

Medway Improvement Board

Final Report of the Board's Advice to Secretary of State for Justice

30th March 2016

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Acknowledgements

This Review is the product of the commitment and dedicated work by members of the Medway Improvement Board and the Secretariat who supported them so ably. We could not have delivered such a comprehensive report, however, nor been able to reflect on such a range of perspectives, without the involvement of a considerable number of people.

We would like to extend particular thanks to the young adults who came to see us, facilitated by User Voice, and spoke expressively and bravely about their own experiences in custody. During our visits to establishments, we also heard from the young people we met there. We are immensely grateful for the honesty and the insight of these contributions, which we considered very carefully.

There were too many valuable contributions to this Review for us to name them individually. Those who participated in our Round Table event, who hosted visits by the Board or who provided oral evidence to the panel are listed in Appendices C and D of this report. We would also like to thank the YJB for providing the Board with requested material swiftly to aid their review.

Last but not least, we would like to thank the directors, governors and the staff at the establishments we visited, who provided honest and illuminating accounts of their experiences.

Foreword from Chair

The events depicted in the Panorama programme broadcast on BBC1 on 11 January 2016, were, by common consent, deeply shocking. In the programme, we saw highly vulnerable children in custody at Medway Secure Training Centre (STC) being physically and emotionally abused by those who were employed to protect and care for them.

Our review group was set up in the wake of the broadcast in order to establish whether it was safe to continue to place young people in the STC; to reach a judgement about the robustness of the plans put in place by both G4S and the Youth Justice Board (YJB) to ensure necessary changes in policy and practice; and to put forward any wider learning for the youth justice system.

All of us on the group were deeply conscious of the need to work at pace, but at the same time to ensure that we listened carefully to the widest range of stakeholders possible, including current and former offenders, those who provide daily care to young people in custody, those in operational and strategic leadership positions and those who play a role in monitoring and regulating the provision.

The team never for a moment underestimated how difficult it can be to work in the secure estate, and in STCs in particular. At various times during the course of the work, we felt saddened, uplifted, humbled and angered by what we saw and heard.

Our overriding sense is that, as a society we must do better by these vulnerable young people. This is not to denigrate the excellent practice we observed in the STC. We had the privilege to meet and talk to some highly committed staff who provide outstanding care to vulnerable young people in very challenging circumstances.

We understood why the reaction of some stakeholders was to call for more surveillance, more security and a tougher regime for both staff and young people.

On the other hand, we were troubled by the cultural norms that have grown over time in all three STCs. We noted that accountability for outcomes appears to sit uneasily between G4S and the YJB. This means that the monitoring regime appears to focus more on confirming contractual compliance than on meeting young people's needs. We also discovered that frontline managers have considerable authority but there is little regular oversight of their work. We further noted that a very high proportion of staff have been in post for a year or less and so have little experience of dealing with very challenging behaviours demonstrated by some of the young people.

At the heart of all this are some of society's most vulnerable young people, frequently victims themselves of previous experiences of abuse and neglect, whose complex needs are not being met.

Stakeholders we spoke to impressed upon us the need to ensure better ongoing connectivity between custody and the young person's community; for STCs to achieve a better balance between control, therapeutic services and personalised education; and for STC managers and YJB monitors to spend more time engaging with young people and listening to their concerns. More than anything, we were urged to seize the moment and revisit the vision for STCs and youth custody in general. In formulating our recommendations we were driven by the question: '*what would good provision look like?*'

We asked ourselves what outcomes would be best for the young people in custody and for the society they will eventually return to, and what potential might reside in young people if only it could be unlocked, however serious the crime they have committed. This is summed up perfectly by Jonathan Sacks:

“Children grow to fill the space we create for them, and if it’s big, they grow tall....I’ve not yet met a child not capable of greatness if given the opportunity and encouragement.... The best present we can give our children is the chance to do something great. It’s a gift that will last a lifetime and transform their lives.”

BBCRadio 4 Thought for the Day, 12th December, 2008

We are immensely grateful to all those who helped in the production of this report, and a full list of acknowledgements is included. I would like to record my personal thanks to my fellow team members, Bernard Allen, Sharon Gray and Emily Thomas, whose passion and commitment drove the project and from whom I have learnt so much. On behalf of the whole group, I also record my heartfelt thanks to Dr Deborah Browne and her colleagues in the Secretariat without whose untiring efforts on our behalf we could not have produced this report.

Dr Gary Holden,

Chair Medway Improvement Board

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Executive Summary

- i. The independent Medway Improvement Board was appointed on 26th January 2016 by the Secretary of State for Justice. The Board was appointed as a response to a BBC Panorama programme on 11th January which highlighted the allegations of physical and emotional abuse of young people by staff at Medway STC.
- ii. The Board was asked to investigate the current safeguarding arrangements at Medway STC and report to the Secretary of State on the confidence of its members in the capability of YJB and other organisations to meet appropriate safeguarding standards at Medway in the future and on performance and monitoring arrangements. The Board was also asked to feed into the Improvement Plan that G4S were asked to put in place.
- iii. In the time that the Board was appointed, they spoke to 34 stakeholders in person, either as a Board or on a one-to-one basis. Stakeholders included key individuals from G4S and YJB, inspectors from HMIP and Ofsted, the Children's Commissioner, and senior staff at Medway Council. The Board also spoke to staff and children at the STC and conducted a roundtable event with stakeholders from lobby groups and charities.
- iv. From very early on in the investigations, the Board found problems that members found alarming. The most immediate concerns were raised in the interim advice presented to the Secretary of State on 2nd March.
- v. The Board found that there was a lack of clarity on the purpose of an STC and that leadership within the STC has driven a culture that appears to be based on control and contract compliance rather than rehabilitation and safeguarding vulnerable young people. The Board continues to have significant concerns that this culture and the emphasis on contract compliance may be leading to reports of falsification of records etc. that were seen in the Panorama broadcast.
- vi. There are blurred lines of accountability and an ambiguous management structure. A clearer child-based vision needs to be driven by strong leadership. The purpose of STCs needs to be more clearly articulated with a focus on prompting a nurturing and safe environment. The Board is recommending that an independent Governing Body be appointed to provide overall oversight and scrutiny arrangements for safeguarding in all STCs.
- vii. Current safeguarding measures are insufficient and outdated. There is too much emphasis on control and contract compliance and not enough on the best interests and mental wellbeing of the trainees. YJB has not done enough to change this and current policies and practices need to be reviewed.
- viii. The Board is not convinced that the various organisations that currently play a role in scrutinising and responding to safeguarding at Medway STC are coordinated in their approach. This increases the risk of safeguarding issues falling through a gap. These findings further support the need for an independent governing body.
- ix. There is a history of similar concerns being raised repeatedly in letters from whistle-blowers and former staff. The Board feels that policies which form part of the STC contract need to be reviewed to ensure that they support the overall safety of young people rather than

focus on contractual penalties. Whistle-blowers and children inside of the STC need to have an effective support framework in which they feel safe to raise concerns and complaints.

- x. The Board noted that there is a qualitative difference between how behaviour management and Restrictive Physical Interventions (RPI) are used in the secure children's estate and in other sectors, despite the fact that in some cases staff are dealing with very similar behaviours. There is a lack of understanding of the causes and drivers of behaviour problems and too much focus on controlling behaviour rather than dealing with underlying vulnerabilities. The Board feels there needs to be a wider review of behaviour management policy and practice in STCs, across the wider youth justice system and across other sectors, with a view to developing a coherent and consistent policy on risk, restraint and behaviour management across government.
- xi. The Board continues to have concerns about how YJB manages their contract and monitors safeguarding at the STC. It welcomes some of the changes that have been made as a result of earlier advice in the course of the term of this Improvement Board and acknowledges that YJB are reviewing their approach to monitoring in the STC. The Board feels there is a need for formal separation of the often conflicting YJB monitoring functions of ensuring contractual compliance and monitoring safeguarding.
- xii. The Board feels that while the revised Improvement Plan, received from G4S on 15th March, takes on board earlier feedback from the Board, it does not go far enough. In particular it does not take into account the Board's concerns about handover and continuity if, following the announcement of their intention to sell the contract, responsibility for managing the STC and for implementing the Improvement Plan moves from G4S. Regardless of who manages Medway STC, changes in culture, leadership and staff approaches are needed; for these reasons the Improvement Plan needs to incorporate effective mechanism for continuity of improvement, assessment of impact of improvements, and a timetable for handover.

1 Introduction

- 1.1 On 11th of January this year, BBC 1 broadcast a Panorama programme that revealed an undercover operation at Medway Secure Training Centre (STC). The programme claimed to have uncovered allegations of abuse and bullying from staff at the centre. The events depicted in the 30 minute BBC panorama programme showed harsh, punitive treatment of children in the care of the state that shocked viewers.
- 1.2 In response to this, on 26th of January the Secretary of State for Justice announced the appointment of an independent Improvement Board. The terms of reference for the Board (see Annex A) included investigating the current safeguarding arrangements at Medway and feeding into the improvement plan proposed by G4S, who were the contracted provider at Medway STC. As well as G4S, the terms of reference also asked that the Board report to the Secretary of State on the Board's confidence in the capability of YJB and other organisations to meet appropriate safeguarding standards at Medway in the future and on performance and monitoring arrangements.
- 1.3 On Friday 26 February, G4S announced its intention to sell UK Children's Services, including the contracts for Medway and Oakhill STCs. It is not clear whether this decision was in anticipation of an article in the Guardian, published on the same day¹, which set out further allegations against senior G4S staff, or on similar findings from the Board. Whether or not this is the case, the decision has had an impact on the work of the Board and the nature of its findings. Any recommendations now have to take into account that management arrangements at Medway STC will inevitably change at some point. The Board believes that its findings are still relevant to future management, monitoring and safeguarding arrangements at Medway and at all STCs.
- 1.4 The Board submitted interim recommendations for the Secretary of State on 2nd of March. These highlighted initial concerns about the efficacy of monitoring arrangements and about whether G4S staff had sufficient understanding and training in relation to the safeguarding of children in their care. The interim findings included concerns about leadership issues, about the relationship between YJB and G4S, and about YJB's understanding of the terms of the contract. It also conveyed the Board's unease about how previous whistle-blowing cases had been dealt with.
- 1.5 This report provides advice to the Secretary of State for Justice on the findings of the Improvement Board. It sets out what the Board did to fulfil its terms of reference and investigate safeguarding arrangements at Medway and determine its confidence in management and monitoring arrangements and the future of safeguarding standards at Medway. The rest of this section briefly sets out the background of STCs and the involvement of G4S in this sector. It then outlines how the Board conducted its investigations and describes how the rest of the report is structured.

¹ Hattenstone, S. & Allison, E. (2016). Former Medway Inmate: The Guard slammed my face off the ice. *The Guardian*. Published 26 February 2016, 15.15. Accessed on 10 March 2016 at: <http://www.theguardian.com/society/2016/feb/26/former-medway-inmate-the-guard-slammed-my-face-off-the-ice>

The BBC Panorama Programme

- 1.6 On 11 Jan 2016 BBC Panorama aired a 30 minute undercover documentary filmed at Medway Secure Training Centre following reports from a whistle-blower. The reporting of these incidents has led to the suspension of seven staff members. The staff members include one assistant, four team leaders and two managers.
- 1.7 The reporter, Robert Charles, acquired a job as a custody manager for G4S through normal recruitment channels and began secret filming in October 2015.
- 1.8 The programme showed what appeared to be unnecessary and disproportionate use of physical restraint, including footage of a young boy 'Billy' being restrained by four members of staff whilst a senior staff member appeared to place his hands on his windpipe, potentially making it difficult for the child to breathe. In another scene, viewers witnessed a staff member boasting about harming a 14 year old boy when he stabbed him in the leg with a fork. Throughout the programme frightening and intimidating behaviour and language is seen to be used by staff. Staff are also heard discussing how they falsified records because of organisational pressure to ensure G4S was not penalised or fined for breaching the terms of the contract.

The Place of STCs in the Youth Justice System

- 1.9 The current Youth Justice System (YJS) in England and Wales was set up under the Crime and Disorder Act 1998. Formal processes begin when a child, who reaches the age of criminal responsibility (10 years of age) and who is under 18 years, commits an offence. The focus of the YJS, however, is on prevention, and the Act includes provision for local multi-disciplinary Youth Offending Teams (YOTs) to work with children and young people who are at risk of offending.²
- 1.10 Over the past few years, there is evidence that proven offences are down by 71% from their peak in 2005-06.³ The numbers of children who are sent to custody has also fallen by around two thirds since 2007-08.⁴
- 1.11 Children, nonetheless, continue to be sentenced to custody. When this happens, they are sent to one of three types of establishments:
 - Secure Children's Home (SCH). YJB currently commission beds from eight SCHs, which are mixed establishments for 10-17 year olds and are run by local authorities. The focus is on rehabilitation and SCH's have the highest staff-child ratio of all forms of custodial

² For more information see <http://www.chimat.org.uk/yj/na/avis/whatis> and also <https://www.gov.uk/government/organisations/youth-justice-board-for-england-and-wales/about>

³ Ministry of Justice (2015). *Youth Justice Statistics 2014/15*. London: Ministry of Justice.

⁴ Youth Justice Board (2015). *Monthly youth custody report – January 2016*. London: Ministry of Justice.

provision.⁵ This is also the most expensive form of custodial care for children, with each place costing approximately £204,000 per year as at 1st April 2015.⁶

- Secure Training Centre (STC). There are currently three STCs, all of which are privately run. STCs were designed to hold 12-14 year olds, but are now more likely to hold older children. STCs hold both boys and girls, and have a higher staff-child ratio than Young Offender Institutes. They were originally designed to be education-focussed. Annually, STCs cost approximately £163,000, per place as at 1st April 2015.⁷ The cost per place is expected to decrease in financial year 2016/17 due to the signing of new contracts at Medway and Rainsbrook STCs.
- Young Offender Institute (YOI). YOIs are not mixed and hold 15-17 year old boys, but only 17 year old girls. There are 5 establishments that hold young offenders, either as dedicated institutions or as part of other institutions. YOIs have lower staff-child ratios and are also the cheapest form of child custody – a place costs about £75,000 annually as at 1st April 2015.⁸

1.12 The Youth Justice Board (YJB), which is an executive non-departmental public body sponsored by the Ministry of Justice, oversees the youth justice system in England and Wales. Its responsibilities include providing the ‘secure estate’ that includes SCHs, STCs and YOIs. It is also responsible for placing children and young people who are remanded or sentenced to custody. The YJB states that as part of overseeing youth justice for children, they “*ensure custody is safe and secure, and addresses the causes of their offending behaviour.*”⁹

1.13 As well as Medway STC, there are two other STCs that are currently operating. **Rainsbrook STC** is located near Rugby and opened in July 1999. It was originally designed to accommodate 44 boys, but in 2002 it expanded to 76 places for both boys and girls and then expanded further to 87 places in 2006. It includes a purpose-built mother and baby unit to care for detained young mothers and their babies, as well as those in the final stages of pregnancy. **Oakhill STC** is located in Milton Keynes and opened in August 2004. It accommodates 80 children, both boys and girls.

1.14 While many of the findings of this report probably apply to all of the STCs, the focus of the Board’s investigations and analysis have been on **Medway STC**, which is located in Rochester in Kent. When Medway originally opened in 1998, it was designed, like Rainsbrook, to hold 44 males. It also expanded in 2002 to hold 76 boys and girls. It holds children between 12 and 17 years of age. The current interim director is Ben Saunders, who replaced Ralph Marchant in January following the Panorama programme.

⁵ Information accessed on 10th March 2016 at: <http://www.howardleague.org/children0>

⁶ Youth Secure Estate Sector prices as at 1st April 2015 provided by the YJB (for external and public use).

⁷ Youth Secure Estate Sector prices as at 1st April 2015 provided by the YJB (for external and public use).

⁸ Youth Secure Estate Sector prices as at 1st April 2015 provided by the YJB (for external and public use).

⁹ See gov.uk. Accessed on 10th March 2016 at: <https://www.gov.uk/government/organisations/youth-justice-board-for-england-and-wales/about>

- 1.15 It is worth noting that all three STCs have been the subject of investigations and concerns in terms of the treatment of children over the years. In 2004, for example, Gareth Myatt died at Rainsbrook following restraint by staff¹⁰. In 2013, a joint inspection by HMIP, Ofsted and CQC raised safeguarding concerns about Oakhill¹¹. In 2015, a joint inspection by HMIP, Ofsted and CQC concluded that Rainsbrook STC required improvement overall.
- 1.16 In 2014, the Guardian published an article that described how numerous children who had been accommodated at STCs had received injuries following restraint. The article claimed that 14 children who were assaulted by G4S and Serco staff while being detained at STCs between 2004 and 2008 had received damages; a third of this was paid by YJB, with G4S and Serco paying the rest.¹²
- 1.17 Complaints about all three STCs have also been raised in numerous whistle-blowing letters that were sent to the YJB. This will be discussed in more detail later in this report.
- 1.18 For now, suffice it to say, given so many have voiced their surprise about the events depicted in the Panorama programme, the Board did not take long to uncover some troublesome issues that have given them concern about the ongoing safety of children at Medway.

G4S and Secure Children's Homes

- 1.19 G4S plc (formerly Group 4 Securicor) is a large global organisation, spanning 125 countries and has been called the world's largest security company.¹³ It was founded in 2004 by the merger of Securicor with Group 4 Falck. Peter Neden has been president of G4S UK and Ireland since 2015. G4S UK and Ireland, however, has been involved in the criminal justice sector since 1992 (then as Securicor), when they won the contract for HMP Wolds. While they have won contracts across the secure sector, including detention, electronic monitoring, immigration police support, this report is focused on their children's services provision.
- 1.20 G4S Children's Services, led by Paul Cook, delivers services including Residential Children's Homes and Reparation Programmes as well as Secure Training Centres. It has been involved with STCs since 1998 and at the time of writing this report it has contracts with all three of the existing STCs, Medway, Rainsbrook and Oakhill. Before Paul Cook was Managing Director of Children's Services, he was also involved with running Rainsbrook and then Medway.

