Appendix I

CABINET APPOINTED TASK FORCE

REVIEW OF CHILDREN'S HOMES

INSPECTION FORM

Date: .....

NAME OF HOME .....

ADDRESS .....

MANAGER .....

TELEPHONE No. ..... FAX No .....

HOME POPULATION

TOTAL No. of Children .....

No. of Males .....

No. of Females .....

No. with special needs .....

Nos. by age groups 0 - 5 ..... 6 - 11 ..... 12 - 15..... 16 - 18 .....

Rate the conditions using the following scale:

Very Satisfactory	5	( )
Fairly satisfactory	4	( )
Satisfactory	3	( )
Fair	2	( )
Unsatisfactory	1	( )

ACCOMMODATION

Structure - rate using the 1-5 scale

( ) One Storey ( ) Two Storey ( ) Wooden ( ) Concrete

Comments: _____

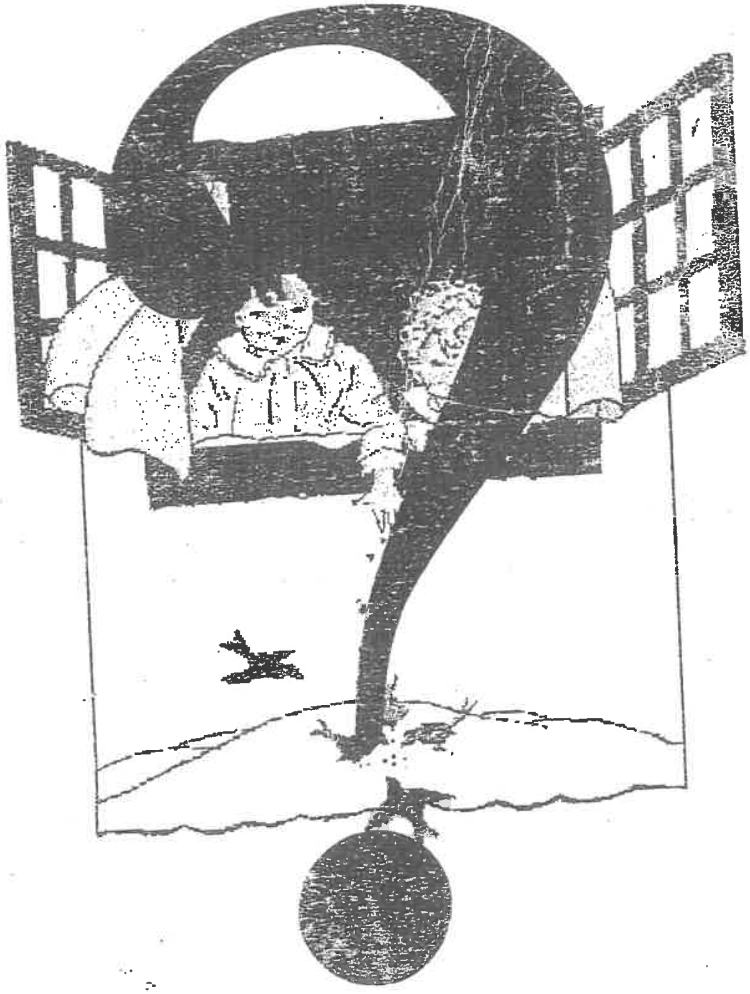
_____

_____

REPORT OF

THE CABINET APPOINTED TASK FORCE TO REVIEW THE OPERATIONS OF CHILDREN'S HOMES AND INSTITUTIONS IN TRINIDAD AND TOBAGO

July 1997



SD:10/3/16

In accordance with the provisions of Sub-Section (1) of Section 31 of the Children Act, Chapter 46:01 of the Laws of the Republic of Trinidad and Tobago, I hereby appoint **MR VASANT RAMKISSOON**, a Public Servant as Inspector of Industrial Schools and Orphanages, with effect from 18th February, 1997.

For the proper and due exercise of his duty, I also hereby appoint the following persons as Assistant Inspectors of Industrial Schools and Orphanages:

Mr Robert Sabga

Mrs Diana Mahabir-Wyatt

Mrs Halcyon Yorke-Young

Ms. Basdai Gayadeen-Catchpole

Mrs Valerie Rawlins

Mrs Sita Beharry

Manohar Ramsaran
Minister

MINISTRY OF
SOCIAL DEVELOPMENT

18th February, 1997

Index

EXECUTIVE SUMMARY

The **Cabinet Appointed Task Force To Review The Operations Of Children's Homes And Institutions In Trinidad And Tobago** began its work by reviewing the *Draft Policy Statement on Standards and Procedures for Children's Homes and Institutions*, in conjunction with the conditions regarding same contained in the *Children Act, Chapter 46:01*. Out of this exercise was developed the *Children's Home Inspection Form*, a key instrument used in assessing the several Homes visited.

Investigations revealed that some 27 Children's Homes of varying sizes were known to be operating in the country. Rather than attempting to visit all, the Task Force, through a process of elimination, narrowed the list to 10 homes. To facilitate investigations and negate denial of access to records, the Task Force petitioned the Minister of Social Development to appoint its members as **Inspectors of Homes**, persuant to Section 31 of the *Children Act*, with the result that they were all so appointed. Visits to Homes began thereafter.

The first Home inspected was **St. Jude Girls Industrial School**. During its inspection the Task Force documented a great many environmental and health hazards, including rodent and insect infestation. Most alarming, though, were the numerous accounts of particularly brutal episodes of neglect and physical, psychological, and emotional abuse visited on the residents by the manager [redacted]. The members of the Task Force were so disturbed by their findings that they sought the urgent intervention of [redacted] immediately having [redacted] from her position, indicating that she posed a very real and present danger to the girls at the Home. While this met with his support, he was unable to act on behalf of the **Statutory Authorities Service Commission**, who were ultimately responsible for her employment. Consequently, the Task Force has recommended that very strong measures be taken, including legal action against her with the potential for incarceration, as well as the removal of authority to run **St. Jude** from the **Carmelite Order,** and instead vesting same with a qualified management team. Several other recommendations focus on health and medical issues, bedding and furniture, food and nutrition, and placement and overcrowding.

The visit to **St. Dominic's** similarly revealed incidents of extreme abuse and neglect of the children housed there. Most distressing of all though, was the discovery of the **repeated sexual abuse of some 30 - 40 children** by a male ex-employee. When discovered, the employee was reprimanded and asked to resign, and then was allegedly *supported* by the management of **St. Dominic's** in procuring employment at **St. Ann's Hospital**, where he now works. The matter was hushed up, and no medical or psychological intervention for the children affected was initiated. The Task Force considered this gross negligence, and recommended a thorough investigation with full legal implications. It also recommended termination of the present manager, [redacted] Other elements documented include sexual harassment, wrongful dismissal, poor living conditions, poor food and nutrition, deterioriation of physical infrastructure, and (especially) water problems. Suggestions and recommendations aimed at addressing these are included.

St. Mary's Children's Home was, by contrast, quite well managed. The problems documented were largely infrastructural, although corporal punishment was also highlighted. Recommendations focussed on refurbishment and/or rebuilding, as well as addressing the reports of night staff beating the younger children.

St. Michael's School for Boys came in for high praise, although it has several pressing problems, including (especially!) chronic water shortages, and the state of some of its older buildings (particularly the kitchen and the dining shed, and the outdoor bathroom). Recommendations focussed on these.

Of the smaller private Homes visited, the **Shri Jayalakshmi Home** was the most distressing. The Task Force was met on both occasions with resistance and even hostility. Investigations revealed an overabundance of food with little evidence of the children benefiting, poor living conditions and hygiene, and possible fiscal malfeasance (including potential **NIS** and **PAYE** fraud). Most distressing was the discovery that a 16 year old boy at the Home was discovered to have sexually abused several of the other children housed there, and yet was still resident at the Home. Investigations further revealed that no psychological intervention for the children affected was sought. Given the resistance to inspection, the hostility the Task Force was subjected to (including becoming the target of poison mail), the neglect and incompetence exhibited in the incidents of sexual abuse, as well as the evidence of possible fraud, the Task Force recommended the immediate suspension of subvention pending a proper Ministry audit. [Since the managers are also the owners, termination of employment is not possible to effect.] Other recommendations focussed on the Home's chronic water problems, staff, plumbing, and bedding and furnishings.

The **Hope Center**, by comparison, was being newly renovated, and had recently added additional staff to address its previous shortcomings. Consequently, the Task Force found little to make recommendations about, short of its need for stronger management skills.

The **Happy Home** in La Brea was discovered to be very overcrowded (it houses 18 children and 2 adults), and lacking in several amenities. Given its location, however, and the absence of any other similar facility in the area, the Task Force opted to focus on reducing the Home's child population while bringing additional resources to bear in assisting the house 'mother'. A note of concern was sounded on the visibly strained relationship the 2 adults shared, and its effects on the children.

The **Trinidad Christian Center**, although found to be adequate, hardly matched its projected image. The Task Force called for a re-evaluation of its subvention or, alternatively, an increase in its staff levels and services offered that are more in line with its stated roles and mission.

The **Lady Hochoy Home** was found to be well appointed and managed. The Task Force voiced concern however, over the Home's practice of tying some of its residents to their beds, some hazard and safety issues that were observed, the state of its kitchen, and the quality of its food.

The **National House for Family Reconciliation** was found to have **no residents**, and yet was being given a sizable subvention ($75,000). The Task Force called for an immediate audit of the Home, and a suspension of its subvention should that audit be resisted, coupled with possible Fraud Squad intervention.

Finally, the Task Force has detailed a host of general recommendations covering the formation of an Inspectorate of Homes; a Licensing System for Children's Homes; Subventions; developing a Child Care Plan; the role of the Statutory Authorities Service Commission; Legal issues regaring the operation of Homes; management and staff issues; and the formation of future Task Forces.

The Report culminates with some closing comments regarding the exercise as a whole.

INTRODUCTION

On January 10th 1997, the Cabinet Secretariat - Office of the Prime Minister advised that the Cabinet had agreed to the establishment of a Task Force to review the operations of children's homes and institutions in Trinidad and Tobago. The specific **Terms of Reference** of the Task Force were defined as follows:

(i) To assess the overall system of health care provided by children's homes and institutions in terms of:

- *physical accomodation*
- *-assessment and evaluation*
- *health care*
- *educational and therapeutic services*
- *nutrition*
- *administration*

(ii) To determine the quality of relationships which exists between caregivers and children;

(iii) To identify children who are victims of abuse;

(iv) To review the Draft Policy Statement on Standards and Procedures for Children's Homes and Institutions, developed by the Ministry of Social Development through the National Family Services Co-ordinating Council.

The Task Force membership consisted of:

Mr. Robert Sabga - **Chairman**
Victimologist

Ms. Halcyon Yorke-Young
Legal Officer
Ministry of Social Development

Mr. Vasant Ramkissoon
Acting Deputy Chief Probation Officer
Ministry of Social Development

Senator Diana Mahabir-Wyatt
Coalition Against Domestic Violence

Ms. Toy Basdai Gayadeen-Catchpole
Social Work Consultant
Ministry of Community Development

Mrs. Valerie Alleyne-Rawlins
Manager - Directorate of Quality Management
Ministry of Health

Mrs. Sita Beharry **- Secretary**
Child Care Officer
National Family Services Division
Ministry of Social Development

The Task Force held its inaugral meeting on 4th February 1997.

PRELIMINARY ACTIVITIES & PREPARATIONS

The Task Force met several times in February without a representative from the Ministry of Health having been named. After discussions with the Minister of Health, Mrs. Valerie Alleyne-Rawlins joined the Task Force on 18th February on behalf of that Ministry. This is significant, because the Task Force had spent its first few weeks giving attention to that part of its mandate requiring that it review the *Draft Policy Statement on Standards and Procedures for Children's Homes and Institutions*. Mrs. Rawlins drew to the Task Force's attention the fact that the *Community Care Program* being developed by the Ministry of Health in conjunction with the Ministry of Social Development, was incorporating some aspects of the same document in its Procedures Manual and its system of dual monitoring of the quality of care in children's homes and in homes for the elderly. In essence, this equalled a duality of effort and therefore time lost on the part of the Task Force in carrying out its mandate. The exercise was not a total loss, however, since the Task Force was able to familiarise itself with the draft standards and procedures proposed, and developed out of it a survey instrument that would aid its information gathering on site visitations (the *Children's Home Inspection Form*, attached). The Task Force immediately suspended any further effort on this particular issue and turned its attention to its principal mandate: the assessment of the existing children's homes and institutions.

When originally envisioned, the scope of the Task Force was thought to be limited only to the four major industrial schools and institutions, ie. St. Michael's, St. Jude's, St. Dominic's, and St. Mary's. Given this, the Task Force was expected to submit its report within six (6) weeks of its first meeting. Investigations soon revealed, however, that instead of only four homes, there in fact are some twenty-nine children's homes and institutions in Trinidad alone that are known to exist by National Family Services, and that there are others in operation that are yet to be identified and visited. This immediately changed the complexion of the Task Force's mandate, and rendered unrealistic its original six week timeline. This fact, combined with other sensitive information, was communicated to the Honorable Prime Minister in writing under private cover, and a lengthy extension was sought and granted.

The Task Force next concentrated on the development of appropriate tools and instruments to enable its information gathering. The first of these was mentioned earlier, ie. the *Children's Homes Inspection Form* (see Appendix I). Further to this, the Task Force's legal officer advised that in order for the Task Force to properly carry out some aspects of its mandate, specifically those having regard to the assessment of administration, evaluation, health care etc., it would require unrestricted access to each institution's records, something that would no doubt meet with resistance if not downright refusal on the part of some homes (as indeed was the case on not one but two occasions with the Jayalakshmi Home in Longdenville). Given that ALL of these homes are in essence PRIVATE institutions (excluding the four large ones, which are listed as Statutory Bodies under the Act), the management of these homes and institutions would legally be within their rights to restrict such access, and the efforts of the Task Force could come to nought. [It is a supreme irony that although Government provides a significant amount of

the funding to these homes and institutions, it has little or no control over what those funds are actually used for, and must rely solely on the reports submitted to it by the management of each home]. To counter as much as possible any potential resistance the Task Force could face, the Chairman mandated the members to research and locate as many legal instruments as may exist that could empower its mandate. After much analysis and debate the Task Force finally settled on Section 31, Subsections (1) and (2) of the Children Act , Chapter 46:01 of the Laws of the Republic of Trinidad and Tobago, which reads:

31.(1) There shall be in the public service an Inspector of Industrial Schools and Orphanages.

(2) The Inspector shall perform all the duties imposed on him by this Part and shall be charged with the general superintendence of all schools established under this Part, or existing at the time of the commencement of this Act, and shall, in particular, from time to time inspect all Industrial Schools and Orphanages and shall make such reports and in such form as the Minister may from time to time direct.

A check by the Task Force revealed that this post (Inspector of Industrial Homes and Orphanages) had been vacant for at least fifteen years (which alone speaks volumes on the issues of accountability and monitoring. In fact, the previous file on the Inspector of Homes - File# 1125 - was found to be missing from the Ministry). Armed with this, the Chairman requested the Minister of Social Development to have Task Force member Mr. Vasant Ramkissoon, Acting Deputy Chief Probation Officer, appointed in this capacity, and for the other members of the Task Force to be appointed as Assistant Inspectors. This was duly done on 18th February 1997 (see Appendix I), and the Task Force was now ready to begin its site inspections.

CATEGORIZING AND SHORTLISTING THE HOMES

The next step faced by the Task Force was to address which of the homes should be shortlisted. Given the large number of these homes, their widespread geographic locations, the restrictive timeframe faced by the Task Force to complete its mandates, and the increasing difficulties experienced by the members of the Task Force in time co-ordination, a three-fold process was agreed on and incorporated: (a) categorise the homes into large, medium, and small institutions; (b) eliminate those that the Task Force members had direct knowledge of and/or involvement in, and could vouchsafe; and (c) group those left by location for field visitation.

