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**Ministry  
of Justice**

# **A Rapid Review of Safeguarding in Youth Custody**

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# Contents

<b>Executive Summary</b>	<b>3</b>
<b>Introduction</b>	<b>12</b>
How the review was conducted	15
The population of children in custody: key characteristics	17
The youth custody sites	18
What the data tells us about safeguarding concerns	19
<b>Part One: The environment and culture of secure care practice</b>	<b>20</b>
What children say about daily life in custody	20
The context for practice	22
What inspection already tells us about management of safeguarding concerns	26
The case review, key findings and areas for development	28
Record keeping, data quality and audit arrangements	31
The role of the national and local counter corruption teams in HMPPS YOIs	32
Roles and responsibilities for the management of allegations	35
The role of the Local Authority Designated Officer (LADO)	37
How restraint is reviewed	38
Thorough, fair and timely investigations	43
Safer recruitment, vetting and the Disclosure and Barring Service	45
National safeguarding governance across the YCS	48
A national practice framework for youth custody	50
<b>Part Two: Safeguarding checks and balances</b>	<b>58</b>
Complaints	58
Independent routine safeguarding enquiry	62
The role of the home local authority & social worker	64
A change in legal status is not a panacea	66
Family engagement as a key protective factor	67

<b>Conclusion</b>	<b>71</b>
<b>Annexes</b>	<b>73</b>
Annex A: Terms of Reference	73
Annex B: Stakeholder conversations	77
Annex C: Youth Custody Provision (England & Wales)	79
Annex D: Workstream lead biographies	81

## Executive Summary

In November 2025, the Prisons and Probation Ombudsman (PPO) published its report into abuse at Medomsley Detention Centre: a senior youth detention centre located in Durham, designed to hold offenders aged between 17 and 21. It was in operation from 1961 to 1987. In response, the Government made a public apology to the survivors of that abuse and announced a rapid review into the safeguarding arrangements in youth custody in England and Wales.

In the twelve months prior to this review, there were approximately 420 children under 18 in custody in England and Wales, many of whom are extremely vulnerable, with high level and complex needs. The majority have already experienced intense trauma, adversity and difficulty in their lives. They have, most often, been accused or convicted of the most serious offences, causing significant harm and pain to others. We must hold these two realities together at the same time.

During the review, I have been constantly reminded, and on occasion shocked, by the reality of children's lives in custody. The difference in the quality of care, and the resource available to provide that care, across the different types of secure setting is stark. Even where the care provided is demonstrably high, a child's deprivation of liberty will have profound and lifelong consequences. This experience and the stories children shared will likely stay with me forever.

This review examined whether decision making, primarily in relation to allegations against staff concerning harm to a child, and the systems and governance arrangements in place to support this, are sufficient to help ensure that children are protected. I make a series of recommendations on the management of allegations, the quality of investigations, safeguarding roles and responsibilities, the checks and balances in place, the culture of practice, safer recruitment and vetting arrangements, and the professional development of, and support to, staff. I have also made recommendations concerning the legal status of children in custody, the complaints process and the introduction of independent routine safeguarding enquiry. Finally, I recommend that the Youth Custody Service (YCS) provides a new service dedicated to reconnecting and rebuilding family relationships so that every child leaves custody with enduring relationships in place to help secure a positive future.

In a context in which there are high levels of violence and some of the highest levels of need, it is of no surprise that allegations and counter-allegations form a major part of daily discourse. Staff in all youth custody settings are working with children who have experienced, and are experiencing, intense chaos and trauma; this fundamental

psychological context plays out in the day-to-day running of secure settings. Children become what one expert described as “threat detectors”. The greater the threat, the more children’s capacity to think clearly reduces. This then creates problems with decision-making, communication becomes blunt, there is a confused sense of fairness and justice, less hope, and a reduced ability to regain perspective and form positive relationships. Staff fear for their own safety too, and this constant threat faced by children and staff alike creates an ever-present high-vigilance, high-arousal state.

Most people working in youth custody are hard-working, caring, resilient and genuinely child-centred in their approach. I met many such people. We must ensure that the safeguarding system is designed, and operates in practice, in a way that supports identification and resolution of safeguarding concerns, and that opportunities to learn and improve are embedded in the culture of practice.

Allegations must be thoroughly and fairly investigated by those with the right expertise, and staff who are found to be unsuitable to work with children must be prevented from doing so again. Those who commit crimes against children should be prosecuted. This all requires a forensic diligence in the investigative process so that evidence to facilitate outcomes which safeguard children is secured.

I concluded that, in general, most safeguarding responses to allegations against staff concerning harm to a child are robust, with some impressive examples of best practice. This overall position is confirmed by the relevant inspectorates through their frequent scrutiny of the management of allegations. However, I also found significant investigative weaknesses, including examples of premature and/or inadvertent disclosure of concerns to alleged perpetrators, and failure to interview alleged victims and perpetrators. This hampers, or prevents, disciplinary action, criminal investigations and charges and, most importantly, the ability to protect children from harm.

There is a significant gap in statutory child protection expertise at critical decision-making points in some youth custody sites and in the National Counter Corruption Unit. This lack of expertise can also lead to an overreliance on external professional judgements. In a system where the scale of allegations is so high, internal child protection capability is essential. I also found that not all abuse of trust allegations are investigated in partnership with the National Counter Corruption Unit in line with their remit. Introduction of greater levels of independence (from the institution) in investigations for the most serious allegations, should be considered.

The YCS central oversight, data quality, and governance arrangements are insufficient for a service of this complexity and risk profile. Pattern recognition and audit activity is weak. Data quality needs radical improvement and proposed new governance arrangements need to be put into place without delay.

Safer recruitment and vetting in line with His Majesty's Prison and Probation Service (HMPPS) policy is generally robust. However, approximately 10% of public sector Young Offender Institution (YOI) staff have out of date Disclosure and Barring Service (DBS) checks as of February 2026,<sup>1</sup> representing a significant governance risk. Whilst new systems are being developed for safer recruitment, this is very early work and is not yet completed.

The [Independent Restraint Review Panel](#) (IRRP) for YOIs and the Secure Training Centre (STC), is a well-embedded mechanism for ongoing and systemic learning, which has led to increased confidence amongst staff that allegations involving restraint are independently reviewed as well as generating new ways of improving practice. It is now part of the culture of those sites, and we found it to be a considerable asset. It is a robust, thoughtful and insightful review process and the level of seniority and expertise involved gives great confidence to the process.

Independent scrutiny of restraint is inconsistent across Secure Children's Homes and the Secure School. Where the Local Authority Designated Officer (LADO) in host local authorities reviews restraints, it is unclear if they have the necessary expertise to do so. Witnesses to restraint under investigation report that judgements made by the LADO are not always underpinned by the necessary expertise.

The YCS across England and Wales does not have a unifying framework for practice underpinned by best evidence. Whilst the Youth Justice Board's [Child First](#) framework for the wider youth justice system is well known and often referred to by people we spoke to, the YCS suffers from the absence of a similar coherent conceptual roadmap from which everything else flows – the core purpose of youth custody, key principles of practice, core outcomes to be achieved for children in custody, key enablers necessary to achieve those outcomes including specific knowledge and skills, the evidence underpinning preferred practice methodology, and clarity about the expectations of practitioners and leaders. A new YCS National Practice Framework should form the core of all performance and contract monitoring, the basis for induction and professional development, and the design of support to staff.

The very significant numbers of highly skilled and experienced staff working on the front line in the YCS should be seen first and foremost as an asset. Conversations with youth justice workers, and staff in the Secure Training Centre and children's homes, quickly framed the realities of practice. Their voices are often hidden and the potential for their constructive contribution to service development and quality assurance is too easily lost amongst the pressures of the job. There is insufficient focus on the impact of institutional

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<sup>1</sup> 18% of staff in prisons where there are mother and baby units were also found to have out of date DBS checks. We have met with the relevant policy team and they are taking proactive steps to address this, but progress should be tracked.

culture on the psychology and practice of staff in the YOIs, and insufficient prioritisation of their training and ongoing development. Given the complexity and vulnerability of children in custody, and the specialist nature of the knowledge and skills required, there is a compelling case for professional registration of YCS staff by an independent body.

From youth justice workers and residential staff to custody managers, through to Registered Managers and Governors, there needs to be much clearer pathways for the development of explicit domain expertise. The HMPPS leadership pipeline into YOIs and YCS headquarters almost always comes from the adult prison estate. Progression routes through senior management grades mean Governors and Executive Directors move back into the adult estate relatively quickly, taking with them the specialist expertise they have developed. Youth custody needs to be seen first and foremost as an integral part of **children's** public services, driven by the shared values-based leadership of both public safety and child welfare.

I recommend new arrangements for raising complaints on behalf of children and the introduction of independent routine safeguarding enquiry. Many children in custody have families who love and care for them, making frequent contact and watching out, so far as they can, for their safety and general welfare. But some children do not have those same strong family bonds, and a few have no family or other community contact at all. There were reports of frequent and positive contact between children and their social workers, but some children and staff report that the home local authority can seem uninvolved, and at worst uninterested, in the welfare of children in custody. There is insufficient national oversight of local authority compliance with statutory duties towards children in custody; this makes it currently very difficult to understand the scale of the reported problem or ways in which it might be addressed.

I concluded that all children in custody should become "looked after" by the child's home local authority. The current arrangements in which only children on remand, and those who were on a care order prior to custody are considered "looked after", is difficult to justify and, in any event, does not maximise the safeguarding opportunity provided through the relationship between the child and their home authority.

It is fitting that we both start and end this review with findings from the Medomsley Review, and the experience of those survivors, firmly held in mind. I would like to put on record my deepest respect and thanks to the survivors of Medomsley who have relentlessly sought truth and justice. They have brought the vulnerability of today's children in custody into sharp relief, and this review would not have happened without their continued commitment to sharing some of the most hideous abuse I have come across during my career over the last 30 years.

The themes and recommendations from this latest review will be familiar to many. It is now incumbent upon the Government and, in turn, HMPPS and local authority children's services to **make change happen**.

I am confident that if the recommendations set out in this report, are fully implemented with the necessary rigour, resource and pace, children in custody will be better protected.

The recommendations are as follow:

1. HMPPS should ensure that all counter corruption allegations involving children are notified to the LADO in line with the statutory guidance Working Together to Safeguard Children.
2. HMPPS should ensure that statutory child protection advanced expertise and advice is integral to counter corruption decision-making and planning of their investigations involving harm to a child.
3. HMPPS should make it a requirement that Governors of the YOIs and the STC should ensure that their counter corruption teams are always included in safeguarding meetings where there is suspected abuse of trust, or other corruption, to assist in planning investigations from their earliest point.
4. The Ministry of Justice should ensure that there is independent inspection of HMPPS counter corruption practice similar to that undertaken by His Majesty's Inspectorate of Constabulary and Fire and Rescue Services.
5. HMPPS should ensure that all YCS sites have ready access to social workers with extensive statutory child protection investigation expertise, routinely involved in triage discussions and decisions with the Head of Safeguarding or Registered Manager, so there is optimum planning for any subsequent investigation. HMPPS contracts for commissioned custody placements should make this a key condition.
6. HMPPS Heads of Safeguarding should have a social work qualification and solid expertise in statutory child protection investigations. Where that is not the case, they should receive an extensive professional development programme on appointment, focused on child protection practice and, specifically, investigations.
7. All Heads of Safeguarding should receive frequent external professional supervision from the host Multi Agency Child Protection Team. This should be resourced by the relevant YCS site.
8. The Department for Education (DfE) should review Working Together to Safeguard Children to ensure that statutory guidance regarding the role and responsibilities of the LADO is clarified for the next edition due in 2027.

9. Host local authorities and the YCS National Team should introduce case review arrangements, so that referrals and consequent decision-making between YCS sites and the LADOs across England and Wales is moderated, with learning and best practice shared.
10. HMPPS should ensure there are robust arrangements in place for independent and expert scrutiny of restraint, based on their own guidance on [‘Use of Force, Restraint and Restrictive Practices in the Children and Young People’s Secure Estate’](#), across all commissioned custody placements and that an overview of system health in relation to restraint is reported to the new YCS Safeguarding Governance Board by the YCS Central Unit Head of Safeguarding every 6 months.
11. The Department for Education should update Working Together to Safeguard Children in the next edition due in 2027 to clarify expectations for host Local Safeguarding Children’s Partnerships (LSCP) in overseeing the independent review of restraint in youth custody and associated reporting responsibilities. Detailed guidance, including on the knowledge and skills required for those undertaking such reviews, should be developed by the relevant departments.
12. In taking forward the recommendation from Dame Lynne Owen’s report to consider establishing an equivalent body to the Independent Office for Police Conduct in the prisons sector, and the suitability of the Prisons and Probation Ombudsman to undertake this role, HMPPS should specifically set out the applicability and functions of any such body to the youth estate.  
  
HMPPS should reconfigure the management of allegations against HMPPS youth custody staff, ensuring that the principle of independence from the relevant YCS site is applied to all investigations regarding allegations against staff concerning harm to a child which, if proven, could result in dismissal (and, in some cases, referral to the Disclosure and Barring Service). HMPPS contracts for commissioned custody placements should include this expectation.
13. HMPPS should ensure that all outstanding enhanced DBS checks across the YCS workforce are completed without further delay. YCS commissioning arrangements should include a standard expectation that enhanced DBS checks are undertaken every 3 years across all YCS sites.  
  
HMPPS Human Resources should report to the YCS Safeguarding Governance Board, and in turn to the Ministerial Youth Custody Performance Board, at the earliest opportunity and no later than September 2026, to confirm all sites are operating in line with the policy.

HMPPS should ensure that arrangements are in place to audit compliance with HMPPS policy on DBS checks, across all YCS sites, including SCHs, the STC and the Secure School.

14. HMPPS should ensure that that all disciplinary matters are satisfactorily concluded even when the person under investigation resigns during the process, and ensure that where the threshold is met, referrals are made to DBS with sufficient evidence to secure inclusion on the barring list.
15. The Home Office should work with the Disclosure and Barring Service to consider together the introduction of outcome notifications and appeal rights for employers, as well as the provision of external scrutiny of DBS decision-making, from which all partners can learn and develop their understanding of safeguarding practice and suitability to work with children.
16. HMPPS should review the YCS National Unit to identify its key functions and to ensure it has sufficient resources and the skill necessary to deliver at pace and to quality. This includes day-to-day operations and additional resource to successfully implement any major new change programmes.
17. A comprehensive central record of all allegations against staff concerning harm to a child should be maintained by the YCS National Unit so that patterns of concern can be readily recognised and acted upon.
18. A regular audit of allegations against staff concerning harm to a child, including those resulting in no further action and those referred out to host authorities, should be conducted by the YCS National Unit across all youth custody sites to provide a check and balance on decision-making. This should be done in partnership with the host local authority.
19. The YCS National Unit should establish a formal process for learning from serious incidents and high-profile events with effective mechanisms for learning embedded across all YCS sites.
20. The proposed new YCS Safeguarding Governance Board should be established with sufficient resource as soon as possible to oversee the development of new systems for data collection, analysis, and audit activity to ensure safeguarding arrangements are working well. It should report to the Ministerial Youth Custody Performance Board at least quarterly.
21. The Ministerial Youth Custody Performance Board, in addition to its existing brief, should routinely seek assurance from the YCS Safeguarding Governance Board about the quality of decision-making regarding allegations against staff concerning harm to a child, safer recruitment & vetting, DBS referrals and renewals, and local authority and

YOT compliance with statutory duties, to ensure strategic oversight of safeguarding the welfare of children in custody.

22. HMPPS should introduce a single National Practice Framework for Youth Custody which clearly sets out the core purpose of youth custody, key principles of practice, core outcomes to be achieved for children in custody, key enablers necessary to achieve those outcomes including specific knowledge and skills for all grades, the evidence underpinning preferred practice methodology, and clarity about the expectations of practitioners and leaders.

HMPPS should ensure that this National Framework forms the core of all performance and contract monitoring, the basis for induction and professional development, and the design of support to staff.

23. HMPPS should develop a knowledge and skills framework underpinned by evidence-based methodology, and an aligned curriculum and assessment methodology which includes a comprehensive focus on knowledge of child development, enduring relationships with family and community, the impact of trauma on behaviour, skills for building trusted relationships, positive behaviour management, restraint as last resort and effective resettlement.

24. HMPPS should introduce a second stage recruitment and redeployment process to ensure suitability and aptitude for working with vulnerable children in youth custody.

25. HMPPS should introduce a supported management and leadership pathway for those without a prisons background to form an expanded pool of talent for future YOI Governor and other management roles.

26. HMPPS should work with YOI Governors to identify policies that do not sufficiently address key differences when working with children and ensure these are amended in line with children's best interests. Priority attention should be given to those covering performance management and disciplinary action.

27. HMPPS should work towards introducing professional registration for YCS staff by an independent body in line with the IICSA recommendation.

28. HMPPS complaints framework should be amended to allow trusted adults to raise formal complaints on behalf of children, with their full involvement at every stage. Commissioned custody placements should be contracted on the basis that similar arrangements are in place.

29. HMPPS should ensure that induction materials and processes across all YCS settings should be reviewed and redesigned to be accessible to children with low literacy levels, neurodiverse needs, and communication differences. Information about rights,

complaints, and safeguarding should be reinforced through regular touchpoints throughout a child's placement.

30. To maximise opportunities for safeguarding in custody, the facilitation and strengthening of family relationships and resettlement plans, all children in youth custody should be considered “looked after” by the home local authority.
31. Independent routine safeguarding enquiry should be introduced as a structured, routine, sensitive, private enquiry undertaken by the home local authority social worker as a distinct part of their duties towards children looked after by virtue of their custodial sentence.
32. HMPPS should establish systems to track when children are visited, by whom and whether this is in line with statutory expectations of the home local authority. Reasons for visits not taking place should also be recorded.  
  
HMPPS should establish the key barriers to scheduled visits going ahead as planned and resolve systemic causes in particular sites and across the secure estate.
33. The Ministry of Justice should introduce a new statutory notification system where local authorities and Youth Justice Services are not meeting their statutory duties to visit children. These notifications should be sent to the local authority and the Youth Justice Service for urgent action, and to HMIP and Ofsted for consideration in their respective inspections.
34. HMPPS should fund a dedicated service to help rebuild and repair fractured family relationships for all children in custody where this is not already being undertaken by the home local authority as an excellent and leading example of corporate parenting responsibilities as defined in the new Children and Wellbeing Act 2026.

This work would not have been possible without the hard work of a number of people. Thank you to colleagues in the Youth Custody Service for working with me so openly and collaboratively. Thank you to colleagues who joined the expert panel, in particular Esther Beresford, Nana Bonsu and Dr Jahnine Davis who each led a workstream.

Thank you too to the civil servants who worked on this review with me, in particular Albert Gordon and Lucie Melvin in the Ministry of Justice, and Lowri Ellcock in the Department for Education.

## Introduction

In November 2025, the Prisons and Probation Ombudsman (PPO) published its [report into abuse at Medomsley Detention Centre](#): a senior youth detention centre located in Durham, designed to hold offenders aged between 17 and 21. It was in operation from 1961 to 1987. Commissioned in October 2023 by the then Lord Chancellor and Secretary of State for Justice, Alex Chalk, the PPO was asked to conduct an independent investigation into what the authorities knew about the abuse which took place at Medomsley, whether there were opportunities for them to have intervened at the time, and what action, if any, they took.

