

A Review of Safeguarding in the Secure Estate

2008

ACKNOWLEDGEMENTS

We would like to thank the following for the contribution they made to the review:

- Clare Chamberlain, Mary Ryan and Jo Tunnard, who, as Associates of the National Children's Bureau, conducted the fieldwork visits to secure training centres and secure children's homes, and commented on an early draft of this report
- All the staff within the secure establishments who helped us to access the information we needed and who contributed their views
- The young people across the secure estate who agreed to share their views and experiences
- Other key stakeholders who gave up their time to be interviewed
- The Local Safeguarding Children Board Chairs or their representatives who participated in the review
- The Cross-Government Steering group that advised the review teams and formulated recommendations.

CONTENTS

BACKGROUND	iii
EXECUTIVE SUMMARY	iv
Introduction	iv
Findings.....	iv
INTRODUCTION.....	1
Policy context.....	1
A definition of safeguarding	2
Methodology.....	3
FINDINGS.....	7
Safeguarding in YOIs	7
Safeguarding in STCs and secure children’s homes.....	39
SUMMARY AND CONCLUSIONS	61
Appendix 1: Data on interviewees	72

BACKGROUND

In 2003, the Youth Justice Board for England and Wales (YJB) and the Prison Service undertook a comprehensive review of child protection and safeguarding arrangements in every young offender institution holding children and young people under the age of 18. This review resulted in the YJB's three-year Child Protection and Safeguarding Programme. A Review of Safeguarding was built into the Child Protection and Safeguarding Programme and in 2007 the YJB commissioned the National Children's Bureau (NCB) to work in conjunction with the YJB and secure estate to assess current safeguarding policy and practice across the secure estate. This report presents the findings of that assessment.

EXECUTIVE SUMMARY

Introduction

This review of safeguarding was undertaken in order to identify what more needs to be done to ensure the safety of children and young people under the age of 18 within Young Offender Institutions (YOIs) Secure Training Centres (STCs) and Secure Children's Homes in England and Wales. The aim of the review was to highlight general themes that would inform a programme of development and improvement over the next three years rather than to inspect or audit individual establishments.

Safeguarding was defined as the protection of children and young people from harm from adults, self or peers rather than the wider agenda of promoting welfare, although it is acknowledged that the best safeguard of all is a setting that meets young people's holistic needs.

Every secure establishment was visited and evidence gathered from documents, including those relating to individual young people, and confidential interviews with a range of internal and external staff and young people. In all 217 young people, 273 establishment staff and 85 external professionals gave their views. The purpose of this approach was to arrive at a judgement on both the theoretical approach to safeguarding and the way it worked in practice.

In spite of the differences between types of establishment, and establishments of the same type, there are common themes across the settings where safeguarding could be improved. Most of these are in the structures and systems within which establishments are operating. Actions have been identified that would support establishments in their wish to keep the young people in their care as safe as possible.

The findings focus inevitably on what remains to be done rather than what is already in place, and must be read in that context. Many examples of good practice were identified and can be found on the YJB's Effective Practice website.

Findings

Overall sense of safety

Young people perceived the biggest risk to their safety as being bullying or violence from other young people, and did not fear direct harm from the staff. They feel safest in secure children's homes and least safe in YOIs, with STCs in between. The exception to this is the girls' units within YOIs, where findings suggest that their feelings of safety are comparable with an STC. A major reason for this difference is the size of the establishments and the relative staffing ratios, linked with the funding provided for each type of placement. The smaller the establishment, the better staff could get to know the young people in their care, making it easier to care for them in a holistic way.

The factors that contributed to a sense of safety were based primarily on the presence and attitudes of staff. Most young people said that their establishment would be safer if there

were more staff and fewer young people. They also referred, however, to their relationships with staff: those who treated them with respect and those who did not. The best relationships with staff were in the secure children's homes, where the culture and ethos of the staff was child-centred. This was also the case for most staff in STCs but the picture was more mixed in YOIs where some staff groups appeared to be split between those with a child-centred approach and those who saw themselves principally as disciplinarians. The extent to which young people are actively invited to express their views is, in part, a reflection of these differing cultures.

The physical environment also contributes to a sense of safety, and the boys' YOIs are at a huge disadvantage here, operating as a number of them do within inadequate and depressing buildings. The escort arrangements operating to take young people to YOIs get them off to a frightening start. They often arrive late, after hours spent in a small, uncomfortable cubicle within a van, frightened not only about where they are being taken to but what will happen to them if the van crashes.

Overall sense of safety: actions required

- The message that young people feel much safer in small units with adequate staffing levels needs to be heard and used to inform the strategic development of the secure estate.
- All establishments should ensure a culture amongst staff whereby they see the young people in their care as children first, offenders second.
- There should be a review of the impact of the built environment, drawing on expert advice about the most suitable conditions in which to care for young people.
- The practice of transporting young people to YOIs in vans designed to transport adults must be reviewed.

A framework for safeguarding

If safeguarding is to be effective, staff need to be given clear direction about what is expected of them; roles and responsibilities must be defined, with sufficient capacity to fulfil these responsibilities; lines of accountability must be transparent; systems should be effective and there must be ways of monitoring the work and effecting any necessary improvements. These elements cannot be developed by the establishments alone: national and local agencies need to create the right framework. Many establishments expressed a degree of frustration at barriers in achieving this framework that were beyond their control.

Effective policies and procedures

All settings had safeguarding policies in place but they did not always fulfil their purpose in providing clear direction about what should happen if a concern arose. The most effective policies were those that were:

- short
- localised to the establishment
- suitable for this age group and the range of difficulties they present

- accompanied by procedures outlining what action should be taken
- supported by summary versions suitable for young people, families and practitioners.

This was not always the case, particularly in YOIs. Prison Service Order (PSO) 4950 expects individual establishments to develop policies either adapted from templates provided, based on other PSOs designed for the adult prison population or devised locally. This is a confusing approach and has resulted in a range of policies which are not perceived as helpful. There are also some contradictions between prison service wide policies and the responsibility to safeguard young people that need to be resolved.

secure children's homes face a similar challenge in that they are often working within general policies developed by their local authority, which may not be suitable for their population. They are, however, suitable for children and young people and were generally more useful to staff. STCs and secure children's homes also have policies on behaviour management and complaints, which are serious omissions from the YOI policy framework.

Adequate structures and resources

Every establishment held meetings where safeguarding issues could be considered but the nature of these depended on the size and type of the establishment. In secure children's homes, STCs and the girls' YOI units, safeguarding was more likely to be integrated into management or other meetings. YOIs are required to have a safeguarding children committee that takes a strategic overview of safeguarding within the establishment and at which relevant internal services and the LSCB are represented. In practice, although YOIs were moving towards this arrangement, it was not always in place. Where the committee was in place, terms of reference and minutes suggested that some had clearly established themselves as a strategic forum whilst others had not. Attendance was variable, and some committees had become bogged down in discussing individual young people rather than driving the work forward.

The same applied to safeguarding roles within the establishment. YOIs are expected to have a safeguarding children manager and coordinators for child protection, suicide and self-harm, anti-bullying and violence reduction. Although all except one did have a safeguarding children manager, the extent to which the post-holder was provided with the resources to fulfil the role varied widely. Some safeguarding children managers were of senior status, were able to give all their time to safeguarding and had a team of individual coordinators and administrators to support them. Others had extensive additional responsibilities, with just part-time safeguarding coordinators that they did not line-manage to fulfil the role. Again, the smaller the unit, the less likely there were to be designated safeguarding roles. In the girls' units, the unit head is also the safeguarding children manager. This was also the case in STCs and secure children's homes, with responsibility for safeguarding normally integrated with other roles and responsibilities although some designated roles were being created where a development need had been identified. We concluded that there is no single ideal model for a safeguarding structure; it will depend on the size and type of establishment.

Effective use of information

If any system is to be effective, there needs to be a process for monitoring and review so that weaknesses are identified and tackled. This needs to encompass both quality

assurance of the work undertaken with individual young people, and an analysis of overall patterns and trends.

Quality assurance was variable across the estate but was being undertaken to some extent in all settings, either formally through regular case audits, a process of reviewing and 'signing off' child protection cases with the LSCB or more informally through managers reading unit logs and supervision. The larger the establishment, the more difficult it can be to know what is going on at the front-line and the more formalised systems need to be. We found particular gaps in the systems for checking the quality of some aspects of safeguarding practice in the YOIs, especially in relation to the use of force and complaints.

In terms of identifying patterns and trends within establishments, a variety of mechanisms are in use. Individual databases have been created, collecting a range of management information such as incidents of restraint, fights and self-harm. Some of these systems are sophisticated, with the capacity to cross-reference information in order to, for example, analyse the ethnicity of young people subject to restraint or the location of fights. Others are rudimentary, allowing only for incidents to be counted rather than any meaningful analysis. Establishments were devising their own methods, with little support.

Establishments have developed a range of mechanisms for hearing the views of the young people, including involvement in meetings, exit interviews and participation in staff recruitment. They may also be involved on a day-to-day level in reviewing their own and others' behaviour and determining what should happen as a result. These mechanisms are much more embedded in STCs and secure children's homes than in YOIs, where there is scope for considerable development.

All establishments recognised and welcomed the need for external scrutiny but felt that the current national framework for performance management and inspection was confusing and even unhelpful. STCs and secure children's homes are currently inspected by Ofsted whereas YOIs are inspected by Her Majesty's Inspectorate of Prisons (HMIP). There is no single framework of standards against which they are measured. In addition, they are subject to a number of other quasi-inspection processes through YJB monitors and regional managers, Prison Service Area managers, W&YPG, Regulation 33 visitors¹ and others. They have to supply a range of information and statistical data to support each of these processes, and complain of inconsistency and duplication. The commonly expressed view was that establishments would like this framework to be rationalised and would welcome more of a balance between support and scrutiny.

A framework for safeguarding: actions required

- The specific needs of young people in secure settings should be specifically addressed in national and local safeguarding policies.
- YOIs need a more helpful policy framework that is specific to young people, and supports staff in knowing what to do. This should include explicit policies on

¹ Representatives from the local authority required to visit residential children's homes on a regular basis. The equivalent in Wales is Regulation 32.

behaviour management and complaints.

- Each establishment's safeguarding structure should be reviewed to ensure it has the following ingredients:
 - ♦ Meetings where safeguarding is considered with clear terms of reference, action plans and follow through.
 - ♦ Good quality management information – and analysis – in order to inform action.
 - ♦ Meeting chairs and members with sufficient authority and skill, and who attend on a regular basis.
 - ♦ Clarity regarding safeguarding roles and responsibilities, and staff with the necessary resources, knowledge and skills to undertake them effectively.
 - ♦ Clear lines of accountability for safeguarding within each establishment and to the LSCB.
 - ♦ Purposeful involvement from young people's representatives.
- The performance and inspection framework needs to be rationalised and based on agreed standards that reflect other children's settings and clarify each agency's roles and responsibilities.
- Establishments should be supported to develop useful systems for the collection and analysis of both qualitative and quantitative monitoring data, and all aspects of activity that are relevant to safeguarding need to be included.

A safeguarding ethos

Safeguarding is a difficult term to define but it is important that all staff within an establishment know when to be concerned and what they should do about their concerns. This was achieved more consistently in secure children's homes, STCs and the YOI girls' units, which tend to take a more holistic view of the young people's needs, including their need to be protected from harm.

Effective safeguarding is strengthened if the establishments are in a position to take an overview of their policy and practice, to identify their strengths and weaknesses and to develop plans to improve. Most establishments were attempting to do this but could be better supported with the input of external bodies, particularly central government and LSCBs. Although it is early days, there is scope for much more meaningful involvement by LSCBs and the majority of establishments expressed disappointment that they were low down on the LSCB's list of priorities.

One challenge, mainly but not exclusively for the YOIs, is the issue of establishment culture. It cannot be assumed that all staff share the same values, particularly in YOIs where some staff, at all levels, may not have chosen to work with young people. One of the STCs was experiencing similar difficulties with negative attitudes amongst a minority of the staff group. Where this is the case, safeguarding will inevitably be compromised. Only secure children's homes appear to reliably contain staff who have expressly chosen to work with challenging young people and who fully understand the implications of this.

A safeguarding ethos: actions required

- The values underpinning effective safeguarding should be embedded throughout all establishments, and be reflected in the recruitment of suitable staff.
- Engagement between LSCBs and secure establishments needs to be further developed so that it goes beyond the tokenistic. It should be supported by protocols, quality assurance arrangements, training and appropriate representation at meetings.
- Establishments should have more opportunities to access information about safeguarding and to share good practice.

Engagement with the outside world

There was a clear sense that all establishments were open to input from the outside world and had developed many creative links with external agencies, resulting in an impressive range of services available for the young people. Statutory services remained the biggest challenge, with some poor or dysfunctional links evident with local authority children's services and local health providers. All establishments have routine contact with external YOTs in relation to planning for individual young people but a number of YOIs have in-house YOTs undertaking a variety of roles, including child protection.

Advocacy services are valued by most staff and young people but there can be tensions in the smaller establishments where there is a more informal approach to problem-solving, when advocates can be perceived as too adversarial. Conversely, YOIs have a more formalised approach to resolving problems and some advocates have found a niche within this that could be further developed. The Independent Monitoring Board (IMB) within YOIs seemed to play a less significant role, and to have less knowledge of the safeguarding function in spite of their more formal involvement in the scrutiny arrangements for YOIs. Finally, we were impressed by how important the chaplaincy service was for young people, and the range of support provided.

An ongoing concern within the YOIs, raised by a number of establishments, is the role of Samaritans. As an organisation, the Samaritans have had an important role in talking to prisoners at risk of suicide or self-harm, or indeed anyone who needs someone who will listen. However, their blanket rule of complete confidentiality may be in conflict with the duty to safeguard young people.

Engagement with the outside world: actions required

- Directors of Children's Services need to be challenged about the services they offer to young people in secure establishments, based on the expectation that they have the same entitlement to be protected from harm as other children.
- The advocacy service should be evaluated and the findings used to determine the future development of the service in each setting.
- The role of the IMB in relation to young people within YOIs should be clarified and they should be supported in developing the necessary expertise in safeguarding.
- The use of Samaritans in YOIs should be reviewed.

Sound safeguarding practice

Harm from self

The systems for managing the risk of suicidal or self-harming behaviour aim to remove any opportunities for self-harm whilst tackling the underlying causes. Establishments are operating within a climate where they are heavily censured for any incidents of self-harm or suicide, which has resulted in a risk-averse culture that finds it difficult to differentiate between self-harm as a coping strategy and suicidal behaviour. A number of staff referred to this as a source of tension, which sometimes led to perverse outcomes whereby young people are cared for within bare and impoverished environments in order to remove all possible risks. Within secure children's homes and STCs, staff report using prolonged physical restraint in order to prevent self-harm and are uncertain about the validity of this approach.

The Assessment Care in Custody and Teamwork (ACCT) system is relatively new within the prison service and has been generally welcomed but there are some weaknesses in the way it is operating. For example, many ACCT care maps are formulaic and it is not evident from the paperwork if actions have been undertaken. The system is not specific to young people and the particular risks or behaviours associated with adolescence have not been identified within the system, although some YOIs have sought out this expertise for themselves.

YOIs struggled with where best to care for young people at risk of self-harm and there were a variety of arrangements in place, including holding young people on 'care and separation units' alongside disruptive young people or in safer cells, which were located in a range of units. Staff pointed out a number of design flaws in these safer cells.

A problem across establishments but particularly acute in YOIs is the lack of multi-agency input into risk assessment and support of young people. The establishments themselves are left to shoulder this responsibility in most cases.

Harm from self: actions required

- The approach to this area of work should recognise the different levels and types of suicide and self-harm risk, drawing on clinical expertise with adolescents.
- Staff should have access to multi-agency support in determining risk and in providing suitable interventions, including psychiatric support, counselling and family work.
- Establishments should be offered guidance on the appropriateness of using prolonged physical restraint in order to prevent self-harm.
- For young people with a significant pattern of self-harming behaviour consideration should be given to the development of specialist units.
- Within YOIs,
 - ♦ ACCT training should be revisited to allow for a more sophisticated and individualised approach to the assessment of risk and the development of care maps.
 - ♦ ACCT documentation should be amended to allow for more dynamic

recording and updating.

- ♦ There needs to be guidance on the appropriate location of young people who are at risk of suicide or self-harm, including the design of safer cells.

Harm from peers

This was the biggest fear for the young people yet was acknowledged to be the weakest area of practice. The identification of bullying behaviour in the context of adolescence is not always as straightforward as it may seem, and young people complained that normal interactions were wrongly labelled as bullying. All the establishments were struggling to devise suitable interventions, with an acknowledgement that there was too great an emphasis on punishing the bully rather than eliminating the root causes. This also resulted in a lack of focus on the victims of bullying, and on the complex dynamic between bullying and victimisation.

There was a perceived lack of support in tackling the problem from the centre. Establishments had sought advice or services from a range of experts and some were linking with work being undertaken within their local authority. Young people did not always trust staff to deal with bullying, particularly in the YOIs. They feared they would be labelled as a victim, making the problem worse, or as a 'snitch' or 'grass'. Trust had been achieved in some settings, particularly but not exclusively the smaller units, and depended on a positive approach by staff that included an awareness of pro-social modelling.

There was particular concern about young people who did not respond to sanctions imposed as a result of bullying, leaving the establishment with nowhere to turn. In spite of these difficulties, staff in all settings took the problem seriously and were searching for solutions. Some establishments were attempting to take a more holistic approach towards challenging behaviour in general, including bullying, and were adopting a variety of measures. These ranged from positive steps, such as involving all young people in reviewing each other's behaviour and awarding points or making plans through complex case reviews, to more negative measures such as the imposition of Anti-Social Behaviour Order-type penalties. The latter could be used punitively and it was our view that it was not a helpful label.

Violence itself was acknowledged to be different from bullying, although there were some complaints from young people about a lack of differentiation. On the whole, young people were reasonably confident that staff would intervene quickly if violence occurred but this was affected by the numbers of staff available and the nature of the environment. There were known 'hot spots' within many YOIs where supervision was lacking or where there were gaps in CCTV coverage. It was generally known that this is where violence would occur and we saw some evidence of patterns of assaults having taken place, particularly in gym showers, which should have been avoidable.

Harm from peers: actions required

- There needs to be a clearer definition of bullying within the context of adolescent behaviour that is suitable for secure settings.
- Where it is lacking, an ethos of trust needs to be fostered whereby young people can feel confident in staff's ability to keep them safe from both bullying and violence.

- A holistic approach to behaviour management that identifies and supports young people with behavioural problems is to be welcomed and establishments should be supported to develop this further.
- Staff, including education staff, should be trained and supported in the best ways of preventing bullying and violence, drawing on the experiences of other settings.
- Effective interventions that are suitable for use in this context should be developed nationally for both bullies and victims. These interventions should tackle the causes of the behaviour rather than simply trying to repress or punish it, and are likely to include mediation approaches. Interventions should be evaluated and the results disseminated.
- The introduction of 'anti-social behaviour' approaches that are not transparent and have no mechanism for appeal should be discouraged.
- The remaining gaps in CCTV coverage and identified hotspots need to be tackled.

Harm from adults

Practice in all settings was hampered by the lack of a clear definition about what constituted a child protection concern, and therefore the threshold for referral to the local authority. Establishments and LSCBs had been left to make their own interpretations of the categories of abuse within *Working Together to Safeguard Children* (HM Government 2006) in the context of a secure setting and had reached different conclusions. Associated with this confusion over thresholds, the meaningful involvement of the local authority was rare in YOIs. Many establishments had got into a routine of referring cases to their local assessment team within children's social care who, equally routinely, sent a notification that they did not reach the threshold of significant harm. This is not to say that serious concerns were dismissed: we saw examples of strategy meetings and some investigations having taken place but numbers were very small.

It was not always clear where decisions about the response to allegations would be taken. Staff involved within YOIs included governors, safeguards managers, child protection coordinators, YOT workers, YOI social workers or police.

There was also confusion over the three types of investigation that may follow an allegation against a member of staff: section 47, criminal or disciplinary processes. There were also instances where the onus had been placed on the young person as to whether they wanted to 'proceed'. It is our view that this is completely inappropriate. The new *Working Together* guidance, whereby all allegations against staff are referred to the Local Authority Designated Officer (LADO) even if they are unlikely to reach the threshold of significant harm or police investigation, seems a positive step. This system was beginning to have an impact on STCs and secure children's homes but was much less evident in YOIs and it is unclear how the arrangements will work in relation to prison service guidance on disciplinary processes. There needs to be more clarification as to the proper procedure to follow in such cases, including the process for 'signing off' that an investigation has been satisfactorily completed.

It is a positive reflection on secure settings that previously unrecognised child protection concerns come to light when young people are in custody, and such concerns were

consistently referred to the appropriate local authority but with mixed results and poor feedback. There was a need across all settings to ensure that support was available for the young person and staff when allegations were being investigated and for outcomes to be communicated.

We were interested to understand not only those cases that had been considered within child protection procedures but those that had not, and for this reason use of force or records of restraint were examined, as were complaints. In some establishments it was clear that there were 'missed' child protection cases within these records, whilst others had systems for screening and cross-referencing into safeguarding processes.

Harm from adults: actions required

- The suitability of arrangements for undertaking child protection, criminal or disciplinary enquiries needs to be reviewed at government level and the links between the processes mapped.
- A working definition of child protection that is suitable for the setting needs to be developed, supported by appropriate and explicit thresholds for referral to local authorities, approved by the LSCB.
- Roles and responsibilities in relation to child protection decision-making need to be reviewed to ensure that only staff with sufficient expertise and authority are involved and lines of accountability are clear.
- Where allegations or incidents involving staff do not reach the threshold of significant harm, it must be clear what alternative investigatory process is to be followed and the mechanisms for deciding this should be explicit and accountable, including the role of the LADO and other mechanisms for external scrutiny.
- The practice of asking young people if they want to 'proceed' following a child protection allegation should be stopped.
- Where child protection or related investigations are taking place, staff and young people should be provided with independent support.
- The outcome of all child protection enquiries, whether historic, community or within the establishment should be clearly recorded and communicated to all relevant people, including care staff, external agencies, the young person and their family.
- Establishments should ensure they are screening areas of practice where child protection concerns or allegations against staff may arise, including complaints, use of force, adjudications, full searches, use of special accommodation and unexplained injuries.