Following is the listing of the various homes and institutions assembled by the Task Force from information obtained from the National Family Services - Ministry of Social Development, including the quantum of their Government subvention (where known), and the Task Force's size ranking:

INSTITUTION	MANAGER	SUBVENTION	RANKING
St. Michael's Industrial School for Boys	[redacted]	*$ 3,300,000.00*	*Large*
St. Dominic's Children's Home	[redacted]	*$ 5,387,000.00*	*Large*
St. Mary's Children's Home	[redacted]	*$ 4,670,000.00*	*Large*
St. Jude Industrial School	[redacted]	*$ 2,000,000.00*	*Large*
Princess Elizabeth Center	[redacted]	*unknown*	*Large*
School for the Deaf	[redacted]	*unknown*	*Large*
Lady Hochoy Home for Retarded Children	[redacted]	*unknown*	*Large*
Shri Jayalakshmi Home	[redacted]	*$ 60,000.00*	*Medium*
Christ Child Convalescent Home	[redacted]	*unknown*	*Medium*
Marian House	[redacted]	*unknown*	*Medium*
School for Blind Children	[redacted]	*unknown*	*Medium*
Islamic Home for Children	[redacted]	*$ 40,000.00*	*Small*
Hope Center	[redacted]	*$ 25,000.00*	*Small*
Trinidad Christian Center Children's Home	[redacted]	*$ 100,000.00*	*Small*
Emmanuel Cradle	[redacted]	*NIL*	*Small*
Ferndean's Place Children's Home	[redacted]	*$ 40,000.00*	*Small*
Vision of Hope	[redacted]	*unknown*	*Small*
Goshen House	[redacted]	*unknown*	*Small*

INSTITUTION	MANAGER	SUBVENTION	RANKING
The Shelter	[redacted]	$ 60,000.00	*Small*
The Halfway House	[redacted]	$ 65,000.00	*Small*
Mizpah	[redacted]	*unknown*	*Small*
National House for Family Reconciliation	[redacted]	*75,000.00*	*Small*
The Happy Home	[redacted]	*unknown*	*Small*

From the above listing, and following the three-point elimination process outlined earlier, the Task Force short-listed the following homes/institutions for visitation:

(1) St. Dominic's Children's Home
(2) St. Jude Girls Industrial School
(3) St. Michael's Industrial School for Boys
(4) St. Mary's Children's Home
(5) Lady Hochoy Home for Retarded Children
(6) Shri Jayalakshmi Home
(7) Trinidad Christian Center
(8) Hope Center
(9) National House for Family Reconciliation
(10) The Happy Home

Visitations commenced on March 5th, 1997, beginning with St. Jude Girls Industrial School.

MODUS

The modus employed in the visitations was guided by the philosophy that the Task Force should seek to investigate and identify existing problems and deficiencies with a view to informing and helping the particular institutions to address, correct, or improve (where possible and practical) said problems and deficiencies, while similarly sensitising and informing Cabinet of same. The Task Force was very mindful that a great deal of fear and apprehension already existed in the various homes and institutions that the Task Force was on some kind of "witch hunt", and the members wanted to ensure that this perception could be annulled as much as possible during site visits. Its efforts in this regard achieved only limited success, however, especially in those homes/institutions with the most serious deficiencies, as will be seen later in this document.

The modus employed during each site visit was straightforward: each Task Force member was charged with specific duties eg. examining administrative records, food and nutrition issues, health and hygiene, education, sleeping and living conditions, etc. Where ever possible the Task Force performed visitations as a whole unit, although in some cases, due to conflicting schedules, visits had to be split up. At almost no time did a Task Force member perform a visit alone - it was almost always with at least one other member in attendence, so that all procedures performed could have at least one witness. The visits were never pre-announced [although in almost every case the larger institutions had some advance knowledge of the Task Force's movements, something that was most unnerving at times to members, and a development that takes on a most interesting significance when weighed with other issues uncovered].

SECTION II

VISITATIONS

1.0 ST. JUDE GIRLS INDUSTRIAL SCHOOL

[Visited 5th March 1997]

Of all of the homes and institutions visited by the Task Force, St. Jude was beyond question the worst in all aspects. St. Jude has been the subject of several very alarming newspaper articles over the years, the most recent ones prior to the Task Force's visit being in the *Mirror* newspaper in December 1996, and the *African Option* news magazine in January 1997 (see Appendix II). The Task Force found that many of the allegations contained in these articles were factual, and often horrifyingly so, and were corroborated by both the girls and by two Supervisors [redacted], and [redacted] who refused to remain silent or to be cowed by [redacted] manager of St. Jude.

OBSERVATIONS

1. Health Risks:
Roaches, rats and mice are rampant in the dorms. Live roaches and mice were actually seen by the Task Force in the Carmel House dormitory despite the fact that pink rat bait had been put out the night before by one of the night Supervisors, contrary to procedure ([redacted] refuses to put out rat poison because she claims that the girls might use it to attempt suicide). Roaches were visible in other dorms. The vermin attack all foodstuff, and Task Force members were shown mouse and roach droppings on the clothing and personal toiletries kept in the girls' lockers.
The gas stove in the Treetops dorm was leaking gas (the Chairman had to turn off the gas cylinder).
The drain at the rear of the courtyard was blocked and stagnant, and had pondscum and mosquitoes breeding in it.

2. Food/Diet:
Before the article in the Mirror in December 1996, breakfast reportedly consisted of sugared water ("sugar tea") and (often) stale bread. Breakfast is now mostly "milk tea" (Monday, Wednesday, Sunday) and a single bread bun/slice with butter. They may get hotdog or cheese one day per week. Juice is served once per week. There is no cereal (hot or cold). Food is still a major problem for the girls, both in terms of quality/variety, and also (especially) quantity. Ice cream is served once per year (although individual girls may get a "treat" from time to time, for eg. spying on the other girls and bringing news to [redacted]). As indicated above, milk ("milk tea") is usually given on Mondays, Wednesdays and Sundays, and only on those Fridays when they have to appear in court (so that when questioned as to whether they had a wholesome breakfast that morning, they could reply in the affirmative). Vegetables (when served) are mostly carrots and spinach. Pumpkin, tomatoes and cucumbers are served only *very* occasionally. Chicken served consists of wings, feet and necks (the rest of the chicken is alledgedly kept for the Sisters), boiled with white rice. There are often "worms", rubberbands, nails, stones, hair, weevils, bits of blue soap, and even bits of plastic bag in the cooked food. The girls all

complain that the quantity of food served is too little, and they are always hungry. [redacted] reply is that they have no reason to complain - if they were at home they would not be getting as good (food, that is). Lunch is never more than one pot spoon of rice with some meat, often half-cooked. Vegetarians are forced to eat plain rice with no meat substitute (eg. peas, beans). Food allergies are ignored (very dangerous!). Due to the iron deficiencies in their diet, many of the girls are chronically anemic and suffer erratic menstrual cycles. Many others have chronic skin rashes (observed by the Task Force), due to a combination of poor nutrition and compounded health risks and sanitation problems (detailed elsewhere).

3. Food used as punishment
Children stated - and Supervisors corroborated - that regardless of their personal religion, all of them were forced to say Catholic prayers or else food is withheld by [redacted] (they get 1/2 breakfast). Food is therefore related to prayers and is used as a means of punishment. [See *Item #8: Punishment / Abuse*]

4. Bathroom Routine/Conditions
Children are awakened at 2-3 am for bathroom activities (showers, etc.), due to the insufficient number of showers for the number of girls. The water is unheated. The bathrooms (in the Treetop dorm, for example) are open and without curtains (no privacy), and had no lights (the Matrons', by contrast, was well lit). Another was flooded with water and appeared unfit for use, but was nonetheless in regular use. The bathrooms in general smelled rank, and the toilets had no toilet seats. The Task Force was told that "Pinesol and Vim" are "rare". Several of the showers had no showerheads, or were inoperative.

5. Health needs
Six girls had their hair sprayed for lice with 'BOP' insecticide the day before the Task Force visited. This is the common method of treating for lice at St. Jude (and is hopelessly ineffective, since the eggs are unaffected, and the bedding and linen are untreated). The dangers of the insecticide being absorbed through the scalp and into the bloodstream of the girls so treated are ignored.
There is no doctor on call. Instead, there is a 'Nurse's Aide' [redacted] who visits daily (credentials unknown), and who dishes out vitamins, cough syrup and Panadol for every ailment. [The indiscriminate use of cough syrups, many of which contain antihistamines, is very worrisome, since several of the girls interviewed suffer from asthma and allergies, and antihistamines aggravate rather than help especially asthma attacks. Severe attacks of asthma can lead to respiratory failure and death in the absence of epinepherine and/or a proper oxygen delivery system, neither of which exist at St. Jude.]
The girls report that when they complain of feeling unwell, [redacted] accuses them of faking, and withholds medical intervention. Sister gets the Supervisors to pour cold water on those who complain of feeling unwell - she insists they are faking. [One girl - [redacted] - was accused of faking illness and had water thrown on her. She had to be rushed to hospital the next day with raging fever]. Girls and Supervisors indicate that complaints about illness are never investigated, and many times girls have become

frighteningly ill. One girl [redacted] for instance, who was interviewed by two Task Force members, had an injured foot she had been forced to bandage herself. The foot was cut and swollen, and possibly infected. Her injury was not treated seriously by Sister. The Task Force met another girl who was obviously very distressed because of constipation (3 days). She was being made to drink water and eat bananas (crazy advice: banana binds bowel contents, not softens). A supervisor was sitting with the girl and getting her to drink water during the visit, with the result that by 5pm the child was really quite distressed. One Task Force member advised that the girl should be given a laxative suppository, to which [redacted] replied that she would administer the suppository later. The member suggested that the girl was capable of self administration of the suppository. [redacted] explanation for the constipation was that this girl had been sexually abused, to which the member pointed out that it was all the more reason why the girl ought to be allowed to self-administer the suppository.
One major complaint from the Supervisors is that they are not told what communicable diseases the girls have when they are admitted (this is a VERY serious matter, since the already unsanitary conditions and cramped living quarters the girls are kept in create a very condusive environment for disease transmission).

6. Threats
The girls report that they are always being threatened about their behaviour and about being sent to the Golden Grove Prison. Eight girls in Carmel House were actually sent there last year (for 1 month and 3 weeks) because [redacted] reported that they had attempted to burn down the building, an event that the Supervisor on duty on the night this event was supposed to have occurred [redacted] totally denies ever happened. The Task Force was shown where the "event" alledgedly occured: no burn or scortch marks were evident, just grime. The "crime" these girls had actually committed was that they had spoken candidly last year to Robert Sabga (the Task Force Chairman) when he had visited St. Jude informally, and had alerted him to many of the goings-on there. The girls in question are:

[redacted]

[redacted] in particular appears to have been singled out by [redacted] for special abuse. The Task Force Chairman was contacted by Woman Police Constable Brigid Callender who detailed a history of disturbing events surrounding [redacted] and the abusive treatment she has endured at the hands of [redacted], events that so moved her that she applied to the courts to have the child released into her care. [WP Callender's report is tabled in Appendix II]

7. Court

Children are taken to Court by [redacted], Supervisor (in Law, the children should be taken by a Social Worker, NOT by an employee of St. Jude). Most times they are committed to the Home by the Court. The girls feel that they are treated like criminals, and report that they have often been verbally abused by police officers when going to and from Court. Girls who have been placed in St. Jude for being "beyond control" (for which there is no legal authority under the Children Act) often end up being committed to the institution, despite parental willingness to have the girls come back home. The Court is often told that the girls would receive counselling at St. Jude, but this very rarely happens, and when it does the quality of same is unknown. Two Task Force members visited the Court several Fridays in a row to observe the actual proceedings in progress.

8. Punishment / Abuse

Corporal punishment is rampant and brutal. The Task Force was shown a corridor leading to the music room where whipping is done. The L-shaped corridor is sealed at both ends by locked wrought iron gates. Children are reportedly whipped with curtain wire, belts, slippers, and even aluminum strips from suspended ceiling assemblies. One [redacted] is alleged to be the Supervisor who does the most brutal beatings, followed by [redacted]. The Task Force got several reports of a particular incident where one girl ([redacted]) was stripped and beaten some 65 times in the corridor, and then had her head shoved in a bucket of water by one [redacted] Another report involved a young girl who was whipped mercilessly with curtain wire. [This particular girl - [redacted], age 13 - was interviewed by three members of the Task Force. She is very small and frail, and claims to have a heart condition. She was placed in St. Jude by the Court for protection, as she is a victim of incest and physical abuse by her father.] One girl (unnamed) was reportedly held in the corridor for two weeks as punishment.

Yet another girl (interviewed, but name unrecorded) was hit in the face with a big paintbrush by [redacted] during a heated argument. This apparently is a common occurrence.

As noted above, food deprivation is often used as punishment for a variety of "wrongs", such as failure to do chores, say prayers, etc.

Verbal and psychological abuse are also rampant. [redacted] accuses girls who run away of "going to meet man", and other kinds of "man" talk. She accuses girls who are especially close of being lesbians, and has them separated, so close friendships rarely develop. The most common verbal threat, as mentioned earlier, is to have the girls sent to either Golden Grove or to the Belmont Police Station.

Girls who are non-Christian (eg. Muslim, Hindu) and who suffer some accident or misfortune, are told sarcastically by [redacted] that they are being punished (by God, supposedly) for praying to the wrong God or being in the wrong religion. Also, if they do not attend Mass on a Sunday, they are verbally abused (called "heathens"), and denied the opportunity to see their parents when parents visit. [These practices are in clear violation of the Children Act, the Constitution, and the United Nations Charter on the Rights of the Child, to which T&T is a signatory.]

9. Records

Records are inadequate. There are no admission forms, and books are not properly kept. When questioned about why abscondents are not documented, [redacted] stated that there are too few staff and they are therefore unable to properly keep the records. The Police are informed about absconders by telephone, but no entry is made in the records. As a result, St. Jude depends on the information from the Courts and Probation for working with the children, rather than internal records.

[Items 10 - 17 are based on verbal information from Sister Dominic]

10. Admission

There is no admission policy. Girls are placed in St. Jude through the Court system with only the odd exception when [redacted] gets a request for custody from a parent or child facing difficult times, requests she claims she is unable to refuse. The proportional breakdown of reasons for admission she gives as follows (obviously some overlap must exist for the math to make sense):

Beyond control: **60%**
No parents: **6%**
Incest: **50 - 60%**

[The Task Force was advised that [redacted] encourages parents to let their children remain at St. Jude until they turn 18. This is her way, supposedly, of getting more money.]

11. Discharge

Discharges are effected on Fit Person Order, or on reaching the end of the committed period. There were no discharges in 1996/7.

12. Home leave

Home leave is granted on school holidays and special occasions. [redacted] also gives consideration in individual circumstances. [She has no authority to do so.]

13. Children on Remand

[redacted] claims to exercise her discretion in treating with girls on Remand, and admits to having sent girls on Home Leave without the necessary authority.

14. Visiting times

There is no policy on this and no information to give to visitors/parents. Family visits are generally allowed twice monthly only (second and fourth Sunday of each month). One girl admitted that she would willingly go to the female adult prison at Golden Grove only because she would be able to see her family more often. The girls in Carmel House, which faces Belmont Circular Road, are not allowed to look through the ventilation blocks or call out to any family members who may be visiting. If they did so, they would then not be allowed to formally visit those persons. As stated elsewhere, girls are restricted from visits with their families as a form of punishment. The girls also complain that Staff are often doubtful of their family's "credentials", particularly when it is a young man who is visiting ([redacted] constant "man" talk, especially). The girls in Carmel House are incarcerated virtually full time, except when required to attend classes.

15. Staffing Ratios and Qualifications

[redacted] indicates that the Supervisor-to-inmate ratio is 1 to 39/43, with 3 8-hour shifts in effect daily (24 hours). She says that Staff qualifications are 4 Subjects (although this is not supported by the Staff Personnel Files), with some psychology and child care training (of which there are few examples in the Staff Files). [The in-service training is organised and facilitated by [redacted], though what her program of training covers - or her ability or competence to so do - are unknown.] She indicated that she looks for good observational skills, communication skills, and interactional skills in her workers. [The Task Force, by comparison, met very dour, authoritarian employees, as well as employees who were very scared or skittish, with the exception of the three who were most forthcoming with information. Sister appears to prefer employees with minimal education, so that she can control or silence them by threatening them with their jobs. Hiring practices are addressed elsewhere.]

There is no psychologist, no resident doctor, no resident cook, no social worker, no nutritionist. [redacted] acts as all of these (except doctor - but then as far as she is concerned all the girls fake illness anyway). She is fiercely anti-union, and this is one of the reasons she chooses to hire those she can threaten.

