Safe inside?
Child sexual abuse in the youth secure estate

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IICSA Research Team
February 2019
Disclaimer

This research report has been prepared at the request of the Inquiry’s Chair and Panel. The views expressed are those of the authors alone. The research findings arising from the fieldwork do not constitute formal recommendations by the Inquiry’s Chair and Panel and are separate from legal evidence obtained in investigations and hearings.
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Acknowledgements

First and foremost, we would like to thank all of the children and members of staff who volunteered to participate in this research and share their views with us. We are also indebted to the participating establishments for their time, cooperation and support in facilitating this research.

Thanks are also due to TONIC Consultants Ltd, in particular Dr Sarah Senker and Dr Lucy Wainwright who conducted the interviews with us and provided invaluable support and expertise throughout the different stages of the project.

We would also like to thank members of the Inquiry’s Victims and Survivors Consultative Panel (VSCP) for contributing their knowledge, expertise and perspective to this project and report. Finally, we are thankful for the contributions of the Inquiry’s Research Ethics Committee, the report’s peer reviewers, as well as other Inquiry colleagues.
Introduction

The Independent Inquiry into Child Sexual Abuse (‘the Inquiry’) aims to consider the extent to which state and non-state institutions in England and Wales have failed in their duty of care to protect children from sexual abuse and exploitation, and to make meaningful recommendations for change. This research explores perceptions and experiences of safeguarding in the youth secure estate in England and Wales, specifically in relation to child sexual abuse. It complements the Inquiry’s investigation into the extent of any institutional failures to protect children from sexual abuse while in custodial institutions. The research provides contemporary insight from staff and children across different establishments in the youth secure estate. The study sought to find out the extent to which children feel safe from sexual abuse in the youth secure estate, and the role of staff, systems and processes within this.

The youth secure estate in England and Wales currently comprises three different types of establishment: Young Offender Institutions (YOIs), Secure Training Centres (STCs) and Secure Children’s Homes (SCHs). These three types of establishment vary by size, the age and gender of children they accommodate, staff to child ratios, and their management and governance structures. The establishments also differ in terms of the legal basis for detaining children: YOIs and STCs hold children detained on criminal justice grounds only, however SCHs are able to hold children for criminal justice reasons as well as children held on welfare grounds for their own protection.

Children in secure establishments generally come from disadvantaged backgrounds. Prior experience of abuse, sexual or other, and local authority care is common amongst the population (Mendez Sayer et al., 2018). The youth secure estate in England and Wales has seen a continual decline in numbers from an average of 2,932 children and young people for the year ending March 2008 to 900 for the year ending March 2019 (HMPPS, 2018a). This has altered the characteristics of the population, resulting in secure settings holding children serving longer sentences who display more challenging behaviours, have multiple and more complex needs, and pose a greater risk to both themselves and others.

The youth secure estate has been assessed by recent independent inspections as being unsafe to hold children. Concerns have been raised around the levels of violence, restraint and children’s perceptions of safety. The 2016/17 Her Majesty’s Inspectorate of Prisons for England and Wales (HMIP) survey highlighted that 39 per cent of children reported feeling unsafe at some point in their current YOI and 22 per cent of children felt unsafe at some point since arriving at their STC (HMIP, 2017b). In 2016/17, there were around 2,700 reported assaults in the youth secure estate and 4,500 recorded incidents of restraint (Youth Justice Board, 2018). This shows the high levels of violence and restraint present across the estate given the relatively small population. Prevalence statistics in relation to child sexual abuse also indicate there were around 200 alleged incidents in the youth secure estate in 2016 and 2017 (Independent Inquiry into Child Sexual Abuse, 2018). These figures are again worryingly high for a population size which has consistently decreased since 2008.

Methodology, ethics and limitations

We adopted an exploratory case study approach, carrying out qualitative in-depth interviews with children and staff members across a small number of establishments within the youth secure estate. A case study method is a common qualitative approach when investigating complex phenomena. In this instance, it allowed us to gain an in-depth understanding of safeguarding practices in specific establishments.

Interviews were carried out in four different establishments in England and Wales – one YOI, one STC and two SCHs. Due to their comparatively smaller size, two SCHs were visited in order to achieve our
sample in this establishment type. A summary of the sample and number of interviews carried out per establishment type is shown in Figure 1.

Figure 1: Sample summary

<table>
<thead>
<tr>
<th>Interviews in total</th>
<th>YOI</th>
<th>STC</th>
<th>SCHs</th>
</tr>
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<tbody>
<tr>
<td>48</td>
<td>10 children</td>
<td>8 children</td>
<td>9 children</td>
</tr>
<tr>
<td>27 interviews with children</td>
<td>5 staff</td>
<td>6 staff</td>
<td>10 staff</td>
</tr>
<tr>
<td>21 interviews with staff</td>
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As part of the sample selection we reviewed population data provided by the establishments and randomly selected children aged 14–17, ensuring a range of characteristics were included such as: age, gender, ethnicity and sentence type. Targeting children with prior experience of sexual abuse (either within or prior to entering the youth secure estate) did not form part of our sampling criteria for ethical reasons.

We took a stratified approach to selecting staff to ensure we spoke to individuals from a range of professional backgrounds, at different grades, and with varying lengths of service. This allowed us to capture the views of a cross-section of staff and the multidisciplinary roles involved in different aspects of safeguarding practice.

Interviews were audio-recorded and transcribed, and transcripts were thematically coded and analysed.

The project was subject to rigorous ethical scrutiny. A number of ethical considerations were carefully managed and measures were put in place to ensure the safety of research participants and researchers was maintained at all times. These included: ensuring researchers had Disclosure and Barring Service (DBS) clearance; having two researchers present for all interviews; and ensuring a disclosure protocol was in place should any concerns arise during interviews. Informed consent was collected from all participants.

There were a number of limitations to the project. The sample criteria and consent restrictions meant the sample was not representative of the wider population across the youth secure estate, and with a small case study sample our research findings are not generalisable. It is also likely, linked to barriers to disclosing sexual abuse, that children may not have felt able to openly discuss any issues or raise concerns with researchers.

**Learnings from the research**

**Perceptions of safety in the youth secure estate**

Establishments were making efforts to cultivate safe environments and improve safety and safeguarding practice. Recent and ongoing change was notable.

Children initially reported feeling safe in their respective establishments and believed the necessary measures were in place to protect them. They perceived that staff had a duty of care to keep them safe and overall did a good job of doing so. However, when safety was explored in more detail with
them, it was clear they did not feel as safe as they initially indicated and had concerns about their safety in relation to other children. In particular, they worried about physical violence and bullying, the general unpredictability of other children's behaviour, and had anxieties about who they were sharing a living space with. Children were employing self protection strategies to help them feel safe with many operating on the basis they needed to be vigilant at all times. Children's initial reporting of feeling safe was also relative – rather than absolute. They reported feeling relatively safe in their current establishment compared to other secure establishments they had been to before, or feeling safer in their current establishment compared to their expectations about the youth secure estate before they arrived. For children placed on welfare grounds, the secure environment was a 'safe space' compared to the outside world.

**Prevention measures and protective factors**

There were various prevention measures and protective factors in place intended to contribute to children’s sense of safety and wellbeing. We categorised these as individual, interpersonal and operational factors.

In terms of factors specific to individuals, some children employed self protection strategies to help them feel safe, for example, projecting a sense of confidence to avoid being seen as ‘weak’ or consciously keeping their distance from other children. Many (in the YOI in particular) described being in a constant state of vigilance. The physical characteristics of other children, for example physical size and strength, influenced perceptions of vulnerability and capability to cause harm.

Interpersonal factors related to relationships and meaningful, positive relationships between children and staff emerged as a critical – and arguably the most important – factor to children feeling and being safe in these environments. It helped children feel at ease in an often unfamiliar environment and facilitated any disclosures. It enabled staff to better understand children and identify changes in behaviour. Most children had at least one member of staff that they trusted and could talk to. Attitudes towards staff were generally more positive in the SCHs compared to the STC and YOI, where views were more mixed. Children articulated various attributes they valued in staff such as reliability and someone they could ‘have a laugh with’. However, a number of issues impeded children and staff from being able to build quality relationships including: a lack of staff continuity, a lack of time to develop relationships, being moved between units, and perceived breaches of trust.

Operational factors related to the management of the wider secure environment and processes within establishments. The following factors played a critical role in managing the environmental risks: staff recruitment processes; staff to child ratio; how children were allocated to specific units; the design and management of the physical space; and information sharing. However, children were not always aware of certain operational processes that were in place to keep them safe – and knowing about these may have helped to alleviate some of their concerns. There were mixed views between children and staff in relation to some operational measures designed to contribute to safety, especially closed circuit television (CCTV) and body worn video cameras (BWVCs). It was also concerning to see how often restraint appeared as a theme in the accounts of children and staff and that there was no backstop against restraint being used on children with known past experiences of sexual abuse. There were different and complex challenges of managing mixed populations, which included mixing children by gender and by status (welfare and criminal justice cases), requiring a dynamic and considered approach to assessing risk.
Perceived risk of child sexual abuse

Both staff and children perceived that the risk and opportunity for child sexual abuse to occur in their respective establishments was low. There was a widely accepted belief among children that child sexual abuse ‘couldn’t happen here’ or ‘wouldn’t happen to me’. This was perceived to be due to the range of prevention measures and protective factors in place, most notably meaningful positive relationships between children and staff.

