Youth Custody Service Safeguarding Review
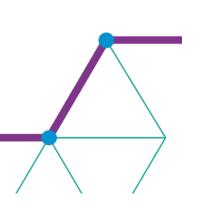
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Foreword

Helga Swidenbank, Executive Director

This review of safeguarding across youth custody comes at an important time for the YCS, particularly in the context of the recent Independent Inquiry into Child Sexual Abuse (IICSA). Having been commissioned last year as a small-scale internal review, it outgrew its initial scope and now stands as a comprehensive report to which we in the YCS are all accountable. Reflecting back, its expansion was inevitable as it represents the reality that safeguarding is everywhere you look – and where it isn't, it should be. I welcome the recommendations made in this report, many of which are already in progress. The recruitment of a national Head of Safeguarding, is one example of our commitment to making safeguarding central to all we do within YCS.

As the adage says, if we want to see different results we must try different approaches. This report challenges the harmful cultures that have become inherent parts of the system, and provides a refreshing first look at what can be done to address them. In accepting this report on behalf of the YCS, I signal our desire to continue to strive for positive change, both as an organisation and among the children and young people we care for.

I thank the team for their hard work on what is a very honest and open review, and look forward to the next steps as we progress the report's findings into action.

Helga Swidenbank

Executive Director

Youth Custody Service

Safeguarding Review: Youth Custody Service

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"You have the authority to set things in motion, to make changes, to make the children of today better and the children of tomorrow safe."

– F27[1]

[1] Independent Inquiry Child Sexual Abuse (IICSA) (2018). *IICSA Inquiry Children in Custodial Institutions Investigation*. [Transcript]. (Original hearing broadcast July 20, 2018).

1 Introduction

1.1 Purpose

The Youth Custody Service (YCS) was established in September 2017 as a distinct arm of her Majesty's Prison and Probation Service (HMPPS). YCS has operational responsibility for the children and young people's secure estate, which accommodates all children and young people aged 18 years and under held across England and Wales. With a moral and legal duty to provide a safe, decent and secure living and working environment, YCS is responsible for ensuring provision maximises safety outcomes for young people and staff whilst also reducing reoffending.

As such, concerns are shared regarding perceptions of safety and levels of violence as highlighted by various stakeholders including Her Majesty's Inspectorate of Prisons (HMIP)[2] and Ofsted. Together with the Youth Justice Reform programme's vision and purpose to address concerns around safety, there is a need for YCS to review, define and communicate policies, procedures and responsibilities in relation to safeguarding children and young people. In response, an internal national review was commissioned of Safeguarding across and by YCS. Its purpose was to assess the current landscape, focusing on the responsibilities of YCS but also considering the interplay with other agencies in safeguarding children and young people in custody.

This report summarises the findings from the national review, noting themes and recommendations to inform future strategic direction of safeguarding practice within YCS. Good practice is highlighted throughout.

1.2 Background

With an overall decline in the number of children and young people entering custody, the remaining cohort are typically the most vulnerable and disadvantaged[3] and often present significant risk factors to self or others[4]. As such, YCS services must be responsive to a vast range of needs. The method and extent to which these needs are met vary by establishment and sector, which includes five Young Offender Institutions (YOIs), three Secure Training Centres (STCs) and eight Secure Children's Homes

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[2] Her Majesty's Inspectorate of Prisons (2018). HM Chief Inspector of Prisons for England and Wales Annual Report 2017-18. London: Her Majesty's Inspectorate of Prisons.

[3] Mendez Sayer, E., Rodger, H., Soares, C. & Hurcombe, R. (2018). Child Sexual Abuse in custodial institutions: A rapid evidence assessment. London: Independent Inquiry Child Sexual Abuse.

[4] Wood, A., Bailey, S., and Butler, R. (2017). Findings and recommendations of the Youth Custody Improvement Board [online]. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/594448/findings-and-recommendations-of-the-ycib.pdf

(SCHs). Inspection reports indicate that SCHs tend to have a good understanding of children's needs, which alongside positive relationships between young people and staff and good staff-to-child ratios, contribute to effective safeguarding and child protection procedures[5]. This is consistent with evidence that relationships are an important aspect of welfare of children and young people[6]. Indeed, SCHs are considered the best model of practice within the sector[4]. In contrast, safety is considered a key risk among YOIs and STCs[3] due to; size[7], structures in accountability[2], less child-centred approach, rising levels of violence[8], inconsistent application of rules and sanctions, difficulties in recruiting and training staff and poor communication between staff and young people[4].

Of course, a key difference between SCHs, STCs and YOIs is also in resource. The annual placement cost is almost three times more in an SCH than a YOI[4]. Further, the operational context of the secure estate is characterised by fluctuations in resourcing, imbalances between supply and demand and priorities in accordance with current strategy[6]. It is therefore important to ensure attempts at improving safety also maximise cost and impact effectiveness. This means addressing risk and need through an evidence-based approach, recognising that many children and young people entering custody have endured emotional trauma and social disadvantage[9]. Protected characteristics such as gender, ethnicity, sexual orientation and history of abuse also contribute to risks for victimisation[2], which highlights a need to consider such characteristics in the development of safeguarding policy and practice.

Custody provides a potentially traumatic environment and establishments with a punitive, macho, hierarchical culture can further impact on vulnerability and risk of harm[10]. Conversely, a rehabilitative culture, with safety and decency as the foundation[11], is associated with reduced violence[12], suicide and self-harm[11][13] and recidivism[14][15]. The gradual shift towards a rehabilitative culture in youth custody is

[5] Independent Inquiry Child Sexual Abuse (IICSA) (2018). *IICSA Inquiry Children in Custodial Institutions Investigation.* [Transcript]. (Original hearing broadcast July 20, 2018).

[6] User Voice. (2012). "Why are they going to listen to me?" Young people's perspectives on the complaints system in the youth justice system and secure estate. London: Office of the Children's Commissioner.

[7] Jarman, B., Delap, L., Jackson, L., Lanskey, C., Marshall, H. & Gelsthorpe, L. (2018). Safeguarding children in the secure estate: 1960-2016. University of Cambridge.

[8] Her Majesty's Inspectorate of Prisons (2018). HM Chief Inspector of Prisons for England and Wales Annual Report 2017-18. London: Her Majesty's Inspectorate of Prisons.

[9] Independent Inquiry Child Sexual Abuse (IICSA) (2018). *Interim report: A summary.* London: Independent Inquiry Child Sexual Abuse.

[10] Erooga, M. (2009). Towards safer organisations - Adults who pose a risk to children in the workplace and implications for recruitment and selection. London: National Society for the Prevention of Cruelty to Children.

[11] Her Majesty' Prison and Probation Service (HMPPS) (2018). *Rehabilitative Culture Handbook* (2nd Eds.). Her Majesty's Prison and Probation Service: England and Wales.

[12] Van der Helm, G. H. P., Stams, G. J. J. M., Van Genabeek, M., & Van der Lann, P. H. (2011). Group climate, personality and self-reported aggression in incarcerated male youth. *Journal of Forensic Psychiatry and Psychology*, 1, 23-39.

[13] Ludlow, A., Schmidt, B., Akoensi, T., Liebling, A., Giacomantonio, C., & Sutherland, A. (2015). Self-inflicted deaths in NOMS' custody amongst 18-24 year olds: Staff experience, knowledge and views. Cambridge: RAND Europe.

[14] Rehabilitation Services Group & Maruna, S. (2010). *Understanding desistance from Crime*. National Offender Management Service.

reflected in the recent expansion of HMPPS Psychology Services within YCS who, in partnership with YCS and NHS England have developed a Behaviour Management Strategy (BMS) that aims to redress such risk and need. Integrated within this strategy are various evidence-based approaches which continue to be implemented across YCS, such as incentivising and promoting good behaviour, noted a strength across some sites[16].

Thus, while YCS continues to take positive steps towards a safer custody for children and young people[17], evidence suggests effective safeguarding approaches are not consistently evident within all institutions and by all staff[18,19]. Safeguarding is an ongoing, iterative process[20] and this report aims not only to assess where YCS is in terms of current practice but also to identify future direction and provide guidance to support this.

1.3 Terms of reference

The Safeguarding Review terms of reference aim to ensure parameters remain relevant and appropriate:

1. Review, and where appropriate revise, the current operational policies for Safeguarding within the Youth Secure Estate

2. Review the processes for handling allegations and complaints, including but not limited to, access, response, investigation and the support offered to children and young people

3. Review the corporate governance structures for safeguarding given the transfer of functions from the Youth Justice Board to the Youth Custody Service

4. Review the staff recruitment and vetting procedures in place and systems for referral to the Disclosure and Barring Service (DBS)

5. Review the safeguarding training offer and arrangements for all staff

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[15] Lipsey, M. W., & Cullen, F. T. (2007). The effectiveness of correctional rehabilitation: A review of systematic reviews. *Annual. Review of Law and Social Science*, 3, 297-320.

[16] HM Chief Inspector of Prisons (2018). *Report on an unannounced inspection of HMYOI Werrington.* London: Her Majesty's Inspectorate of Prisons.

[17] Her Majesty' Prison and Probation Service (HMPPS) (2019). *Building Bridges: A Positive Behaviour Framework for the Children and Young People Secure Estate.* Her Majesty's Prison and Probation Service: England and Wales.

[18] Youth Justice Board and National Children's Bureau. (2008). *A review of safeguarding in the secure estate.* London: Youth Justice Board.

[19] Almond, T. (2012). The provision of mental health care and services in young offender institutions. Practice, 24(3), 189–200.

[20] Jarman, B., Delap, L., Jackson, L., Lanskey, C., Marshall, H. & Gelsthorpe, L. (2018). Safeguarding children in the secure estate: 1960-2016. University of Cambridge.

6. Review information sharing arrangements between different departments within establishments, for example between Safeguarding and Security teams

7. Ensure the YCS is compliant with and executing its duties in relation to the Working Together guidance issued by the Department for Education, and any other relevant statutory requirements

8. Scope and establish working relationships with relevant external stakeholders. For example, the chairs of Local Safeguarding Children Boards on the custodial care of children; Association of Directors of Children's Services; Youth Justice Board etc.

9. Make recommendations on policies, processes and procedures, as deemed necessary to improve safeguarding measures for children and young people

10. Share and disseminate good practice with staff across the youth secure estate, in line with the YCS's emerging continuous improvement model.

1.4 Scope

The review comprised all three sectors of YCS, including five Young Offender Institutions (YOIs), three Secure Training Centres (STCs) and eight Secure Children's Homes (SCHs). Although YCS has operational oversight of HMYOI Feltham (B), this was out of scope as the population is over 18 years old.

Various reviews have been commissioned alongside this one, namely use of pain inducing techniques in restraint and behavioural management. While this review did not assess the current landscape of restraint, invariably several points were identified which, where relevant, are discussed throughout. It has also been beneficial to this review that the Independent Inquiry into Child Sexual Abuse (IICSA)[21] has run concurrently, as many of its preliminary findings have informed this report.

Safeguarding is an expansive and sensitive topic and thus, while this review occurred within the parameters of the terms of reference, ethically there were no such constraints. Throughout the review, in event of findings of concern, appropriate and remedial actions were taken. For those within scope and therefore included within this review, it is expected some recommendations will already be in progress at stage of publication.

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[21] Independent Inquiry Child Sexual Abuse (IICSA) (2019). Sexual Abuse of Children in Custodial Institutions: 2009-2017. London: Independent Inquiry Child Sexual Abuse.

1.5 Methodology

The review used a qualitative approach to explore the current Safeguarding landscape across YCS.   Evidence from different sources was triangulated to strengthen the validity of the review, although limitations are discussed below.

Primary fieldwork was conducted over a six-month period between July and December 2018, during which time all five YOIs, three STCs and eight SCHs were visited across England and Wales (see Table 1).   As the review was not a mandatory inspection or audit, sites facilitated each visit to varying degrees.   At a minimum, each site visit comprised a tour, interviews with members of the senior management team and examination of policies and procedures. In most sites young people were interviewed in brief and some sites included interviews with operational staff and attendance at meetings.   As reviewers were HMPPS YCS staff, public sector sites were generally more accessible than private sector counterparts.   This is a limitation of the review, which may be subject to bias due to the potential skew of information provided.

Table 1: List of YCS sites and commissioned bedspaces

Name of site	Commissioned bedspaces
Adel Beck SCH	14
Aldine House SCH	4
Aycliffe SCH	8
Barton Moss SCH	24
Clayfields House SCH	12
Hillside SCH	6
Lincolnshire SCH	11
Vinney Green SCH	24
Medway STC	67
Oakhill STC	80
Rainsbrook STC	76
HMYOI Cookham Wood	188
HMYOI Feltham	180
HMYOI Parc	60
HMYOI Werrington	118
HMYOI Wetherby (Main)	288

HMYOI Wetherby (Keppel)	48
Total: 16	**1208**

To supplement site visits, analysis of the most recent inspection reports for SCHs, STCs and YOIs was undertaken. Ofsted and HMIP were also invited and attended one-to-one meetings with a member of the review team. For confidentiality reasons, Ofsted reports on SCHs are not identifiable and thus it was not possible to reference them in this review. Nevertheless, as well as HMIP and Ofsted reports the review considered the latest evidence from Section 11 (Local Authority) self-assessment tools, Promoting Risk Intervention by Situational Management (PRISM)[22] reports, Independent Inquiry into Child Sexual Abuse (IICSA) literature, the Lammy Review[23] and a range of other sources. Additionally, focus groups were conducted with Dedicated Social Workers (DSWs) from YOIs. Where relevant these are referenced accordingly throughout this document.

1.6 Acknowledgements

The team would like to extend their thanks to all those who have been involved in this Safeguarding Review, particularly the sites where visits were facilitated, the children and young people interviewed, and colleagues across and beyond YCS who provided the wealth of information that informed the review.