16. Assessment and Intervention

[redacted] is also the person who undertakes all of the assessments (psychological, educational, and/or substance abuse/addiction), though what qualifies her to do these is unknown. Her treatment for drug addiction, for instance, is highly questionable: she claims to "correct" addiction by feeding the addicts copious amounts of bread and butter, as she diagnoses their withdrawal symptoms as *hunger*. She also deals with, diagnoses, and treats incest cases, and again her expertise and methodology for so doing are unknown.

17. Nutrition Issues

There is no nutritionist on staff. [redacted] claims she is a trained nutritionist, and she decides on the menu, dispenses foodstuff from the storeroom, and claims that she even does the cooking. "On a whim", she says, she will decide that she will give a 'treat' to the girls and cook Pelau for them. [By comparison, the girls and supervisors indicate that the older girls are made to cook for the younger ones. Every morning, one girl prepares breakfast for her housemates while the rest are at prayers. The staple lunch diet is white "dog rice" boiled with chicken feet, wings and neck, with lots of salt. As noted in *Item #2*, vegetables are rare, and fruit a virtual unknown. There is no set meal plan, and dinner on the night the Task Force visited consisted of one Hops bread and a chicken frank.]

18. Beds and Furniture

In Carmel House, the beds are jam packed close together, in very poor repair. Many have shifting boards underneath and most have rotten foam for mattresses. There are no pillows anywhere. Couches and chairs in sitting areas are generally broken and need replacing.

19. Relationships with Staff

There do not appear to be many close, nurturing relationships between most of the staff and the girls (there are some exceptions). Letters from the girls written to their families are opened and read by [redacted] and sometimes by the Staff (contrary again to the Rights of the Child, in this case the Right to Privacy). "Undesirable" letters are destroyed or kept back, and the girls writing them are punished in several ways. Parcels from home are searched before the girls get them. Some foodstuff and treats sent by parents are withheld by [redacted] on the grounds that it is insufficient to share among all the girls, and on the grounds of "fairness" if all can't get, then none will get. The fate of the confinscated foodstuff is unknown, although the girls insist that the really nice items (chocolates etc.) are consumed by the Sisters, while the rest are used as rewards for [redacted] spies.

20. Renovations / expansion

There is a new building under construction annexed to the main administration building. [redacted] indicated to one Task Force member that it is to be a new dorm, and to another that it is a sickbay. The Supervisors, however, indicate that it is neither, that it is in fact a new office building for [redacted]. A visual examination of the partial structure by the Task Force tends to reinforce the latter explanation, since the building is far too small to be a dorm, and a sickbay is unlikely since (a) it is a 2-storey structure with a cubicle-type floorplan (judging from the walls), and (b) there is no doctor or nurse on staff (and [redacted] is adamant that the girls fake illness). The question remains as to why [redacted] would want to mislead the Task Force about the building (and more interestingly, how was it financed, and why does it take precedence over so many other needs at St. Jude, like food and beds and staffing).

The Task Force was also advised that [redacted] plans to have the entire compound surrounded by barbed or razor wire (no reason given). [redacted] garden, although overgrown, is already surrounded by barbed wire.

21. Education

Classes are provided between 8:30 - 11:30am weekdays on the compound, and YTEPP on some evenings. These classes do not appear to be meeting the needs of the girls, and their formal education appears to be suffering as a result (although it was reported that 3 girls did get CXC). Most girls who were in secondary schools prior to being placed in St. Jude lose out completely by not being able to continue their education. This is particularly distressing for those girls who are incest victims or otherwise placed there for some sort of protective reason (as opposed to unlawful behaviour): they are in essence being punished yet again through no fault of their own, and denied opportunities they would otherwise have enjoyed.

There are 128 girls living under these conditions at St. Jude.

ACTIONS & RECOMMENDATIONS

1. [redacted]
It is the opinion of every single member of the Task Force, without exception, that [redacted] presents a clear and present danger to the children at St. Jude, and that she must be removed immediately. She is beyond question guilty in the extreme of reckless and criminal endangerment often resulting in bodily harm; physical and psychological abuse and torture; abuse of power; and professional incompetence with criminal implications. She may also quite possibly be guilty of malfeasance, relating especially to the new building under construction, although this requires a proper audit to verify (her deliberate attempt to mislead the Task Force on this issue is most suspicious).

So alarmed and concerned did the members of the Task Force become, based on both the physical evidence and the many corroborated reports encountered, that the Chairman sought an urgent meeting with His [redacted] At that meeting, members of the Task Force sensitized [redacted] to the grave nature of their findings and conclusions regarding St. Jude and [redacted], and indicated their strong recommendation that her employment be terminated with immediate effect. His Grace in turn indicated that he was aware of "strong concerns" regarding [redacted], and that he had had many complaints and reports over the years about her, which in turn he had forwarded to her superiors, as he had to follow certain protocols. He had assumed that some action had been taken, but the Task Force's presentations indicated that obviously this was not so. To his credit, he then gave the commitment that he would, with immediate effect, see to [redacted] removal as manageress at St. Jude. The Task Force left with a sense of profound relief, since many individuals had indicated that His Grace would waffle and skirt around the issue. At the time of this writing, however, [redacted] still operates at St. Jude. When contacted about this, His Grace indicated that he had done all he could within the purvey of his power, but that the problem now lay with the Statutory Board, which is the Government agency that employed her. He is not in a position therefore to do any more than he had, which was to liase with her superior and solicit her support in the matter, support which he says he recieved despite a rallying of opposition from senior members of the Carmelite Order. That being as it may, the bottom line is that [redacted] is still in charge at St. Jude (legitimately or otherwise, since her last contract ended in December 1996, and has not been renewed), and the reign of terror continues.

Further to these events, the Task Force has uncovered some disconcerting information regarding [redacted]. Sources at the UWI who administered the Child Care and Counselling Program she took there indicated the following: (i) she took six years to complete a three year course; (ii) her completion certificate was given under duress, because in the opinion of her examiners she was undeserving of the award; and (iii) it was the expressed opinion of those who trained her that she had very serious psychological and emotional problems that manifested themselves throughout her program of study, that indicated her profound unsuitability to engage in the type of activities that she was and continues to be engaged in.

Having exhausted the "politically correct" option of trying - in the interest and welfare of the children at St. Jude - to have Sister Dominic retired via the Catholic Church bureaucracy, the Task Force now has no option but to make the following strong recommendations:

With immediate effect, [redacted] should cease to be in any way allowed to manage, operate, or seek to influence the management or operation of any aspect or facet of St. Jude; that she be debarred if possible from residence there; and that the equivalent of a restraining order be imposed on her expressedly forbidding any contact between herself and the management of St. Jude (she has demonstrated that she is quite able to run the place by "remote control"). **[The Task Force is aware that the above recommendations may be difficult to effect, as the property on which the School and the Convent stand belong to the Carmelite Order, and as such her presence within the Convent is a matter for her Superiors]** It is further the opinion of the Task Force that a full investigation be mounted to determine the degree and extent of the episodes of abuse and neglect uncovered and detailed in this document, and, [redacted] status of being a nun notwithstanding, that any criminal proceedings that are called for be vigorously pursued, up to and including incarceration if so indicated. In short, the Task Force feels that the evidence of abuse is so profound and so extreme that the full weight of the Law needs to be brought to bear. The same goes for all of those matrons / supervisors similarly implicated.

It is further the recommendation of the Task Force, given that all of the atrocities documented above occurred under their patronage, that the management of St. Jude be forfeited and removed totally from the Carmelite Order, who now have no fit claim to its operation. Said management should instead be given to a properly assembled team of professionals including, but not limited to, a manager, an accounts clerk, a counsellor or social worker, a nutritionist, a doctor (or a qualified nurse supported with regularly scheduled medical visitation by a doctor), properly trained matrons / supervisors, appropriate teaching personnel (administering an appropriate curriculum), etc., all recruited by and reporting to an appropriately assembled Board of Directors, none of whom have served in that capacity before. As an extension of this (dealt with again later on), the hiring and termination capabilities should be removed from the Statutory Board and vested instead with the said Board of Directors.

2. Health and sanitation

The vermin problem at St. Jude is currently a quantifiable unknown. The Task Force was so astonished by the proliferation of rodents and cockroaches in evidence during its visit that its member from the Ministry of Health, Mrs. Valerie Rawlins, was directed to communicate with the relevant health authorities to initiate urgent intervention. This she did by letter dated 11th March 1997, addressed to Dr. Kameel Mungrue, Medical Officer of Health for the Port of Spain City Council (see Appendix II). The letter read in part: *"An inspection conducted at St. Jude's home ... revealed poor environmental sanitation as evidenced by rodents and vermin in the dormitories and store room; leaking faucets in some bath facilities; poor condition of all toilet facilities and clogged drain at the back of the premises... ".* Inspection and appropriate intervention was requested as quickly as possible.

To the profound amazement of the Task Force, the Public Health Department at the Port of Spain City Hall submitted a report to the City Medical Officer of Health dated 8th April 1997, which was forwarded to the Task Force under cover from Dr. Daniel Chang, PMOH, on 15th April 1997 (see Appendix II). That letter reads in part: *"An inspection ... revealed **no evidence** of poor environmental sanitation as stated by the cabinet appointed Task Force... **no evidence** of rodent or vermin infestation were observed in the dormitories and store room ... there were **some German cockroaches** in the kitchen area of the Carmel House unit. **Insecticides are currently being used** to abate this nuisance.... The toilet facilities at this institution were generally in a **satisfactory state of repair** save and except for a few missing seat and tank covers... **no evidence** of leaking faucets in the bath facilities were observed... maintenance workers were **actively engaged** in clearing a clogged drain under the **front** main building ... **information recieved at this institution** also indicated that personnel from the Insect and Rodent Control Units of the P.O.S. Corporation make visits **on a weekly basis**. **Clearly** this institution is being **satisfactorily maintained** bearing in mind its age and the very sensitive nature of the services it provides."* It is signed by one R. Ramkissoon, Public Health Inspector I, Section A (emphases added).

On receipt of this latter report the Task Force found itself wondering if it had newly arrived in the Twilight Zone, or if indeed the institution visited by the Public Health team was in fact St. Jude. Totally dissatisfied with the report, Mrs. Rawlins instituted an investigation to determine what was going on. The first revelation was that, contrary to the assertation by Mr. Ramkissoon that "*...personnel from the Insect and Rodent Control Units of the P.O.S. Corporation make visits on a weekly basis...*", such visits had been attempted several times in the distant past, but were eventually abandoned because Sister Dominic would refuse them entry to St. Jude. [Mr. Ramkissoon *does* indicate that this information was "*received at this institution*", so this is perhaps excusable.] As regards there being no evidence of rodentia during their visits, and of all the washrooms being in good repair, the Task Force is firm in what it observed. It is entirely possible that in the two weeks between the Task Force's visit and that of the Health Inspectors, Sister Dominic had the compound treated for vermin and had the plumbing fixed (she *does* have workmen on site, afterall, working on the new building). Mrs. Rawlins' investigations, however, paint a picture instead of a Public Health Department that had been "caught out", so to speak, in that the Task Force had uncovered and highlighted significant health and environmental problems at an institution within their domain that the very Public Health Inspectors were supposed to be visiting regularly (further investigations revealed sporadic, incomplete, and inconsistent visitation records, none of them recent). The letter, therefore, assumes the proportions of a document 'for the records' designed to deflect any suggestion of dereliction of duty by the officers or the department by denying the validity of the Task Force's reports (note especially its cryptic last sentence - a most curious commentary at the end of an inspection report). [There may well be another, darker agenda at play, but that will be addressed elsewhere].

All that being as it may, the vermin problem, if indeed it has been addressed as indicated in the Health Department's report, needs to be properly managed and must never be allowed to revert to the condition encountered by the Task Force. To this end, therefore, the Task Force recommends an urgent high level inspection of the compound utilising personnel

not drawn from the Port of Spain City Council, accompanied by Mrs. Rawlins who, apart from being a member of the Task Force, is the Director of Quality Management for the Ministry of Health. Subsequent to that visitation and the findings thereof, a properly monitored and documented timetable of visits from the Insect and Rodent Control Unit should be drawn up and implemented. Naturally, any plumbing problems also identified at that time need also to be addressed and rectified (Sister Dominic's new offices can wait).

Further to her letter to the MOH, Mrs. Rawlins also wrote to Dr. Violet Forsythe-Duke, County Medical Officer of Health for St. George West, requesting health assessments to be conducted on several children at the home who had communicated to the Task Force a history of *'heart disease, fever, and dysfunctional bleeding'* (see Appendix II). No report on the results of these assessments has to date been forthcoming. The Task Force nonetheless is firm in its recommendation that a doctor be on staff (or at least be on call, with a qualified nurse - not a nursing assistant - employed fulltime). No meaningful health records for the girls are kept, so no one knows what their real histories are, what communicable diseases they come in with (there is no preliminary examination), what drug or food allergies they may have, etc. The Task Force also recommends that a full medical team visit St. Jude to do general examinations of all of the girls in order to assess their current physical condition. They should all be wormed and, where appropriate, treated for lice (using proper medication, **not** *'BOP'* insecticide). The dorms and sleeping areas should also be appropriately treated, and bedding treated, disposed of, or boiled. Finally, toilets and washrooms should be throughly sanitized using properly mixed and applied disinfectants, and a properly managed maintenance schedule for so doing drawn up and implemented. The provision of hot water to the showers should be given serious consideration (solar heating could be a very cost effective solution in this situation), as should the addition of more bathroom and shower facilities.

3. Bedding and furniture

The Task Force is of the opinion that most of the beds and mattresses at St. Jude need to be replaced. The same goes for the sheets and blankets. The mattresses consist in large part of very old, very dirty, often rotten slabs of foam. Many of the beds need new supporting boards and/or frames. In addition, the children have no pillows. [All of these can be sourced free of charge from FEEL . This has been confirmed by Mr. Clive Pantin, Chairman of FEEL, who indicated that he had over 40 beds and mattresses immediately available, with more coming in all the time. If he is advised as to what exactly is required, he will be able to target those items as needed.]

Similarly, the furniture in the common areas needs replacing, since much of it is broken or in poor repair.

Generally, the physical appearance of the dorms needs attention, and most of the cupboards used by the girls for storing clothing and personal items need repairs or replacing.

4. Food and nutrition

The entire food aquisition, storage, and distribution system at St. Jude needs to be overhauled. The addition of a qualified nutritionist who can develop a proper meal plan for the institution, taking into account the varied diets extant in the diverse child population, will resolve this. Vegetarians eat no meat and therefore will need adequate protein substitutes in their meal plans; those with food allergies will need to have special diets and care taken regarding cross-contamination of foodstuffs; some religious tenets prohibit the eating of certain meats (pork, beef), or of foods not prepared in certain ways; and so on. A proper bulk food aquisition schedule needs to be developed.

The food storage area needs to be emptied, properly cleaned and rehabilitated (or simply moved to a more adequate area), and restocked, with rice, flour, etc. kept in proper sealed containers to prevent vermin and insect access. Stoves and ovens used for cookng need servicing, repair and/or refurbishment. Food preparation areas also need to be repaired and refurbished, and properly sanitised.

5. Placement and overcrowding

There is the distressing reality that the girls at St. Jude are hopelessly overcrowded. By [redacted] own admission, some 50-60% of those there are there because of incest or sexual abuse. Yet these girls are housed in a haphazard fashion along with those who were placed there by the courts for juvenile offences, among other things. The Task Force is of the opinion that a team of social workers should go into the home and conduct a case-by-case psychological and situational assessment of the girls there, with a view to reducing the population where ever possible, and therefore easing the overcrowding of the dorms and all of the concomitant difficulties that follow from that (disease vectors, food quantity, allocation of physical and human resources, etc.). A more structured approach to housing those left needs to be developed, with dormitory groupings kept more in line with the reasons for being warded at St. Jude rather than the 'where there is space' method currently in practice. Where possible, girls not 'incarcerated' should be re-united with their families or some other family support group. Similarly, those not 'incarcerated' but who cannot return to their homes or relatives should be placed where possible in some smaller NGO or private home (this points directly to the long-expressed need for a foster care system to be developed).

The other much needed result of this exercise is that a comprehensive record base of the residents of St. Jude will be produced, to be enhanced with additional information from the courts and police, as well as the health data generated by the visiting health team.

