in the driveway. The tezam was informed that the team lead had to call CATT and they will direct him as to what the next step is as opposed to immediately calling the police.	Discussions during site visits	current system undermines the security measures for preventing and managing absconding	HIGH	the current process facilitates many opportunities to abscond.	The procedure for absonding or emergencies need to be clarified.
Tacarigua Center	SEXUAL ABUSE	FAILURE TO SAFEGUARD	sexual interaction between residents- 3 boys ages 12 and 13, 1 girl aged 10. Boys in bedroom watching movie- girl asked to watch movie- given permission to watch from the corridoor. Girl entered the room. There was inappropriate sexual touching and boys masturbating. One boy kept watch. One caregiver present who admits that she left briefly.	Critical incident report dd 2. 08. 20 undated interviews with children contained in Critical incidents file	Caregiver ought not to have given permission for the child to watch the movie while the boys were in the bedroom and should not have left them unattended.	HIGH	poor supervision by staff	Proper protocols need to be put in place to prevent inappropriate interactions between residents. Supervision ought to be increased where the residents are of different sex.
Tacarigua center	SEXUAL ABUSE	FAILURE TO SAFEGUARD	consensual sexual interaction between residents- 4 boys (1 boy referred to in incident above) and 2 girls (one of whom was referred to in incident above) Incident happened while children were supposed to be cleaning their bathrooms and while caregiver was in the corridoor sweeping. Two of the boys stood outside keeping watch	Critical incident report dd 20.04.20	caretaker should have at least been alerted by the two boys outside keeping watch	HIGH	poor supervision by staff	CSC to institute and implement clear policies re supervision of children especially where the residence houses chilldren of both sexes.
Tacarigua Center		PHYSICAL ABUSE	Arguement between resident and caregiver Caregiver physically held child causing her to have scrapes about her neck and back	Critical incident report dd 11.05.20	unnecessary force used by caretaker	HIGH	physical abuse by staff	CATT should institue a no tolerance policy re physical abuse by staff. draft policy on behaviour

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								management should be revised in accordance with Team's recommendations and implemented
Tacarigua Center	SEXUAL ABUSE	FAILURE TO SAFEGUARD	Aliane Reed reported that a resident aged 15 years engaged in sexual intercourse with security officer Kevin PHillip	critical incident report dd 24.09.20 22.10.20		HIGH	child sexual abuse by security officer	Ensuring that staff recognises mandatory reporting.

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Tacarigua Center	FAILURE TO SAFEGUARD		The home can accommodate 12 children maximum, however they have 14 children currently. The home is in a residential area (iron fenced railing in front of house, 6-8 feet walls in height in front and 6 feet to the sides and back of home with mesh wire. About 1/2 lot of yard space to the back of the house. Staff to children ratio is higher than in any other home. 2 nurses, 2 caregivers, security guards on perimeter watch and security cameras operational. Staff share space, e.g. team lead, psychologist, house mother. So no private space for psychologist to interview children. At this point, the psychologist only does check-ins because there is no private room for her to do therapy or assessments. The room where children are expected to do their schooling (with computers present) is also the living room and a common area for other residents. 2 beds downstairs room for 3 beds each with 1 bathroom and toilet facilities for residents. There is a room for orientation that has toilet used for staff only. Kitchen has the cook and assistant; The house mother keeps her files in the kitchen. Child Service Advocates usually prepares lunch sometimes. Foyer area is used as a study room too. 4 bedrooms upstairs, each can hold 3 beds (1 is used as a quarantine room). Only 1 bathroom and toilet upstairs that is available but at this time it is out of commission totally sealed off with yellow tape and padlocked. Therefore, there is only 1 bathroom and toilet available for the entire home of 14 boys at the moment. The quarantine room has its own bathroom and toilet. A security is placed outside the door on a chair to ensure the child does not break quarantine. The home provided reading material/ tablet for child to keep occupied. The one room for quarantining is not enough in the event that there is more than one child who may have Covid-19. There is a stairway to lead downstairs to the back of the house, but it's closed off and it is only supposed to be used for emergency or new residents coming in. It has burglar proofing. However, the burglar proofing needs to be re-enforced and upgraded. No kind of privacy at the home for the staff. Child Service Assistant also present. A room at the side of the house that the head of security uses. There are security cameras present except for dorms and toilets. Never had a fire drill since before 2019 and team lead seems not to be knowledgeable about a lot of safety questions. Team Lead feels like they are not respected for their roles and recommendations to improve the home's security have been futile. There is a room downstairs that has a leak from the upstairs bathroom that is out of service and there is mold on the wall. The place looked dirty, walls were dirty, at least 9/10 doors are broken and are patched with cardboard (the children broke the doors). Covid-19 cases: Persons who have covid or in quarantine: 1 CSA, 1 house mother, 1 security guard and 4 boys (in Caura Hospital for being Covid positive).			MEDIUM	Lack of confidential space for psychologist to assess and provide confidential services.	1. Proper Behavioral Intervention Plans for children with severe behavioral dysregulation. 2. Proper confidential space for the psychologist to provide clinical services. 3. Security infrastructure improved.

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			Absconding incidents: *At the time that the 5 boys absconded, there were 16 boys. The boys escaped by jumping on top a kennel in the back of the property and scaled the wall. Poor security: *The boys at Caura have tried to abscond 2-3 times already. One of the boys (R) who a trying to abscond from the hospital have absconded 4 times already from that center. One of the times, R was missing from March to June. The 4 boys at Caura are giving the hospital officials a very hard time. The boys have been brushing their teeth and spitting out the window and the spit lands on persons passing underneath the window. The boys are mixing with the patients there and borrowing phones and making all kinds of contact with persons from the outside. The staff at the home are very concerned as to what will happen given the nature of the boys and the connections that they have on the outside. R. assaulted an elderly man twice at the hospital. R. has been diagnosed with ADHD and conduct disorder by the psychologist. Police was called in several times before to speak to the boys before the absconding occurred. However, to ease the home and the boys being together at the police station together, they were sent 2-3 at a time. However, when they came back, the boys were more aggressive and energized than before they had gone. It seems like the talk with the police caused the boys to feel more empowered, entitled and emboldened with aggression. CATT involvement: CATT seems to be disconnected with what is going on at the homes. When the home goes on lockdown the staff is expected to sleep on the floor both males and females and they were told by CATT that they would get compensated, but this never occurred. Residents: One of the boys looks depressed and has been prescribed medication however the mother (cannot look after him so he now a ward of the state) refused to allow him to take it but it seems like he desperately needs the medication. One of the other boys (15 years old) vocally stated that he wants to get out of "here" and "the only thing Iz do inside of here is eat, shit and sleep" and he repeated it constantly. When asked why he was there by a committee member, he stated that his mother brought him before the court because she could not deal with his behaviour anymore which included the following activity: smoking marijuana (since he is 7 years old). Another boy stated "this place is not nice you know. I doh know what they telling allyuh but this place not nice". This boy was placed there by his mother (beyond control), and he ran away from home and was located in some house. He stated that "they does promise you a setta thing in here and then don't do it. I just want to get out of here". The interviewer from the committee, believes at any given opportunity that the two boys will abscond.					