The subsequent report contains descriptions of the sexual and psychological abuse that took place and highlights the culture of systemic physical abuse that became embedded as the dominant practice of “short, sharp, shock”. Those with additional vulnerabilities were often deliberately targeted, including those from ethnic minority backgrounds, who were also subjected to appalling racism. Disclosures of abuse were made to staff, but these disclosures were not believed. Some young men were hospitalised because of the abuse, and there were at least two tragic deaths, which were likely caused by neglect from the staff who should have been caring for them.

Evidence suggests that many staff knew or suspected that certain members of staff were perpetrators of abuse but took no action to stop it. Together, societal attitudes, a lack of clear direction for the centre, poor and ineffective governance and oversight, failures in leadership and unchecked, inappropriate power imbalances all contributed to Medomsley operating effectively beyond the reach of the law for 26 years.

Jake Richards, Parliamentary Under-Secretary of State in the Ministry of Justice set out in his [statement on Medomsley](#) in November 2025:

“The youth custodial estate today bears little resemblance to the one in which the abuse at Medomsley took place. The number of children in custody has significantly reduced and children are no longer detained for less serious offences. The Government’s approach is that depriving a child of their liberty must always be a last resort and where that is unavoidable, we must provide decent and dignified care, with rehabilitation at its core”.

However, the system is very far from perfect. There can be no doubt that much of the quality of care of children in Young Offender Institutions is of considerable concern. The differences in quality of care across different types of youth custody provision are, frankly, deeply unjust and, in some instances, tragic. In YOIs, children can be locked in their rooms

for over 20 hours a day, receiving minimal education. These circumstances can only exacerbate an already tense, volatile and often violent environment. Governors are stuck with buildings that require the most astonishing set of daily logistics to manage children's safety. Governors in publicly-run YOIs have no control over the staff who come to work for them and must also often run services with much reduced capacity. Many staff do not have previous experience of working with children. Concerns about the quality of care, however, are not the sole preserve of YOIs. There are, and have been, significant concerns about the quality of care and protection in some of the local authority-run Secure Children's Homes (SCHs), the Secure Training Centre (STC) and the Secure School. The disparity in funding between YOIs and SCHs is stark, alongside what that money buys. These concerns are very well documented through inspection. There is undoubtedly a pressing need for systemic change.

The disproportionate representation of children from Black, Asian and ethnic minority communities throughout the criminal justice system continues to be the focus of considerable attention and deep consternation. The [Lammy Review](#) identified that the proportion of children in custody from ethnic minorities rose from 25 to 41% between 2006 and 2016<sup>2</sup>, and the most recent [youth custody data](#) shows that at least 53% of the children in custody are from Black, Asian, mixed ethnicity or other ethnicity groups. It is also of note that 79% of Black children in custody were placed in a YOI, compared to 62% of white children.

It is striking just how many and how frequently reviews are commissioned that relate to children in custody. In the 2016 [Review of the Youth Justice System in England and Wales](#), many staff working within the YOIs and STC were found not to have the skills and experience to manage the most vulnerable and challenging children in their care. In 2019, the [Independent Inquiry into Child Sexual Abuse](#) reported that children in custody are extremely vulnerable to abuse, particularly as they include a high proportion of 'highly complex, high-needs children' and recommended that YOIs and STCs must change their culture to become more child-centred. That same year, a [YCS Safeguarding Review](#) recommended that the YCS develop a needs-led, child-focused framework, distinct from wider HMPPS practice. It also recommended that senior social workers should be responsible for the oversight of safeguarding and child protection functions. In 2020, [a review into the use of pain-inducing techniques in the youth secure estate](#) concluded that 'there is a substantial gap between the high-end needs of many of the children in YOIs and the STC and the ability of staff and leaders in the secure estate to meet them'. In 2023 HM Inspectorate of Prisons (HMI Prisons) undertook [a joint thematic inspection of work with children subject to remand in youth detention](#) together with HM Inspectorate of Probation and Ofsted. The inspection found that there were weaknesses in care planning, that children in custody did not always receive their specific entitlements and that families

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<sup>2</sup> [Lammy publishes historic review - GOV.UK](#)

did not get help with travel costs. In 2023 the Children's Commissioner's [review into family contact in youth custody](#) found that almost half of all children in custody (44%) did not receive an in-person visit in a two-month period. In 2025 the review, [Delivering the Best for Girls in Custody](#), recommended that stronger strategic oversight of the youth custody system was needed.

The key messages and recommendations from this latest review in 2026 will be familiar to many. It is incumbent upon the Government and, in turn, HMPPS in partnership with local authority children's services, to **make change happen**. Too much time and public money is spent repeating the same messages of systemic failure. Without adequate investment and support for radical reform and its implementation, even the best ideas will flounder and fail.

I welcome the Government's proposals to move away from large custodial institutions towards smaller, more rehabilitative settings, with the quality of care provided by the best secure children's homes. As the recently published White Paper '[Cutting Youth Crime, Changing Young Lives](#)' acknowledges however, this is likely to take years and, in any event, consideration must be given to the benefits of having diversity of placement choice. Not every child will excel in a secure children's home, particularly if they have been there for years. Action must be taken now to protect, care for, and rehabilitate children to the best of the state's ability. Many people I have spoken to believe that this is possible.

The innovators, the reformers, and the stalwart core of custody must be given a fighting chance to achieve ambitious change for children in custody.

Staff working in the youth custody sector have, without a doubt, one of the most difficult jobs in the public sector. In fact, it is hard to identify a job more difficult. The emotional labour of the task is second to none. It is inevitable that reviews of this nature focus on things that need to change and this can obscure the day-to-day resourcefulness, resilience and deep expertise that is present across all YCS sites. Whilst there are very serious systemic weaknesses well documented and commonly acknowledged, there are outstanding people in post, at all levels of seniority, as well as examples of excellent practice, some of which we highlight in this review. Ensuring that this expertise is shared and built on across the YCS must be a priority.

Despite these strengths, allegations against staff concerning harm to children are made most days of the week. Many of these are not substantiated but a significant minority of staff are found to have harmed children, including harm from sexual abuse. Far from it being something from the past, perpetrators of abuse live amongst us – on our streets and other public spaces, inside our homes, within and across institutions that have access to children, including nurseries, schools, residential homes, hospitals and, indeed, youth custody. It happens; and the people that abuse are often masters in the art of manipulation and deceit.

This review examined whether decision-making, primarily in relation to allegations against staff concerning harm to a child, and the systems and governance arrangements in place to support this, are sufficient to help ensure that children are protected. I make a series of recommendations on the management of allegations, the quality of investigations, safeguarding roles and responsibilities, the checks and balances in place, the culture of practice, safer recruitment and vetting arrangements, and the professional development of, and support to, staff. I have also made recommendations concerning the legal status of children in custody, the complaints process and the introduction of independent routine safeguarding enquiry. Finally, I recommend a new YCS service dedicated to reconnecting and rebuilding family relationships so that every child leaves custody with enduring relationships in place to help secure a positive future.

Safeguarding means many different things to many different people. This review was rapid by design, with a core focus on allegations against staff concerning harm to children. I appreciate that there will be other safeguarding issues which are not referenced in this review or reviewed to the depth others may have liked. For example, whilst the review makes some comments about restraint, this is restricted to the safeguarding arrangements to review those incidents and does not comment on the appropriateness of restraint more generally or indeed the ethical concerns about pain-inducing techniques. Similarly, resettlement of children back into the community, when done well, can safeguard the welfare of children; whilst I reference the resettlement teams in this review, I do not provide an in-depth review of the quality of resettlement practice.

The full terms of reference for this review can be found in Annex A.

## **How the review was conducted**

To support this review and ensure that I had access to the relevant expertise and experience, I quickly brought together key stakeholders to form a safeguarding panel which had strong representation from across the youth custody sector. This included representatives from all types of secure setting including Young Offender Institutions, Secure Children's Homes, the Secure School and the Secure Training Centre, as well as officials from the inspectorates, local government, the Office of the Children's Commissioner, and safeguarding, advocacy and youth justice experts.

Senior leaders from the YCS were also part of the panel, as well as policy officials from the Ministry of Justice and the Department for Education. The panel was managed by my Office of the Chief Social Worker for Children and Families. Full details on the membership of the panel are available in Annex A. There was a wide range of voices and expertise on the panel, some with competing interests and difference in opinion; thus, the views in this report may not reflect the views of individual panel members.

Outside of the panel, I worked in partnership with senior leaders from the YCS for much of this review. Working closely with them in an open and collaborative way has allowed the YCS to address some areas for immediate improvement as the review has progressed. I have been pleased to see their openness to change and their commitment to improvement.

It was important to consult with colleagues in Wales, given the joint working arrangements for youth custody across England and Wales. There are two youth custody sites in Wales: Hillside Secure Children's Home and HM YOI Parc, both of which were represented on the panel. I have ensured that leaders from Welsh local councils were consulted. I met with Care Inspectorate Wales and Social Care Wales as part of the review too, and I am grateful for their insights and support. Colleagues in Welsh Government have also been consulted as part of the process.

A small review team was created from the membership of the panel to lead specific workstreams, as well as help facilitate conversations with a wide range of stakeholders and attend site visits. As well as the valued contributions from the wider panel, the review team was an integral sounding board for me throughout the review, offering different perspectives and insights. They have been fundamental in helping me shape my final conclusions and recommendations and I am hugely grateful for their time, expertise and diligence. We visited all four of the YOIs (Feltham in December 2025, Wetherby in February 2026, and Parc and Werrington in March 2026), as well as two of the SCHs (Hillside in March 2026 and Vinney Green in April 2026) and the Secure Training Centre (in April 2026). Our visit to Feltham coincided with the Independent Restraint Review Panel so we were able to observe that Panel in action and join the focus groups with children too. On each visit, we spoke to various groups of staff and senior leaders and were able to establish a good sense of place for each of the sites. We saw where children slept, ate, learnt, exercised and socialised, as well as speaking to them directly about their daily lives. The visits also allowed us to understand more about the various reward and recognition systems in place, among the various schemes and activities offered.

We have met with Governors, Deputy Governors, Registered Managers, Heads of Safeguarding, on-site social workers, resettlement leads and practitioners, educators and staff on the wings. At one YOI we held a focus session with youth justice workers. We also held a round table with officers and custody managers who had completed their training through the graduate scheme [Unlocked](#). In addition to the visits and the panel, I spoke to a wide range of professionals and stakeholders. I am grateful to these colleagues for sharing their views and expertise. We also met the Chaplaincy Service, Local Authority Designated Officers (LADOs), social workers and volunteers from the [Independent Monitoring Board](#). Further conversations were held with officials from the inspectorates of YCS sites in England and Wales as well as unions representing staff at all levels.

We worked closely with colleagues in His Majesty's Prison and Probation Service, including those working in counter corruption work. Staff from the Prison and Probation Ombudsman also contributed to the review and were able to provide insights and expertise from their work, and specifically from the Medomsley Review.

A full list of stakeholder conversations is included in Annex B.

Whilst the recommendations of this review will apply to all children across the YCS, the review has almost exclusively focused on safeguarding activity involving boys. Girls are no longer placed in YOIs and make up less than 3% of the youth custody population overall. [The 2025 Hancock Review](#), 'Delivering the best for girls in custody' makes a set of important recommendations addressing the specific welfare and protection concerns for girls which are in the process of being implemented.

## The population of children in custody: key characteristics

As at the year ending March 2025, the average daily custodial population of children aged 10–17 in England and Wales stood at around 420 – the lowest level on record, down 3% from the previous year and 60% lower than ten years ago.<sup>3</sup> Of these, 63% were held in Young Offender Institutions, 22% in Secure Children's Homes and the Secure School, and 15% in Secure Training Centres. 44% were on remand at any given time. Given the very high number of children living in YOIs or the STC, much of the commentary and many of the recommendations focus on those settings.

The YCS population is overwhelmingly male (around 96–97%) and predominantly aged 15–17.<sup>4</sup> The median length of custodial remand is relatively short (around 40–50 days), while sentenced children typically receive custodial terms of approximately 12–18 months. The most common offences among those sentenced are violence against the person, robbery, and weapon-related offences. While the majority of children are held less than fifty miles away from home, a significant proportion of children are not, and can be placed far from their family, home and community.

As of 2024–25, 65% of children surveyed by HMI Prisons had been in local authority care.<sup>5</sup> Almost 90% came from the most deprived neighbourhoods and two in five had special educational needs,<sup>6</sup> which is likely to be an underestimate due to assessment gaps. Many had experienced prolonged periods out of education prior to custody and a

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<sup>3</sup> [Youth Justice Statistics: 2024 to 2025 - GOV.UK](#)

<sup>4</sup> [Youth Custody Population Report - Mar - 26.ods](#)

<sup>5</sup> [Children in custody 2024-25. An analysis of 12-18-year-olds' perceptions of their experiences in secure training centres and young offender institutions. September 2025](#)

<sup>6</sup> [The educational journeys of children in secure settings](#)

quarter of children in secure settings had experienced a permanent school exclusion.<sup>7</sup> Black children made up approximately 22% of those in custody, while mixed ethnicity children accounted for approximately 18%.<sup>8</sup> Reoffending rates for children leaving custody were around 66%.<sup>9</sup>

It is well established that children in custody are a highly vulnerable and marginalised group, with significantly higher rates of mental and physical health problems, substance use and neurodiversity, alongside elevated levels of unmet need, compared to their peers in the general population.<sup>10</sup> They are also far more likely to have experienced the care system and social disadvantage.<sup>11</sup> The proportion of children in custody with complex needs has risen over the last 10 years, in line with the overall decrease in the use of custody more generally.<sup>12</sup> These statistics depict children in custody as one of the most vulnerable groups in society.

## The youth custody sites

In England and Wales, children from the age of 10 years old can receive a custodial sentence. They may be placed in one of four secure setting types: Young Offender Institutions (YOIs), the Secure Training Centre (STC), Secure Children's Homes (SCHs), and the Secure 16–19 Academy (referred to as 'the Secure School'). The settings vary in size and operator. YOIs accommodate boys aged 15 to 17 years old and are the largest setting within the secure estate, housing the most children. There are four YOIs across England and Wales; three are run by His Majesty's Prison and Probation Service (HMPPS) and one is privately managed. YOIs have the lowest staff-to-child ratio within the secure estate; therefore, children who are deemed as more vulnerable are typically placed into SCHs or the STC. The STC is privately managed, accommodating boys and girls between ages 12 to 17. SCHs are the smallest setting type, with the largest typically having 34 beds available. They accommodate both boys and girls from the age of 10 and are run by local authorities. The YCS contracts beds in 7 SCHs, 6 of which also house children for welfare reasons. Only one of the SCHs is exclusively for children in custody. In 2025, the first Secure School opened, privately operated and dual classified as an SCH and 16–19 academy, but not run by the local authority and larger than a typical SCH. The Secure School was not in operation at the time of this review.

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<sup>7</sup> [The educational journeys of children in secure settings](#)

<sup>8</sup> [Youth Justice Statistics: 2024 to 2025 - GOV.UK](#)

<sup>9</sup> [Youth Justice Board 2023-2024 Insight Report: Trends and Recommendations](#)

<sup>10</sup> [An Updated Systematic Review and Meta-regression Analysis: Mental Disorders Among Adolescents in Juvenile Detention and Correctional Facilities - PMC](#) and [Mental health needs of young offenders in custody and in the community - Abstract - Europe PMC](#)

<sup>11</sup> [secure-settings-for-young-people-a-national-scoping-exercise-paper-2-census-report.pdf](#)

<sup>12</sup> [Youth Justice Statistics: 2023 to 2024 - GOV.UK](#)

Further details on the types of settings can be found in Annex C.

## What the data tells us about safeguarding concerns

Substantial numbers of safeguarding concerns are raised each year from across all types of secure sites. In 2025, there were 2,718 safeguarding referrals logged centrally by the YCS, spanning a wide range of issues, including harm experienced both within custody and in the community, pre- and post-custody. The most common categories of harm were physical abuse (20%, over half of which related to restraint), inappropriate professional conduct (18%), and risk by association<sup>13</sup> (16%).

Of the cases progressing beyond the initial triage, 68% were referred to local authorities, equivalent to around 20% of all referrals. 11% of these were subsequently substantiated. However, these figures must be treated with caution. Data quality issues persist, including incomplete information on outcomes (with 12% of local authority decisions unknown), and limitations in how safeguarding concerns have historically been categorised and recorded. Indeed, inspection and briefing data from individual YOIs suggest that the true scale of safeguarding need may be considerably higher than central figures indicate. Through the course of this review improvements to YCS data recording were introduced. This includes clearer tracking of referrals and outcomes which is likely to enhance the reliability and transparency of future reporting and is a welcome improvement.

The Prisons and Probation Ombudsman (PPO) has recorded a marked increase in complaints from children, which doubled from 20 in 2023 to 42 in 2025. Whilst an increase in complaints does not necessarily indicate a deterioration in the quality of care and protection provided, the 'upheld' and 'partially upheld' rate for YCS complaints is 47%, which is significantly higher than the approximately 30% rate across comparable services within the PPO's remit. Complaints relating to staff behaviour also appear disproportionately high, accounting for around 20% of YCS complaints compared with approximately 8% across the wider custodial estate.<sup>14</sup>

There are persistently high levels of violence within YCS. From October – December 2025 there were 489 reported incidents of assault. The annualised rate of assault incidents per 100 children and children per year was 432.6 in the 3 months October to December 2025, which is an increase of 6% compared to the same period last year.<sup>15</sup>

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<sup>13</sup> "Risk by association" refers to safeguarding concerns arising from a child's relationships and social context, including exposure to harmful peer groups, family environments, or exploitative networks. It reflects the recognition that vulnerability among justice-involved children is often shaped by relational and contextual factors rather than solely by individual behaviour.

<sup>14</sup> [Prisons and Probation Ombudsman annual report: 2024 to 2025 - GOV.UK](#)

<sup>15</sup> [Safety in the Children and Young People Secure Estate: Update to December 2025 - GOV.UK](#)

# Part One: The environment and culture of secure care practice

## What children say about daily life in custody

The single most consistent theme across children's accounts of custodial life in YOIs is the amount of time spent locked in their cells. The [HMIP Children in Custody 2024/25 report](#) which drew on survey responses from 82% of children across the four YOIs and the STC, found that only 61% of children received more than two hours out of their cell on weekdays. At weekends, this fell to 45%. 39% of children at one site reported no engagement in any education, work or training.

The 2024 HMIP and Ofsted joint thematic review, [A Decade of Declining Quality of Education in Young Offender Institutions](#), drawing on 32 full inspection reports over ten years, found that children in some establishments were allowed as little as half an hour outside their cells per day. An October 2024 [HMIP progress review on separation](#) found that, four years after an initial thematic review identified children in effective solitary confinement, the problem persisted: 179 separation episodes lasting between 21 and 100 days were recorded, and 21 children were separated for over 100 days.

The [HMIP 2024/25 survey](#) found that 43% of children said they had felt unsafe at some point in custody, compared with 40% in 2023–24 and 31% in 2022–23. More than six in ten children (61%) reported experiencing some form of bullying, violence or victimisation from other children. Children who reported feeling unsafe described consistently worse outcomes across every dimension of daily life: greater cell isolation, less access to activities, and minimal human contact. HMIP characterised this as a “vicious cycle” in which violence and disorder led to more time locked up, which generated further frustration, which produced more violence. Parc YOI was the outlier – children there consistently reported more time out of their cells, stronger staff relationships, and better access to activities. 90% of children surveyed at Parc said they felt supported by staff, compared with substantially lower figures at other establishments.