¹⁰ Jerrom, C. (2004), Teenager dies after being restrained at secure training centre. *Community Care*. Published online on 23 April 2004. Accessed on 24th March 2016 at: <http://www.communitycare.co.uk/2004/04/23/teenager-dies-after-being-restrained-at-secure-training-centre/>

¹¹ Puffet, N. (2013), Oakhill STC inspection raises safeguarding concerns. *Children & Young People Now*. Published online on 23rd May 2013. Accessed on 24th March 2016 at: <http://www.cypnow.co.uk/cyp/news/1077293/oakhill-stc-inspection-raises-safeguarding-concerns>.

¹² Allison, E. and Hattenstone, S. (2014). G4S and Serco pay out in youth restraint claims. *The Guardian*. Published online on 24th October 2014 19:46. Accessed on 16th March 2016 at: <http://www.theguardian.com/uk-news/2014/oct/24/g4s-serco-pay-out-100000-youth-restraint-claims-stc>.

¹³ See <http://fortune.com/2014/11/12/worlds-largest-employers/>.

- 1.21 The contract for Medway STC ends in March 2016 and the contract for Rainsbrook STC ends in May 2016. G4S submitted a bid for the new contract for both institutions, but lost out to MTC Novo for Rainsbrook. G4S already have the contract for Oakhill, which was due to run until 2029.
- 1.22 The G4S bid for the contract at Medway STC sets out a good understanding of the importance of safeguarding. G4S emphasises, for example, its robust training and procedures to deal with incidents or potential incidents of harm, including in-depth Minimising and Managing Physical Restraint (MMPR) training and how staff learn how to take positive and constructive action to help resolve a deteriorating situation. It acknowledges that negative actions/ comments can often make the situation worse.¹⁴
- 1.23 Although G4S won the contract for Medway STC and the new contract was due to begin in April, G4S announced in February the intention to sell their Children's Services, including the contracts for Medway and Oakhill STCs. The Justice Minister, Andrew Selous, announced on 1 April that the current contract would be extended for a short period.¹⁵
- 1.24 Ralph Marchant was Director of Medway STC at the time the events in the Panorama Programme were recorded. He stepped down in January 2016 when the accusations were revealed. At that point Ben Saunders was brought in as interim Director while G4S recruited a replacement. This appointment was approved by YJB and the Secretary of State for Justice.
- 1.25 As well as the BBC Panorama programme on Medway STC, G4S has been the subject of negative publicity in recent years, including around electronic tagging, security for the Olympics, and the death of Jimmy Mubenga, who died in 2010 after he was restrained by G4S guards when he was being deported from the UK. Use of restraint by G4S staff also led to the death of 15 year old Gareth Myatt at Rainsbrook STC in 2004.

The Medway Improvement Board

- 1.26 The Improvement Board was appointed by the Secretary of State for Justice on 26 January following the recommendation in an inspection report by HMIP and Ofsted that a commissioner be appointed to provide additional oversight following the allegations of abuse at Medway.
- 1.27 The Board was appointed to fulfil the same function and is composed of four members. It was chaired by Dr Gary Holden, chief executive officer of The Williamson Trust. The other members were Bernard Allen who is an expert in behaviour management and restraint, Emily Thomas, who is Governor of HMP Holloway, and was formerly governor at HMYOI Cookham Wood, and Sharon Gray who is an educational consultant and former head teacher at specialist schools. Further details for Board members can be found at Annex B.

The Approach of the Medway Improvement Board

¹⁴ Set out in Appendix A6 (Safeguarding) of G4S response to Stage 2 of Invitation to Participate in Dialogue (ITPD) for the contract.

¹⁵ *Youth Custody*, 1 April 2016, <https://www.gov.uk/government/speeches/youth-custody>

- 1.28 The Medway Improvement Board began its work on 1st February this year. With only two months to become familiar enough with the STC and the organisations associated to fulfil its terms of reference, it was clear that the pace of work was going to be challenging.
- 1.29 The Board held its first meeting on Thursday 4th February and visited Medway STC for the first time on Friday 5th of the same month. Between then and when the report was submitted, the Board held 9 Board meetings and members visited Medway STC a total of 8 times. During visits to Medway, Board members and the Secretariat visited all parts of the STC, including a number of units, and had opportunities to speak to a number of children and staff. A member of the Board participated in MMPP training (to be discussed later in the report) and another member attended a safeguarding meeting. Staff at different levels of seniority were spoken to, and the panel arranged to meet individuals from key areas (e.g. chaplaincy, education, psychology).
- 1.30 The Board spoke to 34 stakeholders in person, either as a Board or occasionally 1 to 1. Stakeholders included key individuals from G4S and YJB, inspectors from HMIP and Ofsted, the Children's Commissioner, and senior staff at Medway Council. A full list of the stakeholders spoken to and when is provided at Annex C.
- 1.31 The Board held a round table event on the 9th of March where it heard from a further 13 stakeholders, including lobby groups and organisations involved in safeguarding (e.g. Prison Reform Trust, Howard League, Office of the Children's Commissioner, Barnardo's). The event explored the three themes of: *the challenge of balancing safeguarding, rehabilitation and behaviour management, the purpose of monitoring and inspection in the STCs and the interaction between the role of different organisations and finally, the purpose of STCs in the youth justice system: is this being achieved and what else should we be doing to achieve it?* A full delegate list is attached at Annex D.
- 1.32 The Board met young people who had previously spent time at an STC/YOI at a meeting facilitated by User Voice. They also met and spoke to trainees at Medway STC during visits. One board member held a couple of focus groups with young people at Medway STC to ensure their perspective of life at the STC was taken into account.
- 1.33 In order to ensure that they understood the context of the wider youth custodial estate and were able to inform practice, the Board also took some time to understand other custodial options for children and additionally looked at other residential care for children. Members of the Board also visited Rainsbrook and Oakhill STCs, and HMYOI Cookham Wood. A representative from the Board visited St Edwards School, which is a special school for boys who experience behavioural, emotional and social difficulties. The Board heard from Claire Lillis, the head of Ian Mikardo School for children with severe and complex social, emotional and behavioural difficulties.
- 1.34 The Board is very grateful for the input of everyone who they spoke to during the 2 months of this review, particularly those who met the Board at short notice.

The Structure of the Report

- 1.35 The rest of this report sets out the findings and recommendations of the Medway Improvement Board. The next chapter sets out the considerable apprehension the Board has about the culture and leadership at Medway STC, extending more widely into G4S. It

describes the ambiguous management structure at the STC, some worrying evidence of practices that appeared to endorse falsification of records in order to avoid contractual penalties, and a style of management and leadership that focused more on controlling young people than safeguarding. It sets out recommendations about the future of leadership and governance in the STC and also looks at the implications for the future of the wider youth secure estate. It is hoped that the findings and recommendations will help inform the Youth Justice Review.

- 1.36 Chapter 3 describes what the Board found in relation to safeguarding arrangements at Medway STC. The Board felt that overall arrangements are not currently adequate, with little evidence of constructive practices to help support vulnerable young people through a difficult experience. The Board is also concerned about the lack of co-ordination and consistency between all of the bodies who currently have responsibility for visiting Medway in some inspection or scrutiny capacity. As many policies and practices apply to all STCs, the Board feels that many of the findings and recommendations in this chapter apply to all STCs.
- 1.37 Chapter 4 of the report describes the Board's views on use of restraint and behaviour management techniques at Medway STC. As with safeguarding, use of restraint appears more about control and contract compliance than about the best interests of the young person. There is little evidence of exploring more effective behaviour management techniques that might help develop more adaptive behaviours.
- 1.38 Chapter 5 outlines considerable concerns about the contract management arrangements at Medway STC and the role of YJB monitoring. The fact that these arrangements have been clearly failing for years and yet little has been done to improve them until now remains a source of unease.
- 1.39 Finally, the Board has set out the actions it has taken in relation to the Improvement Plan during the course of the two months it has been involved in this work. Recommended changes to the version of the improvement plan that was discussed with G4S on 17 March are set out. The Board feels that these improvements need to be taken on board by whoever takes over leadership of the STC in order to ensure appropriate safeguarding standards are developed at Medway STC. Recommendations include an appropriate handover of the improvement plan between G4S and new management, whenever this takes place.

2 Leadership, Culture and Management at Medway STC

- 2.1 From their first meeting, the Board has had significant concerns about cultural and leadership values at Medway STC. Concerns stem from what both G4S and YJB bring to the culture of the institution, and also from the relationship between the two organisations. When the Board presented their interim findings to the Secretary of State, they explained that they felt there had been a breakdown of trust between the two organisations, although they could not determine whether this was as a result of the Panorama programme or if it was something more systemic. Since then, the Board's conversations with senior staff from each organisation have confirmed that there is a recognition that the relationship has deteriorated.
- 2.2 The Board feels that the YJB can do more to influence leadership and culture at the STC through its contract management and monitoring processes. This is expanded on elsewhere in this report. This section focuses mainly on the culture, leadership and management of Medway as it has been sustained by G4S, and how it needs to move towards a healthier, more open and nurturing environment.

Management Structure at Medway STC

- 2.3 Medway STC is headed by a Director. The current interim Director is Ben Saunders, who replaced Ralph Marchant following the revelations of the Panorama programme in January. Ben reports to the Director of Children's Services, John Parker, and the Managing Director of Children's Services, Paul Cook. Paul Cook reports directly to the President of G4S for UK and Ireland, Peter Neden.
- 2.4 Ben Saunders' position is as interim Director and the future of this position remains unclear, even as the Board writes the final report. The Board understands that there are plans to replace Ben with a more permanent leader. Given the uncertainty of the future of the STC, the Board's concerns about consistent and stable leadership at Medway, as expressed in the interim advice, remain. The Board feels that frequent and temporary changes of leadership will hamper effective cultural change and confidence in the direction of leadership.
- 2.5 The Board also feels that great care needs to be taken in appointing a replacement. The control culture that has grown at Medway STC, as this chapter will describe, needs to be transformed, and this needs to happen with transparent and strong leadership that promotes a nurturing and rehabilitative culture.
- 2.6 The positions directly underneath the Director level include the senior leader positions of Head of Operations, Head of Care, Head of Resettlement (current post holder is also the deputy director) and the Head of Education.
- 2.7 The Head of Operations is responsible for health and safety, security, information officer, chaplaincy, facilities and the Deputy Operations Managers (DOMs), as well as the control room. The Head of Care is responsible for the Residential Service Managers (RSMs), team leaders and training assistants, for both the day and nights, as well as being the manager for the training officer. The Head of Resettlement is responsible solely for the resettlement team and the Head of Education is responsible for the teachers, vocational trainers and youth workers.

- 2.8 The next level of management, the middle managers, include DOMs, RSMs and Team Leaders and the Training Officer.
- **DOMS** responsibilities include assisting in the provision of advice, guidance and practical support to the operational management of the Centre. They are also responsible for promoting the safeguarding of young people's welfare, in order to promote and maintain good order and a safe and effective regime. This includes completing relevant paperwork to ensure that the centre is contractually and legally compliant.
 - The **RSM** is responsible for all aspects of the day-to-day running of a residential housing level, including promoting the safeguarding of young people's welfare. The RSM assists in the review of documents and incident reports, to ensure anomalies are identified, rectified and policies and procedures are followed and improved where necessary.
 - **Team leaders** are responsible for the daily management of a shift, providing advice and support to other staff to promote the safeguarding of trainees' welfare and ensuring that a stable and secure environment is provided for all trainees that promotes anti-offending behaviour in line with legislation, contractual and company requirements.
- 2.9 The Improvement Board raised specific concerns about middle management in their interim advice to the Secretary of State. At that point, they raised concerns about leadership capability and safeguarding knowledge at this level, particularly DOMS and Team Leaders. It was pointed out that this had been acknowledged by senior staff at G4S and by individual staff members the Board had spoken to. These concerns have been backed up by further evidence the Board has seen and heard throughout March, including former and current staff at Medway STC.
- 2.10 The Board found that in practice the hierarchy of management was ambiguous and junior frontline staff gave different views on who should report to who, and on which middle manager was responsible if an incident occurred. This was also backed up by the clinical psychologist, who said that accountability for provision and outcomes for young people was blurred.

The View of Stakeholders on G4S Culture and Management

- 2.11 The Panorama programme and the article published in the Guardian on 26 February¹⁶ both convey concerns about G4S culture and transparency of management processes, including some indication of systemic bullying and falsification of records that predate those referred to in the Panorama programme.

¹⁶ Hattenstone, S. & Allison, E. (2016). Former Medway Inmate: The Guard slammed my face off the ice. *The Guardian*. Published 26 February 2016, 15.15. Accessed on 10 March 2016 at: <http://www.theguardian.com/society/2016/feb/26/former-medway-inmate-the-guard-slammed-my-face-off-the-ice>.

- 2.12 These accusations are further substantiated by whistle-blowing material that the Board has seen (see Chapter 3) and with accounts told to the Board by former members of staff. These concerns are echoed elsewhere.
- 2.13 Ahead of the Panorama broadcast, the then Chief Inspector of Prisons Nick Hardwick commissioned a visit to Medway STC on 11th January 2016 by six inspectors, the Deputy Chief Inspector of Prisons and an OFSTED Senior Her Majesty's Inspector (SHMI). Following this visit, Nick Hardwick issued a press release in which he concluded that, while the actions taken by G4S and the YJB were 'adequate' to ensure the safety of young people, he had "significant concerns" about the Centre. He commented that staff must have been aware of the falsification of records, on the high rate of staff turnover and concern about how staff behaved where there was no CCTV. He said "*managerial oversight failed to protect young people from harm. Effective oversight is key to creating a positive culture that prevents poor practice happening and ensuring it is reported when it does.*"¹⁷
- 2.14 When Nick Hardwick met the Board on 16 February, he told them that he remains concerned about the culture in STCs and the impact of high staff turnover on the capacity of recently appointed staff to cope with the needs of the young people placed there. He felt the G4S over-controlling management culture might inhibit staff from raising concerns and that the various monitoring systems in Medway STC lead to blurred accountability. He also had concerns about the use of pain compliant techniques on children and the impact this had on staff culture and relationships.
- 2.15 Peter Clarke, the current Chief Inspector of Prisons, also told the Board of his concerns about leadership and the unhealthy staff culture that appears to prevail in the STC. He felt that the DOM role is a particular concern: they have considerable operational power and there is little evidence of proper oversight of their role by senior leaders. He felt that leadership, under pressure with staffing, contractual targets and media scrutiny, have developed an over-reliance over the years on DOMs to keep good order in the STC. If a young person wishes to complain, for example, the complaint has to be routed through the DOM, so this may be a disincentive for young people to complain.
- 2.16 The YJB have also raised concerns about leadership and culture at Medway STC. In communication with the Board over the course of the review of Medway, YJB acknowledged that they shared the Board's concerns. In addition, the Head of Contracts and Business Management also agreed with the Board that there were worries about the sort of people drawn to work in STCs and that there needed to be better management supervision, even when unsubstantiated concerns were raised. He said that STCs needed to have the right people with a career path in the justice arena.

Views on Culture and Management of G4S and Medway STC Staff

- 2.17 The Board has had the opportunity to speak to staff at all levels inside Medway STC and in G4S. Peter Neden, Regional President for UK and Ireland, commented that there was a need

¹⁷ Nick Hardwick's Advice Note to Secretary of State on 12 Jan 2016, on behalf of HMI Prisons and Ofsted <https://www.justiceinspectorates.gov.uk/hmiprisons/inspections/medway-secure-training-centre-4>

to encourage a change of culture, and for people to be able to openly raise their concerns. In a discussion with the Board about why people might not be comfortable raising their concerns, he acknowledged, when questioned, that in theory overly firm management could lead to staff being reluctant to raise complaints.

- 2.18 When Paul Cook, Managing Director of Children's Services for G4S, spoke to the Board he discussed a number of issues relevant to the culture and management of the STC. When asked about the vision for the STC, for example, he stated that G4S were trying to achieve 'good citizens', not 'good prisoners', but that this vision was challenged by the different lengths of time children were at the STC for example, 8 weeks in custody for a young person sentenced to a 4 month Detention and Training Order.
- 2.19 Paul Cook also voiced his concern about finding the right calibre of staff locally to take on a Custody Officer role, in a professional capacity. It is a multi-faceted role, caring for and building relationships with the young people in STCs. When describing training, he also said that while the training they gave staff compared to other sectors was a good starting point, he did not think it prepared staff for the challenge of managing these young people when they went live, which led to high attrition rates within the first 6 months.
- 2.20 Paul Cook felt that G4S might have inadvertently developed a culture that wasn't helpful. He gave an example of the dangers of losing the value of learning from an incident because staff did not feel able to report it upwards. He explained that G4S and YJB may be sending mixed messages to staff who had lost confidence in both organisations to deal with incidents proportionately; decisions were being made to discipline or dismiss staff too quickly, when in some circumstances supervision and retraining might achieve a better outcome. As a consequence, staff might deal with issues themselves rather than reporting them upwards.
- 2.21 John Parker, Director of Children's Services for G4S also conceded that staff training at all three STCs needed to improve. He felt that a dedicated and skilled team of trainers was needed to ensure all staff have the input and development opportunities they need.
- 2.22 As Board members themselves noticed during visits to Medway STC, John Parker also said he believed accountability for STCs is blurred and so Directors are not able to exercise strong leadership and make decisions they believe are in the best interests of young people. He felt that the relationship with YJB had deteriorated and he did not think some monitors have significant skills or training to carry out their role. He said that there are too many external influences on G4S management of the STC.
- 2.23 The Board also met with the Interim Director of Medway STC, Ben Saunders, who felt the key to the problems lie in organisational culture. He questioned whether the front line staff are sufficiently mature in their thinking and consciousness to receive feedback from peers if challenged about their behaviour or performance.
- 2.24 He pointed out that although there is a training and induction programme for new staff, there is no specific training for those in middle leadership positions, in particular training in behaving ethically and in reflective/conscious management. He believed that the key to recovery for the STC lies in creating a healthy workforce. This included the need to invest in the people that work at the STC so that they know the values and standards they are expected to uphold and so that they have the support and challenge they need to do this.