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[22] Johnstone, L. & Cooke, D.J. (2008). PRISM Promoting Risk Intervention by Situational Management: Structured Professional Guidelines for Assessing Situational Risk Factors for Violence in Institutional Settings.

[23] Lammy, D. (2017). The Lammy Review: An Independent Review into the Treatment of, and Outcomes for, Black, Asian and Minority Ethnic Individuals in the Criminal Justice System. Lammy Review: London.

2 Governance

YCS has operational responsibility for all children and young people held in youth justice secure accommodation, either remanded or convicted. With custody a measure of last resort, these young people typically present with complex needs which often manifest as difficult, challenging and sometimes violent behaviour. Around 40% of the population have been in Local Authority care[24]. Coupled with the over-representation from children and young people with Black, Asian and Minority Ethnic (BAME) backgrounds[25][26], mental and physical ill health, learning difficulties and disabilities and social or economic disadvantage[16], YCS acts as the corporate parent for a highly vulnerable and marginalised population. These complexities, highlighted in both Charlie Taylor's[17] and David Lammy's[22] reviews, inform the Youth Justice Reform Programme which is currently being implemented across YCS.

As such, the governance processes are of paramount importance to the safety of the children and young people in YCS care. Decisions taken by YCS affect not just young people and their families but also staff and the public, to whom YCS also have a duty to protect. As the shift towards a rehabilitative culture continues, governance must reflect the needs of children and young people whilst also keeping them safe. The impact of such decisions must not be underestimated, as they have the power to shape the path of each child or young person entering and leaving the system through into adulthood.

2.1 Legislation

YOIs are governed by Young Offenders Institution Rules (1988)[27], STCs are governed by Secure Training Centre Rules (1998)[28] and SCHs are governed by Children's Home Regulations (2015)[29] in England and Children's Home Regulations (2002)[30] in Wales.

YCS is also informed by legislative guidance from the Department for Education, which includes Working Together to Safeguard Children (2018)[31]. This document is underpinned by the Children Act (1989; 2004)[32] and the Children and Social Work Act

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[24] Simmonds, J. (2016). Children in custody 2015-2016: an analysis of 12–18-year-olds' perceptions of their experience in secure training centres and young offender institutions. London: HM Inspectorate of Prisons.

[25] Lammy, D. (2017). The Lammy Review: An Independent Review into the Treatment of, and Outcomes for, Black, Asian and Minority Ethnic Individuals in the Criminal Justice System. Lammy Review: London.

[26] Taylor, C. (2016). Review of the Youth Justice System in England and Wales. Ministry of Justice: London.

[27] Young Offenders Institution Rules, 1988, no. 1422.

[28] Secure Training Centre Rules, 1998, no. 472.

[29] The Children's Homes (England) Regulations, 2015, no. 541.

[30] Children's Home Regulations/Rheoliadau Cartrefi Plant (Wale/Cymru), 2002, no. 327 (W.40).

[31] Department for Education (2018). Working together to safeguard children: a guide to interagency working to safeguard and promote the welfare of children. HM Government: London.

[32] The Children Act, 1989, c.41 and The Children Act, 2004, c.31.

(2017)[33], which places legal responsibilities on those providing care for children and young people. Different sections of the Children Acts apply across the three sectors within YCS.

Given the variations in rules and regulations across YCS, as these sectors and those in Wales are managed differently in accordance to the rules and regulations, effective governance can be a challenge. Language between these rules and regulations are very different, with YOI Rules reflective of the time in which they were developed. Terms such as "trainee", "inmate" and "prisoner" are in stark contrast to the term "children" used in Children's Homes Regulations. Given that language shapes culture, which in turn informs decision-making[34], this is an important consideration for the leaders responsible for influencing and driving change.

2.2 Strategy and policy

Public sector sites follow Prison Service Instructions (PSI) or Prison Service Orders (PSO), which are written for the adult male population and amended for use with children and young people. The PSI for the Care and Management of Young People[35] was written specifically for use in YOIs; however, it relies on overarching PSOs and PSIs to supplement areas not covered. This means that there is a lack of child focus at strategic level, thus all subsequent levels of governance within YOIs.

Where the Children Act[30] tends to value prevention, PSIs and PSOs support detection. The bureaucracy of HMPPS processes can makes systems such as performance management slow and complex, which deters managers from effectively utilising them. Delayed and lengthy processes hamper prevention and thus potentially increase risk of harm to children and young people. It is noted that the Staff Supervision Strategy under implementation as part of the joint YCS and NHS England BMS which incorporates SECURE STAIRS[36] is likely to improve these concerns through a formal and auditable process of staff support.

Recommendation
• 2.2.1 YCS should develop their own frameworks that are needs-led, child-focused and distinct from HMPPS including a specific Safeguarding framework

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[33] The Children and Social Work Act, 2017, c.16.
[34] Jarman, B., Delap, L., Jackson, L., Lanskey, C., Marshall, H. & Gelsthorpe, L. (2018). Safeguarding children in the secure estate: 1960-2016. University of Cambridge.
[35] Her Majesty's Prison and Probation Service (HMPPS) (2012). Prison Service Instruction 2012-08: Care and Management of Young People. Her Majesty' Prison and Probation Service: England and Wales.
[36] Taylor, J., Shostak, L., Rogers, A. & Mitchell, P. (2018). Rethinking mental health provision in the secure estate for children and young people: a framework for integrated care (SECURE STAIRS). *Safer Communities*, 17, 4, 193-201.

The public sector STC currently straddles STC Regulations or Rules and PSI/PSOs, which can cause greater confusion with governance of STCs. The public and contracted STCs are managed within different functions of the YCS, with one STC having operational oversight and management, and the other two managed through contracts. There could be risks in this split approach due to the absence of a single function. For example, all three employ Managing and Minimising Physical Restraint (MMPR) but only the public site has Assessment, Care in Custody and Team work (ACCT).

Among SCHs, each have their own local policies which are not generic across all sites. In some cases these come directly from the Local Authority, such as safeguarding and child protection policies. This was particularly evident in the use of force/restraint guidance across all sites. Although use of force was out of the scope of this review, it was noted that all YOIs and STCs use MMPR, whereas SCHs adopt their own restraint syllabus. This inconsistency means that children and young people moving between sites may be subject to different practices, thereby increasing risk of harm to both staff and young people who may find the variance in approaches confusing or distressing.

Of the safeguarding policies developed by YOIs, STCs and SCHs, not all were reviewed and ratified annually as required by Working Together[37] guidance. Locally, health and education providers appeared to have their own safeguarding policies which were not routinely reviewed or ratified by YCS or the Local Authority.

Recommendations

- 2.2.2 YCS should promote consistency across all sectors by providing standardised policies for operational aspects of Working Together (2018), such as risk of harm, information sharing and restraint

- 2.2.3 Safeguarding policies in all sites should be reviewed and ratified jointly on an annual basis by YCS and the Director of Children's Service (i.e. Local Authority), including commissioned/contracted service providers

Websites for all establishments were searched as part of this review. Some had limited information and others were inaccessible. There were still references to Youth Justice Board (YJB) commissioned bed spaces rather than YCS. This outdated reference also extended to the wider brand, such as policies and other documents, which continue to be distributed to a variety of stakeholders.

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[37] Department for Education (2018). Working together to safeguard children: a guide to interagency working to safeguard and promote the welfare of children. HM Government: London.

> **Good Practice** ☑
>
> 2.2.1.1 Good practice was observed among some SCHs, who had published their safeguarding and child protection strategies and/or policies on their websites

> **Recommendations**
>
> - 2.2.4 YCS should publish all safeguarding and child protection strategies and/or policies on their and local providers' websites
>
> - 2.2.5 YCS branding should be used across websites, documents and all other relevant publications

Protection for whistle-blowers is key to protecting children against abuse[38] and sensitive and confidential processes increase the likelihood of staff reporting. Most sites had an up-to-date whistleblowing policy, which was best understood in the SCHs. Among YOIs and STCs this was not present within the current culture. When speaking with staff in these sectors, it was apparent that once they had made a referral to the safeguarding department that marked the end of their perceived duty to report. Similarly to IICSA[39], it is thus recommended that staff receive whistleblowing training so that they are more clear and confident about when and how to whistleblow.

> **Good Practice** ☑
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> 2.2.1.2 Good practice relating to whistleblowing was observed in Vinney Green SCH, where the photo and contact details of the Local Authority Designated Officer (LADO) was displayed around the site.

> **Recommendation**
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> - 2.2.6 All sites should have an up-to-date and accessible whistleblowing policy, which is available as part of staff induction and actively promoted by senior managers. The policy should prioritise protection for staff who whistleblow
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> - 2.2.7 All staff should receive whistleblowing training that includes process and

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[38] Jarman, B., Delap, L., Jackson, L., Lanskey, C., Marshall, H. & Gelsthorpe, L. (2018). Safeguarding children in the secure estate: 1960-2016. University of Cambridge.

[39] Independent Inquiry Child Sexual Abuse (IICSA) (2019). Sexual Abuse of Children in Custodial Institutions: 2009-2017. London: Independent Inquiry Child Sexual Abuse.

> procedure as well as promoting protection for staff who whistleblow

2.3 Commissioning and contracts

The review team found that commissioned contracts had insufficient emphasis on safeguarding. The nature of contract management appeared to impact the culture at private STCs, whose focus on reporting and delivering quantitative key performance targets meant less of a child-centred approach.

In one example, a young person was prohibited from playing the guitar due to concerns around self-harm and the use of its strings as a potential ligature. Contracted providers are penalised for not taking steps to minimise identified risk factors, which is what motivated this decision. However, the guitar had also previously been identified as a protective factor for this young person and thus this opportunity was missed. When speaking to the contracts team, they explained that financial penalties are not applied so long as defensible decisions are made that support and promote the welfare of the children and young people. It is apparent that this is not fully understood by providers, whose risk aversion is driven by financial penalty rather than a child focus. This is consistent with findings[40] that suggests monitoring weighs too far in the direction of contract compliance, as opposed to the safety and welfare of children. It is important that YCS recognises its duty not just to prevent death but to promote life, which means maximising protective factors not just minimising risk factors.

Recommendations

- 2.3.1 Commissioning and contracts teams should ensure appropriate emphasis on safeguarding within service specifications

- 2.3.2 Monitoring arrangements should value both qualitative and quantitative measures of performance.

2.4 Partnerships

Learning from Prison and Probation Ombudsman (PPO) reports, findings and recommendations was not a theme observed in all sites, which means important and relevant learning is not being taken forward to prevent further harm from taking place.

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[40] Walters, A. (2019). *Medway Safeguarding Children Board Serious Case Review: 'Learning for organisations arising from incident at Medway Secure Training Centre.'* Medway Safeguarding Children Board: Kent, England.

Following the transition from YJB to YCS there has been no central log of PPO recommendations and YCS responses to these.

Recommendation
• 2.4.1 YCS should hold a central register for all recommendations and improvements (e.g. PPO, HMIP, Ofsted, etc.) that have been made and/or achieved

YCS is reliant on many partners within the criminal justice system, including Her Majesty's Court & Tribunal Service (HMCTS) and Youth Offending Teams (YOTs), but does not have direct responsibility for them. YOTs play a crucial part in the journey of children and young people entering and exiting custody, and there were examples of good relationships between local YOTs and sites. However, improved relationships would better benefit outcomes for children and young people, particularly around continuity of care. This would be aided by the sharing of information in a timely manner.

Recommendation
• 2.4.2 YCS and YJB should work jointly on strengthening relationships between community and custody

YCS has many partner agencies at a national and local level. At national level there was representation at several key meetings with the Executive Director or Deputy Directors from YCS. However, there were stakeholders who did not understand YCS' functions and responsibilities, often still referring to YJB. Website searches for YCS only showed 'recruitment' and 'placements' information, and there were no corporate pages for stakeholders.

Recommendation
• 2.4.3 YCS should consider a dedicated website for its services, and the use of social media within an effective communications strategy to promote and raise awareness of the service

At local level there was a good understanding of local children's services; however, relationships differed across sites and Local Authorities. Further work is required to understand the roles and responsibilities each local children's service and YOIs have with respect to one another. Often the relationships were primarily seen at LADO and

Local Safeguarding Children Board (LSCB) level. Although Governors and Directors could name their Director of Children's Service, there were no regular meetings conducive to productive and appropriate challenging of services. An example of this is in the lack of suitable accommodation for children and young people on release, a risk factor that all sites raised.

Recommendation
• 2.4.4 Locally, Governors, Directors, Managers and Director of Children's Services should improve joint working through regular meetings that focus on service delivery

YCS comprises sixteen sites across fourteen local authorities, although the presenting children and young people can come from any of the 326 Local Authorities in England. Within the fourteen Local Authorities, there are different processes and terminology for managing safeguarding; navigating these systems was a challenge for the review team, and thus it is expected that children, young people and their families would experience similar difficulties. This is likely to be even more pronounced among those Local Authorities which do not 'host' any of the YCS sites.

Recommendation
• 2.4.5 Consideration should be given to introducing a forum for all YCS sites and the hosting local authorities

There was evidence of good partnership working with NHS England in improving joint working with the secure estate. At local level there were different health providers and not all services were integrated. This is further discussed in the information sharing section of this report. There were positive signs that SECURE STAIRS is integrated into the YCS Behavioural Management Strategy, demonstrating collaborative working between agencies.

2.5 Quality assurance

As part of the Children Act[41] sites are required to complete a S11 self-assessment tool, which is submitted to their Local Authority. The review examined different versions of this audit toolkit, with some being completed online and others submitted by email. The

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[41] The Children Act, 2004, c.31 s.11.

process is typically completed by sites every two years. In some local authorities there were good robust systems to challenge the auditor on the findings and ratings of the assessment, which was often a combination of visits to the site and discussions at the LSCB. In other areas it was found that the self-assessment was submitted with no assurance checks in place and with ratings that did not reflect the practice. Despite being one of the assurance mechanisms used to assess safeguarding processes in sites, it did not appear to be utilised to its full potential or referred to by Senior Managers. It was also noted that no training had been given to those completing the audit, which increased risk of self-interpretation.