The use of physical restraint

Concerns about the use of physical restraint inevitably arise when we consider the risk of harm from adults, and that was the case within this review. A separate review of restraint in the secure estate is currently being conducted and is due to report in Spring 2008. Our comments about restraint are therefore restricted to current practice.

Within the YOIs, a number of young people described instances where they thought restraint had been used inappropriately or with excessive force and we did see instances where

injuries had occurred. These were in the minority and most young people felt that restraint was usually justified and proportionate. However, there was little evidence of the holistic and planned approach to behaviour management required by the Code of Conduct, including attempts at de-escalation before using force or systematic debriefing. The use of force recording system currently in use does not lend itself to such approaches and some establishments had devised their own formats in an attempt to introduce reflection about whether force could have been avoided, how staff and young people had been affected by the incident and what could be learned from it. These attempts are to be welcomed but there is a long way to go before these standards are embedded throughout the YOI estate.

A more holistic approach to behaviour management was evident in STCs and secure children's homes but restraint is still a source of concern amongst staff. They are uncertain about some of the techniques and their appropriateness for use on very disturbed young people. The incidence of restraint varies widely across settings and those who have introduced more robust methods of de-escalation and reflection report that restraint has declined.

The extent to which restraint is monitored is limited. Although some establishments have set up their own systems for collating information about the use of restraint, this does not appear to be universal. External scrutiny is also limited, although basic data has been reported to the YJB since early 2007, and a few establishments have started involving the advocates following incidents of restraint. We did not see evidence of LSCBs taking an active role in monitoring the use of restraint and this could be an area for development.

A final area of concern across establishments, although the detailed practice differs, is that of 'full' searches and the use of 'special' accommodation or single separation. These practices are potentially harmful to young people and we suggest that they should be the subject of a specific review to determine their appropriateness. Establishments are particularly concerned about the conflicting messages they are receiving from the various inspectorates and government departments about what is expected of them.

The use of physical restraint: actions required

- A separate review should take place of the use of segregation, special cells and full searches, including their suitability for use with young people, the criteria for use, the nature of appropriate risk assessments and suitable processes for authorisation.
- A robust monitoring system with independent scrutiny needs to be established for the use of force, special accommodation and full searches that includes analysis of the reasons they are used, the staff and young people involved and any trends. This is in addition to the reporting mechanisms to the YJB.
- Where it is lacking, staff need to be supported to develop their skills in the de-escalation of conflict and de-briefing following incidents, and young people must also have the opportunity of a de-briefing session following restraint.
- The prison service should amend their policies, systems, recording formats and training on the use of force against young people to reflect the YJB's code of conduct on behaviour management.
- Staff need to be provided with techniques for physical restraint that have been proved to be safe and effective.

Responsiveness to complaints

The ability to complain and have that complaint taken seriously is an important safeguard for all young people living away from home. Although young people were aware of their right to complain, and how to make a complaint, they expressed mixed views about the value of doing so. The way complaints are dealt with in YOIs is particularly disappointing.

Investigations are not independent and many of the responses were poor, either failing to address the complaint or blaming the young person. Young people felt this was particularly likely to be the case if the complaint related to a member of staff, and our examination confirmed this. Allegations which should have been considered within child protection procedures were not always referred and complaints using the confidential access system were sometimes passed back to the staff concerned. There was no consistent approach to ensuring independent scrutiny of complaints, no right of reply and little analysis of themes. Nevertheless, some complaints were dealt with respectfully and appropriately and one establishment had developed sound guidance for staff about how they should respond but there was huge room for improvement if the response to complaints was to reach the standard expected in other children's services.

Complaints were taken more seriously overall in STCs and secure children's homes than in YOIs and investigations were much more effective – even at times being over-formalised and bureaucratic. There was also much more independent scrutiny, either from the local authority's complaints officer or advocates. Not all complaints were dealt with formally due to a more developed approach towards early problem solving and discussion to avoid grievances escalating.

Responsiveness to complaints: actions required

- A balance needs to be struck between independent scrutiny that may result in an overly bureaucratic and slow response, and opportunities for a more rapid, problem-solving approach.
- Complaints need to be screened to identify safeguarding issues that may have been missed, particularly where allegations are made against staff.
- Complaints should be analysed to identify overall trends within the establishment.
- Within YOIs
 - ♦ The approach to complaints within YOIs should mirror that of other establishments for children away from home, including a written complaints policy setting out the investigation process in formats suitable for staff and young people.
 - ♦ The investigation of complaints needs to be transparent, fair and independent, with consideration given to the involvement of advocates.
 - ♦ Young people should have easier access to an appeal process if they are unhappy with the response to a complaint.

A skilled and knowledgeable workforce

All types of establishment identified a need for more training, for all levels of staff. Whilst managers of STCs and secure children's homes were likely to have childcare or other

relevant qualifications, this was much less likely to be the case in YOIs. In most cases, governors, safeguards managers and coordinators have been expected to understand, develop and implement safeguarding policies without any relevant training. The training that is available within the prison service is said to be too basic and there is limited access to external training. Although there is some take-up of LSCB training, this is not always suitable for this age group or the secure setting. Particular gaps were identified in the knowledge and skills base in relation to bullying and child protection work, and more generally in working with adolescents.

Similar problems existed in the STCs and secure children's homes although not so acute. There was evidence of an imaginative range of training having been commissioned on topics including emotional well-being and autistic spectrum disorders. A major difference in terms of developing staff skills is that STCs and secure children's homes have a culture of supervision, although it may not always take place as often as it should.

A skilled and knowledgeable workforce: actions required

- LSCBs should take responsibility for ensuring that their training programme is accessible to staff in secure settings and that course content is suitable.
- Training should be linked into a qualification framework that will enable career progression and linked with other childcare or youth justice qualifications.
- All such training should be evaluated and regularly refreshed, and there should be regular audits of staff knowledge and skills to inform the development of the training programme.
- For YOIs:
 - ♦ A framework for providing suitable training for YOI staff from governor grade down to entry level needs to be developed. This should be both skills and knowledge based and include modules on all aspects of safeguarding (interpreted for this setting), the roles and responsibilities of different staff, adolescent behaviour and pro-social modelling.
 - ♦ Training should be developed and delivered by people with the appropriate knowledge and skills.
 - ♦ The possibility of having a dedicated and trained workforce who want to, and are suitable to, work with young people should be considered.
 - ♦ Opportunities for peer support and individual supervision should be developed to enable staff to learn from each other informally, and to continuously develop their skills.

INTRODUCTION

I sometimes feel unsafe but I don't show it. I don't want to be a coward (young person in secure setting).

This review of safeguarding within the secure estate was undertaken in order to identify what more needs to be done to ensure the safety of children and young people under the age of 18 in these settings. It examined both the theoretical approach to safeguarding and the way this was implemented in practice within all secure establishments where children and young people are detained as a result of their offending behaviour. The aim of the review was to highlight general themes that would inform a programme of development and improvement over the next three years rather than to inspect or audit individual establishments. Staff within the establishments and from partner agencies contributed their own experiences and ideas to the review, as did the young people themselves. They all took the question of young people's safety seriously and were prepared to be honest about shortcomings and committed to helping us identify areas for improvement.

There are three types of establishment within the secure estate in England and Wales: Young Offender Institutions (YOIs) Secure Training Centres (STCs) and Secure Children's Homes (secure children's homes). YOIs take remanded and sentenced young people between the ages of 15 and 17, although girls are usually only placed in YOIs at 17 and are held in dedicated units within larger female establishments. Some of the boys' units are within establishments also catering for 18-21 year olds, although the boys must be detained separately, and are referred to as 'split sites'. STCs and secure children's homes are specifically designated for children and young people, although STCs have taken some children older than their originally intended population of 12-15 year olds. The YJB placement team aims to place younger and more vulnerable young people in these resources rather than YOIs. At the time of the review, within the prison estate, there were five dedicated YOIs for boys, nine boys' units within split sites and five girls' units. There were four STCs and 15 secure children's homes taking young people placed by the YJB. At the time of writing, the total population of children and young people currently detained within the secure estate through the criminal justice system is 3076 and 84% of these are in YOIs. The estimated average monthly cost of keeping a young person in the different types of provision is as follows: YOI – £4,426; STC – £14,355 and SCH – £15,461. This is an important contextual factor and must be borne in mind when reading the review findings. It affects the capacity of establishments to deliver all aspects of safe and effective care. For example, the ratio of staff to young people is much higher in STCs and secure children's homes and accommodation is of a higher standard. The YJB strategy for the development of the secure estate is for modernisation of existing provision rather than a fundamental reconfiguration.

Policy context

The last five years has seen significant change in the law and policy relating to young people within the secure estate. It is now clear that children under the age of 18 within secure establishments have the same entitlement to be safeguarded and to have their welfare

promoted as any other child. The Munby judgement² in November 2002 confirmed that the Children Act 1989 applied to young people in YOIs and as a result the Department for Education and Skills (DfES) issued a circular to Local Authorities³ clarifying their responsibilities towards such young people. The Children Act 2004 subsequently strengthened these arrangements by giving custodial settings and Local Safeguarding Children's Boards (LSCBs) clear duties to cooperate in the interests of children held within them. The revised guidance on inter-agency arrangements to safeguard children⁴ made specific mention of the responsibilities of YOIs and STCs and the Prison Service updated its guidance to YOIs to reflect these responsibilities through Prison Service Order (PSO) 4950. A variety of reports^{5,6,7,8} have suggested that secure establishments are unsafe places for young people and a review of practice within YOIs undertaken in 2003⁹ led to a three-year programme of investment (from April 2005 to March 2008) by the YJB to improve safeguarding. This included funding for a new safeguarding children manager post within YOIs, the introduction of an independent advocacy service, capital funding for improvements to the built environment, the development of young person specific policies and a programme of staff development and training. The YJB has also piloted social work posts within YOIs to ensure that young people receive the services they are entitled to, although the future of these posts remains uncertain beyond 2009. There was no equivalent review or programme within STCs or secure children's homes at that time.

A definition of safeguarding

The concepts of safeguarding and promoting welfare are closely linked and defined as follows within *Working Together to Safeguard Children*:

The process of protecting children from abuse or neglect, preventing impairment of their health and development, and ensuring they are growing up in circumstances consistent with the provision of safe and effective care that enables children to have optimum life chances and enter adulthood successfully (HM Government 2006).

Within this overarching definition, there are separate strands. In the guidance to LSCBs (Chapter 3 of *Working Together to Safeguard Children*) it was suggested that the first imperative was to ensure the safety of children and young people before widening the remit to other aspects of their lives. It is these aspects of safety, or safeguarding, rather than the wider agenda of promoting welfare that are the focus of this review. These are defined as

- protection of harm from adults

² R v Secretary of State (2002) EWHC 2497 (November 29 2002)

³ Department for Education and Skills (2004) *Safeguarding and Promoting the Welfare of Children and Young People in Custody*, LAC(2004)26. www.dfes.gov.uk

⁴ HM Government (2006) *Working together to safeguard children: a guide to inter-agency working to safeguard and promote the welfare of children*. London: HM Government.

⁵ Children's Rights Alliance for England (2002) *Rethinking Child Imprisonment: A report on young offender institutions*. London: Children's Rights Alliance for England.

⁶ Department of Health (2002) *Safeguarding Children: A joint chief inspectors' report on arrangements to safeguard children*. London: Department of Health.

⁷ Commission for Social Care Inspection (2005) *Safeguarding Children: The second joint chief inspectors' report on arrangements to safeguard children*. Newcastle: Commission for Social Care Inspection.

⁸ *The Carlile Inquiry* (2006) London: The Howard League for Penal Reform.

⁹ Prison Service & YJB (2003) *Child Protection and Safeguards Review*.

- protection of harm from self
- protection of harm from peers.

If young people are, or perceive themselves to be, unsafe, then their ability to gain anything positive from the experience of custody will be reduced. It must be remembered that safety is not simply the product of policies and systems. It can only be as good as the people who are interpreting and operating those systems on a day-to-day basis. Sir William Utting noted that the best safeguard of all within residential settings is an '*environment of overall excellence*', and that:

*Homes which meet the personal, social, health and educational needs of children are much more likely to be safe places for children than those that do not.*¹⁰

It must also be remembered, as some of the young people who assisted us with this review told us, that many live in unsafe circumstances in the community. One young person interpreted the question about how safe they felt in the establishment as follows.

It is safe here – the doors are locked, the windows are reinforced, no-one could get over them walls.

Methodology

The review was undertaken by the YJB in partnership with the National Children's Bureau (NCB), with support from the Women and Young People's Group (W&YPG) of the prison service. NCB developed the methodology, with advice from its research department. All YOIs, STCs and secure children's homes were within the scope of this review, and evidence from every establishment has been included and considered.

Broad approach

Although this was a review rather than a research project, it was important that the methods were as rigorous as possible under the circumstances and consistent across all sites. Data collection was undertaken by two teams: one for YOIs and the other for STCs and secure children's homes, comprised of representatives from NCB, the YJB and the W&PG. Every establishment was visited once between May and October 2007 for the purposes of data collection; these visits generally lasted one or two full days and were carried out by a minimum of two members of the review team. A representative from the Children and Families directorate of DCSF accompanied the teams on visits to two YOIs.

The chair of the LSCB and, for the YOIs, the Independent Monitoring Board (IMB) were contacted in advance of the visit and invited to participate in the review, and the establishments were advised of the approach that the review team would be taking.

A range of data (described in more detail below) was gathered directly from each establishment:

- interviews with key internal informants

¹⁰ Utting, W (1997) *People Like Us: The Report of the Review of the Safeguards for Children Living away from Home*. Department of Health

- interviews with key external informants
- interviews with front-line/wing staff
- interviews with young people
- observational data from touring the establishment
- examination of records and logs held by the establishment
- other background information including policies, inspection reports and monitoring data.

The whole team was involved in both gathering and assessing the evidence, and contributing to overall judgements about safeguarding at each establishment.

Sampling and data collection

Documentary sources

Where possible we obtained background documentation in advance of site visits. This included relevant policy documents, terms of reference and minutes of relevant meetings, monitoring reports, action plans, and protocols with LSCBs or local authorities. These were assessed by the review team for content, completeness and quality.

In terms of records and logs, in each establishment we scrutinised a sample of the most recent examples of the following: child protection; suicide and self-harm; anti-bullying; complaints; use of force forms; segregation/special accommodation logs. The numbers of documents seen varied from site to site because of the differing sizes of the establishments and variations in incidence. For example, some sites had had only one or two child protection cases or incidents of restraint in the last year. Where incidence was low, all records were scrutinised; where incidence was high, sample months were selected. These were assessed for content, completeness and quality.

Interviews

At each establishment we conducted semi-structured interviews with all of the following key members of staff with responsibility for safeguarding, where they were available: safeguarding children managers; child protection, anti-bullying and suicide/self harm coordinators; unit managers or other staff with a designated safeguarding responsibility). We also carried out semi-structured interviews with key external informants, such as advocates, representatives from the local children's social care service, the LSCB, the police and IMB. Where it was not possible to interview the relevant individuals during the site visit itself, follow-up telephone interviews were arranged.

In addition to informants with specific safeguarding responsibilities, we gathered the views of other staff who have direct contact with young people. These informants were sampled opportunistically from staff who were available (and willing) to be interviewed whilst the review teams were on site. Similarly, an opportunistic sample of young people was interviewed at each site (an average of 5–6 per establishment). In each case, short semi-structured interview schedules were used.

Interviews were in confidence, unless information was given that suggested someone was at risk of harm. All interviewees were invited to comment on how safeguarding worked within the establishment and also to contribute their ideas about how it could be improved both locally and nationally.

Further detail about the sample of interviewees can be found in the appendix to this report.

Observations

The interviews were supported by a tour of the establishment, enabling judgements to be made on the quality of the environment and the accessibility of information about safeguarding for staff, visitors and young people. Staff we met during the tours were invited to comment on their area of work and relevant aspects of safeguarding. In some establishments the review team were invited to observe key meetings, such the morning briefings or safeguarding meetings.

Assessing evidence and forming judgements

NCB devised templates for summarising and recording information from the above sources. At the end of each day the review team debated their findings based on the evidence they had gathered. The purpose of this approach was to arrive at a collective judgement on both the theoretical approach to safeguarding and the way it worked in practice in each establishment.

Each establishment was assessed on the following broad areas:

- Policies and systems
- Monitoring arrangements
- Strategic approach to safeguarding
- Links with external agencies
- Quality of assessments and interventions
- Staff knowledge and skills
- Perceptions of safety
- Areas for development

Specific areas of concern and examples of good practice were noted and recorded for each establishment, together with examples of supporting evidence.

Although it had been stressed to the establishments that this was not an inspection and that the aim was to draw out general themes from across the estate, in response to requests from governors/managers we provided verbal feedback at the end of each visit about perceived local strengths and weaknesses.

A steering group consisting of representatives from the relevant government departments, inspectorates and the secure estate were informed of the findings and were responsible for developing the recommendations.

FINDINGS

The findings for the YOIs are presented first, followed by those for the STCs and SCHs. They must be considered within the national context because many difficulties can be attributed, at least in part, to the framework or resourcing provided by government departments rather than local inadequacies. Although they manifested differently across different establishments, consistent themes emerged, which provide a clear direction if safeguarding practice is to be improved. These themes were arrived at in partnership with the establishments and they shared many of our perceptions. The findings focus inevitably on what remains to be done, either across the whole estate or to bring all establishments up to the standard of the best. There is much good practice already taking place, however, and anonymised examples are described throughout. Examples of local policies, recording formats or systems that may be helpful to other establishments can be found on the 'Directory of Emerging Practice' section of the YJB's website.¹¹

Safeguarding in YOIs

Overall, it was clear that there had been enormous progress within the last three years as a result of the increased focus on safeguarding and the additional resources provided. We got the sense of a service in transition, with considerable variation in the distance travelled by individual establishments. All establishments demonstrated both positive aspects and gaps, although some were clearly more effective than others within that spectrum.

Policies and systems

The local policies and working arrangements within each establishment were examined because, if safeguarding practice is to be understood, it is important to establish the context in which it takes place. This included specific safeguarding roles and responsibilities, lines of accountability, committee/meeting structures, terms of reference and minutes of meetings, and reports.

It was a recommendation from the 2003 Safeguards Review that all policies should be specifically designed to be suitable for under 18-year-olds. PSO 4950 requires all YOIs to have an overarching safeguarding children policy, including separate components on child protection, suicide and self-harm prevention, anti-bullying/violence reduction, information sharing, safe recruitment and a staff training strategy. It also expects a strategic approach to the integration of these separate strands. The Prison Service Area Manager and LSCB should agree the policy. Templates are provided for the overarching policy, child protection policy and information sharing but the rest are left to local development, although there are prison service-wide PSOs on suicide and self harm, anti-bullying and violence reduction. Although the YJB has developed a code of practice entitled *Managing Children and Young People's Behaviour in the Secure Estate* that is applicable to all the secure settings used by the YJB, establishments were left to implement it in their own way through a process of self-assessment. There is no requirement within PSO 4950 for establishments to have a behaviour management policy as such, although governors should develop an acceptable behaviour statement and guidelines for staff. We did not see a great deal of evidence of this

¹¹ <http://www.yjb.gov.uk/dep/>

other than those relating to rewards and sanctions schemes. Neither is there a requirement to have a complaints policy, and staff are expected to follow the system for adults set out in a separate PSO.

In practice we found considerable variation. Most establishments had at least some of the policies in place but, where the establishment was operating from a split site with an adult establishment, some of the elements were establishment-wide rather than young person specific. Many had also experienced difficulties in getting policies agreed by the LSCB. A disadvantage of providing templates for some aspects of the safeguarding policy was that it reduced the onus on establishments to develop them locally, and thus to make sure they were 'owned'. Some YOIs had simply copied the templates but not set out what the local arrangements for implementation were, whilst others had undertaken considerable work to localise the policies and to make them meaningful. Front-line staff were generally not familiar with the policies, although this did not necessarily mean that they did not know what to do if they were concerned about a young person.

The distinction between a policy and a procedure was not always clear, with bulky documents containing general statements of principle and lengthy extracts from *Working Together to Safeguard Children* about the different types of abuse, which staff told us carried little meaning in guiding their work. In contrast, we came across YOIs that had developed some useful summaries for staff, young people and families, and one establishment had developed pocket guides. These did give a much clearer sense of what the policy actually meant in the day-to-day life of the establishment. There were particular problems with policies on particular aspects of safeguarding but these will be discussed elsewhere.

Key findings:

- The policy framework does not provide YOIs with clear and consistent guidance on all aspects of safeguarding practice.
- The lack of complaints and behaviour management policies is a serious omission.

Meetings

PSO 4950 requires YOIs to have a safeguards committee, reporting directly to the governor and designed to help ensure that the safeguarding policy is implemented. It must meet at least quarterly and include amongst its membership the safeguarding children manager and individual safeguards coordinators, representatives from health care, substance misuse and education, the YOI social worker and a representative from the LSCB. In practice, establishments have set up a range of committees to oversee the safeguarding task. Where available, the terms of reference and minutes helped to get a picture of how these worked in reality. Practice was varied – some establishments have a robust structure of meetings, each with a clear purpose and attended by a range of internal and external participants. For example, one establishment has a monthly safeguards day consisting of a separate safeguards committee and consecutive meetings on child protection, suicide and self-harm and anti-bullying/violence reduction, with reports provided by the relevant coordinator and designed for taking a strategic overview. It also has weekly safeguards meetings to discuss practice. In other establishments, meetings were less clear in their remit and tended to blur the boundaries between general discussions, different aspects of safeguarding and

discussion of individual young people. Moreover, although they may appear to have appropriate representation, some meetings were poorly attended, particularly by external agencies. A number of establishments had created additional meetings in response to identified needs, e.g. a complex needs panel or antisocial behaviour meetings. It was not always clear what had been decided at meetings, or whether agreed actions had been undertaken.

Meetings sometimes took a different format in the smaller units because the higher staffing ratios allowed for greater individual knowledge of the young people. Here there would often be a multidisciplinary meeting where each young person was discussed in turn and a holistic plan put into place, including the measures needed to safeguard them. As will be seen later, this was also usually the case in STCs and secure children's homes.