However, these perceptions must be considered in the context of children’s understanding of child sexual abuse as well as the behavioural ‘norms’ that manifest in this environment. Children had a limited understanding of child sexual abuse and the range of behaviours constituting it. Education on this topic was not offered to all children as standard and was instead limited to targeted interventions for those who had been identified as needing particular support in this area. Children acknowledged that they knew little about this topic and were open to receiving more education to increase their general knowledge, and enable them to identify sexual abuse and sexually harmful behaviours. Children could see the value of having more education around healthy sexual relationships to provide them with knowledge they could take forward when they leave the secure environment.

Children were not always clear or confident about the appropriateness of behaviours between children. They had to decipher and negotiate the different rules and boundaries of behaviour that each establishment enforced. The impact of being in a secure environment also had certain negative implications for children whereby behaviours that were identified as inappropriate could come to be seen as acceptable in this environment, for example the frequent use of sexual ‘banter’. These ‘norms’ in the secure environment had implications for how children would respond to sexual abuse and sexually inappropriate behaviour experienced by themselves or others in these settings, and if and what they would report. Child sexual abuse was not reported as a concern and children perceived the risk of this as being low. Some were experiencing sexual behaviours that made them feel uncomfortable but these were not viewed as harmful or potentially abusive. Experiences of sexualised behaviour was a particularly pertinent issue in the STC compared to the other establishments.

Levels of knowledge and understanding of child sexual abuse amongst staff also varied. A greater emphasis was being placed on training in this area by senior management but the extent to which staff had received training was inconsistent and varied by role. As with children, managing appropriate and inappropriate behaviour in this specific context was also challenging for staff. They recognised that behaviours that were ‘normal’ in the community were less acceptable in secure settings. It was a challenge for them to allow the children in their care to be ‘normal adolescents’ but also ensure they were kept safe. Managing the balance was difficult for staff and there was always a level of subjectivity and discretion in whether or not individual staff members deemed something to be appropriate, or not, in these settings.

Reporting safeguarding concerns

Children were not always aware of the formal process to report a safeguarding concern, but they reported they could talk to a member of staff if they had a problem. Children had different ‘rules’ about what they would and would not report and were unlikely to report incidents of child sexual abuse. This was due to a number of factors including: a lack of understanding of what constituted child sexual abuse; not wanting to get involved in other people’s business; not wanting to get themselves or others in trouble; and not wanting to be labelled a ‘snitch’ by other children.
Staff generally had a good understanding of safeguarding and were able to describe various behaviours that would be a concern. Views became more wide ranging and subjective when considering the more nuanced behaviours. There was no clear articulation of the official safeguarding process. Rather, staff members reported an individualised process that they would personally follow which included a variety of routes. Staff believed any issues raised would be adequately addressed but that there was room for improvement. Staff’s confidence in the referral process was being undermined as they were rarely made aware of the final outcome following their reporting of an incident. There was also a concern amongst some non-operational staff at the YOI that the needs of the establishment came first in response to safeguarding concerns rather than the welfare of the child.

Responding appropriately to safeguarding concerns relied on clear, open and timely communication between staff within an establishment as well as with external agencies. Good working relationships with the local safeguarding teams and the Local Authority Designated Officer (LADO) were a vital part of an effective safeguarding process. Staff reported that communication with external agencies was difficult at times, but had noted some recent improvements.

Based on our research, we have identified eight key findings. These research findings do not constitute formal recommendations by the Inquiry’s Chair and Panel and are separate from legal evidence obtained in investigations and hearings.

Eight key findings from the research

1) Some practices in the youth secure estate do not seem to serve the best interests of the child

As set out in international and national frameworks, the best interests of the child should be the primary consideration when any action is taken or any decision is made in relation to a child in the youth secure estate. The ‘best interests’ test requires establishments to take a rehabilitative approach and promote the reintegration of children into the community. Children deprived of their liberty must be treated with humanity and dignity, and establishments must take appropriate steps to protect children from all forms of abuse and ill-treatment.

A number of practices in the youth secure estate in England and Wales did not seem to serve the best interests of the child. There were challenges to children and staff being able to form positive meaningful relationships, mixed views about the extent to which certain prevention measures promoted safety (notably the normalisation of surveillance and an over-reliance on restraint) and a lack of understanding about child sexual abuse, including identifying signs of abuse.

2) More work is needed to ensure safeguarding and embedding a culture of safety is seen as everyone’s concern

Safeguarding should be everyone’s concern. However translating this vision into reality remains a challenge. The role of leadership is critical in championing and embedding a clear and consistent whole-establishment approach to safeguarding, underpinned by a culture of safety.

Some establishments included in the research had yet to embed a culture of safety and further work was needed to create a safe environment for children.

3) Children in the youth secure estate do not always feel safe or are kept free from harm

The youth secure estate is entrusted with the care of children, many of whom are vulnerable and have complex behavioural needs. Establishments have a duty to take reasonable steps to keep children in their care free from harm, and children should feel safe at all times while in the youth secure estate. Feeling safe is a precondition to children being able to prosper in these environments, overcome any previous trauma they might have experienced, and develop the skills and tools required for their successful rehabilitation and reintegration into society.

Children had several concerns about their safety, particularly in relation to violence from other children.
4) Prevention measures in place to keep children safe do not always reduce risk or promote a safe environment

There are a number of operational factors that require careful and considered management to ensure a safe environment for children. Management of risk requires a whole-system and dynamic approach, grounded in defensible decision-making processes. The utility of technology can be increased when combined with other operational and safeguarding measures.

There were mixed views around the use of technology and restraint. Children were not always aware of certain prevention measures in place, and knowing about these could have alleviated concerns, for example decisions made in the allocation of children to units.

5) Children in the youth secure estate are not well equipped to have healthy sexual relationships

While in the care of the youth secure estate, children need to be equipped with knowledge to enable them to adopt healthy relationships when they return to the community. This includes more education about sexual abuse that is offered to all children in the care of the youth secure estate – and not limited to children identified as needing particular support in this area.

The current understanding of healthy sexual relationships amongst children in the youth secure estate was poor and children did not have the necessary knowledge to properly identify concerning behaviours.

6) Children and staff struggle knowing what constitutes abuse and inappropriate sexual behaviour

Staff need more guidance and support so they feel confident and able to identify sexual abuse and harmful sexual behaviours. This in turn would improve the understanding and behaviour of children in their care. A consistent approach from staff, combined with more education on healthy sexual relationships (and ongoing targeted interventions) would allow children to develop their understanding of what types of behaviour are appropriate.

Children and staff found it challenging to decipher what behaviour was appropriate in secure settings. For staff, this led to inconsistent practice in challenging sexualised behaviours. Children did not identify potentially harmful sexual behaviours they were experiencing. Behaviours deemed inappropriate in wider society could become ‘normalised’ and acceptable in the secure environment.

7) More work is needed to ensure staff in the youth secure estate are equipped to deal with safeguarding issues

It is essential that staff have a detailed understanding of safeguarding practices and implementation, and are adequately trained and supported to raise concerns and respond to disclosures. Senior management need to cascade relevant information to assist staff learning and development. Rigorous monitoring processes are needed to ensure safeguarding practices are being applied in a timely, consistent, safe and proportionate way.

Staff generally understood what safeguarding meant. They were able to describe various behaviours that would be a concern, although views were varied and subjective when considering certain nuanced behaviours (including sexual behaviours). There was a lack of clarity about the formal safeguarding process and the safeguarding vision of senior management. An overly complicated process, coupled with a lack of information and inconsistent training, compounded this issue.

8) Fostering good relationships and multidisciplinary working is a challenge

Establishments need to improve relationships with key partners, both internal and external, in order to improve the effectiveness of the overall safeguarding process. All staff need to better understand the roles of the safeguarding team and the LADO.

All establishments highlighted problems with their relationships with key stakeholders in the safeguarding process. Communication was often poor and the perceptions of safeguarding teams and the LADO among operational staff were not always positive. This impacted on their involvement in the process and the willingness of staff to report incidents to them.
Chapter 1: Introduction
This chapter provides background information about the Inquiry and the aims of this research project.