Good Practice ☑

> 2.5.1.1 Good practice was observed in some sites, where peer auditing of Section 11 assessments was being conducted

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Recommendations

- 2.5.1 Training should be given in the use of Section 11 self-audit tools

- 2.5.2 Section 11 audits should be completed through a peer-auditing system

- 2.5.3 Section 11 audits findings should be used more widely by Senior Managers to inform good/poor practice, concerns and as an assurance mechanism

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Operational and System Assurance Group (OSAG) is within HMPPS and provides assurances against systems through an audit approach. It has in recent months developed an audit for safety and safeguarding, which has been completed in all public-sector sites. This will provide an additional level of focus on safeguarding and inform local policies. Positively, a children and young person specific survey is also being developed by this group, although this will not occur within SCHs.

2.6 Equality, diversity and inclusion

While each protected characteristic is noted independently, recommendations are noted at the end of this section.

2.6.1 Race

Of children and young people in custody, 48% are from a Black, Asian and Minority Ethnic (BAME) background[42]. This is not reflected across the workforce, which is approximately 14% BAME[43], nor in the geographical locations in which the establishments are based. Race and ethnicity are considered to add to vulnerability[44] and are characteristics associated with likelihood of victimisation[45]. Such disparity negatively impacts on experience and services provided and may not meet individual cultural need. Importantly, albeit within a sample of adult males, research indicates that coping strategies and use of support systems varies between ethnic groups in the custodial environment[46], which includes disproportionate likelihood to self-isolate. This has important implications for how sites care for children and young people in custody, which needs to be responsive to race and ethnicity. This is not only a moral duty, but a legal duty in accordance with the Equalities Act (2010).

Given the significant disproportionality that persists within the criminal justice system, and its associated risks, it is essential that senior leaders across all three sectors take active steps to increase cultural competence and address such gaps.

2.6.2 Gender

Due to the lower number of females in custody, some STCs and SCHs only had one female in their care at the time of visit. Such potential for isolation may negatively impact on healthy adolescent development[47] and peer support specific to gender. In general, the needs of females are at risk of being eclipsed by the males, who comprise most of the youth estate. Given the differences in vulnerability, behaviour and need between females and males in secure custody[48], these should be specifically considered in the context of their care.

2.6.3 Pregnancy and maternity

Pregnancy and maternity are relatively rare, and it is by virtue of this fact that young females with children are inadvertently isolated. In one example, a female in an STC was kept in the mother and baby unit which, although providing care responsive to this

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[42] Ministry of Justice and Youth Custody Service (2018). Youth custody data: November 2018. Accessed 21 January 2019 at: https://www.gov.uk/government/statistics/youth-custody-data

[43] HMPPS Youth Custody data (2018); YCS staff protective characteristics (November 2018)

[44] Jarman, B., Delap, L., Jackson, L., Lanskey, C., Marshall, H. & Gelsthorpe, L. (2018). Safeguarding children in the secure estate: 1960-2016. University of Cambridge.

[45] Klatt, T. Hagl, S. Bergmann, M. C. & Baier, D. (2016). Violence in youth custody: Risk factors of violent misconduct among inmates of German young offender institutions. *European Journal of Criminology,* 13(6).

[46] Emsdon, K. (2009). *Race Equality Action Team (REAT) report.* Unpublished manuscript. Her Majesty's Prison and Probation Service: England and Wales.

[47] Arndorfer C. L., Stormshak, E. A. (2008). Same-sex versus other-sex best friendship in early adolescence: Longitudinal predictors of antisocial behaviour throughout adolescence. *Journal of Youth and Adolescence*, 37, 1059–1070.

[48] Her Majesty's Inspectorate of Probation (2014). Girl in the Girls in the Criminal Justice System. Her Majesty' Inspectorate of Probation: Wales.

need, meant that she was separated from others. This was also the case in an SCH; given that SCHs are not formally commissioned to provide this service, sending all females to the mother and baby unit commissioned at the one STC may reduce risk of individuals being isolated. Given the impact of isolation on adolescent development[49] this must be an important consideration for placements going forward.

2.6.4 Disability

The physical environment of most sites did not routinely cater for physical disabilities, with a lack of access to most areas including rooms and showers. The review observed good examples across all sites in personal emergency evacuation plans (PEEPS) and staff could identify the children and young people these applied to; however, this contrasts findings from recent inspections around staff understanding of PEEPS. Facilities overall were not deemed appropriate in providing provision for specific needs, such as those who may be visually impaired or require wheelchair access.

Most sites had good arrangements in place to identify and support those with learning difficulties. However, this primarily applied within Education settings and although information was shared across disciplines there was a lack of understanding on how this impacted on the individual and prevented reasonable adjustments. Many notices and information for children and young people did not consider learning or developmental needs such as dyslexia or autism. A multidisciplinary, psychologically-informed approach would ensure that children and young people with learning difficulties and disabilities are cared for appropriately by all aspects of service provision.

> **Good Practice** ☑
>
> 2.6.4.1.1 Good practice was observed at HMYOI Feltham who have achieved a working with Autism accreditation
>
> 2.6.4.1.2 Good practice was observed at HMYOI Werrington who have a working with Dyslexia accreditation

2.6.5 Sexual orientation

Those identifying as lesbian, gay, bisexual, transgender or questioning (LGBTQ) have increased vulnerability to victimisation in custody[50]. The team did not find routine data collection or recording relating to this area which may also reflect the lack of training

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[49] Reid, S. (2017). The curious case of loners: social isolation and juvenile incarceration. *Legal and Criminological Psychology,* 22, 180-195.

[50] Her Majesty's Inspectorate of Prisons (2018). HM Chief Inspector of Prisons for England and Wales Annual Report 2017-18. London: Her Majesty's Inspectorate of Prisons.

and thus confidence of staff in exploring this demography. It appears to be an area for development required across sites, particularly around increasing awareness and ensuring equity.

2.6.6 Religion and beliefs

The provision for a variety of religions was provided for in most sites. Most children and young people were observing either Christianity or Islam. Respective Ministers for other religions were provided based on need. In some sites areas for worship were multi-use, and efforts appeared to have been made to respect the needs of different religions, albeit in need of capital investment and requiring modernising. Children and young people reported good relationships with the Chaplaincy department and often it is a mechanism to support vulnerable children and young people. The physical environment of these areas could be further enhanced to facilitate the wellbeing of this population.

2.6.7 Marriage and civil partnership

Marriage and civil partnership for this cohort is very low, and has not been widely considered nor routinely reported on. It is deemed an area for future consideration.

2.6.8 Age

Chronological age is considered when placing children and younger people typically resided within SCH and STC environments. However, sites invariably accommodated children and young people ranging in age and psychosocial maturity. In some areas, such as within Educational settings, decisions to mix children and young people of differing chronological age appeared responsive to ability and thus individual need. Nevertheless, exposure to older peers can increase risk[51] and so age remains an important consideration both in the placement and ongoing care of children and young people in custody.

2.6.9 Gender reassignment

Although small in numbers, there is an increase in the number of young people presenting to YCS as transgender. This has important implications for YCS and staff as there is currently no child-centred transgender policy to support decision-making.

2.6.10 Equalities Summary

Overall, the review noted that there is a senior manager within YCS leading on Equalities and the Lammy review[52], which is a positive first step towards addressing

[51] Sabo, V. (2017). *Social Relationships in Young Offenders: Relevance to Peers, Poverty, and Psychological Adjustment.* Electronic Thesis and Dissertation Repository. 4364.

[52] Lammy, D. (2017). The Lammy Review: An Independent Review into the Treatment of, and Outcomes for, Black, Asian and Minority Ethnic Individuals in the Criminal Justice System. Lammy Review: London.

disproportionality and inequality present across the youth estate. The self-declaration, reporting, collation and monitoring of all protective characteristics was typically poor across all sites but is imperative in informing meaningful care and taking appropriate action.

Recommendations
• 2.6.1 YCS should develop a specific Equalities strategy that considers all protective characteristics with respect to safeguarding children and young people • 2.6.2 Each site should have their own Equalities Lead, who should report to the senior responsible officer (SRO) for this area • 2.6.3 Sites should collect data and report on all protected characteristics, which should be monitored at appropriate forums. • 2.6.4 Actions against the Lammy recommendations should be reported and monitored at YCS SLT • 2.6.5 YCS should develop a child-centred transgender policy and guidance for establishments • 2.6.6 YCS placements team should consider all protective characteristics when placing children and young people, and should minimise lone placements of females • 2.6.7 YCS should develop a Strategy for Females

2.7 Leadership and culture

Safeguarding is everyone's responsibility and not supplementary to a job description. Rather than viewing safeguarding as a function, it is important that all staff, regardless of grade, integrate safeguarding into their everyday practice.

Having the right staff with the right leadership is essential[53]; HMIP and Ofsted representatives described leadership as the key to getting the culture right, from senior managers to staff and children and young people. At present, YCS is undergoing large-

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[53] Independent Inquiry Child Sexual Abuse (IICSA) (2018). *IICSA Inquiry Children in Custodial Institutions Investigation.* [Transcript]. (Original hearing broadcast July 20, 2018).

scale change, managed via the Reform Programme. In line with rehabilitative culture, a balanced approach between control and flexibility is needed[54] to empower staff whilst encouraging positive change. The optimism and values of senior leaders and the messages they communicate thus have the power to shape YCS culture and the outcomes that follow.

2.8 Professional qualifications

2.8.1 Senior leaders

To ensure that staff are appropriately competent with respect to their role, specific experience and qualification is attached to certain functions. This provides a level of assurance that YCS is compliant with legislation and regulations around safeguarding. In the context of senior management this means, as cited in Working Together to Safeguarding Children guidance[55]:

> A senior board level lead with the required knowledge, skills and expertise or sufficiently qualified and experienced to take leadership responsibility for the organisation's/agency's safeguarding arrangements.

The YCS senior leadership team (SLT) would benefit from a specific senior advisor on all matters regarding safeguarding, whose qualifications plus relevant experience reflect the importance of meeting the legal duties under S11 Children Act (2004)[56] in safeguarding and promoting welfare of children. This role should report to the Executive Director of YCS which would provide additional scrutiny and assurance in safeguarding policies, practices and decision-making.

Recommendation

- 2.8.1 YCS SLT should recruit a senior advisor with relevant experience and qualifications, who sits at SLT level, advises on agency safeguarding matters and reports directly to the Executive Director of YCS

The role of the Governing Governor in public sector establishments also includes legal duties[2] with regards to safeguarding and child protection, but are not required to have formal qualification in these areas. Given they also discharge responsibilities under S11 Children Act (2004)[2], there is a need for a senior social worker to form part of the senior

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[54] Van der Helm, P., Boekee, I., Stams, G. J. & Van der Laan, P. (2011). Fear is the key: Keeping the balance between flexibility and control in a Dutch youth prison. *Journal of Children's Services*, 6, 248-263.
[55] Department for Education (2018). Working together to safeguard children: a guide to interagency working to safeguard and promote the welfare of children. HM Government: London.
[56] The Children Act, 2004, c.31.

management team (SMT) to provide appropriate expertise and experience in safeguarding matters.

Good Practice ☑

> 2.8.1.1 Good practice was observed in HMYOI Wetherby, who had a qualified senior social worker sitting on the SMT. This supported the transference and assimilation of good practice from the community into custody

Recommendation

- 2.8.2 Governors should ensure representation from a registered and qualified senior social worker, who sits at SMT level, advises on establishment safeguarding matters and reports directly to the Governing Governor

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Directors of all commissioned sites had various models of safeguarding leads. Often the safeguarding lead had other responsibilities that meant this was not a dedicated position.   Having reviewed a sample of contracts, safeguarding did not appear to be explicitly reported on and monitored.

Good Practice ☑

> 2.8.1.2 The contract for Rainsbrook STC mandates that the Head of Safeguarding role requires the person to be a registered social worker.

Recommendation

- 2.8.3 YCS commissioning and contracts teams should consider developing a performance monitoring framework specific to safeguarding practice

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SCH managers had the highest minimum requirements for qualifications that extended to level 5 diploma, all of which were child focused. This is in line with Children's Homes Regulations[57], including the quality standards of April 2015.

2.8.2 Head of Safeguarding

A Head of Safeguarding is in post at each public-sector establishment, of which the job description for this role does not require formal qualification. The remit of their responsibility includes safeguarding, child protection, safer custody, conflict resolution, use of force and oversight of dedicated social workers. In most instances, these senior managers also carry out operational duties such as duty governor and adjudications. In some sites Equalities also sat within this function. The team found that the level of high-risk work was excessive in this one role.

The Head of Safeguarding was also the link with the Local Authority and LADO and sat on the Local Children's Safeguarding Board alongside the Governing Governor. No formal training was given to the post-holder, which could otherwise enhance effective delivery of S11 duties. Although dedicated social workers are a resource in YOI and STC sites these are not typically well-utilised, and it is the Head of Safeguarding who holds responsibility for complaints and allegations from children and young people. Utilising the dedicated social workers more effectively increases the capacity of the Head of Safeguarding while also making best use of the expertise of the social worker in child protection matters. This would also provide an alternative trusted adult to whom children and young people can disclose.

With the exception of SCHs, it was also noted that there was a high turnover within the Head of Safeguarding roles in all but one establishment. There was a varying amount of knowledge and skills across the roles, and although they were dedicated to safeguarding children and young people, most were relatively new in post.

