His Excellency Brigadier David A Granger, MSS
President of the Co-operative Republic of Guyana
Ministry of the Presidency
Shiv Chanderpaul Drive
GEORGETOWN 2016-08-12

REPORT OF THE COMMISSION OF INQUIRY INTO THE DEATH OF ANTONIO AND JOSHUA GEORGE

Reference:

A. Terms of Reference for the COI dated 14th July, 2016.

GENERAL

1. The Drop-in-Centre (DIC) was established to temporarily house vulnerable children. The Centre is a state run facility administered by the Child Care Protection Agency (CCPA). It was at this facility a fire occurred and there was the loss of lives. Consequent to that fire a Commission of Inquiry (COI) was convened.

AIM

2. To Report on the circumstances that led to the loss of lives at the DIC.

SCOPE OF THE INQUIRY

3. The COI visited the DIC and the Sophia Care Centre where the children from the DIC are now housed. A total of twenty-six (26) persons from the CCPA, the DIC, civilians and Red Thread were interviewed. Please see Annex A for the list of persons interviewed.

DOCUMENTS EXAMINED

4. The following documents were submitted for examination. Please see Enclosures one (1) to seventeen (17) for details.

FINDINGS

5. The COI was required to establish the following:

a. The causes, conditions and surrounding circumstances that led to the deaths of Antonio George and Joshua George on the 8th July, 2016 whilst in the care , control and custody of the State.

(i) The COI found that the system for admission to the DIC was adhered to, in that on Wednesday 2016-07-07, five (5) children namely,

Shaquan, Shania, Joshua, Antonio and Anastasia George were placed at the DIC at approximately 5:50 pm. This was after an investigation done by Social Workers from the CCPA, determined that the children were at risk. This placement was intended to be temporary as investigations were ongoing with a view to finding kinship care for the children.

(ii) The COI found that the number of children housed at the DIC at the time of the fire totalled thirty-one (31). Please see Annex B for details. However, based on the evidence collected it was determined that the number of children that the DIC could comfortably house was twenty-one (21).

(iii) On the 7th of July, 2016 at approximately 11:50 pm, there was a fire which claimed the lives of three (3) years old Antonio George and six (6) years old Joshua George. The fire was determined by the Guyana Fire Service (GFS) to be electrical in nature. It completely destroyed the female dormitory which is located at the Southern Section of the first floor and where the bodies of Antonio and Joshua were found.

(iv) The DIC is of two (2) floors and at the time of the fire was occupied by thirty one (31) children, along with Ms. S Jones and Mr. R Hinds two (2) Social Services Assistants (SSAs) at the time of the fire. The children ranged in ages from one (1) year seven (7) months to seventeen (17) years. The girls and the younger boys (infant to five years) occupied the girl's dormitory, while the older boys occupied the common room area on the northern side of the lower flat, since their dormitory was being renovated. There was the exception with eleven (11) year old Shaquan George and six (6) year old Joshua George who were housed in the girls' dormitory because of their small stature and the decision to keep the siblings together.

(v) The COI found that there was inadequate staff rostered to work on the night of the tragedy, which was in direct contravention of the Minimum Operational Standards and Regulations (MOSR) for children's homes in Guyana. The MOSR states that Homes such as the DIC must maintain at all times adequate staff on duty to fulfill the agreed staffer/child guideline ratio.

- For children under five (5) years, one (1) staffer to every two (2) children.
- For children five (5) years, to twelve (12) years old, one (1) staffer to every five (5) children.
- For children thirteen (13) years to seventeen (17) years old, one (1) staffer to every seven (7) children.

(vi) The residents at the DIC at the time of the fire were aged and numbered in the following groups:

- There were two (2) children under five
- Nine (9) children between the ages of five to twelve (12) years old
- Twenty (20) children between the ages of thirteen (13) to seventeen (17)

(vii) Using the children/staffer ratio a minimum of six (6) SSAs should have been on duty to adequately meet the needs of the children. However, on the evening of the fire there were only two (2) SSAs on duty.

(viii) Additionally the House Services Supervisor, Ms. Claudette Mentore had the authority to call out additional staff but failed to do so for no valid reason.

(ix) The COI found that there were adequate written guidelines for the management of crisis situations, including fire, however, the House Manger, House Supervisor or SSAs on duty seemed unfamiliar with them, consequently there were no rehearsals. Thus when the fire occurred there was confusion and panic resulting in the tragedy.

(x) The COI found that the SSAs on duty did not possess the necessary qualification and experience for the responsibility given to them. According to the MOSR qualifications for the position of a SSAs (Caregivers) is a Diploma in Social Work, Sociology and three (3) years' experience working with children, or a Trained Teacher's Certificate along with a valid police clearance or a secondary education and ten (10) years' experience caring for children.