HOME / CENTRE	AREA OF INVESTIGATION (1)	AREA OF INVESTIGATION (2)	RAW DATA (FACTS)	DATA SOURCE	FINDINGS	RISK TO CHILD REN	CONCLUSION	RECOMMENDATIONS
			Did not get to speak to T one on one but a medical report was seen by Aisha where there was abrasion to the anal area which the team lead was unaware of. T is constantly antagonizing the female staff members and making sexual advances at them. He has a history of abuse and is clearly troubled and requires additional assessments by the psychologist. Room containing electronic survillence equipment locked after hours and on weekends					

HOME / CENTRE	AREA OF INVESTIGATION (1)	AREA OF INVESTIGATION (2)	RAW DATA (FACTS)	DATA SOURCE	FINDINGS	RISK TO CHILDREN	CONCLUSION	RECOMMENDATIONS
Valsayn	ABSCONDING	PHYSICAL ABUSE	The responsibility of the CATT is to promote the well being of children; to provide care and protection for vulnerable children; to comply with certain obligations of the UNHCR; and comply with certain obligations under the United Nations Convention on the Rights of the Child.Security Personnel are prohibited from torture, degrading treatment, discrimination and must use minimum force. There are areas in the Valsayn center that are not covered by Surveillance. Residents have stated that they are abused in these rooms by the security guards, nurses and care givers. Critical Incident reports from 2019 to 2021 have boys being escorted to these areas where no surveillance exist after disruptive incidents where they are "spoken to". Physical abuse has been identified by residents. Perpetrators identified included some nurses and security guards. It included picking up the residents, slamming them down and bashing their heads against an object repeatedly. The residents do not report to the CSAs any more.	Ch 46:01 sec 3 para a. FAHSSE Manual :Guidelines in the Use of Security Personel from Private Security . Maslows Theory of Hierarchial Needs. Site visit and interview with Team Lead, Interview with Ms Hailley and Interview with three residents from Valsayn where they all identify the areas of the upstairs corridor and the rooms as areas without surveillance. Intervie	1. CATT do not meet the security requirements in all areas.2. Risk assessment is not used in behavioral management by security.Unity of command is absent in this facility.3. Mixture of CHINS and C&P, results in a tumultous environment. 4. Managemnet does not take into account the children's explanation of incidents.5. Many interactions are deliberately held in unsurveilled spaces. Critical incident reports also show that interactions occur in unsurveilled spaces.6. Security is called upon to discipline residents, in breech of CATT policy.Multiple residents have supported this statement that secuirty guards physically abuse them in unsurveilled spaces7.Children are subjected to degrading comments based on sexual oreintation from guards.8.Team lead does not take corrective action to prevent further abuse.	HIGH	Children who are being physically mistreated and feels unsafe will naturally attempt to relocate. Children in secured facilites who feel unsafe will therefore attempt to abscond.	1. Reevaluation of surveillance system to identify gaps in security camera surveillance. 2. Curriculum development for the training of officers on behavioral management, de escalation and conflict management is necessary to bridge the gap of abusive practices performed by security officers or persons required to physically protect the children. YTRC re-taining programme for Prison Officers may be consulted with. They are currently the most experienced service where this is concerned. Additionally international best practices and new emerging practices should be researched to provide this high quality training. 3. Standardization of practices and unity of command chain. 4. The camera feed must be available 24/7 and monitored externally. 5. Criminal charges are required against officers who perpetrate abuse. By moving a security to a different post perpetuates the cycle of abuse to other children.

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				w with Rolando, Steven and Nigel. Cls dd 12/9/19 ; 20/9/19 ; 2/5/20; 2/6/20; 21/1/21 ; Interviews with Nigel, where he stated that, "I does get lash, but I does take my lash normal normal" He identified the persons who do this by saying, "Rivers and Baker." Steven clearly stated in his interview, "Nurse Vincent does lift me up and slam me down." He also identifie				

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				d that SO Birchwood also does this.Birchwood and Joseph Vincent. Rolando claims in his interview that his head is bashed against the cupboard over and over. The interviews with the residents also revealed that the abuse occurs in areas without cameras and that guards use the term "restraining" to justify their actions.				

HOME / CENTRE	AREA OF INVESTIGATION (1)	AREA OF INVESTIGATION (2)	RAW DATA (FACTS)	DATA SOURCE	FINDINGS	RISK TO CHILDREN	CONCLUSION	RECOMMENDATIONS
Valsayn Center	ABSCONDING		The home can accommodate maximum 12 children, however they had 14 children at the time of visit. The home is in a residential area and the two houses on either side are in close proximity. The facility has: iron fenced railing in front of house; 6-8 feet walls in height in front and 6 feet to the sides and back of home with mesh wire; approximately 1/2 lot of yard space to the back of the house. Staff to children ratio is higher than most homes visited in the investigation. 2 nurses, 2 caregivers, security guards on perimeter watch and security cameras operational. Staff does not have designated and confidential spaces. For example the team lead, psychologist and house mother share the same space. No private space is designated for the psychologist to interview children. At the time of this interview, the psychologist could only do check-ins because there is no private room for her to conduct therapy or assessments. The room where children are expected to do their schooling (with computers present) is also the living room and a common area for other residents. There are 2 bedrooms downstairs with room for 3 beds each with 1 bathroom and toilet facilities for residents on that floor. There is a room for orientation that has one toilet used for staff only. Kitchen is manned by a cook and an assistant. The house mother stores her files in the kitchen. Child Service Advocates prepares lunch occasionally. Foyer area is also used as a study room. 4 bedrooms upstairs, each can hold 3 beds (1 is used as a quarantine room). 1 bathroom and toilet is available upstairs. At the time of this investigation it is out of commission, totally sealed off with yellow tape and padlocked. Therefore, only 1 bathroom and toilet is available for the entire home of 14 boys at present. The quarantine room has its own bathroom and toilet. A security guard is placed outside the door on a chair to ensure the child does not break quarantine. The home provided reading material/ tablet for child in quarantine to keep occupied. The one room for quarantining is not enough in the event that there is more than one child who may have Covid-19. There is a stairway to lead downstairs to the back of the house, but its closed off and it is only to be used for emergency or new residents admitted. The stairway has burglar proofing. However, the burglar proofing needs to be re-enforced and upgraded. No kind of privacy at the home for the staff. There is a room at the side of the house that the head of security uses. There are security cameras present except for dorms and toilets. No fire drills conducted since prior to 2019 and team lead seems not to be knowledgeable about several safety questions. Team Lead feels like they are not respected for their roles, and recommendations to improve the home's security have been futile. There is a room downstairs that has a leak from the upstairs bathroom that is out of service and there is mold on the wall. The place looked dirty, walls were dirty, at least 9/10 doors are broken and are patched with cardboard said	Site Visit and Onsite Interviews with residents and Staff	There is overcrowding at the home Staff does not have designated Office spaces nor adequate storage for official files No confidential spaces for therapetic interventions for children, Children are not receivcing full therapeutic sessions and assessments due to inadequate accommodations Inadquate spaces for COVID quarantine as one quarantine room exist Insufficent operable toilet facilities No designated space for schooling and study Fire drills have not beeing performed for years. CATT is disconnected from the activities and situations experienced at the CSC by both Staff and residents Notable absence of structured	HIGH	the current process facilitates many opportunities to abscond. Mixture of CNPs and CHINS seem to be a major problem. Overcrowded .	Speak to the psychologist, T and the two vocal boys (who may abscond) further to get more insight on what is going on. CATT needs to put better regulations/ policies for CNPs and CHINs children, for eg. separating the beyond control from those who were abused. CHINS should be viewed better instead of the aversion attitude where nobody wants to deal with them. CATT should be made aware of this and provide better assessments and scheduling of assessments. Interview with Ms Beverley John needed. Need to improve how the home engages the children. The center needs to be refurbished.