1.1 Background to the Inquiry

The Independent Inquiry into Child Sexual Abuse (‘the Inquiry’) was set up as a statutory inquiry in March 2015. The Inquiry aims to consider the extent to which state and non-state institutions in England and Wales have failed in their duty of care to protect children from sexual abuse and exploitation, and to make meaningful recommendations for change, to help ensure that children now and in the future are better protected from sexual abuse. Child sexual abuse involves forcing or enticing a child or young person under the age of 18 to take part in sexual activities. It includes contact and non-contact abuse, child sexual exploitation and grooming a child in preparation for abuse.

1.2 Background to the Inquiry’s investigation into custodial institutions

The Inquiry is undertaking an investigation into the extent of any institutional failures to protect children from sexual abuse while in custodial institutions, that is, Young Offender Institutions (YOIs), Secure Training Centres (STCs), Secure Children’s Homes (SCHs) and their precursor institutions. The investigation considers the nature and scale of child sexual abuse within these different custodial institutions in addition to institutional responses to the sexual abuse of children within them.

A public hearing for the investigation was held in July 2018. The Inquiry heard from a number of witnesses and considered evidence on specific issues:

1. Prevalence and culture issues (for example, alleged levels of child sexual abuse in recent years and whether there is a culture that inhibits proper prevention of child sexual abuse).

2. Systems issues (for example, what the current safeguarding and child protection policies are; what the inspection regimes are and how effective these systems are).

3. Specific factual issues (for example, relating to the nature of the youth secure estate; staffing and resourcing issues; the use of restraint and pain compliance; mental health, drugs and gangs; the identification of and response to child sexual abuse and governance issues).

4. Specific examples of institutional responses to allegations of sexual abuse.

5. Recommendations.

The investigation report setting out the Inquiry’s findings and recommendations from the hearing will also be published in February 2019.

1.3 Background to the Inquiry’s research on custodial institutions

To support the investigation, in March 2018, the Inquiry’s Research Team published a rapid evidence assessment (REA) into child sexual abuse in custodial institutions (Mendez Sayer et al., 2018). This summarised the existing research literature on child sexual abuse in custodial institutions in relation to:

- the prevalence of child sexual abuse in these establishments
- socio-demographic characteristics, both of victims and perpetrators
- the factors associated with failure to protect or that act to protect children in the care of custodial institutions
- the nature of the safeguarding systems in place and how they have changed over the years
- recommendations regarding how those systems may be improved to better protect children in these environments from sexual abuse.
The REA highlighted that children in the youth secure estate are a vulnerable population, with many coming from a background of prior maltreatment, including experiences of child sexual abuse. Despite this, there is a lack of robust research on child sexual abuse in the youth secure estate in England and Wales. The literature identified a number of factors as either contributing to keeping children safe, or associated with higher levels of risk for children. These included: the culture within establishments; relationships with staff; staff to child ratios and the size of establishments; the physical environment; and the population mix. Staff training and safeguarding systems, inspection systems and multi-agency working have also been the focus of a number of studies.

This research builds on the REA and complements the Inquiry’s investigation into child sexual abuse in custodial institutions by providing contemporary insight on the views and experiences of staff and children across different establishments in the youth secure estate.

The new research, which is the focus of this report, explores experiences and perceptions of safeguarding in the youth secure estate, specifically in relation to child sexual abuse. The project received ethical approval in March 2018. Interviews with children and staff were carried out across four different secure establishments in July 2018. The research was undertaken by members of the Inquiry’s Research Team in collaboration with TONIC Consultants Ltd.

1.4 Research aims

At its heart, the research sought to find out the extent to which children feel safe from sexual abuse in the youth secure estate and the role of staff, systems and processes within this.

The more specific research questions were to explore:

- the systems and practices in place in the youth secure estate to keep children safe and how these are understood and delivered from the perspective of both children and staff
- whether the systems and practices in place to protect children in the youth secure estate from sexual abuse are effective, and how they can be improved
- the awareness of children and staff of safeguarding procedures and policy
- the adequacy of staff training and how this translates into practice
- the experiences of children and staff around incidents and reporting of abuse, including sexual abuse
- the nature of different types of abuse, in particular sexual abuse, taking place in custodial institutions, perpetrated by both children and staff
- whether responses to child protection issues meet the needs of children who disclose abuse including sexual abuse.

1.5 Report structure

The report is structured in the following way:

- Chapter 2 summarises key contextual information relating to youth justice and the youth secure estate in England and Wales, which helps to situate our research findings. It provides: an overview of the current composition of the youth secure estate, and the profile and demographics of those held within it; an outline of the relevant international, national and local frameworks that govern its
operation; and a brief summary of what is already known about levels of safety in the youth secure estate and prevalence of sexual abuse.

- Chapter 3 outlines the methodology of the research, including: the overall design and approach of the project; research ethics; site selection; the sampling strategy and summary of the final sample; and the approach taken to data management and analysis.

- Chapter 4 presents the general reflections of staff on the current climate of safety in their respective establishments and how they view their role in children's lives. It also presents how safe children reported feeling, factors underpinning their sense of safety, and what their main concerns were about safety in these settings.

- Chapter 5 sets out the various measures and protective factors intended to keep children safe and how these are viewed from the perspective of both children and staff.

- Chapter 6 presents the research findings relating to the perceived risk of child sexual abuse occurring in the various establishments visited. It explores current levels of knowledge and awareness of child sexual abuse among children and staff and also draws attention to wider challenges around behavioural norms and determining appropriate and inappropriate behaviour in these settings.

- Chapter 7 explores the process of reporting safeguarding concerns and how inappropriate behaviour and sexual abuse would be managed and reported, from the perspective of children and staff. It also looks at how establishments respond to concerns raised by staff.

- Chapter 8 concludes the report by drawing together the key research findings and highlighting the main challenges faced in keeping children safe in the youth secure estate.
Chapter 2: The youth secure estate in England and Wales
This chapter summarises key contextual information relating to youth justice and the youth secure estate in England and Wales, which helps to situate our research findings. It provides: an overview of the current composition of the youth secure estate, and the profile and demographics of those held within it; an outline of the relevant international, national and local frameworks that govern its operation; and a brief summary of what is already known about levels of safety in the youth secure estate and prevalence of sexual abuse.

### 2.1 Establishment types and population

The youth secure estate in England and Wales currently comprises three different types of establishment: Young Offender Institutions (YOIs), Secure Training Centres (STCs) and Secure Children’s Homes (SCHs). These three types of establishment vary by size, the age, gender, and status of children they accommodate, staff to child ratios, and their management and governance structures.

There are five YOIs holding boys aged 15 to 17 which are run by the Prison Service or, in the case of the one YOI in Wales, a private provider. YOIs are the largest of all three settings and have a much lower staff to child ratio. YOIs generally hold older children considered to be more resilient and who ‘externalise their risk’ (Mendez Sayer et al., 2018). YOIs have historically been characterised as establishments where the culture is focused on punishment and control (ibid).

STCs hold children (boys and girls) aged 12 to 17, although not all accommodate girls. There are three STCs in England, run by either the Prison Service or private providers. There are currently no STCs within Wales. STCs receive children who are older and more independent, who are deemed more motivated to attend school, or those who have vulnerabilities that would make placement in a YOI unsuitable (ibid).

SCHs are run by local authorities across England and Wales. They can hold children from the age of 10 to 17. Children can be placed in SCHs for criminal justice cases (on remand or under sentence) as with YOIs and STCs, or on ‘welfare’ grounds for the protection of themselves or others. Children placed on welfare grounds will often have (although not necessarily) a relatively short stay compared to those placed on criminal justice grounds. Not all SCHs have the capacity to hold children serving a sentence for a criminal conviction, they are for welfare cases only. SCHs tend to be smaller in size, hold boys and girls and have a higher staff to child ratio. They tend to be used for the youngest, most ‘at risk’ children and those with more complex needs. There are currently eight SCHs with the capacity to hold children allocated by the Youth Custody Service (YCS), seven of which are within England. The YCS will consider a range of factors in deciding where a child will be placed including age, maturity, or requirement for high levels of support. There is a consensus in literature that SCHs are the most child focused type of secure establishment and the care provided is more individualised and personal. SCHs are described as having a more informal, family atmosphere (ibid).

The average number of children held in the youth secure estate has consistently declined since mid-2008 (HMPPS, 2018a). For the year ending March 2008, an average of 2,932 children in England and Wales were held securely; this has decreased to an average of 900 for 2018/19 (see Figure 2.1).
As of July 2018, when this research was conducted, there were 883 under 18s in the youth secure estate, of which 97 per cent were male⁴ (HMPPS, 2018a). Further demographic breakdowns of the population can be found in Figure 2.2.

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3 The 2017/18 and 2018/19 figures are provisional.
4 This figure only includes those children in the youth secure estate for criminal justice reasons and does not include those held in SCHs on welfare grounds.
Comparative figures for children held in SCHs on welfare reasons are not available. As at March 2018, in addition to children held for criminal justice reasons, there were 106 children held in SCHs for welfare reasons (DfE, 2018a).