There is a government expectation that services working with children and young people will enable them to participate in decisions that affect them. Most YOIs are attempting to do this by involving young people in meetings, although this can be complicated where the remit of the meeting includes discussion of individual cases rather than broad themes. Sometimes young people are invited to express their views in separate consultation meetings and their voice is fed into the safeguards committee via a representative, such as the advocacy service.

The effectiveness of all meetings is affected by the quality of the information it has at its disposal, and its authority within the establishment. These issues will be considered in more depth later in this section.

Key findings:

- Establishments all have a structure of meetings where safeguards are considered but some need support to make them more effective.
- There were some deficiencies in terms of clear terms of reference; appropriate chairing and membership; good attendance; sound management information; action plans and follow through and purposeful involvement of young people.

Roles and responsibilities

In spite of the PSO requirement to have a dedicated safeguarding children manager, this was implemented in different ways across the YOIs, with post holders having different levels of seniority, professional backgrounds and operational responsibilities. In most cases the safeguarding children manager had a range of duties and services to manage other than safeguarding. Some were operational managers and fulfilled duty governor responsibilities, others were responsible for specialist services such as substance misuse and psychology. In the girls' units, the unit head is also the safeguarding children manager. Only one YOI had no one in the safeguarding children manager role at all, although one of the coordinators appeared to be fulfilling this function in practice, albeit at a junior grade. These differences affected the safeguarding children manager's ability to do their job: some had neither the time nor the status that the complexity of the task demanded. Whilst there are some advantages in having an operational role within the establishment in terms of credibility

amongst officers and closer contact with the day-to-day functioning of the prison, this must be balanced against the demands of delivering the safeguards agenda.

The same was the case for the individual safeguarding coordinator roles: again the PSO states that there should be coordinators for child protection, suicide and self-harm and anti-bullying/violence reduction. Whilst some establishments had a separate coordinator for each of these functions, others had combined them into one or two roles or added the coordinator role on to other posts, allowing only a few hours a week for the task. This may be appropriate in the smaller establishments, but our findings did not always reflect this: some large establishments had dedicated very little resource to the coordinator roles. Various ad hoc safeguarding roles had been developed, partly in response to limited resources. Where social workers were in post, they had varying levels of involvement in child protection work and needed to link closely with both the safeguarding children manager and child protection coordinator. A number of establishments had also given Youth Offending Team (YOT) staff a formal child protection role, usually on the basis that they had a social work qualification. This was particularly likely to be the case in the girls' units. Other establishments had involved health care or psychology staff in aspects of safeguarding and in one setting the head of psychology was the suicide and self-harm coordinator.

Management lines also varied, with safeguarding children managers not always managing all staff with a safeguards function. For example, in the split sites, coordinators were sometimes responsible for the whole establishment and reported to a manager on the adult site, and social workers and YOT workers had external line managers. This meant that there was not always a clear sense of a safeguards team with clear authority for all relevant areas of practice. Even where arrangements were complex and unsatisfactory, this could be overcome if there were sufficient commitment to make it work and some safeguards staff had achieved a clear sense of their own identity and values. This was not necessarily embedded throughout establishments, with front-line staff often having only a sketchy awareness of what safeguarding was or who was responsible for it. This did not necessarily mean that they did not know what to do if a need arose: they would 'pass it on' when it would become someone else's responsibility. This highlights another danger. Where there is a strong safeguards team there is a risk that they are seen as the people who 'do' safeguarding.

There are some people who think it's all our team's responsibility but we are only the coordinators. Like security, it's everyone's responsibility (member of safeguards team).

Some settings were aware of this possibility and were designating wing staff to act as champions on aspects of safeguarding amongst their colleagues. This has implications for the training needs of staff, since the existing programme offered is universal and at a basic level. This will be considered in more detail within the section on knowledge and skills.

Whatever the local arrangements, YOI governors have an overarching responsibility for the safety of young people in their establishment, and their knowledge and commitment is key.

Key findings:

- Some safeguarding staff do not have enough time, status or resources to fulfil their roles adequately and non-prison service staff may have taken on safeguarding roles as a result.
- Lines of accountability from the governor through to front-line staff are not always clear.

Monitoring and review

All establishments recognised the need for monitoring and review. It is the aim of each establishment to review all policies annually, and more frequently if there was a particular issue, but this has not always been achieved because of, for example, resourcing problems or the need to wait for a new PSO.

Monitoring activity needs to take place at different levels. There is an important quality assurance function in respect of work with individual young people and managers need to have mechanisms to allow them to assess this. There is also a need for mechanisms to review trends, patterns and the overall effectiveness of safeguarding arrangements, which will allow establishments to set an agenda for continuous development.

Quality assurance

There is considerable variation in the quality assurance of day-to-day practice. In terms of individual young people, there was usually evidence of management checks being done on Assessment, Care in Custody and Teamwork (ACCT) documents, which are used to assess and plan the care of young people thought to be at risk of suicide or self-harm, but this was less clear for other areas of activity. Management checks or other audits varied from a rubber-stamping exercise to clear instructions for action. External scrutiny was patchy, with most checks or audits being undertaken internally, but there are some establishments that have involved the local authority or LSCB in monitoring child protection cases. Social workers based within the YOI sometimes became involved with this.

An overview of safeguarding

The collection and analysis of overall management information was very variable, although again the need to do so was recognised. Generally, this was a weak area, both in terms of consistently undertaking monitoring and acting on the information gained. Although numbers of, for example, child protection referrals may be collected and reported to the child protection or safeguards committee, there was often no qualitative data or analysis to make the information meaningful.

We collate a lot of statistics and don't do anything with them (manager YOI).

There were, however, a number of examples of more sophisticated systems being developed that do allow useful analysis. Some establishments are developing databases that enable a number of aspects of safeguarding to be looked at so that the links between, for example bullying and self-harm, can be identified. Other establishments collect and analyse data manually but are still able to consider it in a way that does give them some direction, such as where incidents of restraint took place or whether self-harm attempts had followed episodes of restraint. These are complex systems to set up and establishments

were struggling to develop them in apparent isolation from each other, although some safeguarding managers were informally exchanging ideas and materials.

Responsibility for scrutiny

In some settings the safeguards committee had oversight of the monitoring arrangements, with reports from each of the coordinators being fed in regularly. In other settings, particularly the split sites, some data was reported to the safeguards committee but other information was considered elsewhere, such as a prison-wide Use of Force committee, and it could be difficult to separate out information that applied specifically to the young people's units. This made it more difficult to link the different aspects of safeguarding into a coherent whole, and to make changes to improve practice. Different types of activity were being monitored in different places – some safeguards teams looked at complaints, unexplained injuries and use of force, some did not. Few looked at the use of care and separation¹² or full searches. The responsibility of the LSCB for scrutiny of individual practice or overall monitoring has not yet been fully developed.

Establishments complained that the monitoring function of criminal justice agencies was unclear and unhelpful. YJB central data collection, YJB monitors, Her Majesty's Inspector of Prisons, Prison Service HQ, Area Managers and W&YPG all required information but the framework was not co-ordinated into a single set of expectations, nor had the establishments received consistent help in meeting the differing requirements. The overall message was that there was too much scrutiny and not enough support.

Key findings:

- Establishments had developed a range of monitoring and quality assurance systems in isolation from each other.
- These varied in usefulness and more support is needed, particularly with data analysis, to enable oversight of all aspects of safeguarding.
- Establishments find the present performance monitoring and inspection framework by external agencies unhelpful.

A strategic approach to safeguarding

PSO 4950 states that the YOIs safeguards policy should be strategic, ensuring that the separate policy strands are integrated rather than operating in silos. As with all other areas, the extent to which establishments could be said to be operating strategically varied considerably. This was partly a resourcing issue: it is unreasonable to expect the safeguarding children manager to have developed a strategic approach if they have extensive operational duties, inadequate staffing resources and limited authority. The structures described earlier need to be right before they can fulfil their role. This reflects

¹² Care and separation units are commonly referred to by staff and young people as 'segregation' units, 'seg' or the 'block'.

whether safeguarding is seen as a priority within the establishment, and the commitment of the governor is of vital importance, as is the role of the LSCB.

Understanding safeguarding

If there is to be a strategic approach to safeguarding, the concept needs to be understood. In reality, we found the level of understanding about what safeguarding is to be patchy, with some inaccurate definitions, such as a poster describing safeguarding as the general well-being of all staff and young people. If everything is seen as safeguarding, this leads to a lack of focus and confusion about what action is required to make it a reality. It was rare for safeguarding to be fully embedded throughout establishments, so that all staff were able to describe what it meant and what the component strands were. Notions were either hazy or related to some aspects only, particularly suicide and self-harm. There was a similar lack of awareness about the roles and responsibilities of safeguarding staff, with a minority of officers being able to name both the safeguarding children manager and the coordinators.

The role of the governor

The commitment of the governor may be diluted on a split-site within an adult focused establishment, where s/he may not be as familiar with, or have the time to engage with, the complexity of the children's policy agenda. It is the governor who is expected to represent the establishment at the LSCB and many were doing so, but in other establishments their attendance was poor or representation had been delegated to the safeguarding children manager. Delegation was not necessarily a problem as long as the safeguarding children manager was linked into the SMT and they were prepared to share responsibility for safeguarding.

The role of the safeguarding children manager

Safeguarding children managers saw it as their role to integrate all aspects into something more than the component parts and were making progress but, again, this was harder on a split site and was something that a number of safeguarding children managers would have appreciated more help with. Their professional background and training did not necessarily equip them with the expertise to deliver this complicated task, although they did have the commitment and vision. In some establishments, the minutes of the safeguards committees reflect a lack of understanding about what a strategic approach would look like, instead recording detailed information about individual young people or raw statistics without any analysis. It is reasonable to expect support to be available to safeguarding children managers, with input on strategic development and action planning. In spite of this, some safeguarding children managers had achieved a great deal. For example, one establishment had developed a business plan with the LSCB with clear objectives, plans for achieving them and timescales. A minority of establishments had distinct safeguarding action plans: it was more common for actions to be noted in committee meeting minutes but these often lacked specificity and there was a risk that they would drop off the agenda.

The role of the LSCB

The development of a strategic approach is not just the responsibility of the safeguarding children manager. They need the support of the Prison Service and their senior management team but the LSCB clearly has a role as well. In most establishments

engagement from the LSCB is at an early stage of development, with few having developed the required protocols about their working arrangements with the YOI. It requires more than having the Governor as a member of the LSCB to make the relationship meaningful, and most establishments thought they were low down on the LSCB's list of priorities. There were some encouraging examples, however, of changes taking place, such as YOI staff being active in a number of LSCB sub-groups, YOIs having undertaken a presentation to the LSCB or offering YOI premises as a training venue to promote contact. We had invited LSCB chairs to accompany us on the review and it was encouraging that in 12 of the 19 YOIs they did attend or sent a representative. Where this happened, it proved productive in enabling the LSCB representative to get a clearer picture of how the establishment worked, particularly if they joined us in interviewing front-line staff or young people or in examining case documents. It was often the case that the LSCB representative and safeguards staff then used the opportunity to arrange further meetings or activities to take the work forward.

Establishment culture

A commitment to safeguarding cannot be generated solely from above. Although Governors and safeguards staff can develop robust safeguarding structures, disseminate information and provide training to their staff, effective practice will only be achieved if staff share their vision. It requires all staff to recognise that young people are entitled to be protected from harm, however challenging their behaviour may be. The vast majority of staff we encountered do hold this belief but a small minority did not accept that young people required a different approach than adults or they demonstrated negative attitudes to the young people they were caring for. Although it was clear that establishments would not tolerate overtly abusive staff, this more subtle issue of a lack of commitment to a child-centred approach is harder to tackle. There were clear differences in the level of commitment where staff had actively chosen to work with young people, as is the case on the specialist units or girls' establishments, and it was their view that this is essential:

Staff are here because they want to be here – we don't want to be part of staff rotation (staff member in girl's unit).

Everyone has chosen to come here. It makes a huge difference. The girls are so much fun. I wouldn't go back to adults now (staff member in girl's unit).

There was some evidence of splits within staff groups who did not share the same values, with high levels of whistle-blowing or young people telling us that staff had encouraged them to complain about certain colleagues. In some establishments, young people told us that most of the staff treated them well but that there were some who did not.

If you treat them good, they'll treat you good. There's one or two knob heads: certain teams are alright but some of them speak to you like shit (young person in boys' unit).

The young people were able to identify particular shifts, groups or individuals that had a negative approach towards them. For example, one boy said that he had been bewildered by the fact that staff did not answer him when he spoke until he realised that that was the way it was on this particular unit. Another young person said:

Some staff wind you up so they can give you a nicking.

Key findings:

- Safeguarding was not always understood – or prioritised – throughout the whole establishment.
- Many LSCBs have not yet fully recognised their responsibility to young people within YOIs.
- The culture of some establishments or staff groups is at odds with the values underpinning effective safeguarding practice.

Links with external agencies

There was a general willingness to be open about practice within the establishment and to learn from external partners. Governors and safeguarding children managers were finding creative ways of engaging with local agencies or community groups to access additional expertise or resources for the young people. For example, the local football club was running a programme in one establishment for bullies and victims of bullying; in another, they had enlisted the help of an expert in adolescent mental health to develop their work with young people who self-harm.

Local authority

Engagement with the local authority tended to be through child protection referrals. This will be considered in more detail in the section on child protection practice but links were either with the local referral and assessment team within the social care service from the Children's Service Authority and/or the child protection coordinator or Local Authority Designated Officer for allegations against staff. The level of involvement varied from individual casework to audit/scrutiny arrangements. The local authority usually had a nominated representative on the establishment's safeguards committee, although they did not always attend. In some areas there had been an attempt to widen involvement beyond child protection into other aspects of safeguarding, such as suicide and self-harm or bullying. For example, one local authority had asked to be notified if a young person had attempted suicide and another had deployed its anti-bullying coordinator to assist the establishment. Although outside the remit of this review, there were ongoing problems in involving local authorities with other aspects of a young person's needs, even where they had looked after status or were clearly children in need. The YOI social workers were very engaged in attempting to address these deficiencies.

Advocates

Apart from some isolated tensions, YOIs now have a good relationship with advocates overall. At the time of the review the service was provided by either VOICE or the National Youth Advocacy Service. The role of the advocate varied from establishment to establishment. They were most likely to get involved with adjudications, following a young person being involved in a disciplinary process, and advocating with a young person's home local authority to provide a service. There was less overt involvement with individual complaints against the establishment unless young people had requested it, in which case

the advocate's involvement usually centred on helping the young person write the complaint. In one establishment the advocates were involved in de-briefing young people after incidents of Control and Restraint (C&R), helping them to raise any concerns they may have had, but this was an isolated practice. The advocacy service was usually represented on committees and young people's participation groups, and in some settings was actively developing ways that the young people's voice could be better heard.

Advocates, along with chaplains, were frequently mentioned by young people as an important source of support and they were aware of how they could access them. Most advocates had posters on display explaining their role and the times when they would be available on the unit.

Independent Monitoring Board

The IMB, like the chairs of LSCBs, were invited to participate in the review. Seven responded to the invitation. Although they were sometimes members of the safeguards committee, the IMB generally had no explicit role in safeguarding and their knowledge of the issues was sparse. They were not generally from a childcare background and hadn't received any specific training for their work in a young people's establishment. The IMB has specific responsibility for monitoring the use of special accommodation, with a requirement that they be notified and invited to attend within 24 hours of any person having been placed there. This is the same whether the prisoner is a young person or an adult and the role of the IMB is to oversee the prisoner's welfare and raise any concerns with the duty governor, including any concerns as to whether the use of the accommodation is reasonable. We did see evidence that they had been notified and, on occasion, had visited the young person, but we saw no evidence of their having challenged practice. There were isolated examples where they had interpreted the role more proactively, and one IMB member was actively intervening in the issue of late arrivals.

Health

Relationships with health providers were patchy and some YOI staff felt that links were worse rather than better since the NHS had taken on responsibility for the service. For example, there were some problems with information sharing. The role of health care units varied, with not all establishments having access to in-patient beds. This could be a particular problem on the girls' units, where the main site usually provided the service. At times, this meant 17-year-old girls receiving detoxification programmes on units with adult women substance users. Where there were in-patient units, these varied in their remit. Some cared for disturbed and vulnerable young people and contained a number of 'safer' cells whilst others provided more of a service for physical ill-health, with disturbed young people being cared for within the care and separation unit. One in-patient unit complained of being used as a 'seg' for young people who had no health problems but had to be moved because they had damaged their cells.

Child and Adolescent Mental Health Services' (CAMHS) input varied considerably, with one establishment having a large, skilled and proactive in-house team and others having a service provided from external agencies. Similarly, access to counselling or specialist treatment was patchy.

Police

Contact with the police was usually in respect of allegations made by the young people. Some establishments have an investigations officer from the local police service based permanently on site whose role is to investigate possible crimes that occur within the prison. These could relate to crimes against staff or young people and may or may not be of a child protection nature. In other establishments, child protection concerns were seen as the remit of the local Police Child Protection Team and in one setting they had taken on a monitoring and scrutiny role of child protection referrals.

YOTs

Local YOTs are required to provide a service to remanded young people in order to investigate their circumstances and to see if a bail package could be provided. In many establishments, the on-site YOT workers had taken on additional roles, including child protection work, in a significant minority of sites. This could be as the child protection coordinator or a more informal role but they sometimes acted in a decision-making capacity. All of the girls' units had YOT workers leading on child protection work at some point, although in two establishments the role had been reviewed following difficulties.

Samaritans

A number of staff raised concern about the service provided by Samaritans. Prison establishments have designated phones that can be requested by the young people if they wish to speak to a Samaritans volunteer in private. It is difficult to know how far the young people use this service. They did not identify it as a significant source of support but were aware of it. Concerns arise because of the promise of complete confidentiality that the Samaritans offer, even if the caller expresses an immediate intention to seriously harm themselves or another. This is based on concepts of adult autonomy and the question must be asked about its appropriateness for young people. To date, the Prison Service has stated that they are happy with the arrangements.

Key findings:

- YOIs are keen to foster links with external agencies but continue to have difficulty in accessing local authority and health services.
- Advocates and chaplaincy services are valued by young people and could be developed but the IMB does not appear to be taking a significant safeguarding role.
- The Samaritans' confidentiality rule may be in conflict with the duty to safeguard children.

Safeguarding assessments and interventions

We attempted to see how theory was translated into practice by examining individual case records, talking to young people and front-line staff and reading the minutes of consultation fora or other relevant reports. Individual examples of practice in child protection, suicide and self-harm prevention and anti-bullying and violence reduction were examined, but we also looked at records of complaints, use of force, use of care and separation and special accommodation.

Suicide and self-harm prevention

The system

This was probably the most consistent area of practice, including some consistent problems. All staff are aware of the system and how to initiate referrals, and reasonable numbers of staff have been trained as ACCT assessors or case managers. It is generally acknowledged to be an improvement on the old system in that it is designed to support vulnerable young people rather than just prevent them from committing suicide or otherwise harming themselves. The system ensures that a trained member of staff undertakes an assessment of the young person, identifies factors that are likely to trigger suicidal or self-harming behaviour and other problems that are contributing to the young person's vulnerability, then puts into place a 'care map' to support them. This will include checks on the young person, with the frequency determined by the assessor's view of the level of risk. These checks are meant to involve interaction with the young person, not just observation. The plan should be regularly reviewed and updated.

Thresholds for intervention

One difficult question for establishments is the threshold for triggering an ACCT, with some recognition that it can be over-used and lose its significance. Young people subject to ACCTs ranged from those who had attempted to kill themselves on several occasions to those who were crying on their first night in custody. On the other hand, as one governor pointed out to us, they are working in a risk-averse culture where the perception is that they should err on the side of caution or face criticism. Some establishments were offering a tiered approach, providing additional support and supervision to young people in their early days in custody or at times of crisis without opening an ACCT. This may have advantages in respect of not 'labelling' young people, and in ensuring that practice with young people on open ACCTs is not diluted. Most young people were well aware of the ACCT system and who was on it: one young person said that you get an orange card outside your door if you are at risk and everyone knows about it. Another had not experienced it as helpful.

They stuck me on an ACCT. They didn't work with me – they kept an eye on me every now and again (young person).

Views on effectiveness

Opinions differed as to how well the system was working. In some cases there was clear evidence of attempts to engage, distract and support young people in distress but the system is a bureaucratic one, which can lead to formulaic responses. We identified a number of common problems with the ACCT documents we examined.

Some staff expressed doubts about their capacity, even with training, to be able to accurately assess the risk of suicide.

We're asking people who have no idea to make a judgement about someone they know nothing about (wing officer).

Although many assessors were clearly skilled at engaging the young people and enabling them to talk about how they felt and what was worrying them, this was not always reflected in the risk assessments, which could be unsophisticated and based on poor evidence. This

may well have been a feature of the training because we saw certain judgements repeated across settings: it was common to feel that risk was reduced if the young person '*has good eye contact*' or '*has no plan to kill himself*'. This did not always reflect other aspects of the assessment, particularly where young people appeared to be very disturbed.

The idea behind the identification of 'triggers' is a sound one and we saw some assessments where this had been understood and used well. For example, one young person said that she would be quiet and not want to come out of her cell if she was about to self-harm. Her care map used this information to ensure that staff engaged her in conversation or activities whenever this happened. This was unusual however, and the section on triggers was often left blank or not used to record the factors that were relevant to this individual child's responses.

A similar 'one size fits all' approach was also evident on many care maps. Although the assessments were often skilled at identifying the factors that were upsetting the young person, such as worry about his mum's ill-health or fear of a forthcoming court case, they were weaker on identifying suitable support. In many cases the onus was placed upon the young person to address their own needs, for example saying that they should '*seek help if upset*' or '*sort out family problems*'. One boy whose father had died became distressed and dreamed of him on father's day: the care map goal was for the boy to '*deal with this*'. Even where a service was identified to help the young person, such as substance misuse or the chaplain, the format of the care map does not require recording about whether the service was provided or its outcome. There was no space to update the care map or to sign off that actions had been completed, although some YOIs had taken the initiative to do this anyway.