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			to be broken by the children. Covid-19 cases: Persons who have covid or in quarantine: 1 CSA, 1 house mother, 1 security guard and 4 boys (in Caura Hospital for being Covid positive at the trime of visit). Absconding incidents: *At the time that the 5 boys absconded, there were 16 boys. The boys escaped by jumping on top of a kennel at the back of the property and scaled the wall. Poor security. *The boys at Caura have tried to abscond 2-3 times already. One of the boys (R) who tried to abscond from the hospital have absconded 4 times already from that CSC. One of the times, R was missing from March 2021 to June 2021. The 4 boys at Caura are giving the hospital officials a very diffcult time. The boys have been brushing their teeth and spitting out the window and the spit lands on persons passing underneath the window. The boys are mixing with the patients there and borrowing phones and making all kinds of contact with persons from the outside. The staff at the home are very concerned as to what will happen given the nature of the boys and the connections that they have on the outside. R assaulted an elderly man twice at the hospital. R has been diagnosed with ADHD and conduct disorder by the psychologist. Police was called in several times before to speak to the boys before the absconding occurred. Also, to ease the home and the boys being together towards unhealthy behaviours, they were sent 2-3 at a time to CATT Head Office. However, when they came back (from CATT Head Office, the boys were more aggressive and energized than before they had gone. It seems like the talk with the police caused the boys to feel more empowered, entitled and emboldened with aggression. CATT involvement: CATT seems to be disconnected with what is going on at the homes. When the home goes on lockdown the staff is expected to sleep on the floor both males and females and they were told by CATT that they would get compensated, but this never occurred. Residents: One of the boys looks depressed and has been prescribed medication however the mother (cannot look after him so he now a ward of the state) refused to allow him to take the medication/. One of the other boys (15 years old) voiced that he wants to get out of "here" and "the only thing is do inside of here is eat, shit and sleep" and he repeated it constantly. When asked why he was there by a committee member, he stated that his mother brought him before the court because she could not deal with his behaviour anymore which included the following activity: smoking marijuana (since he is 7 years old). Another boy stated "this place is not nice you know. I doh know what they telling allyuh but this place not nice". This boy was placed there by his mother (beyond control), and he ran away from home and was located in some house. He stated		activities for the development and well-being of the residents Staff and Team Leads do not feel respected by CATT Management. Limited actions are pursued towards the well being of residents.			

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			that "they does promise you a setta thing in here and then don't do it. I just want to get out of here". The interviewer from the committee, believes at any given opportunity that the two boys will abscond. Did not get to speak to Stephen Antoine one on one but a medical report was seen where there was abrasion to the anal area which the team lead was unaware of. Stephen is constantly antagonizing the female staff members and making sexual advances at them. He has a history of abuse and is clearly troubled and requires additional assessments by the psychologist. Room containing electronic survillence equipment locked after hours and on weekends					

HOME / CENTRE	AREA OF INVESTIGATION (1)	AREA OF INVESTIGATION (2)	RAW DATA (FACTS)	DATA SOURCE	FINDINGS	RISK TO CHILDREN	CONCLUSION	RECOMMENDATIONS
Valsayn Center	ABSCONDING	FAILURE TO SAFEGUARD	Valsayn is a Child Reception Center in accordance with the Children's Authority Act (CA) Section 14 Ch. 46:01. Temporary Care of a child includes the security of a child. Valsayn center was not physically designed to contain children with intent to abscond as stated by the Team Lead. It was also not designed to house more than 10 children. The present numbers of children in the centre is 14. There were six security guards, a nurse and two care givers at the facility when the five boys absconded. Camera surveillance is sufficient on the perimiter to detect any unauthorised movement into or out of the facility. The facility is small and the perimiter easily patrolled by one security guard as seen at the site vist to the facility. The security guards are not monitoring the feed from the surveillance on a 24/7 basis as revealed in the interview with the Team lead at the site visit. The ratio of supervision to the residents is supposed to be 1:7. The absconding of the five boys took place on a Saturday and the surveillance feed was not available as it is only available during normal working hours on a weekday.The ratio of the staff to residents was eight to one on the 20th March 2021. The nurses and security guards are not counted in supervision staff for the purpose of the ratio. High risk children are put in Valsayn since St Michaels closed down. the ratio of caregivers to children is still 1:8 as of 12th November 2021 in accordance with Mr Ritchins' interview.Mr Ritchins stated that the facility is overcrowded and they asked for relocation to another facility.	Ch. 46:01 sec 14. , para 3. Interviews with Mr Ritchins. Interview with Ms. Ayana Hailley. Site visit of the facility. Safeguarding Manual. Interveiw with Mr Ritchins on the site visit. Cl dd 30/1/21. Interview with Ms Celestine and Mr Ritchins.	The number of security guards are sufficient to keep coverage of the compound at Valsayn as one guard on the perimiter has sight of the entire perimiter walking at 60 paces per minute and one pace being 12 inches or one foot in three and a half minutes. The absconding occured over a five minute period based on the times reported in CIs and the Internal Audit Report. The facility is too small for the number of residents. The perimeter is easily breeched. The guards were not efficiently deployed. Overcrowding at the facility. High risk children are placed in Valsayn since St Michaels closed down The surveillance feed was not being viewed as the feed is available in a room that is locked when the	HIGH	The act of absconding is permissible based on a failure of some aspect of security. Staff to resident ratio does not meet best practice model as is recommended by CATT as per Joint Select Committee submission dated April 9, 2021 Children were not placed in a facility with the resources to manage their absconding risk. Once the facility is completely secured the act of absconding will be effectively barred. The 6 security guards at the time of the five boys absconding and the 7 security	The surveillance feeds must be available 24/7. CATT to ensure that staff to resident ratio must meet best practice model as is recommended by CATT as per Joint Select Committee submission dated April 9, 2021, if it means hiring more staff and/or creating more centers. Security must receive more training in managing and securing a facility. Children must receive risk assessments prior to being placed at a facility and risk assessments must be updated regularly. Children must be placed in facilites that are adequately equipped in managing their risks.