2.0 ST. DOMINIC'S CHILDREN'S HOME

[Based on visit to the Home (6 March) and discussions with Staff (14, 24 and 25 March]

St. Dominic's Children's Home is a study in opposites. The Task Force found that once again its arrival - though deliberately unannounced - was known to the staff at the Home in advance (the cooks for instance, for the first time in remembered history, wore white caps on the afternoon the Task Force visited). The Home consists of 10 departments or 'Houses', and is run by the Dominican Sisters, who have been responsible for it since 1876. The manageress (since 1990) is [redacted], who seemed quite prepared for the Task Force's arrival, and even went so far as to distribute information packages to the members, with each package individually addressed. Following are the house-by-house observations noted during walkabout:

1. Nursery

The nursery caters for children aged 0-4, and had 9 boys and 8 girls at the time of visitation.

The cribs were painted in light blue high-gloss paint, and had their corners badly chewed (this could be quite dangerous if the paint is lead-based, as most high gloss paint is). No pillows were present.

The nurse's room had been freshly painted (within the previous 2 weeks), and there was a new nurse and doctor on staff (also added within the previous 2 weeks). [The staff indicated that prior to the announcement that the Task Force had begun visitations to homes, there was no doctor or nurse on the compound - children used to be taken instead to the Health Center or to Casualty at the Port of Spain General Hospital].

None of the children's toilets had seats or seat covers.

There was lots of fresh paint everywhere (even the swings outside were freshly painted).

The indoor play area was under renovation, and the walls were being stripped of paint.

The outside of the nursery building, however, needed work - some rotten boards were in evidence, and it needed to be painted (this may well have been done since then).

The security of the nursery appeared to be an area of strong concern to the staff, who pointed to the totally inadequate outside lighting (only one working fixture was observed), and related various incidents of night time prowlers trying to break in. Also, there is no alarm system in place, and the telephone is reportedly not always working.

One complaint noted was that there are no males involved in "family stimulation" for the young children, with the result that when they are old enough to leave the nursery for one of the other houses, they have little or no meaningful exposure to male role models. In general, the staff seem to see their role as being one of "supervising" the children, rather than interacting and playing (ie. providing meaningful stimulation) with them. The ratio of staff to children is woefully inadequate.

2. Nazareth House

Nazareth caters for boys aged 4 to 15. There were 29 resident boys at the time of visitation. [redacted] was on duty, and answered queries.

There was a powerful stench of urine eminating from the building even before entry. The ground floor common area had broken floor tiles everywhere, with obvious hazards given that the boys run around in bare feet. Although furniture was sparse, broken chairs were also evident everywhere, many with stripped seats, or no seats at all.

The ground floor change room (for the showers) badly needed painting. The showers themselves were in poor repair, and none had showerheads. The toilets were almost unapproachable, due to the stench of urine, and appeared to be broken and without seats.

Upstairs in the sleeping area, the situation was only marginally better. A significant number of the boys were reported to be bedwetters, and their mattresses were put to dry up in the attic (this only heightened the stench of stale urine in the building). The beds were generally in poor repair, with many having broken slats. Very few beds had pillows, most did not. Mattresses were by and large rotten slabs of foam (several new mattresses, by comparison, were observed up top in storage). The partitions between sleeping areas sported large holes, and there were several holes in the floorboards reportedly due to termites.

Water was identified as a major problem in the house, and was the explanation given for the reason the toilets were not flushed or clean.

There were only two exits from the building noted, but only one of these was opened. The other exit was locked, and the Task Force was told that there was no key for it (a very dangerous situation in the event of another fire at St. Dominic's!). No fire extinguisher was observed.

The wide range in ages of the boys was a source of deep concern for Task Force members, since several reports of sexual abuse of the younger boys by the older ones had been recieved (more on this elsewhere).

3. Maria Gorritti House

This house caters to girls 5 to 16 years old. There were 36 girls resident at the time of visitation. The House Mother is [redacted].

The walls in the eating room were peeling and in desperate need of resurfacing and painting. The floor in the eating and common areas had several broken tiles (again with obvious hazards), and the ceiling had several holes in the cellotex. Lighting was inadequate as well, with only two bulbs in the ceiling.

The laundry area was inadequate, with both the washer and the dryer totally non-functional. Washing is done by hand by the girls.

The toilet off the eating and laundry area had no seat, and there was no evidence of any sanitary napkin disposal bin in the stall.

4. Our Lady's House

Our Lady's caters to children in families (ie. brothers and sisters) between the ages of 4 to 15. At the time of visitation, there were 5 families resident comprised of 7 boys and 13 girls. The Home Mother, [redacted] (Supervisor II) answered questions posed by members of the Task Force.

Once again the floor in the sitting and dining area had numerous broken tiles, and the walls again were in need of scraping and painting. Furniture was generally in poor repair, with torn seats and cushions most evident.

The bathrooms once again had a powerful smell of urine. The toilets had no toilet seats or covers, and the showers had no showerheads. Several lacked on/off controls.

[redacted] indicated that there is no set menu plan that is followed. There are no fresh greens as such - only such items as can be deep frozen. Market for vegetables is done every two weeks or so, and only items that will last until the next market are purchased. The quality of produce purchased is not the best - only the cheapest.

The sole fire extinguisher present was last checked and filled on 8/8/94 (the visit date was 6/3/97).

The beds were in fair repair, but again the mattresses were old foam slabs in need of replacement, and again no pillows were evident. One sleeping cubicle was partially destroyed - an 11 year old boy had set fire to his bed there on 1/1/97. No repairs had been effected since then, and the burnt bed, partition and cupboard were still present. This latter incident led to the disclosure that the children in the house had (still) access to matches, pitchoil etc., and that this had been the third incident of its kind in recent times. The general atmosphere in the House was very dark and dismal, with very inadequate lighting provided.

5. St. Thomas House

St. Thomas caters to boys aged 13 to 16+, and had 22 boys resident at the time of visitation.

The House has 3 toilets, none with seats or covers. The showers had no showerheads, and the spout pipes were broken off as they emerged from the wall. There appeared to be a drainage problem in the bathroom area, as there was water all over the floor. Once again, a coat of paint was quite in order to spruce the place up.

Safety practices in the House were questionable. Members observed, for instance, one boy brushing his hair while holding a jagged piece of broken mirror in his hand, an action that was neither corrected nor commented on by the male staff member accompanying the Task Force [redacted]. The risks posed by this piece of broken mirror are enormous: accidental wounding of self or others, use of same as weapon, use of same to attempt suicide, etc. The implications in general as to the overall care and diligence observed in St. Dominic as to safety of the children are troubling, to say the least.

The Task Force noted the presence of new fire detectors in the ceiling. These, it turned out, had been installed only the Monday before. No fire extinguishers, however, were noted.

6. St. Andrew's House

This building used to be the nun's residence, and as such was in much better repair than any of the others visited so far. Like St. Thomas House, St. Andrew caters to older boys. The Task Force was told that, due to the chronic water problems that plague St. Dominic's, the boys here get up between 5 - 5:30am and go to the bottom of the hill to bring back buckets of water for toilets, bathing, etc.

The showers here DID have showerheads, and of the toilets seen, one DID have a seat.

7. & 8. St. Martin's // St. Dominic Savio Houses

These Houses (they are actually one large building split down the middle into two separate housing entities) cater to boys aged 4 - 11, with 24 in residence at the time of visitation. St. Dominic Savio has been without a House Mother for years.

The first striking thing observed was the dangerously low cables running to this building (at or below eye level). Telephone and electrical cables were noted. The electrical cable at the juncture point with the building was cracked and peeling, and in definite need of repair or replacement (definitely a hazard). The upstairs fire exit was locked (it is at the end of the corridor separating the two Houses).

The toilets downstairs were broken, had no seats, and were again almost unapproachable due to the overpowering smell of urine. The showers again had no showerheads, and an open electrical box was observed in close proximity to the water pipes.The upstairs toilets once again had no seats; one toilet was broken. The bathroom floor had several missing or broken tiles, again posing the obvious safety hazards.

The sleepng area floor too had several broken floor tiles, and the walls again badly needed painting. The furniture in the sitting area was in very poor repair, with one couch having no arms at all. The clothes cupboards were old and broken, and badly in need of repair or replacement.

9. St. Catherine's House

This is another family unit catering to children aged 5 to 14. There were 5 boys and 13 girls resident at the time of visitation.

By and large, this House was in very good repair. The only anomalies noted were the presence in the TV room of several cushions with no covers, and a broken couch. Also, in the upstairs 'pantry' the sink had no faucet.

10. Bethlehem House

This is an all-girls house catering to girls aged 5 to 15, with 26 girls in residence at the time of visitation. The House Mother is [redacted].

This House was in very poor repair. The beds and foam mattresses observed were old and in need of replacement. The ironing board in use was similarly broken and in need of replacement. The floors were rotten in places, the pantry sinks leaked, and the walls desperately needed painting.

The shower area was located downstairs, and were in very poor repair. Again, no proper sanitary napkin disposal containers were observed.

The furniture in the sitting room was in generally poor repair, with lots of torn cushions, and several broken couches and chairs.

STAFF CONCERNS

1. Nutrition: Staff report that children are often not given drinks with lunch. They occasionally get "an orange drink", but this is rare supposedly "because of cost", an excuse that staff do not consider legitimate.

2. Water: There is a severe water problem at the Home. Staff report that the water trucks have instructions to only deliver water to the main kitchen and to management's facilities. Consequently, the children spend long arduous hours before and after school toting water up the hill. Water pumps have not been installed for fear that the old pipes will burst under pressure. The water is often so cold that some children develop chills following baths. Because of these two factors (water shortage and chills) the children bathe infrequently, which in turn leads to skin problems developing.

3.Security: Security is a major concern. Trespassers have climbed onto the roof of the nursery from Bella Road. This is scary for staff, since a man was discovered dead on Bella Road some 3 years ago, and more recently someone was mugged on the compound at 8pm one night. The one security guard on duty is unable to respond in a timely manner or do his job effectively. Security lights at certain points in the compound were only installed 2 days before the visit of the Task Force.

4. Sexual Harassment : Staff report that a female staff member was dismissed on allegations made by a male member of staff whose advances she had rejected. The nature of the allegations were that this female staff member had behaved in a sexual and wholly inappropriate manner to a male resident. She was accused of inviting this resident to her home, when in fact she lived with her mother who totally denies this. There are witnesses who say that this male staff member often made remarks in front of the residents about the female staff member, comments like "I wonder what Miss ... would be like in bed". No investigation was carried out, yet she was accused, convicted, and dismissed. The male staff member is reputed to have used the Home as a refuge from the police.

[This Staff report corresponds loosely to the incidents surrounding the alleged wrongful dismissal of [redacted], whose case was championed to the Task Force Chairman by [redacted], a Catholic priest who has worked at the Home for some time. The Chairman met with both [redacted] and [redacted], and familiarised himself with the facts of the case. [redacted], in his report on St. Dominic's to the Chairman (see Appendix III), states that [redacted] *"...was an official relief worker, an excellent care-giver with an impeccable record... She was at Bishop's High School's Bazaar with her two cousins. Some senior boys from the Home happened to be there also. One boy, [redacted], with a record of deviant behaviour, reported that he had seen 'two shadows kissing' and that it must have been [redacted] and another boy from the Home, [redacted]. [redacted] called a meeting on this evidence at which [redacted], without an investigation, told [redacted] that she was sick and needed treatment. Within a week [redacted] had run away from the Home and was sent to YTC. [redacted], who at first denied it, was spoken to by [redacted] who brought him to [redacted] office, where he said that the*

incident did occur. It is to be noted that that [redacted] *worked for some time in that department with* [redacted] *and that she got the boys to behave themselves in areas where* [redacted] *had failed. She had also refused to cooperate with Mr. Thomas in his sexual remarks.* [redacted] *is a gifted care-giver, with three B's at 'A' Level from St. Joseph's Convent, St. Joseph. She ardently desires to work with children and has not yet been able to get another job. She has suffered immensely...".*

The Chairman was sufficiently moved by [redacted] experiences that he took the issue up with [redacted], who in turn promised to investigate the matter. As it turns out, all [redacted] did was to discuss it briefly with [redacted], and no more. [redacted] has meanwhile discovered that [redacted] has spread the rumour to all of the other large children's homes and institutions in North Trinidad, and she is now totally unable to find employment as a result of the slander. She is currently pursuing legal action against [redacted] and the Home.]

5. Management - Staff relations: Relationships with management is a major problem. There is a lack of mutual respect between management and staff, but more disconcerting is the fact that the staff are not told about crucial information about the children, either in terms of special medical conditions (eg. asthma, allergies), or previous histories of dysfunctionality (eg. arson). The managers of the home (especially [redacted]) are described as unkind and uncaring, and as individuals who see the delegation of responsibilities as losing their power - so that very little is ever delegated.

6. Breaches of Confidentiality: Residents who did "on the job training" had access to personal records of staff. Students therefore had knowledge of personal information and were privy to discussions about staff members. This in turn served to undermine the authority of staff members with the children, a position that was readily reinforced by the openly negative attitude of the management towards staff.

7. Special treatment: Some of the older girls enjoy extra privileges through their having befriended individuals "of high status" outside the Home. A backlash from this has been that the rules of the Home and the staff who implement them are now seen negatively. Superiority based on skin colour is reinforced when the children with lighter complexions or those who are of non-African descent are chosen by the management for links with 'special visitors'; they also get first choice for the family unit system of care. [This latter revelation is rather disturbing, especially the part about the 'special visitors', a statement that was not qualified by the staff members who spoke candidly outside the compound. The Task Force prefers to assume that this refers to the many members of NGO's and other private community spirited individuals that go to the Home regularly in a care-giving and otherwise supportive role, rather than about something more sinister which has been rumoured from time to time in discussions on child prostitution in Trinidad and Tobago.]

8. Sexual abuse of children: A male member of staff (who was once a resident there) is alleged to have perpetrated multiple sexual acts with a number of children up to the latter part of 1995. These included forced buggery; encouraging boys to have sex with each other while he watched; stripping and beating the older boys while the younger ones looked on; encouraging the children to 'play' with him, etc. He reportedly hit a child who once told about the 'rough play' at night. One young boy finally disclosed all and the alleged perpetrator was confronted. He admitted his actions and explained that he too had been abused at St. Dominic's [redacted] asked him to volunteer his resignation that day, and all of his leave etc. was paid to him in full. The matter was then promptly swept under the carpet and no counselling or followup with the children involved was done, ostensibly to protect the reputation of the Home.
[Discrete enquiries revealed that the name of the ex-staff member is [redacted], who was indeed an ex-boy from St. Dominic's . He is reputed to have molested some 30 - 40 boys before he was stopped. Amazingly, other than the verbal reprimand he received from [redacted] and his constructive dismissal thereafter, very little else appears to have been done about his actions, either in terms of him getting professional help, or - more importantly, as noted above - any of the staggering number of children he molested getting help either (one child even wrote a letter to a staff member pleading for help). Most astonishing of all is this: [redacted] allegedly got a letter of recommendation from St. Dominic's, and he is now reportedly employed at St. Ann's Hospital!]
It is also alleged that girls are sexually abusing other girls in Bethlehem House, but no details were provided.

9.Visitations: Visits between parents and children are unsupervised, even in cases where there is need for this. Consequently, children have often been severely verbally and physically abused by their parents while being visited; one parent abducted his son; and another parent chopped up a hula-hoop he had brought as a present for his child, in front of the child.

10. Drugs: Staff indicate that they have no control over older boys who smoke marijuana. The practice is largely ignored by management.

11. Nursery: There is only one staff member on duty in the nursery at night. [See the sections above on the nursery, and on security.]

12. Corporal punishment: Corporal punishment is rampant at the Home, and is reportedly administered by all members of staff. Apparently, new guidelines relating to this had been laid down 2 weeks prior to the Task Force's visit, but its effect or the changes produced were generally unquantifiable. One [redacted] in Our Lady's House is reputedly the most abusive of the staff, both verbally and physically.