Children value staff who are responsive, but frequent staff changes mean that even routine requests are handled inconsistently. This creates frustration and erodes the trust needed for children to raise concerns about bullying or violence. Across the estate in 2024–25, only 26% of children felt that rewards and incentives schemes were fair. Children's sense was that good behaviour was not meaningfully recognised and bad behaviour was inconsistently challenged.

Children consistently express a desire to learn. In interviews for the [Children's Commissioner's educational journeys report](#), children spoke of individual teachers who had made a difference and identified education as one domain where custody could offer a genuine opportunity. However, only 20% of children in secure settings who sat English or Mathematics GCSEs passed them, compared to 71% and 72% of their peers in mainstream schools. The Ofsted/HMIP joint review found that children in some establishments received as few as 7.79 hours of education per week – barely half the statutory minimum of 15 hours. When education was available, it was frequently curtailed due to staffing shortfalls.

The Children's Commissioner's November 2025 report, "[A Production Line of Pointlessness](#)": [Children on Custodial Remand](#), drew directly on children's accounts. The dominant theme was powerlessness and uncertainty. Children described not knowing when their court dates would be, how long they would remain detained, or what the outcome would be.

We also spoke to a small number of children during our visits, and we were very grateful for their time and willingness to speak to us. We were mindful of the relatively brief and restricted nature of our conversations with children and debated what we would glean from those interactions which weren't captured elsewhere. However, even the short stories and views they shared were of great value and gave us an important snapshot of their lives in custody.

In the YOIs, some children told us about the efforts families made to visit them only to arrive and be told that the visit was cancelled due to staff capacity. Others said they didn't want family to visit because they were worried they would witness violence and possibly be injured. The children in one YOI said they were given their tea at 4pm and then had to wait until 8am for breakfast. This is a very long stretch for growing adolescents. Some children were frustrated that the money they were entitled to from their home authority did not reach them so even snacks were not always available to them, to see them through the gaps between meals. The quality of the breakfast we saw in one YOI seemed barely adequate.

Social workers and advocates were praised and clearly trusted by some children. Others referred to the wide variance in the use of restraint by officers. Children complained of not being able to get their hair cut or braided and others were very frustrated by the lack of education provision or frequent cancellation of classes. Some children said there was no point about complaining about anything as nothing was ever done in response. We return to this theme later in the report.

Children we spoke to in the STCs and the SCHs gave very different accounts; obviously in part because of the huge differential in staff capacity, quality and access to facilities, education resource and time out of rooms. In one SCH, family could come and see their

child every day if they so wished. Children spoke of the extensive activities provided and long, structured days out of their rooms with generous reward systems for positive behaviour. Children appeared to have warm and trusting relationships with staff where the atmosphere in general was calm and constructive.

## **The context for practice**

In a context in which there are high levels of violence and some of the highest levels of need, it is of no surprise that allegations and counter-allegations form a major part of daily discourse. Staff in all youth custody settings are working with children who have experienced, and are experiencing, intense chaos and trauma: this fundamental psychological context plays out in the day-to-day running of secure settings.

Children become what one expert described as “threat detectors”. The greater the threat, the more children’s capacity to think straight reduces. This then creates problems with decision-making, communication becomes blunt, there is a confused sense of fairness and justice, less hope, and a reduced ability to regain perspective and form positive relationships. This drip, drip, drip threat effect is toxic. It creates a strong sense of dysregulation and if not understood as psychologically driven and organised by chronic stress, staff with limited resource – and sometimes embryonic knowledge and skill – use punishment as their main method of control. Staff fear for their own safety and this constant threat faced by children and staff alike creates an ever-present high-vigilance, high-arousal state (see the SECURE STAIRS case study below). This state in turn inhibits the ability of staff and children to build trust and a sense of psychological safety which leads to interactions that feel purely transactional, as a means of protection on both sides.

This toxic state is most likely to be experienced in the YOIs and STC. When coupled with high turnover and vacancy rates this can mean that trusted relationships between staff and children, particularly in the YOIs, are hard to establish and sustain. Much can be learned from the high-quality practice in SCHs where the culture of practice is generally, very different. A focus on responding to trauma through therapeutic interventions, a core focus on relational security and sector-led improvement all contributes to a calmer environment where children’s needs are much more likely to be met.

As part of this review, we saw evidence of phenomenal attempts to de-escalate crises, sometimes lasting hours. Debriefing following restraint is commonplace. There is, no doubt, very significant expertise held by experienced staff and a phenomenal level of resilience. Many of the staff we spoke to had worked in the secure sector for years, some for decades. Staff report that they are required to handle many types of challenging behaviour, including violence and aggression, stemming from complex needs. This includes assisting children with psychiatric disorders, addictions, and repeated self-harm.

Staff in some sites appear to be routinely managing children whose needs far exceeded their training.

The differences in quality of care between the YOIs, the STC and SCHs is frankly, deeply unjust and, for some, tragic. This is not just about the day-to-day care children receive, but about how their long-term prospects are being shaped by these experiences and opportunities. Nor is this to lay blame at the feet of YOI Governors and staff, whose efforts to try and turn things around in seemingly impossible circumstances should be recognised rather than constantly castigated.

The cost per year for a child in a YOI can be as low as £121,000, compared to up to £490,000 in an SCH. So of course, SCHs have a strong head start and are, therefore, highly likely to provide substantially better care by comparison – but it isn't just about the money. SCHs are small, well designed, often with a handful of children by comparison to the YOIs. In line with Children's Homes Regulations, SCHs are expected to consider very carefully whether they can meet the needs of any child they consider accepting, ensuring that the needs of other children will continue to be met. Occupancy rates are constantly adjusted according to the specific needs of individual children. For example, the latest statistical release shows the occupancy rate for SCHs was 64% – down from 72% last year.<sup>16</sup> The YOIs and the STC do not have any such choice.

The SCHs are brighter, calmer and more aesthetically pleasing places to work, so there is a much better chance of skilled staff being recruited and retained. The work is challenging and can be deeply rewarding. To invest more into this type of care is highly desirable but these are very difficult political choices. The costs for SCHs are eye watering.

In [Charlie Taylor's 2020 review](#), he described how he was constantly struck by the courage of individual officers and staff who put themselves at great risk in order to protect children or colleagues:

“Working in these establishments can be enormously fulfilling, but it can also be frightening and corrosively stressful. After a serious incident or a difficult day, there are limited formal opportunities for staff to reflect on what happened or the effect it has on individual officers. While I have seen leaders invite staff members to come forward if they have been affected, officers usually talked about an expectation that people ‘just have to cope’.”

Six years later, the situation has not changed substantially, for children or for staff. Whilst this is particularly stark in the YOIs, it is not exclusively so.

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<sup>16</sup> [Release home - Children accommodated in secure children's homes - Explore education statistics - GOV.UK](#)

As previously set out in the report, Black boys are more likely to be placed in YOIs than in other sites. Data provided by the YCS on the average monthly population from December 2024 to November 2025 showed that 79% of children from a black background resided in a YOI, compared to 62% of children from a white background. Whilst there may be a wide range of factors for this placement decision (age, individual welfare needs, previous custodial experience, risk of harm to self / others and distance from home / family), the difference is striking and further work should be undertaken to look at how placement decisions are made.

In May 2026, whilst this review was underway, the Ministry of Justice published '[Cutting Youth Crime. Changing Young Lives: The youth justice system reform and delivery plan](#)'. This White Paper sets out a vision for a move away from large custodial institutions towards smaller, more child-centred settings. This is a very welcome direction of travel and something which has long been called for by experts across the sector. There is value, however, in having different types of facility across the estate to meet the diverse needs of the children. There should be continued investment in, and ambition for, all existing settings for as long as they have children in their care. When we visited the Secure Training Centre we heard of their vision to become a specialist facility for girls; this is very welcome.

### **Good Practice – Hillside Secure Children's Home**

Hillside has been committed to fundamentally transforming the culture of the service over the last 5 years, moving away from traditional, risk-focused approaches and instead developing a nurturing, therapeutic culture where children feel safe, understood and supported to heal from trauma.

Recognising that meaningful cultural change requires investment in people, they prioritised workforce development through specialist training. To date, 40 staff members have achieved the Level 5 Diploma in Trauma Informed Schools and Communities, equipping them with the knowledge and skills to better understand the impact of trauma and respond therapeutically to children's needs. In addition, other staff have progressed to become Advanced Practitioners, enabling them to provide enhanced leadership, guidance and reflective support to teams.

Through consistent training, reflective discussions and leaders modelling practice, teams have developed greater compassion in their responses to children and have become more relational in their practice, recognising the importance of connection, emotional regulation and trust in supporting children. They have worked hard to create a psychologically safe environment where staff feel empowered to reflect, learn and respond therapeutically rather than reactively. This has enabled stronger relationships between staff and children and improved consistency across the homes.

The homes have seen a physical transformation too, creating warm, nurturing and aspirational environments. They strongly believe that a child's surroundings have a significant impact on their wellbeing, sense of belonging and emotional safety. The homes have moved away from feeling institutional and instead provide welcoming, homely spaces that promote comfort, dignity and pride.

Hillside has created a culture where both children and staff can thrive, delivering care that is compassionate, therapeutic and life changing.

### **Good Practice – HM YOI Parc Conflict Resolution**

Conflict Resolution is an evidence-based intervention designed to address harm between children, and between children and staff. Supported by one full-time and four part-time practitioners, the process begins with a "Juggler 1" session to explore the incident with each participant, focusing on their thoughts, feelings, and needs.

After identifying pro-social options and passing a safety assessment, all parties consent to a "Juggler 2" meeting to reach a peaceful conclusion. During this session, parties reach an agreement outlining how to maintain a positive relationship. This is followed by a "peaceful play" activity, such as pool or gaming, to rebuild the relationship in a safe environment. A follow-up check-in is conducted within two weeks to monitor the agreement.

Conflict Resolution is helping to transform the custodial environment by shifting the focus to pro-social engagement. It provides children with opportunities to learn non-violent conflict resolution skills, including listening, perspective-taking, empathy, and negotiation. This rebuilds trust and creates safer communities for both children and staff.

Since its introduction to the Young Person's Unit at Parc, over 300 referrals involving staff and residents have been made. In the last six months, Conflict Resolution has facilitated 29 cases (14 between children and 15 between children and staff), with 27 resulting in "positive peace" outcomes. This work has allowed both children and staff to feel safer and has increased opportunities for children to engage in education and enrichment, better preparing them for successful reintegration into society.

## What inspection already tells us about management of safeguarding concerns

YOIs are inspected by HM Inspectorate of Prisons through biennial inspections, with Independent Reviews of Progress conducted in the intervening years. These assessments are structured around four tests: safety, purposeful activity, resettlement and care, and education provision (assessed in partnership with Ofsted in England and Estyn in Wales). Outcomes across YOIs have been consistently poor, with most sites receiving the lowest ratings (levels 1 or 2 out of 4) for safety and purposeful activity. Parc YOI in Wales remains a notable exception as the highest performing site.

Secure Children's Homes in England are inspected by Ofsted and the Care Quality Commission (CQC) under the [Social Care Common Inspection Framework \(SCCIF\)](#) through a programme of regular, typically unannounced inspections, while the sole SCH in Wales is inspected by Care Inspectorate Wales under the [inspection framework for care home services, secure accommodation services, residential family centres, and domiciliary support services](#). These inspections assess children's safety, education and learning, health, resettlement outcomes, leadership and management, and overall experiences and progress.

Secure Training Centres are subject to joint inspection by Ofsted, HMIP and the Care Quality Commission, with Ofsted acting as the lead inspector. Inspections are unannounced and include both full inspections and monitoring or assurance visits.

As secure schools were legally established as both a Secure Children's Home and a Secure 16–19 Academy, Oasis Restore, England's first Secure School, currently operates under two separate inspection frameworks: the SCCIF and the Post 16 [Further Education and Skills \(FES\) inspection framework](#), which is inspected by Ofsted.

### What HMI Prisons say about the management of allegations

HMI Prisons considers in detail how the senior leadership team respond to child protection issues and how safeguarding processes support this. They look to see that there are close ties with the local authority and that independent oversight and safeguards are in place. As part of their inspections, they review a broad range of referrals and look to satisfy themselves that, where staff are the subject of a safeguarding concern, these concerns are dealt with rigorously and transparently. Prior to inspection they conduct a survey that asks specific questions of respondents about safety, inappropriate behaviour by staff and peers and about the quality of relationships between staff and children. Any concerns raised in the survey are reviewed by inspectors and if necessary, referred to the safeguarding lead; outcomes of these cases are also tracked.

A significant amount of information is requested and reviewed, including any meeting minutes that are relevant to safeguarding, any databases of referrals, contact with the local authority, case notes for children, and relevant policies, strategies, quality assurance activity and related action plans. They then check for timeliness of response, if the child and their family were contacted, and critically, what decision was made around the referral and the appropriateness of those decisions. They also cross reference with other parts of the inspection process: for example, if they have recorded several injuries during restraints they check to see if these are reflected in the safeguarding referral process and reviewed appropriately.

In addition, inspectors speak to staff, including those who are responsible for safeguarding, the social work team and prison officers. They look to satisfy themselves that staff know what and how to report an issue. Independent agencies, such as Barnardo's, are always seen to check if they have confidence in internal systems, and what, as an advocacy service, children are telling them about safeguarding.

Inspectors will identify a few children who have been the subject of a safeguarding referral and ask them what happened, how they felt and if the concern was addressed. Inspectors also contact the local authority, the Local Authority Designated Officer (LADO) when available, and the onsite social workers, to check their views.

Whilst inspectors do not specifically track counter corruption cases, they will check to see that a suitably senior leader is responsible and that the process is understood by staff. They also look to see if safeguarding reporting procedures are well advertised and if reports are received from a broad range of internal and external sources. Whistleblowing is looked at alongside this, ensuring that the policy is in place and it is advertised, and that both children and staff have confidence in it.

HMI Prisons reports find that the quality of safeguarding practice is varied across YOIs and the STC (for example the STC was found in its joint HMI & Ofsted inspection to have serious weaknesses) but in general, the high number of allegations are managed effectively. Mostly, referrals are responded to within expected timescales, with a good level of scrutiny. Where there are weaknesses, action is taken and improvements can be seen; increasingly practice is considered child-centred.

Links to host local authorities are found to be generally effective, with the LADO attending sites frequently and involved in scrutiny of safeguarding processes and decisions. There is good evidence that children are spoken to by independent social workers, although unfortunately on occasions, security and capacity means that sometimes the openness of discussion and confidentiality is restricted.

## **What Ofsted say about the management of allegations in Secure Children's Homes**

At every full inspection, Ofsted considers whether safeguarding arrangements meet statutory requirements and effectively promote children's welfare, alongside the robustness of safer recruitment practices and the regular monitoring of staff. Inspectors evaluate how well risks are understood and managed, how staff oversee and respond to behaviour, and the appropriateness of the use of restraint, separation, and searches. They also assess the quality of supervision, appraisal, and training provided to staff, as well as the strength of leadership and management oversight. In addition, Ofsted examines the quality of professional relationships, how actively leaders challenge inadequate external responses, and the overall impact of children's participation and the extent to which their views are considered.

For the most part, Ofsted finds that the SCHs manage allegations well, and in line with their policies and statutory guidance, [Working Together to Safeguard Children](#) or equivalent Wales safeguarding procedures where applicable. Inspection reports consistently reflect good induction and training, and leaders with effective oversight of practice. Ofsted has ongoing oversight through Regulation 40 notifications<sup>17</sup>, an annual survey of children, monthly independent visitor reports, and information from the Children's Commissioner and advocacy services. Enforcement powers, used proportionately, have driven rapid improvement when practice has fallen short. Where SCHs fall short of expected standards, inadequate and requires improvement judgements have most commonly related to physical restraint or separation practices, rather than to allegations against staff. There is a strong national network among SCH managers, and best practice identified through inspections and published reports tends to promote improvement across the secure estate.

## **The case review, key findings and areas for development**

Alongside an understanding of what inspection tells us about the management of allegations, the review team undertook a small case review of allegations against staff concerning harm to children. This helped orientate the review team around the day-to-day operation of YCS and enabled a better understanding of the quality of practice and the context in which it takes place. It also opened new lines of enquiry for the review to explore. We undertook a review of 20 cases where allegations against staff concerning harm to a child had been made, across Secure Children's Homes (7), the Secure Training Centre (2), and Young Offender Institutions (11).

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<sup>17</sup> Regulation 40 requires children's homes to notify Ofsted and other relevant authorities without delay about serious incidents affecting children, including deaths, safeguarding referrals, and other significant events.

In general, we found that most safeguarding responses to allegations against staff are robust, with some impressive examples of best practice. However, we found that there are significant investigative weaknesses, including failure to interview alleged victims and perpetrators and premature or inadvertent disclosure of concerns to alleged perpetrators, which in turn hampers or prevents disciplinary action, criminal investigations and charges. This investigative weakness was seen within all types of youth custody provision.

### **Cohort overview**

Of the cases we reviewed, most children were serving sentences for the most serious violent offences, including murder, wounding or grievous bodily harm, and sexual offences. There was a high prevalence of children diagnosed with ASD, ADHD, speech and language difficulties, and broader neurodevelopmental needs. Some children indicated possible Foetal Alcohol Spectrum Disorder, physical disabilities, or significant self-harm histories.

Almost all children sampled had experienced significant trauma, including domestic abuse, exploitation (risk outside the home), physical abuse, neglect, and/or sexual abuse. Several children had been looked after prior to entering custody.

These factors help to highlight some of the vulnerabilities of children within secure provision, as well as the challenges staff may face in meeting their needs. Additionally, several children were known to be involved in gang-related activity, which could increase risks to both children and staff, through intimidation, group dynamics, or retaliatory behaviours.

### **Nature of allegations**

12 of the 20 cases involved allegations of sexual assault, sexualised behaviour, or inappropriate conduct by staff. These ranged from sexualised comments and inappropriate physical contact to allegations of sexually inappropriate relationships. Of particular note was that 11 of these 12 allegations were against female staff. Although most were not substantiated, the volume of allegations underscores the heightened vulnerability of children, the importance of clear professional boundaries, and the significant reputational and safeguarding risks for establishments. Notably, where concerns were substantiated, we found that appropriate actions were taken against staff, with one being dismissed.

Other categories of allegations included inappropriate restraint, mostly concerning restraint techniques or proportionality (a number of these appeared to relate to staff inexperience, rather than deliberate misconduct); intimidation, threats, or unprofessional behaviour; and in one instance, illicit substances being sent to a child.

### **How allegations were reported**

Allegations were raised through a wide range of channels including direct allegations from children, third-party reporting (teachers, police, local authority, advocacy services, Childline, other children), CCTV review, security intelligence reports – which demonstrated strong multi-agency awareness of safeguarding responsibilities and a shared understanding of risk.

### **Key practice themes identified**

Most (16 of 20) allegations were investigated in full and with an appropriate outcome. This included the use of multi-agency strategy meetings, liaison with the LADO, s.47 enquiries, management investigations and disciplinary actions in line with statutory guidance (Working Together to Safeguarding Children or equivalent safeguarding procedures in Wales) with no significant delay identified.