(xi) The COI found that the DIC did not comply with all fire regulations. There were no operational fire escapes, no smoke alarms, no marked fire exits and signs on the wall stating what to do in case of fires. There were however fire extinguishers, and fire blankets on both floors of the DIC. The children and SSAs were not trained to use the fire extinguishers nor fire blankets.

(xii) The COI found that the fire was caused by a defective electrical point fitted with exposed wires on the eastern wall of the girl's dormitory. This played a role in the fire ignition and subsequent heat transfer, which caused the fire to travel via the electrical conduits in the ceiling.

(xiii) The COI found that recommendations from the GFS in 2010 and 2015 in the interest of improving "Life and Fire Safety" at the DIC were not fully implemented. Please see Enclosures nine (9) and ten (10) for details.

The 2010 inspection and subsequent report was done after a fire of similar origin at the Centre.

b. The nature of injuries sustained by all children who were in the care and custody of the state at the DIC on Hadfield Street, Georgetown on 2016-07-08 and to assess the dangers to which the children and staff were exposed at the time.

(i) The COI was able to definitely determine that Joshua George and Antonio George died as a result of smoke inhalation. Please see enclosure number twelve (12) and thirteen (13) for the details. The remaining twenty nine (29) children and two (2) SSAs did not suffer any physical injuries.

(ii) The COI determined that some of the older girls including seventeen (17) year old Jennel Hinds, nine (9) year old Shania George, sixteen (16) year old Jasmine Shepherd, twelve (12) year old Lisa Miguel, thirteen (13) year old Ayanna Limerick and fourteen (14) year old Thalia Mc Gregor were still traumatized as a result of the tragedy. These children who blamed themselves for the deaths of the two (2) children, were often having flash backs and not sleeping well at night.

(iii) The COI was challenged to assess the danger to which the children and staff were exposed at the time of the incident. This was due to the absence of medical reports, however, the danger would have been the possibility of imminent death and the effects of smoke inhalation. All smoke contain harmful substances which are injurious to the body. The children and staff seemed not to have been exposed to the smoke for any length of time.

c. Determine whether the conduct of the staff at the DIC who were on duty on the 2016-07-08 was in confirmatory with the required statutory obligation of the State and Standard Operating Procedures.

(i) The COI found that the conduct of the staff on duty on the night of the fire was not in conformity with the required statutory obligation of the State and Standard Operating Procedures (SOP's).

(ii) The COI unearthed an absence of understanding and rehearsals of the SOPs for the handling of crises situations. Consequently they were not applied before or during the fire, resulting in an unplanned, adhoc evacuation of the children at the DIC.

(iii) Mr. R Hinds one of the SSAs on duty sought to alert the emergency services of the fire by calling 911, but was unsuccessful.

d. Blameworthiness of Individuals:

(i) The COI found that this was a tragedy waiting to happen and that there was collective responsibility for the tragic event which claimed the lives of Joshua and Antonio George. The system to protect the children failed and therefore all the players are collectively responsible.

(ii) While Ms. S Jones the SSA who was on duty at the time cannot be entirely absolved, the two (2) children died in her care. It must however be noted that the administration of the DIC in collaboration with the CCPA failed to ensure that she possessed the skill set to perform her responsibilities adequately.

(iii) Ms. S Fraser who is currently carrying out the duties of Deputy Director of Policy and Development and has overall responsibility for the administration of the three (3) child care facilities (including the DIC), should be held accountable for not ensuring adherence by the Manager and Supervisor, to the SOPs governing human resource and protection from fire and other disaster.

(iv) Ms. M Gentle, Manager for all the Care Centres, including the DIC, who is directly responsible for monitoring staff performance, arranging staff training and ensuring that all buildings which house Care Centres are maintained and secured should be blamed for failing to discharge her responsibilities in an efficient manner.

(v) Ms. C Mentore, the House Services Supervisor of the DIC with responsibilities for the general administration of the facility should be blamed for not calling out additional staff on the night of the tragedy an authority vested in her appointment. She also shared the responsibility with Ms. M Gentle for arranging staff training.

e. To report on whether there was a failure on the part of State Officials to deal appropriately or adequate with matters that gave rise to the loss of lives and whether there were any unsafe or improper arrangements for the care, custody and welfare of the children.

1. The COI made the following observation: State Officials failed to:

(i) Hire competent and qualified staff.

(ii) Put in place adequate supervisory and oversight mechanisms to ensure compliance with the MOSR.