COMMENTS FROM AN EX-RESIDENT

[redacted], a 23 year old ex-girl from St. Dominic's, gave some alarming testimony as to events that have occurred there. She alleged that she had, over the years, been kicked, slapped, and had her head bounced against the wall by both supervisors and nuns alike, and that this treatment is very common at St. Dominic's. She reported that another girl was deliberately burned with a hot iron by one of the sisters. She confirmed that children do not get a midday drink (with lunch), and that some children get preferential treatment when it comes to clothing. She herself was made to leave at 16, even though this jeopardised her sitting her CXC exams, as she was promptly sent by her father to live with an aunt with whom she had no relationship, and the aunt lived far from her school. The management of St. Dominic's knew that her father would do this, since he was incapable of looking after her, but took no steps to at least allow her to complete her studies before releasing her. As a result, her life is now at a dead end. She was reportedly an 'A' student. [redacted]estimony on the above and on other matters says much about the lack of preparation leading to discharge and/or the interpretation of a discharge policy at St. Dominic's in very literal terms. While it may be too late to be of benefit to her, there are many children currently at St. Dominic's that progressive intervention now may yet make a difference for. The most telling part of her particular trajedy (not to belittle the opportunities now forever lost to her) is her revelation that there are many other ex-St. Dominic's girls - several of whom she named - who had found themselves similarly treated, and who are now prostitutes in and around Port of Spain.

ACTIONS & RECOMMENDATIONS

1. Water: probably the most pressing problem to be solved at St. Dominic's is that of water. An adequate water supply will go a long way in resolving a number of issues: the toilet situation, health and hygiene issues, bathing problems, laundry problems, the children having to tote water up the hill, etc. It is the opinion of the Task Force that it ought to be a fairly simple matter to run new lines from the storage tanks in the main water storage area at the top of the hill (next to the nursery) to the water mains down on Belmont Circular Road, and affix a water pump of suitable PSI to this new link to pump water up to the tanks. These in turn could be fed into those tanks (where they exist) at each of the Houses. Where tanks do not exist, they can be added, and the capacity in the main storage area can be increased with additional water tanks arrayed in a cascade topology. Each House should ideally be fitted with at least 4 to 6 400-gallon tanks each to ensure adequate capacity to satisfy demand. Water heaters ought also to be added (possibly solar or gas heaters, depending on cost).
It was dismaying to the Task Force to see that the Sisters had given priority to building themselves a new residence and new offices before addressing something as fundamental as water. It was also most distressing to see that the nuns enjoy having the Fire Services bring water up to their residence and the main kitchen, while the children - some as young as 6 - are forced to tote water up that torturous hill twice daily.

2. Management: While the degree of ineptitude and abuse was not as immediately clear at St. Dominic's as it was at St. Jude's, the testimonies of the several members of staff who met with the Task Force outside of the compound, in addition to the testimony of [redacted] who has been with the Home since 1979, make it evident that it is still significant and alarming. The incidents involving [redacted] and [redacted], and (especially!) [redacted], clearly implicate the management of the Home in the most negative manner. Stated differently, those managing the Home (ie. [redacted] et al) are culpable, morally and legally, for the past and present abuse of the children and staff. Indeed, [redacted] handling of the [redacted] alone qualifies her for immediate dismissal as manager, as indeed she would have been were she employed anywhere in the private sector.

It is simply not enough that she made [redacted] resign once his sexual abuses were exposed. The fact that she would allegedly give him a recommendation and support him in getting a job at St. Anns after the heinous things he committed with not 1 or 2, but 30 to 40 of the boys in her care is an outrage! And that this was swept under the carpet to save the Home public embarassment and negative press reports is equally outrageous. In our local newspapers it is not uncommon to see a man being sentenced to 15 years for serious indecency with a minor - ONE minor. Given the enormity of his crime, [redacted] would in any other society be branded a monster of the worst kind, and he would be put away for life. What makes [redacted] most culpable in this instance, though, is that she failed to provide immediate, meaningful, therapeutic intervention (both medical and psychological) for the children involved: this alone makes her party to their abuse and to their ultimate psychological destruction. Primarily for this reason, therefore, the Task Force recommends that her services be terminated with immediate effect, and that she be replaced in the first instance with a member of her Order with *proven* managerial skills or, failing this, with a suitably qualified manager duly selected through public advertisment.

The Task Force further recommends that the [redacted] incident be thoroughly investigated, and that [redacted] be brought to justice for his terrible abuses.

Similarly, the accusations of sexual harassment of [redacted] should be investigated, as well as the circumstances surrounding her dismissal. If, as was alleged, [redacted] is found culpable in this regard, then he too must be dismissed and brought before the courts, and the cause of Justice must be served on all those implicated. [redacted] name needs to be publically cleared, and her job at St. Dominic's - assuming that she still wants it - must be reinstated.

Further to these, the Task Force is of the opinion that the same interventions recommended for St. Jude be similarly applied here, ie. that a new management team be established for the Home; that a medical team and a team of social workers be sent in for in-depth situational, physical, and psychological assessments of the children and for the proper documentation thereof; and that the Board of Directors be re-organised and re-constituted. While the inclusion of the Dominican Sisters in the running of the Home should be continued, their role needs to be reduced and replaced with individuals with greater core competencies in the running of institutions of this kind more in keeping with the standards desired and considered acceptable by the Government.

3. Building refurbishment: It is abundantly clear that, in varying degrees, all of the buildings need repair and refurbishment. Some - like Nazareth House - ought simply to be demolished and re-built. The visitation observations detailed above give a House-by-House breakdown of the substantive repairs that are required. [redacted] had indicated that she had drawn up a list of all of the repairs that were needed for St. Dominic's, and that she estimated that they would cost approximately $250,000 - $300,000 to effect. How real - or realistic - that estimate is, the Task Force was unable to verify.

4. Bedding and furniture: Virtually all of the mattresses - especially those of the bedwetters - need to be replaced. Washable plastic slip-covers ought to be used on the new mattresses to prolong their life and to prevent urine penetration. Pillows and blankets ought to be provided. New bed linens are also required.
The furniture - especially in the common areas - generally needs replacing.

5. Psychological intervention: Given the inordinantly large number of bedwetters at St. Dominic's, it is abundantly clear that a significant number of the children suffer from emotional problems, usually the leading cause of bedwetting behaviour (bedwetting can also be due to urinary tract infections, but that is unlikely to occur on such a large scale as this). The Peters Affair must undoubtly have contributed in some measure to the emotional problems so indicated, especially among the boys he molested, but regardless of the causes, the situation is clearly of crisis proportions and adequate therapeutic intervention must be initiated as soon as possible. This can follow from the assessments recommended in *'Management'* above.

6. Food: The system of food procurement, distribution and preparation needs revamping. It is simply not good enough to have a situation where fresh vegetables are purchased every other week - it ought to be done every week. Care ought to be taken to identify the special needs of children especially as regards allergies and religious strictures (addressed next). There is a 'nutritionist' on staff - one [redacted] - but her expertise and qualifications are unknown. No meal plan or menu system was seen.

7. Denial of religious rights: One of the more distressing revelations for the Task Force was the information that the children are all 're-baptized' or 're-christened' on arrival at the Home, regardless of their religious background. Even though St. Dominic's is run by a Catholic Order, this is no excuse for the denial of fundamental religious rights as guaranteed in the Constitution, the Children Act, and the UN Charter of Rights. This procedure ought to be stopped immediately.

8. Health: There are a number of health issues that need to be properly and urgently addressed. There is reportedly an outbreak of ringworm in the Home for instance, along with other skin rashes. Staff tend to link this with the chronic water problems identified above, but be this as it may, the Task Force re-emphasises the need for a proper medical team to go into the Home and do a case by case medical assessment of the children, and build proper files and histories for them.

9. Corporal punishment: Ideally, this must be stopped at St. Dominic's, not least because it is unacceptable and of questionable legality. The staff need to be reminded that *'discipline'* and *'punishment'* are not the same thing. There are many other more effective methods of instilling standards of conduct besides trying to beat good behaviour into a child. Similarly, beating an emotionally disturbed child for bedwetting does not curb the bedwetting - it only further leads the child into a psychology of despair and self hatred, and can ultimately breed rage and violence. The services of a full-time psychologist on staff will go a long way to addressing many of these deficiencies. [It should be noted that St. Dominic's has had one post of Social Worker vacant for almost ten years. It should be filled, and the staff of the Vocational Training Shops should be upgraded to the Servol or YTEPP instructor level.]

As mentioned earlier, [redacted] in Our Lady's is reputedly one of the more abusive staff members. In his report to the Task Force, [redacted] states: " *I am disturbed by the abusive approach of* [redacted]*, the House Mother of Our Lady's. I have personally witnessed the continuous aggressive shouting at the children. A primary school teacher complained to me last year about the marks on the body of an eleven year old girl. Two members of the staff of Our Lady's could not take the abuse, verbal, psychological, and physical, meted out to the children - and the abuse they personally received as members of staff and had to be transferred to another Department. Another member of staff has asked to be removed. Another member of staff, recently appointed to Our Lady's, went to* [redacted] *in her anguish just last week, but got no satisfaction. I certainly blame the Manager for this situation - but then* [redacted] *is her friend! So is* [redacted] "
The position of the Task Force is that if the allegations against [redacted] are proven to be true (and the several staff members interviewed insist that they are), then [redacted] has no place in an institution like St. Dominic's, and her employment must be terminated forthwith. Further, steps should be taken to ensure that she does not secure employment elsewhere in a similar job function, since that will only expose a new child population to potential abuse at her hands.

3.0 ST. MARY'S CHILDREN'S HOME

[Visited 12th. March 1997]

St. Mary's Children's Home (aka the Tacarigua Orphanage) is situated at the intersection of Orange Grove Road and the Eastern Main Road in Tacarigua. It is home to 113 boys and 57 girls, between 2 months to 18 years of age. It is an Anglican Institution, and is operated by the Anglican Church in collaboration with the State, with the Anglican Bishop acting as Chairman of the Board of Directors. The current Manageress is [redacted]. Of the Homes visited by the Task Force, St. Mary's was one of the better managed facilities.

OBSERVATIONS

1. Environment

Some of the buildings on the compound, including the school, have been condemned as unfit and unsafe for use, and yet are still in active use. One of the boy's dormitories is badly in need of repair and renovation, as is the health center and the nursery section. [redacted] indicated that there are plans for complete refurbishment and/or rebuilding of these blocks, but resources (ie. money) is a problem, and so these plans are taking a long time to come to fruition. [In spite of this, a new office block was being completed feverishly while the Task Force was visiting, as it was due to be formally opened and blessed by the Bishop that weekend.] The Task Force was shown areas where some renovations had recently taken place, but it was often difficult to equate the Home's sense of priorities: the inner wall along the driveway, for instance, was newly constructed, while the roof over the play area in the nursery was full of holes and leaked badly.

The bathrooms, though generally clean, were overall in terrible condition. There were chipped tiles in the showers, broken doors in the toilets, no shower heads in the shower stalls, and dripping faucets everywhere, and yet the Task Force encountered the staff plumber in the plumbing shed fiddling around doing nothing important when he could have been better occupied repairing the leaks observed. His perspective seemed to be that he was there to teach the boys plumbing as a trade, not to act as a handyman around the compound. The Task Force suggested that he could perhaps combine the two to better effect, something he agreed to, albeit somewhat grudgingly.

Similarly, there is a woodworking shop on the premises where carpentry and cabinet making are taught, yet many of the beds and other furniture in the dorms required repair and/or replacement (in the senior boy's upstairs sleeping area, for instance, the couches were ripped up, had springs showing, and had no legs). It was distressing to see some chairs that had been brought from an external source into the shop as a 'private job' for "the boys to learn on", while there was so much else to be done on site. Needless to say, similar suggestions were made to the woodworking instructor/teacher as were made to the plumber.

The emergency exits in the senior boy's upstairs dorm were boarded up (very dangerous), and some doors literally led nowhere (there were no steps behind them - just a 10 foot drop to the ground). The wooden floor had broken floorboards and/or holes in the floor.

The Task Force was most impressed by the kitchen, headed by one [redacted], who used to be the head nutritionist at the Ministry. She helped to develop the meal plan, which was very well thought out indeed.
The Task Force observed that the filter screens above the kitchen were badly in need of cleaning. On pointing this out, [redacted] indicated that they were usually cleaned by a firm called '[redacted]', but that they had not come recently. She promised that it would be attended to.
The roof in the kitchen appeared to have a bad leak over the large stationary cookers, bad enough for some of the styrotex to have collapsed. The Task Force was told that the regular handyman had suffered a mishap, and as a result many things that needed to be done had been left hanging. Again, action was promised.

As mentioned above, the nursing area / health center was in a delapidated condition, and was scheduled for renovation. Nonetheless, the Task Force was told that a Registered Nurse from the Ministry of Health visited on Mondays, Wednesdays, and Fridays, and that a doctor visited on Tuesdays and Thursdays. Neither was present on the day the Task Force conducted its visitation.

In the junior boys' dorm, the pillows were kept in storage, with no pillow cases evident.
The junior boys had only one shower, and the toilet area offered no privacy (there were no stalls, just an open row of toilet bowls).
The sink in the junior boys' eating area had a number of broken tiles, with obvious safety risks associated with these.

Behind the laundry shed soap water is pumped from the washing machines into a canal, which in turn flows into a large open drain that runs the width of the property. This is an obvious environmental pollutant. [redacted] indicated that it was only so 'temporarily', and that new buildings were coming. The Task Force took note, however, that the canal was clogged in several places, and that the area had a look other than 'temporary'.

In the girl's dorm, on the ground floor there were no seats on 2 of the toilets, roaches in one of the toilet stalls, and an open floor drain cut into the ground. Further, there were no shower heads in 2 showers, broken floor tiles, and no shower controls to turn the water on and off. The roof, however, had been recently replaced.
The upstairs bathrooms had a sanitary napkin bin in only 1 toilet, and again no shower heads in the shower stalls.
Leaky faucets were everywhere.

The toilets upstairs in the infants' dorm had no seats and smelled of urine. The showers again had no showerheads or faucet controls, and dripped water. One sink was missing.
The toilets downstairs again stunk of urine; 2 toilet bowls were missing; one had no seat.
There were very few hooks on the wall in the shower for towels.
Several of the beds/cots in the sleeping area were broken and in need of repair.
The Task Force observed an electric insect 'zapper'in the dorm that had obviously not been cleaned in ages - it was full of dead insects. Also, there were no fire extinguishers visible, but holders for extinguishers were affixed to the wall.
As mentioned earlier, the roof at the entrance was rotten and leaky.

The hoops on the basketball courts were broken and/or bent, and needed replacing.

2. Relationships
Generally, there appeared to be a caring, nurturing atmosphere at the Home as far as the staff's ability to provide for the children was concerned (especially the younger ones). Morale among the staff was reportedly good, and the children all appeared happy and valued. The Task Force was informed that there were 76 adults on staff in various capacities, with some 35 supervisors to tend to 200 children (several children are day students only, not residents).
One practice at the Home is that 'special' children (ie. handicapped, mentally challenged, or children with Down's syndrome) are kept with the general population, despite the special needs they require individually, many of which the Home is frankly not equipped for.
Family visitation was reportedly encouraged as much as possible.

3. Education
A primary school is situated within the compound which provides schooling up to Common Entrance level. As noted above, the school building itself has been condemned, but continues to be occupied. The school is understaffed, especially given the number of children enrolled (some, as mentioned above, are day students only and not residents), and the varying learning abilities of the children.
Most of the children at the Home have been placed there by the courts.

4. Corporal punishment
[redacted] insisted to the Task Force that there is "no licks" at the Home, that corporal punishment had been "outlawed". The children, on the other hand, told a different story. According to the children, the night supervisors in the dorms beat the children with "sticks and belts" to make them stop crying and go to sleep (very confused rationale). In the school, one male teacher who has been on staff for some 15 years, a [redacted], reportedly gives "bad licks with his belt" (this was verified by 2 student teachers interviewed privately). The Principal of the school, one [redacted], is reported to also flog especially the older children.
Happily, the Task Force was satisfied that food is not used as a form of punishment at the Home.

RECOMMENDATIONS

1. Repairs

There is clearly a significant need for general repairs at the Home. Some of it, such as the plumbing problems and to some extent the repair of beds and furniture, can be done by the residents and the relevant trade instructors, as indicated earlier. At most some expenditure will be required to procure materials to carry this out, but it is doable without significant cost.

Building renovations, however, are a different story. Given that several of the buildings have been condemned outright, the Home is walking a fine line indeed when it comes to the question of endangerment of the children who continue to use these buildings. The Task Force recognises the difficulties the Home has faced in securing funding to demolish and rebuild these buildings, but it must recommend that the use of the condemned structures must cease as soon as possible for the safety of all concerned. The Government is therefore encouraged to assist the Home in the rebuilding of new structures as soon as possible, before a serious mishap occurs.