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					senior CATT Security Guard is not on the compound. The absconding of the five boys occured when the camera feed was unavailable. The attempted absconding two days earlier took place after hours and hence the surveillance feed was also not available. The absconding with RD took place after hours and again during the time when the surveillance feed was not available.		guards now, are more than sufficient based on the posts that are required filling. These posts are: 1.the surveillance feeds; 2.the reception area (during working hours), 3.assistance to the facility's staff; and 4. perimeter patrol. A major element that facilitates the absconding at this facility is the lack of availability and utilization of the surveillance feed on a 24/7 basis.	

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Valsayn interview (5 boys)	PHYSICAL ABUSE	FAILURE TO SAFEGUARD	N.B.: Got to the home in 2019, he had conduct disorder, ADHD, intellectual disability from the psychological assessments that were there. He is on medication and has a history of abuse. He absconded (by himself and he came back) once at the home "he thought the home wasn't worth it no more". He is easily influenced sometimes and other times he has a level of independence and can do what he wants to do. The security staff when using restrains tend to become abusive with the boys. The boys mentioned that the security officer Mr. Birchwood would choke the boys, slam them on the wall, push them, curse and hit them. N said that the house mother (Amanda Daniel) usually takes matters into their own hands. There is this book that the complaints are meant to be placed in but when complaints are made, it is not recorded, or the report is diluted. The books are not inspected and there is no higher person to go to, to make complaints. (J)One resident has allegations of him sexually abusing peers at a previous home. Seemed very reserve and barely spoke. (RJ)Another resident identified as a CHiN ordered to the home by the court. No history of abuse, medical reports say that he is generally healthy but there is no psychological assessments on his file (no physical file staff had to print all related documents from him). History of stealing, sexual advances, poor academic performance. Boys speaking to R a lot but he seems very aggressive. Security guards mentioned in abuse and misconduct: Mr. Rivers, Mr. Baker, Ms. Cummings (buts into the boys convos). R has been to several homes and have several siblings in the system. R did not want to share on the Valsayn incident. S (15 years old: Guardian Carol Alexander): was present in the absconding situation. The boys are allowed to get devices but its very restricted and social media is not allowed on them. Currently the boys are separated from the other boys downstairs and cannot speak to them. He ran away from his mother's home as he said she use to abuse him and went to live with the Guardian and then ran away from the guardian. He mentioned that Nurse Vincent also abuses the children by hitting, slapping and cuffing and even jack someone on the wall. The staff behave very differently in the corridors verses in closed rooms, as the corridors have cameras. The house mother does not believe the boys. The house mother takes a picture of the book and claim to do something about it. Makes a lot of sexual advances and once bit off a piece of someone's ear without any remorse. C:Mr. Mc Intyre (security) is said to make the boys feel emotionally distress when they ask about their court dates. The security will say things like "you not leaving here, why you asking me that". "You staying here forever". The boys are not allowed to get the devices more than 2 hours a day (7pm-9pm) which is not enough time to do their homework. Boys not allowed to engage in any activities e.g. football together or do anything else. The food is not enough; staff fills up their plate and leaves with	Site Visit and Onsite Interviews	Residents reported there have been occurence where staff and security use excessive force. Security engage in excessive use of force when restraining residents. Security emotionally abuse residents. Residents have no faith in the current complaint reporting procedure.Children with behaviors that are high risk to harm themselves and others, are placed at this facility.	HIGH	There are complaints of abuse by staff and security that go unreported. The complaint reporting procedure is inadequate. The number of residents with high risk behaviors and the lack of adequate staff trained in developmentally appropriate, trauma-informed behavioral management approaches, allows for abuse to occur. Security untrained in using restraint with children, leads to use of excessive force and physical abuse.	Criminal investigation into reported incidents of physical abuse.Establishment of an independent body to receive confidential reports of child abuse from residents and staff, and has power to take action independent of CATT. Staff to be trained in developmentally appropriate, trauma-informed behavioral management approaches Staff to be trained in developmentally appropriate, trauma-informed use of restraint.All residents should receive a risk assessment prior to placement. Resident should only he placed in a facility with adequate staffing, procedures and services that can mitigate and protect against their risk.

HOME / CENTRE	AREA OF INVESTIGATION (1)	AREA OF INVESTIGATION (2)	RAW DATA (FACTS)	DATA SOURCE	FINDINGS	RISK TO CHILDREN	CONCLUSION	RECOMMENDATIONS
			it, but the boys get very little food (Investigative team saw the security guard with a huge plate of food and eating it in front of the boys). Usually get a cup of porridge for breakfast.Ms. Villeuial: one of the residents forced a broom stick up another resident's anus but when the boy was asked about it in the interview, he said there was no history of sexual abuse (inconsistent reports).					
YTRC			The center is highly focused on the care of the children as best as they can. There are lot more resources in this center to ensure the children are well taken care of. For eg. HSSE guidelines were followed. 2 psychologist and 4 welfare officers and correctional officers present.	Site Visit and Onsite Interviews		LOW	Home is well managed.	A conversation with National Security is needed to understand how the regulation is act is about to be carried out to meet the needs of the homes. Some residents at this center need to be interviewed especially on the abuse that may be taking place. CATT can use this center as an example for other centers to follow in terms of regulations and

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								policies. Mentorship programme needed to guide youths in the right direction.
St Dominics -Sunnyhill	FAILURE TO SAFEGUARD	SEXUAL ABUSE	Non-staff member allowed frequesnt interaction with residents, getting close to residents and their family, resulting in sexual abuse of resident	Incident report May 20th 2019	Failure of staff to identify and protect residents from grooming and thus sexual abuse	HIGH	Staff lack knowledge and training in identifying and preventing sexual exploitation of residents. lack of proper vetting of volunteeers, non-staff members, other members of public prior to interacting with residents	Staff training in identifying child sexual rexploitation and grooming behaviuors. protocols and policies to be established for the interactions with residents with volunteers, non-staff members and other members of the public
St dominics	FAILURE TO SAFEGUARD	ABSCONDING	"...Staff noted that S's cellphone was observed in her possession. Staff pursued the resident, however she jumped the wall of the compound.."Another incident -altercation between residents, residents absconded by jumping fence and one returned with relatives armed with weapons. Current surveillance system is extremely limited and non-functioning. The perimeter fence is compromomised.	CI dd 9/10/20 , CI dd 30/4/20 Site vists/on site intervie ws	Inadequate supervision of electronic device use. Inadequate Surveillance system and fencing	HIGH	current security system is compromised and facilitates opporunites for absconding and makes it vulnerable to intrusion from external violence	Implementation and enforcment of standardized requlations for perimeter fencing and electronic surveillance policy