Multi-disciplinary input

There was a widespread lack of multi-disciplinary engagement in the process, from care maps to interventions and attendance at reviews. It was not unusual for the only people to be present at the review to be the young person and the case manager. We were particularly surprised at the lack of healthcare input. Related to this, decisions to raise or lower the identified level of risk sometimes seemed arbitrary. Where only the young person was present at the review, they sometimes reassured the case manager that they felt better and the ACCT was closed. If a young person genuinely intended to attempt suicide, they may well offer false reassurances.

Suitable interventions were not always available, particularly where the young person appeared to have unmet mental health or emotional needs. We were particularly concerned about cases where young people complained of hearing voices, or of memory lapses, that psychiatric assessment may not have been offered. There was also little access to counselling or family work, although it was clear from the assessments that many young people were facing overwhelming personal problems, ranging from recent traumatic bereavements, their own children being adopted, the break-up of relationships, guilt and shame about their offence and fear of long-term imprisonment.

Young people were usually cared for on normal location but some very vulnerable young people were thought to need specialist settings. Young people could be placed in a 'safer' cell, that is to say a cell without ligature points or furniture/fittings that could be used to self-harm, although staff often pointed out flaws in the design. The location of these cells varied.

Some were on the ordinary wings, some on healthcare and some on care and separation or other specialist units. We saw some cells with gates rather than solid doors to allow for constant watch. Overall, there seemed to be no consistency of approach and we found some establishments had specialist units where all young people needing additional supervision were cared for together, resulting in disruptive, aggressive or bullying young people being accommodated with those who are disturbed or suicidal.

Monitoring

Management oversight and quality assurance was patchy. Establishments were clearly complying, on the whole, with the requirement that managers check and sign ACCT documents but examples of more active contributions were less evident. We did see some good practice, where managers had made entries in the document not only to comment on inadequate interventions but also to commend positive work with a young person. Overall monitoring was also patchy, although most establishments were attempting to undertake some level of monitoring, if only to record numbers of incidents. There were encouraging developments, however, with some establishments actively trying to understand patterns of behaviour. For example, one suicide and self-harm co-coordinator identified that a particular young person self-harmed if there had been a disturbance on the unit even if she had not been directly involved. Once staff were aware of this, they made a point of reassuring her after any incident that everyone was unharmed and involving her in an activity.

Suicidal behaviour v. self-harm

A final question that arose, particularly in girls' settings, is that of the distinction between suicidal and self-harming behaviour and whether they are part of the same phenomenon or should receive a different response. For some young people, self-harm is a coping strategy and there are some experts who would advise allowing limited and safe self-harm to take place. Others question whether this is appropriate for a prison setting. Both suicide and self-harm need to be understood within the context of adolescent development, and the meaning of self-harming behaviours may not be the same as for adults. The PSO that determines this area of practice is again prison service-wide and does not draw on clinical expertise with adolescents. Some establishments had sought out this expertise themselves, and one establishment had produced an excellent leaflet for young people about suicidal feelings in adolescence, but it is not disseminated throughout the estate.

Key findings:

- The ACCT system is prison service-wide and does not fully recognise the needs of adolescents, particularly in relation to self-harm.
- Although there is a welcome move towards support rather than surveillance, risk assessments and care maps were not always based on individual needs.
- There was a lack of multi-agency input into assessment and interventions.
- Young people who are at risk of suicide or self-harm may be inappropriately cared for alongside those who pose a discipline problem, or in unsuitably sited and designed safer cells.

Anti-bullying and violence reduction

This was generally acknowledged by most establishments to be both the biggest problem and the weakest area of practice.

We're trying to be more proactive than reactive but there are pressures from gangs and overcrowding that makes it difficult. We'll never eradicate it but staff do work very hard (member of safeguards team).

A number of establishments have undertaken a bullying survey, and were trying to use the information to develop their response.

Definitions

Again, the problem of definitions arose, particularly in relation to 'normal' adolescent behaviour. Some of the young people said that their interactions with peers were sometimes loud and insulting but that they were actually good mates and it didn't mean anything. They felt very aggrieved if anti-bullying procedures were applied unfairly:

She's been put on it for nonsense. Not everyone gets along – they're just not talking to each other (young person).

Staff were struggling to identify bullying where they did not know the young people or understand the relationships between them: behaviour may be bullying in some contexts but not in others depending on where the power lies. They recognised that the distinction between a bully and a victim was complex and one of the establishments that had sought external advice had found the concept of the bully-victim helpful. Unit staff were alert to the issues of young people acquiring canteen items from more vulnerable young people and kept an eye on this. They had rules about borrowing or going into each other's cells but said that they knew there would be instances of bullying that they were unaware of. The practice of 'shouting out' of windows to taunt other young people perceived as vulnerable continues:

They make them do shout-outs like 'baa baa black sheep' – then they try to hurt themselves (young person).

Anti-social behaviour

Overall, staff didn't feel they had the tools to deal with bullying effectively and were struggling – again in isolation – to develop their approaches. In an attempt to do this, some establishments had developed an anti-social behaviour policy to cover all types of behaviour that they deemed to be negative, which is potentially confusing and discouraging for the young people. For example, one establishment referred to giving young people 'anti-social behaviour orders' (ASBOs); although they were not official ASBOs many young people were confused about the status of them and there was no formal process for the young person to be informed what they had done wrong or to exercise their right to reply. In fairness to the establishment, they had not intended the system to be punitive but were trying to adopt a holistic approach to behaviour management that encouraged young people to respect staff and other young people, and to take responsibility for their own behaviour. However, in another unit we found young people that had been given an anti-social behaviour label for failing to concentrate in class or being 'loud'. One young person in that unit told us:

I don't really know what it's all about. There must be some rules that I don't know about. There's a lot of young people that do stuff worse and they don't get anti-social behaviour. I'm sometimes only just being myself – it's not fair.

He also didn't know what he had to do to 'get off it'. The YOI's definition was:

Antisocial behaviour involves an individual displaying a solemn disregard for rules. They may do so by failing to work properly or refusing to follow instructions. It can also include an individual being disrespectful. Such behaviour may involve swearing or making inappropriate comments/ suggestions. Other behaviour can include: disrupting activities, being improperly dressed, refusing to participate in regime.

Although we did not feel that the anti-social behaviour approach was a helpful one, it is to the credit of establishments that they recognise a need for a more sophisticated approach than the ethos of 'stamping out' bullying provided by the PSO. One particularly positive initiative was to tackle challenging behaviour through a Complex Needs Conference, whereby a multi-disciplinary meeting was held to plan the care of young people who were struggling to manage within the regime and who were repeatedly being restrained or subject to adjudications. Other establishments had sought external help, for example through the local authority's anti-bullying coordinator, academic experts or psychologists. A number of establishments are also developing mediation to resolve conflicts between young people and some have extended this to conflicts with staff. These varied in the levels of sophistication and staff do not necessarily receive any training to undertake mediation but it is a promising approach and staff felt that it was more productive than labelling someone as a bully or a victim.

Interventions

There was widespread dissatisfaction with the measures at their disposal to tackle bullying. Most operate a level system, with level one involving a period of monitoring through a bullying log, and level two some loss of privileges and targeted work, but they all struggled with level three. Where young people had not responded to interventions and had no more privileges to lose, they felt there was little they could do. The perception amongst young people was that you get 'shipped out' to another establishment at that point but this did not always happen in reality and, in any event, was not seen by staff as a solution. In some establishments there was a practice of keeping the young person behind their door, participating in an isolated regime.

A difficulty with the interventions was that in order to protect the victim, the actual incident that had prompted the bullying log was not recorded or described to the young person. This meant that the young person did not know what they were meant to have done, but neither did the staff in other parts of the establishment who were responsible for contributing to the monitoring. Some bullying logs contained vague and unhelpful entries as a result: '*came out on association – no problems*'. In some cases, attempts were made to separate bullies and victims in activities, for example assigning them to different workshops, and sometimes one or other would be moved to another wing but, as one wing officer pointed out:

Sometimes the victim is moved away and this might seem that they are being punished.

Interventions for victims were rarely in place, with a general perception that staff would just 'keep an eye on them' although there were some examples of self-esteem or other work being undertaken.

A number of establishments had developed specific programmes or workbooks for bullies, either in groups or to be undertaken on their own or in a one-to-one session. We are not in a position to know how effective these are and there was clear evidence that some young people had little motivation to complete a workbook on their own. Other establishments felt that a more generalised approach would be better, including sessions within education about the nature of bullying and its impact. We were impressed with the initiative of involving a group of bullies and victims (unidentified to each other) in a football project run by the local club.

Unit culture

This relates to the idea of positive approaches rather than trying to eliminate bullying through punitive means: for example, demonstrating ways of interacting through pro-social modelling that the young people can learn from. We saw many examples of positive, caring, interactions from staff but some hostile and negative behaviour. One establishment in particular seemed to accept that this was the way to speak not only to the young people but to us - and to each other. In many of the boys' establishments, there is a high level of banter or teasing towards the young people.

The gavs are just jokers like us (young person).

Sometimes the young people enjoyed this but sometimes they did not and there is clearly a fine line between teasing and bullying, with some young people feeling hurt by what staff said to them. They also complained that they would not get away with speaking to the staff like that so why should they have to put up with it?

Generally, young people in the boys' units agreed with staff that bullying was a major problem. We asked the young people what they would advise someone to do if they were being bullied.

I've seen it happen – there's certain people that would be left to get on with it – if they're big: smaller ones, I might stick up for them (young person).

A significant number said that they would advise them to sort it out themselves – or get another young person to intervene on their behalf – rather than go to staff.

I was bullied. It's still going on. My boys are going to sort it out for me because they are bigger than me (young person).

Reasons for not telling staff were being labelled as a 'grass', or feeling that they couldn't trust staff to sort it out, making the problem worse. One boy said that '*the worst thing that can happen is to be seen as a victim*'. Other young people said that they would advise victims of bullying to tell staff and that, in certain circumstances, they would go directly to staff themselves.

If it was serious and he was talking about killing himself (young person).

Some establishments seemed to generate more trust in staff than others, perhaps reflecting the cultural issues described earlier. This was much more likely to be the case in the girls' units where, because they are so small and the staff are able to get to know the young people, there was a perception that staff would nip bullying in the bud.

Violence reduction

This was often linked with bullying, although there is recognition that it is not the same thing. The definition of violence is less contentious, although it is interesting and positive that some establishments include the reduction of the use of force by staff against young people as one of their aims within the violence reduction strategy. Fights between young people can break out or punches be thrown without it being part of an attempt to target a more vulnerable young person, although physical intimidation can of course be one element of bullying. Some young people felt aggrieved that they had been accused of bullying following a fight, which they perceived to be a very different thing. Again, some young people were very afraid of violence from other young people and varied in the extent to which they had faith in staff to protect them from it. With one or two exceptions, they thought that staff would move in immediately to break up any fights but that depended on whether they were there when it happened and whether there were enough of them. Again, one young person said she would tell staff about violence in certain circumstances:

If I saw someone being battered in her room I would.

The young people were able to tell us about 'hotspots' within the prison where observation by staff was problematic or where there were gaps in CCTV coverage. These were most commonly in the gym showers, although other 'unsafe' places mentioned were association areas, staircases or education. Several young people said these areas would be used if you had something to sort out:

If you really want to hurt someone without anyone finding out – the fact that they lock the doors in the showers on the wing

Staff were usually aware of these areas and, although there has been improvement through the capital investment programme, they felt there was more to be done. The low ratio of staff to young people also had an inevitable effect on the prevention of violence and having more staff was cited by the young people as the single most significant factor in keeping them safer. There were clear differences within the smaller units, particularly the girls' units, where the size, design and higher staffing ratios made the young people feel much safer.

Key findings:

- Bullying or violence from peers is perceived by young people as the biggest risk to their safety and they do not always trust that staff will protect them.
- The prison service approach to bullying and violence has not been adapted to reflect the needs of adolescents: definitions are unclear and responses inadequate for both bullies and victims.
- The emphasis is mainly on punishment, including the introduction of 'anti-social' behaviour policies, rather than a holistic approach to behaviour management.

- Establishments recognise the inadequacy of the current policy and would welcome more training and guidance. There are some welcome initiatives within individual YOIs that could be better supported.
- There are known gaps in CCTV coverage and hotspots where it is accepted that violence takes place.

Child protection

Definition and thresholds

Many of the staff reported a lack of a clear 'child protection' definition, and thresholds varied widely across establishments, with some including fights or bullying between young people as child protection referrals and others clearly excluding these.

The first month, I was thinking – is that or isn't it? But it's very much suck it and see. I hear the goal posts change (manager YOI).

Even where staff had been on the Juvenile Awareness Staff Programme (JASP) so were familiar with the broad categories of significant harm from *Working Together to Safeguard Children*, this definition is general to all ages of children in all contexts. Interpretation needs to take place if physical abuse, neglect, sexual or emotional abuse are to have any meaning in the specialist setting of a YOI. Neglect of a three-year-old living in the community may look very different from neglect of a 16-year-old in prison but none of the policies provided by the prison service assist staff in making this interpretation. Local definitions were rarely written down, although there were some examples where the threshold for referral to local authority children's social care team had been agreed with them or the LSCB and was recorded in the child protection policy. In the absence of this clear definition, only allegations about physical assault or historic abuse were reliably recognised as child protection matters: verbal abuse, bullying, inappropriate banter or staff's failure to respond to a child's needs were not consistently identified or included within child protection processes across all establishments. In fact the procedures in one establishment stated that allegations of verbal abuse were not to be referred to the local authority. This raises an important issue about the 'right' response to such incidents: if these are not considered to be child protection concerns, then how should they be dealt with?

Processes

Although all establishments had mechanisms for referring child protection allegations or concerns to the local authority, meaningful involvement was rare. Very little was considered to reach the threshold for a S47 investigation and this led to the many examples we saw of tokenistic exchanges. The YOI would refer an incident to the local authority and they would reply on a standardised letter saying that they would not be taking any action because the allegation did not meet the threshold for significant harm. This may well have been the case, but it raises important questions about the value of the process, and whether it is the right one for the majority of concerns that arise. It was clear that the YOIs were keen to be transparent in their response to concerns and, in the rare cases we came across where allegations had been seen as serious, strategy meetings had taken place and thorough investigations had usually followed.

A major problem is the confusion over the difference between the thresholds for:

- criminal investigation
- child protection enquiries
- disciplinary proceedings.

Young people who had made an allegation against a member of staff were often asked if they 'wanted to proceed' and, if they said no, the whole matter was dropped. This may have been an appropriate course of action in respect of a criminal prosecution but is completely inappropriate for child protection or disciplinary matters. There were also concerns about who put this question to the young person. In some cases it was the social worker, YOT worker or police: in other cases it was a member of the safeguards team or a prison officer. There was some evidence of unfair pressure being put on the young people. For example one case record describes a conversation with a young person following an allegation:

I took the opportunity to discuss the fable of the boy who cried wolf. [Young person] was informed of how officer X was feeling right now, having been accused in this way. Although [young person] did not apologise, he accepted my point of view. He was again asked if he wished to make and record a complaint which would initiate a child protection investigation. He replied 'no'.

The unease that allegations cause was reflected in documentation in one establishment that described the purpose of child protection referrals following allegations about the use of force as follows:

External referral is required to verify the actions of the restraining officers and refute the allegations made by the young person.

There is a sense within this message to staff that all allegations are inevitably malicious. This was echoed by a wing officer in another establishment:

The voice of the boy is listened to. You only have to look at a boy the wrong way – they are overprotected. They can lie and exaggerate – nothing gets done. Too many people are out of touch with what's real.

The way in which the child protection process should link with disciplinary processes is unclear. The existing PSOs that relate to conduct and discipline are prison-wide, make no reference to child protection processes and indeed are incompatible with them. For example, it is up to the establishment to decide whether to initiate disciplinary action, simple investigations will usually be undertaken by a line manager and there is no mention of the important role of the LADO. We came across examples where an allegation against a member of staff did not meet the S47 threshold but a recommendation for an internal inquiry within the establishment had not been followed through. *Working Together* makes it clear that allegations against staff do not need to reach the threshold of significant harm to require rigorous investigation because they may raise important questions about that person's suitability to work with young people. The local authority designated officers should oversee

such investigations. New guidance has been developed by W&YPG¹³ that describes the need to involve the local authority in allegations against staff, even where they do not appear to be serious, to ensure they '*are examined objectively by someone independent of the organisation concerned*'. However, there is clearly some tension between the PSOs and scope for ambiguity. Local authority designated officers are only just beginning to get involved in YOIs, although the process of investigation or its level of independence were not always clear.

The links between investigations as a result of whistle blowing and child protection processes may also be dealt with separately and we saw some establishments where they were cross-referenced with the child protection log but kept in separate files, thus reducing the opportunity for external audit or scrutiny by the local authority. In one establishment, there was an allegation of inappropriate sexual comments and approaches having been made by an officer to a young person. This was not deemed to reach the threshold for a S47 enquiry but it was requested that the establishment undertake an investigation. An internal investigation took place and the officer returned to work without any further reference to the local authority.

Roles and responsibilities

For child protection work to be effective, roles and responsibilities need to be clear, particularly in respect of decision-making. Who has the authority to decide whether a case is or isn't a child protection matter? Is it reasonable for a prison governor to be able to filter out child protection concerns raised by young people or staff? Who is ultimately accountable for deciding the nature of the investigation that should be undertaken? Who is responsible for deciding if any further action is needed to protect young people from further abuse? What is the role of the YOI social worker and YOT staff in the decision-making process – and in investigations? Establishments had developed local solutions to these problems and, in some, there was evidence of appropriate and transparent decision-making and regular external scrutiny: for example, meetings with the local authority child protection co-ordinator or local authority designated officer to review and 'sign-off' child protection cases. Arrangements were less robust in other settings. One establishment expressed doubt about whether an adult-focused duty governor could make informed decisions about child protection and others had not developed arrangements for external scrutiny. On a cautionary note, such scrutiny must be meaningful and provide a healthy level of challenge. We came across one or two establishments where an element of complacency had crept in, with every case being signed off routinely regardless of the quality of the work that had been undertaken.

Historic or community abuse

Practice tended to be much clearer where the concerns related to historic abuse or a child in the community. We saw some excellent practice in identifying potential risk from visitors or through information within letters. A significant number of young people disclose previous abuse to staff, who were generally aware of the need to refer this information on. The social worker, if in post, or another member of the safeguards team, would pass this referral to the

¹³ *Guidance on Managing Child Protection Allegations against Prison Staff*. Annex C – Appendix 1 (H) of PSO 4950.

home local authority. In some establishments, they were well supported in this process by staff within their own local authority who either co-ordinated the referral or helped to resolve problems if there was a poor response. Practice was more variable in terms of ensuring that there was a clear outcome as a result of the referral: some establishments actively followed them up until it was clear what had happened whilst others did not. Front-line staff found this a source of frustration: they did not want to know the detail but would have liked to know whether the information had been acted upon, and wanted to know what to say to the young person. We came across some excellent practice, however, and on-site social workers were particularly likely to pursue referrals and keep everyone informed, including the young person. It helped that they understood how local authority systems worked and what it was reasonable to expect.

Support

This need for perseverance and support were not restricted to cases of historic abuse: allegations against officers generated a high level of anxiety amongst staff and they needed to understand the process and time-scales for investigation. Similarly, the young people needed to know what was happening and what to expect. One establishment had designated clear roles for supporting both staff and young people in these situations, with the social worker supporting the young person and the deputy head of safeguarding supporting the staff member.

Key findings:

- There was no consensus about the definition of child protection or the threshold for referral to local authorities, and some authorities did not take on a meaningful role.
- There was also confusion between child protection and criminal or disciplinary processes following allegations against staff.
- Accountability for decision-making was unclear, with the onus sometimes being placed on young people as to whether they wanted to 'proceed'.
- Where investigations were undertaken, staff and young people were not always provided with independent support, and outcomes were not always recorded.
- Some allegations against staff were not considered within safeguarding processes, such as those arising within complaints or use of force documentation.

Related practices

Child protection concerns may arise through a direct allegation, or an incident that is identified by staff as meeting the child protection criteria. All such concerns should be recorded on the child protection paperwork provided by the prison service and passed to the duty governor and safeguards staff. There is the potential, however, for concerns to be missed if staff are unaware of the definition of child protection. For this reason, we looked at a range of other documents, including records of complaints and use of force forms. Whilst some establishments were rigorous at screening these and making sure that concerns were addressed, others were not. We found some examples of child protection matters that had

been overlooked, particularly where young people had used the complaints system to make allegations against staff.

Complaints

Research in other settings has shown that where young people feel empowered to complain and to have those complaints taken seriously, they are likely to feel safer. This is not to say that all complaints need to be formalised. Some young people told us that they had never needed to use the complaints system because they talked to staff if they had a problem and it was 'sorted'. This is clearly preferable and, again, a sign of a safe and healthy environment.

Young people all knew how to make complaints, and forms were readily available on units, but they had mixed views about whether it was worth making a complaint or not.

I put one in about the mash being lumpy – it's not lumpy any more.

Some thought that staff did look into complaints if they were about issues such as food or kit, but were less likely to look into complaints against staff.

If you say something about canteen or phone credit, they do something about it but anything bigger, they don't do anything.

Other young people had more trust in the system, however, and did feel that their complaint would be taken seriously regardless of the content.

A number of complaints contained allegations of ill-treatment by officers. Some of these related to allegations of minor assault but they were more likely to be about staff treating them unfairly or unkindly. For example, several young people on one unit complained about the way a particular officer spoke to them and maliciously accused them of things they had not done; a young person complained that an officer had insulted his mother and another who was gay said an officer repeatedly called him a 'Barbie doll'.

The response to complaints was sometimes fair and respectful where attempts had genuinely been made to resolve the problem, particularly if it was about uncontentious matters such as property. Apologies were sometimes offered and young people thanked for having brought the matter to staff attention. For example, one young person complained about the delay in deciding on his parole. The response was as follows:

I appreciate your patience. I am sorry for the delay and the concern that this uncertainty is causing you. I will chase again. Kind regards.

Other responses were sarcastic, dismissive and did not address the complaint. For example, several complaints about officers received a response that suggested that the young person was to blame for the incident because of their behaviour. One young person complained that he had been treated disrespectfully. The response was as follows:

Respect is something that has to be earned. Your behaviour is disgraceful. You ask to be treated as an adult yet your actions are petty and childish and you seem unable to follow even the most simple instructions.