For cases where more immediate safeguarding concerns were identified, pertinent actions were undertaken on the same day, or within 24 hours. In most cases, the child was spoken to directly. Where there was an on-site social worker in YOIs, children and staff benefitted from a swift response and being able to verbalise any worries or concerns directly. Other significant learning included:

- Staff were commonly removed from either frontline or all duties during an investigation.
- There was effective use of the LADO, with their input central and constructive, offering both advice and challenge.
- Body-worn cameras and CCTV were often decisive in evidencing or resolving allegations; for example, a proactive CCTV review identified an inappropriate restraint which led to a safeguarding referral.
- There were strong examples of coordinated practice where information was clearly captured, with full chronologies and a clear outcome recorded – this was more prevalent where there were on-site social workers within safeguarding teams.
- For several of the cases reviewed, there was evidence of appropriate support being implemented for staff against whom allegations had been made, whilst recognising the need for these to be investigated in full.
- For some cases, even where allegations were not substantiated, there was evidence of learning and specific actions for staff to improve practice. This included further training around restraint, de-escalation, and professional boundaries.
- Conflict resolution was appropriately employed when allegations were not substantiated, but professional relationships between staff and children were strained.

## Areas for development

However, approximately 1 in 5 cases showed investigative weak points: critical actions were not proactively pursued; children were not always spoken to; alleged perpetrators were not interviewed or were alerted to the allegation prematurely. For example:

- In one case of an allegation that a member of staff was in a sexual relationship with a young person who had been subsequently released from custody, both the young person and the perpetrator were inadvertently alerted to the investigation prematurely, giving them time to dispose of evidence and liaise with each other about how to respond. This allegation was later substantiated when a 3rd party came forward to verify.
- In another case, an allegation had been made that a young person who had been released from custody was being sexually exploited by a member of staff. There was only one attempt made to contact the youth justice worker/local authority who were thought might hold significant information, but this line of enquiry was not followed up to a satisfactory conclusion, and the matter was closed due to a lack of evidence.
- In one case where letters coming from a solicitor's firm were confirmed to be contaminated with drugs, the solicitor's firm was contacted to ask if the letters had come from that office. This was without any investigative planning or consideration as to the implications for alerting the firm to the concerns.
- One allegation of inappropriate conduct by a staff member was immediately assumed to be malicious and whilst there was evidence to support this theory, the child was not spoken to.
- One allegation of inappropriate conduct was investigated and not substantiated, but the member of staff about whom the allegation was made, was never formally interviewed.
- Body worn cameras were not always utilised: in one case, two members of staff had failed to turn their cameras on during an alleged incident, thereby leading to evidential difficulties in either proving or disproving an allegation. In the Taylor Report (2020) it was noted that while there are some circumstances in which things escalate too quickly for officers to turn on their body-worn cameras, in most incidents there is at least some build-up during which cameras could be turned on.

## Record keeping, data quality and audit arrangements

One of the most striking features of the case records we reviewed was the excellent quality of some of the formulations provided by the psychology service in the YOIs, the model for which varies by site but includes input from NHS Psychology. The best of these, in an instant read, gave a very detailed understanding of who the child was, their specific needs, their likes and dislikes, family relationships, likely triggers for escalating harmful behaviours, and how to work alongside the child productively. Our understanding is that these brilliant formulations are not utilised sufficiently well to realise their potential in day-to-day practice which is a very significant missed opportunity.

More broadly, case records were not always easy to read with chronologies sometimes confusing or absent. There were also email trails which were not always easy to follow and referenced individuals without any context as to their job role or involvement in an allegation/investigation. Some safeguarding records were written verbatim, therefore lacked clarity and the expected formality required for a safeguarding investigation.

### **Good Practice – HM YOI Wetherby Child Protection**

Each Monday at Wetherby there is a meeting to discuss all open child protection referrals and any new ones that have been submitted over the weekend. The child protection team, the social work team, the Head of Security and Counter Corruption will be present. This meeting enables Wetherby senior leaders to make sure that any referrals are shared, that any escalation required has been actioned and that live investigations are making progress.

The updates from this meeting are then shared with the Governing Governor and Deputy Governor the next day to make sure they have a detailed update on any concerns and the actions that are to be taken, as well as any support that they may need to provide.

More recently the Head of Safeguarding completed security vetting to support attendance at the weekly Counter Corruption meeting to ensure safeguarding arrangements are in place and appropriate. This is a new way of working being rolled out across HMPPS YOIs.

## **The role of the national and local counter corruption teams in HMPPS YOIs**

Not all abuse of trust allegations were investigated by HMPPS Counter Corruption in line with their remit. LADOs are not always notified of live counter corruption investigations involving children, contrary to statutory guidance (*Working Together to Safeguard Children* in England or equivalent Wales safeguarding procedures). Inspection does not look at cases of counter corruption where children need to be safeguarded and there is currently no other external mechanism for scrutiny of this aspect of counter corruption casework.

HMPPS policy defines corruption as ‘a person in a position of authority or trust who abuses their position for benefit or gain for themselves or for another person’. Abusing a position of trust may include acting or failing to act (e.g. turning a blind eye) in a way that constitutes a breach of the duties of that office. ‘Benefit’ or ‘gain’ can include financial, emotional, sexual or other personal and / or work-related reasons or any other perceived or actual gain or benefit. Staff may be motivated by malicious or “noble causes” (i.e. where

individuals break the rules “for the right reasons”). Inappropriate relationships can take place in several guises. The policy clearly states that an inappropriate relationship compromises the staff member’s ability to appropriately perform their duties. This includes, but is not limited to, intimate or amorous relationships, friendship, improper emotional relationships and/or familial feelings towards an offender, likening them for example to your own children and/or siblings (and treating them as such).

A central concern and trigger for this review was abuse of trust cases which clearly fall into the examples of criminal activities listed in the HMPPS Counter Corruption policy i.e. forming inappropriate relationships with prisoners, sexual behaviour with a prisoner, sexually assaulting a prisoner or supervised individual. In our case review we saw examples of abuse of trust cases that would fall within the definition of HMPPS Counter Corruption Policy but saw no record of their involvement of the National Counter Corruption Unit or the Local Counter Corruption Manager. A follow up exercise showed that in some cases Counter Corruption were involved, sometimes peripherally, and in other cases, they were not involved at all. Of the cases we reviewed, there were eight we would have expected to have been referred to Counter Corruption. Only four were. Whilst this is a small sample of the number of incidents and cases across YOIs, it is concerning that half of cases were not referred to Counter Corruption when they should have been. The quality of investigations would likely have benefitted from their involvement. Whilst YCS is a discrete part of HMPPS, and there are certainly important differences in approach to practice between adults and children, this is one area where YCS should routinely draw on the extensive expertise of counter corruption investigators.

There is always a tension between the need for surveillance of staff suspected of involvement in corruption, to secure sufficient evidence to, in turn, secure dismissal or arrest, and the fact that in doing so, children may be further exposed to criminal activity. The National Counter Corruption Team confirmed that they would benefit from child protection expertise to assist decision-making in cases where children need to be safeguarded either immediately or as part of any investigation.

Through our discussions with the many practitioners and senior managers we spoke to, including the National Counter Corruption Team itself, the statutory guidance, Working Together to Safeguard Children or equivalent Wales safeguarding procedures where applicable, is not always followed in counter corruption cases. We heard of examples where Heads of Safeguarding sometimes struggled to get the information they needed in a timely way to triage through to the LADO in the host authority. Some on-site social workers said that they were certainly not party to counter corruption cases involving children.

There have been recent policy changes which allow the Head of Safeguarding to attend the Local Counter Corruption Management meetings chaired by the Deputy Governor of the YOI. This is a welcome change but has yet to be rolled out across all YOIs. However, given our later commentary (see: **Roles and Responsibilities**) about the knowledge and

skills of Heads of Safeguarding this may not yet be sufficient assurance that child protection expertise is a constant contributor to counter corruption risk assessment and decision-making.

Lastly, it has come as some surprise that there is no external inspection of Counter Corruption decision making in relation to the safeguarding of children. HMI Prisons does test whether staff know how to make referrals to Counter Corruption and that a senior leader has responsibility for this, but does not test decision-making or quality of investigations. His Majesty's Inspectorate of Constabulary and Fire & Rescue Services' inspection framework includes a range of relevant questions about the capacity and capability of counter corruption arrangements, and the effective management of corruption-related intelligence. There should be similar routine inspection of the quality of practice in relation to counter corruption and safeguarding children in the youth custody estate. And it should, as a minimum, review if:

- The counter-corruption unit has sufficient capacity and capability to enable it to tackle corruption effectively where safeguarding children applies.
- Abuse of position for a sexual purpose is recognised as serious corruption, and the counter-corruption unit trains its supervisors to identify the warning signs of it.
- Corruption-related intelligence is effectively assessed, considering the safeguarding of children
- The risk posed by individuals suspected of corruption is sufficiently monitored where they are in contact with children.

**R1**

HMPPS should ensure that all counter corruption allegations involving children are notified to the LADO in line with statutory guidance, Working Together to Safeguard Children.

**R2**

HMPPS should ensure that statutory child protection advanced expertise and advice is integral to counter corruption decision-making and planning of their investigations involving harm to a child.

**R3**

HMPPS should make it a requirement that Governors of the YOIs and the STC should ensure that their counter corruption teams are always included in safeguarding meetings where there is suspected abuse of trust, or other corruption, to assist in planning investigations from their earliest point.

R4

The Ministry of Justice should ensure that there is independent inspection of HMPPS counter corruption practice similar to that undertaken by His Majesty's Inspectorate of Constabulary and Fire and Rescue Services.

## Roles and responsibilities for the management of allegations

There is no standard expectation about how allegations are handled across the YCS. This is not inherently problematic and preserves the autonomy of each senior leadership team and type of provision. However, it is essential that those triaging referrals and investigating allegations have the requisite knowledge and skill to do so effectively.

Within the YOIs, there is a Head of Safeguarding and a Child Protection Coordinator, and both the Deputy Governor and Governor play very active roles in understanding live matters of concern and checking that investigations are thorough and completed. Every Head of Safeguarding and Child Protection Coordinator we met was experienced and rooted in safeguarding practice. However, this level of expertise was more by chance than by design. A system of rotation means that every 3 years operational heads of function (including those of safeguarding) can be rotated into a different role. Whilst we heard anecdotal reports that this system of rotation isn't always utilised (one YOI had the foresight to arrange for their longstanding and highly valued Head of Safeguarding to remain in post despite being up for rotation), this arrangement means that any new Head of Safeguarding might not have had **any** experience or training in safeguarding before being appointed to that role. The person appointed would also be unlikely to receive a specific induction at the start of the role, or ongoing supervision and support by someone with a statutory child protection background, to develop that knowledge and skill. This is a significant weakness.

In 2019, the Independent Inquiry into Child Sexual Abuse published [its report on children in custodial institutions](#) detailing significant flaws in the investigation of allegations of sexual abuse. Sonia Brooks' subsequent [review of safeguarding in the Youth Custody Service](#) of the same year, noted that the Head of Safeguarding did not require a formal qualification despite the remit including responsibility for all safeguarding and child protection matters, including use of force and the oversight of dedicated social workers. The Head of Safeguarding is also the link with the host local authority and LADO. Brooks recommended that qualified senior social workers should be responsible for oversight of safeguarding. This recommendation has not yet been implemented.

There are certainly operational efficiencies to be gained by not being prescriptive about the qualification background of the Head of Safeguarding. Schools for example, have Designated Safeguarding Leads who are not qualified social workers and have a similar role in triaging safeguarding concerns, bringing in the local authority only when necessary.

Heads of Safeguarding are certainly skilled and have a strong operational understanding of the context in which safeguarding concerns arise, which is certainly an advantage. However, we concluded that the investigative weaknesses to which we refer above is highly likely to be because those making decisions do not have statutory child protection experience of planning and undertaking investigations. The knowledge, skills and experience of those responsible for child protection in youth custody is a long-standing concern and needs to be corrected and prioritised.

Each of the YOIs have a small and varying number of social workers on site, on secondment from the host local authority and funded from the site budget. Their purpose differs across the secure estate. Some of the host authorities who supply the social workers raised questions about their purpose and felt strongly they should not be seen as a panacea for the multitude of unsolved safeguarding concerns within the institution. Whilst some social workers are heavily engaged in all safeguarding concerns and child protection investigations, this is not universally the case. The social work teams are a valuable resource. They should be recruited because of their child protection expertise and utilised much more in the day-to-day management of allegations.

The Secure Training Centre has recently appointed a very experienced qualified social worker as their Head of Safeguarding who will bring that specific expertise to the site. This is to be welcomed.

SCHs, run by local authorities, have a much closer relationship to local authority child protection expertise and have different arrangements in place for accessing social worker expertise through the local authority. The Secure School has recently revised its safeguarding arrangements to make sure there is robust and, where necessary, independent input into safeguarding concerns.

**R5**

HMPPS should ensure that all YCS sites have ready access to social workers with extensive statutory child protection investigation expertise, routinely involved in triage discussions and decisions with the Head of Safeguarding or Registered Manager so there is optimum planning for any subsequent investigation. HMPPS contracts for commissioned custody placements should make this a key condition.

**R6**

HMPPS Heads of Safeguarding should have a social work qualification and solid expertise in statutory child protection investigations. Where that is not the case, they should receive an extensive professional development programme on appointment, focused on child protection practice and specifically investigations.

R7

All Heads of Safeguarding should receive frequent external professional supervision from the host Multi Agency Child Protection Team. This should be resourced by the relevant YCS site.

## The role of the Local Authority Designated Officer (LADO)

There is sometimes a lack of clarity about the role of the LADO, and, on occasions, this leads to an over-reliance on their judgement. In a system where the scale of allegations is so high, internal child protection capability is essential. Whilst volumes of safeguarding concerns are very high, relatively few are sent through to the host LADO and the rate at which this happens varies considerably across sites. This suggests that there is inconsistent reporting, likely the case, at least in part, because there are no systematic audit or moderation exercises undertaken across YCS sites and their host authorities exploring the threshold for referral. One SCH told us that any physical touch in the management of compliance is considered a restraint and would be subject to LADO review on a weekly basis.

The LADO is frequently consulted about the use of restraint. There is a significant question about the knowledge and skill necessary to do this well. Witnesses to restraint under investigation reported that judgments made by the LADO are not always underpinned by the necessary expertise. Experience of restraining a child or use of pain-inducing techniques is not a pre-requisite, but LADOs themselves were considerably concerned about the lack of consistency of induction and development to ensure they are properly equipped for the role.

There were many examples of positive and trusted relationships between the YCS site and their local LADO. However, one expert we spoke to highlighted an inherent tension – good working relationships facilitated access and trusted judgements, yet too close a relationship can result in the LADO becoming fettered or at least create a perception of compromised independence.

We have raised these matters directly with the Department for Education who have confirmed that they are currently consulting on clarifying the role and responsibilities of the LADO as part of the consultation on the statutory framework for help, support and protection. We have been assured that consultation responses will be considered alongside the findings of this review. This consultation is expected to inform future updates to Working Together to Safeguard Children, and the Department for Education will also work with the sector to ensure that any sector led operational guidance reflects revised expectations.

The Department for Education also intends to use the consultation to consider the knowledge, skills and support required for LADOs to carry out their role effectively, including access to training, supervision and expert advice, and expectations in relation to the use of restraint.

R8

The Department for Education (DfE) should review Working Together to Safeguard Children' to ensure that statutory guidance regarding the role and responsibilities of the LADO is clarified for the next edition due in 2027.

R9

Host local authorities and the YCS National Team should introduce case review arrangements, so that referrals and consequent decision making between YCS sites and the LADOs across England and Wales is moderated, with learning and best practice shared.

## How restraint is reviewed

HMPPS/YCS guidance on [Use of Force, Restraint and Restrictive Practices in the Children and Young People Secure Estate](#), operational since February 2024, applies to all types of secure provision. It sets out the Government's policy on the use of approved restraint techniques and restrictive physical interventions across the children and young people's secure estate. It encompasses the legislation and guidance that YOIs, STCs and SCHs and escort contractors must follow. It says the YCS will monitor compliance with the requirements through its assurance, performance and contract management processes.

The authority for staff in secure settings to use restraint or physical intervention is given by the legislative rules and regulations which apply to each site:

- In YOIs: [The Young Offender Institution Rules](#) (2000) – Rule 44 (Maintenance of order and discipline) and Rule 50 (Use of force)
- In the STC: [The Secure Training Centre Rules](#) (1998) – Rule 31 (Maintenance of order and discipline); Rule 37 (Use of force); and Rule 38 (physical restraint)
- In SCHs: [The Children's Homes \(England\) Regulations](#) (2015) – Regulation 2 (Interpretation); Regulation 12 (The protection of children standard); Regulation 19 (Behaviour management and discipline); 20 (Restraint and deprivation of liberty); Regulation 35 (Behaviour Management policies and records)
- In Wales for the Welsh SCH, [The Children's Homes \(Wales\) Regulations](#) 2002 as amended by The Children's Homes (Wales) (Amendment) Regulations (2017)<sup>10</sup> and The Regulated Services (Service Providers and Responsible Individuals) (Wales) Regulations 2017<sup>11</sup> – Regulation 29 (The appropriate use of control and restraint)

The behaviour management and restraint system, [Minimising and Managing Physical Restraint](#) (MMPR) is a longstanding guide in the use of restraint and has been used by the YOIs and STC for years. More recently, and increasingly so, it is used as the main framework for restraint in some of the Secure Children's Homes and the Secure School. It aims to provide secure estate staff with the ability to recognise children's behaviour and use de-escalation and diversion strategies to minimise the use of restraint through the application of behaviour management techniques. It sets out a number of physical restraint techniques. The use of force on a young person must always be viewed as the last available option. The message within MMPR is clear – staff must assess all the available options to managing an incident (i.e. de-escalation techniques, verbal communication) prior to using restraint. Staff must be able to clearly demonstrate why restraint was necessary. In line with existing legislation and guidance, MMPR sits within a wider framework of effective behaviour management guidance. It is underpinned by a clear commitment to minimise the use of force and is designed to continually analyse the effectiveness and safety of individual techniques and the manner in which providers use them.

There is a clear expectation that the process of learning, review and modification to the MMPR system is continuous.

The arrangements for reviewing restraint were considered as part of Charlie Taylor's [independent review of the use of pain-inducing techniques in the youth secure estate](#). He found that although extensive arrangements were in place to make sure that detailed information about any incidents involving children where staff have used force or any MMPR technique (including pain-inducing techniques) was captured, it was unclear how this informed development of a strategic approach to address the current high levels of restraint in custody. Taylor recommended that an independent restraint review panel be established to review incidents in which serious injuries or warning signs have been identified, or where a pain-inducing technique had been deployed, not to look "simply at the mechanics of restraint but should have free range to make observations about behaviour management, staff behaviour and leadership". Independent scrutiny provided would hold Governors and Directors, the YCS and the Government to account for improving behaviour and practice, reduce restraint and make sure that any use of pain was genuinely justified.

[The Independent Restraint Review Panel](#) (IRRP) was set up in 2021 to regularly review a sample of incidents where serious injuries or warning signs have been identified or where pain-inducing techniques have been applied. Its primary aim is to deliver practical improvement for children by influencing attitudes towards the use of restraint, avoiding its use where possible, promoting de-escalation and looking systemically to learn from incidents. It reviews practice only in the YOIs and the STC. Whilst it looks at numerous restraints, and at the use of pain-inducing techniques, the focus has been as much on

antecedents to restraint, de-escalation, and opportunities to reduce the trauma associated with restraint when it is otherwise unavoidable. By focussing on behaviour management, alternatives to restraint and de-escalation, the ambition is to see force used less and, when it is unavoidable, that it is minimised and less traumatic for all. The Panel membership includes the Governing Governor or Director and always includes a medical expert, someone with MMRP expertise and, wherever possible, senior local authority representation. For each establishment, Governors and Directors have included operational, healthcare and safeguarding staff.