Recommendation
• 2.8.2.1 Senior social workers should be responsible for oversight of safeguarding and child protection functions

2.8.3 Dedicated social workers

Across all YOIs, dedicated social workers were introduced following the Munby Judgment[58] to fulfil Local Authority responsibilities and provide independent support.

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[57] The Children's Homes (England) Regulations, 2015, no. 541.
[58] The Munby Judgment (2002). Accessed 8th February 2019 at:

These are managed through a service specification between the YOI and respective Local Authorities. All YOIs were using their dedicated social workers in different capacities and there were some vacancies carried during site visits. It was reported by sites that some Local Authorities had taken over a year to recruit vacant positions. With such small resource, this leaves a high-risk area vulnerable as provision for young people is not provided.

Information sharing and working relationships between some sites and dedicated social workers was exceptionally good, and in others, progress was hindered due to lack of involvement between the safeguarding department and dedicated social workers. One of the Local Authorities has prevented dedicated social workers from being involved in allegations made against the professional, which in turn meant the site was not benefitting from the knowledge and expertise that independent social workers bring.

From discussions with young people it was evident that social workers were a valued and trusted resource when they had concerns around safeguarding, when raising concerns around risk of harm to self and others. Importantly, this included historical disclosures as well as current. This is likely a benefit of their independent status, but also because of their qualification and experience in this area.

Recommendations
2.8.3.1 The service specification for dedicated social workers should be reviewed   2.8.3.2 Dedicated social workers should manage child protection and allegations against professionals, including initial contact, debriefing and ongoing support for the complainant until a conclusion has been reached   2.8.3.3 The provision for dedicated social workers should be reviewed to reflect the needs of the current population

In the contracted STCs, one Head of Safeguarding was a qualified and practising social worker as per contractual requirements, and both carried out operational duties. Their functions carried the same risks as the public sector as the responsibilities that they held within their function appeared just as vast in scope.

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https://howardleague.org/wp-content/uploads/2017/06/judgment_R_2002.pdf

- 2.8.3.4 STCs should consider the work-load of their Head of Safeguarding ensuring appropriate time is given to safeguarding

- 2.8.3.5 The extent and usage of social workers should be reviewed in STCs to ensure equity of access across sites

In SCHs the Safeguarding Lead was a senior manager with other responsibilities, although this does not pose the same risk in terms of resource as YOIs or STCs given the higher staff-to-child ratio[59].

2.8.4 Youth Justice Foundation Degree (YJFD)

In response to the Charlie Taylor review[60], YCS has introduced a bespoke, voluntary level 4 course in youth justice that contains effective practice modules including a "learning block" dedicated to safeguarding. Assessed through reflective practice, assignments, case studies and written assignments, it aims to develop officers' understanding of causes and contexts of youth offending, such as child development. Initial uptake on this course has been positive, and takes a promising step towards professionalising the workforce[61].

2.9 Professional Standards

2.9.1 Conduct

All staff working within the three sectors should present themselves professionally and with a child-centred focus. The review indicated that boundaries of behaviour were not always clear when observing interactions between staff and children and young people. Touching and physical contact varied, from no physical contact in some sites to physical contact with little boundary in others. For children and young people this could be misleading, and the latter carries particular risk for those with a history of abuse[57].

The language used by some staff, primarily in YOIs and STCs, at times caused concern. Certain language (e.g. "locked up", "behind his door") originates from historic 'prison speak' which has not yet fully phased out. It is important that appropriate language is used that reflects the specific, decent, respectful and caring culture that YCS strives for.

[59] Independent Inquiry Child Sexual Abuse (IICSA) (2018). *IICSA Inquiry Children in Custodial Institutions Investigation.* [Transcript]. (Original hearing broadcast July 20, 2018).

[60] Taylor, C. (2016). Review of the Youth Justice System in England and Wales. Ministry of Justice: London.

[61] Ministry of Justice (2016). Government response to Charlie Taylor's review of the youth justice system. Ministry of Justice: London.

Offensive language used towards children and young people actively undermines this rehabilitative approach. It also creates a double standard whereby staff engage in behaviour and language that they also apply sanctions to young people for. This causes potential conflict between young people and staff, undermining relationships and missing an invaluable opportunity for pro-social modelling[62].

Recommendations
• 2.9.1.1 YCS to develop a Code of Conduct for all adults within the sector
• 2.9.1.2 Supervision of staff should include professional conduct and appropriate challenging of inappropriate behaviour / language
• 2.9.1.3 Guidance on appropriate touching should be developed and shared with all sites

2.9.2 Staff dress

Overall, the standard of dress across the YCS Sites appeared acceptable. Within the YOIs and STCs operational staff wore a soft uniform as issued by their respective employers. Residential staff in the SCHs are not issued with uniform and dress in an informal manner, which was appropriate to the setting and is child-friendly. However, within two public YOIs the team observed staff wearing uniform of adult establishments, which does not reflect the ethos of the YCS. Research suggests authorative uniform can exacerbate power imbalance[63] and have a psychological impact such as eliciting emotions that can include anger, hostility, dominance and aggression[64].

Other roles in all establishments wore a mixture of formal and informal dress; mainly this was at an appropriate standard but there were instances where clothing could be deemed inappropriate in the set working environment.

Good Practice ☑

[62] Jekielek, S. M., Moore, K. A., Hair, E. C. & Scarupa, H. J. (2002). Mentoring: A promising strategy for youth development. Retrieved 31 August 2018 at: http://www.childtrends.org/wp-content/uploads/2002/02/MentoringRB.pdf

[63] Haney, C., Banks, C., & Zimbardo, P.G. (1973). Interpersonal dynamics in a simulated prison. *International Journal of Criminology and Penology*, 1, 69-97.

64 Šterman, S. (2011). The protective role of uniforms and their communication power in society. *International Interdisciplinary Journal of Young Scientists from the Faculty of Textile Technology*, 1, 9-15.

2.9.2.1.1 Good practice was observed in HMYOI Wetherby, where the SMT were dressed in polo shirts presenting a non-hierarchical approach to a custodial setting

Recommendation

- 2.9.2.1 Staff on site should wear uniform appropriate to establishment and role, which should be made clear in the Code of Conduct

2.9.3 Young people's dress code

In some SCHs the children and young people wore a polo-shirt, emblazoned with the SCH logo, when attending education. The wearing of the polo-shirt was part of the compact for education and linked to the incentive scheme. The team felt that this presented a clear separation between education and social time, replicating community life.

In YOIs and STCs it was observed that boys often wore their trousers/jogging bottoms significantly below the waist line. This was deemed inappropriate, as it can encourage unwanted attention and inappropriate sexual conversation, as well as the opportunity for peers to play pranks such as pulling them down.

It was observed that some children and young people were not in appropriate clothing for their size or the weather. This was either due to the site not having adequate clothing, or due to the Looked After Child (LAC) not receiving their allowances in a timely manner from their parent Local Authority.

Recommendations

- 2.9.3.1 All children and young people should have appropriate clothing to their size and the weather conditions
- 2.9.3.2 Local authorities should ensure allowances are provided to LACs in a timely manner

2.10 Dual sites

2.10.1 Adults and young people

The review looked at the two YOIs that were dual sites, HMYOI Feltham and HMP/HMYOI Parc. HMYOI Parc had dedicated staff with no cross-deployment from the adult side, which prevented any risk in relation to safeguarding of young people. HMYOI Feltham, although having two distinct sides on one site, was governed

singularly and had some shared functions, such as Operations and Security. This allows for smoother transition of 18-year-olds from (A) to (B) side, including ease of inter-agency working and transfer of young adults. Positively, while it still has some shared areas such as the inpatient unit, Feltham (A) no longer shares the separation unit in which young adults are segregated.

However, the cross-deployment of staff between HMYOI Feltham (A) and (B) increases the risk of cross-contamination of systems and policies, such as use of force. The distinct needs of the two populations make it difficult to maintain a child-centred approach and this was evident in the language used by different managers and staff. At times, application of the correct policy was not adhered to due to confusion from staff. The team found the current model was not conducive to supporting and promoting the needs of children and young people

Recommendation

- 2.10.1.1 Consideration should be given to HMYOI Feltham becoming a single site, or full separation of the two sites with distinct governance and oversight

2.10.2 Males and females

The safeguarding needs of female children and young people in custody differs significantly from those of males, with the former demonstrating higher levels of self-harm and attempts of suicide[65]. However, as most of the secure population is male, YCS is more designed towards this gender's needs and there is currently limited policy and guidance available for managing females within YCS and across both SCH and STC settings. As such, this creates risk in relation to gender-specific needs, particularly around safeguarding issues.

In some sites it was observed that boundaries between male and female children and young people were not always maintained, and inappropriate behaviour was not always challenged. Additionally, staff felt guidance around recognising and managing such behaviour was unclear, which may have impacted on their confidence and ability in identifying and challenging such behaviour.

Recommendations

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[65] Mooney, A., Statham, J., and Storey, P. (2007). Health of children and young people in secure settings. Final report to the Department of Health. London: Thomas Coram Research Unit.

- 2.10.2.1 YCS should develop a Strategy for Females (repeat action from 2.6.7)

- 2.10.2.2 Education should incorporate 'healthy relationships' into their curriculum

- 2.10.2.3 YCS should issue guidance to staff on appropriate behaviour and healthy relationships

2.11 Placements and transitions

2.11.1 Placement

The responsibility to place a child or young person into YCS sits with central placements team, who liaise with courts and youth offending teams (YOTs). Decisions are made in the best interests of the child or young person for the most appropriate custodial setting.

The size of an institution and children being placed far from home are factors which negatively impact its ability to keep children safe, as well as how safe children feel in custody and the risk of victimisation[66]. Due to the overall shrinkage of the custodial population the number of sites have reduced, which means children are placed in areas many miles from home. Indeed, IICSA noted the uneven availability of SCHs, with none in London and the South East[67]. This limits protective factors such as family support, and affects access from the home Local Authority for looked after children. Further, some of these sites are not easy to access by public transport, and among others residents living within short distance of its perimeter have visibility of the site.

Recommendations

- 2.11.1.1 A assessment should be completed that considers security and decency of young people accommodated in SCHs, including consideration of whether any areas are visible from outside the site

- 2.11.1.2 Commissioning teams should consider contracting bed spaces across a wider geographical area

It is essential for placements to identify need at the earliest opportunity to ensure that children are kept safe. This involves sharing of information between community and

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[66] Mendez Sayer, E., Rodger, H., Soares, C. & Hurcombe, R. (2018). Child Sexual Abuse in custodial institutions: A rapid evidence assessment. London: Independent Inquiry Child Sexual Abuse.

[67] Independent Inquiry Child Sexual Abuse (IICSA) (2019). Sexual Abuse of Children in Custodial Institutions: 2009-2017. London: Independent Inquiry Child Sexual Abuse.

custodial settings. It is acknowledged that the YCS placements team have a limited time to gather information and make appropriate decisions. Additionally, the use of the Youth Justice Application Framework (YJAF) has not been fully implemented due to lack of robust connectivity in the community. Therefore, the "no docs"[68] scenario presents risk at the decision-making stage around initial placement, as well as assessment in the establishment on first night.

The placements team would benefit from multidisciplinary input that extends to operational staff, forensic psychology and social workers. This would allow for a more rounded approach in assessing and managing risk and promoting welfare and placement of the child. As well as a multidisciplinary approach, it is also important that placements consider the impact of placing children because of their characteristics, as discussed earlier under equality, diversity and inclusion. There is currently a review of placements underway, and it is hoped that these areas of safeguarding are considered within its scope.

Recommendations
• 2.11.1.3 YCS should work with YJB to improve and expand the use of YJAF • 2.11.1.4 The social worker vacancy should be fulfilled within YCS placements team • 2.11.1.5 YCS should consider multidisciplinary input within YCS placements team, such as operations and forensic psychology

2.11.2 Escorts

It was concerning that many sites reported and evidenced the late arrival of children and young people from court, often at unacceptable times and past 10pm. This can also be impacted by placement being geographically distant from the court. There is a general belief amongst YCS sites that the late arrivals are contributed to by the escort contractor, who drops off adult males/females first in line with the adult estate's more stringent core day. YCS sites do not have restrictions on times that they can receive children and young people. These delays affect the ability to make thorough assessments on first night, which increases risk for an already vulnerable time for young people entering custody[69]. Nonetheless, internal data reports indicate that it is also due

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[68] The "no docs" scenario refers to instances where documents are missing and therefore information regarding a young person is not available

[69] Andrews, D. A., & Bonta, J. (2010). *The psychology of criminal conduct.* Routledge.

to listing times and post-court activities and in the majority of cases children and young people are arriving on time.

Additionally, there are risks associated with mixing adults and young people on transport as among YOI escorts there are no child-centred safeguarding measures in place. Furthermore, there are concerns that young people who are categorised as Restricted Status (RS) in the public sector are transported to court via the high security estate. In each scenario, this means that staff are trained in adult-focused use of force techniques and risk of harm assessments, which increases risk for children and young people in transit.

From a decency perspective, late arrivals also impact the ability to access showers and phone calls upon arrival, which may heighten stress levels and reduce protective factors from speaking to family or friends. Although staff give high priority to gaining information to assess risk, this can be hindered by the long day that the child or young person has experienced, who is often tired and unable to engage meaningfully in the induction process.

Recommendations

- 2.11.2.1 Escort Services provided for children and young people should be reviewed

- 2.11.2.2 Transportation staff should receive age-appropriate safeguarding training, including child protection and use of force

- 2.11.2.3 Young people being moved between establishments and/or from court should not be transported alongside adults

- 2.11.2.4 Young people should arrive at their accommodation in sufficient time for completion of a meaningful risk assessment

2.11.3 Lodging

It is recognised that attendance at court, particularly trials and sentencing, are a significant and stressful life event for young people. There are times when it is necessary to lodge at a different establishment, typically due to travel time when the court is far away. Factors such as the unfamiliar environment, staffing group, peer population and varying processes and procedures, all work to heighten risk to and vulnerability of the child, as well as negatively impacting their experience. In at least two instances during the review, young people from YOIs had lodged in SCHs. Whilst this is good practice in reducing travel times to court, such practice minimises familiarisation with staff thus undermining protective relationships.