Others blatantly said that the young person's version of events must be untrue because the respondent knew the officer concerned and did not believe he or she would have behaved in such a way. One young person complained that a staff member had not been supervising association, allowing a fight to develop and delaying intervention to break it up. The response was:

You should be thanking her not criticising her. A false allegation is a criminal offence.

We were struck by the lack of independence within the complaints system. Complaints were often investigated by wing staff, who clearly had a close working relationship with the officer who was the subject of the complaint. Even where young people had used the confidential access system to ensure the complaint went to someone more senior, the complaint was often passed back down the line for a response. Advocates were not routinely involved in complaints and neither were the IMB or other independent person. Most young people were unaware that they could appeal if they were unhappy with a response.

We did come across one establishment that offered guidance to staff on responding to complaints, including the expected timescales and expectations regarding the tone of the response, but otherwise did not get the sense that complaints were taken particularly seriously. A minority of establishments were beginning to consider complaints within the remit of safeguarding and were attempting to collate information for the safeguards committee but analysis was limited. This is a missed opportunity. Complaints provided a significant insight into the concerns and preoccupations of the young people and into the attitudes of staff towards them. Clear themes emerged within some establishments: one appeared not to respond to simple requests, such as the repair of broken fittings, until young people finally resorted to the complaints system in frustration and another had repeated claims of money that had been sent in to them going missing.

Key findings:

- The approach to complaints did not meet the standard expected of other children's services and was not independent, fair or transparent.
- Some responses were very poor, particularly in relation to allegations against staff.
- Links were not always made with safeguarding and attempts to identify overall trends were rare.

Use of force

All YOIs require staff to record incidents where force has been used. There was some variation across sites as to the interpretation of this, with some recording of fairly low-level incidents, but as a minimum all should record incidents where C&R has been used. All staff who were involved need to make their own record and there is a separate sheet for healthcare staff to note any injuries resulting from the incident. Staff usually provided a solid written account of the incident and the techniques they had used, although the representatives from W&YPG who accompanied us on the site visits were concerned that techniques were sometimes used inappropriately, such as the 'figure of four' hold or the routine taking of young people to the floor.

There was only very limited information within the records about what had led to the incident or what could be learned from it. This is not necessarily the fault of staff – the recording format provided by the prison service does not require this information. There is no separate recording system in the under 18's estate in spite of the YJB's code of practice *Managing Behaviour in the Secure Estate*. It is to their credit that a number of establishments had tried to address this by developing additional formats, mainly for debriefing after incidents, but some also encourage staff to identify the factors leading up to the incident and what could be learned from it. The quality of the entries was sometimes disappointing, however, with sections left blank or responses failing to address the question. It seemed that some staff had not understood the purpose of the form, highlighting a training need. One site routinely uses advocates in the debrief of young people following the use of restraint, and these forms were more effectively filled in, with some evidence of young people feeling able to raise any concerns they had. Although a representative from healthcare did usually complete their form, there was no evidence of their being actively engaged in challenging or reviewing practice.

On reading the use of force records, it was difficult to get a sense of whether staff had used de-escalation techniques because, as stated earlier, there is no requirement for them to record this. It did appear, however, that in some cases staff had actively escalated the situation by, for example, going into cells to forcibly remove young people who were being verbally abusive rather than leaving them to calm down. In another establishment, there seemed to be a link between young people's frustration at routine problems not being resolved, leading to a final loss of control and the use of force. There also seemed to be a lack of understanding about what de-escalation means. For example, we came across one record that stated:

To de-escalate the situation, he was taken to the floor.

Where young people are invited to comment on the use of force, they are not necessarily critical. Many young people interviewed in confidence said that staff usually have no choice and that it is 'fair enough'.

I've been twisted up a few times. I deserved it.

They use restraint sometimes but it's justified – they're not rough.

Most also said that they did not think that excessive force was used but there were a minority who reported rough handling, verbal abuse during restraint and the deliberate infliction of pain without good reason.

They don't know when to stop – I've got a scar on my arm. [During a restraint] I called him a prick. He said 'Every time you talk like that, I can give you pain' - he twisted my arm up. It was basically torture.

You might get it worse if you've given them lip.

There were also one or two descriptions of deliberate assault. For example, one young person said that he had seen a young person punch an officer who had later gone into his cell and punched him back.

One young person said that he had witnessed staff deliberately preventing good quality recording during a planned episode of restraint by breathing on the camera lens so that the image would be unclear. We did come across evidence of injuries as a result of C&R, including fractures and head injuries, and these had triggered an investigation of some sort, whether child protection or internal. Even where young people had told us about episodes of restraint that had been, in their view, inappropriate or excessive, this did not seem to lead to a generalised fear of staff. Most young people said they felt very safe when alone with staff: *'they are trustworthy'*; *'we get on OK'*; *'the officers are nice'*.

The extent to which force is used seemed to vary considerably across the estate, and this variation did not seem to be based entirely on differences in the population of young people. For example, there are different levels across the girls' units in spite of their similar populations. The reasons for this are not entirely clear but could be related to the skills that staff have been supported to develop in finding alternative approaches to problematic behaviour or may again be an aspect of staff culture. For example, we were struck by the use of language in one establishment where staff and young people frequently referred to everyone in terms of their size, such as *'he was a really big lad'*, which suggested a macho and physical environment.

He was small and frail – looked like the kind of person you could break his arm. I felt sorry for him (young person).

There were different arrangements in place for monitoring the use of force, such as a specific use of force committee, internal audits or regular reports to the safeguards committee. Some settings did not appear to have any meaningful monitoring and only one establishment appeared to routinely inform the young person's family that an incident of restraint had taken place. One establishment had made it clear that the use of force was a safeguarding issue and that every incident would be reviewed. They had also set up a database to provide detailed information about every incident and said that the use of force had reduced as a result.

Care and separation unit and special cells

The YJB intends to review this area of practice and it was clear that such a review is much needed. When young people were removed under restraint, they were usually taken to the care and separation unit, still usually referred to as the segregation unit or 'seg'. At times, this was because they had damaged or flooded their cell; on other occasions it was because they were placed on report as a result of the incident and were awaiting adjudication. The code of practice *Managing Behaviour in the Secure Estate* states that the care and separation unit should not be used as a punishment for young people, although there is some conflict between this and other prison service guidance and it is common practice for young people to serve a designated period of time there as a result of an adjudication hearing.

We found evidence of some young people being placed in a 'special' cell without furniture within the care and separation unit. In all units that had such cells, staff assured us they were used for the minimum time possible and only if it was necessary as a result of a risk assessment. There are certain safeguards in the use of these cells, in that they must be authorised by a governor who stipulates the frequency with which the young person must be

checked and the level of search that can take place. They must be seen by someone from healthcare and the IMB must be informed. After 24 hours, a review must take place, and a governor must authorise the young person's continuing detention. We examined documentation on the use of special cells and found instances where the criteria had been breached. It was obvious that some establishments were using the cell routinely for a short time to 'process' the young person on their arrival in the segregation unit, including strip or 'full' searches. For example, one unit told us that young people might have blood on them or be holding something with which they could injure themselves so they were *all* told to strip and given 'sterile' clothing, which consisted of a clean set of standard issue kit. Special protective gowns which cannot be torn to make ligatures were also used in some cases. Again, they did not always appear to be used on the basis of a risk assessment and we found that many duty governors were failing to direct the level of search or clothing as required by the PSO. The criteria for using the special cells were often not clearly documented, with the reason given as the young person being 'disruptive' or 'abusive'. The cells were usually used for a short time but we did come across instances where young people had been there for several hours and, in one case, the young person had been there without clothes for over five hours after he appeared to be calm.

Although it was clear that the IMB were routinely notified, we found no evidence of their challenging the use of special cells, even where it appeared to us that the regulations had been breached. One of the cells in particular was grossly unsuitable, being a cell surrounded by an additional outer wall so that the young person was completely isolated and could not be heard from outside. It was dark, with only a mattress on the floor and a cardboard bedpan, and to be held there would be a frightening and alienating experience for anyone, let alone a young person. This cell was routinely and regularly used for under 18s.

Key findings:

- There was little evidence that establishments had adapted the approach to behaviour management required by the YJB code of practice *Managing Behaviour in the Secure Estate*.
- Practice in relation to the use of segregation, special cells and full searches appears at times to be in conflict with the duty to safeguard young people.
- Monitoring and external scrutiny are limited, and the use of force is not routinely considered within safeguarding processes.

Joined-up practice

The balance needs to be struck between over-generalising so that everything is safeguarding, and it therefore has no separate profile, and making sure that there is whole-establishment approach. Many aspects of prison life impinge on whether young people are, or feel themselves to be, safe and these need to be linked in so that safeguards staff can have an overview of practice within their establishment. These must include complaints and use of force as a minimum. We are aware that the relevant PSOs do not necessarily help staff to make these links, as some have an adult focus. Although PSO 4950 does set out the expectations and aspirations for the establishments caring for young people, it does not necessarily help to make sense of this within the context of the wider prison service

expectations and, at times, the policies appear almost contradictory. Some governors and safeguards staff seem to have been able to develop a more joined-up approach than others, and the constant issue of staff culture is relevant here. In some places, staff have embraced the rapid changes brought about since 2000 and are excited about the challenges of working in a different way: others are resisting the suggestion that their practice should become more child-centred. For example, one officer told us:

The older staff don't seem to care about the young people. They can't be bothered to talk to them and just wind them up.

Young people are sensitive to these differences in attitude, and it affects how far they feel they can trust staff to look after them. Interestingly, a young person from the same establishment as above said:

The gaol is full of old men and women. The old men officers are grumpy: the old women do care.

An advocate described the problem as follows:

There's a small tight knit group who want to punish them twice i.e. you are in prison and you aren't entitled to the niceties of life.

Staff knowledge and skills

The complexity of the task for staff working in YOIs must be recognised, particularly given the paucity of the environment and the resources they have to work with. Staffing ratios are low, the turnover of young people is high, with many coming from different areas of the country and new arrivals may be accompanied by little information. It must also be recognised that most prison officers will not have entered the profession specifically to work with young people: it is not a separate career path and in order to gain promotion, officers are expected to have experience of different types of prisons serving different populations. This may mean that staff at all levels have little experience or interest in working with young people. We were impressed with the fact that most senior managers recognised this tension, and had an expressed commitment to moving staff on if they were not felt to be suitable to work with young people, even where there were no formal disciplinary matters. It was unclear what would happen if senior managers did not themselves have the skills to work with young people.

Prison service training

New prison officers receive eight weeks general training and in 2003 a specific module was developed for those working in young people's settings, Juvenile Awareness Staff programme (JASP). This now consists of two programmes – JASP 1 (three days) and JASP 2 (four days). JASP 1 covers child protection and an understanding of working with young people in custody. JASP 2 covers mental health, substance misuse, vulnerability assessments, resettlement and training plans, managing difficult behaviour and safeguarding. These are meant to be mandatory but it is not a requirement that staff be trained before they have contact with young people.

The general view amongst staff – and external partners – was that whilst some staff may have skills acquired from experience on the job or personal attributes, this was not supported by adequate training. JASP training was patchy in its delivery, with some settings reporting that very few people had been trained. The quality of the training was also said to be ‘basic’. Some staff said that JASP 1 had given them some awareness of general issues, and had made them think about the reasons for young people’s behaviour but they did not feel it had taught them relevant skills. JASP 2, which contains a specific module on safeguarding, is accompanied by tests; for example, participants are told that they must be able to name three of the five *Every Child Matters* outcomes at the end of the course. This was said to be an unhelpful distraction. The course content is very general. It runs through the legislative basis for safeguarding and child protection work and the definitions of significant harm from *Working Together*, but does not attempt to help participants interpret the information for the settings they work in or to support them in knowing what their particular responsibilities are. A particular weakness of the training offered by the prison service is that there is no training for governors, safeguards staff or other managers. They are therefore expected to make significant decisions about the safety of young people with no training. As some managers pointed out to us, if they had only ever worked in the adult prison estate, how are they meant to know what safeguarding is, let alone implement it effectively throughout their establishment?

There was a sense that, whilst ACCT training had been provided throughout the estate, there was a complete absence of training in bullying or violence reduction, which were more endemic problems. The whole issue of skills in responding to adolescent behaviour and pro-social modelling was recognised as a major training need that should underpin more formal knowledge about aspects of safeguarding. There are ways of developing these skills other than formal training. One ACCT caseworker told us of lunchtime meetings that had been set up for ACCT assessors, which gave them an opportunity to share their experiences and learning. The model of supervision that exists in other care settings is not so far part of the YOI culture, but a couple of senior managers are hoping to develop it. This would provide an individualised opportunity to ensure that staff were better equipped to do their job.

Other sources of training

Some managers had been proactive in trying to overcome these deficiencies, either through accessing LSCB or YJB training, or through commissioning targeted training for their staff. YOI staff should have access to multi-agency training provided by the LSCB, although we came across one YOI who were not allowed to access this training because they had declined to make a financial contribution to the Board. Another YOI had provided the venue for LSCB training as their contribution to LSCB funds, which had the added benefit of making it easier for staff to attend. Opinions were mixed about LSCB training: some had found it very helpful and had enjoyed the opportunity to learn alongside staff from other more traditional children’s services. Others said that they found the experience frustrating because the course content was not sufficiently relevant to this age group or setting. On the whole, however, it was felt to be more useful than JASP.

Other safeguarding children managers and YOI social workers had devised in-house training, particularly on child protection, and had enlisted the support of local authority staff or the local police to deliver it with them. Most had attempted to ensure that someone from

the safeguards team had a session with new staff during their induction to make them aware of local policies and who to approach with safeguards concerns. Other local training that was considered to be useful was RAID, which is practical skills-based behaviour management training for staff developed by clinical psychologists, input from the local authority anti-bullying coordinator and sessions from the advocacy service.

Key findings:

- Internal and external training for all levels of staff, including governors and those in safeguarding roles, was considered to be inadequate.
- There were tensions caused by the fact that not all staff had chosen to work with young people, and may not be suitable.
- There was evidence of splits within staff groups based on differing values.
- The prison service does not have a culture of individual supervision or learning from peers.

Perceptions of safety

In spite of the many areas that need further development, young people generally said that they felt reasonably safe. They were not afraid of staff – *‘they’re not going to hit you or bully you’* – and, if they were afraid of anything, it was other young people. This was also a reflection of many of their lives on the outside: their concerns centre on the ability of adults to keep them safe. We asked the young people how safe they felt overall in the establishment on a scale of 1–10. For the boys, the lowest individual score was 1 and the highest 10, with an overall average of 7.1, but it was clear that young people felt safer on some units and in some establishments than others. Many of the young people (79 out of 128) had previously been in other secure settings and we invited them to make a comparison across all the places they had been. A very consistent message emerged that the safest establishments are secure children’s homes, followed by STCs and with YOIs the least safe. Interestingly, staff, whether safeguarding staff, wing staff or external professionals, rated the establishments as being safer than did the young people.

Perceptions of safety were different for the girls: they rated their units as being very safe. The lowest individual score was a 5 and the highest 10, with the average score being 7.8 and they often said it was *‘like a children’s home’*. Where they had been in other types of secure establishment, their perceptions did not suggest that the YOI was significantly less safe. Any concerns expressed by the girls tended to be individualised and relatively minor, such as the risk of dehydration in the gym. Many of the questions about the safety of different areas of the establishment had little meaning for them because the units are small and self-contained, with in-cell bathrooms.

When we asked young people what would make them safer, more staff and smaller units were the improvements most commonly cited. Other comments were the need for more CCTV cameras, separating remanded from sentenced young people and having separate wings for long-stay young people. Others mentioned staff attitudes:

If officers treated you like they wanted to be treated themselves.

Staff shouldn't be allowed to have so much power; if they don't like you, they can do something to you.

Feelings of safety also seemed to be connected to an overall ethos. Where young people had good relationships with the staff, and could therefore talk to them about their concerns, they were likely to feel safer.

I feel I can have a decent conversation with most officers (young person).

Their opinion often reflected our observations about the 'feel' of a particular unit or establishment, and the advocates were also able to comment on this. This did not always correlate with the size or nature of the establishment: a number of establishments are moving towards a child-centred approach even in more challenging environments. This is usually a feature of the passion and commitment of the governor and safeguards staff, and the safeguarding children manager in particular.

The prison context

You can never feel safe: it's a prison (young person).

In April 2007 the W&YPG on behalf of the YJB undertook a review of the capital investment that had been made in 2005 to assess the need for further investment. The main areas identified were: the installation of more CCTV cameras; continued investment in cubicular showers in gymnasiums to reduce bullying and support decency; new windows that will prevent young people from 'shouting out' and harassing each other and, finally, it was identified that one establishment needed a new first night area.

The living conditions for the boys are generally fairly bleak, although there were attempts to improve things. The clanging of doors and keys, the poor decoration and occasional dirtiness of the units can be frightening for young people who have not been in prison before.

It's a very, very, very low standard. It needs a complete makeover – especially down the block. I think it's against my human rights it's so dirty (young person).

Although there were posters and leaflets designed to inform the young people about safeguarding, many were not young person-friendly. Some units had photocopies of wordy policies on the walls, which young people would be unlikely to read, whilst others had attempted to design more suitable materials, sometimes involving the young people themselves. Most young people said that they thought they had received information about safeguarding when they first arrived but were hazy about it. None were able to tell us about anything they had found useful or informative, although they did say that there were posters around about bullying.

Escort arrangements

The first night arrangements and induction for the young people generally took account of their potential vulnerability but staff were hindered both by inadequate environments in which to assess new arrivals, and the fact that many arrived very late. It continues to be the case that escort companies wait until they have a full van before setting off to take young people to their allotted YOI. Establishments were asked to provide data from a one-week snapshot of the young people's arrival times at the establishment. The IMB in one establishment had

been independently collecting this information and provided us with data for six months which showed that 112 young people had arrived after 9pm and seven after midnight. There were other examples across the estate of young people waiting in court cells for over seven hours after their case had been dealt with before they left for the journey to the establishment, and they may then have been driven around the country for several more hours. If they then have to reappear in court the next day, they may only get four or five hours sleep. In spite of the contracts stating that young people must not share vans with adults and that they should not mix males and females, we came across instances where this was happening and an example where a girl who was pregnant had been transported in a van rather than the required people carrier. Staff feel that this situation is caused, in part, by the fact that YOIs for young people under the age of 18 cannot refuse to accept late arrivals (as is the practice in adult establishments after 8pm) so the young people are delivered last. Staff also felt that late arrivals were more likely if their establishment was near to the escort base.

Many of the young people told us that they had not felt safe in the vans or 'sweatboxes': not because of the staff but because they were scared what would happen to them if it crashed. They said it was impossible to get comfortable, and that they were sometimes on the van for a long time.

If it crashed your face will smash the metal thing in front – it's not safe.

I was with big men. They were banging on the door- I didn't feel safe.

Sweatboxes are the worst thing ever. I don't know how the government can put people in that thing – little windows with scum on it, hard chairs - when they brake, you slide off.

For those who were upset or anxious about their imprisonment, this is clearly a negative experience that gets them off to a distressing start.

Key findings:

- Young people feel least safe in the boys' YOIs compared with other secure settings, whilst the dedicated girls units are perceived to be the safest setting within YOIs.
- Having enough staff, and staff who treat them with respect, are important factors in making young people feel safer.
- The practice of transporting young people in vans designed to transport adults makes them feel unsafe, as do poor environments and a lack of CCTC coverage.

Safeguarding in STCs and secure children's homes

A separate team visited all the STCs and the secure children's homes that take children and young people placed there by the YJB. The same methodology was used, data was collected under the same headings and the teams met and exchanged information regularly to ensure a consistency of approach.

Some of the identified challenges were found to be the same as those facing YOIs whilst others were different. The fact that STCs and secure children's homes are exclusively for children and young people means that they have not had to face the tensions of adapting policies, premises and personnel suitable for an adult population. All staff will have elected to work with this age group, and the establishments are managed by personnel who can be expected to have a focus on children and young people. Secure children's homes are, with two exceptions, part of their local authority's childcare provision so they should be fully integrated into the philosophy and expectations of *Every Child Matters*. This clearly gives these settings an advantage over YOIs: they have not had to engage in the same rapid learning curve or culture shift in order to implement their safeguarding responsibilities. They are also better resourced, with higher staffing ratios, better facilities and more pleasant environments.

In other respects, however, the challenges are the same. The young people STCs and secure children's homes care for may be younger but they have the same multiplicity of social, emotional and behavioural difficulties. Because they take the more vulnerable young people, there is likely, if anything, to be a greater risk of self-harm or victimisation. The units also face the same challenges in terms of accessing resources from external agencies or making sense of child protection thresholds. The findings for STCs and SCHs are presented together but with differences highlighted where they occur.

Policies and systems

All the STCs and secure children's homes had relevant written policies covering Child Protection/ Safeguarding, Anti-bullying, Self-Harm and Suicide prevention, apart from one SCH that did not have a specific policy on self-harm and suicide because self-harming behaviour was such a rare occurrence. This establishment did, however, have a risk assessment policy and all staff were familiar with the established practice if there were incidents of self-harm. All the establishments also had policies on Complaints and Behaviour Management, which was not something that we had seen within the YOIs. In the secure children's homes, some policies were several years old and there did not seem to be any standard approach to reviewing and updating policies, although this did not necessarily mean that they were unfit for purpose.

Whereas STCs have policies specifically developed for their establishment, SCHs are usually operating to local authority-wide policies, which could be unhelpful if consideration had not been given to the particular needs of a secure establishment. Where shorter guidance, specifically for the SCH, had been developed this tended to be clearer and more helpful to practitioners. Policies which combined details of the policy itself with background information, for example underlying causes for self-harm or difficult behaviour or the different forms that bullying can take, with procedures to follow and practical tips on what staff could do or could advise young people to do, were particularly useful. There were examples of these across a range of establishments. One member of staff commented on the importance of good quality practice rather than policy:

I have come from working in a prison where the self-harm and suicide prevention policy is very long and very rigid. The difference here is there is not so much policy but the quality of practice is better.

The Secure Accommodation Network (SAN) provides a forum for secure children's homes to come together in order to share information and good practice. Some policies have been developed or disseminated throughout the network, such as the policies on restrictive physical intervention and searches, and have been adopted by individual establishments. The STCs do not have such a formal network, although two are run by the same provider and therefore have mostly shared policies. There is a Director's Forum that has been in operation since 2002, which meets quarterly to share practice and information.