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St dominics	FAILURE TO SAFEGUARD		resident ate rat poison in food that was placed by another resident. Staff ratio-2:8 or 1:1 if necessary	CI dd 20/1/20 Site vists/on site interviews	Staff ratio adequate .inadequate supervision allowed resident access and opportunity to poison food	HIGH	Staff ratio meets standards but poor supervision procedures, facilitates opportuites for child endagerment Children have access to poisionous substances.	Needs to be closer supervision of children. Policies and procedures for supervision of children need to be established Ensure hazardous compounds are not in reach of children. Establishment and enforcement of policies regarding storage of harzadous substances.
St. JUdes		PHYSICAL ABUSE	2 girls absconded on 16.09.20 and returned to the home on the same night. Absconsion occurred when Member of Staff left the house to visit another House and girls left unattended. (admitted by staff member) Investigation by CATT confirmed that on their return the children were handcuffed. Child alleges handcuffed to a gate for whole night and hit several times by Security Guards including Ms. Myers. other child confiirms handcuffing. Deputy Manager admits giveng Security Officers instructions to handcuff girls. Security guard admits pushing one of the girls up the stairs and that they were both handcuffed first to the gate and then while in bed. No action taken by home or CATT. Note no Critical incident form sent to CATT CATT only advised of incident when report made by one of the child's grandmothers	report containing interviews with key players. Interview with Ms. Frogat-Miller child's Grandmother.	no Critical incident report made to CATT, children handcuffed, physical abuse by security guard, Inappropriate security procedure resulted in absconding. no disciplinary action taken against Staff	HIGH	Improper means of restraining children used in the Home, Assualts by Security Guards condoned. No police reports made No reporting to CATT as required by Regulations	Disciplinary measures should be taken against the member of staff for leaving children unsupervised and against the deputy manager for authorising the use of handcuffs. Consideration be given to bringing charges in accordance with section 17A(2)(c) of the Children's Community residences Foster Care and Nurseries Act against the deputy Manager Mr. Deoraj Sookdeo and Ms.Myers for authorising the use of handcuffs and inappropriate use of force towards the children

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St. Judes	PHYSICAL ABUSE	FAILURE TO SAFEGUARD	incident occurred on 9.10.20 riot in two houses fires started and police called out. Damage to premises. Complaint by resident Destiny Odle not involved in altercation of beating by police. Home refused to allow her to make a report. Pictures of injuries to child attached to report. CATT investigation makes no recommendation to treat with resident's allegation.	Licencing and Monitoring complaint form 2.10.20. Interviews with O and LC	Resident not allow to make report about injuries sustained. No evidence of action taken by Home or CATT	HIGH	reports by residents of assault by the police not treated with any seriousness by the Home or CATT	The Home needs to have proper measures in place to treat with complaints of abuse by residents. CATT needs to investigate these complaints in accordance with its statutory mandate Establishment of an independent body to receive confidential reports of child abuse from residents and staff, and has power to take action independent of CATT.
St. Judes	PHYSICAL ABUSE	FAILURE TO SAFEGUARD	Nurses station broken into and medication stolen- caregivers distracted while girls kicked a hole in the door to the nurses station. incident discovered by CATT on a routine monitoring visit 3 days later. Reccommendation for the relocation of the medicines not immediately actioned.	L & M Complaints form. dd 21.04.20 confirmation by Acting Manager in interveiw dd 19.11.21	inadequate supervision of girls in terms of number of staff and quality of supervision No proper security with respect to storage of medication;	HIGH	staff to child ratio inadequate; staff not properly trained to provide adequate supervision for the degree of behavioral managemnt the girls in the Home require management poor	Ensure that staff to resident ratio follows best practice guidelines Establishment and enforcement of policies and procedures to ensure adequate supervision for children of varying developmental levels as well as varying degrees of behavioral disturbances. Staff need to be trainined in proper supervision Establishment and enforcement of policies regarding storage of harzadous substances, including medications.

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								Management in the Home needs to be improved
St. Judes			Complaints of child victims made to CATT by CTU on their behalf : number of incidents involving child victims of human trafficking- included:- verbal and physical abuse by other residents;-some in the presence of staff;-verbal abuse by staff and-refusal of staff and management to take steps to protect the victims;-inability to make phone calls to access hygiene products --request by victims to be housed in the Rehab "prison" for their own protection. -translator unable to continue as experiencing problems with the Home but would be willing to continue working with the children if they are in another location.-No action taken by CATT with respect to complaints except to endorse the girls removal	L and M Complaint monitoring form dd 5.02.20. Interviews with victims dd 11.11.21 and 12.11.21 Meeting with Director CTU - Wheeler	Management of the Home not responsive to the complaints of abuse;- routine monitoring of Home by CATT not adequate to address complaints made by child victims;-Inadequate response by CATT representative to treat with complaints-Failure of CATT and the Home to safeguard the child migrant victims	High	conditions under which child victims housed contravenes their rights under the Human;-CATT monitoring system inadequate to deal with issues;-St. Judes not appropriate location for migrant child victims of trafficking;-Ineffective management by home in managing child vicitms of trafficking	Immediate actions are required to provide appropriate accomodation for migrant child victims of trafficking in accordance with our international responsibilities and the Persons in Trafficking Act.

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St. Judes	FAILURE TO SAFEGUARD	PHYSICAL ABUSE	Meeting held Jan 2020 between staff and CATT staff arising out of injury of a member of staff by residents (see below). Complaints by Staff re overcrowding - 9 girls over capacity; at time staff to child ratio could be 1 :21 when members of staff did not turn up. problems with child victims: fight among themselves, do not accept what is offered to them; make complaints to CTU when they do not get what they want and report to CTU mistreatment by staff and residents	L& M Complaints formdd 9.01.20. Confirmation as to complaints to CTU by victims in interviews dd 11.11.21 and 12.11.21. Confirmation on overcrowding and staff to child ratio in excess of reccomended number from interveiw with Ag. Manager Ms. Bruce.	Overcrowding at St. Judes; poor supervision; staff to child ratio exceeds the reccomended number; staff unclear of their role with respect to child victims and the role of CTU with respect to them	HIGH	Severe overcrowding in home; Staff to child ratio not in accordance with best practice model as indicated in CATT guidelines(3:1) as contained in submission to JSC in April 2021; systemic problems with respect to the presence of child victims of human trafficking; There are Communication issues between CATT/St Judes and CTU	CATT must take steps to prevent overcrowding of Home; CATT to prioritize increasing number of homes CATT placement policy to be reveiwed;CATT 's placement in the Home must not exceed the capacity of the Home CATT to establish and enforce staffing best practice model not only to CSC but also to CR- children at CR and CSC should benefit from best practice model. Staff to child ratio must not exceed 3:1; increase if staff necessaory Procedures to be established to maintain best practice staffing standards in emergency situations, such as staff shortages. Immediate actions are required to provide appropriate accomodation and treatment for migrant child victims of trafficking in accordance with our international responsibilities and the Persons in

HOME / CENTRE	AREA OF INVESTIGATION (1)	AREA OF INVESTIGATION (2)	RAW DATA (FACTS)	DATA SOURCE	FINDINGS	RISK TO CHILD REN	CONCLUSION	RECOMMENDATIONS
								Trafficking Act. Communication between CATT/St Judes and CTU as to defining their roles, methods and policies on communication and treatment of child victims of trafficking management of the Home needs to be improved.