2. Punishment

Despite [redacted] best protestations to the contrary, the Task Force has little doubt that corporal punishment continues to be practiced at St. Mary's. Of particular concern were the reports surrounding the beatings inflicted on the children at night, as these have the effect of terrorising especially the younger children. Whatever positive nurturing offered by the day staff will clearly be undermined by this 'secret' activity. The Task Force recommends therefore that the night supervisors known to beat the children be strongly cautioned about this behaviour, and if it is not stopped, then they should be summarily dismissed. Further to this, it is strongly recommended that a qualified social worker or child psychologist be called in to conduct some mandatory retraining workshops for all the supervisors, with a view to helping them develop alternative coping skills and ways of working with the children, instead of the simple custodial role they currently appear to play.

The teachers, especially [redacted] and [redacted], ought to be similarly cautioned.

By and large, despite the problems identified above, the Home is managed in an enlightened and progressive manner, and [redacted] ought to be commended for doing as well as she has despite the strictures she faces. The Task Force was impressed by many aspects of the overall operations of the Home, and encourages any efforts and assistance aimed at assisting her in correcting the deficiencies highlighted.

4.0 ST. MICHAEL'S SCHOOL FOR BOYS

[Visited 21 March 1997]

St. Michaels School for Boys is situated in Diego Martin, and is home to 136 boys. Its current total residential capacity (double bunked) is up to 250. There is a ten member Governing Council headed by the Bishop of the Anglican Diocese of Port of Spain that advises the administration of the school, but the overall administration and direction of the institution falls under the jurisdiction of the Ministry of Social Development and Family Services. The Manager [redacted] and the Deputy Manager report to that Ministry. Further to this, the Ministry of Education operates an elementary school with a Principal and teaching staff reporting to the local Ministry of Education office. Both Ministries operate as a team at St. Michael's. Of all of the large homes and institutions visited by the Task Force, St. Michael's was definitely the best.

OBSERVATIONS

[The various Houses at St. Michael's are named after T&T male sporting heroes, a most innovative and admirable concept indeed.]

Water was immediately identified as a MAJOR problem at St. Michael's in all of the dorms, with the result that the bathrooms, although fairly new, were largely unused or, in some cases, unflushed. They generally were in a fair state of repair.

1. Ato Boldon Dorm
Of the 3 showers in the bathroom, 2 were broken (no showerheads). Also, the bathroom door needed repairing.
The beds had no pillows. By and large the beds were in fairly good condition, but some mattresses needed new covers.
The dorm was very airy and cool, and well lit.

2. Sobion Cropper Dorm
Again, water in the toilets was a problem. The toilet seats here were broken.
It was learned that the boys themselves are responsible for cleaning the toilets.

3. Brian Lara Dorm
Toilet problems again, as above.
This dorm had one bed that had its springs rotted out in the middle - its resident was identified as a chronic bedwetter. It needs to be replaced. [The Chairman, in conversation with the welding instructor later in the tour, made reference to this bed, and challenged the instructor to make its refurbishment a project, which he promised to do. Whether or not this was actually done is unknown.]

4. Dwight Yorke Dorm
Again, the toilets were in a similar state as above. The showers here were not in use - they were instead used as a storage area, and contained a Christmas tree, several large tins or barrels, some boxes, and a door.

5. Laundry
The waste water from the laundry was pumped into an open drain, which in turn ran out back into a stream or river and not into a soakaway. This is unacceptable environmental pollution. The laundry room itself needs to be modernised and revamped.

6. Outdoor bathrooms
These are intolerable. Due to the chronic water problem, the boys are forced to bathe at the side of the clothes room building, and must clamber up and down a treacherous pathway to get to the 'bathroom'. The far end of the building doubles as an open air urinal and toilet, and smells unbelievably foul. Runoff from this area drains down an overgrown ditch to places unknown.

7. General observations
There is no groundsman or formal grounds management. As a result, much of the property is overgrown.

The clothes storage room is simply a disaster area, and needs to be removed from its present site and much better organised. It is a definite fire hazard in its current state.

There were no fire extinguishers visible anywhere. This is especially distressing given the already major water difficulties experienced by the school.

The 'dining area' is currently an open shed next to the kitchen, featuring very old and rickety long tables and benches. Although fairly clean, the kitchen is also quite old and dilapidated.

There is no doctor on staff, but one reportedly visits every Thursday. There is a resident 'nurse', however, one [redacted], who acts as medical nurse, nutritionist and meal planner, and also counsellor to the children. Her qualifications are unknown.

All the bedwetters are segregated into particular rooms in particular dorms. Transfer to a non-bedwetting dorm is used as an incentive to motivate the bedwetters to stop the behaviour (the rationale and efficacy of this approach are dubious).

Most of the boys at St. Michael's were placed there through the courts for being "beyond control".

RECOMMENDATIONS

1. Water

Beyond question the most pressing need at St. Michael's is to have an abundant supply of water. The Task Force believes that, in much the same manner proposed for St. Dominic's, a large water tank storage area could be constructed higher up the hill behind the school (on the same level as the playing field), and then have gravity act as the force to provide pressure to all of the dorms and the other buildings downhill from there. Again, a water pump of suitable PSI ought to be installed at the bottom of the hill where the intake from the WASA mains comes in, to pump the water uphill to the storage tanks. Once this is done, most of the chronic problems at St. Michael's will be resolved. This will include the end of the health and sanitation disaster that is the current outdoor bathing and washroom area.

2. Kitchen and dining area

Although a new, modern kitchen and dining area was built recently, it is currently unoccupied because it was reportedly not constructed to specification. The Task Force was told that much of the interior had to be demolished and rebuilt before it could be used as intended, and as a result the boys were forced to continue to use the old kitchen and dining shed. The Task Force urges the relevant Ministry - probably the Ministry of Works - to expedite the necessary renovations so that the new building can be made available as soon as possible.

3. Grounds

The state of the grounds at St. Michael's is deplorable. The Task Force strongly recommends either the hiring of a properly equipped groundsman to maintain the compound, or (preferably) the scheduling of regular visits from a URP gang to cut the grass and generally upkeep the grounds (the compound is sufficiently large that it will require the efforts of several persons in the short term just to clear the grounds and get things in shape, much less to maintain them afterwards).

Special care should be taken to properly sanitise and rehabilitate the area currently being used as the outdoor washroom. It is already a significant health hazard, and its current use needs to be discontinued as soon as possible (the untreated effluent from here may well be seeping into open drains downhill, and thus may already be posing a health hazard to residents in the area).

By and large, the Task Force was very impressed with St. Michael's. Its physical problems aside, its management model is more in keeping with that so desperately needed at St. Jude's and St. Dominic's Homes, and its policies and guidelines very modern, progressive, and humane. It offers a comprehensive vocational training program in auto mechanics, baking and catering, electrical installation, leathercraft, masonry, plumbing, welding, and woodwork, and the general morale of the boys appeared very high indeed. Further, it is one of the few institutions with an established Code of Conduct. Consequently Mr. Francis, the manager, earned the Task Force's vocal admiration and congratulations for his successes despite the problems identified above.

5.0 SHRI JAYALAKSHMI HOME

[Visited 19 March 1997]

The Jayalakshmi Home is located on Alexander Street in Longdenville. The Manager is [redacted], who is also one of the Home's two Directors (the other is her husband, [redacted], an attorney, who acts as Chairman). Since no records were made available for examination, the Task Force could only rely on Ministry records for the approximate number of children resident. The Ministry files indicate that there are (or were) 19 girls (4 to 17 years of age) and 20 boys (2 to 16 years of age) resident at the Home. The Home is operated as a Hindu institution. The Task Force visited in two groups (not all could visit on the same day), and was met with differing levels of hostility each time. Of all of the small to medium homes visited, the Jayalakshmi Home was the most worrysome - the Task Force members all left with the feeling that something was VERY wrong there.

VISITS

The manager, [redacted], was out of the country when the Task Force's first visit occurred. The Task Force was welcomed and invited into the Home by the 'matron', [redacted], and was later joined by the pre-school teacher, [redacted], who was most cooperative throughout the visit. [redacted] had returned when the 2 Task Force members not present on the first visit ([redacted] and [redacted]) attempted to do an inspection a week later. [redacted] report on this reads: *"The management of Sri Lakshmi Home refused to allow* [redacted] *and myself to inspect. They gave us the strong impression that there was something they did not want us to see. The staff was obviously untrained and unqualified, and on the day we visited, there was no management staff present - they had to be contacted by phone..."*.

OBSERVATIONS

1. Kitchen

The cupboards in the kitchen were opened and examined. One contained a bottle of BNT antibiotic powder (veterinary medicine?); an open and mixed bottle of CECLOR antibiotic (once mixed, CECLOR should be refrigerated and used within 2-3 days; this bottle had reportedly been there for weeks); and a Chubby bottle of a liquid identified as a lice control shampoo supplied by the Ministry of Health at school. [The CECLOR was reportedly supplied by the visiting doctor, one [redacted], who allegedly visits once every 3 weeks or so.]

The cupboard had no lock and was accessible to all the children.

Of strong concern was the observation that the gas tank hooked up to the stove had no on/off lever.

2. Food

The food pantry or stockroom (it is an actual room about 10' X 12') was astonishing. It was packed to capacity with all sorts of canned and packaged foods (rice, flour, beans, peas, etc.). There was a large box filled with potatoes (supplied by 'pundits') on the floor, but all of the potatoes were sprouting (it was unclear if they would still be cooked and fed to the children in that state). The cans and packages were all grouped and labelled according to donor and date of donation (it was interesting to note that one of the donors was the Central Tenders Board). The Task Force was informed that sometimes the Home gets so much foodstuff it often donates food to other families. Much of the foodstuff does not appear to be used for the children, as the Home is supplied almost every day with cooked meals from supporters and wellwishers (while the Task force was there, hot curried channa and bussupshut was delivered for the noon meal). Further, the record book kept in the kitchen shows foodstuffs coming in, but very little of it supplied to the children.

3. Rest area

Rest time is 12 noon to 3pm every day. The children are put to rest on old sponge and a mattress on the floor in a shed out back. [The Task Force saw several brand new floor mats in the storage room off the kitchen, along with bags and bags of donated children's clothes and several new mattresses as well.] The shed is divided into 2 unfinished rooms, an open stall (where the children rest), and the laundry area.

4. Water

Water is clearly a serious problem for the Home. There was water in only one storage tank at the back, and everything - laundry, dishes, hands, etc. - was washed from the trickle that came from the tap at the bottom of the tank.

5. Washrooms

The toilet at the very back of the kitchen (identified as the boys' toilet) was totally disgusting. It stunk of urine and was unapproachable. The shower next to it had no showerhead.

Also downstairs but off the dining area was a bank of 3 brand new toilets and a shower that were at first identified as the girls' toilets. The Task Force was told that they were not working. Some time later, however, one of the staff used one, and the Task Force was then told that they were in fact in working order, but that only the staff were allowed to use them.

The boys' washroom upstairs was terrible. The showers were inoperative (insufficient water was the reason given); the toilets were positively filthy (the smell was overbearing); there were no doors on the toilet stalls (except for one stall and the urinal); and the whole bathroom was painted in an awful dark reddish brown colour. The Task Force was initially told that the toilets were cleaned by "[redacted]" (the maid), but later discovered that the boys themselves were made to clean the toilets (many of the boys are 5-8 years old). This no doubt accounted for their condition.

The girls' washroom upstairs by comparison was remarkedly different. The showers were operational and clean (there was even water on the shower floors, belying the 'insufficient water' claim for the condition of the boys' showers); 2 of the toilets had doors on their stalls, 2 had no doors, and 1 was out of order. There was no disposal bin for sanitary napkins present.

6. Boys' dorm
By and large, the mattresses in the bedrooms were slabs of old cracked foam (despite the several new mattresses noted in the storeroom earlier). The cupboards were broken in most of the rooms, and all of the rooms were badly in need of paint.

7. Girls' dorm
The mattresses on the girls' side were much the same as the boys' - old cracked slabs of foam badly needing to be replaced. Similarly, the rooms also needed painting. The cupboards tended to be in better repair.

8.. Laundry
The laundry area is part of the shed described earlier. The girls' underwear and panties were hung on old bedsprings to dry.

9. The grounds
The grounds were generally overgrown and unkept. The swings, slide, and seesaw at the side of the Home were broken down and overgrown, yet the children reportedly were still allowed to go and play there (quite dangerous).

10. Toothbrushes
The children's toothbrushes were all kept together (approx. 40 of them) in a small clothes basket in the eating area by the kitchen. The toothbrushes were quite worn, and their bristles were pushed almost flat from length of use. This was considered by the Task Force to be totally unacceptable, given the ease with which children with orally transmitted diseases could contaminate other children via their toothbrushes. Also, the toothbrushes ought to be changed at most every 3 months for proper dental hygeine.

11. Fire extinguisher
The sole fire extinguisher observed was noted to have been last charged in March 1996.

AREAS OF SERIOUS CONCERN

1. Sexual molestation

There is a 16 year old boy resident at the home by the name of [redacted]. Last year, [redacted] was taken to court for sexually molesting several of the children at the Home. Those molested include: '[redacted]' (age 8); '[redacted]' (age 9); [redacted] (age 16-17; [redacted]); [redacted] (age 11); and [redacted] (age 10).

Shockingly, [redacted] was represented by the Home's Chairman (and husband of the Manager), [redacted], who acted as both his accuser in court AND his defence attorney. Further to this, having brought [redacted] before the court, [redacted] then petitioned the court to have [redacted] returned to the Home (and back among the children he had molested), a petition the Court granted.

[redacted] now resides in one of the two unfinished rooms in the shed mentioned earlier, where he is reportedly 'isolated'. He sleeps on a mattress on the floor at night, and has to move an unmounted door across the doorway for privacy.

The Task Force was told privately that no psychologist or counsellor of any kind was ever called in or visited the Home to work with either [redacted] or the children he molested. The children were reportedly seen by one [redacted] right after the incidents were discovered, but no one else. The incidents were said to have occurred at night over an indeterminate period of time.

2. Staff salaries

After being told over and over that the keys to the Manager's office were with the manager (who was in England) and that therefore the Task Force could not view the Home's records, the Chairman, knowing that he was being stonewalled, attempted a bluff and offered to call in a locksmith. Miraculously, the keys were suddenly discovered, and the office was opened by [redacted]. The mood of the staff, up until this point somewhat hesitant but compliant, shifted dramatically once inside the office and they became most jovial and cooperative. [redacted] produced the salaries book for the Task Force's inspection, but indicated that the filing cabinet, which was also locked, she definitely did not have the key for.

A cursory inspection of the salaries book was most informative (especially for [redacted] and for [redacted]). [redacted] was being paid $175 a week for working 7 days a week, 9am - 5pm. [redacted] was being paid $250 per week for working 6 days a week, 8am - 4pm. Both had NIS and PAYE deducted from these salaries, but there was no record anywhere that the NIB was being paid the monies so deducted. Other employees had no deductions made from their salaries, although they were being paid the same rates more or less. [redacted] was paying herself $3,500 a month, and again no record of NIS or PAYE deductions were noted. The anger they expressed at these revelations was remarkable, and at this point the Task Force was openly told many of the practices that go on at the Home that had them all upset (most of which are of nuisance value and need not be recounted in detail).

In light of these discoveries, it is not surprising that [redacted] and [redacted] were denied access to the records by [redacted].

RECOMMENDATIONS

1. Accountability

The Task Force is of the opinion that the $60,000 Government subvention to the Shri Jayalakshmi Home should be withdrawn forthwith, until such time that the Ministry is allowed to go in and do a complete audit of the Home's records. Further to this, the National Insurance Board and the Board of Inland Revenue should also be encouraged to likewise perform an audit.

Given the vast amount of goodwill the Home obviously enjoys (as evidenced by the enormous food stocks and the copious amounts of donated clothing, mattresses, mats, etc. observed by the Task Force), the quantum of the subvention also needs to be revisited, since it is clear that the Home is quite capable of operating without it. Given the several indicators of malfeasance noted above, how the subvention money is actually being spent remains to be seen.