- 2.25 Ben Saunders noted that the quality of training given to middle managers (this is the level that includes DOMS) was not adequate. He also said that more should be done to recruit and develop professional frontline staff. He felt that the current focus on process or task rather than people has led to a high staff attrition rate.
- 2.26 Board members also spoke to frontline staff at the Centre, including recent recruits, Residential Service Managers (RSMs), Team Leaders, and Duty Operational Managers (DOMs). This was done through both 1 to 1 interviews and more informal conversations during visits.
- 2.27 Staff invariably spoke of their shock at the Panorama programme and of their belief that the incidents shown were not typical or representative of daily life at the STC. At the same time, there was recognition that staff tended to have varying levels of skills and capability, particularly at Team Leader level. It was considered that this was because staff had been promoted earlier than might have otherwise been the case.
- 2.28 Staff expressed concern that not all of their colleagues shared the same values and could not say whether there could be a repeat of the same kind of treatment towards young people has had been shown.
- 2.29 Many members of staff criticised G4S management. An experienced DOM also claimed that when issues are brought to their attention, little or nothing is done. He also noted that there are currently no formal meetings of the DOM team with management, and DOMs play no role in the recruitment process for new staff.
- 2.30 The Board also noted that DOMs do not appear to be held to account for their decisions in a way that is proportionate to the apparent amount of power that they have in the STC. It was clear that more junior staff often felt intimidated by DOMs, something backed up by accounts by former staff members.
- 2.31 Staff also spoke of poor communication, particularly after the Panorama broadcast. Many different members of staff commented that there had not been any adequate debrief following the broadcast.

Leadership and Culture

- 2.32 The summaries given of the views of some of the stakeholders and staff that the Board heard from demonstrate that there are widespread concerns about the culture and values at Medway STC. Culture is driven by leaders, and the Board feels that G4S is no exception.
- 2.33 In earlier advice to the Secretary of State, the Board explained that it had significant concerns about the leadership values that are being modelled from the top at Medway STC. The Board now feels that transcends the STC, and goes higher into G4S leadership.
- 2.34 The Board has seen and heard evidence from whistle-blowing letters and from former staff members that suggests that the culture in G4S is about control and contract compliance rather promoting a culture where staff feel confident about raising concerns. They describe a culture of bullying and falsification of records and unclear boundaries between staff. This is described in more detail in Chapter 3, where the apprehension of whistle-blowers about speaking out is also described.

- 2.35 One example of the unclear boundaries between staff and trainees was described as follows. When a trainee raised a concern with the YJB monitor, the concern was followed up with other staff. Instead of supporting the monitor to resolve the problem, G4S staff told the trainee that the monitor had been talking about him, prompting the young person to confront the monitor and to avoid asking for help again. The Board found this example of manipulation of the trainee by G4S staff very disturbing.
- 2.36 The Board feels that it has been subject to some of this controlling culture in the short time its members have been involved with the STC. Board members felt that there were attempts by G4S to control where they visited within the Centre, and who they spoke to. Staff seemed to deliberately time movement of young people so that they would not 'run into' members of the Board. On one occasion a trainee shouted out to a passing Board member that she had not been allowed to speak to the Board. When the incident was followed up, the young person reiterated the claim.
- 2.37 The chapters that cover safeguarding, restraint and contract management in this report also raise disquiet about the cultural values at Medway STC. They highlight concerns about the fact that safeguarding is not given sufficient emphasis at Medway, that the 'control culture' influences how often and how severely young people are restrained, and how the culture at Medway is to avoid contractual penalties often at the expense of safeguarding and nurturing.
- 2.38 The Board also heard evidence to suggest that the management culture valued control and contract compliance over rehabilitation. One example of this is that children who needed to see a psychologist were not allowed to do so during school hours because of concerns that it would have an impact on their 25 hours per week of education and risk a contractual penalty. This meant that the times available for treatment were very limited and so behavioural change and rehabilitation were compromised. While the Board understands that this problem has now been rectified, it is concerned that it took a long time to deal with the issue.
- 2.39 The Board spent some time discussing the 'control culture' and how it might have developed in an institution that should be caring for and nurturing vulnerable children. It was noted that the senior leaders at G4S have been involved with Medway and the other STCs for a very long time. The early history of Medway STC was tempestuous, with media attention at the time reporting riots and poor order¹⁸. Interestingly, a Home Office report at the time reported confusion over issues such as the purpose of the Centre and the model on which the intervention should be based and that "*staff were ill-prepared to deal with the trainees*" (Hagel et al, 2000, p.xi)¹⁹
- 2.40 By 2003, however, Ofsted reported improvements including a more coherent management structure and "*a much calmer atmosphere*" (2003, page 1).²⁰ In the Board's discussions with

¹⁸ See for example: <http://news.bbc.co.uk/1/hi/uk/254354.stm> and <http://www.independent.co.uk/news/inmates-go-on-rampage-at-child-jail-1167726.html>. Both accessed 22 March 2016.

¹⁹ Hagel, A., Hazel, N. & Shaw, C. (2000). *An Evaluation of Medway STC*. London: Home Office.

²⁰ OFSTED (2004). *Inspection of Medway Secure Training Centre Kent, October 2003*. London: Department of Health.

G4S, it became clear that much of this improvement was considered to be due to input from Paul Cook, who, as Director of the more successful Rainsbrook, was brought in to restore good order.

- 2.41 The Board feels that pressure to bring Medway under control at that time and the fact that G4S, and its predecessor Group 4, is ultimately a security firm, meant that a culture of control and containment developed. Instead of evolving into something more appropriate to caring for young and vulnerable children after the early disorder had been brought under control, the culture was maintained and became entrenched. The fact that the same individuals have been part of G4S leadership, often getting promotion within the organisation, has helped imbed this culture.
- 2.42 As well as this, the Board also felt that the purpose of STCs has changed over the years, but that this is not reflected in current policy and practice. When STCs were originally set up, they were set up to deal with a different demographic, mainly 12 to 14 year olds who were in custody for different reasons. A report from 2000 claimed that the age on arrival at Medway STC was 12 to 15 years of age.²¹This has now changed, and children are more likely to be 15-17 years.
- 2.43 STCs now usually accommodate older children, and some staff are not trained or prepared to deal with the often volatile behaviour associated with this age group. As is set out in the chapter on restraint, and as appealed for by the Clinical Psychologist at Medway, more needs to be done to focus on understanding behaviour and applying these principles to appropriate behaviour management techniques than on simply demonstrating control over an angry and acting-out teenager.
- 2.44 The Board feels that their historical focus on a younger age group has meant that leadership and focus in all of the STCs has become increasingly out of touch with the needs of the older age group, particularly the importance of education aimed at 16 and 17 year olds and vocational training.
- 2.45 The Board feels STC leadership has not shown sufficient understanding and acknowledgement of developments such as the framework for safeguarding children, “Working Together”²², which was set out under the Children Act 2004, approaches to school discipline in the Education and Inspections Act 2006, and approaches to special educational needs under the Children and Families Act 2014.
- 2.46 The Board noted that G4S is a firm that has been described as the world’s largest security organisation²³ and that it is therefore not surprising that it focuses on control and containment. Going forward, a more proactive model needs to be developed that centres on nurturing vulnerable children and the individual needs of the young people the service is designed to support and rehabilitate.

²¹ Hagel, A., Hazel, N. & Shaw, C. (2000). *An Evaluation of Medway STC*. London: Home Office.

²² Working Together to Safeguard Children <https://www.gov.uk/government/publications/working-together-to-safeguard-children-2>

²³ See <http://fortune.com/2014/11/12/worlds-largest-employers/>.

Staff Training and Development

- 2.47 As this chapter has set out, many of those people, both inside and outside of Medway STC, the Board spoke to raised concerns about the quality of staff training.
- 2.48 The Initial Training Course (ITC) programme lasts 7 weeks, and includes a compulsory element mandated by YJB, which includes, among other things, training in MMPPR, first aid, food hygiene, safeguarding, SASH, resettlement and acting inclusively.
- 2.49 Additional elements designed by G4S include training on Female Genital Mutilation (FGM), Child Sex Exploitation, 'Prevent' anti-extremism training and training on education issues such as special needs and disabilities (SEND).
- 2.50 In addition to ITC, 'Team training' takes place approximately once every 6 weeks, and lasts for one shift. Recent topics have included: diversity training; gang awareness training; corruption and manipulation.
- 2.51 Before recent events, G4S was due to begin its new contract with the Ministry of Justice on 1st April 2016. This contract extends the training period to 9 weeks, with 10 days spent on site. The other elements of the programme are largely unchanged.
- 2.52 Staff training is led by a well-established and committed member of staff who has worked at the STC for 10 years. He spoke with enthusiasm about his role and about the contribution staff training makes in developing a healthy organisational culture. He suggested that going forward there should be a greater focus in the ITC and ongoing training programmes on special educational needs and medical conditions that might influence the way a young person behaves.
- 2.53 The Board saw some positive evidence of staff development during the two months of the review. A DOM, who was also an MMPPR coordinator, described various training sessions and briefings that he had attended. A team leader who spoke to a member of the Board was shadowing one of the DOMs in order to learn key aspects of the role to which he aspired to be promoted.
- 2.54 However, as well as hearing from numerous stakeholders that G4S training and development is not fully fit for purpose, the Board also saw evidence during visits that staff development was not sufficient. For example, one recent recruit told a member of the Board that she felt ill equipped to deal with some of the behaviour of young people. In particular, many concerns were raised about training at DOM and team leader level.
- 2.55 The Board was also concerned about the high attrition rate of staff after the six months of probation. The Board heard that this is usually because the role is more challenging than expected and staff struggle to understand the young people they are caring for. A member of the psychology team at Medway said that she felt that inexperienced staff had difficulties establishing the correct boundaries and maintaining consistent behaviour towards the young people. This was supported by a new member of staff, who told the Board that she felt she had received insufficient support from her team leader when dealing with challenging behaviour. DOMs felt that this inability to support and mentor staff through their early experience is a key factor in explaining the high staff turnover.

- 2.56 The Board agrees with the Clinical Psychologist at Medway, who told a member of the Board that she felt that staff should have the space to be more curious about why young people behave the way they do. She said they should be trained in understanding this rather than just dealing with the behaviours they present.

The Conclusions of the Board on Culture and Leadership

- 2.57 The discussions with stakeholders and visits to the STC undertaken by the Board have led the Board to reach the following conclusions:
- The culture at Medway STC appears to be one of containment and contract compliance rather than support and rehabilitation. While historically this may have grown from the volatility of the centre, it has not served a functional purpose for many years. It is, nonetheless, embedded and maintained by current leadership;
 - There is a lack of clarity about who is accountable for young people's outcomes. There is evidence that the focus of G4S leaders and the YJB is distracted by questions about contractual compliance as opposed to the wellbeing of staff and young people;
 - There is insufficient oversight of the work of operational staff in the STC, in particular DOMs. In addition, provision for their ongoing training and development is inadequate, particularly in relation to behaving ethically;
 - Staff recruitment, along with initial and ongoing training, does not adequately prepare new staff for their role, in particular in understanding the range of special needs young people present with. This has led to an unacceptably high attrition rate for staff, which has in turn left the STCs exposed, having to manage the consequences of both staff shortages and inexperienced staff and leaders on site.
- 2.58 The Board believe that these issues lie at the heart of the unhealthy culture that has been identified by several stakeholders. In particular the Board believes that a better balance needs to be achieved between the need to maintain a secure environment, the need to offer a range of therapeutic services to highly vulnerable young people and the need to educate and rehabilitate them.
- 2.59 The Board believes that a fundamental restructure of the governance and leadership arrangements at the three STCs is needed.

The Future of Secure Training Centres

- 2.60 Almost every respondent we spoke to during the review was of the opinion that STCs are not fit for purpose and that the Improvement Board marked an opportunity to rethink their role and remit.
- 2.61 When STCs were originally established in 1998, it was envisaged that they would provide a secure and nurturing environment for young, vulnerable offenders for whom a YOI would be inappropriate. Trainees aged 12-14 were to be housed in units of between 5-8 beds to create a more 'homely' and nurturing atmosphere. However, as the number of young people

held in custody has fallen, the average age of trainees has risen and the crimes they have committed are more serious.

- 2.62 According to senior managers at G4S, the consequence of this has been that young people placed in STCs have become more violent, frequently belong to gangs and present with a greater range of behavioural, social and emotional issues. This increases their propensity to argue, resulting in both staff and trainees being subject to frequent, violent attacks. In addition, 'mixing' (described more in Chapter 3) needs are more complex.
- 2.63 It is clear that G4S managers believe that running the STCs is also made more difficult by the contractual, legal and physical constraints imposed upon them: Directors' hands are tied by over prescriptive monitoring by the YJB; the STC Rules are outdated, and the 'unit' arrangement exacerbates the problem of mixing.
- 2.64 The Board concluded from what it heard that G4S believes that the rules of STCs should be revised, for example by relaxing the requirement that a trainee cannot be placed in his or her room for longer than three hours in any one day, and giving more protection to staff and young people by being able to prosecute trainees who are violent towards others.
- 2.65 Most other respondents from whom the Board heard, including some members of staff at Medway STC, expressed a very different view. For them, the answer lies not in more security measures but in creating a more nurturing environment, in which the young person's voice is listened to and a significant investment is made to improve links with young people's home communities, to increase the quantity and quality of therapeutic interventions, and to personalise the education offer.
- 2.66 The Board's view is that there is much excellent work going on in Medway STC, facilitated by caring and committed individuals who do all they can to support and make a difference to outcomes for the young people. This appears to be happening, however, in spite of the dominant leadership culture, not because of it. It appears that the current ethos, culture, climate, system, as well as many of the policies, procedures and monitoring arrangements are based on mechanistic, contractually driven conceptions of safeguarding and education, rather than what might be in the best interests of the young people in their care. The Board believes that this is evidenced in the comments of senior G4S managers summarised above.
- 2.67 Furthermore, a young person who had been detained at Oakhill STC within the last two years described to the Board routine verbal bullying and intimidation of trainees by staff, with abusive and racist language a daily occurrence. The Board believes this to be unacceptable, both because it deprives young people of their dignity as human beings and because it believes such a climate creates the conditions that make the kind of poor staff behaviour it saw in the Panorama broadcast more likely.
- 2.68 The Board supports the fundamental rethink of the youth estate that is currently in train. In the context of this review, the Board also proposes a reshaping of the leadership, governance and culture of the three STCs. It is clear that the current model is failing our young people. The Board feels that G4S struggles to recruit staff of the right calibre and experience to meet the needs of young people and have clearly signalled their intention to withdraw from the running of at least one of the two STCs for which they are currently responsible.

- 2.69 Furthermore it appears the vision of what STCs are for and what the desired outcomes for young people who are placed in them have got lost. As one member of the Board put it, *“do G4S or the YJB know what ‘good’ looks like?”*
- 2.70 It is vital that the secure estate for young people achieves the right balance between security, safeguarding, therapeutic services and education. The Board’s view is that the current regime at Medway STC prioritises security over therapy and education.
- 2.71 Stakeholders the Board has spoken to have pointed to two other models of governance, leadership and management that might be considered as alternatives to the current arrangements for STCs: secure children’s homes (SCHs) and multi-academy trusts (MATs).
- 2.72 The ethos of SCHs is to create a nurturing, family atmosphere in which young people can be helped to overcome the educational, social and emotional issues that led to their offending behaviour. The leaders of the best SCHs are driven by moral purpose rather than contractual compliance. The ratio of staff to young people is higher than in STCs and so they are more expensive to run. However, this needs to be set against the cost of continuing to fail young people by placing them in unacceptable accommodation that exposes them to risk.
- 2.73 The confusing leadership arrangements at the STC are also a concern to the Board, with blurred accountability for outcomes and unclear lines of communication between frontline staff, middle managers, centre-based leaders and senior managers within G4S. The model that has been commended to the Board is that of a multi-academy trust (MAT) specialising in alternative provision. Well run academy trusts provide the following:
- Robust governance that holds leaders to account
 - Strong leaders who are driven by moral purpose
 - A well communicated strategic vision and plan
 - Clear quality assurance systems running through the whole organisation
 - Effective use of data to improve and refine practice
 - Skilled management of risk
 - Well-planned career development and succession planning for key leadership posts within the MAT.
- 2.74 The Board’s view is that all these features are currently missing or underdeveloped in the current leadership arrangements for the STCs. These elements to change the leadership of the STC need to be combined with changes to a more therapeutic model. The Board has seen how viable this is when it looked at models that focused on the social, emotional and mental health needs in well-run special schools for children and young people.
- 2.75 The Board suggests that the future vision for STCs be informed by the principles and practice that underpin the best secure children’s homes and well-run multi-academy trusts and consideration is given to items such as:
- An ethos that is focused on rehabilitation of young offenders through the provision of well targeted therapeutic services and personalised education, designed to support them in becoming self-regulating, functioning young adults with the skills and competences needed to live as successful citizens
 - Strong leadership and governance, informed by a compelling vision for young people’s outcomes

- Clear lines of accountability for outcomes, underpinned by robust and supportive performance management arrangements.

2.76 The Board does not underestimate the challenges implied in this vision. Working in any setting with people and particularly with vulnerable young people with such intricate needs is immensely complex. The Board believes, however, that the moral imperative is to meet this challenge.