We heard that operational staff and their managers have embraced the objectives of the IRRP, largely treating this independent challenge as a learning opportunity. As an integral part of each IRRP, they meet with children to listen to their views on restraint with a promise of anonymity to encourage participation. The Panel reports that, in most cases, they see good levels of care and professionalism from staff, alongside sometimes extreme bravery in the face of the levels of violence they face.

We had the privilege of attending one of the IRRPs. It was a robust, thoughtful and insightful review process and the level of seniority and expertise present gave confidence to the process. There was honest and frank debate and the use of footage to review incidents was hugely valuable. It was indeed a humbling, if troubling, experience, to see the levels of violence and distress of children, as well as the skill and tenacity of the staff involved.

In short, the IRRP for YOIs and the STC, is a well-embedded mechanism for ongoing and systemic learning across a number of custody sites, which has led to increased confidence amongst staff that allegations are independently reviewed as well as generating new ways of improving practice. It is now part of the culture of those sites, and we found it to be a considerable asset.

### **Good Practice – The Independent Restraint Review Panel (IRRP)**

The IRRP reviews a sample of restraint incidents through regular visits to the YOIs and STC. It aims to review every use of a pain-inducing technique (PIT) during restraint whilst also seeking to support improvements in behaviour management and reducing the need for the use of restraint. It approaches its reviews with the intention of driving a learning culture which helps improve practice and to consider what might have negated the need for restraint, in addition to how restraint is done when it is used.

IRRP always makes time to talk to children about their experience of restraint, seeking to gain a holistic view of restraint and how other agencies are engaged. They have also involved local authority leaders, tapping into their expertise whilst building relationships with partner agencies.

PITs had previously been judged to be used without the fullest of justification and where alternatives to its use had not been fully considered, but IRRP now sees far fewer such instances. They see much more focus on de-escalation during restraint, body-worn cameras being activated sooner and more widely, better incident management, much more focus on communication – two ways – with children and, although still variable in quality, better debriefing of children after restraint to understand what happened and what might be done differently in future to reduce the need for restraint. Individual formulations for the most challenged, vulnerable and challenging children have been developed. New restraint techniques have also been introduced – alongside a new syllabus; soft wrist restraints are now available, for example, as an alternative to hand cuffs. Full searching is now used far less than previously.

### **Good Practice – Oakhill Use of Force**

In line with their duty to comply with the Advancing Equality for Offenders and Children in Custody Framework, Oakhill senior staff review the use of force data on a monthly basis. Every incident that occurs where some form of restraint is used, is cross-referenced with the child's ethnicity. This data is then collated and presented to the senior leadership team who interrogate the data to identify any patterns and/or trends for the purpose of monitoring disproportionate use of restraint across the centre.

Data for the week commencing 20/04/2026 showed an increase in the use of force data for one cohort of children. Closer examination revealed that the recent arrival of a child with increasing levels of self-harm, requiring restraint as a last resort to prevent further significant harm, accounted for this shift in the data.

Suicide and self-harm (SASH) plans were updated after every incident to ensure that all relevant staff were immediately aware of the increased risk and need for prevention strategies to reduce both self-harm and restraint.

In England, [Working Together to Safeguard Children](#) sets out statutory expectations for multi-agency safeguarding arrangements. Within this framework, local safeguarding partners have flexibility to design how they implement oversight and review processes, including those relating to practices such as restraint. There is a wide range in approaches to reviewing restraint in host authorities: some LADOs visit SCHs periodically and sample physical restraint incidents then provide feedback to the provision; views on restraint are included in some Local Safeguarding Children's Partnerships (LSCP) annual reports but not all. Some LSCPs will ask a SCH registered manager to attend an annual partnership meeting and present data about restraint practices. There is not, however, a universal

approach. The Department for Education has confirmed it will consider how guidance can better support safeguarding partners in the oversight and review of restraint.

The Welsh Government's [Reducing Restrictive Practices Framework](#) provides guidance for childcare, education, health, and social care settings to minimise the use of restrictive practice. It promotes a person-centred approach which emphasises prevention and understanding behaviour as a form of communication. It looks at improving wellbeing to reduce situations where restrictions might otherwise be used. The framework states that restrictive practices should only ever be used as a last resort to prevent harm and must be proportionate, time-limited, and part of a clear personal plan. Overall, it aims to protect individuals' dignity, safety, and rights while encouraging practitioners to adopt positive, supportive strategies that reduce reliance on restriction. Where a restraint has taken place, post-incident support should be available to those who were restrained and who witnessed the restraint. Individual plans should also be reviewed after a restraint, and a post-incident review should take place.

There are high numbers of restraints used across the secure estate, but not all sites are subject to the same independent expert scrutiny provided by the IRRP. The same level of discipline and rigour for children in custody subject to restraint should be in place across the entire estate, including SCHs and the Secure School too. Whilst pain-inducing techniques are not used in all sites, review of restraint is still an important way to learn and develop practice in the same way as described above.

Furthermore, the YCS central team should develop a method for drawing together all intelligence about restraint so that lessons learnt and best practice is understood and shared. Ofsted, for example, carry out a minimum of bi-annual inspections of SCHs, review monitoring systems and directly sample physical restraint practices setting out their findings in individual reports. This is important intelligence, but it does not provide an overview of system health across the secure estate. This naturally falls to the YCS National Team to do, and to work with MoJ and DfE where a change in practice, and the policy underpinning it, is indicated.

R10

HMPPS/YCS should ensure there are robust arrangements in place for independent and expert scrutiny of restraint, based on their own guidance on [“Use of Force, Restraint and Restrictive Practices in the Children and Young People’s Secure Estate”](#), across all commissioned custody placements and that an overview of system health in relation to restraint is reported to the new YCS Safeguarding Governance Board by the YCS Central Unit Head of Safeguarding every 6 months.

R11

The Department for Education should update *Working Together to Safeguard Children* in the next edition due in 2027 to clarify expectations for host Local Safeguarding Children's Partnerships (LSCP) in overseeing the independent review of restraint in youth custody and associated reporting responsibilities. Detailed guidance, including on the knowledge and skills required for those undertaking such reviews, should be developed by the relevant departments.

## Thorough, fair and timely investigations

The scale of allegations against staff concerning harm to a child – and, more broadly, the culture of complaints in the secure estate – is very significant and has considerable impact on staff and the day-to-day running of services. Many allegations are not substantiated, and some are found to be fabricated or malicious. This raises two competing pressures: ensuring children are protected, and recognising the vulnerability of staff subject to frequent, numerous allegations. Our case review saw examples where the allegation was considered likely to be a hoax but was still extensively investigated. This is as it should be. Child protection must take priority. However, the interests of both children and staff must be protected by ensuring skilled, unbiased and evidence-led processes are in place with sufficient resource available to ensure investigations are completed in the shortest time possible. Often the more serious allegations can take months to resolve, with staff being suspended for long periods of time – with all the adverse personal and operational consequences that this entails.

We have spoken to groups of staff, and unions (Prison Officers' Association, Prison Governors' Association and national trade union groups) who have set out the impact high frequency allegations and subsequent investigations have on the personal and professional lives of the workforce, the lack of independence in the investigation process and the length of time taken to investigate. Where criminal investigations are proceeding, this extends the timeline considerably, yet rarely results in conviction, charge or arrest.

In Dame Lynne Owen's [independent report into prison releases in error](#) (2026), she was,

“surprised to observe the internal investigation process in HMPPS. Understandably the need for quick reviews necessitates local input, but the transition from that to more formal investigation and then a conduct enquiry remains unclear. Inevitably, I draw on my policing knowledge and the comparison between the two systems. One (policing) being highly regulated and one not – despite the coercive powers used daily by police and prison officers being similar. I am unclear why the principles of independence and transparency required of the policing system are less identifiably required of HMPPS.

Currently, HMPPS does not prescribe how individual incidents must be investigated. Decisions on whether to undertake a lessons-learned review, fact-finding exercise, or

formal investigation are made at the discretion of the Governor. In rare cases, Prison Group Directors may commission investigations, particularly where there are serious failings or patterns of concern. It is my view that investigations in cases with such significance as this, require the selection of a standalone team with the professional background appropriate to investigating such serious matters.”

Dame Lynne argues that consideration should be given to the establishment of an equivalent body to the Independent Office for Police Conduct in the prison sector. It should operate in the same way in terms of matters which meet a certain seriousness threshold, which includes a public interest test. HMPPS should have to self-refer to the independent body. After investigation, that body would have the power to insist on an independently chaired discipline hearing. She argues that an extension of the functions of the Prisons and Probation Ombudsman could be considered to fulfil this role.

It is worth noting that the central recommendation of Jennifer Rademaker’s [Professional Standards Review](#) (2024) examining bullying, harassment, discrimination and victimisation (BHDV) across HMPPS was for HMPPS to establish an independent channel outside the line management structure for reporting, investigating, and deciding BHDV complaints, handled by a dedicated team of experts in a ring-fenced, confidential, and standardised process. MoJ accepted this recommendation and a new central unit has been set up and begun operating. It seems somewhat incongruous to have accepted the principle of independence in investigations for BHDV but not to extend that logic to other serious incidents requiring specialist investigative expertise.

It is also noted that many public service professionals working with children – for example, teachers, social workers, doctors, lawyers, nurses, midwives and police – all have an independent body to scrutinise conduct or fitness to practice concerns. Those working in youth custody currently have no such mechanism. I make further comment on the potential for professional registration of the youth custody workforce elsewhere.

I was struck by the closeness of relationships between staff at all levels of seniority and how reliant they were on each other for personal safety throughout the day, particularly where there are very high levels of violence. Teamwork, trust and camaraderie are crucial in these circumstances. The very best of us would struggle not to feel compromised if, at the same time, we were expected to investigate our colleagues for potential wrongdoing. This would be particularly difficult when the allegation is so serious that, if proven, it could result in a colleague being subject to criminal prosecution and dismissal. There is very significant merit in Dame Lynne’s recommendation but, at the time of writing, the Government has not yet committed to this. Should the recommendation be accepted, this would obviate the need for a special route for youth custody as it would be naturally incorporated into this new body.

In its absence, or until there is external professional registration of youth custody staff (see below), at the very least for allegations against staff concerning harm to a child, which could, if proven, result in dismissal (and in some cases referral to the Disclosure and Barring Service), investigations should be undertaken by somebody external to the chain of command within the YCS site.

In taking forward the recommendation from Dame Lynne Owen's report to consider establishing an equivalent body to the Independent Office for Police Conduct in the prisons sector, and the suitability of the Prisons and Probation Ombudsman to undertake this role, HMPPS should specifically set out the applicability and functions of any such body to the youth estate.

**R12**

HMPPS should reconfigure the management of allegations against HMPPS youth custody staff, ensuring that the principle of independence from the relevant YCS site, is applied to all investigations regarding allegations against staff concerning harm to a child which, if proven, could result in dismissal (and in some cases referral to the Disclosure and Barring Service). HMPPS contracts for commissioned custody placements should include this expectation.

## **Safer recruitment, vetting and the Disclosure and Barring Service**

Ensuring that new appointments are appropriately vetted is a critical first line of defence against corruption and a key mechanism for maintaining professional standards. HMPPS policy requires that pre-employment vetting is completed prior to appointment, at a level proportionate to the role. Responsibility for this process sits across the Approvals and Compliance Team (within MoJ Shared Services), the Vetting Contact Point, and the Designated Vetting Decision Maker within each business unit. They must ensure that all staff are subject to the appropriate level of vetting before taking up post, and that vetting is subject to periodic review throughout employment. The relevant policy framework is set out in [PSI 07/2014 and PI 03/2014](#) (Security Vetting) and [HMPPS vetting policy and standards](#). No individual should take up a role within custodial services without appropriate vetting clearance, and ongoing monitoring is required to mitigate evolving risks. Governors maintain ultimate authority on who may enter their prison and what level of access is authorised and are expected to routinely satisfy themselves that all relevant security checks have been completed.

There is not a consistent standard expected regarding checks with the Disclosure and Barring Service (DBS) checks across all YCS sites. HMPPS policy is that DBS checks

should be undertaken every three years for eligible roles. In undertaking this review we found that approximately 10% of public sector YOI staff had an out-of-date DBS check, as of February 2026. This represents a governance risk. Whilst there has been significant work to set up new systems for safer recruitment, this is very early work and is not yet completed. Within a small sample we reviewed, 2 out of 13 staff did not have DBS checks in line with the policy.

Prior to this review, HMPPS policy was not extended to contracted services as a standard expectation, including SCHs. This has now been corrected apart from the Secure School. Renewed DBS checks every three years should apply to all sites across the YCS. Whilst DBS checks have their limitations, it is not logical to endorse exceptions to the policy.

It has wisely been suggested to us by one expert that the live DBS scheme should be used instead of the current HMPPS policy of new checks every three years. This allows the employer to re-check if there is any new DBS intelligence, at any point. Given how recent the HMPPS policy changed, and the struggle to complete implementation, I am not recommending another change at this stage. However, the proposal is certainly worthy of serious consideration at the next policy review point.

Where a person resigns before an investigation is concluded, the matter should reach a conclusion in their absence, with appropriate notifications to the HMPPS Personal Vetting and Security Team, the LADO and, where appropriate, to DBS. It has been reported that within HMPPS this does not always happen. The DBS system is only as good as the information it holds. It is imperative that HMPPS policy on pursuing disciplinary outcomes for those who have resigned is diligently pursued and where appropriate for DBS to be notified along with robust evidence to support the referral.

Those responsible for referring to DBS across both the YCS and local authorities, told us they were concerned that they were not told about the outcome of DBS referrals or given an opportunity to strengthen their case. They reported that, in their view, this has resulted in people deemed unsuitable to work with children found to be working with children again in a different setting. There was considerable disquiet about this point from various sources, notably the National Network of LADOs. Given the centrality of the LADO role in children's safeguarding across England and Wales, it is concerning to find a distinct disconnect in views about suitability to work with children between children's services and DBS. This disconnect also extends into YCS who, as the employer, has the responsibility to make the DBS referral (but often on the advice of the LADO).

The Office of the Children's Commissioner published a paper in 2025 on [improving safety and accountability for vulnerable children](#) and also noted that DBS does not routinely provide feedback to those who make referrals, arguing this makes it difficult for professionals to know whether appropriate action has been taken. In February 2023, [the Independent Review of the Disclosure and Barring Regime](#) concluded that the existing

regime is routinely helping employers and organisations to make safer employment decisions. It had a strong focus on eligibility and exclusions but did not look specifically at decision-making or quality assurance arrangements.

We did pursue this line of enquiry with the Home Office, as the sponsorship department, and DBS itself and I have concluded that new and more effective feedback loops need to be established so that thresholds for inclusion, and evidence required to support referrals, is better understood and applied across children's services. There is currently no appeals process on a DBS decision, and I am not aware of any external scrutiny of DBS decision-making. This needs to be reviewed.

**R13**

HMPPS should ensure that all outstanding enhanced DBS checks across the YCS workforce are completed without further delay. YCS commissioning arrangements should include a standard expectation that enhanced DBS checks are undertaken every three years across all YCS sites.

HMPPS Human Resources should report to the YCS Safeguarding Governance Board, and in turn to the Ministerial Youth Custody Performance Board, at the earliest opportunity – and no later than September 2026 – to confirm all sites are operating in line with the policy.

HMPPS should ensure that arrangements are in place to audit compliance with HMPPS policy on DBS checks, across all YCS sites, including SCHs, the STC and the Secure School.

**R14**

HMPPS should ensure that that all disciplinary matters are satisfactorily concluded even when the person under investigation resigns during the process, and ensure that where the threshold is met, referrals are made to DBS with sufficient evidence to secure inclusion on the barring list.

**R15**

The Home Office should work with the Disclosure and Barring Service to consider together the introduction of outcome notifications and appeal rights for employers, as well as provision of external scrutiny of DBS decision-making from which all partners can learn and develop their understanding of safeguarding practice and suitability to work with children.

## National safeguarding governance across the YCS

The YCS was established in September 2017 as a distinct part of HMPPS, with responsibility for children in custody in England and Wales. The YCS provides secure accommodation for children, with the aim of supporting their positive development while in a secure setting and working with partners to reduce the risk of reoffending so they are better prepared to make a positive contribution to their communities. There is a YCS National Unit led by an HMPPS Executive Director, who holds a range of responsibilities including the placement and safeguarding arrangements for all children who are remanded or sentenced to custody in England and Wales.

In December 2025, when this review started, there was no overarching formal governance arrangements for frequent senior scrutiny of safeguarding practice across the estate. Whilst there is a national safeguarding team in place, this comprised of just two full time posts. Plans are now in place to establish a new Safeguarding Governance Board, chaired by the Executive Director, but this is not yet fully operational. Additional staff are being recruited into the YCS National Unit to bolster their safeguarding work.

There are no formal arrangements to ensure system-wide learning from serious cases and high-profile incidents. Learning from serious incidents is not systematically shared. The oversight mechanisms that do exist – Ofsted, the PPO, the IMB, local authorities – are valued but operate in silos, without the connective tissue of a well-resourced central function that draws intelligence together and drives change.

### Good Practice – The Secure Accommodation Network (SAN)

The SAN uses bi-monthly check-ins and wider conference opportunities to share examples of good practice, as well as highlighting learning that can help improve practice. The SAN forum provides a valuable space for collective reflection, communications, and the sharing of ideas and new policies. Although each home operates with its own unique identity, all SCHs come together cohesively as part of the SAN.

At their most recent conference, there was a strong focus on:

- Connect – Building strong relationships and sharing knowledge
- Collaborate – Working together to drive innovation and best practice
- Celebrate – Recognising achievements and creating positive impact

Some data is collected by the YCS National Unit on allegations, but coverage is incomplete and has very significant gaps. The data that is available is not being used analytically. Data on allegations and complaints is fragmented across sites and the YCS National Unit. Pattern recognition is weak: the quality of data makes it impossible to

ascertain with confidence the rates and types of allegations by institution, the age and race of children of concern, the outcome of investigations, or any patterns emerging about the conduct of individual members of staff or groups of staff within or across institutions. The weakness of this data prohibits any analysis for learning purposes or identification of workforce needs and / or service improvements.

There is a complex array of notification arrangements between different types of YCS site and their respective inspectorates for serious incidents,<sup>18</sup> but no mechanism (or expectation) within or between each inspectorate to draw this information together systematically. It is therefore essential that this data work is undertaken by the YCS National Unit.

Furthermore, the YCS National Unit does not have systems in place to routinely audit the quality of triage or investigations undertaken, to check that allegations have been satisfactorily concluded, particularly those designated as no further action, or to extract learning on a systematic basis. Whilst some of these allegations are referred out to the LADO so will benefit from independent oversight, and others may be picked up and scrutinised through inspection, most are not. It is not sufficient to rely on inspection alone for assurance. Internal assurance functions must be robust and frequent enough to surface matters arising so that corrective action can be taken at pace.

Greater clarity is needed about the function of the YCS National Unit and the resource and skills required to deliver it, moving beyond the day-to-day placement arrangements and fire-fighting, which characterises much of the activity, towards solid data analysis; evidence-building; quality assurance of practice including management of allegations; systemic learning; and strategic direction of improvement and change.