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St. Judes	PHYSICAL ABUSE	ABSCONDING	9.01.20 one staff member on duty Staff member hit over the head with a toilet tank cover. While being attended to by one of the residents another resident called for the staff member's assistance The staff member gave the keys to the matron's room to the resident who was attending to her and instructed her to take what was needed. Girls used these keys to gain entrance to the Matron's room, kicked out the windows and jumped the wall into St. Dominic's grounds. Two children (Venezualans) were injured(leg broken). Told by Ag. Manager to get up and walk. All girls taken to "tennis room" by security. No indication they were immediately taken to hospital. No Critical incident form filled out.	L & M complaint form dd 9.01.21	Poor supervision: Inadequate staff on duty; Serious security breach by staff member; No consideration by manager re need for medical attention; critical incident reporting procedure not followed.	HiGH	Staff to child ratio is not in accordance with recomedations from CATT as per Joint Select Committee submission dated April 9, 2021 ; Security lapses by member of Staff No immediate medical attention pursued for the injuries of girls	CATT must enforce its staff to child ratio policy; CATT must insist that the Home conform with the submission of Critical incident report in accordance with the regulations; CATT must establish and enforce a policy of ensuring that once a child suffers any injury or suspected injury the child must be taken to the nearest hospital no matter the circumstances surrounding the injury; CATT's monitoring system needs to be reviewed to ensure compliance with its statutroy mandate; St Judes must reconsider its employment policies regarding the experince, skills and quality of staff employed as Caregivers and at the Management level.

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st. Judes	FAILURE TO SAFEGUARD		On a walk through on 9.01.20 CATT L&M officer indicated "all dormitories were observed to be over capacity. Some dorms (Maria Goretti, Carmel House B(Rehab Centre) were observed to have mattresses for girls to sleep on the floor and one house did not have sufficient beds. The girls indicated that they push all the beds together and everyone finds a space to sleep on the floor and everyone finds a space on the joint beds to sleep at night.	L&M complaint form dd 9.01.21	Home overcrowded; Every child does not have own their bed	HIGH	Breach of regulations 9(1)(c), and 10(1)(a) of the Childrens Community Residences (Children Homes) Regulations 2018	Immediate steps be taken by CATT to ensure compliance with the regulations Children's Community Residences, Community residences, Foster Care and Nursuries Act to be amended to allow to close Homes in the event that it is operating without a licence and in circumstances where it does not comply with the prescribed standards. CATT 's placements to the Home must not exceed the capacity of the Home CATT to prioritize increasing number of homes Capacity building initiatives and facilities explored to support increased use of familial placements or supervised placement with relatives that may meet the criteria but are under resourced.

HOME / CENTRE	AREA OF INVESTIGATION (1)	AREA OF INVESTIGATION (2)	RAW DATA (FACTS)	DATA SOURCE	FINDINGS	RISK TO CHILDREN	CONCLUSION	RECOMMENDATIONS
St. Judes	SEXUAL ABUSE	FAILURE TO SAFEGUARD	An incident occurred on night of 7.02.20 however no report was made until 11.02.21 (orally). L&M officer advised by Ag Manager that incidents of sexual activities involving residents and a security guard occured on that night. Practice of asking security guard to cover when staff does not turn up revealed. Sexual activity between security guard and resident and between residents. Incident reported by one of the residents. Security Guard's mother is the supervisor of the security firm assigned to the Home and her brother and cousin also work there. CATT recommendation that Security firm be removed was ignored, rather Management requested that the Myers officers not be posted at the Home and a new officers assigned to the Home. CATT officer reccommended that security firm be changed. Request to OPM to have security changed only after persistent rumours and reports of the officers bringing in contraband, specifically marijuana, into the Home for residents confirmed by Ag Manager. Despite this Security Firm still providing security for the Home.	L&M Complaint form dd 14.02 20. Interview with Ms. Bruce 19.11.21 interveiws with past residents Millington and Corerea	Sexual abuse and sexual activity between residents confirmed at St.Jude's; Exposing children to and giving children dangerous drugspattern of gross negligence on the part of Managment in the use of Security Guards for the supervision of the girls; no steps taken by management or CATT to institute a proper investigation re crimes disclosed or to prevent sexual activity between girls. No adequate steps taken by management or OPM to have security firm removed.	HIGH	Sexual abuse and sexual activity between residents confirmed at St.Jude'soffences under the Childrens Act 2012 revealed (section 35&36...)Inadequate supervision of girls Security doing tasks outside of their job roles. criminal negligence by management query the role of OPM re the provision of security servicespoor management of Home;	Management of the Home needs to be criminally investigated for persistent failures to safeguard children and documented reports continued abuses. Police reports must be made re allegation of criminal activity re sexual abuse and trafficking of marijuana; There should be enforcement of laws regarding failure to report crimes against children. Establishment of an independent body to receive confidential reports of child abuse and endangerment from residents and staff, and has power to take action independent of CATT. Security firm needs to be removed; Adequate background checks must be made on all officers providing security at the home; Security should adhere to roles for which they have received training. Staffing at home should be increased to adhere to international best practice model, and a policy/protocol be put in place to ensure maintenance of this model during times where staff may be absent - this

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								is so that there is no need to call upon security personnel to do jobs for which they have not been trained.

HOME / CENTRE	AREA OF INVESTIGATION (1)	AREA OF INVESTIGATION (2)	RAW DATA (FACTS)	DATA SOURCE	FINDINGS	RISK TO CHILDREN	CONCLUSION	RECOMMENDATIONS
St. Judes	PHYSICAL ABUSE	FAILURE TO SAFEGUARD	Allegation by FK- a resident, that a member of staff woke her up, cursed and threatened her over an incident that had occured the day before. During the exchange the staff member made mention of confidential information concerning the relationship between the child and her mother. Member of staff admits approaching the child at night while she was in bed and speaking to her about the incident but denies waking her up, cursing and mentioning her mother. The investigation consisted of the L&M officer interveiwing the child, the children in the dormitary at the time and the member of staff. At the end of the investigation by the L & M officer, despite confirmation by all witnesses that an arguement happened between the resident and the member of staff in the dormitory that night, the CATT officer found the allegations to be unsubstantiated because the other residents did not confirm what was said. The issue was only investigated in the course on another investigation of three of the girls beating FK-resident	Complaints monitoring form dated 25.03.21	Actions of the member of Staff improper even if it was as the member of staff stated. It was noted that staff initiated a confrontation with the resident at night in the view of other residents Given the investigation of the L & M the information surfaced warrants the need for mandatory training for the Staff memeber in effectiuve communication and treatment of residents in care. "Investigation" conducted inadequate and incomplete.	MEDIUM	Steps taken by CATT to investigate complaints of mistreatment not adequate	CATT must implement place proper procedures to investigate complaints of mistreatment. Simply relying on an enquiry by a L&M officer is not enough to discharge its statutory responsibility.