The decline of under 18s in the youth secure estate has altered the characteristics of the population. Those with less serious or fewer convictions are now being diverted from these environments leaving a population serving longer sentences who display more challenging behaviours, have multiple and complex needs, and pose a greater risk to both themselves and others (Mendez Sayer et al., 2018). There is more violence, more reports of drug and alcohol dependency and more children suffering from emotional or mental health problems (Wood et al., 2017; Bateman, 2016). These factors combined result in a population that is more vulnerable.
Children in secure establishments generally come from disadvantaged backgrounds with prior experience of abuse, sexual or other. Experience of local authority care is also common amongst the population. Around four in ten children in secure settings have previously been in local authority care and between three in ten and nine in ten have experienced neglect or maltreatment. High levels of mental health problems and substance misuse are also evident amongst children in this population. Research data on the prevalence of sexual abuse prior to entering the youth secure estate is scarce. The studies that do exist are from over 20 years ago and therefore may not be an accurate reflection of the experiences of children in these establishments. However several studies examining sexual abuse amongst children and young people in these environments indicate that around 30 per cent had experienced sexual abuse prior to entering them (Mendez Sayer et al., 2018). See also section 2.3.4.

2.2 Frameworks, legislation and policy

2.2.1 International standards and rules

There are a number of international conventions, standards and rules which are worth highlighting as important context to the youth secure estate and the children held within it. The UK has signed and ratified various international human rights instruments, including the United Nations Convention on the Rights of the Child (UNCRC), which safeguard children’s rights. These rights can be considered by domestic courts and the European Court of Human Rights and the UK is under an obligation to implement them. However they have not been incorporated into domestic law and as such do not create free-standing individual rights. An exception to this is The Rights of Children and Young Persons (Wales) Measure (2011) which provides a statutory duty for Welsh Ministers to have due regard for all articles in Part 1 of the UNCRC; no equivalent provision exists in England. There are also various international standards and rules that apply to all children who come into contact with the youth justice system. Together they set out a number of principles, including non-discrimination, best interests of the child, proportionality in relation to the circumstances and gravity of the child’s offence but also to the circumstances and needs of the individual and of society more widely. Detention is also positioned as a measure of last resort. These standards make clear that the primary purpose of detention for children must be for their rehabilitation and reintegration rather than punishment or the protection of society. Children deprived of their liberty must be treated with humanity and dignity, and appropriate steps must be taken to protect them from all forms of abuse and ill-treatment. This includes neglect, exploitation and physical, sexual and emotional abuse. Article 19 of the UNCRC specifically states that a State has to take all appropriate legislative, administrative and educational measures to protect children from all forms of abuse or exploitation while in the care of any person who has responsibility to care for a child (UNODC, 2013).

In 2009 the European Committee for the Prevention of Torture recommended that the UK discontinue the use of ‘manual restraint based upon pain compliant methods’ and that only specifically designed non-pain compliant manual restraint techniques, combined with better risk assessment of those held in the youth secure estate and enhanced staffing skills, should be used in these secure establishments (Council of Europe, 2009). However, pain compliant techniques are still in operation across the youth secure estate.

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5 These include, among others, the United Nations Standard Minimum Rules for the Administration of Juvenile Justice (the Beijing Rules), the United Nations Rules for the Protection of Juveniles Deprived of their Liberty (the Havana Rules), and the Guidelines for Action on Children in the Criminal Justice System (the Vienna Guidelines). The General Comments of the Committee on the Rights of the Child has also set out children’s rights in juvenile justice (in General Comment No. 10).
2.2.2 National legislative framework

In England and Wales, youth justice is a matter reserved to the UK Parliament and Government. However many agencies employed within the youth justice system operate within areas of devolved competence in Wales, for example healthcare. Some of the core elements of the legislative framework relevant to children held in the youth secure estate in England and Wales include:

- **The Children Act 1989** which provides a comprehensive framework for the care and protection of children and centres on the welfare of children up to their 18th birthday. The Act provides a general duty on local authorities to safeguard children in need in their area and promote their being brought up by their families. Section 25 of this act sets out the relevant legislation for local authorities for children held in SCHs for welfare reasons.

- **The Human Rights Act 1998** which provides essential protections for the rights of children and is a crucial remedy when their rights have been violated (EHRC, 2016).

- **The Children Act 2004** which states that the interests of children and young people are paramount in all considerations of welfare and safeguarding and that safeguarding children is everyone's responsibility. It introduced provisions for the safeguarding and welfare of children in the youth secure estate via statutory Local Safeguarding Children's Boards (LSCBs) (DfE, 2015).

- **The Equality Act 2010** which prohibits unlawful discrimination, harassment and victimisation on the basis of nine protected characteristics.

- **The Children and Families Act 2014** which made changes to the safeguarding and child protection system and services for children and families.

- **The Criminal Justice and Courts Act 2015** which brought in a number of changes to the criminal justice system. It intended to establish ‘Secure Colleges’, a new form of large custodial institution with a greater emphasis on education and integrated multi-agency working, and specialist provision for the most vulnerable children. Plans to build these were later abandoned due to resource pressures and a decreased offender population (Centre for Crime and Justice Studies, 2015). The Government, however, announced in June 2018 new plans to establish secure schools (MoJ, 2018b).

- **The Children and Social Work Act 2017** which has a new provision to allow local authorities in England and Wales to place children in secure accommodation in Scotland, and those in Scotland to place children in secure accommodation in England. The Act also made several significant changes for safeguarding at both local and national levels, by amending the Children Act 2004. It established a new national Child Safeguarding Practice Review Panel. It also effectively abolished Local Safeguarding Children Boards, and in its place put duties on three safeguarding partners (the local authority, any Clinical Commissioning Groups operating in the area and the Chief Officer of Police) to make safeguarding arrangements that respond to the needs of children in their area (Children England, 2017).

A more detailed overview of key legislative and policy shifts in relation to youth justice can be found in the REA mentioned above into child sexual abuse in custodial institutions (Mendez Sayer et al., 2018: Appendix F).
2.2.3 Policy framework

The Youth Justice Board (YJB) was the first body to have oversight of the whole youth justice system and was uniquely placed to guide and advise on the provision of youth justice services. Its statutory responsibilities included: commissioning youth custodial provision; promoting good practice; and monitoring and advising ministers on the operation of the youth justice system. Whilst the YJB has no specific statutory safeguarding duties placed upon it, it has an internal child protection policy in place to guide and support staff, embedding principles set out by the Department for Education (DfE). The YJB also has national standards for youth justice services which includes guidance and minimum standards for the care of children in the youth secure estate, including safeguarding (YJB, 2013).

The Taylor review of the youth justice system in England and Wales (Taylor, 2016) recommended a more devolved youth justice system with local authorities taking on greater responsibilities, reducing the centralised function of the YJB. Although not all recommendations from the Taylor review have been accepted, the review would see local authorities deliver and oversee more integrated youth offending services, with inspectorates monitoring quality and outcomes. In 2017, the Youth Custody Service (YCS) was created as a distinct service for children in the youth secure estate within Her Majesty’s Prison and Probation Service (HMPPS), taking over many of the previous functions of the YJB.

2.2.4 Local policy

Each establishment within the youth secure estate must maintain and follow policies and procedures specific to their establishment, which set out how they are going to fulfil their safeguarding responsibilities. These responsibilities are outlined in the DfE’s Working together to safeguard children guidance. This was updated in 2018 alongside Local safeguarding - transitional arrangements statutory guidance. The revised guidance strengthens relationships by placing new duties on key agencies in a local area. The revisions aim to clarify processes or to reflect recent changes to policy, for example, through the insertion of guidance on contextual safeguarding which includes protecting children from threats such as criminal and sexual exploitation (DfE, 2018b; DfE, 2018c).

All four establishments involved in this research had safeguarding and whistleblowing policies. Local practice of disclosure and reporting incidents differed between establishments, with some operating a more complex reporting process than others. All establishments had governance arrangements in place for recording incidents involving a restraint.

2.3 Inspection, culture, and assessment of safety

2.3.1 Regulatory and inspection frameworks

YOIs are governed by The Young Offender Institution Rules 2000 and Prison Service Instructions (08/2012): Care and Management of Young People. These provide the principles by which establishments holding children and young people must operate and outline the differences from the adult estate. YOIs are inspected on an annual basis by Her Majesty’s Inspectorate of Prisons for England and Wales (HMIP) alongside Ofsted, or Estyn in Wales, and the Care Quality Commission, or Healthcare Inspectorate Wales. The HMIP inspections are guided by criteria called ‘Expectations’, which are used to assess the treatment and conditions in prisons in which they are held. There are specific criteria used to inspect establishments holding children, which include safeguarding and child protection arrangements (HMIP, 2012). HMIP also has a specific safeguarding and child protection policy outlining the overarching principles in identifying and responding to concerns about safeguarding and protection of children and young people (HMIP, 2015a; HMIP, 2015b). HMIP assesses establishment performance in four key areas, one of which is safety.
Establishments can be given the following ratings: good; reasonably good; not sufficiently good; or poor. Each YOI has an Independent Monitoring Board (IMB) whose role it is to monitor whether children are treated with fairness and humanity while in these establishments (IMB, 2016).