2. [redacted]

It is the opinion of the Task Force that [redacted] ought not to be allowed to remain at the Home, and recommends that steps be taken to have him transferred to eg. St. Michael's or YTC. A full investigation of the incidents of sexual abuse he is alleged to have committed needs to be done. If the management is unwilling to submit to same, then the children who were reportedly abused must be removed from the Home and placed in another facility where proper psychological and medical assessments and intervention can be executed. Any such reluctance to allow same by the management should be interpreted as an indication that the managers are not fit and proper to continue to operate such a Home, and steps should be initiated to have them debarred from so doing.

The manner in which the whole affair was dealt with is totally unsatisfactory to the Task Force, and there is the strong possibility that the management could well be held liable for knowingly engineering and permitting a situation wherein the children in their care were re-exposed to someone who had sexually assaulted them before. It is tantamount to reckless endangerment of a very high order.

3. Water

Regardless of the outcome of the above recommendations, it is clear that water is a serious problem for the Home. Given that the entire area around the Home is similarly compromised, however, the Task Force is unsure as to how to overcome this problem (WASA needs to become involved somehow).

4. Repairs and refurbishment

The toilets and the bedroom furnishings, as detailed above, are the most urgently in need of attention. The grounds similarly need clearing and the swings and slides made servicable as soon as possible.

ADDITIONAL COMMENTS

The Task Force was most intrigued to learn that the Chairman of the Home, [redacted], had written a stinging assault on the Task Force to the Permanent Secretary in the Ministry of Social Development, that was in turn copied to the Honourable Prime Minister, the Minister of Social Development, the Secretary of the Cabinet, and even the Ombudsman (see Appendix III). In the letter he goes to great lengths to try to discredit the Task Force, and by extension its findings regarding the Home: *"...I would like to point out that whatever information was obtained by Mr. Sabga and his cohorts was in fact unlawfully obtained and cannot be relied upon or given as any authentic information in any report concerning this Home and the manner in which they sought to obtain such information was most wicked, biased and malicious..."*

Apart from the fact that he totally misrepresented events that he did not witness (he was in England with his wife), it was most offensive to the Task Force to note that he tried to play up the 'Indian' and the 'Hindu' aspects of the Home to his addressees while at the same time viciously attacking the members of the Task Force, all of whom are reputable and level headed professionals or experienced members of the social and health services. This 'playing-up' was interpreted as an attempt to win sympathy and favour from persons whom he felt would rise to the defense of what he terms *"...a reputable private Hundu institution fully supported by the Hindu and other communities of this country...targeted for abuse and humiliation"*.

The letter is all the more incredible because of how he ends it, to wit (and one cannot help but take note of the persons referred to, even though the letter was addressed to the Permanent Secretary): "*We wish to advise the Honorable Prime Minister and the Honorable Minister of Social Development that we do have a wealth of knowledge and experience which could assist the government in formulating policies and we are still willing to be of assistance in this exercise.*"

The Task Force looks forward to the findings of the other "*wicked, biased and malicious*" agencies when they do their audits on the Shri Jayalakshmi Home.

6.0 THE HOPE CENTER

[Visited 27 March 1997]

The Hope Center is located on Point-a-Pierre Road in San Fernando. It caters to children 4 to 14 years of age, most of whom are placed by the courts, the police, or by social services. Some are 'walk-ins'. There were 5 boys and 10 girls resident when visited. The Manager is [redacted].

OBSERVATIONS

The Center had been recently painted when the Task Force members visited. Indeed, renovations and repairs were still being done on the house. The handyman, [redacted], indicated that most of the renovations had been done in the last month (most interesting, given that they coincided with the commencement of the Task Force's site visitations).
The showers were in good shape. The toilets, though clean, needed new seats.
The clothing closets were very cluttered and jumbled up.
Some of the windows appeared to have had new ironwork installed.
The beds and furniture were all in good shape.
The swings and slide in the playground out back were most unsafe, but were still in use by the children. This was pointed out to the manager.
The kitchen was tidy and clean.
A separate room was provided for two older teenagers.
The basement of the house was excavated and newly renovated into a new pre-school for the younger children.
All in all the house was in good shape, especially after the much needed renovations.

STAFF

The Hope Center has 6 full time employees: 4 house mothers, a teacher, and a cook.
The cook had only worked at the Center for one week when the Task Force visited. Prior to her employment, there was no dedicated cook - the caretakers took turns cooking.
There was a well thought out menu plan being followed. The cook is paid $150 a week and works for 1/2 day each day.
The 4 Caregivers (house mothers) are paid $250 a week each, and work on a shift basis.
There is no remedial teacher on staff (although one of the Center's Committee members is reportedly a remedial teacher). The staff teacher, [redacted] is not a formal teacher - he was not government trained. He has only been employed at the Centre full time for 1 year. He comes in 4 days a week (Tuesday - Friday) from 10am - 12 noon.

RECOMMENDATIONS

None. The Hope Center at best needs some stronger management skills.

7.0 THE HAPPY HOME

[Visited by 2 Task Force members on 2 May 1997]

The Happy Home is situated in La Brea, and was 'founded' by the late "[redacted]" (not her real name). It is currently being run by "[redacted]" son and his common-law wife, [redacted] (last names unrecorded). It is home to the 2 adults and 18 children, 3 of whom are [redacted] natural offspring.

1. Environment

Despite the good intentions of [redacted] and her husband, this home is woefully inadequate in providing for the needs of the 18 children and 2 adults living there. The house is very dark, and is so small that it can by no stretch of the imagination comfortably accomodate the number of persons living there. The overcrowding alone is a significant health risk.

There are 9 beds for 11 girls, so 2 sets of girls double up, one set being siblings. The beds are clean, but not tidy - there is just not enough storage space for clothes.

There is sleeping accomodation in the boys' room for 4, but it has to sleep 7, so every boy but the oldest - who is 12 - has to share a bed.

The children's shoes and slippers are kept in a box outside. When not outside, the children run around barefooted.

There are serious water problems in the area Consequently, when the older children return from school they have to tote water every day for bathing.

The toilet and shower are outside. They are modern and relatively clean. There is a new washing machine in the house, but this has not yet been hooked up.

There are numerous hazardous objects all around the yard, including acetylene and oxygen cylinders (used for welding), pieces of boats and engines, and various other sharp objects.

The kitchen is indoors. It is clean and tidy but needs modernisation.

2. Health and nutritional needs

Breakfast usually consists of porridge or some other cereal.

Meat is served every day except Friday.

ENRON gives a monthly donation of $500 for groceries.

3. Education

Of the 18 children living at Happy Home, 8 are below the minimum school age, and range between 2-4 years old. These children are at home day in and day out with [redacted]

One other child is of school age, but apparently has no birth certificate and therefore cannot be registered at school. No attempts have been made to obtain a birth certificate for the child.

All of the other children attend age-appropriate schools.

4. Relationships

The children who were at home when the Task Force members visited appeared genuinely attached to [redacted] some even called her 'Mummy'. She in turn appeared nurturing and loving to them.

There does however appear to be some strained relations between [redacted] and her common law husband ("[redacted]" son). They do not share a room, and he appears to play little or no part in the upbringing of the children.

5. Legal status

Three of the children are [redacted] natural offspring, all girls. None of the other children have been placed there through any legal avenues and no records are kept by [redacted] herself. None of the children are orphans: their parents are drug addicts who visit occasionally.

The children are apparently placed at the Home by a Sister Paul of La Brea, who reportedly keeps records.

RECOMMENDATIONS

The Happy Home is one of the several anomalous small private homes that have sprung up spontaneously in various parts of the country over the years. They constitute a grouping of places that offer very limited services, far from the ideal, in areas where little else exists, and one is left with the dilemma as to what to do with them. In a very real sense, the children are damned if you do, and damned if you don't, and the prevailing wisdom remains that it is better to have a poorly equipped and run home than none at all. This reality is not lost on the Task Force, but it is the opinion of its members that rather than either close the Happy Home down, or leave it well enough alone, the Ministry ought to get more involved in assisting [redacted] wherever possible so that the quality of the valuable service she is providing can be upgraded. This may well require a multi-disciplinary team visiting with her over a period of time to identify the needs there, followed by real action in either (a) expanding and improving the physical structures there, or (b) reducing the child population by seeking placement for (especially) the younger ones in other homes (such as Hope Center), or both.

Of deep concern to the Task Force, however, is the revelation that [redacted] and her common law husband have strained relations. Without knowing the particulars of the situation, this could well be a most disruptive and destabalising influence in the home, one that ought to be addressed before it becomes a crisis (which it well may do, given how overcrowded the home has become). To this end, a social worker should pay regular visits to the home, monitor the situation, and seek to non-invasively explore the reasons for the strain. Alternatively, one or the other adult may have to leave, and all things being equal, this may well end up being "[redacted]".

8.0 THE TRINIDAD CHRISTIAN CENTER

[Visited by 2 Task Force members on 2 April 1997, and by 1 member a week later]

The Trinidad Christian Center is located on the Eastern Main Road in Sangre Chiquito, Sangre Grande. Its stated objectives are to provide food, clothing, care and shelter for abused, neglected, orphaned, and abandoned children. At the time of the visit, it was home to 17 boys and 10 girls aged 4 to 15 years old, some of whom were away at the time. Its manager is [redacted].

1. Environment

The Trinidad Christian Center is a fairly modern building. Although the bedrooms were reasonably tidy and fairly clean (the girls' rooms moreso than the boys'), they were very dark and gloomy, and required the use of electrical lighting all of the time.

The bathrooms were reasonably clean. Their cleanliness is the responsibility of the children.

The TV room / lounge area was fairly spacious, as was the dining area. There was a small library present for the children to use.

2. Health and nutrition

These needs are being met to a reasonable enough standard. Meals prepared are fairly balanced and of sufficient quantity.

The kitchen could have been a lot tidier.

3. Relationships

The ratio of children to staff was quite high, although the staff did appear to be nurturing towards the children.

For some odd reason most of the children's toys were kept locked up in a storeroom until requested by a child.

4. Education

There was a small school on the premises for those children unable to fit in to a mainstream school. A special education / remedial teacher is employed by the Center.

5. Legal status

The majority of the children at the Center do not appear to have arrived there through legal avenues (ie. via the Court). Records are kept by the administration, but not all of them are complete.

Only 2 children have legal status at the Center under Fit Person Orders. There were other children at the Center who were placed there by the Court improperly, since there is no authority in law for doing so, given that the Trinidad Christian Center is not a Certified School under the Children Act.

RECOMMENDATIONS

In reviewing the truly impressive supporting documents provided by the Trinidad Christian Center (the Survey of NGOs in Receipt of Government Subvention, the Overview document, etc. - see Appendix IV), the Task Force had some difficulty in rationalising what was projected on paper versus the reality of what actually obtains at the Center. In particular it has extreme difficulty in understanding the quantum of the subvention the Center enjoys ($100,000), given the number of children it caters to, and given the general quality of the care observed, which, while not poor, certainly is below the standard projected in the profile and documents on which the subvention was based. The Task Force therefore counsels a re-visiting of the subvention award by first having a small investigative team visit the Center and do a qualitative analysis of its services and an audit of its records, and then, based on the outcome of said audit, re-process the Center's application for subvention making such adjustments as may be suggested by said findings. Said differently, ensure that the Ministry is getting value for its money, as opposed to having its money mis-appropriated.

The alternative is to leave the subvention unchanged (assuming that no malfeasance is discovered), and have the Center increase its staff levels and services to better cater to the needs of the residents therein. Either way, an in-depth qualitative analysis is called for, and ought to be undertaken with dispatch.

9.0 THE LADY HOCHOY HOME

[Visited 16 April 1997]

The Lady Hochoy Home for the mentally challenged is located in Harding Place, Cocorite, and houses some 125 residents, the majority of whom are adults. The Home's administrator is [redacted]

1. Girls' section

The premises were generally clean and tidy, but there were areas that could have been cleaner (eg. the bathroom in the 'independent girls' section needed retiling and more cleaning).

The girls' dorm had no pillows on the beds.

There was a shattered mirror still mounted on the wall; and a nail was sticking out of a cot bumper dangerously close to the small child in the cot. These were pointed out to staff, who promised to attend to same.

There were no toilet seats in any of the bathrooms. One bathroom in the physiotherapy area was being used as a storeroom.

One severely challenged girl in a cast was observed with her arm tied to her bedhead. She was crying miserably and in obvious pain and discomfort. When questioned as to why she was tied up, the dorm staff indicated that they did so to prevent her from interfering with the cast. They were requested to untie her, and to perhaps place a mitt or glove over her hand instead which would make it difficult for her to pick at the cast. When informed of this discovery, [redacted] insisted that she had outlawed this practice (tying residents to beds), but that some staff continued to do it. She promised that she would re-address the issue with them.

There was a broken mirror in the solitary classroom, but instead of it being removed, the cracks in the mirror had simply been taped up.

Fire extinguishers were evident and were functional.

There were lots of animals in the compound, especially dogs.

2. Boys' section

The boys' dorm was clean and tidy.

The toilets again had no seats, but were clean.

An open drain near the boys' dorm was obviously being used as a urinal, and stunk of urine. Its proximity to the area where some snacks are prepared and served, as well as where water is stored, was pointed out to the matron, who promised that the activity would be curbed.

3. Education

There is a school next door to the Home which provides the necessary special education for the children. There is also one classroom on the compound for more individualised teaching.

Most of the students at the school are not residents of the Home.

4. Relationships
Since most of the resident children were at school during the visit, it was difficult to assess the relationships between children and staff. There did, however, appear to be some strong bonds between those who were present and some members of staff.

5. Health and nutrition
A physiotherapist, [redacted], comes in Monday - Friday every week.
A medical doctor, [redacted], visits on Wednesdays.
[redacted], the Administrator, is also a qualified nurse, as is [redacted].
The services of the Child Guidance Unit are also used in assessing the children.

The kitchen at the Home was in poor condition, with layers of grease and grime everywhere.
There was no meal plan visible. The Task Force was told that '[redacted]' was responsible for deciding on the meals each day, though her qualifications for doing so are unknown. The quality of the food cooked did not appear appetizing: one pot had chicken foot and white rice in it, remnants of that day's lunch.
The food storeroom was organized but dirty. Many of the items on the shelves were well past their expiry date. Much of the stocks were either 'junk food' or Jewish matzoh wafers and mixes, all expired. The 2 freezers were startling in contrast: the one for the Sisters contained whole chicken and other quality frozen items, while the larger one for the residents contained bags and bags of chicken feet. No fresh vegetables were visible.

6. Legal status
Most of the adult residents have been there since childhood. The minor residents are mostly placed there voluntarily by their parents. None of the residents were placed at the Home via the Court.

RECOMMENDATIONS

By and large the Lady Hochoy Home was well appointed and managed. The Task Force members, however, were most concerned by (a) the practice of tying residents to their beds, which, despite the administrator's best protestations, was obviously a long standing practice at the Home; (b) the number of hazardous objects (nails, broken mirrors, etc.) present that had not immediately been removed or replaced; (c) the condition of the kitchen; and (d) the lack of a meal plan and the general quality of the food cooked and served, including the quantum of expired foodstuffs in the larder. All of these matters were addressed with [redacted], but what meaningful outcome will result remains to be seen.
The Task Force therefore recommends that the Home be visited by a Health and Safety Officer to address the environmental hazards identified, and that the services of a qualified nutritionist be made available to the Home to develop a more meaningful and effective meal plan, with appropriate followup and with periodic inspections of the kitchen and of the food acquisition records.

10. NATIONAL HOUSE FOR FAMILY RECONCILIATION

[Two visits were attempted, but both were cancelled for different reasons. This brief is based on information provided by Task Force member [redacted], who has visited this Home several times.]

The National House for Family Reconciliation is located on Ashram Avenue in El Socorro, by the El Socorro Mandir. It is administrated and managed by [redacted] (brother of [redacted]).

Despite the NHFFR's claims to the contrary, [redacted] reports that the NHFFR has no children resident there (indeed, it has had few adult residents if any either), and any services provided there tend to be on a 'drop-in' basis, although the quality of such services is unknown, as are the qualifications of the [redacted] himself to offer them. It is a mystery to the Task Force as to how, with no residents to speak of, and with no visible support network or service delivery system, the House was able to qualify for any subvention from Government, much less the sizable quantum of the subvention ($75,000) it actually gets. [redacted] further reports that any attempt she has made in the past to examine the home or its records have been strongly resisted by [redacted], who in turn would then promptly call her superiors and lodge vociferous complaints against her, even accusing her on at least one occasion of trying to prevent the home from getting its subvention money.