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St. Jude's	PHYSICAL ABUSE	FAILURE TO SAFEGUARD	report made by text on 25.04.21 of an incident that occurred two days before. Only one member of staff on duty. member of staff rushed when opening the gate to the rehab centre and tied up in an attempt by two residents to abscond. Attempt failed. After sending the girls to bed and after speaking with the injured member another member of staff (Elizabeth Peters) admitted to retreiving a peice of broom stick that she uses to chase the girls into their dorm when they are not responding to the call to go into the dorm in the evening and hit one child 3 lashes on her bottom and the other two lashes on her bottom. In response to being cursed by one of the girls Ms. Peters responded " mu mother dies when she was 102 years old so her c--t already rotten." According to the girls they were beating all over their body. A report to the police was made with respect to the tying up of the member of staff. No reccomendations made by the CATT officer re the beating of the girls with the broomstick.	Complaints Investigating Report dd 26.04.21	Inadequate staffing at this home No report to the police re beating of the girls; Action of Peters-Thomas inappropriate with respect to comments and contrary to the law with respect to the inflicting of corporal punishment; No Critical incident report filed, no steps taken by CATT re the beating of the girls; CATT's no comment on the beating of the girls, suggests that actions condoned by CATT.	HIGH	Inadequate staffing increases risk of untoward behaviors by residents, putting themsevles and staff at risk for harm. The use of corporal punishment on residents seems to be accepted in this Home and ignored by CATT. This is supported by the fact that the broomstick is kept in the matron's room and used to make the girls follow orders and by the failure of the CATT officer to comment on its use or recommend disciplinary proceeding be commenced against the member of Staff. Monitoring procedures of CATT failing to prevent abuse of girls	Management needs to ensure staffing to be adequate. monitoring procedures insituted by CATT to be reviewed CATT to regulate and monitor home's adherence to best practice model regarding staffing. Disciplinary action and criminal proceeding to be instituted against Peters-Thompson; Role of Management re condoning the use of the broomstick to coerce girls to be investigated;

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St. Judes	PHYSICAL ABUSE		complaint received by CATT from CTU concerning treatment meted out to a Venezuelan resident- (child victim of Human trafficking) -complaint that she was struck by two security guards (a mother and a daughter) and handcuffed. No Critical Incident form filed. "Investigation carried out in absence of the Venezuelans. Altercation between two Venezuelan residents and three Trinididadian residents over the Trinidadians cutting up some of the V's clothes. Comments made by one of the T girls of favouritism shown to Vs and the Vs habit of disrespecting the staff. Decision taken by staff to remove one of the Vs to another house. According to a member of staff the V objected to being removed and security had to be called to assist. They had to physically hold her. Statement by Asst Manager that never had to use handcuffs on compound.(note his instructions in another matter in September 2020 to security guards to restrain two other children with handcuffs). Security guard admitted using handcuffs in a written statement. No recommendation by CATT relating to the use of handcuffs. Venezuelan residents are targetted and victimized my Trinidadian residents, calling names "prostitute" and receive group beatings. Nothing comes out of reports made by Venezuelan residents.	L&M complaint form dd 8.06.20 Interview with past Venezuelan residents	Handcuffs were used to restrain children contrary to policy; Statement by Asst Manager on use of handcuff policy inconsistent with earlier position; Issue of the use of handcuffs to restrain not dealt with by CATT. Investigation by CATT is limited. Animosity exsits between Venezuleans and Trinidadians based on difference in treatment.	HIGH	Handcuff are used at the Home to restrain children; Home not following the reporting procedure as required by regulations; monitoring procedures instituted by CATT inadequate Venezulean residents are at increased risk of abuse from their Trinidadian peers.	Home to establish and enforce restraint policy. Use of Handcuffs to restrain residents should be banned. Staff to receive training in developmentally appropriate, trauma-informed descalation and behavioral management approaches. Staff to receive training in the appropriate use of developmentally appropriate, trauma-informed restaint management. CATT to regulate and monitor behavioral managment approaches at home. A risk assessment should guide placement of residents. Vulnerabilites of residents should be taken into account when considering placement. Immediate actions are required to provide appropriate accomodation and treatment for migrant child victims of trafficking in accordance with our international

HOME / CENTRE	AREA OF INVESTIGATION (1)	AREA OF INVESTIGATION (2)	RAW DATA (FACTS)	DATA SOURCE	FINDINGS	RISK TO CHILD REN	CONCLUSION	RECOMMENDATIONS
								responsibilities and the Persons in Trafficking Act.

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Tacarigua CSC	FAILURE TO SAFEGUARD		Complaints by staff: (i) of threats to and assaults, including sexual assaults to and threats of sexual assault, of staff; (2) attempts by residents to make poison to administer on other residents; (3) damage to the premises and vehicles of staff; (4) damaging the premises for the purpose of making weapons; (5) an attempted rape of a female resident by a male resident on 24.04.21; (6) non functioning quarantine space; Staff attribute the problems to (1)lack of resources to engage children; (2)lack of resources for staff to execute duties;(3) little support when critical incidents occur over the years; (4) no one to turn to when children engage in behaviours beyond the control of staff; (5) Police support only provides temporary de-escalating of the situation (6) mixing of children with varying child protection issues; (7) overcrowding with the attendant difficulties re the facilities and staff to child ratio	letter of complaint dd 28.04.21 from members of Tacarigua staff to Minister. Confirmation from interviews with Jenna Samaroo dd 16.11.21; Patrice Jones dd 17.11.21 and Reesa Hernandez dd 18.11.21; site visits and site interviews 1.09.21. Critical incident reports.	the complaints made by the staff are credible and the reasons given by them for the situation have been found by the team based on the site visits and an examination of the Criticl incidents reports to be justfiable.	HIGH	the situation at the CSC is untenable:(i) the residence houses both male and female Chins, children in need of care and protection and at times child victims of Human trafficking- this runs the risk of chiildren with a high risk of harm to others causing injury to other children and staff and influencing other lower risk childen to adopt their behaviours it therefore presents a danger to both children and staff and does not allow for proper safeguarding of the children; (ii) the buliding is a four-bedroom house unsuited for the purpose and for the number of children	CATT to cease the policy of placing children with various risks of harm to self and others in the same premises. CATT to ensure that premises are not overcrowded. CATT ensure that the staff to child ratio does not exceed the limits identified by them as according to best practices that is 1:3 for low isk cases with minimum challanging behaviour; 1: 3 for meduim risk cases with some challenging behaviour and 1:1 for high risk cases with extreme challenging behaviours/suicide watch/psychiatric diagonis. CATT to identify and utilise a suitable and fit for purpose buliding CATT to audit the human and material resources allocated with a view to provinding addittional resources.