- 2.11.3.1 If a young person is required to lodge, a familiar member of staff should accompany them during their stay

2.11.4 Transitions

A framework for transitions is currently being developed by YCS. It is recognised that children and young people may be required to transition between the three sectors in YCS, as well as into the adult estate. Movement between SCHs, STCs and YOIs can occur in all directions, but for young people with longer sentences this typically follows a progressive pattern into YOIs. There were examples of where males, following their eighteenth birthday, were moved from an SCH directly to the adult estate. Due to the lack of YOI provision for females, all females on longer sentences move straight from SCHs or STCs to the adult estate.

Compared with the adult estate, there are significant differences between the SCH and STC/YOI regimes and staffing ratios, which can make transition a vulnerable process for both males and females. Staff receiving these children and young people do not have specific training, and this is an area which could heighten risk in early days of transition. This also applies between YCS sectors and there appeared to be limited understanding of roles and functions of one another's differences.

- 2.11.4.1 Planning of transition should begin as soon as possible and in conjunction with host and home establishments

- 2.11.4.2 HMPPS should consider training needs in working with young adults transitioning from YCS

- 2.11.4.3 The Transitions Strategy should be reviewed and implemented

- 2.11.4.4 Awareness should be raised between all three YCS sectors on the functional responsibilities and differences of one another

3 Operational Delivery

Services that ensure outcomes for safeguarding are delivered efficiently and effectively.

3.1 Staff Recruitment

Safer recruitment practices prevent people who pose a risk of harm from working with children by adhering to responsibilities around recruitment, selection and vetting of staff[70]. Currently safer recruitment practices are not consistently applied across YCS; notably, officers are recruited and selected through a national process whereby a formal youth custody interview is not required. This means that this staffing group enter initial training without assessment of values or child-centred focus. While competencies and skills can be rehearsed and developed, values are an indicator of ethos and personal approach and contribute to a rehabilitative culture[71].

Recommendation

- 3.1.1 YCS should consider moving more towards values, rather than competency, based recruitment

3.1.1 Recruitment and selection

Registered Managers of SCHs spoke widely about the use of Warner Interviews[72] in the staff recruitment and selection process, which minimise risk of abuse to children looked after by Local Authorities by attempting to identify the "right" person for each role.

Good Practice ☑

3.1.1.1.1 Good practice was observed in some sites when young people were involved in recruitment and selection of new staff at all levels. Although the final decision sat with the recruiters, children and young peoples' views were considered. This practice would benefit the wider youth estate in promoting user voice

IICSA[73] also note the value of having the right staff in custody, which at present is a concern in YOIs and STCs where Warner Interviews are more sporadically used.

Recommendations

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[70] Department for Education (2018). Working together to safeguard children: a guide to interagency working to safeguard and promote the welfare of children. HM Government: London.

[71] Her Majesty' Prison and Probation Service (HMPPS) (2018). *Rehabilitative Culture Handbook* (2nd Eds.). Her Majesty's Prison and Probation Service: England and Wales.

[72] Warner, N. (1992).   Choosing with Care. Her Majesty's Stationary Office: London.

[73] Independent Inquiry Child Sexual Abuse (IICSA) (2018). *IICSA Inquiry Children in Custodial Institutions Investigation.* [Transcript]. (Original hearing broadcast July 20, 2018).

- 3.1.1.1 Warner Interviews are implemented into the recruitment process across all sectors of YCS

- 3.1.1.2 A minimum of one person sitting on each interview panel should be safer recruitment trained

3.1.2 Vetting

Disclosure and Barring Services (DBS) clearances are required for roles involving interaction with children or vulnerable adults, carried out through either a Standard or Enhanced check. This includes staff that are contracted on behalf of YCS to deliver specific services, such as Prisoner Escort Contracts (PECs) and Long Term High Security Estate. While vetting is conducted among STC/SCH PECs element, staff from outsourced services are not subject to the same scrutiny as directly employed staff, which places children accessing those services at higher risk.

Recommendation

- 3.1.2.1 Contract managers should gain assurance that providers have appropriate levels of vetting in accordance with their job roles

Across the three sectors, the frequency in which vetting is renewed varies from three to five[74] years for directly employed staff. Processes for recording this information were reviewed within the public sector and it was apparent that not all sites have a local monitoring system regarding renewal dates for employees. There was also no clear forum in which vetting was discussed, monitored and assured. The responsibility for alerting and renewing vetting within the public sector sites sits with Shared Services Connect Limited (SSCL), and the HMPPS policy holder for vetting is Security Group.

Recommendations

- 3.1.2.2 Consideration should be given to renewing DBS checks more frequently, moving towards the use of the new electronic DBS system

- 3.1.2.3 All sites should have a local database as a contingency to ensure directly and non-directly employed staff are in date with their vetting

- 3.1.2.4 All YCS sites should have a forum in which vetting is a standing

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[74] Her Majesty's Prison and Probation Service (HMPPS) (2012). Prison Service Instruction 2014-07: Security Vetting. Her Majesty' Prison and Probation Service: England and Wales.

> agenda item to gain assurance at senior level
>
> - 3.1.2.5 HMPPS Security Group to ensure compliance through a service level agreement (SLA) in relation to renewal of all vetting with SSCL
>
> - 3.1.2.6 Staff personnel records should hold data on their vetting levels to allow managers to monitor this information

Within the public sector the level of vetting is currently not expressly mandated within the job description. The review revealed that there is insufficient understanding and clarity around appropriate vetting levels for the differing roles, especially roles within headquarters who interact with sensitive information about children and young people.

For some sites resource issues undermined the efficiency of the vetting process. The vetting coordinator is not a standalone role, and is typically attached to an administrator job description. This places reliance on a small number of individuals for whom vetting coordination is not their primary role, increasing the risk that renewals are not done in a timely manner.

Recommendations

> - 3.1.2.7 All job descriptions that have been published for staff working within YCS should include the level of vetting required for that role, including any barring list checks for working with children
>
> - 3.1.2.8 Vetting coordination should be sufficiently resourced to safeguard against overreliance on a small number of individuals

3.1.2.1 Referral to DBS

YCS sites must make referrals in line with DBS guidance[75] around their legal duty to refer when there are concerns that an individual may have harmed a child or placed them at risk of harm. SCHs demonstrated awareness of this process, which is also reflected among STCs within their contractual framework. However, public sector sites appeared to lack understanding of this guidance, including the need for referrals to be made when such conditions are met.

Recommendation

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[75] DBS website accessed 11 February 2019 at: https://www.gov.uk/guidance/making-barring-referrals-to-the-dbs

- 3.1.2.1.1 HMPPS instruction around conduct and discipline[76] should reflect DBS guidance on referrals, including all annexes and templates[i]

Given the risk identified in this area, all public-sector sites within YCS were issued guidance to put local processes in place on 16th July 2018. This was considered an interim measure whilst policies are updated.

3.2 Training

Training and continuous professional development is pivotal to an engaged workforce, and paramount to those responsible for the welfare of children[77]. Training and supervision that is specific to working with children is a key theme in the Wood's report[78], and a recommendation from IICSA[79]. The current concentration of children and young people in custody present as complex and vulnerable, which require its workforce to be skilled and continually developed to meet the needs of those in its care. This includes core understanding of factors such as adolescent behaviour, and emerging needs that reflect an ever-changing community.

On reviewing the training provision across YCS it is apparent that the mandated qualifications and training varied somewhat. This appeared largely due to regulatory differences across the three sectors. Currently no YCS site appears to be delivering training to a standard that meets the needs of the population in which it serves, and there are gaps in provision centrally and at management level as well as across frontline staff.

Recommendations

- 3.2.1 Training provision for central YCS services should be expanded and reflective of roles and responsibilities

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[76] Her Majesty's Prison and Probation Service (HMPPS) (2012). Prison Service Instruction 2010-06: Conduct Discipline. Her Majesty' Prison and Probation Service: England and Wales.

[77] Independent Inquiry Child Sexual Abuse (IICSA) (2018). *IICSA Inquiry Children in Custodial Institutions Investigation.* [Transcript]. (Original hearing broadcast July 20, 2018).

[78] Wood, A., Bailey, S., & Butler, R. (2017). Findings and recommendations of the Youth Custody Improvement Board [online]. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/594448/findings-and-recommendations-of-the-ycib.pdf [Accessed 2 February 2018].

[79] Independent Inquiry Child Sexual Abuse (IICSA) (2019). Sexual Abuse of Children in Custodial Institutions: 2009-2017. London: Independent Inquiry Child Sexual Abuse.

3.2.1 YOIs

The training offer in YOIs is working with young people in custody (WYPC), which is mandated through job descriptions. There are four modules, of which one is e-learning, and there is no requirement for any other training in relation to Safeguarding. On review of the Child Protection and Safeguarding Module it was evident that this required reviewing and updating, ensuring that new areas of concern are delivered within the module.

Reviewing the training data revealed that uptake of existing provision is not sufficient across all public-sector sites and there is no official forum in which this is monitored.

Recommendations

- 3.2.1.1 WYPC Child Protection and Safeguarding Module to be reviewed and updated

- 3.2.1.2 Training figures should be a standing agenda item at local safeguarding meetings and quarterly at regional safety meetings

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Staff are required to attend anything between one to two week's induction, which varies across establishments. The processes were not fully embedded across all sites, and the demand for delivery was often overtaken by operational need.

Recommendations

- 3.2.1.3 All new starters, directly or non-directly employed, should receive a comprehensive induction appropriate to their role before commencement of their work.

- 3.2.1.4 Inductions should be local, and specialist roles should meet with central YCS functions as appropriate

- 3.2.1.5 Business hubs should record all staff induction completions locally, and alert line managers when inductions are not complete

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All operational staff are required to complete a Prison Officer Entry Level Training (POELT) course on entry to the service. In 2017 a Youth Custody variant of this course was implemented with a greater focus on safeguarding. New staff work towards a Custodial Care Level 3 Diploma, which encompasses elements of safeguarding. Throughout the review, there were instances where staff had attended the adult POELT course, which undermines the child-focused ethos of YCS.

- 3.2.1.6 All new youth custody officers should complete the young person-specific POELT course

The one private sector YOI is situated within an adult male prison. There is no cross-deployment of staff or resources between the two custodial settings. All staff are trained as per the requirements of the contract and regular training is delivered.

3.2.2 STCs

The training offer within the STCs varies across the three establishments, two of which are contracted and one is public sector. The public-sector site is aligned with all training requirements detailed for YOIs above.

Within both STCs staff are subject to completing an initial training course, which includes safeguarding training. Both STCs utilise the LADO to advise on the content of this training.

3.2.3 SCHs

SCHs delivered training to a high standard, which they cited a benefit of close working relationships with the Local Authority.

3.2.4 Cross-sector training

Multi-agency training is key to supporting a collective understanding of local need. Staff have a responsibility to identify symptoms and triggers of abuse and neglect, as well as share information and provide young people with the support they need.

This means having knowledge and understanding of relevant topics that are underpinned by a trauma-informed approach. Training in dealing with children with sexually harmful behaviour[80] and children who have experienced abuse[81] is currently lacking across YCS. Whilst the SECURE STAIRS and joint YCS and NHSE BMS incorporates this throughput, it is yet to be fully implemented.

- 3.2.4.1 In conjunction with the LADO, YCS sites should develop specific and

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[80] Hackett, S., Masson, H. and Phillips, S. (2005). Services for young people who sexually abuse: a report on mapping and exploring services for young people who have sexually abused others. London: Youth Justice Board for England and Wales.
[81] Howard League for Penal Reform, Commission on Sex in Prison. (2015). *Healthy sexual development of children in prison*. London: Howard League for Penal Reform.

> localised training that meets the emerging needs and threats of the sector
>
> • 3.2.4.2 SECURE STAIRS and associated training to be fully implemented across all YCS

3.2.5 Monitoring and evaluation

To ensure practice is ethical, impact- and cost- effective, all training should be evaluated[82]. This is currently not routinely carried out across YCS, which means that quality and depth of training cannot be guaranteed.

> **Recommendation**
>
> • 3.2.5.1 All training packages should be evaluated to ensure effectiveness

3.3 Information sharing

Effective sharing of information between YCS and agencies with responsibilities for the welfare of children and young people in custody is essential for early identification of need, assessment and service provision to keep children safe[79].

Across all YCS, sites appeared to have gaps in sharing information with those with legal responsibilities working with children and young people. This ranged from community to internal functions, and appeared to stem from a lack of understanding of what was relevant to share. At times information was not shared and conversely, there were also occasions where information was over shared. This was often by email, where distribution lists were extensive and not on a need to know basis. This added to confusion over accountability, which increases risk of harm not being managed in a timely manner.

Interdepartmental sharing of information, specifically in YOIs and STCs, appeared to be sporadic and therefore counter-productive in managing the holistic care plan for the young person. Pockets of relevant information were not routinely shared with those that were on the frontline managing the day-to-day activities with those in their care.

3.3.1 Multi Agency

The community tend to hold a wealth of historic information about a child or young person. There appeared to be barriers in accessing this information; for example,

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[82] Department for Education (2018). Working together to safeguard children: a guide to interagency working to safeguard and promote the welfare of children. HM Government: London.

health records, school records and chronological histories from social workers. These would assist in preventing the need to reassess and ensure that a timely and appropriate plan for custody is implemented, considering the needs of the young person.