STCs are governed by the Secure Training Centre Rules 1998 and Secure Training Centre (Amendment) Rules 2007, which set out the provision for the regulation and management of STCs. STCs are also inspected on an annual basis and this inspection is led by Ofsted with the support of HMIP and the Care Quality Commission.⁶ Ofsted published an inspection framework for STCs in 2015, which was updated in 2017 (Ofsted, 2017a) and all inspections are conducted in accordance of Rule 43 of the Secure Training Centres Rules 1998 (SI 1998/472). STCs are assessed against seven criteria set by Ofsted, including safety. A four-point scale is used for each area: outstanding; good; requires improvement; and inadequate. Each STC has a YCS monitoring team in place whose responsibility it is to monitor contract compliance which includes: site inspections; reviewing incident reports and closed circuit television (CCTV) to make sure appropriate actions have been taken; and carrying out minimum staffing checks (Mendez Sayer et al., 2018).

The Children’s Homes (England) Regulations 2015 and quality standards set out the outcomes that all children’s homes in England, including SCHs, are expected to achieve. The Children’s Homes (Wales) Regulations 2002 and minimum standards frameworks provide a similar framework for children’s homes in Wales. Ofsted (or Estyn in Wales) inspects all SCHs to assess the quality of care being provided and compliance with the relevant regulations. The inspection framework for SCHs is set out within the Social Care Common Inspection Framework (Ofsted, 2017b). SCHs are inspected, as a minimum, twice a year against four criteria, including how well children are helped and protected. Inspectors make judgements on a four-point scale: outstanding; good; requires improvement; and inadequate. Children placed on welfare grounds in SCHs are also to be independently reviewed by the local authority at particular points, meaning they have the opportunity to speak to an independent reviewing officer about the placement (RRC, 2017; Coram Voice, 2015, 2012).

2.3.2 Assessments of safety in the youth secure estate

Various inspection reports in recent years highlight ongoing concerns about the safety of children being held in the youth secure estate. In 2017 the Chief Inspector of Prisons stated that based on inspection findings, none of the YOIs or STCs were assessed as safe environments for children (HMIP, 2017a). Since then inspection bodies have noted some improvements across the youth secure estate, however several establishments still have concerning safety levels. The 2017/18 HMIP annual report shows that two YOIs still have safety ratings of ‘not sufficiently good’, one YOI has a ‘poor’ rating for safety and all three STCs had ratings of ‘requires improvement’ or ‘inadequate’ for safety (HMIP, 2018a). The 2016/17 HMIP survey highlighted that 39 per cent of children reported feeling unsafe at some point in their current YOI and 22 per cent of children felt unsafe at some point since arriving at their STC. Half of the children in STCs reported victimisation from another child, while 22 per cent reported being victimised by a staff member. In YOIs these figures were 28 per cent for victimisation by both other children and staff⁷ (HMIP, 2017b).

SCHs are not inspected by HMIP and therefore there is no equivalent assessment of safety. However the 2018 Ofsted inspections for the seven SCHs holding children for justice reasons in England indicated that in the majority of cases safety received a good or outstanding rating. These ratings may be used to indicate that SCHs are a safer environment for children than STCs and YOIs. However it is not possible to conclude this definitively as direct comparisons are difficult given the differing inspection standards.

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⁶ There are no STCs within Wales and therefore no alternative Welsh inspection body.
⁷ The HMIP Children in Custody 2017/18 report was not available at the time of publication of this report.
2.3.3 Levels of violence and use of restraint

In 2016/17, there were around 2,700 recorded assaults (both child on child and child on staff) in the youth secure estate. 37 per cent of these occurred within YOIs, 46 per cent in STCs and 17 per cent in SCHs. This equates to 228 assaults each month on average. The majority of assaults were against other children, however the level of violence towards staff increased in the year to March 2017 (YJB, 2018). These figures need to be considered in the context of the overall (decreasing) population size of the youth secure estate, as well as the differing population size of the three establishment types. Many children reported that violence, fighting and bullying were an inevitable part of being in the youth secure estate (HMIP, 2018b). There were also around 4,500 incidents of restraint in 2016/17 – an increase of five per cent from the previous year and the first increase since 2012 (YJB, 2018). These figures are alarmingly high given the international standards that restraint against children should only be used as a last resort. Table 2.1 below provides a breakdown of assaults and restraint per establishment type. Restraint, in the context of this research, is discussed in Chapter 5.

Table 2.1: Incidents of proven assaults and restraint incidents per 100 children by establishment type, April 2016–March 2017

<table>
<thead>
<tr>
<th>Establishment type</th>
<th>Average number of children per month</th>
<th>Number of proven assaults per 100 children per month</th>
<th>Proportion of children involved in assaults</th>
<th>Number of restraint incidents per 100 children per month</th>
<th>Proportion of children involved in restraint incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>YOI</td>
<td>861</td>
<td>9.5</td>
<td>10 per cent</td>
<td>15.3</td>
<td>13 per cent</td>
</tr>
<tr>
<td>STC</td>
<td>181</td>
<td>59</td>
<td>30 per cent</td>
<td>88.3</td>
<td>40 per cent</td>
</tr>
<tr>
<td>SCH</td>
<td>133</td>
<td>30.2</td>
<td>19 per cent</td>
<td>64.5</td>
<td>30 per cent</td>
</tr>
</tbody>
</table>


2.3.4 Prevalence of child sexual abuse in the youth secure estate

As highlighted in section 1.3, there is a lack of robust research data on the prevalence of child sexual abuse in the youth secure estate in England and Wales. HMIP collects self-reported data from children held in YOIs and STCs as part of the survey administered during the annual inspections, which has consistently reported relatively low overall levels of sexual abuse. In 2016/17, one per cent of children in YOIs and STCs reported being a victim of sexual abuse perpetrated by either staff or other children (HMIP, 2017b). It is likely that this survey does not capture all incidents of sexual abuse occurring within the youth secure estate for two key reasons. Firstly, the surveys are self-reporting and a child may not necessarily identify that they have been sexually abused or classify certain behaviours as abusive. Secondly, there may be a number of reasons why children do not disclose sexual abuse, including shame and embarrassment, fear of not being believed or of a negative reaction, and a fear about potential negative consequences for themselves or their family (Royal Commission into Institutional responses to Child Sexual Abuse, 2017). Indeed, the 2016/17 HMIP survey highlighted that only 28 per cent of boys in a YOI said that they would report any kind of victimisation to a member of staff and only 27 per cent thought that staff would take them seriously if they reported being victimised. This reluctance to report victimisation to a member of staff may be linked to some children having poor relationships with staff, a lack of confidence in staff's ability or desire to help them if they were being harmed, dissatisfaction with a complicated and impersonal complaints system or because they do not want to be seen as ‘grassing’,
which would leave them open to reprisals from other children, or in some cases staff (HMIP, 2018b; Mendez Sayer et al., 2018).

The Inquiry’s investigation into children in custodial institutions obtained data as part of its collection of evidence that provide an indication of the prevalence of reported child sexual abuse within the youth secure estate between 1 January 2009 and 31 December 2017. The evidence gathered indicates that there were 1,070 alleged incidents of sexual abuse and potentially 1,109 victims between 2009 and 2017. Recent years have indicated an increase in the number of reported incidents of sexual abuse, which may in part be due to higher levels of sexual abuse reported in STCs. Table 2.2 provides further detail on the number of alleged incidents by establishment type. Almost half of alleged incidents relate to abuse perpetrated by a member of staff. In 385 of the reported cases the alleged perpetrator was another child (Independent Inquiry into Child Sexual Abuse, 2018). Further detail on the prevalence statistics is available in the Inquiry’s investigation report.