The Task Force believes that the NHFFR needs to be properly audited by the Ministry, and the true nature of its facilities and its operations verified and documented. Failure by the Home to allow such an audit should result in the immediate withdrawal of its subvention, coupled with the threat of possible Fraud Squad intervention (as detailed under Item D of the Ministry's Guidelines For Grant of Financial Assistance to Non-Governmental Organisations, to wit *'Guidelines Governing Discontinuation of Subvention'*).

GENERAL

RECOMMENDATIONS

GENERAL COMMENTS

As noted earlier in this document, although charged with the review of the **'Policy Statement on Standards and Procedures for Children's Homes'** as one of its mandates, the Task Force did not wish to duplicate the efforts of the Ministry of Health who, in conjunction with the Ministry of Social Development, are developing their *Community Care Program* incorporating the same document in its Procedures Manual and in its system of dual monitoring of the quality of care in children's homes and in homes for the elderly. This said, however, the Task Force nonetheless wishes to highlight several of the excellent recommendations made in that document, and to add its own support to their speedy execution.

The 'Policy Statement', under *Section 2: Roles and Responsibilities of the Ministry of Social Development and Family Services: Functions of the Nation Family Services Coordinating Council, Item 2.1.3* states:

"Responsible for formation of the Inspectorate of homes. Inspectorate must include a multidisciplinary team comprising members from various ministries and organisations represented on the Council (Psychologist, Psychiatrist, Social Worker, Public Health Specialist, Educator, Auditor, etc., and other persons deemed appropriate by the Council). It is obvious that one person is inadequate, and the Act which states that 'any public officer can be assigned as Inspector of Orphanages' is vastly inadequate for the present needs of the country."

The Task Force is 100% supportive of this recommendation. Although it chose to implement the relevant provision in the Children Act and have all of its members appointed as Inspectors of Industrial Schools and Orphanages, that designation is no longer useful in the current context, and a full-time multi-disciplinary team is definitely the preferred solution. [It should be recalled that prior to these appointments, the post of Inspector of Industrial Schools and Orphanages had been vacant for almost **15 years**.]

The document, in the same section under Item 2.1.4 recommends:

'The development of a "Licensing System" (Rules and Regulations) for the homes/centers/institutions which must be in brochure or booklet form to be handed out to the operators of homes/centers/institutions as part of the procedure."

And 2.1.5 adds:

"The establishment of criteria as the yardstick for periodic (every 3 months) monitoring, supervising, and evaluating persons, institutions, homes and centers involved in caring for children with a view to granting new licensure, the maintaining of license, and to assist in upgrading deficient situations."

There is no question that the optimum situation that should be aimed for is that wherein every home/center/institution in the country is duly certified and licensed, operating cohesively as a collective as opposed to operating as insular entities as currently obtains, and all monitored by a specialised arm of the Ministry. This is the only practical way that consistent, coordinated, quality service can be guaranteed. To this end, the Task Force's comments follow, many of which echo those contained in the abovementioned 'Policy Statement'.

LICENSING OF HOMES

1. All Homes, Foster Homes, Institutions, etc. ought to be licensed **annually** and registered with the proposed *Children's Authority* currently being formulated by the Ministry. The Requirements for Registration should include that:

- Each facility should register with the Registrar General's Department under the Companies Act.
- Each must be adequately staffed taking into account the numbers, ages, and special requirements of the children it caters to.
- The premises of each facility must conform to all relevant Health and Building regulations.
- Staff must have appropriate training and experience.
- Staff must be able to produce documentary proof of on-going training where required.
- Staff must be 'fit and proper' persons with no personal habits or history that would constitute a detrimental influence to a child. Further, staff must provide certificates of good character.

2. Mechanisms should be put in place in the Ministry to determine and administrate criteria for the renewal of licenses. To this end a new section or department within the Ministry needs to be created to treat specifically with this, and then staffed with appropriate personnel. It will function as an Accreditation Board for Homes and Institutions.
3. Institutions should be graded (ie. Grade A, B, C etc.) and the range of subventions they qualify for should be tagged to their grading. The grading criteria should be multi-faceted and encompass size, physical facilities, staff qualifications, services offered (including quality thereof), source(s) of funding (other than the Ministry), and so on.
4. Quarterly status reports should be submitted to the Ministry detailing activities, achievements, expenditure, relevant resident statistics, and comments and evaluations thereof.
5. The Regulations for Homes should include:

- Annual medical certificates including blood tests for each member of staff.
- Annual food handling certificates for each staff member so involved.
- Immunisation cards for all children must be up to date. Medical records must be kept for all children in the Homes, and must be available for inspection at any time by the (proposed) Children's Authority or any authorised agent of same.
- Records to be kept by the Homes should include:
  - Name, address, place of employment and telephone number of parents
  - Name and address of family physician (if any)
  - Record of attendence for children
  - Record of meals served
  - Fees or contributions made in respect of each child
  - Date of admission and discharge
  - Fire precaution procedures and drills conducted at each Home

Further to the above, the Children's Authority or its equivalent, once established, should be notified immediately on the occurrence of any of the following:

1. Death or serious accident involving a child, as well as circumstances surrounding same.
2. Gastroenteritis or other infectious disease.
3. Outbreak of fire if, as a result, it is necessary to remove the children.
4. Police charge(s) against a child.
5. Abuse (sexual, physical or psychological), mistreatment or neglect of a child.
6. Absence of a child without knowledge or permission of the Officer / Manager / Supervisor in charge of the Home.
7. Police charge(s) against a member of staff.
8. Substance abuse by a child or member of staff.
9. Any evidence of malfeasance or misappropriation of funds or property involving either staff or children.

Once notified of any of the above, the Authority must conduct investigations, following which it must give directions to the Home as to the appropriate action(s) to be taken. Failure of the Home to comply with these directions could result in the suspension of its licensure.

INSPECTION OF HOMES

1. Every Home or child care facility must be visited at least twice monthly by a Child Care Officer employed by the Authority, who will determine whether the facility is being administered in a proper manner.
2. The Child Care Officer or any other person authorised by the Authority may at any reasonable time enter any child care facility for the purpose of interviewing staff and children, and inspecting books and records.
3. The child care centers should also be visited at least once every 3 months by a medical officer so that he could perform routine medical examinations on each child, advise on the health of the children and the hygienic conditions of the premises, and to supervise the compilation of the medical records for each child.
4. Each facility must make arrangements for the dental care of all of the children in its care.

SUBVENTIONS

The Task Force was most distressed to learn that the Auditor in the Ministry of Social Development does NOT visit Homes to assess their physical accomodations, psychological and physical welfare services, etc. Instead, monetary subventions are routinely granted on the basis of submitted audited accounts only. The Task Force strongly recommends that these practices be amended immediately, and that site visitations become a mandatory procedure before subventions are granted.

CHILD CARE PLAN

Every Home should carefully develop a Plan of Care for each child in its protection. Following an appropriate Ministry approved format, the Plan should set out:

1. The Legal Status of the child.
2. Date of commencement of placement.
3. Reasons why the child is in care.
4. Information on the child's family network.
5. Relevant background information about the child's family.
6. Relevant background about the child.
7. The childs needs in relation to health, education, diet, social and emotional needs, identity arising out of the child's age, religion, racial origin and cultural background.
8. Arrangements for the child's education, dental and health needs.
9. The wishes and feelings of the child.
10. Contact arrangements.
11. The short and medium term plan for the child.
12. The long term plan for the child such as whether the child is to return home or be prepared for independence.
13. What is the plan seeking to achieve and within what timeframe.
14. Date to review the plan.

STATUTORY AUTHORITIES' SERVICE COMMISSION

The Task Force was most surprised to learn that the responsibility for the appointment, promotion and disciplining of Staff in the larger Homes (ie. St. Jude's, St. Michael's, St. Dominic's and St. Mary's) is vested in the Statutory Authorities' Service Commission (SASC). It was also reported to the Task Force that the individual managers of each of these institutions are the ones who actually decide who will be hired or fired, and that their decisions, couched as '*recommendations*', are simply rubber stamped by the SASC. The four Certified Schools were, by Legal Notice No. 21 of 1980, brought within the Statutory Authorities Act Chap. 24:01. On investigation it was discovered that there has been divided legal opinion on whether this was a proper course of action lawfully to be taken, since by definition a Statutory Authority is defined in the Act as:

"a local authority and any commission, board, committee council or body (whether corporate or incorporated) established by or under an Act other than the Companies Ordinance declared by the President under Section 3 to be subject to the provisions of this Act."

It is now a question of interpretation whether the four schools 'deemed' to be Certified Schools under the Children Act Chap. 46:01 can be said to have been established by that legislation, considering these very schools were set up by the Catholic and Anglican churches more than a century ago, and were previously governed by the Education Act. Whatever interpretation that legislation is given, the responsibility for staffing of pensionable officers currently rests with the SASC, while the Board Members are appointed by Government on the recommendation of the Churches involved. The Task Force believes that this entire mechanism needs to be revisited and restructured.

RECOMMENDATIONS ADDRESSING SOME OF THE LEGAL ISSUES

1. Managers of institutions should cease usurping the functions of the Minister to grant home leave to inmates.
2. Magistrates need to be sensitized to the fact that young persons and youthful offenders should not be committed to industrial schools and orphanages on application of 'beyond control'.
3. A holding area should be established at St. Jude's for girls who have been remanded for safe-keeping (eg. in cases of incest) pending the outcome of their court hearing. At present the girls so placed are housed with other girls who have been committed to the Home by the Court for unlawful activities, and are thus exposed to their influence.
4. Remandees should be taken to Court at each and every hearing of their court matter (it is not uncommon for boys and girls remanded at St. Michael's and St. Jude's to remain in custody for periods in excess of one year before their matters are determined).
5. The Welfare Officer and/or Manager should submit a report to the Court indicating the suitability or unsuitability of the remandee for commital to the relevant Home. At present this is only done for commitals to the Youth Training Centre (YTC). In addition to the suitability report a probation officer's report should be mandatory.
6. Remand homes should be established . At present remandees of St. Michael's are accomodated at the YTC, while at St. Jude's remandees are placed with girls already committed.
7. A Children's Witness Protection Program should be established for children who are (unfairly) remanded in custody while awaiting their matters to be determined in court. This means a kind of double punishment for these children. For example, a minor whose father allegedly sexually molested her was placed in custody pending an inquiry at the Magistrate's Court (Tunapuna). Her matter is still pending 18 months later, and she is still in custody at St. Jude's having committed no crime at all, but for merely being the victim of one.
8. Managers who admit children to their Homes on humanitarian grounds should seek a Fit Person Order from the Court in order to validate their stand.
9. The Court should NOT commit children to St. Dominic's and St. Mary's up to age 18 - the cutoff limit should be age 16. [An example of this is Case No. 17602/95 POS Juvenile Court 07.03.97]
10. Mechanisms should be put in place to recapture inmates who abscond from especially St. Michael's and St. Jude's. Currently, there is every indication that when this occurs, no appropriate followup action at these institutions are undertaken. [For example, inmate T.M. absconded from St. Jude's and was allowed to remain at large for 14 months, at which point she was eventually sent to the State Prison when she committed a further offence. Even at this point, she was officially still listed at St. Jude's, as St. Jude's had not reported her missing, nor had they entered same in their records].

MANAGEMENT AND STAFF RECOMMENDATIONS

1. Staff in all Homes need to have certain basic training. Many of them in the Homes visited were not qualified in any way (and it showed). The Task Force believes that the basic qualification for any staff person to work with children who are by definition emotionally and psychologically damaged must have a Certificate in Social Work plus completion of the UWI Parenting Programme. The UWI School of Continuing Studies offers an adequate Certificate Programme which existing staff can do part-time over a three year period. Said staff should be encouraged to pursue this certification by being given time off to attend classes, assistance with text books, and a monetary recofnition upon graduation. Only St. Mary's seems to encourage this on the part of their staff. Other Homes have staff who pursue extra studies, but they seem to get pressure rather than positive support in so doing.
2. Management Committees with representatives from the Board of Directors, from the Institutional Staff (both lay and religious where the Home has both), and chaired by a lay person with management experience should be in charge of the day-to-day management of the Homes. [Boards can be too remote, and it is the exception rather than the rule for a Management Board to operate effectively in any of the institutions.] The lack of management training shows clearly where those in charge adopt an autocratic/ownership style of management, being unwilling to divulge information to their co-managers or to delegate either responsibility or authority to them. It is a characteristic of insecure or untrained management to be autocratic and authoritarian and to over-react to any suspicion that they are facing implied or overt criticism. This was virtually a characteristic of the management of many of the Homes inspected, which does not translate into good and effective child development practices.
3. In managing large institutions, the Family Unit System should be adopted wherever possible. Siblings should not be separated, and the Family Unit Homes should be limited to 20 children at the very most. There should be no dormotories by age group, no communal kitchens, and no communal laundries. Children should be encouraged to participate in the housekeeping in their own house unit, and afforded as normal a life as possible. Apart from being more economical to run, this encourages the dissolution of the autocratic management style encountered by the Task Force, as the 'parents' in each Home would perforce have to be instrumental in making and implementing any decisions affecting their unit, and would allow the children greater personal attention and care.
4. In the larger institutions, there should be an attending psychologist/social worker to do the intake and to identify any deep seated problems that need to be addressed. For the smaller Homes, there should be a Field Social Worker paid by Government who performs this function on a rotating basis. The smaller Homes should also be assigned a nurse and a nutritionist on the same basis, individuals who could visit periodically and offer advice and assistance where this is necessary for the good of the children.
5. Disciplinary action in the form of dismissal should be taken against an employee who sexually, emotionally, physically, or psychologically abuses a child, with relevant legal action where appropriate.

A RECOMMENDATION Re. FUTURE TASK FORCE MEMBERSHIPS

Those members of this Task Force who are employed in the various Ministries represented, regularly faced increasingly annoying difficulties in coordinating times for meetings and site visitations due to conflicting commitments vis staff meetings, other Task Forces and Committees they were on, etc. This had the compound effect of fragmentation of effort and of constant delays in executing sensitive functions, or even in collaborating on strategy or analysis of data gathered. It is the very strong recommendation of the Task Force, therefore, that in future appointments of this kind, members so appointed who are employed at Ministries should be relieved of their other responsibilities until such time that their mandates have been completed and their reports compiled and submitted. Certainly, in the instance of this Task Force, its mandate would have been completed in a much shorter period of time than it actually took, had this been the case.

CLOSING COMMENTS

The findings reported in this document are by no means exhaustive, yet they detail some situations and events that are so atrocious, it boggles the mind that they have been allowed to develop and continue for so long. Events such as the mass sexual molestations at St. Dominic's, or the profound abuse and neglect at St. Jude's, have been featured in the media many times over the years, or have been the topic of quiet (and not so quiet) gossip in certain circles among influential and substantive members of society. And yet they were allowed to continue without so much as a simple independent investigation by the relevant authorities.

Completing the mandates given to this Task Force was not easy. The difficulties associated with the compilation and analysis of the data presented aside, the Task Force members were all deeply and profoundly affected by this exercise, emotionally and psychologically. In a very real way they were often witness to the true Dark Side of institutionalisation: the reality is that many of the children who are committed to State supported institutions for their own protection and welfare, have often instead found themselves in situations far worse than those they were removed from or from which they sought protection. That having been said, however, there were also many instances when the Task Force was pleased and impressed to note the really good work being done in other, more progressive institutions. There is a balance, perhaps, from a distance. But up close it is the images of the anguish and the despair that dominate one's field of vision, that haunt the spirit when one is alone.

The work of this Task Force is far from over, but it is better suited to a full time body such as the Children's Authority or the Inspectorate of Homes. It is the hope of this Task Force that the work so begun will be continued, and that ultimately all of the children's homes and institutions in the country will be duly inspected, certified and licensed.

BIBLIOGRAPHY & REFERENCE

1. "*CARE: Options for Children in Need of Special Care*" - Report of Cabinet Appointed Task Force 1991
2. *Children Act*, Chapter 46:01
3. *Child Care Services Bill*, 1990
4. "*Guidelines for Grant of Financial Assistance to Non-Governmental Organizations*" - Ministry of Social Development, March 1997
5. *Children's Home Admission Form* (G.P., Tr./To.-I 1174-2,000- /92)
6. "*Draft Policy Statement on Standards and Procedures for Children's Homes/Institutions*"