Sharing of information was best observed in sites where a fully integrated multi-disciplinary approach was taken. Barriers for sharing information between providers and sites caused unnecessary delay for partner departments to act; this was mainly due to misconception around what information could be shared. This concern was most prevalent among frontline health providers who often were unsure of what was relevant to share. It is noted that NHS England are currently reviewing the comprehensive health assessment tool (CHAT), which will improve information sharing across multiple disciplines.

Recommendations

- 3.3.1.1 Clear guidance on information sharing should be issued to all partners working with young people in the secure estate

- 3.3.1.2 Guidance should be issued on how to report and escalate incidents where under-sharing of information has occurred

3.3.2 Secure Stairs

All participating sites are at different stages of implementing NHS England's SECURE STAIRS model, and among SCHs it is largely embedded practice. This review noted that due to being in Wales, Hillside SCH and Parc YOI are ineligible for SECURE STAIRS. Oakhill STC, as a private healthcare provider, is also not aligned with this approach, which means that these sites will not benefit from the enhanced sharing of information characteristic of this model.

Recommendation

- 3.3.2.1 Consideration should be given to meeting the gap in SECURE STAIRS provision for ineligible sites

3.3.3 Security

Within public sector sites and STCs, sharing of information between safeguarding and security departments was limited and was dependable on relationships rather than process. Together, both departments hold more vital information and intelligence regarding staff and young people than they do individually and thus the whole is greater

than the sum of its parts.   In some YOIs, systems to improve information sharing between these departments were in their infancy; these processes should be more formalised as the benefits should not be underestimated.

The review revealed an incident which had been submitted to security but not to safeguarding. As a result, appropriate referrals were not made or dealt with in a timely manner and the young person was not supported appropriately. Where security intend to investigate professional standards, this should take a joint approach with the lead for safeguarding, as any action taken should prioritise prevention of harm over security[83]. Multi-departmental working in this area would ensure that all safeguarding matters have been considered appropriately.   Staff within the security department are trained by national learning and development in security functions, which is primarily aimed at the adult estate.

Recommendations

- 3.3.3.1 Formal arrangements should be put in place for and Heads of Security and Leads of Safeguarding to share information and intelligence

- 3.3.3.2 Information that is submitted directly to security involving a safeguarding concern should be shared immediately with relevant others to prevent risk and provide appropriate support to children and young people

- 3.3.3.3 Corruption prevention managers and security analysts should receive appropriate safeguarding training

3.3.4 Business continuity

Safeguarding departments within YCS sites continue to move towards an electronic filing system for child protection and allegations. It is important that access to these are granted to approved and relevant personnel, and arrangements are in place in event of IT failure.

Recommendations

- 3.3.4.1 YCS safeguarding leads should be granted access to relevant information systems, such as the corruption prevention database

- 3.3.4.2 YCS safeguarding leads should ensure that relevant people have

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[83] The Children Act, 2004, c.31 s.11.

> • access to their information systems
>
> • 3.3.4.3 YCS safeguarding functions should provide regular assurance that access to information systems is on a need-to-know basis
>
> • 3.3.4.4 YCS sites who utilise electronic filing systems should ensure that data is backed up on a Kingston USB stick

3.4 Allegations, Complaints and Concerns

The language of allegations, complaints and concerns is not a consistent one, and each are interpreted and used differently across site and sector. For example, IICSA refer to complaints in the context of alleged sexual abuse, which sites would refer to as an allegation. For the purposes of the review, the following definitions are used:

- **Allegations:** an alleged incident that has been reported by a child or young person about a professional, for example: *allegation of assault during restraint*
- **Complaint:** an issue that a child or young person has raised within the establishment, for example: *missing canteen*
- **Concerns:** a matter that has been raised by an external person, for example: *a mother phoning to report that her child has not received a shower that day*

Recommendation

- 3.4.1 For a uniform definition of allegations, complaints and concerns to be utilised across YCS

3.4.1 Allegations

All YOIs have a Child Protection policy in place, which is one of the ten core component policies[84] and forms part of their overarching Safeguarding Policy. Similar policies were present at some of the STCs and discussed procedures for allegations against staff working with children at all YCS sites. For all SCHs they followed Local Authority guidance for allegations and child protection. Of note, SCHs operate within Children's

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[84] Her Majesty's Prison and Probation Service (HMPPS) (2012). Prison Service Instruction 2012-08: Care and Management of Young People. Her Majesty' Prison and Probation Service: England and Wales.

Home Regulations, which mandate the registered person to notify Ofsted when a child is involved in or suspected of being involved in allegations of abuse[85].

The rational for deciding whether and when to report serious allegations to police was unclear among managers. In most instances, it was deemed sufficient to simply make a referral to the safeguarding department. Delaying police involvement may inadvertently impede evidence-gathering at a critical time.

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Recommendation

- 3.4.1.1 Clearer guidance on criminal thresholds should be developed and agreed to ensure defensible decision-making around how and when to involve police

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Up-to-date Child Protection logs were provided within YOIs and the data held at STCs and SCHs were discussed. The review team were informed that all child protection information reports are logged on their Child Protection log and those in paper form were stored securely in lockable cabinets, the majority of which were held electronically.

Sites visited were all aware that allegations against staff meeting the set thresholds[86] are referred to the Local Authority Designated Officer (LADO) within one working day as far as is practicable; with a telephone conversation being made where delays were foreseen. Discussions were observed with the LADO, which were recorded on the Child Protection log, although the rationale for not referring out was not always clearly documented.

In some HMIP and Ofsted reports, it was noted that certain sites do not refer out in a timely manner. It was noted by the review team that the cover during weekends from the safeguarding department and dedicated social workers was limited. Consequently, timely referrals may be hindered and appropriate support and action is missed.

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Good Practice ☑

3.4.1.1.1 Good practice was observed in Oakhill STC where there was social worker cover on evenings and weekends.

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[85] Independent Inquiry Child Sexual Abuse (IICSA) (2018). *IICSA Inquiry Children in Custodial Institutions Investigation.* [Transcript]. (Original hearing broadcast July 20, 2018).

[86] Department for Education (2018). Working together to safeguard children: a guide to interagency working to safeguard and promote the welfare of children. HM Government: London.

- 3.4.1.2 Senior and Dedicated Social Workers should be involved in allegations from the outset, and have independent oversight of this process

- 3.4.1.3 Social worker shift patterns should include weekend and evening cover, or on-call, to ensure support is accessible for young people and senior managers on duty

Information was not always recorded on frequency or type of support for the young person. The Child Protection file did not always reflect contact made with family/carer, YOT or external Social Worker. When the advice from the LADO is to deal with the allegation internally, the actions taken by the Safeguarding Manager and rationale for these were not always clearly entered on the chronology on the Child Protection log. This includes any decisions as to whether to investigate.

Recommendations

- 3.4.1.4 A detailed record of all contact with professionals, families and the young person should be noted within the chronology on the Child Protection log

- 3.4.1.5 A defensible decision form should be maintained to record rationale for no further action taken, which is multi-disciplinary:

    a) No referral to LADO
    b) No S47 strategy meeting
    c) No action following internal investigation

3.4.2 Complaints

The review looked at the processes in place within YCS sites with regards to complaints made by children and young people. All establishments had a process to administer complaints, with escalation procedures in place should these be required.

In YOIs and public sector STCs, a "COMP1"[87] form is completed by the young person either themselves or with support from advocacy services. This is submitted into a confidential box placed on residential units, and is collected by non-residential staff and

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[87] COMP1 refers to a young person's stage one formal complaint form

processed by the Business Hub. As part of the review, it was noted that not all staff opening complaints had received sufficient training around identifying safeguarding issues, which increased risk of referrals not being appropriately actioned or signposted. The responses to complaints were often non-courteous and did not address the issue that had been raised.

Evidence suggested that the complaints process was not child-centred, with complaints not being processed or discussed with the young person's involvement. The Lammy Review recommended that a 'problem-solving' approach should be taken, where complainants have a say in what they want to happen because of an investigation into their complaint[88]. Children and young people that were spoken to as part of the review did not appear to have confidence or faith in the complaints system. This is consistent with evidence from PRISM reviews[89], and that only 27% of young people in YOIs felt that a member of staff would take their allegation or complaint seriously[90]. During one of the focus groups, a young person said:

> *"Why will we ever be believed? We're criminals, and the 'staff are always right'. Managers will always take their side. It's pointless putting in a complaint."*
>
> *– Young Person, YOI*

Evidence suggests that perceptions of procedural injustice can act as a driver for violence in custody, and conversely, perceived procedural justice can act as a driver for safety. In the youth estate, perceptions of procedural justice were poor, which may explain why only 28% of boys stated that they would disclose abuse to members of staff[91]. There is a need to improve confidence in the complaints system in YCS, as this has been routinely associated with lower levels of disclosure, as well as increasing risk of harm through acting as a catalyst for violence and self-harm[92].

Young people also had the option of submitting a confidential access complaints form directly to the Governor or Deputy Director of Public Youth Operations. These will be opened by the person in these roles, and assessed as to how they should be managed.

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[88] Lammy, D. (2017). The Lammy Review: An Independent Review into the Treatment of, and Outcomes for, Black, Asian and Minority Ethnic Individuals in the Criminal Justice System. Lammy Review: London.

[89] NOMS (2015). PRISM Thematic Review: "Turning down the heat." Her Majesty's Prison Service: England and Wales.

[90] Independent Inquiry Child Sexual Abuse (IICSA) (2018). *IICSA Inquiry Children in Custodial Institutions Investigation.* [Transcript]. (Original hearing broadcast July 20, 2018).

[91] Simmonds, J. (2016). *Children in custody 2015-2016: an analysis of 12–18-year-olds' perceptions of their experience in secure training centres and young offender institutions.* London: HM Inspectorate of Prisons.

92 Her Majesty's Prison and Probation Service (2018). HMPPS evidence-based practice summary: Procedural Justice Perceptions. HMPPS: England and Wales.

There was an absence of support and regular updates for young people during the complaints process. Responses and outcomes were often not explained or discussed with the young person, which reinforced a lack of faith in the complaints system for those young people. The way complaints were handled appeared to respond more to the process itself than the individual, which meant that the child-centred focus was lost. This theme was also present among private sector STCs, where it was found that the child was not centred to allegations investigations[93].

It is important to highlight that, in YOIs, young people who require multiple officers to open their doors are not able to access confidential services such as psychology and social work. Professionals are only able to speak with them through the doors of their rooms, or in meeting rooms in the presence of officers. Until such restrictions are lifted, which in some instances may last weeks, young people have no opportunity to speak in confidence; this means that if abuse is taking place or the young person is experiencing distress, the risk that it will continue or go unreported is heightened. It also means that work undertaken by professionals that has the potential to address problematic behaviour and reduce risk of harm towards self and others is not being carried out, creating missed opportunity to safeguard and protect both staff and young people.

Recommendation

- 3.4.2.1 A comprehensive review of the complaints process should be commissioned as a separate work-stream, which should be child-centred, consider advocacy and take into account principles of procedural justice

- 3.4.2.2 Young people with Safe Systems of Work restrictions must be granted frequent opportunity to speak with professionals in confidence to provide an avenue of making a confidential complaint

Within most of the SCHs the process used for complaints followed the practice of the Local Authority, with the escalation of any complaint being dealt with external to the establishment. Site visits revealed that children and young people had access to phones in their rooms, which was conducive to encouraging complaints to third parties in confidence.

Ofsted inspection reports indicated that SCHs were child-centred and had higher staff ratios. This lent itself to better relationships, and one of the key distinctions between the

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[93] Independent Inquiry Child Sexual Abuse (IICSA) (2019). Sexual Abuse of Children in Custodial Institutions: 2009-2017. London: Independent Inquiry Child Sexual Abuse.

practices of SCHs in comparison to the other sectors is that the principle role of staff working in these homes is that of carers[94].

> **Good Practice** ☑
>
> 3.4.2.1.1 Good practice was observed in Adel Beck and Barton Moss SCHs, in which a direct line to the children's commissioner and NSPCC was available from the children and young peoples' rooms

Two establishments considered the use of age-appropriate language to support a child-focused complaints process. These 'Grumble Books' were accessible to all children and young people around the sites in place of or as well as a complaints system. They appeared to be processed in a timely manner.

Recommendations

- 3.4.2.3 HMPPS are rolling out an in-room telephony system. YCS should be prioritised for this to ensure that any room with a young person should have in-built telephony

- 3.4.2.4 Access to a wide range of children's services, such as Children's commissioner and NSPCC should be available in all site

3.4.3 Matters of Concern

YCS have a Matters of Concerns policy to manage concerns raised externally (e.g. family members, youth offending teams) around the welfare of children and young people within the estate. The person raising the concern is required to email a central YCS inbox, which is managed through the placements team. This team have not had any specific training in child protection, which would be beneficial to the role.

Recommendation

- 3.4.3.1 Staff dealing with Matters of Concern should receive appropriate and

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[94] Independent Inquiry Child Sexual Abuse (IICSA) (2018). *IICSA Inquiry Children in Custodial Institutions Investigation.* [Transcript]. (Original hearing broadcast July 20, 2018).

> sufficient training in safeguarding and child protection

As well as the central inbox, it is also possible to write in or telephone. The review revealed that this process was not widely used or understood outside of YCS and thus this pathway is not used as effectively as it could be. The lack of external understanding means that delays often occur in getting the concern to the right people at the right place at the right time. On the other hand, there are occasions where the distribution list to which concerns were communicated could be extensive. This added to confusion over accountability, which increases risk of harm not being managed in a timely manner.