Table 2.2: Population\(^8\) and alleged incidents of child sexual abuse by establishment type, January 2009–December 2017

<table>
<thead>
<tr>
<th>Year</th>
<th>YOI Population</th>
<th>YOI Incidents</th>
<th>STC Population</th>
<th>STC Incidents</th>
<th>SCH Population</th>
<th>SCH Incidents</th>
<th>Total Population</th>
<th>Total Incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>2,155</td>
<td>67</td>
<td>270</td>
<td>12</td>
<td>171</td>
<td>35</td>
<td>2,596</td>
<td>114</td>
</tr>
<tr>
<td>2010</td>
<td>1,661</td>
<td>58</td>
<td>275</td>
<td>25</td>
<td>177</td>
<td>21</td>
<td>2,113</td>
<td>104</td>
</tr>
<tr>
<td>2011</td>
<td>1,587</td>
<td>44</td>
<td>282</td>
<td>15</td>
<td>172</td>
<td>16</td>
<td>2,041</td>
<td>75</td>
</tr>
<tr>
<td>2012</td>
<td>1,300</td>
<td>33</td>
<td>265</td>
<td>14</td>
<td>142</td>
<td>19</td>
<td>1,707</td>
<td>66</td>
</tr>
<tr>
<td>2013</td>
<td>866</td>
<td>52</td>
<td>239</td>
<td>9</td>
<td>123</td>
<td>43</td>
<td>1,228</td>
<td>104</td>
</tr>
<tr>
<td>2014</td>
<td>738</td>
<td>29</td>
<td>257</td>
<td>30</td>
<td>105</td>
<td>30</td>
<td>1,100</td>
<td>89</td>
</tr>
<tr>
<td>2015</td>
<td>670</td>
<td>48</td>
<td>208</td>
<td>19</td>
<td>117</td>
<td>30</td>
<td>995</td>
<td>97</td>
</tr>
<tr>
<td>2016</td>
<td>638</td>
<td>84</td>
<td>144</td>
<td>79</td>
<td>107</td>
<td>40</td>
<td>889</td>
<td>203</td>
</tr>
<tr>
<td>2017</td>
<td>649</td>
<td>51</td>
<td>167</td>
<td>110</td>
<td>108</td>
<td>44</td>
<td>924</td>
<td>205</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>466</td>
<td>313</td>
<td>278</td>
<td></td>
<td></td>
<td>1,057*</td>
<td></td>
</tr>
</tbody>
</table>

Sources: YJB, 2018, Independent Inquiry into Child Sexual Abuse, 2018

Note: * In 13 incidents there was no information on the date and establishment in which the alleged incident occurred and therefore the total provided in the table differs to the overall total provided earlier in the text.

As with the HMIP data on prevalence of child sexual abuse in the youth secure estate, the data obtained through the Inquiry’s legal investigation does not include all incidents of sexual abuse that may have occurred in the youth secure estate given the barriers to disclosing. Additionally, some official records may not have been maintained or disclosed to the Inquiry. However, it provides the most comprehensive data currently available in relation to prevalence of child sexual abuse in the youth secure estate.

2.3.5 Culture in the wider custodial estate

Government publications cite a commitment to developing safe and rehabilitative prison environments (HMPPS, 2018b; MoJ, 2016) yet levels of violence, suicide and self-harm are continuing to hit

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8 Population figures are as of June of each year. The SCH population figures do not include those children held for welfare reasons.
unprecedented levels. There are ongoing concerns about the safety of establishments across the prison estate, including establishments holding children.

Levels of safety, trust, fairness, respect, staff professionalism and the judicious use of power are important principles that shape the prison experience (Crewe, 2011; Crawley, 2004; Liebling, 2004). How staff, and in particular operational staff, use their authority has a profound impact on the prisoner experience, including perceptions of safety, psychological wellbeing, order and on the overall ‘moral quality’ or legitimacy of custodial institutions (Liebling, 2004, 2002).

Authority in secure settings is pervasive and exercised in every interaction between staff and those in their care, making relationships the cornerstone of a safe and rehabilitative prison culture (Mann et al., 2018). The importance of increasing perceptions of procedurally just and fair processes and systems has also been associated with less misconduct and violence in secure settings as well as better psychological wellbeing (Beijersbergen et al., 2015, 2014).
Chapter 3: Methodology and ethical considerations
This chapter outlines the methodology of the research, including: the overall design and approach of the project; research ethics; site selection; the sampling strategy and summary of the final sample; and the approach taken to data management and analysis.

3.1 Methodology overview

The research used individual in-depth qualitative interviews to collect data on the experiences of safeguarding within the youth secure estate from the perspective of children residing in it as well as staff working in it.

We conducted a total of 48 interviews across four different establishments – 27 interviews with children and 21 with staff. Interviews were conducted in private rooms at each establishment away from the presence of others so that research participants could speak freely and confidentially. Interview schedules were used to guide conversations with both groups. This ensured a level of consistency between interviews but also allowed researchers to be flexible and responsive to individual participants. Each interview was conducted by two researchers, with one taking the lead and the other observing and following up where appropriate. The duration of interviews ranged from 14 minutes to 1 hour 20 minutes.

3.2 Establishments

The research took a case study approach whereby a small number of establishments were selected from the overall youth secure estate. A case study method is a common qualitative approach when investigating complex phenomena. In this instance, it allowed us to gain an in-depth understanding of practice in specific establishments and how and why certain practices work well or present challenges. This approach did not create generalisable data, representative of the whole youth secure estate, but allowed for a detailed exploration of safeguarding across the different types of establishments that the youth secure estate comprises.

When selecting establishments, we considered geographical spread to ensure both England and Wales were represented. A range of other institutional characteristics were also considered. For example, whether they were privately or state run, and if they were single or mixed sex establishments. The type of SCH was also considered to ensure that only those SCHs (10 of 17 SCHs) which accommodate children placed on both criminal justice and welfare grounds were considered for selection. This was to ensure we considered criminal justice cases in all the different types of youth secure setting to complement the custodial institutions’ investigation, but without unnecessarily excluding welfare cases. The population at each establishment was taken into account to ensure we achieved broad coverage in terms of the characteristics of children in our sample. These included: gender, age, ethnicity and sentence type. Given the small number of establishments of each type (at the time of fieldwork five YOIs, three STCs and eight SCHs), the extent to which it was possible to select establishments representing all of the above characteristics was limited. Establishments identified as case studies for the Inquiry’s investigation were excluded from this research. The sample selected at each establishment was broadly representative of its population at the time of the research.

Interviews were carried out across four different establishments – one YOI, one STC and two SCHs. Due to the comparatively small population size in SCHs compared to YOIs and STCs, two SCHs were selected to ensure the target sample of ten children per establishment type could be achieved.
3.3 Sample

3.3.1 Children

A sample of children aged 14–17 was identified at each establishment using population information held by the establishment. Children under 14 were excluded from the sample as they were considered unlikely to have the capacity to consent to participate in this kind of sensitive research. This age group also constitute a very small proportion of children held in the secure estate. The research set out to interview ten children from each establishment type (five in each of the SCHs). Children were selected randomly from a full population list, ordered by room location. We ensured our sample was broadly representative of the population held at each establishment at the time of our visit in terms of age, gender, ethnicity and sentence type. For ethical reasons, children with prior experience of sexual abuse (either within or prior to entering the establishment) did not form part of our sampling criteria.

We selected a reserve list of children at each establishment in the event of a child declining to participate or withdrawing. The profile and characteristics of children on the reserve list mirrored as far as was possible those on the initial list. We worked with staff at each establishment to ensure there were no concerns in approaching children to participate in the research, and ensure there would be no adverse impact on any child taking part in the research.

In total 27 children participated in an interview: ten from the YOI, eight from the STC and nine from the SCHs. We were unable to achieve ten interviews in the STC and across the two SCHs. This was because children either declined to take part or circumstances meant it was no longer appropriate for us to approach them, and there was no alternative child to approach once the reserve list and other possibilities had been exhausted.

The majority of the sample were boys aged 16 and 17 and approximately half of the children interviewed were from a Black, Asian and Minority Ethnic (BAME) background. This reflects the overall makeup of the youth secure estate population. The final sample included children on remand and serving different sentences for a variety of offences. It also included children being held on welfare grounds in SCHs. Further details about how children ended up in these secure settings were not explored in this research but they had spent a varying amount of time at establishments, ranging from one week to 22 months. Children came from a range of backgrounds. Many had previous experience of the secure estate or of non-secure care homes. The final sample included some children with specific vulnerabilities who had experienced previous sexual abuse, and some children who were receiving support to address sexually harmful behaviours. Experience of gang involvement and criminal exploitation were all represented in our sample. Characteristics of the final sample of children are broken down in more detail in Figure 3.1. To protect the anonymity of the children, these have not been broken down by establishment type.
Children were provided with an information sheet about the research prior to interview. Where possible, these were given to them up to 24 hours in advance to make sure they did not feel any pressure to participate. The research team then met with each child to reiterate the voluntary nature of the research and answer any questions before gaining informed consent. We took every child through the information sheet and consent form verbally before the start of each interview, and they were reminded that they could stop the interview at any time and decline to answer any question. As part of the information sheet, children were given information about who to contact should they wish to withdraw their consent after the interview, within a six-week period, should they no longer wish their data to be included in the research. They were also given contact details of local support services specific to the establishment.

3.3.2 Staff

We took a stratified approach to selecting staff to ensure we spoke to individuals from a range of professional backgrounds, at different grades, with varying lengths of service. This allowed us to capture the views of a cross-section of staff and the multidisciplinary roles involved in different aspects of safeguarding practice. The research set out to interview five members of staff in each establishment.