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Tacarigua CSC	SEXUAL ABUSE		report by another child of sexual acitivity between a child aged 15 and a security officer employed by CATT. This occurred sometime between 24 09.21- 22.10.21 not reported until 1.12.21 after child had been discharged into the care of her grandfather.. Incident occurrred while the other children were watching a movie; 3 caregivers on site. No indication whether a report was made to the police or of what steps taken by CATT	critical incident report dd 1.12.21	serious failure in supervision; possible lack of failure to comply with laws re reporting of sexual abuse	HIGH	lax supervision measures in place;no proper vetting of security guards; secuirty guards should not be allowed to be alone with or in close contact with children in the absence of caregivers	CATT to ensure proper vetting of secutiry guards and to implement a polic that ensure that security guards are not in close proximity to children in the absence of a caregiver. Staff to child ration to be in accordance with CATT policy in this case 1:3
Tacarigua CSC	ABSCONDING		Two incidents of absconding and one attempt: Two Venezuelan residents went missing after outdoor activity; : Child was sitting talking to caregiver when the child jumped over the wall near the security desk and absconded; A.M. in the presence of two staff members broke through a window and was injured in the process	Critical incident report 3.03.20; critical incident report 23.08.20 ; Critical incident report 14.04.20	all three incidents occurred in the presence of staff	HIGH	poor supervision by staff	CATT must formulate, implement and enforce the standard operating procedures for the supervision of children and monitor them for an improvement of the system . CATT must increase the staff to child ratio in accordance with their stated guidelines
Tacarigua CSC	SEXUAL ABUSE	FAILURE TO SAFEGUARD	report by Raisa Jackman mother of A.J. (13 years) that the child has no access to Caregiver while at the Mt. Hope Medical Hospital in an adult ward. CATT confirmed Hospital of not allowing the caregiver to stay with child while in the adult ward. Child left in the hospital for over 5 days after being discharged before being collected by CATT.	interview dd 28.10.21 confirmed in part by Patrice Jones 17.11.21 and Reisa Samaroo dd 16.11.21	CATT failed to provide the necessary care and protection for a child in their care; child abandoned by CATT for at least 5 days; Minor child should not have been housed in an adult ward.	MEDIUM	CATT failed in its duty of care to the child; gross negligence in not collecting the child amounting to an abandonment of the child	CATT to ensure that Ministry of Health provides an appropriate in patient facility for children requiring psychiatric care. CATT to investigate the circumstances that led to the child being abandoned by them and take appropriate disciplinary measures

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Tacarigua CSC	SEXUAL ABUSE		on a three -way call with her parent and CATT official child advised that she had been sexual abused by a Security officer employed by the CSC while in insolation at the CSC. Complaint by mother that CATT sought to discourage from making a police report. Security Guard has since been removed pending investigation.	interview with Raisa jackman confirmed in part by Patrice Jones and Raisa Samaroo	credible allegations of sexual abuse by child; Poor supervision by staff	HIGH	CATT's attempt to discourage mother from making police report inappropriate and contrary to the requirement in the law re immediate reporting of sexual abuse; poor supercvision of the child by CSC staff while in isolation	Staff to child ratio to ne increased; CATT must ensure that proper supervision methods to be put in place; CATT to foster healthier communication with parents so as to better bulid relationships and trust and assist with transistioning the child back to the community.
Tacarigua CSC	SEXUAL ABUSE		sexual abuse by male resident on female resident	critical Incident report dd 24.4.21; letter dd 28.04.21 from staff to Minister.	attempted rape by one resident on another	HIGH	Poor supervision	staff to child ratio to be improved to ensure more effective supervision
Tacarigua CSC	SEXUAL ABUSE		residents fondling and engaging in anal sex while watching a movie in bed durng the day.	critical incident 25.01.20	inapropriate and risky sexual behaviour between residents .	HIGH	poor supervision of children	CATT must formulate, implement and enforce the standard operating procedures for the supervision of children and monitor them for an improvement of the system CATT must reinforce seessions on appropriate sexual behaviour with residents
Tacarigua CSC	PHYSICAL ABUSE		resident slapped by a caregiver resulting in his neck being swollen	critical incident report dd 16.5.20	physical abuse by caregiver	HIGH	actions in contravention of legislation re corporal punishment	disciplinary action reccommended to be taken against member of staff; CATT to implement policy appropriate behaviour

HOME / CENTRE	AREA OF INVESTIGATION (1)	AREA OF INVESTIGATION (2)	RAW DATA (FACTS)	DATA SOURCE	FINDINGS	RISK TO CHILD REN	CONCLUSION	RECOMMENDATIONS
								managemnt policy and train staff on comlpliance with such policy
Tacarigua CSC	FAILURE TO SAFEGUARD		threats to kill two residents by another two residents armed with a razor blade	critical incident report dd 9.04.20	children not supervised - children in possession of weapons	HIGH	poor supervision; children im possessions of weapons risk of leading to inury of children in CSC care	CATT to impliment stricter measures with respect to items that are capable of being used as weapons; staff to child ratio to be in accordance with guidelines set by CATT

(Appendix 9: Annual Treatment Plan Tracker)

TREATMENT PLANS TRACKER

for the period January 2020 to December 2021

2020											
Jan	**Feb**	**Mar**	**Apr**	**May**	**June**	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**
7	14	14	17	16	8	16	**0**	**0**	**0**	**0**	**0**

Board installed in December 2020

2021											
Jan	**Feb**	**Mar**	**Apr**	**May**	**June**	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**
7	20	6	32	13	33	34	17	17	20	14	**TBD**

Prepared: 7th December, 2021

(Appendix 10: Simple Initial Clinical Risk Assessment Form)

Appendix: **Sample Initial Clinical Risk Assessment Template**

NB: this is only a simple example and does not incorporate all major risks to be assessed.

Initial Clinical Risk Assessed	Risk Level (High or Low)	Screening Tools (PHQ9-A, CSSRS, YLS, based on clinical judgement)	Biopsychosocial Factors Impacting Risk (predisposing, precipitating, perpetuating)	Interventions to target Biopsychosocial factors	Placement Type Required to Mitigate Risk(eg. Level of security, level of supervision, specialized needs, communication needs etc)
Harm to Self					
Self-Harm/Suicide					
Substance Use					
Self-neglect (physical, medical, mental care)					
Absconding					
Fall					
Harm to Others					
Violence (including emotional, sexual and physical violence					
Intimidation/threats					
Property damage					
Harm from Others					
Exploitation					
Violence (including emotional, sexual and physical violence					
Intimidation/threats					
Strengths/Protective Factors					
Barriers to Risk Assessment					
Barriers to Implementation of Interventions					