Recommendations

1. The Board recommends that a new Vision is developed for STCs, or any arrangement that replaces STCs, that clearly articulates the purpose of these establishments, their focus on education and rehabilitation, and cultural values that promote a nurturing and safe environment. The operationalisation of this vision must be set out in a strategic plan.
2. The Board recommends that MoJ commissions an independent governing body, similar to the Board of Governors in a school, to provide oversight and scrutiny for safeguarding for all STCs. The GB should be appointed on a basis similar to the Improvement Board, with authorisation to visit all parts of the institutions and speak to staff and young people, and should consist of individuals with varied background and expertise. They should not be bound by the inspecting and monitoring frameworks of other inspecting bodies. They should act as a point of reference for other bodies involved with the STC, and their regular reports to the Secretary of State should include any recommendations for change or improvement that they feel should be made for any of the organisations involved with safeguarding children at the STCs. The GB should have a budget to commission research or analysis if they feel it is necessary to improve safeguarding.
3. The Board recommends that a new leadership and governance structure is developed for STCs with unambiguous lines of accountability and a strong leader who is held to account for delivering the vision and strategic plan.
4. The new governance structure should redefine lines of responsibility for all managers and include:
 - formal mechanisms to improve day to day communication between those involved in security, education and pastoral functions;
 - stronger appraisal and supervision arrangements so that the work of all staff members is rigorously supervised, particularly those in middle management positions (i.e. those currently in DOM, RSM and Team Leader positions) and that these staff members benefit from relevant ongoing training and continued professional development in childcare, behavioural management and supervision.
5. The person responsible for leading the new structure (the 'Director' in the current structure) must report regularly to the Governing Body, who can hold them to account for safeguarding of children at the STC.
6. The Board recommends that, as part of the wider review of youth justice, a cross-departmental working group is set up to address inconsistencies the Board has identified around the treatment and placement of children across YOIs/STCs and SCHs. As part of its terms of reference, this group should consider:
 - the place of the secure estate within the broader spectrum of provision for vulnerable children and how to ensure that vulnerable children sent to STCs, or their equivalent, receive protection and care comparable to those in other types of care;
 - Whether current legislative and policy provision is sufficient to make sure children who are sentenced to custody are adequately protected under the umbrella of the Special Education Needs and Disability (SEND) framework, or whether additional measures need to be put in place to facilitate regular multi-disciplinary reviews for these children and young people, with regard to their education, health and care needs.
7. In order to improve the balance of security, rehabilitation and education, focus must be moved from the number of hours spent in Education to identifying and delivering individual educational needs of each child.

3 The Safety of Young People in Custody at Medway STC

- 3.1 From the first meeting of the Medway Improvement Board, trepidation was expressed about whether the children who were being accommodated at the Medway STC at that time were safe. This question achieved further poignancy when the Board was asked its views on whether placements at Medway STC should recommence.
- 3.2 In the Board's interim advice to the Secretary of State on 2nd March it was stated that the Board had not seen evidence to satisfy itself that children at Medway STC were any more or less safe than they were before the Panorama programme was aired.
- 3.3 The Board acknowledges the surprise expressed by some stakeholders, including the YJB, that it was not satisfied that all of the extra measures put in place following the revelations of the Panorama programme were sufficient to make children 'safer' than they were before. This conclusion was, however, based on the Board's very early findings that the safety of children was potentially being compromised by culture and practices within the centre that were ongoing for many years. This includes the highly disconcerting finding, at their first visit to Medway STC on 5th February 2016, that the YJB monitor did not have unfettered access to CCTV and that there was evidence that G4S was manipulating what the monitor had access to. This problem had not been resolved in years and was not considered when YJB put in place early additional measures that they assured the Board were designed to improve monitoring. These particular concerns, which the Board feels have a direct impact on safeguarding because they demonstrate obstacles to adequate monitoring, are discussed in more detail in Chapter 5 of this report.
- 3.4 Since the Improvement Board began advising the Secretary of State on their findings, MoJ has been feeding back the Board's recommendations to YJB and G4S. The Board has kept an open dialogue with both organisations for the duration of the two months review and has met senior leaders from each on multiple occasions. Despite attempts being made by both organisations to improve assurance around safety, the Board's conclusion, at the time of writing this report, remains that the actions taken are insufficient to improve their confidence in safeguarding standards at Medway STC now and in the future. These measures do not go far enough to address concerns that will be described in this chapter as well as in other parts of the Board's report.
- 3.5 On 25th February, YJB recommenced placements at Medway STC, with each placement being assessed on an individual basis. The Board understands that reasons for recommencing placements include operational pressures and that the YJB must balance the risk of sending a child to Medway against potentially greater risks of placing them elsewhere. The Board also acknowledges that there remain concerns about safeguarding at the other STCs, including those raised in recent joint inspection reports on Rainsbrook STC²⁴.

²⁴ See reports.ofsted.gov.uk/sites/default/files/documents/secure-training-centre-reports/rainsbrook/Rainsbrook%20STC%20Ofsted%20report%20September%202015%20%28PDF%29.pdf.

3.6 This chapter describes the bodies and processes that are designed to support safeguarding at Medway STC. It outlines the evidence the Board has seen from visits and discussions with stakeholders and young people that has led to their conclusions and recommendations. In light of the concerns around safeguarding and stability at the other STCs expressed to the Board by stakeholders and expressed in recent HMIP/OFSTED inspection reports, the Board feels that these issues apply across all three STCs.

Safeguarding Policy and Practice at Medway STC

3.7 Policies relating to safeguarding at Medway STC are produced by G4S and are then approved by the YJB. As YJB have approved all policies and procedures currently being applied in the STCs, the Board has assumed that the YJB has concluded they are appropriate for safeguarding vulnerable children.

3.8 Key policies that relate to safeguarding in STCs include:

- **SB1 Suicide and Self Harm (SASH):** This focuses on protecting children and young people who are at risk of self harm or self-inflicted death and looks at the emotional wellbeing of the young person.
- **SF2 Safeguarding Children Policy:** This has been produced in line with 'Working Together' statutory guidance that sets out the legislative requirements and expectations on individual services to safeguard and promote the welfare of children. The policy is reviewed annually and approved by the Local Safeguarding Children's Board.
- **SF1 Anti-bullying Policy:** The aim of this policy is to promote an atmosphere in which young people feels safe, and to make sure staff protect and safeguard the welfare of young people by preventing and dealing appropriately with bullying behaviour.
- **SH1 Complaints and Representation Policy:** The aim of this policy is to make sure that young people to have access to a high quality, comprehensive and responsive complaints and representations procedure to enable them to speak out when they feel that they have been treated unfairly or inappropriately and if they want to challenge decisions made about them.

3.9 A number of stakeholders that the Board spoke to raised concerns about how these policies were being applied at the STC, particularly around the cultural change needed to provide a better balance between care and control (e.g. this was raised by the Children's Commissioner, Anne Longfield).

3.10 Nick Hardwick, who was Chief Inspector of Prisons at the time the Panorama allegations were made known, told the Board of his concerns about bullying of young people at Medway STC. His view was that a small number of boys were being bullied and that other children and staff were looking the other way. Rather than applying the Anti-bullying policy appropriately, Nick Hardwick felt that some staff systematically bullied young people. This

was what was reflected in the joint inspection report into Medway STC in January 2016, which raised concern about targeted bullying of children by a small number of staff.²⁵

- 3.11 This view was backed up by accounts fed back to the Board by young people themselves at Medway STC. Young people told the Board that, while they had good relationships with some members of staff, other staff were less pleasant. At a focus group held by one of the Board members, one young person said:
- “It’s like there are rules, but different staff treat different trainees different and it’s not fair. There’s one that targets me... this girl kept telling this staff member who doesn’t like me that I kept threatening her, but no one ever spoke to me... the staff member likes her and so she was ok... She [staff member] targets me because she doesn’t like me.”*
- 3.12 The Board is particularly concerned that staff who should be implementing safeguarding policies such as the anti-bullying policy might actually be part of the problem.
- 3.13 Key tools used to support safeguarding are **Behaviour Management Plans/ Individual Support Plans** and **Vulnerability Plans**. Both plans are reviewed and updated on a weekly basis.
- 3.14 The G4S Head of Resettlement at Medway STC explained that young people are put on what until recently were called ‘**Behaviour Management Plans**’ (now called Individual Support Plans) if they have been involved in a number of incidents, or there have been concerns about negative behaviours they have displayed.²⁶ A young person can be put on an Individual Support Plan on admission if there are significant concerns about their behaviour. The plan highlights concerns such as upcoming court appearances and any relevant background information. It highlights triggers, daily risks and protective factors. The young person signs up to an agreement to work towards specific targets.
- 3.15 The Board noted that Individual Support Plans could be viewed as a punishment rather than a tool to help support positive behaviour change; this was reinforced by the wording of the minutes of the weekly safeguarding meeting. Young people are warned that if their behaviour deteriorates they will be put back on plans and that if they come off plans they will gain access to privileges denied to them whilst on a plan. As an example, if a young person is subject to an Individual Support Plan they cannot go to the dining room to eat.
- 3.16 **Vulnerability Plans** on the other hand are opened if staff members have concerns about the young person’s vulnerability at any point from admission or throughout their stay at the STC. Plans are individualised and a key component of them is risk assessment of personal items that are in a trainee’s room based on the specific concerns raised.
- 3.17 The Board was struck by the evident confusion between policies which are supposed to protect vulnerable young people and those which are supposed to maintain good order and discipline. The Board felt that one of the most striking aspect of policies and practice

²⁵ Ofsted, HMIP and CQC (2016). *Advice note to the Secretary of State for Justice, January*. Accessed on 23rd March 2016 at: <https://www.justiceinspectorates.gov.uk/hmi/prisons/wp-content/uploads/sites/4/2016/01/Medway-Secure-Training-Centre-advice-note.pdf>

²⁶ These plans have been more recently been called ‘Individual Support Plans’, but the Board noted that staff tend to still refer to them by using the older terminology.

focussed on managing vulnerability and behaviour of young people is the importance placed on items allowed in possession within a young person's room. Within Individual Support Plans, for example, items are allowed or removed as part of a system of reward and sanction, while in Vulnerability Plans items are only allowed in possession following a 'risk assessment' as to whether they may be used to self-harm. A clear distinction needs to be made between protective measures and sanctions.

- 3.18 Young people that the Board talked to were troubled by SASH processes at the STC, including being watched if they wanted a shower or going to the toilet, which they found degrading. They particularly raised disquiet about having their rooms stripped of their possessions and having their bathroom doors locked after incidents of visual self-harm, such as scratches on their arms. One young person said *"they take it too far man, it's like they treat you like an animal and it's when you need real help."* He went on to describe an incident he witnessed involving another young person who had self-harmed: *"he was left in his room with like nothing and he couldn't speak English and he doesn't know where his family are so he was just all alone with no-one and nothing. It's not on, he didn't really do anything real bad to hurt himself. Like, I know he has to be kept safe, but he's like all alone. I don't think that is really safe. I think it did his head in proper."*
- 3.19 The Board noted the irony that a young person being held at an STC was able to articulate this concern, but that all of the professionals involved in supporting safeguarding at Medway STC did not seem to be able to understand the impact of such a policy on mental wellbeing of children. Overall, the focus on what items should or should not be in a young person's possession as a safeguarding measure has struck a cautionary chord with the Board. The Board is concerned that that:
- it establishes at the centre of policy the opportunity for conflict between young people and staff on a regular basis;
 - it centres policy around the exertion of control by adults on children;
 - it displays a lack of imagination and knowledge of evidence based practice in terms of changing the behaviour of children or supporting those who are vulnerable.
- 3.20 The Board noted that the use of the term 'risk assessment' appears very frequently in all documentation. It would appear that many decisions around denying young people access to items or to time outside, and even to education, are made on the basis of a 'risk assessment'. It was noted, for example, that no young person subject to an Individual Support Plan is allowed to go to the dining room to eat, based on a risk assessment. The Board is concerned that this practice appears more about control and containment than safeguarding vulnerable children or demonstrating an understanding of what support the young person needs to modify their behaviours. Blanket bans on young people doing certain activities when subject to an Individual Support Plan do not suggest a sufficiently individualised process is in place to deal with particularly difficult children.
- 3.21 An even greater concern is with the suicide and self-harm strategy. Whilst incidents of self-harm are relatively low within the STC, the practice for dealing with it seems to be more focussed on preventing the potential for young people to have access to the means to commit self-harm, than on alleviating the causes of vulnerability and distress.

- 3.22 The Board found it alarming that the most vulnerable children at Medway STC are placed on a constant watch in bare, minimal accommodation and dressed in anti-suicide clothing. Policy within the wider adult prison estate and within the YOIs has moved away from this practice for many years over concerns that is dehumanising and contrary to improving the individual's mental wellbeing. The policy on this is set out in Prison Service Instructions, *PSI 64/2011 'Safer Custody'*, which states that removal of items "*should be kept to a minimum and never be automatic*" and that "*alternative clothing should only be used as a measure of last resort and for the shortest time possible.*" It is suggested in the PSI that constant supervision be considered before alternative clothing is, but in the STC there appears to be simultaneous constant supervision, alternative clothing and removal of items ²⁷.
- 3.23 If these actions are felt to be inappropriate for vulnerable adults, it was surprising, therefore, to find that the practice was still being applied to vulnerable children. There is no distinction made between periods of acute crisis, when such actions might be necessary, with other times when the Board felt the actions might be dealt with more effectively with proper care and support than with loss of possessions and anti-ligature clothing.
- 3.24 After further investigating, the Board felt that that practice of removing possessions from a young person was to all intents and purposes embedded within the contract of the STC. The Board understands that the YJB are keen to ensure that the contractor is not penalised for a child self-harming in order to avoid driving them to be too risk adverse around their management of self-harm. Having said that, the Board is concerned that the practice of penalising the contractor if the plan that they have put in place is not followed might lead to even more risk adverse behaviours. One example that struck the Board was that in order to avoid penalties under the terms of the contract, management of the STC try to make sure that a young person has nothing in their possession with which to self-harm. Whatever the intentions of this policy, the impact of this on the ground appears to be that staff focus more on making sure young people do not have particular possessions with them than whether they are feeling supported or vulnerable.
- 3.25 The Board feels that the terms of the contract, or the terms of any future contractual or service level agreement with a provider of services at an STC, should focus on ensuring an appropriate support plan is in place for a vulnerable young person and that clauses within the contract do not unintentionally make the young person more vulnerable because they take the focus away from well-being and towards compliance. The Board feels this would promote positive engagement with a young person rather than punitive activity that could potentially make them feel more isolated and distressed.
- 3.26 Another issue that the Board noticed is that 'mixing' is a significant issue for the STC. If there is a concern that certain individuals should not come in to contact with each other because there may potentially be a fight, they are put on the 'mixing list'. It would appear that all activities are governed by the 'mixing list'.
- 3.27 The mixing list appears to be owned by the DOMs, who manage it on a daily basis. All managers within the STC, however, can add young people to the list, if they receive information or following an incident. As has been commented on elsewhere in this report,

²⁷ PSI 64/2011 Safer Custody can be accessed at: <https://www.justice.gov.uk/offenders/psis/prison-service-instructions-2011>

the Board found lines of responsibility and accountability at Medway to be blurred and the Board is not fully clear how this list is being governed, or how it is assessed in terms of how appropriately it is being managed and maintained.

- 3.28 In order to control which young people mix together, living units do everything together. This means that one person in a unit not being allowed to 'mix' with someone from another unit has an impact on everything the entire unit does, including having access to privileges like time on the 'Green' (the open grassy area at the centre of the buildings). Movement around the STC is very carefully controlled; even in education young people are taught as a unit and not by ability, stage of education, or educational and vocational needs. This is discussed further in Chapter 2.
- 3.29 One particular example that was brought to the attention of the Board was when staff believed a boy and a girl 'liked' each other and staff decided that their respective units would therefore not be allowed to mix. This resulted in each unit losing access to privileges such as going on 'the Green' in the evenings. The Board noted that, given the level of security and staff supervision, it was not possible that the boy and girl in question would ever be alone anyhow. This decision appeared over-controlling and degrading and denied the young people involved appropriate association time.
- 3.30 Members of the Board attended some of the weekly safeguarding meetings to get a better understanding of how decisions about all of these issues were reached. In addition, one Board member also read through the weekly safeguarding meeting minutes.
- 3.31 The Board concluded that whilst there is clear evidence, both from what was witnessed at meetings attended and from the meeting minutes, of careful consideration of individual young people, the staff members attending this meeting is limited. The Board is not confident that concerns discussed and actions agreed are effectively communicated to residential staff or DOMs. The Board feels this is another consequence of the blurred lines of responsibility and accountability at Medway STC.
- 3.32 The Board also felt that there is greater emphasis at weekly safeguarding meetings on process rather than outcomes for young people. More emphasis was put, for example, on whether Individual Support Plans or Vulnerability Plans should be opened or closed than on whether the underlying causes of concern were being dealt with.
- 3.33 Decisions around dealing with difficult behaviour at safeguarding meetings appear to be around punishment and imposing penalties such as removal of items of possession, restrictions on mixing, attending education and moving trainees to different units. This is despite the fact that more sophisticated techniques for achieving behaviour change in children have been used for many years in other sectors, particularly education (e.g. successful intervention with the use of behaviour analytical techniques in dealing with ADHD and behaviour problems in children aged 11 to 15²⁸; application of a range of cognitive,

²⁸ Murrell, A.R., Steinberg, D.S., Connally, M.L., Hulsey, T. & Hogan, E. (2015). Acting Out to ACTing On: A preliminary investigation in youth with ADHD and Co-morbid Disorders. *Journal of Child and Family Studies*, 24, 2174-2181.

behavioural and cognitive-behavioural techniques to change behaviour in children and young people at risk of future educational disengagement²⁹).

- 3.34 Information on those young people who are spending more than 10 hours in their rooms is brought to the weekly safeguarding meeting but the Board saw less evidence that there were adequate discussions on the reasons why trainees were spending so much time in their rooms. These discussions appear to be related to 'elective separation', whereby a young person asks to go to their room at lunch time or in the evenings. When they make this request they are locked in their rooms. Rooms appear to be locked at all times the young people are not in their rooms and when the young people are in their rooms, they must be locked in. The Board feels that, given levels of supervision on living units, this is another example of when it would seem more sensible and less controlling to leave rooms unlocked so young people could move in to and out of their rooms when they wanted to. The Board understands that technology is available to allow young people to lock their own rooms to prevent other trainees from entering without preventing staff access.
- 3.35 The overall conclusion of the Board from the two months that were spent assessing safeguarding arrangements at Medway STC is that the emphasis is on control and containment when it should be on engaging positively and supporting young people to modify their behaviour. There are elements within the policy and practice that may even cultivate conflict unnecessarily between staff and young people.
- 3.36 The staff that the children have most contact with, many of whom appear deeply dedicated to the care of these young people, are not all fully engaged in the discussions and plans to support them through difficulties. Experienced staff who have the best interests of young people at heart might be able to negotiate and manage the controlling elements of these policies effectively. There are those however who may feel, for whatever reason, that complying with the policy is more important, or those staff who are less experienced may find this more difficult and find themselves in conflict with young people.