In total 21 members of staff participated in an interview; five from the YOI, six from the STC and five from each SCH. Staff from a range of disciplines were included in the final sample, including unit staff, healthcare staff (nurses and mental health teams), teachers, social workers, resettlement staff, designated safeguarding staff as well as senior management. Length of service ranged from one year to 18 years working in the youth secure estate. The variety in job role and service length allowed us to capture the views of staff from multidisciplinary backgrounds, with wide ranging experiences.

Characteristics of the final staff sample are broken down in Figure 3.2. Again, these have not been broken down by establishment type to protect anonymity.
3.4 Data collection and analysis

All interviews were audio-recorded, with the consent of the establishments and participants, to ensure an accurate record of the conversation. The audio recordings were transcribed verbatim and were coded using computer assisted qualitative data analysis software (Nvivo 11). Data from each transcript were allocated to broad categories, predetermined by the research team following interviews, then refined and tested. Material was then summarised and analysed using thematic analysis (Braun & Clarke, 2006) – a method for identifying, analysing, organising, describing and reporting themes found within a data set. These themes were not predetermined but rather developed as the data was interrogated.

3.5 Ethical considerations

The project was subject to rigorous ethical scrutiny both through the Inquiry’s own Research Ethics Committee and from the HMPPS National Research Committee (NRC), which governs research undertaken in YOIs and STCs. Approval from the Inquiry’s Research Ethics Committee was granted in January 2018. Approval from the HMPPS NRC was granted in March 2018. Approval and access in relation to SCHs were negotiated through direct correspondence with individual establishments.

There were several ethical considerations that had to be carefully managed. These included the following.

3.5.1 Safety of research participants

Ensuring the safety of research participants and researchers was of utmost importance and therefore measures were taken prior to and during the fieldwork. All researchers were enhanced level cleared by the Disclosure and Barring Service (DBS). All interviews were conducted with two researchers present. Whilst
it could be intimidating for some children to be interviewed by two adults, it was deemed important to protect both the children and researchers from any potential harm.

3.5.2 Informed consent

Informed consent was collected from all participants. This included consent for the audio recording of interviews. The consent process covered the purpose of the research, arrangements of who to contact for withdrawal from the research, confidentiality and anonymity and how data would be used and stored. Information on establishment specific support services available to participating children and staff was provided should they become distressed by the conversation. All interviews were voluntary and staff and children were asked to sign a consent form stating they understood what it entailed and that they were agreeing to participate.

Standard research protocol (YJB, 2016; ESRC, 2012; Shaw et al., 2011) is to seek parental consent for any research participants under the age of 16. Where it is not feasible or necessarily appropriate for parents to provide agreement, consent can be gained from a suitable alternative. When children enter the youth secure estate, the establishment becomes their ‘corporate parent’, in that they take on the responsibility for looking after and safeguarding that child. We therefore sought consent from establishments and relevant local authorities, where necessary (rather than parents).

3.5.3 Confidentiality

Every effort was made to maintain confidentiality of the research participants by minimising the number of other staff and children who were aware of their involvement. It was also reiterated to participants that the information they shared in the interview would be kept confidential and would not be shared with others at the establishment or linked back to them in any research reports. The only exception to confidentiality was if any participant disclosed information which suggested that either themselves or someone else was at risk of harm, or they disclosed any illegal activity, this would be passed onto the relevant departments both with the establishment and the Inquiry. This disclosure protocol was shared with all participants prior to interview and agreed with each establishment.

3.6 Limitations

There are some limitations with the research that need to be borne in mind when considering the research findings below.

It is not possible to generalise the findings from the four establishments included in the research to the wider youth secure estate. The sample size and number of establishments included in the research is small and therefore does not represent the entirety of the youth secure estate. During the selection of the establishments efforts were made to try to ensure they broadly represented the variety of characteristics of the population. However, it was not possible to ensure that all the differences were captured in the sample.

To ensure the research was ethically safe, we took the decision not to approach children under the age of 14. The research findings presented here do not therefore represent the experiences of the youngest age group within the youth secure estate, which may well be different to those of the children who participated in the research.

In one establishment there was a requirement to seek parental or, for those children in care, local authority (LA) consent for any children under 16 in order for them to be able to participate in the research. Given the desire not to seek parental consent as part of the research, and some difficulties in
obtaining LA consent in a short time frame, this meant that any child in the establishment aged under 16 was not able to be considered for the research. Therefore the final sample at this establishment was not representative of the entire population held there and the views of younger children were not captured. In one SCH, we were only able to speak to children held on welfare grounds who, given their backgrounds, are perhaps more vulnerable or have different perceptions of abuse than other children. These factors, combined with the sampling criteria and consent restrictions, mean the sample is not representative or generalisable to the wider youth secure estate.

All interviews were voluntary and participants had the opportunity to decline to participate or withdraw their consent. Some children declined to take part due to a clash with other activities or a decision was taken for ethical reasons that it was no longer appropriate to approach a child to take part due to existing vulnerabilities.

Finally, it is important to acknowledge the potential bias in some of the responses from participants. Given the purpose of the Inquiry is to investigate the extent to which state and non-state institutions in England and Wales have failed in their duty of care to protect children from sexual abuse and exploitation, there is a possibility that this affected the response of the establishments and staff to our questions. Staff may have been aware of our remit and this may have influenced the responses provided. There is also a real possibility that, linked to barriers to disclosing sexual abuse, the children did not feel able to openly discuss any issues and raise current safety concerns with researchers.
Chapter 4: Perceptions of safety in the youth secure estate
This chapter presents the general reflections of staff on the current climate of safety in their respective establishments and how they view their role in children’s lives. It also presents how safe children reported feeling, factors underpinning their sense of safety, and what their main concerns were about safety in these settings. Findings relating to how safe children felt from sexual abuse specifically are presented in Chapter 6.

Summary

- Establishments were making efforts to create safe environments and improve safety and safeguarding practice. Recent and ongoing change was notable.
- Children reported feeling safe in their respective establishments and believed that the necessary measures were in place to keep them safe. They perceived that staff had a duty of care to keep them safe and overall did a good job of doing so.
- Children’s initial reporting of feeling safe was relative – rather than absolute. They described feeling relatively safe compared to their previous experiences of other secure establishments. For children who were new to the secure estate, they felt safer than they had expected to before they arrived. For children placed on welfare grounds, the secure environment was a ‘safe space’ compared to the outside world.
- Children had concerns about their safety in relation to other children. Their main concerns were the threat and fear of physical violence and bullying, the general unpredictability of other children’s behaviour, and anxieties around who they were sharing a living space with.

4.1 Creating a culture of safety

Overall, establishments were committed to ensuring that children in their care were kept safe. Recent and ongoing change, including a desire to put effective safeguarding at the forefront of practice, was notable across all establishments – perhaps unsurprisingly so given recent inspection assessments of safety in the youth secure estate (see section 2.3).

“I mean it’s drummed into us from senior management all the way down the welfare of the kids is paramount and that everything is checked and double checked...”

Non-operational staff, SCH

A culture of safety and wellbeing appeared to be more embedded in some establishments than others. Staff in the STC and YOI in particular readily accepted that there was still room for improvement. However, it was clear that across all establishments, staff were reflecting on where change was needed and steps were being taken for the continuous improvement of children’s safety. This was evident in relation to a number of different practice areas. For example:

- management of the physical space
- how children were allocated to different units
- processes for recruiting staff
- the creation of new safeguarding roles and teams
- use of trauma-informed approaches to working with children
- a focus on training and upskilling and an appetite for more training amongst staff to help them better understand the needs and vulnerabilities of children in their care
- recognition of the need for more tailored responses to safeguarding concerns
- promotion of an open culture of challenge.
"We have now I think a staff team who are here for the right reasons, they’re committed to making sure that the young people are safe but ... building up that experience, building up you know that sort of level of challenge and that level of consistency in terms of you know expectations and standards of behaviour and things like that I think that’s where we’ve got kind of a little bit further to go."

Non-operational staff, STC

Staff recognised that the profile, needs and vulnerabilities of children in the youth secure estate have shifted over time and these continued to impact on the nature of safeguarding required. Staff identified a range of characteristics and backgrounds of the children in their care which chimes with the wider context set out in Chapter 2. Staff were alert to particular changes in the population, and a perceived increase in children entering the youth secure estate who have been involved in gang-related activity; have been criminally or sexually exploited in the community; and who have perpetrated more serious offences including violent and sexual offences. In the SCHs in particular, staff reported a perceived increase in the proportion of girls entering these establishments on welfare grounds, deemed at risk of or having experienced sexual exploitation. There was consensus among all staff that the children in their care are now presenting a more varied, challenging and complex set of behaviours, including extreme violence, sexualised behaviours, mental health concerns and self-harming behaviours. This highlights the importance of secure establishments being able to create a safe environment which is able to identify, respond to and manage individual children and their needs in safe and appropriate ways.