**R16**

HMPPS should review the YCS National Unit to identify its key functions and to ensure it has sufficient resources and the skill necessary to deliver at pace and to quality. This includes day-to-day operations and additional resource to successfully implement any major new change programmes.

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<sup>18</sup> Secure children's homes and secure 16-19 academies that commission with the YCS are required under Regulation 40 of the Children's Homes Regulations 2015 to notify Ofsted without delay if—

- there is an allegation of abuse against the home or a person working there;
- a child protection enquiry involving a child —
  - (i) is instigated; or
  - (ii) concludes (in which case, the notification must include the outcome of the child protection enquiry).

For YOIs and the STC, HMIP receives a list of all serious incidents each weekday, but this does not include all safeguarding concerns. HMIP are given access to safeguarding logs during each inspection

**R17**

A comprehensive central record of all allegations against staff concerning harm to a child should be maintained by the YCS National Unit so that patterns of concern can be readily recognised and acted upon.

**R18**

A regular audit of allegations against staff concerning harm to a child, including those resulting in no further action and those referred out to host authorities, should be conducted by the YCS National Unit across all youth custody sites to provide a check and balance on decision-making. This should be done in partnership with the host local authority.

**R19**

The YCS National Unit should establish a formal process for learning from serious incidents and high-profile events with effective mechanisms for learning embedded across all YCS sites.

**R20**

The proposed new YCS Safeguarding Governance Board should be established with sufficient resource as soon as possible to oversee the development of new systems for data collection, analysis, and audit activity to ensure safeguarding arrangements are working well, reporting to the Ministerial Youth Custody Performance Board at least quarterly.

**R21**

The Ministerial Youth Custody Performance Board, in addition to its existing brief, should routinely seek assurance from the YCS Safeguarding Governance Board about the quality of decision-making regarding allegations against staff concerning harm to a child, safer recruitment & vetting, DBS referrals and renewals, and local authority and YOT compliance with statutory duties, to ensure strategic oversight of safeguarding the welfare of children in custody.

## **A national practice framework for youth custody**

The YCS across England and Wales does not have a unifying framework for practice underpinned by best evidence. Whilst the Youth Justice Board's excellent [Child First](#) framework for the wider youth justice system is well known and often referred to by people we spoke to, the YCS suffers from the absence of a coherent conceptual map from which everything else flows: the core purpose of youth custody, key principles of practice, core outcomes to be achieved for children in custody, key enablers necessary to achieve those outcomes including specific knowledge and skills, the evidence underpinning preferred practice methodology, and clarity about the expectations of practitioners and leaders. This

national framework should form the core of all performance and contract monitoring, the basis for induction and professional development, and the design of support to staff.

The [NHS England Framework for Integrated Care \(SECURE STAIRS\)](#) is the closest attempt to introduce an overarching practice framework across the secure estate. It is a sophisticated framework developed to address the multifaceted needs of both children and staff working in the secure estate in England. Its potential for transforming practice is currently underutilised. In YOIs, the high-quality formulations of children discussed earlier in this review, and the reflective sessions held by psychologists for staff as an opportunity to learn and develop, are two key elements of the framework for which we have heard about or seen evidence of their potential.

The Framework for Integrated Care was originally developed to improve support for children with the highest levels of vulnerability and most complex needs. It aims to improve safeguarding, safety and outcomes by focusing not only on children but also on the cultures, systems and adult behaviours shaping their daily experiences. It recognises that systems supporting highly traumatised children can themselves become trauma organised, replicating threat, reactivity and harm. Traditional diagnosis or behaviour-led interventions, delivered in isolation, risk fragmenting care and reinforcing crisis-driven practice. It shifts the focus from “what is wrong with the child?” to a shared understanding of “what has happened” – for the child, the adults around them, and the system itself.

### **Good Practice – SECURE STAIRS**

Chronic exposure to threat can lead individuals, teams and organisations to mirror the difficulties of the children they support, resulting in hyper-arousal, silo working, reactive or authoritarian responses, and breakdowns in communication. These patterns can increase safeguarding risks despite good intentions. SECURE STAIRS therefore emphasises trauma-responsive cultures, where systems may contain, reflect and respond thoughtfully, rather than reactively.

SECURE STAIRS is not a prescribed model, but a guiding scaffold for practice, culture and organisational change, aligning health, custody, education, care and community partners around a shared, psychologically-informed understanding (formulation). The focus is twofold: creating stable, relational and developmentally attuned environments where everyday interactions are the primary intervention and aligning agencies prioritise and sequence interventions by developmental need, readiness and context rather than behavioural labels or diagnosis alone. Multi-agency, co-produced formulations (“My Story”) are central, integrating perspectives into a shared narrative of the child’s experience and enabling more consistent responses across the system. These psychologically informed formulations consider both the child’s experiences and the system’s responses, including where change is needed.

Staff are supported through training, reflective practice, supervision and aligned, psychologically-informed leadership to remain regulated, curious and compassionate under pressure. This enables adults to better regulate children, reduce escalation and maintain safer, more therapeutic environments.

Embedding SECURE STAIRS principles within established systems presents inherent challenges. The Youth Custody Service is shaped by adult-oriented HMPPS structures, which prioritise rigid pathways, compliance, security and risk management, with less developmental focus. Children are not 'mini-adults', and this context can undermine the relational, developmental and trauma-responsive principles required for effective support and safeguarding. This cultural mismatch creates tension. Unless these competing cultural drivers are acknowledged and addressed, trauma-responsive practice remains constrained and vulnerable to adult-oriented norms, particularly during pressurised periods.

Whole-scale culture change is a long-term endeavour requiring sustained investment, strong, aligned leadership, and significant human and practical resources. Despite the challenges, emerging evidence is promising. Where SECURE STAIRS is embedded, evaluation and inspection evidence indicates improvements in emotional and relational safety, staff confidence and wellbeing, multi-agency working and consistency of care. In more established (often smaller) settings, reductions in violence, restraint and crisis-driven responses have been reported. Evidence from secure children's homes also suggests improvements in children's emotional regulation, including reductions in anger, dissociation and depressive symptoms.

Focus and resource, however, has been largely insufficient for implementation and sustained impact of this framework across the whole of YCS. The formulations in place for children in YOIs are underused as a key tool for planning how to work with individual children on a day-to-day basis. Staff reported that, often, the reflective sessions led by NHS psychologists that are held in some YOIs become a place for staff to decompress, vent their frustrations and offload huge emotional weight. Before anything constructive can come out of those sessions, they are back out on duty. The value of feedback loops as a resource to support a step change in the quality of practice needs to be recognised and hard wired into day-to-day practice. Otherwise, reflective sessions risk becoming stilted, losing authenticity, and impacting on staff morale. To engage in reflective conversations takes courage and vulnerability – to do so repeatedly, with no tangible change, is not conducive to staff morale. Staff cannot hold children in mind, if they are not provided the space and support to do so. Whilst there are teams of psychologists providing training to staff in the YOIs, for example, this is piecemeal and not located within a credible transformation plan which draws together the complexity of security with therapeutic care for children, alongside meaningful psychological support for staff.

A 2025 [systematic review of qualitative research on staff experiences in secure care settings](#) found that staff were routinely expected to manage their emotional responses in highly charged environments without adequate psychological support, and that the cumulative demands of doing so – particularly without structured debriefing and reflective supervision – contributed directly to burnout, emotional disengagement, and compromised care. The review found that staff who lacked structured emotional support were more likely to escalate conflict rather than de-escalate it, with direct consequences for children’s safety. The same review identified strong peer relationships, regular debriefing sessions, and supported reflective practice as the most effective protective mechanisms for staff working in secure care settings. Staff in secure care settings are consistently expected to regulate their emotional responses; suppressing fear, anger or distress in volatile situations without adequate psychological support. The review found that staff who adopted a non-authoritarian, strength-based, and empathetic approach consistently achieved better outcomes for children. Strong staff-to-resident relationships, characterised by warmth, consistency, and mutual respect, were associated with reduced violence, improved participation in therapeutic programmes, and greater trust. Higher staff-to-resident ratios and consistent staffing were directly linked to better emotional stability in children. Conversely, settings in which the emphasis on physical security and risk management dominated the environments in which both staff and children were less safe. The review called for structured, coordinated training initiatives which equip staff to address complex needs and manage their own emotional responses, and for robust support systems including reflective practice, regular debriefing, and peer supervision.<sup>19</sup>

In general, a more sophisticated and consistent approach to understanding the task of youth custody, the knowledge and skills required to be effective in role, and the evidence underpinning that is needed. There are some key knowledge and skills areas that are essential for any practitioner working with children in custody which should flow from the national framework described above. The induction and safeguarding training seen as part of this review does not address some practice areas which would be of significant value to practitioners. The YCS and Ministry of Justice may wish to draw on the [early career standards](#) (ECS) published by the Department for Education (DfE) in 2026 which reflect key learning needs for working with children and families, including how to: build and maintain impactful relationships and communicate effectively with children which successfully balance empathy with authority; use of adaptive techniques which demonstrate active listening and responses to expressions of emotion; development of effective coping strategies and interventions which promote wellbeing to help counter the effects of vicarious trauma; and the management of stress and maintenance of composure in challenging and high pressured situations. For more experienced staff, and particularly those involved in child protection investigations and decision-making, drawing on the DfE

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<sup>19</sup> [Exploring staff perspectives of working in secure care accommodation for young people: a systematic review of qualitative research](#)

standards for lead child protection practitioners may also be useful. From youth justice workers and residential staff to Custody Managers, through to Registered Managers and Governors, there needs to be much stronger pathways with explicit planning for the development of specific domain expertise.

Crucially, youth justice workers in the YOIs and the STC need to be brought centre stage. In SCHs and the Secure School there is often extensive effort to train, develop and support staff underpinned by consistent, evidence-informed methodology, which permeates through to the overall culture of the setting. Practitioners in these settings are often rooted in child development and seen as the key agents of change by working alongside children in ways which can flex and respond to individual and complex needs. One impressive manager I met in a Secure Children's Home, who had moved away from punitive responses to one of therapeutic care, described how he learnt that the deprivation of liberty is the punishment; everything from that point forward is about growth and rehabilitation. Too often, especially in YOIs, youth justice workers look on as all the direct change work is farmed out to external professionals, leaving them stuck in security roles only. Many officers want to do so much more, and some find ways of doing so.

### **Good Practice – Unlocked: Transformative Practice**

Many members of frontline staff are doing incredible work on the landings of YOIs, ultimately transforming outcomes for the people in their care. Large-scale projects can make a real difference. But much of this transformative work happens quietly through consistent leadership, driving culture change and supporting those in their care with the aim of radically improving outcomes.

- An Unlocked participant at HMYOI Feltham was approached by a prisoner who wanted help reading the instructions on his protein powder label. She sat with him, wrote out the alphabet and got him to practise it. Other boys on the wing saw what was happening and got involved, suggesting ways to memorise it. It ended with 30 of them, many of whom were excluded from school at a young age, on the exercise yard singing the alphabet song with him.
- During the COVID-19 lockdown many prison officers sought out content like puzzles and other distractions that could be done behind cell doors. In Feltham, one of Unlocked's participants took this further. He set Maths homework and incentivised one particular child who he thought had potential to complete it and let him mark it. As other boys saw this in action they also wanted to get involved and began completing these educational worksheets and getting them marked.
- One participant at HMYOI Feltham was approached by a young person on his wing who wanted to learn Spanish. He started teaching some basic words and phrases every day. This inspired other boys on the unit to get involved in education on the wing, and this participant has been helping others to engage.

Participants on the Unlocked Graduates programme complete initial training at master's level, which is commensurate with social work and teaching qualifications. This embeds reflective practice and evidence-based decision making. All participants also complete research projects in their settings, enabling them the opportunity to take a step back from their day-to-day roles and investigate the theory behind driving change in their settings, and contributing to research within the criminal justice system. Recent examples have included: an investigation into the challenges facing education within a YOI, research looking at the experiences of children on remand, and research focusing on frontline staff working with neurodiverse children in custody.

The HMPPS leadership pipeline into YOIs and YCS Headquarters almost always comes from the adult prison estate. Progression through senior management grades means Governors and Executive Directors move back into the adult estate relatively quickly, taking with them the expertise and experience of drawing together the essential pre-requisites of both prison security and care of children. Youth custody needs to be seen first and foremost as an integral part of children's public services, driven by a shared values-based leadership. Who can become a Governor of a YOI needs to be reviewed, with new pipelines developed which help those with ambition for children in custody become part of the future pool of talented leaders for the secure estate and its headquarters.

There is a confusing and sometimes contradictory policy landscape for YCS direct delivery sites. The fact that YCS is a distinct part of HMPPS, means it is **different** to the adult estate. It follows then that operational practice (the regime), the necessary knowledge and skills, practice standards, recruitment processes, conduct and performance policy, should also be different. Governors of YOIs have to follow a set of rules which, at least in some instances, does not meet the needs of their child-focused institutions. For example, whilst Parc YOI, SCHs, the STC and the Secure School all choose the staff who work for them, Governors in the other YOIs must rely on centralised HR processes to recruit and redeploy suitable staff to work within the children's estate. Whilst we met many staff who had worked in the YOIs for years – some for over twenty – we were told that staff often arrive at the YOIs with no experience of working with children. There was a consensus that working in the YCS is much harder than the adult estate. Whilst suitability to work with children is often not established until staff are already in situ, there are certain expectations, values and behaviours which are a necessary pre-requisite (adjusting to child vulnerability and sensitivity). These should be explored as part of a second stage recruitment and redeployment process.

We were told by some Governors and the YCS National Team that there are policies designed for working with, and managing, adults in prison which do not take account of the fact that their staff are working with children, which can fundamentally change how certain

behaviours are understood and responded to. This in turn, has implications for disciplinary action, thresholds for gross misconduct, as well as broader decisions about suitability to work with children.

**R22**

HMPPS should introduce a single National Practice Framework for Youth Custody which clearly sets out the core purpose of youth custody, key principles of practice, core outcomes to be achieved for children in custody, key enablers necessary to achieve those outcomes including specific knowledge and skills for all grades, the evidence underpinning preferred practice methodology, and clarity about the expectations of practitioners and leaders.

HMPPS should ensure that this National Framework forms the core of all performance and contract monitoring, the basis for induction and professional development, and the design of support to staff.

**R23**

HMPPS should develop a knowledge and skills framework underpinned by evidence-based methodology, and an aligned curriculum and assessment methodology which includes a comprehensive focus on knowledge of child development, enduring relationships with family and community, the impact of trauma on behaviour, skills for building trusted relationships, positive behaviour management, restraint as last resort and effective resettlement.

**R24**

HMPPS should introduce a second stage recruitment and redeployment process to ensure suitability and aptitude for working with vulnerable children in youth custody.

**R25**

HMPPS should introduce a supported management and leadership pathway for those without a prisons background to form an expanded pool of talent for future YOI Governor and other management roles.

**R26**

HMPPS should work with the YOI Governors to identify policies that do not sufficiently address key differences when working with children and ensure these are amended in line with children's best interests. Priority attention should be given to those covering performance management and disciplinary action.

Given the complexity and vulnerability of the children in custody, and the specialist nature of the skills required, there is a compelling case for professional registration of YCS staff by an independent body. The Independent Inquiry into Child Sexual Abuse reached this

same conclusion in 2022, recommending the introduction of mandatory registration for staff working in children's homes, young offender institutions and secure training centres.<sup>20</sup>

To move towards this model, preliminary work should include a set of refreshed professional standards specific to the youth custody context, a knowledge and skills framework, and an aligned curriculum. This should naturally flow from the National YCS Practice Framework described above. HMPPS's Enable Programme for prison staff, which includes dedicated 'professional standards' learning packages at multiple levels, offers a partial model, but is not sufficient for the specialist knowledge and skill that working in the youth custody estate demands.

Over the last few years, HMPPS has introduced an internal register for probation staff, requiring staff to hold the right qualifications, knowledge and skills. Registration became mandatory for qualifying roles from 30 September 2024, underpinned by six Probation Professional Registration Standards aligned to HMPPS-wide values and embedded from initial qualification through to continuing professional development. Most recently it has been announced that registration of probation staff will be undertaken by an independent body. This creates an opportunity to expedite the journey towards registration for youth custody staff.

**R27**

HMPPS should work towards introducing professional registration for YCS staff by an independent body in line with the IICSA recommendation.

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<sup>20</sup> [E.2: Regulation of the workforce | IICSA Independent Inquiry into Child Sexual Abuse](#)

## Part Two: Safeguarding checks and balances

### Complaints

The Medomsley Review showed how children's complaints were ignored, disbelieved or suppressed within institutional cultures that protected the perpetrator. Trainees (the term used in the review) needed to be able to read and write to make a complaint, and official figures from the period show that literacy levels were poor. As prison staff were the gatekeepers for complaints from trainees, there was an obvious risk that they could obstruct the process by persuading or intimidating trainees not to complain, or by losing documentation or stalling complaints. If prison staff did not believe the allegation that the trainee was making, they did not record it as a complaint. The complaints procedure appears to have been viewed as an adversarial process between trainees and prison officers rather than as a formal way for trainees to raise concerns about their treatment or conditions. There was also no mechanism for trainees to submit official complaints via third parties. In situations where trainees tried to raise a complaint with a visiting third party such as a family member or legal advisor, officers were instructed to intervene and state that the proper procedure needed to be followed. There was a lack of independence of those investigating and the prevailing attitudes towards young offenders meant that they and their families were not believed when they made allegations.

The Review argued that,

“the system for children to make a complaint in today’s criminal justice system remains broadly the same as the system in place when Medomsley operated. To make a complaint, children must write to the governor, or the establishment. Some children have low literacy skills or will fear the reprisal of doing so. From the complaint investigation work my office carries out, I know that children are more likely to disclose their feelings and experiences to people they know. It remains the case today that family members or trusted people cannot make a complaint on behalf of someone in prison.”<sup>21</sup>

A well-functioning complaints system is part of an effective safeguarding architecture – a feedback loop that surfaces harm and drives improvement: complaints systems give children a voice when something has gone wrong; create a formal record that can trigger action or escalation; signal systemic problems to managers, inspectors and oversight

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<sup>21</sup> [Operation Deerness final report into widespread abuse at Medomsley Detention Centre](#)

bodies; and provide accountability for institutions. However, despite comprehensive policy and procedural frameworks underpinned by legislation, the realities facing children in custody can become structural barriers to being heard and protected.

The [Independent Inquiry into Child Sexual Abuse's \(IICSA\) custodial institutions investigation \(2019\)](#) remains the most comprehensive analysis of why children do not raise complaints or disclose concerns. Its findings remain directly relevant to this work and have informed much of what we conclude below. Children know that making a complaint against a staff member does not happen in a vacuum. IICSA describes “the power asymmetry” as “total and immediate”. Children are complaining about the very adults who control their daily lives and their privileges; the child has no choice about being there; they cannot leave and depend entirely on staff for basic needs of food, sleep, access to family and education. Real or perceived consequences for raising concerns have a chilling effect on children's willingness to complain. Complaints processes are most often designed for literate, articulate adults and can be poorly adapted for children with neuro-development needs, communication difficulties or trauma responses. Concerns can be reframed as behaviour management issues rather than legitimate grievances about the quality of care. Complaints investigated by the same institution being complained about sets a predictable bias towards self-exoneration and institutional capture. Consideration should be given to children's communication needs, including access to services and support in their preferred language (including Welsh where required).