Inspection and Scrutiny at Medway STC

- 3.37 As well as the YJB, whose role is described in a separate chapter, there are a number of other individuals and organisations that have a role to play in monitoring how safe children are at Medway STC. This section describes some of this input.
- 3.38 Inspections of each STC are commissioned by YJB, usually on an annual basis. Led by Ofsted, these inspections are conducted jointly by Ofsted, HMIP and CQC.
- **Ofsted:** The Office for Standards in Education, Children's Services and Skills (Ofsted) inspect and regulate services that care for children and young people and services providing education and skills.
 - **HMIP:** HM Inspectorate of Prisons has a statutory duty to report on the treatment of prisoners and detainees and the conditions in which they are being kept.

²⁹ Accessed on 23rd March 2016 from: British Psychological Society *Behaviour Change: School attendance, exclusion and persistent absence*. <http://www.bps.org.uk/system/files/Public%20files/education.pdf>.

- **CQC:** The Care Quality Commission is the independent regulator of health and social care in England.
- 3.39 Inspection reports play an important regulatory role as they provide the YJB with information on performance on a range of measures such as the safety of young people, the care of young people, the health of young people, the effectiveness of leaders and managers etc.
- 3.40 The joint inspection report on Medway STC in September 2014³⁰ was ‘Good with some outstanding features’. No specific concerns were raised about the safety of those being held there, but two recommendations in relation to safeguarding practice and identified as issues that needed to be dealt with immediately. These were:
- ensure that child protection records are detailed and thorough to evidence actions taken, decisions made and the outcome of all incidents;
 - revise with the local authority the procedures to be followed to ensure that responses to children in need and children in need of protection are fulfilled in a timely manner.
- 3.41 An inspection was not carried out again until the BBC revealed it was going to broadcast its footage in January 2016. Quite significantly, this report confirmed that children raised concerns with the inspectors that were consistent with the evidence presented by the BBC.
- 3.42 Despite the extra measures put in place at the STC to ensure safety of children, the January 2016 report concluded that the inspectors had significant concerns about the centre, particularly as the BBC footage showed that a number of staff must have been aware of unacceptable behaviour and the practice of falsifying records. The advice states that “*managerial oversight failed to protect young people from harm*” (paragraph 9).³¹
- 3.43 The Board met with both the former Chief Inspector of Prisons, Nick Hardwick, and the current Chief Inspector, Peter Clarke. Both individuals expressed concern about the culture at Medway and at inadequate managerial oversight of how middle management (particularly DOMs) keep order or deal with complaints.
- 3.44 The Board noted a disparity between inspections conducted before and after October 2012, when the inspection framework was strengthened. At that point, concerns started to be raised about practices that had clearly been going on for years but had not been noted by inspectors. This includes, for example, the practice of not allowing young people personal items on their first night in the STC. Despite being a long-standing practice at Medway STC, it was only raised, and consequently changed, following the inspection of November 2012³². The Board was concerned that it took a new inspection framework to identify this problem, even though the YJB routinely approve STC policies.

³⁰ Ofsted, HMIP and CQC (2014). *Medway STC Ofsted Report September 2014*: <http://reports.ofsted.gov.uk/secure-training-centres/medway>

³¹ Ofsted, HMIP and CQC (2016). *Advice note to the Secretary of State for Justice, January*. Accessed on 23rd March 2016 at: <https://www.justiceinspectorates.gov.uk/hmiprison/wp-content/uploads/sites/4/2016/01/Medway-Secure-Training-Centre-advice-note.pdf>

³² Ofsted, HMIP and CQC (2013). *Medway STC Ofsted Report November 2012*: <http://reports.ofsted.gov.uk/secure-training-centres/medway>

- 3.45 The Board noted that the Ofsted system means that an 'Overall Effectiveness - Good' rating could be given even when important measures such as safety are not as robust. In prison inspections, individual scores are given on key areas without an overall score. The Board was concerned that the overall score might risk increasing the focus on this rather than the less adequate scores that could have an impact on safety.
- 3.46 The **Medway Safeguarding Children Board (MSCB)**, chaired by John Drew helps ensure that children are safeguarded by bringing together agencies working with children, and includes representatives from Medway Council, Medway Health bodies, Kent Police, schools and voluntary organisations.
- 3.47 The Chair of the Board met with John Drew, the Independent Chair of MSCB, together with the MSCB's Business Manager, on 26th February who confirmed that the MSCB had not had specific concerns about safeguarding at Medway prior to the Panorama broadcast. The MSCB's judgment relied heavily on a detailed reading of the report of the joint inspection by Ofsted, HMIP and CQC in December 2014 that concluded that Medway STC was 'good with outstanding features'. The MSCB had not been alerted to any contrary indications to this judgment from any of the other authorities charged with responsibility for overseeing the safety of children at the STC, and was specifically in regular discussion with the Local Authority Designated Officer (LADO). John Drew told the Board that the MSCB was considering whether to commission a serious case review in light of the broadcast.
- 3.48 Another key role in safeguarding at the STC is the role of the **Local Authority Designated Officer (LADO)** team from **Medway Council**. The LADO team should be the first point of contact if an allegation is made or a concern raised about a person working or volunteering with children. The Board met with the current Senior LADO for Medway, who confirmed that, in many cases, members of the LADO team visit children at Medway STC when an allegation, has been made, as they do in other settings. Members of the LADO team, together with colleagues from Kent police, visited and spoke to the 10 young people featured in the programme prior to the Panorama broadcast. At that time, only one young person put of these 10 had previously reported any complaint about the matters referred to in the BBC material.
- 3.49 A member of the Improvement Board looked at all safeguarding referrals made to Medway Council between February and October 2015. During this period, 14 referrals were made. The analysis of these referrals was discussed by the Board. In summary:
- Not one referral was substantiated by the LA. In all cases this was because there was no CCTV evidence to support the allegation being made. The Board is concerned about this as in the community lack of CCTV evidence would not necessarily mean that allegations made by children cannot be substantiated. The Board felt that at least some cases warranted further investigation.
 - The Board noted that on average, the length of time taken from an allegation being referred out to a concluding letter being sent to a young person by the LADO is 3 months. The Board does not feel this is robust enough, particularly as some young people will be accommodated at Medway for a shorter period of time. This is the same issue the inspectors identified in the 2014 inspection and required to be dealt with

immediately. The Board is troubled that over the course of 2015 the situation did not improve.

- The Board noted with unease that young people are sent letters from the local authority telling them that their allegations have not been substantiated based on a lack of CCTV evidence (e.g. *“on seeing the CCTV we could not see much due to where the cameras were situated and therefore could not evidence what you said happened”*; *“we have therefore concluded that the allegation of you being hurt by a member of staff is unsubstantiated, which means that we do not have any proof to evidence that the staff member had hurt you and we cannot tell either way what really happened”*). As a consequence, it must be obvious to both staff and young people that CCTV evidence is crucial to action being taken, and may have an impact on when and where staff feel they can behave in this way towards children (as was also evident in the Panorama programme).
- There appears some evidence that staff are sometimes suspended during an investigation, but usually staff are just told not to have contact with a particular young person. The Board feels that if young people see staff visible and unaffected by the allegation, others are less likely to come forward. This, along with the length of time taken to conclude an investigation, means that young people are unlikely to have confidence in the system.
- The Board was disappointed with the lack of evidence of the robustness of internal investigation by Medway STC when allegations were referred back to them by the LA. They were concerned that some incidents appear to have been dealt with in a superficial way. Where there was evidence of formal interviews with members of staff these interviews raised concern about the attitudes of the staff members which did not then seem to be addressed either in the interview or in subsequent decisions on the disciplinary outcome.
- The Board was also concerned that two allegations were brought against the same senior member of staff, who was placed on non-contact with two young people, with some evidence that the staff member breached this but no evidence as to what happened as a result.
- The Board was disturbed about the lack of internal investigation to an incident in February 2015 that appeared to involve 7 members of staff, and yet there is no paperwork to describe the situation. Given that the standard of evidence of the investigatory process was raised in the 2014 inspection and improvement was required immediately, this indicates that these problems are enduring. The review of referrals from February to October 2015 would suggest improvements were not made.

3.50 The Board also noted that Inspection reports of Oakhill, Medway and Rainsbrook from 2012 to 2014 all raise concerns over the strength of scrutiny by local authorities and the evidence of the effectiveness of processes around sending referrals out to the LADO. Scrutiny by LAs appears insufficient across all 3 STCs.

3.51 The **Children’s Commissioner**, Anne Longfield OBE also has a role to play at Medway STC. The Children’s Commissioner for England has a statutory duty to promote and protect the

rights of all children and young people until they are 18 years of age, or 25 if they have been in care, are care leavers or have a disability.

- 3.52 Anne Longfield met with the Board on 9th of March. She said that her predecessor had visited Medway STC 18 months before the Panorama programme was aired to listen to young people there talk about their welfare. Her staff had also visited after the programme was aired. The initial visit was made as part of a programme of visits to institutions where children live away from home and the follow up, because of the issues raised in the programme.
- 3.53 In broad terms, Anne considered her role to encompass promoting the views and experiences of children in the system helping to act as their “eyes and ears”. On the basis of the conversations with children and young people she felt that there needed to be a realignment of the balance between care and control at Medway STC. Anne Longfield said that in the visits made since the programme had been aired her staff had talked to 17 young people at Medway and asked them specifically about their safety and welfare. These conversations had not raised particular concerns. The YJB had also informed her that the STC was in their view now a safe place for young people.
- 3.54 **Barnardo’s** Children’s Charity runs an **advocacy scheme** that allows young people to get involved directly with decisions and discussions and provides peer mentors and befrienders. This scheme is commissioned by the YJB.
- 3.55 The Board met with an advocate from the Barnardo’s advocacy scheme on 24th February. The Board was told that there are three advocates at Medway STC, who visit the STC three times a week as well as doing some extra visits especially if a young person had been involved in an incident or had been subjected to use of force. The advocate assured the Board that advocate presence has increased since the Panorama programme.
- 3.56 Complaints made to a Barnardo’s advocate are escalated to the lead for safeguarding and if necessary referred to the local authority. Barnardo’s are not usually involved with mediation, even though technically young people can ask for them to be present.
- 3.57 When the Board conducted some focus groups with young people, the young people did not speak positively about the Barnardo’s advocates. They did not see them often and did not feel them to be advocates. One young person commented, *“The Barnardo woman doesn’t do nothing. We don’t see her enough so they don’t know if there is a problem... I don’t know what they do on their random days.”* Another said *“they come in now and again I think, don’t know when they are supposed to come in and what they do... they like come in and sit and say ‘are you ok?’ as if we are going to talk to them like in front of everyone. We don’t know them anyway.”*
- 3.58 Overall, the Board was not impressed with the input they felt Barnardo’s advocates were having at Medway STC. This was backed up by Nick Hardwick, who said he felt they were not effective.
- 3.59 Youth Offending Teams (YOTs) also have a role to play at Medway STC. While YOTs have a key role on prevention they also support the young person and their family through all stages of the justice system. When a young person is in custody their role is to stay in touch and engage the young person with rehabilitation back in the community.

- 3.60 A member of the Board spoke to the YOT manager at MedwaySTC, who had been involved in some capacity with Medway STC since it opened. While he felt that either an STC or an SCH was preferable to a YOI as a setting for a vulnerable young person, he felt that staff at the STC were not currently equipped to deal with the vulnerable young people there. He felt that a more therapeutic approach should be adopted.
- 3.61 The Board has been particularly struck by the fact that, despite involvement of all of these organisations at Medway STC, nobody picked up on the sort of incidents that were portrayed in the Panorama Programme. The Board feels that this is at least in part due to poor coordination and communication between the organisations involved. There was a disparity between what each stakeholder told the Board, for example, and what the YJB told the Board, which suggests inadequate communication between the organisations. The Board note here two specific examples that have had an impact on their confidence in the ability of various organisations currently visiting Medway STC to give a cohesive picture on the safety of children there:
- When the CEO of the YJB met the Board it was made clear that one of the reasons YJB were confident that Medway was safe again was because a range of people, including the Children's Commissioner (despite the fact that this was not her role) had not raised any additional concerns, something that was also set out in the YJB's letter to YOTs when it was decided to recommence placements to MedwaySTC on a one by one basis. The Children's Commissioner also told the Board that young people had not raised specific concerns about safety when her staff visited once action had been taken following the Panorama programme; in addition, before she visited Medway, the YJB had informed her that the STC was in their view now a safe place for young people. The Board feels that there is potential for misunderstanding between the various agencies involved in Medway STC about who has overall responsibility for providing reassurances about safeguarding.
 - The Board found the February 2015 joint inspection report of Rainsbrook STC quite shocking. Indeed, Board members felt that if anything should have given the YJB an indication that there were serious problems in the STCs, it should have been this report. Despite this, the Board noticed that instead of acknowledging the implications of this report, the YJB publicly endorsed the more favourable view of the Chair of the Independent Advisory Board on Care of Children and Young People (a Board set up by G4S and the chair's findings were based on a report paid for by G4S).
- 3.62 The Board was concerned that there appeared a misapprehension that because so many different people from different organisations are visiting Medway STC, it is somehow 'safer'. The Board feels that visits alone are not going to change how 'safe' children are; unless those visits include proactive examination of policy, culture and relationships that change policy and practice, then they will not have any substantial impact.
- 3.63 The Board also feels that the YJB relies too heavily on the opinions and findings of other organisations, and needs to be more confident in its own assessment of safeguarding at the STC. These organisations have different purposes, but do not hold, from what the Board can tell, overall responsibility for thoroughly investigating the effectiveness of safeguarding procedures.

Whistle-blowing

- 3.64 The Panorama programme was based on information from a whistle-blower who voiced concerns about the behaviour of staff at MedwaySTC. ‘Whistle-blowing’, which happens when individuals share inside knowledge and evidence, is an important element of ensuring effective safeguarding.
- 3.65 The Improvement Board has been concerned from the beginning of their work about the lack of weight that is being put on information brought to attention by whistle-blowers and with the lack of protection given to whistle-blowers.
- 3.66 When they spoke to them, the Board was struck with the way all senior staff in G4S and the YJB voiced how surprised they were by the events depicted in the Panorama programme, yet the whistle-blowing material that the Board has seen suggests that very similar allegations have been made not once, but many times in the past.
- 3.67 In theory, G4S policy is that someone who wants to report a serious wrongdoing can anonymously contact the G4S independent ‘Speak out’ hotline, and that concerns raised are reviewed and investigated as appropriate. Concerns can be referred to the Compliance and Ethics team who should investigate as necessary. G4S also states that occasionally concerns are referred to specialist independent investigators and that their Speak out arrangements are publicly reported in their CSR report.³³
- 3.68 During the short time the Board investigated this issue, it became clear that, in practice, the G4S whistle-blowing system was not as straightforward as it had been presented. The Board heard evidence from former members of staff that attempts to use the service were thwarted, particularly if they tried to do so anonymously. One example was when someone told the Board that they tried to phone the ‘anonymous’ hotline and were asked for their contact details. The Board heard evidence, also raised in whistle-blowing letters they saw, that G4S tried to stop former members of staff from speaking out.
- 3.69 The Board was also told that those who tried to speak out were moved to different parts of the organisation, or that they lost their jobs. Claims were also made that ‘gagging restrictions’ were placed on former employees which made them too scared to speak out about what they had seen, even years later.
- 3.70 When Nick Hardwick met the Board on 16th February, he explained that he had spoken at length with the reporter who made the Panorama programme during his interview. Nick Hardwick believed the falsification of records was a common occurrence. The film showed evidence of experienced staff attempting to groom new staff (the reporter) by involving them in the falsification of records and Nick Hardwick believed that the zero tolerance approach adopted by G4S to any staff misdemeanour may be a barrier to disclosure. Peter Clarke, current Chief Inspector of Prisons also told the Board that he felt that G4S managers are resistant to any internal challenge.
- 3.71 The Board found these claims that the policy, which should better protect children by enabling staff to raise concerns about what they are seeing, is being intentionally or

³³ <https://www.justiceinspectorates.gov.uk/hmiprison/wp-content/uploads/sites/4/2016/01/Medway-Secure-Training-Centre-advice-note.pdf>

unintentionally, sabotaged very disturbing. It is, however, beyond the remit of the Board to investigate or substantiate the claims made by former members of G4S staff. The Board feels that at the very least there is evidence of a lack of trust in staff in the whistle-blowing process that is detrimental to the best interests of the children in STCs.

- 3.72 When Lin Hinnigan, CEO of the YJB, made reference to whistle-blowing letters, the Board requested to see the letters. These documents, when finally provided to the Board, consisted of thirty five separate digital documents dating back seven years. They came with very little evidence that a serious attempt had been made to organise the accumulated evidence or analyse the data.
- 3.73 One of the Board members spent two days organising and analysing the contents of the letters and found that a number of themes emerged.
- 3.74 The letters were sent from different parts of the country and referred to different G4S managed STCs. They were sent by parents, professionals, and both experienced and newly appointed staff, who expressed shock at some of the things they had seen.
- 3.75 Despite the fact that the letters referred to different sites and came from a range of sources, there were a number of consistencies in the messages they contained. Common themes included:
- Allegations related to senior management rather than junior staff;
 - Descriptions of a culture of corruption in which falsification of records was encouraged by management in order to avoid contractual penalties;
 - Bullying of trainees and staff by senior managers, including allegations that staff who were subject to serious allegations were promoted while staff who raised concerns were forced to leave;
 - Lack of boundaries between staff and trainees, with staff using trainees to intimidate other trainees and staff;
 - Further allegations of staff behaving inappropriately to trainees.
- 3.76 While the letters received directly from the YJB went back about 7 years, the Board was given additional whistle-blowing letters, dating back as far as 2002/3 from another confidential source. Many of these were also sent to the YJB, but were not included in those given to the Board by the YJB. The Board later requested a particular letter from the YJB dated 2003, which they received in due course.
- 3.77 The content of the older material given to the Board by the confidential source was very consistent with the later whistle-blowing letters.
- 3.78 The Board was very concerned that it appeared that YJB was aware for many years of a succession of concerns about G4S that were very similar in nature to those aired on the Panorama programme.
- 3.79 When the Board submitted interim findings to the Secretary of State in early March 2016, it recommended that YJB immediately undertook a full review of all whistle-blowing material received in relation to all STCs, and provide an analysis of their content.