Roles and responsibilities

Because of the smaller size of the establishments, the model of having designated safeguards staff had not usually been adopted in STCs and secure children's homes, although some had including a specific area of safeguarding responsibility within particular job titles or job descriptions. For example, one SCH had recently given one of the four team managers a lead role in safeguarding and they had organised a development day for key staff in conjunction with the manager of the local children's social care assessment team. An STC had recently created a Head of Safeguarding post to which they had appointed a qualified social worker but the general approach was to see safeguarding as inextricably linked with all the work that took place, and to see it, therefore, as everybody's business and managed in the same way as other activities through the usual line management arrangements. It was often the unit manager, supported by their management team, who took overall responsibility for safeguarding.

Meetings

Linked to this, the structure of separate safeguards meetings that has developed in the YOIs is much less evident, although there were a few examples where establishments had recently set up safeguards committees with external representation and others that had set up specific meetings to consider anti-bullying or suicide and self-harm prevention. It was more usual for safeguarding issues to be considered within existing management or quality assurance meetings.

There was a very wide range of meetings held in all the establishments, including many where all the young people were discussed and where it was evident that both care staff and managers knew all the young people and were aware of their individual needs. This reflects the practice described earlier within the girls' units within YOIs. There were also many more meetings involving young people than is the case in YOIs, particularly in the secure children's homes, all of which had regular children's meetings facilitated by staff, and a number of them had a children's council. For example, one SCH holds a unit meeting three times day with staff on duty and all the young people to award or take away points based on a review of each young person's behaviour. Another SCH holds a monthly anti-bullying forum with young people representatives and chaired by the school counsellor, and an STC invites a young person to join the end of their monthly Strategic Management Information Meeting for a general discussion about the information, including their views about the

incidence of physical restraint. All the STCs also hold daily unit meetings with young people and have a trainee council for young people to raise issues across the whole of the centre.

A few establishments had recently set up a regular meeting with external representatives from agencies such as the local authority, the Primary Care Trust and the police, specifically to consider safeguarding within the establishment. These were mainly strategic in focus, considering issues such as safeguarding policies and staff support, but others review individual cases.

Shift handovers were seen as an opportunity for information to be exchanged but the quality varied, ranging from establishments where staff were keen to get off on time to places where staff were happy to stay beyond the end of their shift on to ensure a good exchange of information. Good practice was supported where managers were prepared to factor in sufficient time for proper staff handovers rather than expecting staff to stay on beyond their working hours. This was the case in STCs where at least half an hour is allocated for staff handover between shifts. The concept of a handover meeting is not something that has become a routine part of practice within YOIs, although major issues will be shared in the managers' 'morning meeting', which takes place daily in most YOIs.

A few establishments had recently set up a regular meeting with external representatives from agencies such as the local authority, the PCT and the police, specifically to consider safeguarding within the establishment. These were mainly strategic in focus, considering issues such as safeguarding policies and staff support but others review individual cases.

Key findings:

- Policies and systems were suitable overall, although the secure children's homes sometimes had to adapt council-wide approaches.
- Safeguarding is generally integrated into other roles, systems and processes rather than being seen as a separate activity.

Monitoring and review

As with the YOIs, there is a mixture of formal and informal monitoring taking place, with some having more sophisticated systems for data analysis than others. Differences between STCs and secure children's homes are due, in part, to their different contractual obligations.

Quality assurance

Managers in secure children's homes stressed the importance of qualitative as well as quantitative data in the monitoring of performance, and there were a variety of ways in which the quality of day-to-day practice was assured. For example, one SCH keeps a daily log of sanctions, restraints and single separations, and the young people involved are invited to write in their own comments. The manager of the SCH reads the log regularly and countersigns the record, adding additional comments if necessary about the quality of practice, such as the need to encourage more young people to contribute their views. In all the STCs a senior manager reviews incident reports the following day and in one, senior managers undertake a monthly audit of 10% of all files, examining various aspects of the

work being undertaken with the young person. Other ways of scrutinising practice included inviting feedback from young people, parents and external professionals through questionnaires at various points during the young person's stay and after release, and through regular forums with young people, front-line staff and advocates. Some establishments undertake exit interviews with the young people, either with staff from the establishment or the advocacy service, and the information is fed back into management meetings.

An overview of safeguarding

There was a huge variation across the establishments in their internal monitoring arrangements, including the meetings in which monitoring took place, the range and quality of the management information collected and the analysis of this information. For example, one SCH has a detailed management information file which holds aggregated data on a monthly basis about the following:

- sanctions imposed for each young person
- significant events for each young person
- single separations for each young person
- restraints for each young person and for staff
- staff and young people involved in significant incidents (recorded in a cross-tabulated grid)
- incidents of self-harm
- incidents of bullying
- use of agency staff
- numbers of staff on shift with an explanation if the staff ratio is low
- supervision and appraisals of staff.

The information is used to present a monthly report with added commentary to the Operational Management Team. Patterns, trends and exceptionally high numbers are analysed and acted upon if required.

Similarly, each STC also holds a monthly meeting where a range of management information is reviewed and analysed, including details of incidents involving restraint, incidents in education and so on that enable them to identify trends and to take action. There was a wide variation in the use of, and the types of, electronic collection and storage of information. On the whole there was a positive attitude to the development of e-technology for case recording, information sharing and data collection. Monitoring was most effective where there was a clear analysis of the information collected and this was regularly used to inform the practice of front-line staff. Some establishments had created a designated monitoring post, for example a 'Performance and Compliance manager', to develop systems for collecting and analysing management information.

Responsibility for scrutiny

The arrangements for external scrutiny are complex and there was constant recording in a variety of systems to satisfy the different requirements of the YJB and the Children's Homes Regulations, often with a degree of duplication. It was not always clear to an outsider what the links were between the different recording systems and in a number of sites the collection of manually recorded information in order to enter this on a database took up a considerable amount of staff time. It should be noted that secure children's homes and STCs, although smaller than YOIs, are subject to more outside scrutiny because of being children's homes as well as having a contract with the YJB. For example, all secure children's homes and STCs are subject to visits from Regulation 33 visitors¹⁴, as well as the YJB monitors, and some secure children's homes were also regularly visited by the complaints officers from the local authority. Both secure children's homes and STCs are required to report to the YJB on a number of Key Performance Indicators (KPIs), such as the time young people spend out of their room and education provision, which also brings in a level of external scrutiny. Ofsted also now inspects both types of establishment.

The YJB monitors varied in the way they interpreted their role and in their level of involvement with establishments. For example, one secure children's home was visited by their monitor every three months whilst they are a daily presence in some STCs. When they were actively engaged, they performed a very useful monitoring role, usually reviewing every critical incident and raising issues with managers. The role was not clear or consistent, however, and it was difficult to tell whether it was primarily to monitor compliance with contractual obligations or fulfilled a wider function, including a responsibility for safeguarding. For example, concern was expressed that one YJB monitor had been involved in the filtering of child protection referrals to the local authority.

The arrangements for Regulation 33 visiting vary from establishment to establishment. Some local authorities arrange for senior officers or consultants to undertake them; others are led by elected members, or there may be a mixture. They may be the same people at every visit or they are done on a rotational basis. Where the visitors do not have professional knowledge or expertise, this can result in reports which are incomplete and lacking in detail. In most secure children's homes it appeared that the Regulation 33 inspectors were performing their monitoring role well, although one or two inspection reports referred to the need for visits to all units on a site to take place monthly and pointed out a lack of consistency when several people shared the task.

Although a large number of agencies are involved in the monitoring of practice, the arrangements for them to support the establishments seem to be less well-developed, with limited input into the day-to-day life of the establishment.

¹⁴ Representatives from the local authority or other registered provider required to visit residential children's homes on a monthly basis. The equivalent in Wales is Regulation 32.

Key findings:

- As with the YOIs, establishments reported that the current framework for external monitoring and inspection can lead to duplication and would benefit from rationalisation.
- Establishments had developed a range of systems for collecting and analysing monitoring data, and would welcome the dissemination of good practice.

A strategic approach to safeguarding

As with the YOIs, the term 'safeguarding' is not always understood, particularly among front-line staff, with a common assumption that it relates mainly to child protection. The term 'keeping safe' was more easily understood, both by staff and young people. This does not mean that staff do not generally know what to do if a young person is at risk of harm, although managers within two STCs were aware of the need to create more consistent practice. Safeguarding was high on the agenda in all the establishments and there was a joined up approach to the various aspects of safeguarding. This mainly arose from the holistic approach to meeting the young people's needs, without the need for specific mechanisms, but the Head of Residential Services within one STC had been given clear responsibility for cross-referencing different aspects of safeguarding. This is more likely to be an issue in larger establishments where there is a danger of information being lost within silos.

Across the establishments, all senior managers had a child-centred approach and recognised the importance of having as many staff as possible with a childcare or social work qualification, at least at management level. This approach filtered down through the staff group to a varying degree in the different sites depending on staffing levels, staff training and levels of competence, and arrangements for supervision with secure children's homes being the most consistently child-centred. A number of managers talked about ongoing work to ensure that staff had a child-centred approach and it had been recognised in one STC that the negative views of a small minority of staff must be tackled. In the time available it was difficult to get a clear sense of the approach of all front-line staff but there did appear to be some differences between the workforce in the STCs and secure children's homes. Most staff in secure children's homes are recruited from a childcare background, often having experience in other residential childcare settings or social care settings. Staff in STCs seem less likely to have had specific experience.

In the STC where managers had acknowledged the extent of the work to be done to ensure that all staff understood and were committed to a childcare ethos, this was reflected in the comments of the young people.

It's pretty safe but it depends on the staff. Some are safe – some are just dopey: they make for problems (young person).

In all other settings, young people stated that most of the staff were 'OK' or that they could talk to them, although there were the same distinctions made between different staff members, as was the case in the YOIs.

If a young person is upset staff talk to them and try and comfort them. It really depends on who's on duty. Some staff you can have a relationship with, they come into work wanting to do work with you but others can't wait to get out the door (young person).

The importance of building relationships with young people is generally better recognised than in the YOIs. For example, the director of one STC described how the role of managers is crucial in modelling child-centred practice and ensuring a consistent approach, and was very clear about creating a culture where child development is understood. Other staff endorsed this view and said that the ethos of the centre is to develop self-esteem: every child leaves with some record of their growth. This was supported by one young person who said *'everyone helps by supporting you and making you feel you are someone'*.

Because children's needs are discussed and addressed in a holistic fashion, it is more difficult to disaggregate the aspects of the establishment that relate to safeguarding activity but this is not necessarily a problem. There are not usually separate safeguarding action plans but there is evidence within minutes of meetings that specific areas identified as weak are being tackled. The emergence of specialist safeguarding roles within some establishments, along with safeguards committees and increasing involvement of external agencies, is likely to lead to a more discrete safeguarding framework over time, although again, its absence does not necessarily mean that practice is unsound. The opportunity to seek advice from other agencies through the Secure Accommodation Network or their local authority links helped to keep SCHs in touch with emerging practice, whereas STCs have to draw largely on their own resources, such as taking the opportunity to engage in a range of external working groups.

STC managers are expected to be members of LSCBs whilst secure children's homes are represented indirectly through their local authority. Regardless of these differences, the perceived priority given to secure settings by LSCBs were very variable. There was acknowledgement from managers in STCs and secure children's homes that the LSCB agenda was a very broad one and they therefore understood why young people placed in secure settings might not be seen as a high priority. The LSCB areas that contained more than one secure setting appeared more likely to recognise their particular needs, and one LSCB area with two YOIs and an SCH has set up a sub-committee specifically to consider the secure settings.

On the whole, secure children's homes had better working links with their LSCBs than the STCs because the secure children's home is part of the local authority and their staff described having regular access to training organised by the LSCB. STCs felt that they experienced discrimination because they were privately run settings. For example, one STC felt that it had largely been ignored by the LSCB in comparison to the secure children's home within the same authority until a young person had died, when they suddenly became the focus of attention. This situation is slowly changing, with one STC describing relations as improving from a very low base, and another being linked into a number of sub-groups of the LSCB whilst still feeling that safeguarding at the STC was low down on the LSCB's list of priorities.

Key findings:

- Establishments, particularly SCHs, have a child-centred ethos whereby the approach to safeguarding is embedded throughout the establishment.
- As with the YOIs, the establishments perceived themselves to be low on the LSCB's list of priorities.

Links with external agencies

Local authorities

The issues for secure children's homes were different from those of STCs because, with two exceptions, secure children's homes are part of the local authority and the manager is linked to the senior management structure. This has not always prevented difficulties in resolving individual child protection concerns, although this is now improving with the introduction of the local authority designated officers. For both types of establishment there are concerns about the responsiveness of home local authorities and YOTs to the young people's needs. This is an important factor in keeping young people safe: where young people have unmet needs they are more vulnerable to harm.

Other secure settings

Despite better links between secure children's homes and LSCBs there was nonetheless a sense that all the establishments were somewhat isolated, and would have welcomed more communication with other secure settings and indeed other children's services. Reference was made to a lack of contact with other residential settings in the area, coupled with a perception that such settings resented secure establishments because they saw them as being much better resourced. There was a desire to learn from other settings and to share examples of good practice but concern that different sites, particularly STCs, were unwilling at times to do this because of an element of competition between them and, finally, secure children's homes expressing concern that they did not always get to hear about relevant events or conferences being organised by the YJB for the secure estate. This raises questions about how and to what extent the YJB fosters the exchange of information and good practice across secure settings and also the support needed by SAN to increase their capacity.

Advocates

The vast majority of sites had good relations with the visiting advocates and with the organisation supplying the advocates, although there were some tensions. These seemed to arise where the advocates were seen as having a more adversarial approach in a setting committed to an informal and problem-solving style of working. For example, staff in one setting considered that some of the complaints generated by the advocate would have been better resolved through discussion with staff, and another reported that the advocate did not alert staff when a young person had become upset during a session. One establishment expressed concern that, if the success of the advocacy service was measured by the number of complaints they were involved in, this could lead to formal systems being invoked unnecessarily. In other settings, advocates were embedded in the day-to-day work of the

establishment, undertaking exit interviews, contributing to policy development and having regular meetings with senior staff.

It was clear that advocates were operating differently and that their practice was of variable quality and effectiveness. For example, in one setting young people described the advocate as friendly but not someone who took a role in challenging practice. In our view, good practice in providing advocacy services meant having advocates who were knowledgeable about matters such as: the secure estate and its rules and regulations; the juvenile justice system and looked after children; engaging young people; not overly confrontational and able to raise and discuss issues with staff and managers. An example of 'superb' practice by an advocate was where they had recently intervened to stop a young person being deported.

Health

There were wide variations in the range and type of health support provided across the different sites, with establishments directly commissioning some of their own services and others being provided by the local Primary Care Trust. There were some examples of a very proactive approach by health staff, including attempts to get relevant information from the young person's home PCT and to ensure good links were made with local health services, including specific referrals, prior to the young person's release. In sites where health staff were present on a regular basis and linked into multi-agency meetings, risk assessments and so on, they played an important pastoral role and, in some settings, provided independent monitoring of restraints. There were some isolated concerns from care staff about health professionals not passing on relevant information.

Mental health

There were variable arrangements for mental health support, with some examples of very good practice. It was evident that it was very important for staff to be able to contact mental health professionals easily, to be able to access advice from specialist mental health professionals, and to be able to refer young people to them quickly for direct work where necessary.

In a number of areas service level agreements have recently been reached with the local CAMHS but in others there is still no link. In some establishments there are still barriers to the local CAMHS undertaking individual work with young people from out of the area because of disputes about whose responsibility it is to fund it. Work with young people in need of support because of learning difficulties was also reported to be a major problem.

Other

A number of sites had made real efforts to bring in other services from the local community and were also able to identify local organisations able to respond to the particular needs of individual young people. These included local libraries, the Prince's Trust, local fire services, gang projects, football clubs, young fathers' projects, specialist ethnic minorities, travellers and asylum seekers workers, motorbike clubs and local tradespeople. These organisations offered a range of services and enrichment activities such as offending behaviour work, school-based projects and therapeutic work with young people. Involvement was not all one-way: for example, one secure children's home has involved young people in generating

ideas for fundraising for the local hospice. The Prince's Trust has provided funding to an STC for a newsletter managed and edited by young people that goes to all STC sites.

Key findings:

- As with the YOIs, establishments were open to the involvement of external agencies.
- The establishments expressed frustration at the difficulty in engaging their local authority for young people, adding to their distress and potentially making them less safe.
- Arrangements for the provision of health, mental health and learning disability services were variable and sometimes difficult to obtain.
- Although welcomed overall, there were some tensions with advocates where they were perceived to be taking an adversarial approach to problem-solving.

Safeguarding assessments and interventions

Suicide and self-harm prevention

All settings had clear procedures that staff were aware of and which were followed. The same risk averse approach was seen as in YOIs and in all settings there was a tendency to place young people on the highest level of risk when they first arrived, unless there was very clear evidence available that this was not necessary. Regularity of monitoring on 'high level' varied between settings, so in some this would be every three or five minutes, but in others it would be every ten minutes.

In all settings there was a combination of gaining an understanding of the underlying causes of the problem and providing support, and preventing the behaviour through close monitoring and the removal of items that could be used for self-harm or attempts at suicide. Both STCs and secure children's homes had better access to support from psychologists or other specialists than was the case in most YOIs. In our view, best practice occurred in those sites where there was an emphasis on understanding and support combined with a flexible approach to management but, as with the YOIs, establishments are operating within a culture whereby they will be blamed if a young person does harm themselves. In the case of the STCs, there was a widespread perception that the YJB exacts a financial penalty in such circumstances, although the YJB position is that this would only be the case if the establishment had failed to comply with its own operational protocols.

Protective garments and bedding, which cannot be torn to create ligatures, were in use in only a small number of sites and it was clear that the aim was to use these as little as possible, although one recent inspection report had queried the need for such a garment. There was, however, in the majority of sites, a strict policy of removing items that could possibly be used to self-harm or tie ligatures, which could mean young people being left in very stark surroundings, with little in their rooms and being monitored constantly. This risk-averse approach sometimes extended to banning everyday items such as metal cutlery or staples. In some sites there was a particularly bare room that could be used for children at high levels of risk, and in one secure children's home this was routinely used as a first night room for all young people newly arriving. In addition, all sites had had experiences of

young people with mental health disorders or problems which had resulted in staff restraining young people, often frequently and sometimes for long periods of time, in order to prevent self-harm occurring. It would appear that the expectation that all incidents of self-harm must be prevented can result in young people experiencing emotional and sometimes physical harm. This is a potential source of conflict within the overall safeguarding duty.

It could also be experienced as punitive by young people. In one STC a young person said they wished that he had been offered the opportunity of talking to someone before these restrictions were implemented and that he had experienced the monitoring as punitive.

It would be better if you could have a 1:1 talk with someone first before they do their SASH [suicide and self-harm] assessment and then you can earn or lose points. They don't look at why you are doing it. SASH feels like a punishment. SASH discourages people from talking.

A similar point was raised by an advocate in a secure children's home who had complained about family photos being removed from a young person's bedroom as part of the process of clearing the room of dangerous objects, resulting in a change of practice.

There were a number of secure children's homes where self-harm and/or attempts or threats of suicide occurred very rarely, although it appears from statistical data that this *may* sometimes be connected with the prevention of self-harm through physical restraint. In other sites it was also described as rare but on occasions the placement of one particular young person could lead to a rise in the number, and severity, of incidents.

Suicidal v. self-harming behaviour

Senior managers and health staff in many of the secure children's homes and STCs stated that it would be better to make a clear distinction between, on the one hand, attempts and threats of suicide and, on the other, self-harming behaviour that was either a response to frustration, such as banging a fist against a wall, or a way of coping with distress.

I think sometimes staff overreact a bit. We had one of the practice nurses from a specialist place for self-harmers who came in and gave us some training. Their approach is to try and contain it rather than stamp it out and I would like to see more support for staff here for that sort of approach (staff member).

In a number of sites, professionals from CAMHS or forensic adolescent mental health services were encouraging a more flexible response to self-harm, while recognising the limits imposed by the fact that sites were not therapeutic settings. Many senior staff and some front-line staff were in favour of a more flexible approach that allows low-level self-harming combined with psychological support, in recognition of the fact that self-harming is often used as a coping mechanism.

Two STCs suggested that the YJB should enable them to set up specialist units for young women who are self-harming regularly so they could ensure they received the level of support they needed without that impinging on other young people. Young people talked about the amount of staff time taken up when another young person was attempting to self-harm, which meant less time for them and for activities. This was echoed by senior staff and external professionals, who also referred to the amount of staff time and energy taken up

with responding to self-harm. All staff talked about the distress it caused front-line staff. This would support the idea of specialist therapeutic units within the secure estate. Against this, there is the risk that such units might encourage a culture of self-harm, given the experience of the range of secure children's homes where self-harm is rare, who spoke about young people with a history of self-harm stopping or reducing such behaviour considerably once placed with them.

Key findings:

- Staff expressed some concern about the appropriate balance between the need to prevent self-harm and other aspects of a young person's needs.
- Staff would welcome guidance on the removal of objects from young people's rooms, and the use of prolonged physical restraint in order to prevent self-harm.
- There was some concern about the lack of differentiation between self-harm and suicidal behaviour.

Anti-bullying and violence reduction

This was the most challenging area in relation to safeguarding and is the issue about which young people feel most strongly, with the general perception that peers present the greatest risk to their safety. It did not appear that any of the STCs or secure children's homes had really been able to find a completely effective response, although considerable efforts were being made to do so. Even in establishments with sound policies and practice, there was always some element of a pecking order based on age, size and length of time in the unit often found in residential settings. One establishment explicitly mentioned the possibility of staff being bullies, and were clear that they would deal with this vigorously.

Defining and identifying bullying

In many establishments, there was a clear and well understood zero tolerance approach to bullying and, particularly in the secure children's homes with the high ratio of staff to young people, a practice of challenging bullying behaviour at an early stage. Some establishments were proactive in identifying behaviour that might be construed as bullying, including taking care to notice 'looks' and 'teasing' or pinches and kicks. In one establishment a strong line was taken against homophobic comments. Similarly, some establishments were better than others at encouraging young people to pick up on the issue themselves, and to stress the importance of work with the victim around building resilience. Staff regularly referred to the problems arising from certain young people whose attitude and behaviour make them likely victims: winding other young people up, disclosing details of their sexual offences or boys who do not conform to gender stereotypes.