Arrangements for Young Offender Institutions (YOIs) complaints processes are governed by the [Prison Act 1952](#) and the [Young Offender Institution Rules 2000](#), alongside HMPPS and Youth Custody Service policy frameworks. Under Rule 8 of the YOI Rules 2000, children have the right to make requests and complaints. In practice, complaints are managed through the HMPPS prisoner complaints system. This generally requires individuals to pursue an internal complaints process first before escalating concerns externally. Initial complaints are made using a COMP 1 form, covering issues such as treatment by staff, decisions affecting the individual, regime, or access to services. If the complaint is particularly sensitive, a confidential access route (COMP 2) is available, allowing the complaint to be directed to senior staff such as the Governor or the Independent Monitoring Board. Where a complainant is dissatisfied with the outcome, they may appeal using a COMP 1A form, which is reviewed at a more senior level.<sup>22</sup> Once internal procedures have been exhausted, complaints may be referred to the Prisons and Probation Ombudsman (PPO), which independently investigates complaints from individuals detained in prisons and YOIs. The PPO will normally only accept complaints where the internal process has been completed, although limited exceptions may arise where this has not been possible.<sup>23</sup> In addition to the formal complaints process,

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<sup>22</sup> [Prisoner complaints policy framework - GOV.UK](#)

<sup>23</sup> [About complaints – Prisons and Probation Ombudsman](#)

independent oversight is provided through the Independent Monitoring Board (IMB) in YOIs and inspection regimes. Every YOI has an IMB, established under the Prison Act 1952, whose role is to provide independent scrutiny of the treatment and conditions of those detained. Board members have unrestricted access to all areas of the establishment, its records, and the children held there, and are required to satisfy themselves that individuals are treated fairly and humanely, hear complaints directly, and report concerns to Ministers where necessary. IMBs produce annual reports and act as a regular, on-site source of independent monitoring, complementing, but not replacing, formal complaints mechanisms.

As Secure Children's Homes are typically run by local authorities they therefore fall within the scope of the statutory children's social care complaints procedure where complaints relate to the authority's duties and functions. This framework is established by the [Children Act 1989](#) (in particular sections 24D and 26), the [Children Act 1989 Representations Procedure \(England\) Regulations 2006](#), and statutory guidance [Getting the Best from Complaints](#). This is a formal three-stage statutory complaints procedure: Stage 1: Local Resolution where the complaint is made to the home / provider and should be resolved quickly and informally where possible. If unresolved, the complaint moves to Stage 2 for formal investigation. An investigating officer is appointed; and an independent person oversees fairness. If still unresolved, the child can ask for an Independent Review Panel to review the complaint as Stage 3. If that remains unresolved, they can go to the Local Government and Social Care Ombudsman in England and the Public Services Ombudsman in Wales. For Welsh Secure Children's Homes the policy is set out in [Representations Procedure \(Wales\) 2014](#) and [relevant guidance](#).

Secure Training Centres operate under a distinct legal framework. They are provided for under the [Criminal Justice and Public Order Act 1994](#) and governed operationally by the Secure Training Centre Rules 1998. These rules require each centre to operate a comprehensive grievance procedure, to which children and their parents must have access, alongside mechanisms for raising concerns confidentially and access to independent persons. In practice, children also have access to independent advocacy services. In addition to internal procedures, children detained in Secure Training Centres may escalate complaints to the Prisons and Probation Ombudsman, provided they have first completed the internal complaints process.<sup>24</sup>

Children in YOIs and the STC are often isolated from trusted people. Calls are monitored and recorded, visits do not take place in private, and many children are held hundreds of miles from their families. Some children we spoke to said there was no point in complaining because nothing ever changed. Children simply cannot be bothered to pursue an onerous process when their experience tells them it's not worth the effort. This entrenched experience, combined with the complexity of the arrangements described

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<sup>24</sup> [Prison and youth custody complaints – Prisons and Probation Ombudsman](#)

above clearly illustrates the barriers to raising concerns. It means that children who have had poor experiences of complaining, who lack literacy, who fear reprisals, or who do not understand the process are effectively excluded from formal recourse. This is disturbingly similar to the findings in the Medomsley Review. It is noted, however, that many children do complain despite the barriers set out above.

Crucially, under the current framework in the YOIs, only the child can submit a formal complaint: professionals working with the child, including advocates, cannot raise a complaint on a child's behalf. This is a fundamental structural barrier.

A review of induction materials across sites found that a large volume of information is provided to children on arrival into a YOI. In practice, this can result in cognitive overload: one induction pack reviewed contained more than 40 slides, many of which relied heavily on dense written content. Such formats are inherently inaccessible for children with low literacy levels, learning difficulties, or neurodiverse needs, all of whom are overrepresented within the custodial population. Even for children without these additional needs, the reliance on text-heavy materials limits comprehension and retention. The point of arrival is also one of the most disorienting and frightening experiences a child is likely to face. It is likely the worst possible moment to expect children to absorb and retain information about their rights, complaint routes, and safeguarding. It risks overload at the point of greatest vulnerability and follow up is crucial.

Parents and carers face their own version of this problem. There is no single, consistent process across the secure estate for parents and carers to raise concerns. We were told that in the YOIs, where concerns are raised, they tend to be treated as official correspondence rather than formal complaints, leaving families without recourse, without a clear pathway, and without feedback.

Through engagement with the Prisons and Probation Ombudsman (PPO) we heard that responses to even the most serious complaints in the system can be vague, and children are often not included in, or informed about, the investigation process, leaving them without clarity on outcomes. Where a complaint is upheld, the PPO has no statutory power to enforce action against staff: the office can recommend an HR investigation or managerial guidance but cannot compel any outcome. This enforcement gap means that even when the PPO finds something wrong, children and families may see no visible consequence, further eroding confidence in the system. Children placed in SCHs do not have access to the PPO but instead can complain to the Local Government Ombudsman.

R28

HMPPS complaints framework should be amended to allow trusted adults to raise formal complaints on behalf of children, with their full involvement at every stage. Commissioned custody placements should be contracted on the basis that similar arrangements are in place.

R29

HMPPS ensure that induction materials and processes across all YCS settings should be reviewed and redesigned to be accessible to children with low literacy levels, neurodiverse needs, and communication differences. Information about rights, complaints, and safeguarding should be reinforced through regular touchpoints throughout a child's placement.

## Independent routine safeguarding enquiry

The concept of routine safeguarding enquiry (RSE) comes primarily from domestic abuse policy and public health practice. Its modern origin is in the health response to UK domestic abuse policy, especially NHS and midwifery safeguarding practice in the 2000s, when clinicians and public health services began adopting the principle that professionals should ask routinely about abuse, rather than wait for disclosure.<sup>25</sup> One of the clearest formal early adoptions was routine enquiry for domestic abuse in pregnancy, which was introduced because pregnancy is a known point of increased risk and a rare point of repeated professional contact. The core idea is simple: because abuse is common, hidden, and often undisclosed unless asked about directly, practitioners should make a routine, safe enquiry part of ordinary assessment.

It meant a structured, routine question asked of everyone in a defined group, usually: in private, by a trained professional, regardless of visible signs, to identify hidden abuse, and to enable safe support/referral. It is better understood as a preventative identification practice: a structured, routine, low-threshold way of asking about harm to identify risk early.

The National Institute of Clinical Excellence advises that safe enquiry requires staff who can: recognise abuse, ask safely, respond with empathy, assess immediate safety, document appropriately, and refer to specialist support. This can be summarised as an 'ask, respond, refer' approach.<sup>26</sup>

In the [Medomsley Review](#), the Prison and Probation Ombudsman argued:

“it is still not a requirement for every child in detention to be proactively, and regularly, asked by an independent party about their custody experience seen through a safeguarding lens. If the right environment was created and they were conducted by suitably trained, trauma-informed professionals, these conversations would provide a degree of reassurance to families and all interested parties, along with building public confidence in the criminal justice system. The number of children in custodial detention

<sup>25</sup> [Quality statement 1: Asking about domestic violence and abuse | Domestic violence and abuse | Quality standards | NICE](#)

<sup>26</sup> [recognising-responding-domestic-violence-abuse-quick-guide.pdf](#)

is such that the resource required to achieve this annually, or even more frequently, would be extremely small.”

We support the introduction of independent routine safeguarding enquiry for children in custody in principle, and have debated extensively about who is best placed to make the enquiry. It is certainly true that there is an extensive array of practitioners who frequently meet with children in custody. We were particularly struck by the extensive contact YOI Resettlement Teams have with children. In one YOI, resettlement practitioners see the children they have responsibility for at least twice a week. Children need to be able to trust the person they are disclosing to; they need to believe something will happen as a result which will not in any way make their lives harder. In this context independence matters a lot. Despite the close relationship that resettlement workers have with children, they are very much part of the fabric of the institution.

All youth custody sites provide advocacy services under various formal contractual specifications, which sets out an ambitious and detailed framework for what the service should deliver.<sup>27</sup> For example, under the specification for the YOIs’ advocacy service, every newly arrived child must be visited in person by an advocate within 72 hours of arrival. A fuller induction meeting must follow within 7 calendar days, in which the advocate introduces themselves, explains the service's independence and confidentiality, and covers the various ways in which a child can make contact. Within 14 days of arrival, every child must also receive a Children's and Young People's Rights Awareness Session, covering rights under the UNCRC and the Human Rights Act. Children must be able to access the service 24 hours a day, with a maximum response time of 72 hours to any referral, and 24 hours for urgent matters. Advocates are required to visit every part of the residential unit, including healthcare units, enhanced support units, and care and separation units, on a regular, publicised schedule. Where a child has been subject to a full search, or where a Serious Injury Warning Sign is generated following restraint, contact must be made within 24 hours. Where a child is transferred, released, or transitions to adult custody, the specification requires careful case handover and – with the child's consent – coordination with community and other advocacy providers. The specification also places obligations on the provider in relation to safeguarding: advocates must follow local safeguarding protocols, establish relationships with the LADO and Designated Safeguarding Person at each site, and report child protection concerns directly to those persons. The service is required to hold monthly Advocacy Review Meetings with senior managers of the YOIs to raise thematic issues, and to produce monthly data returns, quarterly management reports, and an annual report. Advocates must have knowledge of children's rights and core safeguarding practice, the impact of trauma and other adverse childhood experiences, as well as the necessary communication and relationship building skills essential for high quality advocacy.

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<sup>27</sup> <https://www.barnardos.org.uk/get-support/services/barnardos-your-rights-your-voice-secure-estate>

Specifications are explicitly child-led and strengths-based. We heard of some of the great work done by advocates across the sites and several children said that their advocates were their most trusted adult. Some we spoke to thought that the advocates could on occasion have more robustly pursued a positive outcome for a child; others questioned the perception of independence given the advocates were located on site.

Advocates have a distinct and important role to play on site. Whilst there is not universal agreement on this point, a persuasive argument has been made by one advocacy organisation, that it would not be appropriate for it to undertake routine safeguarding enquiry in addition to its advocacy function as these are very distinct functions. Professional advocacy is fundamentally about amplifying and representing the child's expressed wishes feelings and interests. The advocate's role is non investigative; they receive what the child tells them, support the child to articulate it, and ensure it reaches the right people through the right channels. The advocate's obligation runs to the child, not to an institutional truth-finding process. Their engagement with the disclosure is to support the child making it; not to probe, assess or evaluate it. I am persuaded by that argument.

## **The role of the home local authority & social worker**

Effective routine safeguarding enquiry requires independence from the institution, and a certain set of skills and safeguarding expertise. I have concluded that it follows that the best placed professionals, who have the relevant knowledge and skills and independence, would be social workers located within the home authority.

The vulnerability of children across the youth custody estate, makes it intuitively correct that there is a legal relationship between all children in custody and their home local authority. The home local authority should have an unequivocal set of duties and schedule for delivery, to ensure high-quality safeguarding and resettlement practice. This should include independent routine safeguarding enquiry. Whilst the local Youth Justice Service already has responsibilities towards children in custody, guidance leaves significant room for interpretation. Local authorities do have specific duties within clearly defined timelines, but these only apply to children with 'looked after children' status. In addition to the critical importance of local connections and sense of belonging described above, and despite the recognised challenges of distance, the home authority is often the only truly external and independent safeguarding mechanism unfettered by day-to-day working relationships.

Currently all children on remand are considered 'looked after' by their home local authority. Children who were looked after before they were remanded retain that status upon sentencing. So, for many children in custody, they are already looked after children and are safeguarded through the discharge of those duties. However, a significant proportion of children on sentence are not – data on this is not currently available from the YCS but we estimate it is around 65%. This group of children, some of whom are facing long

sentences in closed institutions, are arguably the most vulnerable. This is particularly true, and often exacerbated, where there are fractured family relationships. Extending care status to all children in custody as the right mechanism to achieve maximum safeguarding and support family and local connection has been periodically explored but, in the end, always rejected.

Many staff I spoke to were passionate advocates of all children acquiring looked after children status, although mainly because of the support this would secure for them once released from custody (assuming they were still under 25). Many local authorities object to assuming responsibility for the care of children when they have little, if any, control of the quality of care on a day-to-day basis. The experience of children on remand, with automatic care status, brings this conundrum into sharp relief; local authorities hold significant responsibility but without any power to hold the YCS provider to account (in the same way that local authorities do for all other placement arrangements for children in care). Some senior leaders in local authorities told us that responsibility without power is pointless as it makes local authorities complicit in the treatment these children receive, without the ability to change anything. This is ethically deeply uncomfortable for some. Others felt strongly that such a change in policy should not be made only to address the deficits of care in the YCS service. We think this is a fair challenge and this change must not be seen in any way to ameliorate the concerns about quality of care.

Some I spoke to raised significant and valid concerns about how automatic looked after status could undermine existing family relationships, leaving family feeling disempowered. However, acquiring looked after children status will certainly enhance the child's rights to contact with their families. Furthermore, local government as a dominant partner, and every single local authority and their Director of Children's Services firmly holding YCS to account for the quality of care and protection for every child in custody, will always be a far more powerful advocate than any individual family could be.

Whilst there was valid concern about the resource implications of such a change from some local authority leaders we spoke to, the reality is that children in custody are already looked after by the State. The home authority is **already** substantially involved because of the responsibilities of the local Youth Justice Services, and their resettlement responsibilities post-custody; home authorities are best placed to help rebuild fractured family relationships, and support engaged families to keep in contact – not because all (extended) family members necessarily live in the home authority (although many will do) but because the home authority often has access to family history, or can more easily acquire it when the child in question is not known to children's social care.

R30

To maximise opportunities for safeguarding in custody, the facilitation and strengthening of family relationships and resettlement plans, all children in youth custody should be considered "looked after" by the home local authority.

R31

Independent routine safeguarding enquiry should be introduced as a structured, routine, sensitive, private enquiry undertaken by the home local authority social worker as a distinct part of their duties towards children looked after by virtue of their custodial sentence.

## A change in legal status is not a panacea

Whilst extending care status to all children could be symbolically powerful, it won't in and of itself generate the change we want to see.

The Child Safeguarding Practice Review Panel's [report on the Hesley Group Children's Homes](#) in which a wide range of safeguarding failures were identified, scrutinised the over-reliance of visits in closed institutions. This "closed culture" dynamic is central to understanding why visits don't always function as a safeguard. Even when visits do occur, due to security concerns and capacity issues, children are rarely seen alone for long periods of time, or with sufficient frequency. This limits the ability of professionals to develop a trusted relationship with children, and in turn limits the child's ability to divulge personal information privately without fear of retribution. Practitioners need to think through how to develop ongoing relationships with children over extended periods of time, how to establish an accurate understanding of how a child is being treated and what a child is experiencing. It is essential that there is at least one person who holds a complete picture of the child's life or at least gets as close to that as possible. Scheduled visits can become procedural and compliance-focused, rather than being used as a vehicle for genuinely understanding children's experiences. Practitioners need to actively listen to children in ways that work for the child and triangulate what they hear and see with what families know; families are most likely to notice changes in behaviour or appearance, raise concerns and challenge poor practice. The best safeguarding practise requires curiosity, scepticism and a willingness to interrogate concerns rather than merely accept reassurances.

There were reports of frequent and positive contact between children and their social workers and/or youth justice workers, but some children and staff report that the home local authority can seem uninvolved, and at worst uninterested, in the welfare of children in custody, even when they do have looked after children status. There is certainly an array of practical barriers to visits taking place (capacity, resource, distance, cancellations because of security) and we were given many examples of how difficult it can be to gain access to children. We were told one heart-breaking story from one boy whose mother had taken time off work (and had a corresponding loss of earnings) on three occasions, travelling a considerable distance at considerable expense, only to be told the visit was cancelled on arrival. She has not tried to visit since. The barriers to visiting in the YOIs were relayed to us almost as a *fait accompli*. A themed joint inspection report published in

2023 described a wide range of familiar barriers to visiting but inspectors found it striking that these were known barriers rather than unforeseen ones, that agencies frequently accepted them as practical difficulties instead of actively trying to overcome them, and that the response was insufficiently proactive.<sup>28</sup>

There is insufficient national oversight of local authority compliance with statutory duties towards children in custody; this makes it currently very difficult to understand the scale of the reported problem or ways in which it might be addressed. Tracking compliance is important, as the visit represents a gateway into something much more meaningful, and potentially powerful, in the safeguarding of children in custody.

The YCS has recently begun to track local authority compliance with statutory duties to visit children across the public YOIs. This exercise should be extended to all YCS sites. Regardless of whether the legal status of 'looked after' is extended to all children, efforts must be made to ensure that all respective statutory duties are met on all sides. This should include close scrutiny of the reasons why planned visits do not go ahead, and serious efforts made to remove barriers.

**R32**

HMPPS should establish systems to track when children are visited, by whom and whether this is in line with statutory expectations of the home local authority. Reasons for visits not taking place should also be recorded.

HMPPS should establish the key barriers to scheduled visits going ahead as planned and resolve systemic causes in particular sites and across the secure estate.

**R33**

The Ministry of Justice should introduce a new statutory notification system where local authorities and Youth Justice Services are not meeting their statutory duties to visit children. These notifications should be sent to the Local Authority and the Youth Justice Service for urgent action, and to HMIP and Ofsted for consideration in their respective inspections.

## Family engagement as a key protective factor

Family relationships are the most important protective factor for children in general, and this naturally extends to those children in custody. Many children in custody are deeply connected to their families and receive ongoing emotional and financial support, as well as visits – some across many years. Even when parents have experienced significant

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<sup>28</sup> [A joint thematic inspection of work with children subject to remand in youth detention](#)

difficulties in their own right – such as poor mental health/addiction/poverty and/or custody – which may have adversely impacted their parenting, their love and commitment to their child can withstand many challenges – their children going into custody being one of them. These enduring relationships need to be celebrated and supported.

Some children do not have this level of familial support. Their family relationships are fragile or completely fractured, with some children having no one visiting them at all. Where this happens, social workers, advocates, and formal visiting arrangements can play a vital role in maintaining connections, ensuring children do not lose contact with people important to them, and providing an independent adult voice in their lives.

Over the last few years, the importance of family contact for children in custody has been evidenced from a consistent line of official reviews, inspections and thematic reports. Across them, the same conclusion is repeated: family contact is not an “add-on” to custody, but central to children’s emotional stability, safety and rehabilitation, and fundamental to safe and effective youth custody.