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Recommendation

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- 3.4.3.2 The Matters of Concern policy should be reviewed and widely communicated as part of the overarching review of complaints, including public access to better enable family and friends to raise concerns

3.5 Operational Safety and Environment

3.5.1 Physical Environment

3.5.1.1   Closed Circuit Television (CCTV)

All sites within YCS had the use of CCTV. In one site, this was constantly monitored throughout the day by an external provider, and in other sites footage was either routinely checked for quality assurance or downloaded for reviewing incidents or allegations. Unless it had been downloaded, each server stored data for varying timescales before it was deleted automatically from the system. This means that if a child or young person discloses an allegation past these timeframes, crucial evidence is lost.

Some sites had poor figures around maintenance and coverage of CCTV systems, and often there were cameras not working or recording. This means that there are often blind spots which potentially increase risk of harm to children and young people in those areas. Risk is particularly elevated when rooms without CCTV are used to facilitate lone working.

Two establishments had CCTV that covered communal areas including shower facilities. Although this coverage did not include inside the shower itself, the changing

area surrounding it was in view which could potentially mean that young people are unwittingly exposed.

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Recommendations

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- 3.5.1.1.1 YCS should review and agree a uniform timescale by which to retain CCTV footage on the server

- 3.5.1.1.2 Any area whereby lone working takes place should have CCTV

- 3.5.1.1.3 YCS should review the use of CCTV so that it maintains children and young people's safety whilst also respecting their privacy

CCTV is considered a vital aspect of intelligence, and tends to be used to review incidents that have already taken place. However, it can also be used proactively, as seen in some SCHs whereby live monitoring or review of the lead-up to incidents informed prevention as well as detection. Given that it is a resource already in place across all sites, CCTV is thus an under-utilised resource in prevention of future harm across YOIs and STCs.

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Recommendation

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- 3.5.1.1.4 CCTV should be used for quality assurance and preventative purposes as well as review following an incident

It is acknowledged that CCTV is a costly resource; however, there is a Capital Safeguarding Programme in place to negate financial concerns around these recommendations.

3.5.1.2 Body Worn Video Cameras (BWVC)

BWVC is an important aspect of safeguarding[95] as it enhances CCTV systems that have no sound. It can also be a deterrent, both to staff and young people, in escalation of behaviour, and provides an additional layer of protection against false allegation or testimony of staff or young people. BWVC have been implemented across YOIs and STCs, although further work is required to fully realise its use. Similarly to CCTV, often

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[95] Independent Inquiry Child Sexual Abuse (IICSA) (2018). *IICSA Inquiry Children in Custodial Institutions Investigation.* [Transcript]. (Original hearing broadcast July 20, 2018).

there were cameras not working or recording. Coupled with staff often forgetting to turn on their cameras, this appeared to undermine the benefits of their use.

Some SCHs are starting to introduce the use of BWVC, and are working with one another to share best practice and full benefits of the system. However, use of BWVC is in its infancy and benefits are yet to be fully realised.

Recommendation

- 3.5.1.2.1 YCS should commission an evaluation of the use of BWVC to determine future implementation

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3.5.1.3   Showers

Although varied, the quality of shower facilities across the YCS was consistently poor. Some were communal, while others were in-room. Private, in-room showers, which are common to all STCs and SCHs, were considered safest as the risk of abuse is lower than in shared, open areas, of which there are still some in use among the YOIs.

Good Practice ☑

3.5.1.3.1.1 Good practice was observed in Adel Beck where when the young person stepped into their in-room shower, the blinds automatically closed.

It can be challenging to balance safety and decency needs when shower areas are communal. Unless shower provision is private, risk will always be present in both areas of safety and decency. Navigating the intense physical, psychological and emotional changes during adolescence are a challenge for young people in custody[96], and lack of privacy can worsen this experience or even be traumatising for those who have been subject to abuse or bullying. In one instance, the review noted that communal showers were in plain sight of the association area, which undermined the HMMPS decency agenda[97].

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[96] NOMS (2014a). Young People's Group Custody Support Plan: Theoretical Rationale. Her Majesty's Prison Service. England and Wales.
[97] HMPPS decency agenda. .

Recommendations

- 3.5.1.3.1 In line with the Decency Agenda, consideration should be given to installing and/or refurbishing in-room showers

- 3.5.1.3.2 Where communal showers are used in the interim, necessary refurbishments should take place to ensure these areas are to an acceptable standard

3.5.1.4   Viewing panels

Viewing panels are prevalent in all rooms across all sites, and in some toilet areas. In one instance, viewing panels led straight into the toilet area and were accessible from the main unit. This means that other children and young people can open viewing flaps to individual rooms and, in these cases, their toilets.

The method of coverage varied, with some SCHs using more home-like materials such as curtains and YOIs and STCs using metal flaps. Young people's privacy was observed to be respected to varying degrees, with many YOI staff failing to knock before entering or opening viewing panels. In contrast, SCHs were very considerate to the young person's privacy, before entering rooms or opening viewing panels.

Good Practice ☑

3.5.1.4.1.1 Good practice was observed in Adel Beck where viewing panels are always closed, and a fob is required to 'de-mist' the viewing panel. This was time-limited so that the viewing panel would mist up again after a short period.

The benefits of using a fob is that it is possible to identify which staff member viewed the room, and when.

Recommendations

- 3.5.1.4.1 Rooms with viewing panels leading to the toilet should not be accessible from the main units. Decency screens should be assembled in rooms where shower and toilet facilities are visible from inside the room

- 3.5.1.4.2 Unless there is an emergency with the young person, staff should knock prior to opening a viewing panel or entering a room

Across the sites using MMPR it was reported that full searches under restraint were used sporadically. Whilst this technique will be subject to the aforementioned review, the risk of causing further trauma to the child or young person when carrying out this technique is high. It is not fully identified whether staff working within the YOIs and STCs are fully aware to previous history of sexual abuse and trauma of the child and young person when making the decision to conduct full searches or full searches under restraint. Equally, the review was not assured that appropriate aftercare is in place for the child or young person following this occurrence. A review of full searching across YCS is necessary to understand this further and to action accordingly.

Recommendations
• 3.5.1.4.3 YOIs and STCs to implement appropriate aftercare following the use of a full search and full search under restraint • 3.5.1.4.4 History of abuse should be considered in MMPR handling plans • 3.5.1.4.5 A review of full searching should be commissioned across YCS

3.5.2 Isolation

Across all three sectors cases of isolation were reported during site visits. However, it was felt by the review team that the number of reported cases may be higher due to lack of understanding in this area, in particularly within the SCH's.

In combination with the outcome of the judicial review of Child AB[98], guidelines were produced around how isolation is determined by the Human Rights Convention. Within YOIs cases of isolation varied across the sites along with the understanding of staff within this area. The team felt that staff were working towards meeting the minimum required time frame that a young person should spend outside of their room, as opposed to enhancing the experience of the aim of also shortening the period of isolation. This poses a risk of harm to the young person, who may be subject to prolonged periods of isolation that with a different approach may not be necessary. Given the significant impact of isolation on adolescent development, as well as the increase in risk of suicide and self-harm[99], from a moral, ethical and legal standpoint this

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[98] Approved Judgment (2017). Child AB Judicial Review. Accessed 10th March 2019 at:
https://www.judiciary.uk/wp-content/uploads/2017/07/oa-ab-a-child-v-sosfj-and-others.pdf
[99] British Medical Association (2018). Joint position statement on solitary confinement of children and young people. British Medical Association: London.

has received, and must continue to receive, pressure[100] to ensure that it is used as a measure of last resort for the shortest period possible.

Recommendation

- 3.5.2.1 YOI staff to receive further training with regards to isolation and the risk of harm to young people

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According to local PRISM reports keeping young people apart can increase risk of violence. Maintaining keep apart/non-association lists can promote an ongoing culture of violence without addressing the underlying function. The review found that some sites had multiple keep apart/non-association lists without always having a clear or defensible rationale as to why young people were kept apart. In some cases, young people reported not knowing the people they were not allowed to mix with. Among sites delivering conflict resolution interventions, an overreliance on this function to reduce keep apart/non-association lists undermined the integrity of the process.

Recommendation

- 3.5.2.2 YCS to conduct a full review of the "keep apart"/non-association process and revise the strategy accordingly

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STC Rules define isolation as removal from association (RFA), although the term single separation is also used. Those staff members who were questioned around this area had a clear understanding of the use of any periods of isolation. Due to the prescriptive STC Rules, methods of recording this period of isolation were positive.

It was reported within an SCH that a child was living within an annex to main residential unit by themselves due to struggling to associate with peers and attending a court trial. During this period, the review team were informed that the child did not associate with other peers at any point and only had contact with staff. Other cases were reported of children been separated from peers for prolonged period of times due to the risk of harm they may cause to their peers. No methods of recording the period and rationale of the decision were evident.

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[100] Children's Commissioner (2018). A report on the use of segregation in youth custody in England. Children's Commissioner: England.

- 3.5.2.3 SCH Contract Managers are to ensure the SCHs are not isolating children or young people.

3.5.3 Enabling environments

According to PRISM[101], situational factors, that is to say, the environment, contributes to institutional violence and thus risk of harm to young people and staff. As such, all YOIs are working towards achieving the College Centre for Quality Improvement (CCQI)'s 'Enabling Environment' accreditation, which is characterised by standards such as belonging, safety, structure, leadership and boundaries[102]. If achieved, it means the environment successfully promotes a stable and positive culture and atmosphere for staff, children and young people in which to thrive. Indeed, Enabling Environments has been associated with lower staff sickness[103], enhanced workforce engagement[104] and improved outcomes for mental health[95].

It is encouraging that each of the YOIs has commenced this process, given their impact on the safety and quality of living and working for both staff and young people. The benefits of this would be amplified if this was extended to other units and YCS sites.

- 3.5.3.1 Consideration should be given to wide scale implementation of the College Centre for Quality Improvement (CCQI) Enabling Environments accreditation

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[101] Johnstone, L. & Cooke, D.J. (2008). PRISM Promoting Risk Intervention by Situational Management: Structured Professional Guidelines for Assessing Situational Risk Factors for Violence in Institutional Settings.

[102] College Centre for Quality Improvement (2019). Enabling Environments Quality Improvement Process. Royal College of Psychiatrists: London. Accessed 2 February 2019 at: https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/quality-networks/enabling-environments-ee/the-enabling-environments-process-document-2019.pdf

[103] West, M. & Dawson, J. (2012). *Employee Engagement and NHS Performance.* The Kings Fund: UK.

[104] Rondeau, k. Wagar, T. (2012). Employee high-involvement work practices and voluntary turnover: does human capital accumulation or an employee empowerment culture mediate the process? Examining the evidence in Canadian healthcare organisations. Paper presented at the Organisations Proceedings of the European Conference on Intellectual Capital.

4 Conclusion

The purpose of the Safeguarding Review was to obtain a landscape assessment of safeguarding practice across YCS. It was intended to be high level and thus focused on themes and key areas for consideration. It is these broad, overarching themes that each of the recommendations are informed by, which alongside best practice provide a framework for all sites to improve on their existing practices.

The review takes a promising step in the ongoing journey towards a safer youth custody and its recommendations seek both to enhance the direction of travel and accelerate its upward trajectory. Many of the recommendations that have arisen are already in progress, some of which coincide with those noted in the IICSA review[105]. Others are medium or longer term, and will require ongoing review and action in order to be meaningfully integrated into existing practice. Many of the recommendations, particularly those around culture and ethos, can be achieved without cost; however, it is recognised that many require resource. As noted by IICSA when considering the financial implications, *"caring for people does cost money, but that is no reason for not doing so where the safety of children is concerned"*[106].

The review was necessarily extensive, which reinforces the point that safeguarding underpins all aspects of youth custody. However while far-reaching, the review was limited by several factors. First, given that it was an internal review commissioned by and within YCS, it was not a fully independent review. However, it ran alongside other independent reviews and thus complements existing recommendations issued by external bodies such as IICSA, HMIP and the Children's Commissioner. Second, the methods of data gathering were reliant on the receptiveness and capacity of sites and thus was not consistent across the estate. Although efforts were taken to ensure all aspects of the review were comprehensive, the differences in information provided may have impacted the integrity, and potentially scope, of the review. The work-streams that arise from this review will need to further interrogate these issues, to take a deep dive into each of the high level themes found in the report.

It is recommended that a strong governance group be established to drive this forward. YCS leaders must continue to drive change towards a child-centred, rehabilitative culture, with safeguarding seen as an overarching aspect of all roles and functions. Indeed, this is just the beginning; we hope that, going forward, the conversation initiated

[105] Independent Inquiry Child Sexual Abuse (IICSA) (2019). Sexual Abuse of Children in Custodial Institutions: 2009-2017. London: Independent Inquiry Child Sexual Abuse.

[106] Independent Inquiry Child Sexual Abuse (IICSA) (2018). *IICSA Inquiry Children in Custodial Institutions Investigation.* [Transcript]. (Original hearing broadcast July 20, 2018).

by this review will lead to continued dialogue on how best to safeguard children and young people in custody.