Many bullying policies described underlying causes and the different forms that bullying can take. In interviews with staff and young people, there was always discussion about what constituted bullying. In most sites, in accordance with YJB guidelines, 'play fighting' was not allowed, but the YJB monitor in one STC had noted that some front-line staff did allow play fighting. In another, concerns were expressed about play fighting within the staff group.

Interventions

Some policies focused much more on the bully and some emphasised the importance of work with the victim but there was the same recognition as within the YOIs that simplistic approaches were unhelpful.

Bullying policy is problematic in that it is focused on preventing a bully from taunting young people deemed to be eccentric or vulnerable but you also need to have a focus around enabling the victim to develop skills in managing and solving problems, seeing themselves as agents of change (psychologist).

Many made use of restorative justice techniques, such as 'resolution meetings' as well as sanctions. Some sites have specific and clear bullying programmes, with a staged process, restorative justice approaches and sanctions and work with both bully and the victim. In most settings, if initial interventions failed, the bully could be moved to another unit or otherwise kept separate from the victim. Requests to the YJB to move the bully altogether were made as a last resort. There was often an attempt to ensure that bullying was discussed openly and to adopt a problem solving approach, for example through group work or a method called Teen Talk. In one STC where Therapeutic Crisis Intervention (TCI) was being piloted, staff skills in understanding and preventing conflict were said to have increased with a resulting decline in bullying and violent behaviour, and a significant reduction in the number of restraints.

There were also a number of ways of involving young people in the establishment's approach to bullying: some establishments get involved in anti-bullying week and one had recently had an anti-bullying day that included exercises, poems and balloons with messages that the young people released. The young people had clearly valued this and asked for a repeat session.

On the whole, young people trusted that staff would try to stop bullying:

Staff always notice if someone is being bullied. We have group forums sometimes, like last week we all sat in a group and talked about it and that cleared the air. Staff are very up front. They do pick up on things very quickly. They help you sort it out.

A number of establishments had a designated member of staff leading on anti-bullying: in two cases because staff had requested the role. Where specialist anti-bullying staff were in post they co-ordinated the work and monitored practice and procedures. They had developed programmes based on their knowledge of programmes in other secure settings, the local authority or other sources.

There were some problems of consistency in staff approaches to bullying. Additional problems identified were; a lack of clear programmes for moving a young person on through different stages; ensuring clear recording and information sharing. As with the YOIs, there were also difficulties when young people were resistant to any intervention and unperturbed by sanctions, particularly when on short sentences or on remand.

Violence reduction

Interviews with staff, external professionals and young people indicated that staff were good at de-escalating problems between young people and usually intervening quickly if there was

any actual violence. It was clear that the young people expected this to happen and one young person had felt let down when it did not:

I got into a fight last night. The member of staff here just walked away and said, 'I don't come into work for this'. She let it get out of hand.

In a number of settings, the need to ensure education staff had similar skills in de-escalation was noted in order to avoid situations where conflicts were allowed to develop until young people lost control and care staff had to be called in to classrooms to restrain them.

Key findings:

- Bullying and violence from other young people is the main source of anxiety for young people in spite of staff's attempts to tackle it.
- Staff would welcome more support in developing ways of understanding and de-escalating problematic behaviour.

Child protection

Staff in all establishments were clear about the processes to follow in the event of a child protection issue and there was evidence that concerns or complaints about physical restraint were commonly referred, or at least discussed, with the local authority. Allegations were taken seriously by establishments and there was evidence that the young person's family, home authority YOT and social worker were kept informed. There was evidence of whistle-blowing by other staff, and use made of CCTV cameras to check allegations or concerns. There were also instances where staff had been suspended completely, transferred off the relevant unit or away from direct work with young people whilst allegations or concerns were investigated. More referrals were made by the STCs than by the secure children's homes, with one having particularly high levels reflecting the difficulties they are currently experiencing. In some secure children's homes hardly any referrals are made to the local authority, with one having made no referrals in the last two years. This low level of referral means there is little evidence about how allegations or child protection referrals are dealt with in these settings. This problem solving approach may, or may not be, more effective in dealing with young people's complaints than going through the formal child protection process. Further analysis would be required to give a definitive answer. It does highlight the variable approach to allegations against staff across the secure estate and the need for a more consistent approach.

Definitions and thresholds

Because of the more straightforward management roles in secure children's homes, the expectation that concerns would be passed up the line seemed unproblematic, although some managers expressed concerns about the ability of all staff to recognise all situations that should be referred. In some STCs, the YJB monitors had previously had a role in filtering and making child protection referrals, causing some delay. This practice was also questionable in terms of their statutory role in making such decisions and where they fit in terms of accountability but does appear to have stopped.

The establishments are experiencing some of the same difficulties as YOIs in defining what is and is not child protection, and whether to include assaults between young people or serious incidents of self-harm. There was variation in whether or not incidents between young people were referred into the child protection process or dealt with internally through anti-bullying procedures or through sanctions. Overall, incidents of physical restraint seemed to generate a significant proportion of the child protection referrals but in a small number of establishments, concern was expressed by external inspectors about complaints or cases of physical restraint where the young person had expressed dissatisfaction *not* being dealt with through child protection procedures. In one secure children's home, an advocate had questioned whether the removal of personal items, including family photos, from young people's rooms could be seen as emotional abuse and the establishment had been prepared to review their practice as a result.

There was also the same issue as we came across in the YOIs about the appropriate threshold for referral to the local authority. In some settings local definitions have been agreed to provide a more consistent approach but in others there are ongoing tensions with the local authority about the thresholds for referral.

I was involved in one allegation where a young person said the restraint had been inappropriate. It was referred to [LA] but they didn't deem it worth investigating. I thought that sent the wrong message to the young person – if you're locked up then you're not worth it. No one came to see him afterwards. He told me he was disappointed (advocate).

As with the YOIs, young people were also sometimes asked if they wanted to 'proceed' with an allegation.

Response to concerns

In the main the processes for responding to allegations of abuse against a person who works with children set out in *Working Together* (paras 6.20-6.30 and Appendix 5) are being followed, although senior managers and Ofsted inspectors had expressed concern about a poor response to allegations from the local authority arising in one establishment. Local authority designated officer and/or teams working specifically on these types of allegations are still quite new and in some of areas had only just started. This means that there are different processes being followed in different settings, with some establishments contacting their local referral and assessment team in relation to allegations rather than the local authority designated officer. In one secure children's homes where the local authority designated officer was established in post, the new arrangements have led to a great improvement in the relationship with the local authority and a better response to allegations.

It was not possible to check in any detail whether the timescales suggested in *Working Together* were being followed, although it was clear that in some settings there was a quick response, with both the young person and the staff being kept fully informed of progress, while in others there were more delays and less good communication with young people. One STC expressed dissatisfaction about the very slow response of the local authority designated officer, not necessarily to the initial allegation but in relation to further investigations, making a decision or recommendation and informing the young person. Lengthy delays impacted both on the young people because of the delay in them hearing

anything about their allegation, and on staff, who could end up being suspended for long periods of time before being re-instated. In one case this took a year to resolve.

If allegations/concerns against staff were substantiated there was evidence of dismissal of staff or clear management action to address the concerns identified. Some staff who had been involved in whistle-blowing and subsequent criminal and then disciplinary proceedings were critical of the ways in which these were handled. This raises the same question as with YOIs about whether concerns should be internally or externally investigated, and the links with other investigatory processes.

Historic or community abuse

Staff were clear about how to deal with disclosures of historic abuse and, in particular, the need for confidentiality, the importance of not asking leading questions, recording the disclosure and passing on to senior staff with responsibility for safeguarding. Front-line and senior staff frequently expressed concern about the response of the young person's home authority to such disclosures or allegations, in particular delays in responding to the allegations and/or a failure to take them sufficiently seriously. In many settings these concerns are raised with the local authority designated officers as well as with the home authority, and on occasions the local authority designated officer has been involved in chasing the home authority to ensure action is taken. There was evidence of joint police/social worker videoing of allegations of historic abuse made by young people in some instances.

In the secure children's homes staff were also very clear about possible risk of harm to the young people from visitors and others in contact with them through letters or phone calls and these issues were handled sensitively. Action taken to protect young people in these circumstances included different levels of supervision during visits, checks on phone calls and letters and an awareness of any changes in the mood of young people following these contacts. For example, a number of sites were picking up that girls were starting to receive letters from men in adult prisons or pressure being put on girls from older boyfriends through phone calls. It was less clear whether these issues were so readily identified in STCs. Once again staff in many sites expressed concern about the home authority YOT and/or social worker for the young person giving agreement to contact, which the staff in the secure setting considered possibly harmful.

Key findings:

- As with the YOIs, there was a lack of clarity about the definitions and thresholds for referral of child protection concerns.
- There was also some lack of clarity about the appropriate response to allegations against staff, including links with criminal and disciplinary processes and appropriate timescales for investigation.

Related practices

Complaints

The processes for dealing with complaints were sound, on the whole, although some were overly bureaucratic and lengthy and some had only recently introduced a way for young people to complain directly rather than going through staff. The secure children's homes were expected to operate their local authority system, which requires the central oversight of complaints by a designated complaints or customer care officer, ensuring an element of independence. Advocates tended to be more involved in the complaints process than was the case in YOIs and were reasonably satisfied with the way complaints were dealt with:

The staff here are very open about complaints, they are not defensive. Anyway most of the complaints to me are about their home areas and the fact that there are no plans for their futures or a lack of choice (advocate).

There was not the same experience as with the YOIs, where some significant complaints against staff appeared to have received a poor response. Young people knew how to complain and had mixed views about whether it was worth complaining or not but did not have major criticisms: some said they had nothing to complain about and others were able to describe positive outcomes.

My complaint was about the way a member of staff treated me. I spoke to [advocate] and then that member of staff was spoken to and now they are very good with me (young person).

Good practice appeared to be: where complaints could be made in a variety of ways, including designated letter boxes; where they were taken seriously and investigated quickly, either internally or externally; where young people got feedback on the response and the reason for it and where the young person was able to reply. Also helpful were 'grumbles books' where young people could identify issues below the level of a formal complaint and where staff recorded their responses, often affirming the 'grumble' and setting out what would be done about the problem – providing these were easy to access by young people and checked externally on a regular basis. In one establishment where a young person was making up to five complaints a day, he was encouraged to record his grievances on an 'issues sheet' which staff then responded to rather than escalating everything into the formal complaints procedure.

Key finding:

- Complaints were taken seriously but there was a risk that this could lead to a bureaucratic and slow response rather than a rapid, problem-solving approach.

Physical restraint

This was a big issue for staff:

I don't like restraining, it worries me. It should be used as the absolute last resort (staff member).

The extent to which restraint is used varies widely across establishments. Because of the fact that there is no consistent recording system across establishments, although some key data is now submitted to the YJB, it is difficult to make comparisons across sites but it does appear that some are more dependent on physical methods of control than others. Because of the small size of many of the units, data about the incidence of restraint can vary dramatically depending on the particular young people being cared for. For example, one secure children's home was able to identify one or two young people with ADHD who had led to an increase, indicating the need to look at the story behind the statistics.

STC staff expressed a range of concerns about the method that they are required to use – Physical Control in Care (PCC). These were:

- whether it is appropriate/effective for the size and age of young people now being dealt with
- restraints going on for too long
- restraints to control the behaviour of young people with mental health problems, such as head banging
- restraints to prevent self-harm.

There is a wide variation in the techniques used in secure children's homes and a number reported that they had found that combining a method known as PRICE with TCI had reduced the number of restraints and provided a good framework for ensuring that staff focused on de-escalation before anything else. CALM, another method, was used in one site, and liked by staff there. Overall, methods that included elements of de-escalation and an understanding of the origins of the behaviour were thought to be effective. Staff wanted to be able to mix these with different physical techniques, however, and there was a general unease about methods that involved the prone position.

CCTV cameras, although initially viewed with suspicion by staff in some settings, were now welcomed because they provide evidence to substantiate or disprove allegations.

Unlike YOIs, most establishments develop individualised risk assessments and behaviour management plans. Some involve young people in doing their own risk assessments and identifying what helps them to calm down or what should *not* be done to them during a restraint.

Although physical restraint did generate some child protection referrals, either because the young person had complained or sustained an injury, young people did not express major concerns overall. Most felt that restraints they had experienced, or witnessed, had been fair.

Sometimes other young people kick off for ridiculous things. I've been restrained – staff try not to hurt you, they're safe.

The opportunity to have a proper de-briefing session following an incident of restraint seemed to contribute to their feeling of satisfaction.

Key findings:

- Staff would welcome more guidance on safe and effective restraint techniques, and a more consistent approach across establishments.
- There was evidence of the development of holistic approaches to behaviour management that were proving helpful in reducing the need for restraint.

Staff knowledge and skills

It must be noted that working in a secure setting is a difficult job, dealing with the most vulnerable young people, and that it is being carried out by largely untrained and poorly paid staff.

Recently there was a young person here with mental health problems and severe behavioural problems – self-harming and autistic. The staff here do phenomenal work with young people no one else will take but they have had a couple of young people recently (including the above), who needed constant watching. The staff really cared and they were running ragged. It was an enormous strain on everyone (advocate).

There was a universal plea from senior and front-line staff for more training. The level of initial training that staff had received was extremely variable: for example, some settings required new staff to undertake two days training before they started work with the young people whilst others required seven weeks. This did reflect, in part, the differences in background and experience between STCs and secure children's homes. Staff, particularly managers, had a range of previous relevant training such as qualifications in social work or psychology, which helped to bring a theoretical and child-centred ethos to the work. Others were being supported to gain such qualifications whilst in post.

The most positive training approaches contained a good induction programme, followed by shadowing and regular supervision; a planned programme of training with key subjects incorporated and building on practical experience. Some establishments, in spite of their small size, had invested in a full-time training and development manager to co-ordinate training; this work was supported by a database enabling individual staff training to be tracked and monitored. Other positive approaches were the encouragement of reflective practice and flexibility in responding to new challenges. For example, some settings had provided training on specific disorders experienced by young people in the setting, such as autistic spectrum disorders, and how to manage them.

The range of training was much wider than that of the YOIs, including courses on emotional health and well-being, anti-discriminatory practice, change management, restorative justice, solution-focused brief therapy, the identification of mental health issues, and bereavement awareness, in addition to child protection and physical restraint. One secure children's home stressed that their training focuses on ethos, challenging assumptions, and awareness raising rather than didactic methods: for example their most recent child protection session had included input on values and on black and minority ethnic issues.

Some sites are very isolated and all training is done internally: others are better linked into other residential or wider networks. Staff in secure children's homes can access their local authority or LSCB training and some of the courses are linked to NVQs. The lack of co-ordination between this and the YJB training framework is a problem, with qualifications not being recognised across the sectors and staff finding it harder to access training as a result. The benefits of having opportunities to learn alongside staff from other settings was recognised in some comments.

It would be good to have training with other establishments. I have benefited from meeting others and hearing about good and bad practice (staff member).

Unlike the YOIs, there is an expectation that staff will receive supervision and that this is important, although it was not always happening as often as it should. Some sites were better than others at tracking supervision and monitoring its frequency.

Key findings:

- Staff at all levels would like both training that is specific to their role within a secure setting and multi-agency training. They would also welcome opportunities to share information about practice across the secure estate.
- There is a culture of individual supervision lacking in YOIs.

Perceptions of safety

As one staff member in an secure children's home said:

We can never be totally safe, the young people we work with are so diverse, we have very damaged kids in a totally false environment.

This was reflected in the following comment:

Normally it feels very safe here but there is a new boy who is a bit freaky. They are keeping him away from us (young person).

Nevertheless, young people felt reasonably safe overall. Those in secure children's homes who had also been in STCs said they felt safer in a secure children's home, because there were more staff and less young people and some differences in behaviour.

It's safer here than [STC] because a lot more people there kick off – it's harder, people are showing off (young person).

On the other hand, as with the girls' units in the YOIs, there were issues about the inability to have space from the group in the very small establishments, with a somewhat claustrophobic atmosphere.

There are too many girls in here, it does my head in. They bitch all the time, I try and keep out of it (young person).

Some young people also said they felt safer in the settings than in other placements.

The last place I was in [open children's home] was crap, they let me run away all the time.

In response to the question about how safe they felt on a scale of 1–10, the average for secure children's homes was 8.3 and for STCs it was 7.8. When asked what would improve safety, most talked about the need for more staff:

To make it safer: maybe you could do with more staff – have three on the unit so when one is away for something you can have two people around.

None of the young people we spoke to were frightened of the staff and the vast majority felt there was always someone among the staff they could speak to, with many saying they could talk to all the staff if they were worried about anything.

If I didn't feel safe here I would contact my nana or any of the staff here.

Inevitably, others said that they found some staff to be nicer than others but one young person did suggest he would not talk to staff at all:

If I was upset I would talk to my mum. I wouldn't talk to staff, they would just tell everyone about you and people would get at you.

In secure children's homes it was clear that staff knew the young people well and this meant they were able to pick up quickly on changes of mood or anxiety which generated a sense of safety without formal procedures. Other child-centred practices were also empowering for young people and contributing to their feelings of safety. For example, a number of establishments involved young people in the staff recruitment process and others had worked with them to make DVDs or videos about the setting to be shown to new arrivals. All sites had young people's artwork on display, with some particularly good examples of regular, up-to-date and well presented displays in a number of secure children's homes, giving young people a sense of being valued.

All sites also had information for young people, both displayed in posters and contained in information packs given on arrival. These included information about advocates, complaints and anti-bullying.

Environment

In relation to the built environment, those settings where there was more open space indoors, with less cramped corridors, felt better. In some sites there was a very homely feel in the living areas, with books and games lying around rather than locked away, and staff talking about the various board games that were popular and all the other activities available. The best outside areas were those which were informal in layout, included plants, places to sit, murals and less obvious signs of security such as high walls and fences.

There seemed to be a huge variety in relation to what was allowed in bedrooms generally, and what could be earned through a reward system. For example, in some sites all children had a TV in their room from the beginning, behind a screen and operated from outside. The young people appeared to feel safe and secure in their rooms, overall:

It's a cell – but it's a nice cell. I love it (young person).

Based on the interviews and from seeing the places where young people arrived and were first assessed, it would appear that arrival procedures were handled with sensitivity in all sites. Some had made the reception room very welcoming whilst in others it was more stark. In all sites children were searched with sensitivity, given a dressing gown to wear, and having to expose their top and bottom halves separately. This seemed to us to be an unfortunate practice nonetheless. One secure children's home had abandoned this practice altogether. Instead, young people were encouraged to have a shower on arrival and their clothes were searched then.

Key findings:

- Young people felt safer than those in YOIs, with secure children's homes being judged the safest establishments followed by STCs. The presence and attitudes of staff were again important factors in this.
- The size of units and the built environment are also important.
- As with the YOIs, the practice of full searching is of concern.

SUMMARY AND CONCLUSIONS

An overall sense of safety

In spite of all the challenges that have been described, young people generally feel safe. They perceived the biggest risk to their safety as being bullying or violence from other young people, not the staff. It must be remembered that many of the young people come from unsafe families or communities and have low expectations about what they are entitled to, but the routine and containment of life within a secure setting seemed to be reassuring for some.

It was clear from the review that young people feel safest in secure children's homes, slightly less safe in STCs and least safe in YOIs. The exception to this is the girls' units within YOIs, where findings suggested that their feelings of safety were comparable with an STC. In fact, a couple of the girls referred to the unit as being '*like a children's home*'. A major reason for this difference is the size of the establishments and the relative staffing ratios. One of the factors in this sense that smaller meant safer appeared to be the fact that staff could get to know all the young people in their care, and the dynamics between them, making it much easier to care for them in a holistic way. When we asked young people what would make their establishment safer, they referred most commonly to the need for more staff and fewer young people, especially the boys in YOIs. Conversely, very small establishments could present challenges in terms of the intensity of some of relationships and the inability to get away from the dynamics within the group, particularly if there was a particularly disturbed young person in residence. The optimum size appears to be one where staff can get to know the young people but where the group is big enough to allow young people some space from staff or other young people they may be having problems with.

The factors that contributed to a sense of safety were based primarily on the presence and attitudes of staff. Most young people said that their establishment would be safer if there were more staff and less young people, although there did seem to be a point at which establishments became too small for comfort. They also referred, however, to their relationships with staff: those they could talk to and who treated them with respect and those who did not. In some settings, young people felt they could talk to all the staff and in most there were at least some staff that young people identified as OK – although one young person in a boys' YOI estimated this as being only 2%. This variation reflects the variation in staff culture and ethos that we had observed, and some staff groups in YOIs and STCs appeared to be split between those with a child-centred approach and those who saw themselves principally as disciplinarians. The extent to which young people were actively invited to express their views is, in part, a reflection of these differing cultures.

The physical environment also contributed to a sense of safety, and the boys' YOIs are at a huge disadvantage here, operating as a number of them do within inadequate and depressing buildings. The escort arrangements operating to take young people to YOIs get them off to a frightening start. They often arrive late, after hours spent in a small, uncomfortable cubicle within a van, frightened not only about where they are being taken to but what will happen to them if the van crashes.

In spite of the differences, there are common themes across the settings where safeguarding could be improved. Most of these areas for development are in the structures and systems within which establishments are operating and detailed information about individual strengths and weaknesses would be inappropriate within this report. Instead, it is important to identify the ways in which the national infrastructure could support establishments in their wish to keep the young people in their care as safe as possible.

A framework for safeguarding

We were concerned to understand the context within which safeguarding practice with individual young people takes place. Practitioners need to be given clear direction about what is expected of them; roles and responsibilities must be defined, with sufficient capacity to fulfil these roles; lines of accountability must be transparent; systems should be effective and there must be ways of monitoring the work and effecting any necessary improvements. Our findings suggest that the need for all these elements to be in place has been recognised across the secure estate but that there is more work to be done to develop a comprehensive and robust framework. It is not solely the responsibility of individual establishments to bring about these changes: indeed many of them expressed frustration at barriers beyond their control.