- 3.80 In response to the interim report, YJB committed to undertake a thorough review of their responses to past whistle-blowing cases by 18 March and share the results of that review on Monday 21 March which they did.
- 3.81 The Board remains concerned that complaints procedures and whistle-blowing is not given enough priority by the YJB. There needs to be a more robust, consistent approach to dealing with concerns that are raised by those who have access to STCs, particularly staff.

The Voice of the Young People

- 3.82 It is interesting to note that following the publication of the Pindown Inquiry in 1991, similar suggestions were made about complaints procedures. Lindsey (1991), for example, noted that complaints procedures at the time were not effective, and that this was often due to organisational attitudes to complaints. The article argued that too much emphasis was placed on the assumption that government and Department of Health complaints procedures at the time were sufficient to safeguard children, but that in fact complaints procedures were not set up to deal with the most serious complaints of children themselves.³⁴
- 3.83 This chimes with the Board's view that the voice of the children is not being effectively heard by any of the organisations involved.
- 3.84 In a press release following the joint inspection carried out in January 2016, Nick Hardwick said that effective oversight is particularly important in institutions that deal with children because "*they are significantly less likely to submit a complaint about their treatment than their adult counterparts.*"³⁵
- 3.85 Despite this, it is clear from what has been described so far that the voice of the young people is not being properly heard. The Board feels that systems put in place by Medway LA and the YJB commissioned Barnardo's advocacy service do not give due regard for complaints made by children. When Nick Hardwick met the Board, he commented that Barnardo's advocates were not effective, and this is certainly the same conclusion the Board came to after several visits to Medway STC.
- 3.86 The Board is also concerned about the role the DOMs might play in preventing the voice of the young person from being heard. When Peter Clarke met the Board, he said that he felt that leadership at the STC had developed an over-reliance on DOMs to keep good order. In particular he was concerned that if a young person wishes to complain, the complaint has to be routed through the DOM, which may be a disincentive for many young people.

³⁴ Lindsey, M.J (1991). Complaints procedures and their limitations in the light of the "Pindown" inquiry. *Journal of Social Welfare and Family Law*, 13 (6), 432-441.

³⁵ Ofsted, HMIP and CQC (2016). *Advice note to the Secretary of State for Justice, January*. Accessed on 23rd March 2016 at: <https://www.justiceinspectors.gov.uk/hmiprisons/wp-content/uploads/sites/4/2016/01/Medway-Secure-Training-Centre-advice-note.pdf>

3.87 As far back as the Uttering Report of 1997, a recommendation was made for “*more effective avenues of complaint and increase access to independent advocates.*”³⁶ It would appear that this recommendation has not yet been implemented. The Board finds this unacceptable.

Recommendations:

8. The Board recommends that the terms of STC contracts that refer to Suicide and self-harm (SASH) policies are reviewed to make sure that they support the overall safety of young people rather than focus on imposing penalties on the contractor (e.g. a penalty for allowing the young person to have something that could cause self-harm but not for actual self-harm) that distract from the safety and wellbeing of the child.
9. Formal mechanisms need to be set up to enable the young person’s voice to be heard, both within the STC (e.g. a council) and by outside agencies (e.g. via the governing body). A charter needs to set out how these mechanisms operate and what protections are to be put in place to ensure that children are supported to speak out when needed.
10. Policy for whistle-blowing and acting on information received from whistle-blowers needs to be redeveloped in both YJB and within the STC and it must ensure that whistle-blowers feel supported and listened to.
11. All whistle-blowing communication must be made available to the Governing Board on a monthly basis.
12. The role of the Barnardo’s advocate needs to be re-examined as the Board feels it is currently not fit for purpose.

³⁶ Uttering, W. (1997). *People like Us: The Report of the Review of the Safeguards of Children Living Away from Home*. London: The Stationary Office.

4. Behaviour Management and Use of Restraint

- 4.1 One of the elements of the footage shown on the Panorama programme that has resonated most strongly with people to whom the Board has talked has been what looks like disproportionate and punitive use of force. The images shown of big, burly men holding down young, vulnerable and relatively small boys upset many people involved in child protection and safeguarding. Indeed, senior staff at G4S have assured the Board that they have been similarly affected by the events depicted.
- 4.2 The incidents, however, are tragically not new to establishments involved in the care of children, and there are notable similarities between them and previous scandals involving excessive use of restraint.
- 4.3 As far back as 1991, the Pindown Inquiry chaired by Allan Levy revealed an abusive culture in Staffordshire Children's homes, following a Granada World in Action exposé. In 1993, a BBC Panorama programme exposed abusive practices at the Aycliffe Secure Centre in Durham, where several young people were injured during restraints. Another BBC exposé in 1999, 'Macintyre Undercover' exposed abusive practice including unsafe and ineffective methods of physical restraint being used in residential care homes Kent. In 2004, Gareth Myatt died at Rainsbrook STC after he was restrained on a bed in a seated position, with his head forced forward. This incident also involved G4S staff.
- 4.4 This chapter looks at the issue of physical restraint at Medway STC and will outline why the Board has concerns about the interaction between current policies on restraint and behaviour management and safeguarding and rehabilitation at the institution.

The Development of Policy and Practice in Restraint and Behaviour Management in Children

- 4.5 The development of current policies on restraint and behaviour management probably date back to reactions to the scandals exposed in the 1990's and following the death of Gareth Myatt.
- 4.6 The 'Pindown' Inquiry was so called because it investigated the 'pindown' method of punishment that was used in Staffordshire children's homes in the 1980's. This involved locking children as young as 9 years of age into 'pindown rooms' in a manner similar to a lockdown or solitary confinement in a prison and the removal of their personal possessions. They were sometimes kept like this for weeks or even months. The final report of the Pindown Inquiry described it as a "*narrow, punitive and harshly restrictive experience*", with children suffering despair, humiliation, boredom and frustration (page 167).³⁷
- 4.7 By the time the Pindown Inquiry was underway in 1990, the practice, which was used in the homes between 1983 and 1989, had already ceased after a solicitor had two children made wards of court. The report led to changes in practices, particularly in Staffordshire, and also to a growing recognition of the importance of trained staff and regimes that were designed

³⁷ Levy, A. & Kahan, B. (1991). *The Pindown Experience and the Protection of Children: The Report of the Staffordshire Child Care Inquiry*. Stafford: Staffordshire County Council. See <https://www.staffordshire.gov.uk/yourcouncil/dataprotectionandfreedomofinformation/publicationsscheme/The-Pindown-Experience-and-the-Protection-of-Children.pdf>

by those who understood behaviour management, rather than social workers with limited knowledge. One of the striking things about those involved in implementing the pindown method was that they made detailed notes of their method and that they “*were clearly proud of what they were doing.*”³⁸

- 4.8 Emphasis on training for staff working with children began to get stronger. Following the Aycliffe scandal in 1993, the Prison College and Durham Social Services were commissioned to create a new training model aimed at children’s services. The package developed, called PRICE, was adapted for use in a number of secure children’s homes. The system used for many years in STCs (PCC) is based on the principles of PRICE.
- 4.9 In 1997 a report by Sir William Uttering, ‘*People like us: The report of the Review of the Safeguards for Children Living Away from Home*’ was published. This called for improved protection for children in state care, including the penal system. Among other things, the report recommended more vigilant management and the enhancement of separate regimes for children that reflected “*the principles and guidance contained in the Children Act 1989 and its regulations.*” It also called for a common framework of care across all settings and provided the impetus for the establishment of Secure Training Centres.³⁹
- 4.10 The government response to the Uttering Report, published in November 1998, promised a wide range of improvements across all children’s services, including training programmes and more emphasis on the voice of the child. It promised the setting up of a new Criminal Records Agency (the Criminal Records Bureau was provided for in the Police Act 1997) in an effort to try and stop dangerous people working with children. It also announced the establishment of a Youth Justice Board “*with responsibilities to advise on and monitor standards for the care of sentenced and remanded children in all forms of juvenile secure accommodation, including Prison Service accommodation.*”⁴⁰
- 4.11 In terms of physical restraint, the emphasis in custodial settings in the 1980’s had been Control and Restraint (C&R) processes, which started at HMP Wakefield and was said to have reduced rates of injury to both offenders and prison officers when it replaced an older system called Minimum Use of Force and Tactical Intervention (MUFTI). The focus of C&R is a series of escalating responses to the sort of problems encountered in secure settings, but it does use pain as part of the techniques used. It was used in juvenile YOIs as well as adult prisons, but not in STCs.
- 4.12 With the introduction of the 1989 Children Act and in response to the scandals of the 1980’s, new systems of behaviour management, including physical restraint, began to be developed specifically for children. However, this has mostly taken place outside of the secure sector.
- 4.13 Outside of the secure sector, there are other areas where advice is provided to staff on Restrictive Physical Intervention (RPI) for children and when it is appropriate to use it. The

³⁸ See for example the Care Leavers association website, ‘Uncovering the past abuse of children in care.’ Accessed on 14th March 2016 on: <http://www.careleavers.com/abuse/history>

³⁹ Uttering, W. (1997). *People like Us: The Report of the Review of the Safeguards of Children Living Away from Home*. London: The Stationary Office.

⁴⁰ Department of Health (1998). *The Government Response to the Children’s Safeguards Review*. London: The Stationary Office.

guidance written for different sectors is not always consistent. The Department for Education, for example, produces guidance stressing the powers of school staff to use reasonable force to maintain good order and discipline. The *Behaviour and Discipline in Schools: Advice for Headteachers and Schools* (2016)⁴¹ guidance includes guidance on when staff should use their power to use force and also on seclusion or isolation rooms.

Department of Health guidance stresses the need for vulnerable children and young people to be protected and tries to minimise the use of restrictive interventions.⁴² In all these sectors, staff are often expected to deal with similar behaviours to that encountered in the youth secure estate yet they approach the task in different ways.

- 4.14 As they considered different approaches, the Board noted that there appears to be a qualitative difference between attitudes to restraint of children depending on whether they are inside or outside the secure estate rather than on the actual behaviour that the adults involved are seeking to manage.
- 4.15 In 2008 the Smallridge and Williamson report *Independent Review of Restraint in Juvenile Secure Settings* was published.⁴³ Peter Smallridge and Andrew Williamson looked at all of the types of RPI being used in all three types of secure establishments (SCHs, STCs, and YOIs). While YOIs were subject to similar methods used in the adult estate (C&R), SCHs tended to offer a more varied array of techniques – the report identified 8 different methods (including PRICE) across 19 SCHs. At the time of the report, all STCs used Physical Control in Care (PCC).
- 4.16 The report found concerns about all of the restraint methods used in the youth secure estate, with enough concerns about PCC used in STCs to recommend that it should be “replaced by a new simpler, safer and more effective system” (page 53). It was noted that the method had been developed by the Prison Service for use on younger children and that it was inadequate to manage the physically stronger young people that are currently found in STCs, which the report felt compromised both their safety and the safety of staff.
- 4.17 The Review Report also raised concerns about how individual institutions interpreted their powers to use force. Although Smallridge and Williamson were told that levels of restraint at a particular institution could vary depending on whether they were accommodating particularly difficult individuals, the report found that the same individuals could receive significantly different levels of restraint in different parts of the estate (see page 40). This suggests that rather than levels of restraint being down solely to particularly troublesome young people, something about certain establishments meant it was more or less likely that that an individual young person would be restrained.
- 4.18 The Board feels that this is a key finding with implications for all childcare settings. The finding supports the Improvement Board’s view that the culture of the organisation and how the management views behaviour management plays a significant part in how staff implement policies.

⁴¹ Department for Education (2016). *Behaviour and Discipline in Schools: Advice for headteachers and school staff*. London: DfE.

⁴² Department of Health (2014). *Positive and Proactive Care: Reducing the need for restrictive physical interventions*. London: DH.

⁴³ Smallridge, P. and Williamson, A. (2008). *Independent Review of Restraint in Juvenile Secure Settings*. London: HMSO.

- 4.19 Smallridge and Williamson looked at different types of restraint (e.g. prone, supine, basket holds etc.), but concluded that *“there is no such thing as ‘entirely safe’ restraint. Restraint is intrinsically unsafe. Even where it does not end in physical injury the experience and the memory can be profoundly damaging psychologically”* (page 5).⁴⁴
- 4.20 Smallridge and Williamson also made recommendations around building in safeguards to minimise the use of certain techniques, such as wrist locks, flexion and rotation. They also felt that these safeguards should be allied to rigorous monitoring of the use of restraint involving pain in STCs.

Minimising and Managing Physical Restraint

- 4.21 In response to the Smallridge and Williamson report, NOMS was commissioned to develop a new restraint system for secure training centres and under 18 YOIs. The new system, Minimising and Managing Physical Restraint (MMPR) was published in 2012. The aim is to *“provide secure estate staff with the ability to recognise young people’s behaviour, and use de-escalation and diversion strategies to minimise the use of restraint through the application of behaviour management techniques... The use of force on a young person must always be viewed as the last available option”* (page 2).⁴⁵
- 4.22 The Initial Training Course (ITC) given to new staff at Medway STC lasts 7 weeks and includes a compulsory section on MMPR. The MMPR training course element is 7 days in total and is delivered by a combination of trainers from the MMPR training national team (from NOMS) and local trainers.
- 4.23 There are six volumes of the MMPR manual used by trainers to deliver the MMPR syllabus to staff. The training covers aspect of behaviour and incident management, medical advice, physical restraint techniques and report writing. Staff must complete a written assessment and scenario based exercise after the training event to demonstrate learnings.
- 4.24 There is a one-day refresher MMPR training programme that staff must undertake every 6 months to demonstrate an understanding of the theory and practical elements of MMPR.
- 4.25 The NOMS MMPR National Team mainly consists of trainers who have previous experience of working in the prison service, although though some staff also have experience of working in STCs. To qualify as an MMPR trainer, staff must undertake an additional 10-day training course, followed by a period of training with the national team that includes lesson observations.
- 4.26 Despite this rigorous preparation for trainers, there remains some concern about the new techniques. The Independent Restraint Advisory Panel (IRAP) reviewed the implementation of MMPR in 2014. It reported an unexpected increase in the use of restraint and an increase

⁴⁴ Smallridge, P. and Williamson, A. (2008). *Independent Review of Restraint in Juvenile Secure Settings*. London: HMSO.

⁴⁵ MoJ, NOMS & YJB (2012). *Minimising and Managing Physical Restraint*. Accessed on 15th March 2016 at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/456672/minimising-managing-physical-restraint.pdf

in head injuries. It also reported a perception amongst managers that staff were confused about when they should intervene, possibly waiting too long to allow incidents to escalate.⁴⁶

The Findings of the Board on Restraint at Medway

- 4.27 Although the events depicted on the Panorama programme have been condemned by senior representatives from all of the major organisations involved at Medway STC, particularly G4S and the YJB, the Board has heard evidence that they were not unique, either to Medway or to STCs in general. The Board spoke to a 17 year old young man, for example, who had recently been detained at Oakhill STC, and who said he was not surprised at the incidents depicted. He told the Board *"I've seen it. It's normal... You can't stop it... Every day something like that could happen."*⁴⁷
- 4.28 During the course of its investigations into whether restraint processes at Medway STC continue to cause safeguarding concerns, the Improvement Board considered the training manuals of MMPR and were all taken through the basics of what was involved with the technique and the training. A member of the Board took part in a staff training day at Medway STC and with staff from Oakhill and Rainsbrook at Milton Keynes. The Board also met with MMPR trainers and discussed the techniques and problems encountered at Medway, in terms of implementing MMPR and the establishment's interpretation of the training.
- 4.29 The Board has concluded that MMPR has been professionally developed and delivered and is an improvement on the previous model. The Board feels that from what it has seen and heard, training has been high quality when it is delivered by experienced and qualified instructors.
- 4.30 Despite this, the Board remains concerned about whether the techniques go far enough to ensure improved safeguarding of children at STCs and YOIs. Not enough of the recommendations made by Smallridge and Williamson have been fully applied. Physical techniques are still very similar to those used on adult prisoners, including wrist flexion, wrist rotation and the application of pain.
- 4.31 The Board has noted that 'head holds' are still a prominent feature of training in the secure juvenile state, whereas they are rarely used outside of it in Children's Services. The Board has been concerned to come across some confusion at operational level about whether the purpose of the head hold is to protect the head or to control the head as a means of controlling the body. Forcing the head downwards is used to control kicking.
- 4.32 This is relevant because some of the footage from the Panorama programme involved three members of staff holding a young person, with one member of staff on either side, each holding an arm, and another taking hold of the head and forcing it forwards and downwards. The footage led to some experts claiming it was not part of normal procedures, but this probably indicates a lack of familiarity with the training. The Board found, however, that

⁴⁶ IRAP (2014). *Implementation of the Minimising and Managing Physical Restraint System in Secure Training Centres and Young Offenders Institutions*. Accessed on 15th March 2016 at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/368626/irap-mmpr-final-report-2014.pdf

⁴⁷ Meeting between Board and young people on 11th March 2016, facilitated by User Voice.

staff training at Medway STC included a very similar technique to that used on the programme. In the training, the staff member in front puts an arm around the back of the young person's head and supports the young person's chin with the other hand. The Board member who attended the refresher training course, who is an expert in restraint techniques, noted that this technique was adapted in the refresher training given at Medway in February 2016, so that staff no longer place the hand under the chin.

