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Sir Martyn Oliver
His Majesty's Chief Inspector

The Rt Hon Shabana Mahmood MP
Lord Chancellor and Secretary of State for Justice
Ministry of Justice

Sent by email

Our ref: 510418

Dear Secretary of State

Urgent Notification: Oakhill Secure Training Centre

In accordance with the 'Joint inspection framework: secure training centres' guidance that refers to the Protocol between His Majesty's Chief Inspector of Prisons and the Ministry of Justice (MoJ), I am writing to invoke the Urgent Notification (UN) process in respect of Oakhill Secure Training Centre (Oakhill).[1]

The joint inspectorates carried out a full inspection of Oakhill, from 21-25 July 2025. This letter sets out the visit history and inspection findings, which have led to the Chief Inspectors' decision to invoke the UN process.

What the UN process requires

The decision to invoke the UN process in respect of secure training centres (STCs) is determined by the judgement of the Chief Inspectors of Ofsted, HMI Prisons and the Care Quality Commission (CQC). It is informed by the findings at the full inspection.

The joint inspection framework for STCs sets out that this letter will be published, and that the Secretary of State will respond publicly within 28 calendar days of publication. The response will explain how the care, safety and wellbeing of children at Oakhill will be improved in both the immediate and longer term.

[1] 'Joint inspection framework: secure training centres', Ofsted, Care Quality Commission, His Majesty's Inspectorate of Prisons, April 2025; https://www.gov.uk/government/publications/inspecting-secure-training-centres-framework/joint-inspection-framework-secure-training-centres.

Recent full inspections of Oakhill

October 2021	Inadequate – Urgent Notification issued
May 2022	Requires improvement to be good
October 2023	Requires improvement to be good
October 2024	Inadequate

With regard to the criteria set out in the Urgent Notification Protocol, the findings of our most recent visits should be seen in the context that since 2017, Oakhill has not been judged higher than 'requires improvement to be good' for the 'overall experiences and progress of children' and judged 'inadequate' at its last full inspection in October 2024. Additionally, Oakhill looks after vulnerable children needing more support than can be provided by a young offender's institution. It continues to present weaknesses that were identified at previous inspections. Given the recent leadership and staff suspensions, we are unable to assess it as having the capacity to improve.

As required by the Protocol, we set out the key evidence for the decision to invoke the UN process.

Key findings of the full inspection 21-25 July 2025

- There are profoundly serious and systemic failures that mean children have been and remain at risk of harm. Safeguarding systems are in disarray with failures to report serious matters, including in a timely manner, to local authority children's services and the local authority designated officer. This means wider safeguarding mechanisms are not triggered. Some matters are significantly delayed. There have also been further delays in the Oakhill safeguarding team acting on serious concerns and making referrals to the relevant agencies.

- The centre Director and one of the two deputy directors were formally suspended from their duties on Sunday 20 July 2025. The other deputy director was recently dismissed from employment.

- An interim Director and new deputy director started work at the centre on Monday 14 July 2025. There has been very limited opportunity for the interim director to have any meaningful impact.

- Staff conduct is of significant concern. Aside from the leadership positions, from November 2024 and up until 13 July 2025, 23 staff members have been suspended, of which suspensions, 16 related to allegations about their conduct with children. Five of the 23 investigations remain ongoing, with 18 resulting in various managerial actions including dismissals. Since 14 July 2025, seven more staff members have been suspended relating to their conduct with children.

- Monitors from the Youth Custody Service have failed to identify and/or take sufficient action to help safeguard children and to ensure that children receive good quality care.

- A number of serious issues relating to allegations about staff conduct have not been shared with the centre's human resources department and therefore appropriate actions have not been taken as a result. This means that in some instances, staff have continued working with the children when it appeared inappropriate to do so given the gravity of allegations. Children are then left without appropriate safeguards.

- Some children have experienced unintentional pain during the use of physical restraint by staff. Centre staff use inverted wrist holds; an approved technique under the 'Minimising and Managing Physical Restraint' (MMPR) manual. Wrist flexion can by application alone cause pain to children, which inspectors observed, and children reported. A newer manual that would mean this technique is not used on children is available. Leaders and staff at the centre have not been provided with this training.

- Some children have been separated for lengthy extended periods. The rationale for continuing separation into many days is inappropriate, not always clearly documented, and is contrary to the STC Rules. Inspectors could not be assured that separation ended at the earliest and safest opportunity.

- There is a palpable change in culture across Oakhill since the last inspection. The culture in the centre is no longer child centred. A number of staff shared repeated concerns with inspectors. For example, some reported that confidential information is leaked across the centre. When this and other worries and concerns have been raised by staff with managers, some staff have been threatened with unauthorised punishments. Staff convey a culture of fear, mistrust and reprisal.

- Staff report that rotas do not reflect the true staffing levels. Some staff told inspectors they have been left at times working on units on their own, leaving them feeling unsafe.

- A new healthcare provider was commissioned to work at the centre at the end of April 2025. The new provider is working to address the range of concerns identified at the last full inspection. The scale and complexity of the service means there is insufficient leadership capacity to make the required improvements at pace.

- Children with known mental health concerns do not always receive timely care. For example, one child with multiple complex mental health diagnoses was not seen by a mental health professional for 12 days following admission to the centre. In another case, a referral was made to the mental health service with concerns the child had reported suicidal ideation. No mental health support was offered for eight days.

- Not all children are administered medicines safely. One child was administered two medicines that should not be given simultaneously as they are known to increase the risk of harmful side effects.

- Not enough is being done to protect children from known risks to their health. For example, one child was known to have a severe nut and shellfish allergy. Not all visitors were informed of the risks or told not to bring nuts into the centre. Children's physical health concerns are not always investigated promptly, leading to delays in any required treatment. For example, one child required a sample sending for laboratory analyses relating to very worrying health symptoms. The test had not been processed by centre health staff for over three months.

- Some children live in unsanitary conditions. The living units have deteriorated, and some children live in dilapidated and dirty conditions.

- All children, including those on remand, were inappropriately charged from their personal money to contribute towards charities under the umbrella of a victim fund. Although the interim director stopped this practice immediately when it was raised with him by inspectors, there is more to do in considering how monies taken from every child that has been subject to this at Oakhill can be identified and reconciled.

- Sensitive information such as children's offence details, or private information about staff, are frequently shared inappropriately by some staff members to children, which could place children and staff at risk.

- Despite multiple layers of governance, quality assurance mechanisms and management grip are weak across critical areas of practice.

Ofsted and partner inspectorates have shared these findings with officials at the Ministry of Justice and the Youth Custody Service, so that they can ensure that the necessary actions are taken promptly. We will publish the inspection report in due course and will review progress at our next inspection.

Yours sincerely

Sir Martyn Oliver
His Majesty's Chief Inspector