The Office for the Children’s Commissioner’s 2023 [report into Family Contact](#) in Youth Custody, which drew on statutory data requests and visits across YOIs, SCHs and STCs, found that maintaining family relationships is one of the most important protective factors for children in custody, but that the secure estate routinely makes this unnecessarily difficult. It concluded that contact with family is crucial to children’s emotional wellbeing, identity, and prospects of resettlement, and criticised the “structural barriers” that prevent meaningful contact. Key findings cited that almost half of children in custody (44%) had no in-person visit in a two-month period; 83% had no video call in that same period. This is notably stark when children have described family support as one of the few things helping them to cope in custody.

HMIP’s annual Children in Custody reviews do not focus solely on family contact, but they consistently treat contact with family as one of the core indicators of a child-centred custodial environment. The inspectorate links poor wellbeing, isolation and insecurity in custody to children being locked up, under-supported and disconnected from ordinary relationships. The repeated inspection theme is that children do better where relationships with family and trusted adults are maintained, and worse where they are isolated. Family contact appears repeatedly as part of the wider “healthy child environment” test: children feel safer, more hopeful and more settled where contact is consistent.

The [Youth Justice Legal Centre’s commentary](#) on ‘Children in Custody’ highlights that children face significant structural barriers to maintaining contact with their families and wider support networks, including distance from home, cancelled visits, and poor institutional prioritisation. Drawing on the Children’s Commissioner’s 2023 review, it demonstrates that many children receive little or no meaningful contact with family members, pointing to systemic failings within the secure estate. These issues are framed

not merely as matters of welfare, but as fundamental children's rights concerns relating to the maintenance of family life.

The central point is consistent: distance from home weakens family contact, increases isolation, and makes resettlement harder. This must be addressed.

### **Case study – Lifelong Links**

Lifelong Links is an approach co-created by the Family Rights Group with children, to build a support network with, and for, children in care and care leavers. Many children in the care system are separated from siblings and live far away from family and friends leaving them isolated and vulnerable. The Family Rights Group supports local authorities to implement Lifelong Links with children in care and care leavers. This includes training Lifelong Links coordinators, developing practice guidance, publishing resources, and providing specialist one to one support to help local authorities set up and embed a Lifelong Links service.

Y was 17 years old when he began his Lifelong Links journey. At that time, he was in custody at HMYOI Wetherby and navigating a period of uncertainty and transition. When asked who he had around him for support, Y identified only his best friend and his best friend's mother, who was providing emotional and financial support while he was in custody. Beyond this, Y felt his support network was extremely limited and described feelings of isolation.

Y approached Lifelong Links cautiously. His experiences of disrupted and inconsistent relationships meant that reconnecting with people from earlier stages of his life felt uncertain and emotionally challenging. Through a young person-led and relational approach, Y was supported to identify individuals who had been meaningful to him and to explore reconnection at a pace that felt safe and manageable, allowing him to remain in control throughout the process.

As reconnections began, the impact on Y was clear. During these experiences, he appeared calmer, more settled, and noticeably happier. Reconnection with his maternal grandmother was particularly significant. She made it clear that her door will always be open to him, providing reassurance that there is a place of safety, continuity, and belonging available beyond custody. This message appeared to offer Y comfort and emotional stability during a difficult period.

Y also reconnected with his previous foster parents, who expressed continued care and commitment to him. They offered emotional support and stability, as well as inclusion within their wider family and church community. Y identified this as a positive and supportive environment where he feels accepted. Importantly, plans have already been made for Y to spend Christmas Day and Boxing Day with his foster parents, with his siblings also invited. This forward planning has been especially meaningful for Y, representing inclusion in family life and providing something positive to look forward to following his release.

Alongside these reconnections, Y shared aspirations for his future. He expressed a desire to pursue a career in property development and spoke about wanting to build a more stable and positive life. His foster parents have offered practical support with exploring courses, applications, and next steps, which has helped Y feel encouraged and motivated to plan for life beyond custody.

Reconnection with Y's older brother has also been central to his journey. His brother has committed to collecting Y on the day of his release and supporting him with his next steps. Knowing someone will be present at that key moment has helped Y feel reassured and less anxious about the transition ahead. Y also reconnected with his younger sister, a relationship that had previously been strong but had weakened over the past three years. Time spent together during the Lifelong Links process was positive and relaxed, involving shared memories and plans to reconnect through activities they previously enjoyed together.

Professionals who supported Y earlier in his life also agreed to reconnect through positive messages, shared memories, and photographs. This contact had a noticeable emotional impact, particularly during periods when custody felt most difficult, helping Y feel valued and remembered.

Y speaks about his future with greater confidence. Lifelong Links has enabled Y to move forward with meaningful relationships beyond statutory services, positively supporting his wellbeing, sense of identity, and readiness for the next stage of his life.

**R34**

HMPPS should fund a dedicated service to help rebuild and repair fractured family relationships for all children in custody where this is not already being undertaken by the home local authority as an excellent and leading example of corporate parenting responsibilities as defined in the new Children and Wellbeing Act 2026

## Conclusion

Despite drawing on historic events about youth custody in the 1960s, the lessons from the Medomsley Review are highly relevant for contemporary youth custody services. The Review is a testament to what can happen when children are not believed, when institutional cultures become self-protective, and when safeguarding systems lack the independence, expertise and persistence needed to act to protect children from abuse.

Youth custody today is different in form and in law, and throughout this review we met many committed, thoughtful and resilient staff, as well as examples of strong practice and genuine care for children. But those strengths do not remove the central conclusion of this review: the current safeguarding arrangements across the YCS are not yet consistently strong enough for the level of risk, complexity and vulnerability it is expected to manage.

Children in custody are among the most vulnerable children in society. Many have experienced trauma, abuse, neglect, exclusion, family disruption, neurodevelopmental difficulty, and chronic instability long before they arrive in a secure setting. The State therefore assumes an exceptional responsibility when depriving them of their liberty. That responsibility must include not only containment, order and security, but protection, care, dignity and a relentless focus on safeguarding the welfare of children.

Whilst most safeguarding referrals are managed well, this review has found significant weaknesses in the investigation of allegations against staff concerning harm to a child, in the consistency of child protection expertise available, in counter corruption decision-making, in the quality of central governance, data and audit, and in the accessibility of complaints and other protective mechanisms for children. These are not peripheral matters. They go to the heart of whether children are safe, whether concerns are heard, and whether institutions can identify and act on patterns of harm before they escalate.

The review also highlights a wider truth. Safeguarding does not operate in isolation from the environment in which secure care is provided. High levels of violence, long periods locked in rooms, inconsistent access to education and family contact, stretched staffing, and the profound differences in quality and resource between different settings all shape the daily reality of children's lives and the culture in which staff work. In such conditions, trust is harder to build, complaints are harder to raise, and professional judgement is placed under sustained pressure. That is why the recommendations in this report are deliberately broader than the management of allegations alone. They are designed to strengthen the whole protective architecture around children in custody: better investigative practice; more independent scrutiny; stronger governance; higher standards for recruitment, training and professional development; improved complaints

arrangements; introduction of independent routine safeguarding enquiry; and a consistent safeguarding role for children's home local authorities.

Many of this review's findings and recommendations echo concerns raised repeatedly over recent years. That is part of the problem. Too often, the same messages about systemic difficulties are restated while the underlying conditions persist. The challenge now is for Government, HMPPS, the Youth Custody Service, local authorities and partners across England and Wales to act with sufficient urgency, discipline and resolve to address them as a partnership. If the recommendations in this report are implemented with pace, rigour and the necessary resource, staff will be better supported to do well, in one of the hardest jobs in public service, and, most importantly of all, children in youth custody will be better protected.

# Annexes

## Annex A: Terms of Reference

### Safeguarding Review Panel – Youth Custodial Estate Terms of Reference

#### **Purpose**

No child should ever be at risk of harm, not least whilst within the care of the State, such as those children detained in a youth custodial establishment. These organisations exist to help children develop and address the issues which contributed to them being in custody.

We must ensure that all children receive the highest standards of support and feel safe, as well as being able to report concerns and have confidence that they will be acted upon.

The Children and Young People Secure Estate (CYPSE) has a statutory responsibility to safeguard children – whether the child is serving a sentence or held on remand. The CYPSE should ensure that each site which accommodates children provides a safe, respectful, and developmentally supportive environment that promotes positive outcomes and enables children to thrive.

This panel was set up following the publication of the Prisons and Probation Ombudsman report into the appalling abuse suffered at Medomsley Detention Centre from 1961 to 1987. The report detailed the abuse of boys and young men by the very people who were employed to look after them. Recent safeguarding failures have also been flagged at several different establishments in today's estate.

The panel will focus on reviewing current safeguarding arrangements to ensure that the CYPSE is in the strongest position to help prevent abuse of children by staff. In the course of the review, if there are concerns for any children, this will be brought immediately to the attention of the YCS.

The review will look at three central questions:

1. How accessible and how trusted are the arrangements for children in custody, their families and all those that work with those children, to raise child protection concerns, and how effective is the advocacy provided by relevant agencies?
2. How effective are the responses from relevant agencies in addressing allegations against staff?
3. How effective are the arrangements for the recruitment of YCS staff, their induction, ongoing support and training as it relates to child protection and broader safeguarding?

The review will consider examples of good practice to reflect the strengths within the CYPSE, with a view to scaling up the most effective examples.

## **Remit**

The youth custodial estate comprises of four distinct types of establishments. Each establishment type plays a unique role in meeting the diverse needs of children and have their own legislative frameworks, operational models, internal processes, and levels of available resources. All of these establishments will be within the remit of this panel's work:

- Young Offender Institutions (YOIs): Typically larger and more prison-like in structure, older children often are often placed in YOIs, where there are more rigid regimes and smaller staff ratios.
- Secure Training Centres (STCs): The remaining STC aims to offer a more trauma informed environment, balancing custody with structured learning and behavioural support, with a higher staff to child ratio than in YOIs. The STC is operated by G4S.
- Secure Children's Homes (SCHs): These are smaller, welfare-led settings that provide intensive care and support, often for younger or more vulnerable children, with a strong emphasis on safeguarding and emotional wellbeing. They are operated by local authorities (LAs) and have higher staff to child ratios than YOIs and STCs.
- Secure School: The first of these is the Oasis Restore Secure School (ORSS) run by Oasis Trust. It is a new model that integrates education, care, and rehabilitation in a therapeutic setting, aiming to reframe custody through a child-first, trauma informed approach.

The panel's remit includes children who are 18 years and under but held in these settings. It does not cover young adults 18–21 in adult prisons with YOIs attached. It covers children in England and Wales.

Statutory oversight for safeguarding sits with LAs and DfE's Working Together to Safeguarding Children underpins how the system should respond when concerns are raised. This guidance includes specifics for the youth custodial context; however, it has been identified that there are inconsistencies in how safeguarding operates in practice among different custodial sites.

## **Forward Look**

From January to June, the panel will take a three-stage approach. It will begin with fieldwork, followed by analysis and interviews, and conclude with final recommendations reported by June 2026. The panel will meet monthly, with progress reports provided to the Minister for Youth Justice every 6–8 weeks.

Within this 6-month period of work, the panel will be structured into 5 workstreams:

1. **An exploration of the feasibility for new arrangements for raising child protection concerns and improving advocacy responses** – led by Dr Jahnine Davis, Independent Children’s Rights and Safeguarding Advisor, with the support of Ministry of Justice
2. **An analysis of the data held on allegations against staff across the Youth Custody Service** – led by the Youth Custody Service
3. **A case review into allegations against staff where abuse is indicated** – led by Isabelle Trowler, Chief Social Worker for Children and Families, with the support of Esther Beresford
4. **A review of staff recruitment, training and support practices across the Youth Custody Service** – led by the Youth Custody Service
5. **Linked to (4), an exploration of the practice culture across the youth custody estate from the perspective of prison staff, children and their families** – led by Nana Bonsu, Director of Relational Practice, Camden Council

### **Membership**

The panel will be chaired by the Chief Social Worker for Children and Families in England, Isabelle Trowler. Whilst the full list may be subject to change as the panel progresses with its work, there will be representatives from across the system:

#### Government Departments

- Children’s Social Care, Department for Education
- National Child Safeguarding Practice Review Panel, Department for Education
- Youth Custody Service, Ministry of Justice
- Youth Justice Policy, Ministry of Justice
- Youth Justice Policy, Welsh Government

#### Inspectorates

- Care Inspectorate Wales
- HM Inspections Prisons
- Ofsted

#### Local Authorities

- Bridgend County Borough Council
- Calderdale Council
- Leeds City Council
- London Borough of Camden Council
- London Borough of Hounslow Council
- Milton Keynes City Council
- Staffordshire County Council
- Stockport Council

#### Secure Children's Homes (SCHs)

- Adel Beck SCH
- Aycliffe SCH
- Barton Moss SCH
- Clayfields SCH
- Hillside SCH
- Vinney Green SCH

#### Young Offender Institutions (YOIs)

- Feltham, HM YOI
- Parc YOI, G4S
- Werrington, HM YOI
- Wetherby, HM YOI

#### Secure Training Centre (STC) and Secure School

- Oakhill STC, G4S
- Oasis Restore Secure School

#### Police

- NPCC (National Police Chiefs' Council)

#### Other Key Stakeholders

- Office of the Children's Commissioner
- Association of YOT Managers
- National LADO (Local Authority Designated Officer) Network

## **Annex B: Stakeholder conversations**

I am very grateful to all of those that have dedicated time and provided perspectives that have shaped this review.

As set out in the report we were able to visit:

- HMP and YOI Feltham in December 2025;
- HMYOI Wetherby in February 2026;
- HMP and YOI Parc in March 2026;
- HMYOI Werrington in March 2026;
- Hillside Secure Children's Home in March 2026;
- Vinney Green Secure Children's Home in April 2026;
- and Oakhill Secure Training Centre in April 2026.

At one YOI we held a focus session with youth justice workers. We also held an in-person roundtable with officers and custody managers who had completed their training through the graduate scheme Unlocked.

We held virtual conversations with Governors, Deputy Governors, Registered Managers, Heads of Safeguarding, Local Authority Designated Officers (LADOs) and on-site social workers.

Other stakeholders we spoke to include:

- The Association of Directors of Children's Services
- Barnardo's
- Care Inspectorate Wales
- Child Safeguarding Practice Review Panel
- HMPPS Counter Corruption
- Department for Education
- Directors of Children's Services
- Disclosure and Barring Service
- Family Rights Group
- His Majesty's Prison and Probation Service
- HM Inspectorate of Prisons
- Home Office
- Ministry of Justice
- NHS England
- Ofsted
- Prison Governors' Association
- Prison Officers' Association
- Social Care Wales

- The Independent Monitoring Board
- The Independent Restraint Review Panel
- The Prison and Probation Ombudsman
- Unlocked
- YCS Chaplaincy Service
- The Youth Custody Service

## **Annex C: Youth Custody Provision (England & Wales)**

There are four types of provision for youth custody in England and Wales:

- Young Offender Institutions (YOIs)
- Secure Children's Homes (SCHs)
- Secure Training Centres (STCs)
- Secure Schools

The core legislation for all settings is as follows:

- Children Act 1989
- Crime and Disorder Act 1998
- Legal Aid, Sentencing and Punishment of Offenders Act 2012
- Powers of Criminal Courts (Sentencing) Act 2000

### **Young Offender Institutions (YOIs)**

Modern YOIs have operated since 1988 under the Prison Act 1952 and the Young Offender Institution Rules 2000.

There are four sites across England and Wales.

England (3):

- HMP and YOI Feltham
- HMYOI Werrington
- HMYOI Wetherby

Wales (1):

- HMP and YOI Parc

### **Secure Children's Homes (SCHs)**

Secure Children's Homes have operated since 1991 under the Children (Secure Accommodation) Regulations 1991 and section 25 of the Children Act 1989, as well as the Children's Homes (England) Regulations 2015.

The Youth Custody Service contracts beds in 7 Secure Children's Homes:

- Adel Beck
- Aycliffe
- Barton Moss
- Clayfields
- Hillside
- Lincolnshire
- Vinney Green

Barton Moss is provision for boys only; the rest are mixed. Similarly, Barton Moss only accommodates children for justice reasons, the others accommodate children detained for their own welfare.

### **Secure Training Centres (STCs)**

The first secure training centre opened in 1998 under the Secure Training Centre Rules 1998 and the Criminal Justice and Public Order Act 1994.

There is currently one STC in the country and it is run by G4S:

- Oakhill Secure Training Centre

### **Secure Schools**

The first secure school opened in 2024 under the Academies Act 2010, the Children's Homes (England) Regulations 2015, the Children (Secure Accommodation) Regulations 1991 and the Police, Crime, Sentencing and Courts Act 2022.

There is currently one secure school in the country:

- Oasis Restore Secure School

At the time of writing this report the secure school was closed.

## Annex D: Workstream lead biographies

### Isabelle Trowler CBE



Isabelle Trowler was appointed as the government's first Chief Social Worker for Children and Families in September 2013. She qualified as a social worker in 1996 and has worked as both a practitioner and senior leader in a variety of local government roles.

The Chief Social Worker for Children and Families offers independent expert advice on a wide range of national policy areas including:

- family help
- child protection
- family justice
- children's social care workforce

She works collaboratively with the Chief Social Worker for Adults from the Office of the Chief Social Worker to:

- support and challenge the profession to ensure that children and adults get the best possible help from social workers
- provide independent expert advice to ministers on social work reform and the contribution of social work and social workers to policy implementation more generally
- provide leadership and work with key leaders in the profession and wider sector to drive forward the improvement and reform programme for social work
- challenge weak practice to achieve decisive improvements in the quality of social work
- provide leadership to the network of principal social workers

### **Esther Beresford**



Esther Beresford is currently the Assistant Director of Early Intervention and Safeguarding at Calderdale Council. Over a career spanning 21 years, Esther has worked in frontline child protection, children looked after, adoption, fostering, child exploitation, leaving care and youth justice, including within a YOI. Esther has specialised in improvement work in local authorities and leading service reviews to ensure children and families receive the right help, support and protection, at the right time.

Esther has previously participated in a government case review of mother and baby placements in prison. Esther has also worked as an independent chair for Mother and Baby placements within prisons.

### **Nana Bonsu**



Nana Bonsu is an experienced senior leader and a qualified social worker, family and systemic psychotherapist, and systemic supervisor.

She is the Director of Children's Safeguarding and Family Help in Camden. Prior to this she led services that support innovation, participatory practices, humanistic and relational infrastructures. Nana has worked in children's services for over twenty years, both in children's statutory services and CAMHS (Child Adolescent and Mental Health Services). Nana has led on the design and delivery of systemic practice as a whole system approach to practice and innovation, successfully in several local authorities.

Nana is an experienced lecturer, teaching at Goldsmiths, University of London, Tavistock and Portman, the Institute of Family Therapy, and for the Association of Family Therapy. Nana was one of four Directors at the Institute of Family Therapy.

## Dr Jahnine Davis



Dr Jahnine Davis a care-experienced professional. She is the nationally recognised expert on adultification bias and its implication to safeguarding children. Dr Davis is the National Kinship Care Ambassador and a member of the National Child Safeguarding Practice Review Panel, bringing 28 years of experience across charities, statutory services and academia.

She holds a Master's in Women and Child Abuse and a PhD focused on safeguarding Black children in extra- and intra-familial harm contexts. Her research and leadership have informed national policy and guidance across children's services. Dr Davis is Director of Listen Up and was named Children and Young People's Champion in 2025. The Davis Scholarship at Durham University, established in her honour, supports care-experienced students into higher education.



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