- 4.33 Young people themselves have complained that the technique of forcing the head downwards interferes with their breathing. The Independent Restraint Advisory Panel have already raised concerns about the over use of head holds in their report on the implementation of MMPR.⁴⁸ Forcing the head forward while holding the young person in a seated position is no longer used as a method of restraint since the death of Gareth Myatt in 2004. The Board fears that over-use or poorly applied use of head holds may lead to a similar tragedy.
- 4.34 The Board is also concerned about the use of pain compliant holds that involve bending and/or rotation of the wrist and the deliberate application of pain. Smallridge and Williamson were persuaded that pain compliance was sometimes necessary to bring an end to extreme expressions of violence that would otherwise have necessitated prolonged physical restraints.⁴⁹ The Board feels if such measures are necessary they should be used rarely and only in exceptional circumstances. The Board is aware that some children, particularly those with Autistic Spectrum Disorders, do not respond to pain in the same way that other children do, which might increase the risk of injury or emotional abuse.
- 4.35 In addition, Nick Hardwick expressed concern about what the routine use of pain compliance was likely to have on the culture within the organisation. There were some shocking scenes in the Panorama programme that depicted staff boasting about hurting children. The Board feels that this may also increase the risk of staff seeking out places where there are no CCTV cameras in order to 'discipline' children.
- 4.36 In support of the findings of the IRAP in 2014, the Improvement Board also found some confusion among staff about when to intervene and at what level. The Board feels that a contributory factor to that might be a prominent but misleading quote in the MMPR manual that advises staff to repeatedly ask themselves "*Have I exhausted all reasonable options?*" While staff need to consider all reasonable options, this question suggests that they should attempt them before moving on to the next one. It would be more helpful to make sure that staff are trained to only attempt options if there is a reasonable chance of them being effective. The question should be changed to "*Have I considered all reasonable options?*"
- 4.37 In discussions with an MMPR trainer, the Board was told that the trainer could not answer the question "*what if?*" because it had been strongly emphasised that they should stick only to what it said in the manual. The Board strongly feels that a trainer should be experienced enough to be able to answer "*what if?*" questions, or if not they should be confident about

⁴⁸ IRAP (2014). *Implementation of the Minimising and Managing Physical Restraint System in Secure Training Centres and Young Offenders Institutions*. Accessed on 15th March 2016 at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/368626/irap-mmpr-final-report-2014.pdf

⁴⁹ Smallridge, P. and Williamson, A. (2008). *Independent Review of Restraint in Juvenile Secure Settings*. London: HMSO.

who they should ask, and that management will support them seeking an answer that is not in the manual. The Board feels that there needs to be a review of staff responses to the manual and MMPR training and feedback should be used to update the manual to make it more effective.

- 4.38 As well as competent trainers and a coherent and logical training manual, an effective and 'safer' behavioural management system requires strong leadership that encourages staff to put safeguarding above the need some staff might feel to control the young people in their care. The culture of STCs needs to be built on a solid ethical framework of shared vision and values.
- 4.39 The Board feels that MMPR, or any RPI method used in the youth estate, needs to be supported by a knowledgeable and confident workforce. The young people in the youth secure estate are vulnerable but also increasingly display extremely challenging behaviour. In order to safeguard them effectively and to know what MMPR options are most appropriate to use in a particular situation, staff need to be equipped with the tools they need to better understand the behaviour of these children and how they, as responsible adults, can influence this behaviour and the responses of the young people to events happening in the STC.
- 4.40 Looking more widely across the system, the Board feels that more needs to be done to look at the gap between how restraint and behaviour management is applied in youth secure settings and how it is applied in non-secure settings in other sectors. The Board feels that the culture across the youth secure estate tolerates a much harsher and more punitive approach to behaviour management in children than would be condoned in other settings.
- 4.41 There are many implications for treating young people in custody so differently, including concerns about their human rights. The Board also feels these vulnerable young people are likely to feel an impact based on their social learning and will model their own behaviour on their experiences. One young man the Board spoke to pointed out that if this behaviour is the norm when he is inside an STC or a YOI, then this is the behaviour he will emulate when he is outside in the community.⁵⁰

Recommendation

13. The Board recommends that MoJ commissions a cross-departmental review of behaviour management policy and practice in STCs, across the wider youth justice system and beyond to other sectors. The purpose of the review should be to produce a coherent policy on risk, restraint and behaviour management across government that proactively drives the best interest of the child and promote interventions that are proportionate to the risks presented by the behaviour rather than the setting in which the behaviour occurs.

5. The Role of Contract Management and Monitoring

- 5.1 One of YJB's key functions, as set out in its statutory duties for the secure estate for children and young people, is the commissioning and purchasing of secure places for young people under the age of 18. As part of this function, it does not manage or run STCs, but commissions other organisations to run them. The three STCs are all run by private companies – at the time of writing this report, G4S was involved with all three of them.
- 5.2 YJB are responsible for managing the contract with G4S at Medway STC. The original contract was awarded on 3rd March 1997 with ECD (Cookham Wood) Ltd, to run for 15 years from the opening of the STC in 1998. The contract was sub-contracted to Group 4, and eventually, after two periods of extension, the sub-contractor G4S Care and Justice Services (UK) Ltd signed an extension on 18th of February 2015 until 31st March 2016.
- 5.3 In the meantime, a new competition for the contract was run, supported by the MoJ Commercial & Contract Management, Competitions Team. G4S won this contract through fair and open competition and signed it on 26th October 2015, although they announced they would sell the contract before it started.
- 5.4 Day to day contract management is overseen by the Contract and Business Management Team in YJB. Contract compliance is reviewed by the Monitor, who also has functions described in the STC Rules. The Monitor and Assistant Monitor are on site at Medway STC.
- 5.5 This section of the report describes the findings of the Board in relation to YJB management of the contract and the role of the YJB monitor.

Contract Management

- 5.6 In order to better understand the requirements of the contract management role, the Improvement Board had time to view both the original contract with G4S and the terms of the new contract, which was due to begin on 1st April 2016 until G4S announced they were selling the contract.
- 5.7 The Board were guided through the sections of the contract and also the competitions process by an advisor from MoJ's Commercial and Contract Management team. They also had a number of opportunities to speak to the Head of Contracts and Business Management at YJB. The contract was also discussed with several members of senior G4S management, and it was occasionally raised by other stakeholders.
- 5.8 The Board had early concerns about the relationship between YJB and G4S, which they felt may have an impact on how effectively the contract would be delivered. In the Board's interim advice to the Secretary of State, it was set out that the Board felt that G4S had a much better understanding of the terms of the contract than the YJB, and that they may be using this knowledge to interpret the contract in terms more favourable to them.
- 5.9 While the Board still maintains this position, it acknowledges that there is a strong focus on delivering the terms of the contract in both organisations. Nick Hardwick told the Board that he felt that there was a risk that G4S would deliver 'what is in the contract' rather than deliver what was in the wider interests of young people. On the other hand, the Board found

that penalties imposed by the YJB for not complying with all terms of the contract can be quite severe and, quite similarly, do not necessarily support a vision of a nurturing and rehabilitative environment. In chapter 2, for example, this report described the Board's concerns about SASH policies and the imposition of penalties when a young person is found with an implement that could harm them but not if they actually harmed themselves.

- 5.10 The Board feels that the terms of the contract mean the contractor is penalised for incidents that do not necessarily improve safeguarding or rehabilitation (this is discussed in chapter 2) and that avoiding contractual penalties has become more important than considering what purpose the provisions behind the penalty serves for the young people. The Board feels that this is recognised, at least to some degree, in both YJB and G4S.
- 5.11 The Board is clear that these concerns about how the contract is set up do not in any way legitimise the evidence shown on the Panorama programme, and additionally further evidence described to the Board by former members of Medway staff, that staff members are falsifying records in order to avoid penalties. It does mean, however, that more thought needs to be given to what purpose the contract serves and whether the penalties support or obstruct this purpose.
- 5.12 In the interim report, the Board highlighted their concerns over senior management in the YJB not being able to articulate clearly what they expected from G4S in terms of delivery of the contract. Building on this, the Board now feels that the YJB has not articulated the contract in terms that enables effective and nurturing care and rehabilitation of vulnerable young people. G4S has been delivering the contract that the organisation has been asked to deliver, which is not the same thing as delivering a contract that will provide the most effective care for the young people in their care.
- 5.13 The Board noted that the Improvement Notice (see chapter 6) that had been issued to G4S very much relied on G4S to identify the reasons leading to 'reduced performance' and for them to put in place an action plan to remedy these. The Board is not at all clear about what processes YJB feels need to be put in place to give them confidence that they can effectively monitor the contract and assure the Secretary of State that children are safe.
- 5.14 Indeed, overall, the Board is increasingly of the view that there is an over-reliance in YJB on the views and opinions of other organisations rather than developing contract management and monitoring arrangements that are robust enough so they are confident in their own assessment of safeguarding arrangements.
- 5.15 The Board is concerned that both YJB and G4S have been focused more on contract scrutiny and respectively pursuing or avoiding penalties. The Board note however, that the new contract, which was due to begin in April, has an improved specification and requirements which would theoretically have delivered a demonstrable improvement on the current contractual arrangements, with more focus on the individual needs of young people. An example of an identified improvement by G4S is that the new contract will enable certain interventions to be delivered by health care and other specialists in the educational day when this is seen to be in the best interest of the young person to meet their needs (currently these have happened after school).
- 5.16 A separate piece of analysis has been undertaken by MoJ colleagues in Commercial and Contract Management Analytics on the current state of Secure Training Contracts, and of

which the Board was given sight. The Board noted the broad findings of this piece of work below as they have come to similar conclusions in respect of Medway:

- due to the 'self-reporting' nature of the current STC contracts, there is a significant reliance on the contractor to provide data without a robust independent assurance mechanism. Underreporting of incidents and issues, therefore, cannot be successfully detected or challenged.
- The assessment of the contracts tend to focus on process and not necessarily the quality of the service delivered. An equal emphasis is needed on both aspects to assess the contract's performance and its compliance to service quality objectives.
- Definition of KPIs do not always reflect the key impact of contractor's service delivery. For example, criticisms of Inspectorate reports have not been successfully captured by regular KPI monitoring.
- There is a critical need for triangulating data from different sources to form a holistic overarching picture, e.g., from monitors, Barnardo's, young offender feedback etc. This would need a radical think of how data is captured, quality assured and used for monitoring contractual performance and service quality.⁵¹

The YJB Monitor

- 5.17 A key component of the YJB's contract management arrangements is the YJB monitor. The role of the monitor is fulfilled by a member of YJB staff; this same arrangement is present across all three STCS and all monitors report to the Head of Performance at YJB, who in turn reports to the Head of Contracts and Business Management.
- 5.18 At Medway, the monitor is supported by an assistant monitor who is a part-time member of staff. The monitor is on site 5 days a week.
- 5.19 The Board has met with both the monitor and the Head of Contracts and Business Management and has discussed the day to day role of the monitor with each of them. They have been told that a core part of the monitor's role is to ensure contractual compliance, which includes site inspections, reviewing incident reports and CCTV footage to make sure appropriate actions had been undertaken and carrying out minimum staffing checks etc.
- 5.20 The monitor is also responsible for meeting with new young people admitted to the STC, and spends a minimum of five hours a week with young people in a range of settings to provide opportunities for any concerns to be raised directly with her. Theoretically, where there are issues of concern, the monitor should be able to escalate these with senior YJB managers and/or challenge G4S if applicable as they were the contracted providers.
- 5.21 The Board met with the monitor at Medway on 5 February and within minutes of meeting, the Board found that she did not have free access to CCTV footage to review incidents. The monitor did not have her own login code so was reliant on someone else logging in before she could view CCTV. In addition, the CCTV VDU was not accessible from her office, but in a room that was often booked out for meetings, and therefore not available.

⁵¹ Information provided by Analytical Services

- 5.22 The Board was very uncomfortable with the lack of access to CCTV because this essentially impeded any chance of productive monitoring. The Board was told that this fundamental problem had been ongoing for many years, despite the fact that it was raised with senior managers in YJB and in MedwaySTC. The Board was told that there were inconsistencies between the levels of access monitors had to CCTV footage at all three STCs for many years, but nothing had been done to rectify the situation.
- 5.23 It was also brought to the attention of the Board that the monitor's office faced the outside of the building instead of internally to the 'Greens' where activity regularly occurs, despite the fact that the monitor has asked for an inward facing office to increase the level of scrutiny she would have. This had also not been provided by the time the Board reported its initial findings to the Secretary of State on 2nd March this year.
- 5.24 At the time the Board reported to the Secretary of State, the monitor was also only able to view footage of reported incidents because she had been informed by G4S that she could not use CCTV for monitoring specific individuals she had concerns about, due to Data Protection issues. This advice was checked with MoJ legal advisors who informed that as the purpose of CCTV in secure training centres was to maintain the security of premises, give confidence to trainees, staff and visitors that they are in a secure environment and to assist with the investigation of incidents and training, it could be reasonably expected that the monitor would view CCTV for fulfilling their functions. This advice was immediately shared with the YJB.
- 5.25 Nick Hardwick, former HMCIP, expressed a view to the Board that the YJB monitoring model was weak and had proved ineffective. Ben Saunders, interim Director at Medway told the Board that he felt that they could manage the STC just as well without a monitor in place. John Parker, Director of Children's Services, echoed concerns about the monitor role as he felt that some YJB monitors had insufficient skills and experience to be able to carry out their role, and that monitoring was not effective.
- 5.26 Young people at MedwaySTC were asked during a focus group about their view of the monitor. Of those young people that were questioned, none of them knew what the role of the monitor was, who they were or what they did, although after some discussion one group thought it was the "boss lady". They fed back that when she was on site, the behaviour of the staff changed.
- 5.27 Taking into account the discussions the Board had with various stakeholders, the Board reported to the Secretary of State in early findings that it felt that G4S management at Medway STC had manipulated the YJB monitor over a number of years.
- 5.28 In the interim report, the Board made immediate recommendations that:
- G4S was to enable immediately the YJB monitors to have full, unfettered access to CCTV, with their own login code, and with login access to CCTV available in the monitor's office. The monitor must be able to access CCTV at any time of the day or night without any restrictions or difficulties. YJB must oversee arrangements to have this put in place within a week.

- In addition, G4S must make sure that the YJB monitor is immediately be moved to an office that has good visibility over the internal STC. The MIB expected to see this change implemented within a week.
 - Because the Board believes that G4S has been managing the independent YJB monitor within the STC, it recommended that a more senior YJB monitor manager (at Grade 6 or equivalent) be appointed immediately to oversee more junior monitors and to provide more effective challenge to G4S management. This monitor should have extensive management experience as well as suitable safeguarding experience.
- 5.29 At the time of writing this report, the Board’s recommendations in the interim report in respect of the monitor have been met. The monitor has a new office facing the ‘Greens’ since 11th of March, and now has suitable access to CCTV. In addition, a new senior monitor has been appointed 7th of March.
- 5.30 At a meeting with the Head of Contracts and Business Management and the Director of Operations at YJB on 17 March, the Board elaborated on the safeguarding aspect of this role which they felt would be better fulfilled by someone with recent experience of working with young people in secure settings. The YJB explained that they were re-examining the monitoring role and would report back to the Board with an update on options they were considering.
- 5.31 On 24th March, YJB sent the Board a summary of their work on monitoring. It suggested a new system of scrutiny and interrogation be developed to move away from the reliance on a single, on-site monitor, to a diverse system of safeguards to scrutinise all aspects of service delivery. An on-site monitor would still form part of this system, but their focus would be to deliver their responsibilities as set out by statute. The Board welcomes these plans but is concerned that it has taken so long for these changes to be brought about.
- 5.32 There is a broader concern around why the Board uncovered the various issues it did within two days of it starting its work, and within a couple of weeks these very serious impediments to adequate monitoring had been rectified. These were not insurmountable problems and they should have been picked up and dealt with years ago.
- 5.33 The strength of monitoring appeared to be poor both in terms of monitoring and scrutiny, and in terms of the effectiveness in providing appropriate challenge to G4S. Overall, the Board found that contract management and monitoring arrangements lacked clarity about who was accountable for young people’s outcomes and there was evidence that the focus of G4S leaders and the YJB was distracted by questions about contractual compliance as opposed to the wellbeing of staff and young people.

Recommendations:

14. There needs to be a formal separation of the often conflicting YJB monitoring functions of ensuring contractual compliance and monitoring safeguarding. For there to be a qualitative impact, both functions need to be carried out on a daily basis by separate individuals who have the necessary experience and expertise for the roles, and have enough seniority to challenge senior staff at the STC and other organisations involved with the institution.

15. The Safeguarding function needs to report to the Governing Body on a regular basis and must be accountable to them for providing assurance of safeguarding in STCs.

6 G4S Improvement Plan

- 6.1 As part of the Terms of Reference (see Annex A), the Improvement Board was asked to investigate safeguarding arrangements at Medway in order to inform the development and approval of the improvement plan that G4S was to produce. In addition, the Board was asked to “oversee, challenge and support G4S in implementing their improvement plan.”
- 6.2 This part of the report summarises what the Board did to fulfil their duties in this regard and sets out their final recommendations for the further development of the Improvement Plan.
- 6.3 The Board is convinced that, regardless of whoever takes over management of Medway STC going forward, these improvements need to be made to support cultural and policy change and improve the Secretary of State’s confidence that appropriate safeguarding arrangements are being made at Medway STC.
- 6.4 The Board also feels that the improvements suggested should be reviewed again in light of the final conclusions and recommendations of the Youth Justice Review. It is important that improvements to safeguarding, staff development and organisational culture are aligned with changes across the youth justice system to ensure better educational and rehabilitative outcomes.

Background to the Improvement Plan

- 6.5 Following the revelations to MoJ about the incidents shown on the Panorama programme, MoJ found that the issues amounted to ‘Reduced Performance’ in terms of the contract.
- 6.6 The contract is underpinned by service outcomes for key delivery areas expected from providers, alongside a clear set of mandatory service requirements, which form the basis of the specification and are underpinned by the STC Rules (1998) and relevant public policy and guidance.
- 6.7 The current contract for Medway STC with G4S Care and Justice Services (UK) Limited expires on the 31st of March 2016. The new contract for Medway STC was awarded to G4S in September 2015 (signed on 26th October 2015), with a Service Commencement date of 1st April 2016.
- 6.8 Under the terms of the new contract an improvement notice can be issued as formal notification to the Contractor where the Authority identifies specific areas of concern where performance has fallen below reasonable standards. The notice requires the production of an Improvement Plan by the Contractor within a specific timeframe, which should detail the operational processes to allow the Contractor to rectify the issue(s). The time period allowed can vary and is dependent upon the seriousness of the breach.
- 6.9 Although the terms of the current contract did not allow for an improvement notice to be issued (a Rectification Notice can be issued under the current contract), the Improvement Notice was issued to G4S as a result of significant issues arising in relation to the Contractor’s management of Medway Secure Training Centre under the Predecessor Contract. The Improvement notice allows a continuation of monitoring issues, which had

occurred under its predecessor, through into the new contract – a position which G4S accepted.