Effective policies and procedures

All settings had developed safeguarding policies, albeit with some gaps. Some policies were out of date or had not been officially approved. Steps were, however, being taken to address these deficiencies. A more significant challenge lies in ensuring that the policies fulfil their purpose by providing a clear explanation of what the policy means, and direction about how it should be implemented. The most effective policies were those that were:

- short
- localised to the establishment
- suitable for this age group and the range of difficulties they present
- accompanied by procedures outlining what action should be taken
- supported by summary versions suitable for young people, families and practitioners.

This was often not the case. YOIs were operating within the policy framework defined within PSO 4950, which expects individual establishments to develop policies either adapted from templates provided (on the topics of safeguarding, child protection and information sharing) based on other PSOs designed for the adult prison population (suicide and self-harm, anti-bullying, violence reduction, safe recruitment and vetting) or devised locally (staff training). This is a somewhat confusing approach and has resulted in a range of policies which are not perceived as helpful, although many YOIs are now beginning to address this by taking ownership and developing their own local policies.

Secure children's homes face a similar challenge in that they are often working within general policies developed by their local authority, which may not be suitable for their population. They are, however, suitable for children and young people and were generally

more useful to staff. STCs and secure children's homes also have policies on behaviour management and complaints, which are serious omissions within the YOI policy framework.

Adequate structures and resources

Every establishment held meetings where safeguarding issues could be considered but the nature of these depended on the size and type of establishment. The meeting structure within YOIs is determined largely by PSO 4950, which requires them to have a safeguarding children committee that takes a strategic overview of safeguarding within the establishment and at which relevant internal services and the LSCB are represented. In practice, although YOIs were moving towards this arrangement, it was not always in place. Where the committee was in place, terms of reference and minutes suggested some had clearly established themselves as a strategic forum whilst others had not. Attendance was variable, and some committees had become bogged down in discussing individual young people rather than driving the work forward. In the girls' units, this model of having a separate committee seemed less useful, and safeguarding was usually incorporated into management or other meetings. Because of the size of the girls' units, there was the capacity to discuss and plan for all the young people more holistically through multi-disciplinary unit meetings. This was reflected in the STCs and secure children's homes. The smaller the unit, the more likely it is that safeguarding will be integrated into other strategic, management or practice meetings.

The same applied to safeguarding roles within the establishment. YOIs are expected to have a safeguarding children manager and coordinators for child protection, suicide and self-harm, anti-bullying and violence reduction. Although all YOIs except one did have a safeguarding children manager, the extent to which the post-holder was provided with the resources to fulfil the role varied widely. Some safeguarding children managers were of senior status, were able to give all their time to safeguarding and had a team of individual coordinators and administrators to support them. Others had extensive additional responsibilities, with just part-time safeguarding coordinators, that they did not line-manage, to fulfil the role. Again, the smaller the unit, the less likely there were to be designated safeguarding roles. In the girls' units, the unit head is also the safeguarding children manager. This was the case with the STCs and secure children's homes, with responsibility for safeguarding normally integrated with other roles and responsibilities although some designated roles were being created where a development need had been identified.

We concluded that there is no single ideal model for a safeguarding structure; it will depend on the size and type of establishment. It is more important to ensure that the safeguarding functions are fulfilled and that the following ingredients are in place.

- Meetings where safeguarding is considered must have clear terms of reference, action plans and follow through.
- Good quality management information – and analysis – must be available in order to inform action
- Meeting chairs and members must have sufficient authority and skill, and attend on a regular basis.

- Safeguarding roles and responsibilities should be clear, and staff should have the necessary resources, knowledge and skills to undertake them effectively.
- There should be clear lines of accountability for safeguarding within each establishment and to the LSCB.

Effective use of information

If any system is to be effective, there needs to be a process for monitoring and review so that weaknesses are identified and tackled, and that there is an expectation of continuous improvement. This needs to encompass both quality assurance of the work undertaken with individual young people, and an analysis of overall patterns and trends. Local policies and procedures need to be adjusted not only in response to this monitoring data but also to any changes in external expectations. It is important that people directly affected by policies, procedures and systems have an opportunity to feed their views into the review process so that qualitative as well as quantitative data is considered. It will be front-line staff and young people who will be able to explain why there has been, for example, an increase in fights in the gym or incidents of self-harm over the weekend.

Quality assurance was variable across the estate but was being undertaken to some extent in all settings, either formally through regular case audits, a process of reviewing and 'signing off' child protection cases with the LSCB or more informally through managers reading unit logs and supervision. The larger the establishment, the more difficult it can be to know what is going on at the front-line and the more formalised systems need to be. We found particular gaps in the systems for checking the quality of some aspects of safeguarding practice in the YOIs, especially in relation to the use of force and complaints.

In terms of identifying patterns and trends within establishments, a variety of mechanisms are in use. Individual databases have been created, collecting a range of management information such as incidents of restraint, fights and self-harm. Some of these systems are sophisticated, with the capacity to cross-reference information in order to, for example, analyse the ethnicity of young people subject to restraint or the location of fights. Others are rudimentary, allowing only for incidents to be counted rather than any meaningful analysis. We were struck both by the range of systems in use and the fact that establishments were often devising them in isolation, raising the question as to whether more central support could be made available.

The importance of qualitative information must also be recognised and establishments have devised a range of methods for hearing the views of the young people, including involvement in meetings, exit interviews and participation in staff recruitment. They may also be involved on a day-to-day level in reviewing their own and others' behaviour and determining what should happen as a result. These mechanisms are much more developed in STCs and secure children's homes than in YOIs, where there is scope for considerable development.

The question of external scrutiny was raised throughout the review. All establishments recognised the need for such scrutiny and indeed welcomed it. Secure settings are often subject to suspicion and criticism and they wanted to be better understood and valued for the things they did well, as well as to get support to continuously improve practice. All types of establishment felt that the current national framework for performance management and

inspection was confusing and even unhelpful. STCs and secure children's homes are currently inspected by Ofsted whereas YOIs are inspected by Her Majesty's Inspectorate of Prisons (HMIP). There is no single framework of standards against which they are measured. In addition, they are subject to a number of other quasi-inspection processes through YJB monitors and regional managers, Prison Service Area managers, W&YPG, Regulation 33 visitors and others. They have to supply a range of information and statistical data to support each of these processes, and complain of inconsistency and duplication. The commonly expressed view was that establishments would like this framework to be rationalised and would welcome more of a balance between support and scrutiny.

A safeguarding ethos

We wanted to know whether the concept of safeguarding was understood and embedded throughout each establishment. It is a difficult term to define, and inevitably shades into the wider duty to promote the welfare of young people. It is possible to safeguard young people effectively without necessarily being able to describe what it means in any theoretical sense. This was often the case with front-line staff: they knew when to be concerned and what they should do about it. The concept is more difficult to isolate in STCs and secure children's homes because they are establishments specifically created to look after children and young people, and tend to take a more holistic view of their needs, including their need to be protected from harm. This is much easier to achieve in a small establishment and the same, more child-centred ethos, is becoming evident in the girls' units within the YOIs.

Nevertheless, effective safeguarding will be strengthened if the establishments are in a position to take an overview of their policy and practice, to identify their strengths and weaknesses and to develop plans to improve. Most establishments were attempting to do this through the mechanisms described earlier in this section. Again, this is something that we thought could be better supported though the input of external bodies, particularly central government and LSCBs. Although it is early days, there is scope for much more meaningful involvement by LSCBs and the majority of establishments expressed disappointment that they were low down on the LSCB's list of priorities. If establishments are to improve their safeguarding processes, they would benefit from clearer expectations about what is required of them, accompanied by support to achieve it. Where a YOI had negotiated objectives and a review process with their LSCB, this had provided a useful focus.

One challenge, mainly but not exclusively for the YOIs, is the issue of establishment culture. It cannot be assumed that all staff share the same values, particularly in YOIs where some staff may not have chosen to work with young people. One of the STCs was experiencing similar difficulties with negative attitudes amongst a minority of the staff group. Only secure children's homes appear to reliably contain staff who have expressly chosen to work with challenging young people and to fully understand the implications of this. This is not to say that staff in other settings do not care about the young people in their establishment: they clearly do and we saw many examples of excellent practice reflected in the fact that young people feel reasonably safe. There were however, some examples of poor practice and a lack of commitment to seeing the young people as 'children first'. Where this is the case, safeguarding will inevitably be compromised.

Engagement with the outside world

There was a clear sense that all establishments were open to input from the outside world and wanted to engage other services in order to support the young people. This is not easy to achieve: closed establishments risk being isolated from and poorly understood by mainstream services and this was the case even for secure children's homes, which are part of the children's services authority. It was difficult for establishments to know where to go to resolve these difficulties, particularly if the LSCB was not fully engaged.

Individual establishments had developed many creative links with services outside and were able to offer an impressive range of services to the young people as a result. Statutory services remained the biggest challenge, with some poor or dysfunctional links evident with local authority children's services and local health providers. All establishments have routine contact with external YOTs in relation to planning for individual young people but a number of YOIs have in-house YOTs undertaking a variety of roles, including child protection. Although they were often satisfied with how this was working, it does raise a concern about accountability for decision-making.

In spite of some initial suspicion, advocacy services now seem to be valued by most staff and young people across the establishment. Interestingly, there seem to be more tensions in the smaller establishments where there is a more informal and problem-solving approach and advocates can be perceived as too adversarial. Conversely, YOIs have a more formalised approach to resolving problems and the advocates have found a niche within this that could be further developed. The IMB seemed to play a less significant role, and to have less knowledge of the safeguarding function in spite of their more formal involvement in the scrutiny arrangements for YOIs. Finally, we were impressed by how important the chaplaincy service was for young people, and the range of support provided.

An ongoing concern within the YOIs, raised by a number of establishments, is the role of Samaritans. As an organisation, the Samaritans have had an important role in talking to prisoners at risk of suicide or self-harm, or indeed anyone who needs someone who will listen. However, their blanket rule of complete confidentiality may be in conflict with the duty to safeguard young people and there is a need for the service to be reviewed.

Sound safeguarding practice

Having considered the context within which safeguarding practice takes place, we looked at the nature of the assessments and interventions undertaken in order to safeguard young people across the secure estate. We defined the areas of risk that young people need to be safeguarded from as harm from self, from peers and from adults. Other areas of practice are relevant to this, such as family and resettlement work, because the better young people are supported, the safer they will be but these are not directly addressed within this review.

Harm from self

The previous system for managing the risk of self-harm within the prison service had been weighted towards surveillance and the removal of any means by which a prisoner could harm themselves but this has been re-balanced to include a more supportive and informed approach. This reflects the approach within STCs and secure children's homes, which aims to remove any opportunities for self-harm whilst tackling the underlying causes. It must be

acknowledged that all establishments are operating within a climate where they are heavily censured for any incidents of self-harm or suicide, which has inevitably resulted in a risk-averse culture that finds it difficult to differentiate between self-harming behaviour as a coping strategy and suicidal behaviour. A number of staff referred to this as a source of tension, sometimes leading to perverse outcomes whereby young people are cared for within bare and impoverished environments in order to remove all possible physical risks.

The ACCT system is relatively new within YOIs and was the most consistent area of practice that we saw within those settings. There has been considerable investment in training staff and rolling out the system. On the whole, it has been welcomed as a huge improvement but there are some weaknesses in the way it is operating. Unlike other areas of practice, these problems seemed to be evident across the YOI estate and are systemic rather than localised. For example, many ACCT care maps are formulaic and it is not evident from the paperwork if actions have been undertaken. The system is not specific to young people and the particular risks or behaviours associated with adolescence have not been identified centrally, although some establishments have sought out this expertise for themselves.

A problem across the types of establishment but particularly acute in YOIs is the lack of multi-agency input into risk assessment and support of young people. The establishments themselves are left to shoulder this responsibility themselves in most cases.

Harm from peers

This area is both the biggest fear for the young people and acknowledged to be the weakest area of practice. The identification of bullying behaviour in the context of adolescence is not always as straightforward as it may seem, and the risk averse culture described above was also evident in some settings. For example, whispering was not allowed in one establishment and young people complained that normal interactions – or fights – were labelled as bullying when they were not. All the establishments were struggling to devise suitable interventions, with an acknowledgement that there was too great an emphasis on punishing the bully rather than eliminating the root causes. This also resulted in a lack of focus on the victims of bullying, and a recognition that a simplistic polarisation between being a bully or a victim was not always the reality. Some young people appeared to have adopted 'victim' status or behaved in ways that made bullying more likely, and the notion of the 'bully-victim' was found to be useful in some settings.

Again, there was a perceived lack of support in tackling the problem from the centre. Establishments had sought advice or services from a range of experts and some were linking with work being undertaken within their local authority. Young people did not always trust staff to deal with bullying, particularly in the YOIs. They feared they would be labelled as a victim, making the problem worse, or as a '*snitch*' or '*grass*'. In an attempt to prevent victims being identified, there was often a lack of information within bullying interventions about what the bully was alleged to have done. This added to the young person's sense of grievance and made the situation more difficult for staff to monitor. There was particular concern, shared by establishments, about young people who did not respond to sanctions imposed as a result of bullying, leaving the establishment with nowhere to turn. As a result many staff felt that they would prefer a more creative or preventative approach, such as universal discussion within education or more recognition of the value of pro-social

modelling. In spite of these difficulties, staff in all settings took the problem seriously and were searching for solutions.

Some establishments were attempting to take a more holistic approach towards challenging behaviour in general, including bullying, and were adopting a variety of measures. These ranged from positive steps, such as involving all young people in reviewing each other's behaviour and awarding points or making plans through complex case reviews, to more negative measures, such as the imposition of ASBO-type penalties. The latter could be used punitively and it was our view that it was not a helpful label.

Violence itself was acknowledged to be different from bullying, although there were some complaints from young people about a lack of differentiation. On the whole, young people were reasonably confident that staff would intervene quickly if violence occurred but this was affected by the numbers of staff available and the nature of the environment. There were known 'hot spots' within many YOIs where supervision was lacking or where there were gaps in CCTV coverage. It was generally known that this is where violence would occur and we saw some evidence of patterns of assaults having taken place, particularly in gym showers, which should have been avoidable.

Harm from adults

Practice in all settings was hampered by the lack of a clear definition about what constituted a child protection concern, and therefore the threshold for referral to the local authority. Some establishments had developed a local protocol but these were not consistent from place to place: agreements may or may not include fights between young people or verbal abuse by staff, and even where included there remains the question of degree. Establishments and LSCBs had been left to make their own interpretations of the categories of abuse within *Working Together* in the context of a secure setting and had reached different conclusions. Associated with this confusion over thresholds, the meaningful involvement of the local authority was rare in YOIs. Many establishments had got into a routine of referring cases to their local assessment team within children's social care who, equally routinely, sent a notification that they did not reach the threshold of significant harm. This is not to say that serious concerns were dismissed: we saw examples of strategy meetings having taken place and some investigations across the estate but numbers were very small.

There was also confusion over the three types of investigation that may follow an allegation against a member of staff: section 47; criminal or disciplinary processes, and there were instances where the onus had been placed on the young person as to whether they wanted to 'proceed'. It is our view that this is completely inappropriate in this context. The new procedure whereby all allegations against staff are referred to the LADO, even if they are unlikely to reach the threshold of significant harm or police investigation, seems a positive step. This system was beginning to have an impact on STCs and secure children's homes although there were some concerns about delay. It was much less evident in YOIs and it is unclear how the arrangements will work in relation to prison service guidance on disciplinary processes. There needs to be more clarification from the YJB, Prison Service and the Department for Children, Schools and Families as to the proper procedure to follow in such cases.

Again, across all settings there was a need to ensure that support was available for the young person and staff when allegations were being investigated and for outcomes to be communicated. It is a positive reflection on secure settings that previously unrecognised child protection concerns come to light when young people are in custody, and such concerns were consistently referred to the appropriate local authority but with mixed results and poor feedback.

We were interested to understand not only those cases that had been considered within child protection procedures but those that had not, and for this reason use of force or records of restraint were examined, as were complaints. In some establishments it was clear that there were 'missed' child protection cases within these records, whilst others had systems for screening and cross-referencing into safeguarding processes.

The use of physical restraint

Concerns about the use of physical restraint inevitably arise when we consider the risk of harm from adults, and that was the case within this review. We are conscious, however, that a specific review of restraint in the secure estate is currently being conducted. The review chairs reported to Ministers in June 2008 and a government response is expected in October. Links have been made with the review team looking at restraint and findings from our work will be used to inform their recommendations. Our comments about restraint are therefore restricted to current practice as we found it rather than our views about the overall system.

Within the YOIs, a number of young people described instances where they thought restraint had been used inappropriately or with excessive force and we did see instances where injuries had occurred. These were in the minority and most young people felt that restraint was usually justified and proportionate. However, there was little evidence of the holistic and planned approach to behaviour management required by the *Managing Behaviour in the Secure Estate* code of practice, including attempts at de-escalation before using force or systematic debriefing. The use of force recording system currently in use does not lend itself to such approaches and some establishments had devised their own formats in an attempt to introduce reflection about whether force could have been avoided, how staff and young people had been affected by the incident and what could be learned from it. These attempts are to be welcomed but there is a long way to go before these standards are embedded throughout the YOI estate.

A more holistic approach to restraint was evident in STCs and secure children's homes but it is still a source of concern amongst staff. They are uncertain about some of the techniques, and their appropriateness for use on very disturbed young people. The incidence of restraint varies widely across settings and those who have introduced more robust methods of de-escalation and reflection report that restraint has declined. It is to be hoped that the current government review of restraint within the secure estate will offer staff more guidance.

The extent to which restraint is monitored is limited. Although some establishments have set up their own systems for collating information about the use of restraint, this does not appear to be universal. External scrutiny is also limited, although basic data has been reported to the YJB since early 2007, and a few establishments have started involving the advocates

following incidents of restraint. We did not see evidence of LSCBs taking an active role in monitoring the use of restraint and this could be an area for development.

A final area of concern across establishments, although the detailed practice differs, is that of 'full' searches and the use of 'special' accommodation or single separation. These practices are potentially harmful to young people and we suggest should be the subject of a specific review to determine their appropriateness. Establishments are particularly concerned about the conflicting messages they are receiving from the various inspectorates and government departments about what is expected of them.

Responsiveness to complaints

As stated earlier, the ability to complain and have that complaint taken seriously is an important safeguard for all young people living away from home. Although young people were aware of their right to complain, and how to make a complaint, they expressed mixed views about the value of doing so. The way complaints are dealt with in YOIs is particularly disappointing. Investigations are not independent and many of the responses were poor, either failing to address the complaint or blaming the young person. Young people felt this was particularly likely to be the case if the complaint related to a member of staff, and our examination confirmed this. Allegations which should have been considered within child protection procedures were not always referred and complaints using the confidential access system were sometimes passed back to the staff concerned. There was no consistent approach to ensuring independent scrutiny of complaints, no right of reply and little analysis of themes. Nevertheless, some complaints were dealt with respectfully and appropriately and one establishment had developed sound guidance for staff about how they should respond but we felt there was huge room for improvement if the standard was to reach that expected in other children's services.

Complaints were taken more seriously overall in STCs and secure children's homes than in YOIs and investigations were much more effective – even at times being over-formalised and bureaucratic so that they caused long delays. There was also much more independent scrutiny, either from the local authority's complaints officer or advocates. There was also a more developed approach to early problem-solving and discussion to avoid grievances escalating.

A skilled and knowledgeable workforce

All types of establishment identified a need for more training, for all levels of staff. Whilst managers of STCs and secure children's homes were likely to have childcare or other relevant qualifications, this was much less likely to be the case in YOIs. In most cases, governors, safeguards managers and coordinators have been expected to understand, develop and implement safeguarding policies without any relevant training. The training that is available within the prison service is said to be too basic and there is limited access to external training. Although there is some take-up of LSCB training, this is not always suitable for this age group or the secure setting. Particular gaps were identified in the knowledge and skills base in relation to bullying and child protection work, and more generally in working with adolescents.

Similar problems existed in the STCs and secure children's homes although they were not so acute. There was evidence of an imaginative range of training having been commissioned, on topics including emotional well-being and autistic spectrum disorders. A major difference in terms of developing staff skills is that STCs and secure children's homes have a culture of supervision, although it may not always take place as often as it should.

What next?

Much remains to be done to support secure establishments in their work to keep young people safe, and it cannot all be achieved at once. The steering group met to consider the findings and arrived at a number of recommendations that have been the subject of further consultation. These recommendations range from the need for a cross-government approach to safeguarding children and young people in the secure estate based on welfare principles through to support for more effective day-to-day practice. They will be supported by a detailed action plan that will inform safeguarding from 2008 to 2111.

APPENDIX 1: DATA ON INTERVIEWEES

The number of staff interviewed in each type of establishment, broken down by role is as follows:

	YOIs	STC	secure children's home	Total
Safeguarding staff/managers	76	25	53	154
Wing/care staff	59	15	45	119
External contacts	36	10	39	85
Total	171	50	137	358

The total numbers of young people interviewed in each type of establishment, broken down by age, ethnicity and religion are as follows:

Age	YOI	STC	secure children's home	Total
13 years	0	1	14	15
14	0	3	15	18
15	7	7	20	34
16	23	10	15	48
17	79	2	2	83
18	18	0	0	18
Blank	1	0	0	1
Total	128	23	66	217

Religion	YOI	STC	secure children's home	Total
None	61	14	41	116
Christian	55	7	16	78
Muslim	7	1	2	10
Other	5	1		6
Blank			7	7
Total	128	23	66	217

Ethnicity			YOI	STC	secure children's home	Total
A	White	British	86	16	44	146
		Irish	2	2	1	5
		Any other White background	4 (2 Welsh; 1 Scottish; 1 other)	1 White Mixed European		5
B	Mixed	White and Black Caribbean	13	1	5	19
		White and Black African	3			3
		White and Asian	1		1	2
		Any other Mixed background	2		1	3
C	Asian or Asian British	Indian				
		Pakistani	1			1
		Bangladeshi	1		1	2
		Any other Asian background	1			1
D	Black or Black British	Caribbean	7	1	5	13
		African	4	1	3	8
		Any other Black background	1	1	1	3
E	Chinese or other ethnic group	Chinese				
		Any other	1 Turkish			1
		Blank	1		4	5
Total			128	23	66	217