5 Appendix

List of Recommendations

Recommendations
2.2.1 YCS should develop their own frameworks that are needs-led, child-focused and distinct from HMPPS including a specific Safeguarding framework   2.2.2 YCS should promote consistency across all sectors by providing standardised policies for operational aspects of Working Together (2018), such as risk of harm, information sharing and restraint   2.2.3 Safeguarding policies in all sites should be reviewed and ratified jointly on an annual basis by YCS and the Director of Children's Service (i.e. Local Authority), including commissioned/contracted service providers   2.2.4 YCS should publish all safeguarding and child protection strategies and/or policies on their and local providers' websites   2.2.5 YCS branding should be used across websites, documents and all other relevant publications   2.2.6 All sites should have an up-to-date and accessible whistleblowing policy, which is available as part of staff induction and actively promoted by senior managers. The policy should prioritise protection for staff who whistleblow   2.2.7 All staff should receive whistleblowing training that includes process and procedure as well as promoting protection for staff who whistleblow   2.3.1 Commissioning and contracts teams should ensure appropriate emphasis on safeguarding within service specifications   2.3.2 Monitoring arrangements should value both qualitative and quantitative measures of performance.   2.4.1 YCS should hold a central register for all recommendations and improvements (e.g. PPO, HMIP, Ofsted, etc.) that have been made and/or achieved   2.4.2 YCS and YJB should work jointly on strengthening relationships between

community and custody

- 2.4.3 YCS should consider a dedicated website for its services, and the use of social media within an effective communications strategy to promote and raise awareness of the service

- 2.4.4 Locally, Governors, Directors, Managers and Director of Children's Services should improve joint working through regular meetings that focus on service delivery

- 2.4.5 Consideration should be given to introducing a forum for all YCS sites and the hosting local authorities

- 2.5.1 Training should be given in the use of Section 11 self-audit tools

- 2.5.2 Section 11 audits should be completed through a peer-auditing system

- 2.5.3 Section 11 audits findings should be used more widely by Senior Managers to inform good/poor practice, concerns and as an assurance mechanism

- 2.6.1 YCS should develop a specific Equalities strategy that considers all protective characteristics with respect to safeguarding children and young people

- 2.6.2 Each site should have their own Equalities Lead, who should report to the senior responsible officer (SRO) for this area

- 2.6.3 Sites should collect data and report on all protected characteristics, which should be monitored at appropriate forums.

- 2.6.4 Actions against the Lammy recommendations should be reported and monitored at YCS SLT

- 2.6.5 YCS should develop a child-centred transgender policy and guidance for establishments

- 2.6.6 YCS placements team should consider all protective characteristics when placing children and young people, and should minimise lone placements of females

- 2.6.7 YCS should develop a Strategy for Females

- 2.8.1 YCS SLT should recruit a senior advisor with relevant experience and

qualifications, who sits at board level, advises on agency safeguarding matters and reports directly to the Executive Director of YCS

- 2.8.2 Governors should ensure representation from a registered and qualified senior social worker, who sits at SMT level, advises on establishment safeguarding matters and reports directly to the Governing Governor

- 2.8.3 YCS commissioning and contracts teams should consider developing a performance monitoring framework specific to safeguarding practice

- 2.8.2.1 Senior social workers should be responsible for oversight of safeguarding and child protection functions

- 2.8.3.1 The service specification for dedicated social workers should be reviewed

- 2.8.3.2 Dedicated social workers should manage child protection and allegations against professionals, including initial contact, debriefing and ongoing support for the complainant until a conclusion has been reached

- 2.8.3.3 The provision for dedicated social workers should be reviewed to reflect the needs of the current population

- 2.8.3.4 STCs should consider the work-load of their Head of Safeguarding ensuring appropriate time is given to safeguarding

- 2.8.3.5 The extent and usage of social workers should be reviewed in STCs to ensure equity of access across sites

- 2.9.1.1 YCS to develop a Code of Conduct for all adults within the sector

- 2.9.1.2 Supervision of staff should include professional conduct and appropriate challenging of inappropriate behaviour / language

- 2.9.1.3 Guidance on appropriate touching should be developed and shared with all sites

- 2.9.2.1 Staff on site should wear uniform appropriate to establishment and role, which should be made clear in the Code of Conduct

- 2.9.3.1 All children and young people should have appropriate clothing to their size and the weather conditions

- 2.9.3.2 Local authorities should ensure allowances are provided to LACs in a

timely manner

- 2.10.1.1 Consideration should be given to HMYOI Feltham becoming a single site, or full separation of the two sites with distinct governance and oversight

- 2.10.2.1 YCS should develop a Strategy for Females

- 2.10.2.2 Education should incorporate 'healthy relationships' into their curriculum

- 2.10.2.3 YCS should issue guidance to staff on appropriate behaviour and healthy relationships

- 2.11.1.1 A assessment should be completed that considers security and decency of young people accommodated in SCHs, including consideration of whether any areas are visible from outside the site

- 2.11.1.2 Commissioning teams should consider contracting bed spaces across a wider geographical area

- 2.11.1.3 YCS should work with YJB to improve and expand the use of YJAF

- 2.11.1.4 The social worker vacancy should be fulfilled within YCS placements team

- 2.11.1.5 YCS should consider multidisciplinary input within YCS placements team, such as operations and forensic psychology

- 2.11.2.1 Escort Services provided for children and young people should be reviewed

- 2.11.2.2 Transportation staff should receive age-appropriate safeguarding training, including child protection and use of force

- 2.11.2.3 Young people being moved between establishments and/or from court should not be transported alongside adults

- 2.11.2.4 Young people should arrive at their accommodation in sufficient time for completion of a meaningful risk assessment

- 2.11.3.1 If a young person is required to lodge, a familiar member of staff should accompany them during their stay

- 2.11.4.1 Planning of transition should begin as soon as possible and in

conjunction with host and home establishments

- 2.11.4.2 HMPPS should consider training needs in working with young adults transitioning from YCS

- 2.11.4.3 The Transitions Strategy should be reviewed and implemented

- 2.11.4.4 Awareness should be raised between all three YCS sectors on the functional responsibilities and differences of one another

- 3.1.1 YCS should consider moving more towards values, rather than competency, based recruitment

- 3.1.1.1 Warner Interviews are implemented into the recruitment process across all sectors of YCS

- 3.1.1.2 A minimum of one person sitting on each interview panel should be safer recruitment trained

- 3.1.2.1 Contract managers should gain assurance that providers have appropriate levels of vetting in accordance with their job roles

- 3.1.2.2 Consideration should be given to renewing DBS checks more frequently, moving towards the use of the new electronic DBS system

- 3.1.2.3 All sites should have a local database as a contingency to ensure directly and non-directly employed staff are in date with their vetting

- 3.1.2.4 All YCS sites should have a forum in which vetting is a standing agenda item to gain assurance at senior level

- 3.1.2.5 HMPPS Security Group to ensure compliance through a service level agreement (SLA) in relation to renewal of all vetting with SSCL

- 3.1.2.6 Staff personnel records should hold data on their vetting levels to allow managers to monitor this information

- 3.1.2.7 All job descriptions that have been published for staff working within YCS should include the level of vetting required for that role, including any barring list checks for working with children

- 3.1.2.8 Vetting coordination should be sufficiently resourced to safeguard against overreliance on a small number of individuals

- 3.1.2.1.1 HMPPS instruction around conduct and discipline[107] should reflect DBS guidance on referrals, including all annexes and templates[ii]

- 3.2.1 Training provision for central YCS services should be expanded and reflective of roles and responsibilities

- 3.2.1.1 WYPC Child Protection and Safeguarding Module to be reviewed and updated

- 3.2.1.2 Training figures should be a standing agenda item at local safeguarding meetings and quarterly at regional safety meetings

- 3.2.1.3 All new starters, directly or non-directly employed, should receive a comprehensive induction appropriate to their role before commencement of their work

- 3.2.1.4 Inductions should be local, and specialist roles should meet with central YCS functions as appropriate

- 3.2.1.5 Business hubs should record all staff induction completions locally, and alert line managers when inductions are not complete

- 3.2.1.6 All new youth custody officers should complete the young person-specific POELT course

- 3.2.4.1 In conjunction with the LADO, YCS sites should develop specific and localised training that meets the emerging needs and threats of the sector

- 3.2.4.2 SECURE STAIRS and associated training to be fully implemented across all YCS

- 3.2.5.1 All training packages should be evaluated to ensure effectiveness

- 3.3.1.1 Clear guidance on information sharing should be issued to all partners working with young people in the secure estate

- 3.3.1.2 Guidance should be issued on how to report and escalate incidents where under-sharing of information has occurred

- 3.3.2.1 Consideration should be given to meeting the gap in SECURE STAIRS

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[107] Her Majesty's Prison and Probation Service (HMPPS) (2012). Prison Service Instruction 2010-06: Conduct Discipline. Her Majesty' Prison and Probation Service: England and Wales.

provision for ineligible sites

- 3.3.3.1 Formal arrangements should be put in place for and Heads of Security and Leads of Safeguarding to share information and intelligence

- 3.3.3.2 Information that is submitted directly to security involving a safeguarding concern should be shared immediately with relevant others to prevent risk and provide appropriate support to children and young people

- 3.3.3.3 Corruption prevention managers and security analysts should receive appropriate safeguarding training

- 3.3.4.1 YCS safeguarding leads should be granted access to relevant information systems, such as the corruption prevention database

- 3.3.4.2 YCS safeguarding leads should ensure that relevant people have access to their information systems

- 3.3.4.3 YCS safeguarding functions should provide regular assurance that access to information systems is on a need-to-know basis

- 3.3.4.4 YCS sites who utilise electronic filing systems should ensure that data is backed up on a Kingston USB stick

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- 3.4.1 For a uniform definition of allegations, complaints and concerns to be utilised across YCS

- 3.4.1.1 Clearer guidance on criminal thresholds should be developed and agreed to ensure defensible decision-making around how and when to involve police

- 3.4.1.2 Senior and Dedicated Social Workers should be involved in allegations

from the outset, and have independent oversight of this process

- 3.4.1.3 Social worker shift patterns should include weekend and evening cover, or on-call, to ensure support is accessible for young people and senior managers on duty

- 3.4.1.4 A detailed record of all contact with professionals, families and the young person should be noted within the chronology on the Child Protection log

- 3.4.1.5 A defensible decision form should be maintained to record rationale for no further action taken, which is multi-disciplinary:

    a) No referral to LADO

    b) No S47 strategy meeting

    c) No action following internal investigation

- 3.4.2.1 A comprehensive review of the complaints process should be commissioned as a separate work-stream, which should be child-centred and take into account principles of procedural justice

- 3.4.2.2 Young people with Safe Systems of Work restrictions must be granted frequent opportunity to speak with professionals in confidence to provide an avenue of making a confidential complaint

- 3.4.2.3 HMPPS are rolling out an in-room telephony system. YCS should be prioritised for this to ensure that any room with a young person should have in-built telephony

- 3.4.2.4 Access to a wide range of children's services, such as Children's commissioner and NSPCC should be available in all site

- 3.4.3.1 Staff dealing with Matters of Concern should receive appropriate and sufficient training in safeguarding and child protection

- 3.4.3.2 Matters of concern policy should be reviewed and widely communicated as part of the overarching review of complaints, including public access to enable family and friends

- 3.5.1.1.1 YCS should review and agree a uniform timescale by which to retain CCTV footage on the server

- 3.5.1.1.2 Any area whereby lone working takes place should have CCTV

- 3.5.1.1.3 YCS should review the use of CCTV so that it maintains children and young people's safety whilst also respecting their privacy

- 3.5.1.1.4 CCTV should be used for quality assurance and preventative purposes as well as review following an incident

- 3.5.1.2.1 YCS should commission an evaluation of the use of BWVC to determine future implementation

- 3.5.1.3.1 In line with the Decency Agenda, consideration should be given to installing and/or refurbishing in-room showers

- 3.5.1.3.2 Where communal showers are used in the interim, necessary refurbishments should take place to ensure these areas are to an acceptable standard

- 3.5.1.4.1 Rooms with viewing panels leading to the toilet should not be accessible from the main units. Decency screens should be assembled in rooms where shower and toilet facilities are visible from inside the room

- 3.5.1.4.2 Unless there is an emergency with the young person, staff should knock prior to opening a viewing panel or entering a room

- 3.5.1.4.3 YOIs and STCs to implement appropriate aftercare following the use of a full search and full search under restraint

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- 3.5.2.2 YCS to conduct a full review of the "keep apart"/non-association process and revise the strategy accordingly

- 3.5.2.3 SCH Contract Managers are to ensure the SCHs are not isolating children or young people

- 3.5.3.1 Consideration should be given to wide scale implementation of the College Centre for Quality Improvement (CCQI) Enabling Environments

accreditation.

List of Good Practice

Good Practice ☑

- 2.2.1.1 Good practice was observed among some SCHs, who had published their safeguarding and child protection strategies and/or policies on their websites

- 2.2.1.2 Good practice relating to whistleblowing was observed in Vinney Green SCH, where the photo and contact details of the Local Authority Designated Officer (LADO) was displayed around the site.

- 2.5.1.1 Good practice was observed in some site, where peer auditing of Section 11 assessments was being conducted

- 2.6.4.1.1 Good practice was observed at HMYOI Feltham who have achieved a working with Autism accreditation

- 2.6.4.1.2 Good practice was observed at HMYOI Werrington who have a working with Dyslexia accreditation

- 2.8.1.1 Good practice was observed in HMYOI Wetherby, who had a qualified senior social worker sitting on the SMT. This supported the transference and assimilation of good practice from the community into custody

- 2.8.1.2 The contract for Rainsbrook STC mandates that the Head of Safeguarding role requires the person to be a registered social worker

- 2.9.2.1.1 Good practice was observed in HMYOI Wetherby, where the SMT were dressed in polo shirts presenting a non-hierarchical approach to a custodial setting

- 3.1.1.1.1 Good practice was observed in some sites when young people were involved in recruitment and selection of new staff at all levels. Although the final decision sat with the recruiters, children and young peoples' views were considered. This practice would benefit the wider youth estate in promoting user voice

- 3.4.1.1.1 Good practice was observed in Oakhill STC where there was social worker cover on evenings and weekends

- 3.4.2.1.1 Good practice was observed in Adel Beck and Barton Moss SCHs, in which a direct line to the children's commissioner and NSPCC was available from the children and young peoples' rooms

- 3.5.1.3.1.1 Good practice was observed in Adel Beck where when the young person stepped into their in-room shower, the blinds automatically closed

- 3.5.1.4.1.1 Good practice was observed in Adel Beck where viewing panels are always closed, and a fob is required to 'de-mist' the viewing panel. This was time-limited so that the viewing panel would mist up again after a short period. The benefits of using a fob is that it is possible to identify which staff member viewed the room, and when.