- 6.10 An improvement notice was issued by MoJ on 17 February. It asked, among other things that G4S develop a plan to improve culture, staffing, leadership, whistle-blowing and sharing concerns, use of force and reporting etc. The Board had sight of the notice on 23 February.
- 6.11 G4S was required to respond to the Improvement Notice with an Improvement Plan providing an explanation of the causes of reduced performance under the above headings and by identifying actions they would undertake to remedy the issues.

Development of the Improvement Plan

- 6.12 The Board saw the first draft of the Improvement Plan on 25 February.
- 6.13 The Plan was discussed at Board meetings and with G4S on 3 and 17 March. The Board was concerned that the plan did not delve deeply enough into the causes of failure at Medway STC. It was particularly disturbed that some of the G4S senior managers who had been implicated in some of the cultural problems at Medway (e.g. were mentioned in the Guardian of 26th February) were to be involved in training.
- 6.14 G4S senior management told the Board at meetings on 3 and 17 March that they were happy to be guided by the Board on the Plan's further development.
- 6.15 Before the Board submitted its early advice to the Secretary of State, it was announced that G4S intended to sell UK Children's Services, including the contracts for Medway and Oakhill STCs.
- 6.16 In the Board's early advice to the Secretary of State the concerns that were raised included handover and continuity arrangements because of an imminent change in management at the STC. Advice at that time included, for example:
- G4S must immediately revise their Improvement Plan to include assurances of how safeguarding and improvement will continue during times of uncertainty for G4S staff at Medway and how they propose to manage these issues during the transition processes. G4S needs to demonstrate their commitment to their own Improvement Plan for their remaining time at Medway STC.
 - G4S management needs to put in place an appropriate training programme (delivered by an external provider) for staff, at DOM and Team Leader levels, that emphasises the role of staff in safeguarding children above other G4S objectives and concern over performance indicators
- 6.17 The Board's advice to the Secretary of State was fed back to G4S by the YJB. Following this advice, the Board met with G4S on 17 March when the revised plan was discussed.

The Revised Improvement Plan

- 6.18 The Board received the revised plan on 15th March this year. The Board met with G4S on 17th of March to discuss the plan. At the meeting, the Board were very mindful about the potential of change in management of the STC over the course of the following months, and

about how this transition should be managed at an institution that needed significant changes in culture and management.

- 6.19 Following the meeting with G4S on 17th March, the Board asked further details on statistics around passive resistance displayed by young people. They also asked for more information about the Advisory Board described in the plan, in terms of its function and makeup. The Board received this information on 22nd March, but it did not change their overall conclusions about further changes that they felt should be made.
- 6.20 Overall, the Board felt that the revised plan focuses almost entirely on outputs. There is insufficient focus on the purpose, success criteria, lines of accountability and implementation timeframes for these actions. The Board has developed further recommendations for improvement to the plan, which are set out below.
- 6.21 The Board feels that these improvements need to be made to MedwaySTC regardless of who is managing the centre if the Secretary of state is to be assured that more is being done to meet appropriate safeguarding standards. The Board would also suggest that similar improvements are considered at the other STCs, at least until the recommendations of the Youth Justice Review are implemented.

Recommendations on Improvement Plan

- G4S must clarify to MoJ their timeframe for implementation of the improvement plan, particularly if the contract is to be transferred. This clarification should set out what the plan is seeking to achieve, what outcomes it is intended to deliver and who is responsible for overseeing implementation of the plan.
- The Improvement Plan should include information on who in G4S is responsible for ensuring effective handover of the document to the new management of the STC and a timetable for handover if new management takes over running the centre.
- Any new management that takes over the running of the STC over the twelve months following the submission of this report must continue to deliver the improvements set out in the Improvement Plan so that the actions it contains are delivered and the safety of young people at the STC is improved.
- The Improvement Plan should include G4S's analysis of what went wrong with organisational culture at Medway to enable staff to feel they could act as they did towards children and how they propose to address this.
- Although it is acknowledged that the current emphasis may be because of the wording of the Improvement Notice, the Board recommends that the *Vision* (as set out on page 6 of the document) needs to be developed and amended so that the emphasis is more on trainees than the staff.
- The plan must clarify what staff the training described is geared towards and must set out specifically how they intend to address the Improvement Board's concern about safeguarding training for DOMs rather than 'middle managers and senior managers'.
- Action on appraisal, as set out on page 12, needs to be strengthened to make sure there is ongoing oversight of performance management to ensure compliance with performance objectives and that staff receive reflective supervision.
- Feedback from focus groups that G4S has already received must be incorporated into the Improvement Plan.
- Under the heading 'Continuous Staff Development', the section on improving supervision needs to be clarified, particularly on whether it refers specifically to the context of clinical supervision and how many staff are being trained to provide this.
- G4S must clarify their recommendation to YJB (page 20) that STC rules need to be revisited around Good Order and Discipline (GOAD) as the Board did not come across any evidence on this being a particular issue when they visited Medway SCT and spoke to staff.

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Annex A – Written Ministerial Statement & Terms of Reference

As I assured the House on 11 January, the safety and welfare of all those in custody is vital. We treat the allegations of abuse directed towards young people at the Medway Secure Training Centre, run by G4S, with the utmost seriousness. Kent Police and Medway Council's child protection team have launched an investigation which will determine whether there is any evidence to justify criminal proceedings. The Ministry of Justice and Youth Justice Board will fully support and co-operate with their enquiries.

Following the allegations, our immediate priority has been to ensure that young people at the centre are safe. HMIP and Ofsted visited Medway STC on 11 January and their findings are published today. The Youth Justice Board, which is responsible for commissioning and oversight of the secure youth estate, has increased both its own monitoring at Medway STC and the presence of Barnardos, who provide an independent advocacy service at the centre. The YJB immediately stopped all placements of young people into the Centre and suspended the certification of staff named in the allegations.

I believe, however, that we need to do more in order to have confidence that the STC is being run safely and that the right lessons have been learned. Today's report by HMIP and Ofsted recommends the appointment of a commissioner to provide additional external oversight of the governance of the centre. I agree that additional external oversight is necessary and am also concerned that it draws on the broadest possible expertise.

I am therefore today appointing an Independent Improvement Board, comprised of four members with substantial expertise in education, running secure establishments and looking after children with behavioural difficulties. This Board will fulfil the same function, with the same remit, as HMIP and Ofsted's recommendation for a commissioner. We have tasked G4S with putting an improvement plan in place, which this Board will oversee.

I have appointed Dr Gary Holden as the chair of the Improvement Board. Dr Holden is the chief executive officer and executive principal of The Williamson Trust, a successful academy chain in Kent. This includes the outstanding Joseph Williamson Mathematics School, located less than a mile from Medway STC. He is also a National Leader of Education and chair of the Teaching Schools Council. His experience as a head teacher and leader of a high-performing organisation make him ideally suited to identify the steps that should be taken to raise standards at Medway STC.

Dr Holden will be joined by: Bernard Allen, an expert in behaviour management and the use of restraint; Emily Thomas, interim governor of HM Prison Holloway and former governor of HM Young Offender Institution Cookham Wood; and Sharon Gray OBE, an education consultant and former head teacher with experience of working with children with behavioural difficulties, including in residential settings.

The Board will provide increased oversight, scrutiny and challenge of managerial arrangements, in particular in relation to the safeguarding of young people. Board members will have authority to visit any part of the site at any time, access records at Medway and interview children during their investigations. The Board will report any concerns about the provision of services at Medway to me.

The Board's work will assist me in determining the necessary improvements that G4S must make to restore confidence that young people are properly safeguarded at the STC.

The Terms of Reference for the Independent Improvement Board are to:

- (i) investigate the safeguarding arrangements at Medway in order to inform the development and approval of the improvement plan to be produced by G4S and any steps to be taken by the Youth Justice Board (YJB) and other organisations;
- (ii) oversee, challenge and support G4S in implementing their improvement plan;
- (iii) report to the Secretary of State on the Board's confidence in the capability of G4S, YJB and other organisations to meet appropriate safeguarding standards at Medway STC in the future, and the performance and monitoring arrangements required to provide assurance; and
- (iv) submit any recommendations on the safeguarding of young people in custody, including the role of the YJB and other organisations, to inform practice in the wider youth custodial estate and Charlie Taylor's review of the youth justice system.

The Board will complete its work by the end of March 2016.

Annex B – Biography of Board Members

Dr Gary Holden

Dr Gary Holden, is a National Leader of Education and is Executive Principal of The Williamson Trust, a multi-academy trust comprising two secondary and four primary schools in Medway. The lead school of the Trust is Sir Joseph Williamson's Mathematical School, which is rated outstanding by OFSTED and is a National Teaching School and a National Support School.

Dr Holden is also the Chair for the Teaching Schools Council.

Before becoming Head teacher of Sir Joseph Williamson's in 2008, he held a variety of roles in education, including as a Deputy Head teacher, as a local authority senior adviser and as an Associate Lecturer in higher education.

He has published a number of articles in academic journals and has contributed to two books on various aspects of teacher research and leadership.

Bernard Allen

Bernard Allen, B.A. (Hons), P.G.C.E., D.A.E.S., MSEW, MBPsS, led a series of successful schools before becoming a writer, consultant and expert witness. He has published a large number of books and papers on issues related to the psychology of mood and behaviour management to reduce risk, restraint and restriction.

He first trained as a Control & Restraint instructor in the early 1990s and went on to create Holding Back, the first UK video training package designed specifically for children's services. He is the author of Team-Teach training manuals, qualified at principal trainer level.

Working across the UK and abroad he is a conference speaker who provides training and advice to courts, insurers and governments on liability issues relating to behaviour. He is a member of the Society of Expert Witnesses and is on the register of expert witnesses, regularly vetted by independent lawyers (most recently in 2015).

Sharon Gray

Sharon Gray, OBE, B.ED. (Hons) NLE, has been a Head teacher for 18 years, 12 of which have been leading specialist schools for children and young people experiencing severe social, emotional and mental health difficulties, 6 in a mainstream school. As the Head or advisory Head, Sharon has taken the lead of 3 schools, 2 special and 1 mainstream school. These schools were previously judged by Ofsted as requiring "Special Measures". Through her dynamic leadership and facilitation of team development, each school went on to be judged as "Outstanding" by Ofsted.

Sharon currently works as an educational consultant, liaising with local authorities, teaching school alliances, academy trusts and individual schools to support SEHM, accessibility and inclusion. Sharon has spoken at national and international conferences focussing on authentic inclusion. Her book "Courageous Journeys in Education" is about to be published.

In addition, Sharon has been an Ofsted inspector for 9 years. She has trained under the new framework from September 2015 and is an inspector of British schools overseas. Sharon is a co-opted member of 'Engage in their Future' a National Committee representing leaders of special schools for children experiencing severe social, emotional and mental health difficulties, across the UK. Sharon has worked closely with the DfE as part of the task force groups developing: The Code of Practice and The Mental Health Task Force, creating the recent guidance "Children in Mind".

Emily Thomas

Emily Thomas joined the Prison Service in 1999 on the Accelerated Promotion Scheme. She has spent more than 7 years looking after young people in custody, as Head of Reducing Reoffending and then Deputy Governor at HMYOI Hindley (2006 – 2009) and then as Governor of HMYOI Cookham Wood (2009 – 2013). Emily was seconded to the Ministry of Justice in 2013 to lead on the Through the Gate element of the Transforming Rehabilitation Programme. She is currently Governor at HMP Holloway.

Annex C – MIB Stakeholder Engagement List

During the course of the review, the Board heard from a variety of stakeholders and discussed various different topics regarding Medway STC.

Stakeholder	Type of Engagement	Further Information
Youth Justice Board	The Board met with the following individuals at both stakeholder meetings with the board and one to one meetings. Lin Hinnigan , Chief Executive Peter Savage , Head of Contracts and Business Management Kate Morris , Director of Operations Monitor for Medway STC Dan Shotter , Head of Commissioning Projects YJB was also invited to the roundtable event.	Members of the Board engaged directly with YJB staff on: 4 th , 5 th , 16 th , February. 3 rd , 7 th and 17 th March.
G4S – Senior Management	The Board met with the following individuals at both stakeholder meetings with the Board and also one to one meetings: Peter Neden , Regional President UK&IE Paul Cook , Managing Director for Children’s Services Katharina Gossens , Project Manager for Medway Improvement Plan John Parker , Director for Children’s Services	The Board met with G4S representatives on: 16 th , 24 th February. 3 rd , 9 th , 10 th and 17 th March.
Medway STC Staff	The Board met with the following individuals at both stakeholder meetings with the Board and also one to one meetings: Ben Saunders , Interim Director of Medway STC Dean Liddle , Head of Staff Training Duty Operational Managers Team Leaders Head of Resettlement Chaplaincy Psychologist (Central and North West London (CNWL) Trust)	The Board met with Medway STC staff on: 5 th , 10 th , 13 th , 24 th , 25 th , 29 th February. 2 nd , 4 th and 7 th March.
HM Inspectorates of Prisons	The Board had stakeholder meetings with the following individuals: Nick Hardwick , Former HM Chief Inspector of Prisons Peter Clarke , Current HM Chief Inspector of Prisons Deborah Butler , Team Leader	The Board met with HMIP representatives on: 16 th February.
National Offender Management Service	The Board had a Stakeholder meeting with Emma Sunley , Head of Minimising and Managing Physical Restraint Nick Pascoe, Young People’s Group came to the	The Board met with Head of MMPR on 24 th February. Round table was held on

Stakeholder	Type of Engagement	Further Information
	Roundtable event Members of the Board met Johnathan French, Governor HMYOI, Cookham Wood	9 th March Members of the Board visited Cookham Wood YOI on 29 th February and 4 th March.
Barnado's	Members of the Board met a Barnado's Advocate at Medway STC	A member of the Board met with a Barnado's representative on 24 th February.
Whistle-blower	Members of the Board met with a confidential source.	24 th February
Local Authority Designated Officer	Stakeholder meeting with Clare Wilkes .	The Board met with a LADO representative on 7 th March.
Office of the Chief Social Worker	A member of the Board met with Stephanie Brivio , Deputy Director for Child Protection	A member of the Board met with a representative from Office of the Chief Social Worker on 8 th March.
Previous Chair of the Independent Advisory Board on Care of Children and Young People (G4S)	A member of the Board met with Sir Martin Narey	A member of the Board met with a Ministry of Justice representative on 8 th March.
Children's Commissioner	The Board had a Stakeholder meetings Anne Longfield OBE , the Children's Commissioner	The Board met with the Children's Commissioner on 9 th March.
Ian Mikardo High School	The Board had a stakeholder meetings with Claire Lillis , Head Teacher. Ian Mikardo is a specialist school catering for those with severe and complex social, emotional and behavioural difficulties.	The board met with an Ian Mikardo representative on 9 th March.
OfSTED	The Board had a stakeholder meeting with Bob Morton , Senior HMI, National Operational Lead for the Secure Estate Janet Fraser , Lead Inspector for Secure Training Centres	The board met with OfSTED representatives on 11 th March.
Kent Police	The Board had a stakeholder meeting with DCI Susie Harper , Lead for Medway STC Police Investigation	The Board met with a Kent Police representative on 11 th March.
Young people who had been in custody	Facilitated by User Voice, the Board had a Stakeholder meeting with a small group of young people. The young people were accompanied by Responsible Adult, Mifta Choudhury , User Voice.	The Board held a focus group on 11 th March.

Stakeholder	Type of Engagement	Further Information
Care and Quality Commission (CQC)	The Board had a stakeholder meetings Jan Fooks-Bale , Health and Justice Manager	The Board met with a CQC representative on 17 th March.
Article 39	A member of the Board met with Carolyn Willow , Director	A member of the Board met with an Article 39 representative on 26 th February.
Medway Safeguarding Children Board (MSCB)	A member of the Board met with John Drew , Chairperson	A member of the Board met with a MSCB representative on: 26 th February.
St. Edward's School	A member of the Board visited the school and met with Larry Bartel , Head Teacher	A member of the Board visited St. Edward's School and spoke to staff and governors on 18 th March.
Redbridge Council	A member of the Board met with Ronke Martins-Taylor , Chief Services to Young People Officer	A member of the Board met with a Redbridge Council representative on 22 nd February.
Medway Local Authority	A member of the Board met with Barbara Peacock , Director of Children and Adult's Services	A member of the Board met with a Medway Local Authority representative on 12 th February.
Oakhill STC	A member of the Board visited and met with Phillip Austen , Director	A member of the Board visited Oakhill STC on 14 th March.
Rainsbrook STC	A member of the Board visited and met with Sue Tydeman , Director	A member of the Board visited Rainsbrook STC on 21 st March.

ANNEX D

MIB Round Table Event

Delegate List

Event held on: 9th March 2016

The Medway Improvement Board held a round table event to enable them to have the opportunity to discuss key issues with a wider range of stakeholders than they would otherwise have been able to reach. Invitations were sent to those on this list.

Delegate	Organisation
Louise King	Children's Rights Alliance for England
Juliet Lyon	Prison Reform Trust
Tabitha Kaseem	The Howard League for Penal Reform
Jacob Tas	Nacro
Mark Blake	Black Training and Enterprise Group
Mark Johnson	User Voice
Lin Hinnigan	Youth Justice Board
Matthew Armer	NOMS Young People's Group
Nick Pascoe	NOMS Young People's Group
Tim Bateman	Office of the Children's Commissioner
Debbie Pippard	Barrow Cadbury Trust (sponsor Transition 2 Adulthood Alliance)
Deborah Coles	Inquest
Nadine Good	Barnardo's
Jonathan French	HM Young Offender Institution Cookham Wood