(iii) Ensure the inspection of the DIC after the girls' dormitory was completed and its reoccupation by the girls.

(iv) Address in a timely manner the recommendations emanating from the GFS to make the DIC fire compliant.

(v) Ensure regular fire inspections of the DIC.

(vi) Closely supervise the operations and staff at the DIC.

(vii) Ensure that there was adequate training and rehearsals of drills to deal with crisis situations at the DIC.

(viii) Conduct in house training for Staff in crises management.

(ix) Call out additional staff on the night of the tragedy to care for the children.

(x) Ensure the release of funds in a timely manner to meet the needs of the DIC.

COMMENTS AND OBSERVATION

6. The COI wishes to make the following comments:

a. That the staff of the CCPA and DIC were unrestrained in their interactions with the COI and cooperated fully with the Inquiry. Most of them felt that much more could have been done to cater for the needs of the children. They also expressed remorse for the death of the two (2) children while in their care.

b. That the CCPA is a very young organization which came into being with the passage of an Act of Parliament through the CCPA Act 2009. The mandate of the Agency is to ensure all Guyanese children have access to the best care and support for development. Consequently the Organisation is still being shaped while at the same time plagued with systemic problems. Attempts to implement new policies and enforce existing ones are ongoing.

c. Perceived tight budgets, increasing demands and heightened media scrutiny impact "perennial pressure" on the staff. Increasing demand on child care protection officials to deliver, has resulted in their position no longer being attractive. Low salaries and benefits attract a low level and quality of staff who in the main lack the capacity for growth.

d. The COI did not find enough evidence to confirm that there was a strained relationship between the CCPA and the DIC. What was discovered was that the

staff of the DIC expected their functional superiors to act blindly on their recommendations.

e. That there was an absence of a functioning oversight body like the Visiting Committee which no longer functions and has the responsibility for ensuring compliance with the MOSR.

f. That the position of Inspector of Children Homes has been vacant for sometime and that the responsibilities of that position were not being addressed in a structured way.

g. That the CCPA continues to recognise the value of NGO in a collaborative role to strengthen the Child Protection System. The NGOs include Child Link, Blossom Ink and Red Thread who provide invaluable services to the children at the DIC. Red Thread has seemingly discontinued their association with the CCPA, while the others are engaged in a limited way. CCPA has acknowledged that engagement with the NGOs are critical since they often fill the gaps.

RECOMMENDATIONS

7. The COI recommends the following:

a. That the Ministry of Social Protection and the CCPA continue to focus on overhauling child protection, cutting red tape and improving the skills and knowledge of social workers so that they could adequately protect children in the State's care.

b. That the Ministry of Social Protection arrange and conduct inspections of all similar facilities nationwide.

c. That the appointment of Inspector of Homes be filled immediately to ensure compliance with the MOSR.

d. That the Visiting Committee be reintroduced to ensure compliance with the MOSR.

e. That emergency evacuation plans be developed and practiced at all child care facilities. These plans must include safety protocols.

f. That in-house training including rehearsal be conducted for staff in crises management at all Child Care Centres.

g. That Child Care Workers be given additional time away from the working environment to allow them to relax after a period of work or tension.

h. That suitably, qualified staff be recruited to meet the increasing demands of Child Care responsibilities.

i. That the DIC be removed from its current location and relocated to a more suited environment to cater to the developmental needs of the children. A suitable name change of the Centre should be considered.

j. That some form of compensation be awarded to Ms. S George, the mother of the two (2) children who died in the tragedy while in the care of the State.

k. That both sides, the CCPA and the NGOs, must put aside perceived personal grievances, stop seeking self-promotion, work together and focus on the objective of providing quality care, service and protection to children in the care of the State.

CONCLUSION

8. The COI satisfied its mandate in that it was able to determine the cause, conditions and circumstances surrounding the tragedy at the DIC, was able to determine in a limited manner the nature of the injuries suffered by the children, determine whether the conduct and performance of state officials were in conformity with statutory obligations, determine blameworthiness and report on the failure of state officials.

9. It is the determined view of the COI that if proper fire safety practices were implemented the fire would not have occurred and there would not have been the loss of life. Further that greater diligence in the performance of duties by State Officials would have resulted in better management of the DIC and better implementation of SOPs.

10. The deaths of Joshua and Antonio was attributed to systemic failures at all levels. Because the child care system was not foolproof failures will have catastrophic consequences. All participants must therefore be held accountable for their own stewardship and for those under their control.

WINDEE ALGERNON
Commissioner

ANNEXES:

A: List of Persons Interviewed
B: List of Children in Residence at the time of the Fire
C: Statement by Ms. Ann Greene