The majority of staff from across all establishments reflected on their role as a multifaceted one, contributing to the rehabilitation, education, and general improvement to the lives of children in their care. This was particularly notable in SCHs, where staff openly expressed a desire to work with and help vulnerable children and sought to nurture and stabilise them. They collectively encouraged them to learn and develop new skills in order to keep themselves safe in the community.

The majority of staff across the different establishments agreed that children in their care must, first and foremost, be seen as children first. While not mentioned by all staff, several viewed themselves as parents of the children for as long as they were in their care, and therefore as playing an active role in keeping them safe. In the SCHs in particular – and aligning with the context set out in section 2.1 – senior management described consciously trying to model a family structure in workforce dynamics.

"...and it’s the good parenting which supports all this, so first thing in the morning how are you doing, did you have a nice sleep, was there any worries..."

Non-operational staff, SCH

4.2 Children's general perceptions of safety in the youth secure estate

In exploring what safety meant to children in their respective establishments, children described this as being someone’s priority. They wanted and expected to feel safe in the environment they were in and protected from harm from others. Signifying the vulnerability of the population, and echoing staff descriptions of this, children also reported that safety was about being protected from themselves in terms of self-harm.

Children initially reported feeling safe in their respective establishments. This was not because they did not have concerns about their safety but rather, they believed the necessary measures were in place to protect them. They perceived that staff had a duty of care to keep them safe and overall did a good job of
doing so. However, when safety was explored in more detail with children, they did share insights which suggested they did not feel as safe as they initially indicated.

Children were relatively positive about the youth secure estate, describing it as better than expected, or at least no worse. They appreciated, for example: having the opportunity to learn through their education classes; being able to take on different jobs; being able to try new things and do 'normal' things like listen to music, all of which contributed to their general sense of wellbeing. Children in the SCHs in particular appreciated that the environment had been made 'homely' for them. They reported feeling that staff were genuinely dedicated to supporting them and preparing them for going back into the community through, for example off-site trips and targeted education interventions. Some reported their experience in the secure estate as beneficial and as having given them positive direction and guidance.

“I think they are keeping you safe yeah, I think it’s the best thing that’s ever happened to me, like, before I come in here I just used to do – think nothing but money, money, money you know what I mean, stupid. I used to go to any extent to get money you know what I mean, so once I’m in here I’ve sorted my shit out. I’ve got decent qualifications and that you know what I mean, so obviously when I get out ... I can do it the right way and not the wrong way.”
Child, SCH

Children in one SCH were given the opportunity to map the different areas within the establishment according to where they felt safe or unsafe. Staff were proactively monitoring how safe children were feeling and using innovative ways to improve their safeguarding practices and consider the views of children in fostering a safe environment.

“I get to say where I feel safe and where I don’t feel safe and everywhere I put was in green so I felt safe ... one of the unit staff just prints ‘em out and says here, say where you feel safe and where you don’t feel safe, so everyone just does it...”
Child, SCH

4.3 Factors underpinning children's sense of safety

The initial response of children who took part in the research was that they felt generally safe. Yet it is important that this is understood in the context of children’s perceptions of what these establishments would be like as well as their former experiences of other secure environments and their vulnerability in the community before they arrived. Four themes emerged in children’s accounts which are set out below and which highlight that children's initial reporting of feeling safe was relative – rather than absolute.

4.3.1 Expectations versus the reality of custodial life

Unsurprisingly, many children described feeling worried and anxious about the secure environment before they arrived. Concerns were primarily linked to a perception that they were entering an unfamiliar and hostile environment where they would be subjected to bullying and violence. These concerns were more pronounced amongst children living in the STC and YOI, and especially for those with no prior experience of secure environments. By virtue of their comparatively large size, and high levels of violence, YOIs have the more notable reputation for fighting and bullying. Children's perceptions had also been informed by media, peers and parents and were even reinforced by staff when they first arrived at the establishment.
“Where did you get that perception from that it was going to be fighting and bullying?”
- “It’s what prison is, innit? And like even officers will tell you.”
Child, YOI

There was, however, a general view that the reality of life in the YOI ‘wasn’t that bad’.

“It’s not that bad to be honest with you. I thought it was going to be fighting every day...”
Child, YOI

4.3.2 Feeling relatively safe compared to other secure establishments

The reputation of YOIs as violent environments was mentioned by children across the different establishments (see section 2.3). Linked to this, there was a sense of relief amongst those living in the STC or a SCH (with no prior experience of the youth secure estate) that they had been placed there instead of a YOI. As a result children believed they ‘must be safer’ where they were.

“I mean I think I’m relatively safe I think I’m safer in here than I would be in maybe a YOI.”
Child, STC

4.3.3 Familiarity with custodial life

Children who had experience of secure establishments described generally feeling safe where they were because they were accustomed to the custodial environment. They could articulate the pros and cons of different establishments and their preferences; this was based on having more freedom and time out of their rooms, having better facilities or food, and having better relationships with staff. However, their overall sense of safety was reported as being the same whichever establishment they were in.

“No, ’cause I’d been to like YOIs, STCs and that before, wasn’t ... it wasn't my first time, so it didn’t really like bother me, you get me.”
Child, YOI

4.3.4 The secure environment as a ‘safe space’

Some children felt safe in the secure environment they were in simply because they had felt unsafe in the community. Staff had confirmed that some children had experienced criminal exploitation as well as sexual exploitation before entering the youth secure estate. For these children, the environment had become protective and was physically keeping them safe from the outside world. This emerged as a particular viewpoint amongst children in SCHs who had been placed there on welfare grounds. For them, being in a secure environment meant they were no longer ‘at risk’ as they had perceived themselves to be in the community.

“They can keep you safe from outside of course, the door’s locked innit ... they’re keeping you safe from outside innit.”
Child, SCH
Children placed on welfare grounds often blamed themselves for ending up in a SCH. They were conscious of, and reliant on the time bounded nature of their stay to ‘make themselves’ safe enough to be in the community. In the course of sharing their views, the language children used indicated that they considered themselves to be the risk, and took on the responsibility of keeping themselves safe, rather than placing blame on those who exploited them. Perhaps this was not surprising when they were placed in a secure environment to protect them from risks posed by others, which could be a confusing message for a child.

“...Like obviously I'm in here for a reason, for them, for people here to work with me to help me to get back out in the community, so they feel like I'm safe enough to be back out there…”

Child, SCH

Children placed on welfare grounds also understood their time in a secure environment as a temporary experience – something keeping them safe for a limited period. It was expressed by children that without support in the community when they leave, they may well end up back in adverse and exploitative contexts.

“I don't think it’s effective, I just think, ‘cause at the end of the day yeah when they're 18, when they leave, whenever they leave this place yeah, they're gonna be back out there anyway, it's not a permanent thing, so they keep, the only thing that they can do is keep you safe for a limited amount of time. Does that make sense?”

Child, SCH

Staff shared these concerns. They were working with others such as local authorities to prepare children for their return to the community, however they recognised that keeping children safe once they left the establishment was largely out of their remit. Staff expressed frustration and a sense of helplessness about the continued safeguarding of children when they leave the secure setting, and the lack of ongoing support required for often very vulnerable children. This highlights the need for effective information sharing and ongoing multidisciplinary provision to ensure continuity of care for children when they leave.

4.4 Children's main concerns about their safety

Children’s main concern about their safety in these environments was being protected from other children. The potential for negative encounters between children was a much more salient issue for them than potential harm from staff or other adults. Children had three main interrelated concerns about other children which are set out below.

4.4.1 Threat and fear of physical violence and bullying

Threat and fear of physical violence and bullying emerged as one of the most prevalent issues. This was more pronounced in the STC and, in particular, the YOI, where the threat of violence and fighting was a recurring theme during interviews; despite children feeling that the levels of violence were not as bad as they envisaged. This links to section 2.3.3 which highlights assaults between children as an ongoing issue.
Movement around an establishment was highlighted as the time children felt most at risk of harm from other children. This was largely due to ‘mixing issues’ between certain children or groups of children where it is anticipated that if they cross paths, it will likely lead to some form of harm. Mixing issues arose because of previous incidents or existing hostilities between children due to gang rivalry or bullying. The allocation of children to specific units allowed staff to manage dynamics between children and keep them separated but movement around the establishment increased the likelihood of those separated coming into contact with one another. Movement between daily activities therefore required careful management to reduce this risk.

4.4.2 Unpredictability of other children’s behaviours

Children also had concerns around the unpredictability of other children’s behaviours. This was a broader issue than the threat of physical violence and bullying and was more closely related to the complex and challenging behaviours that children in these establishments can present. These concerns were driven by having observed children behaving in a certain way on the unit or having experienced certain behaviours directly. Children in SCHs in particular described feeling apprehensive around those with mental health problems or those known to self-harm. They deemed their behaviours unpredictable which therefore negatively impacted on their sense of safety.

“...It depends on what children are in your unit so you might get like an absolutely psycho child in your unit and if you’re sat in the room together that one child could kick off at any moment couldn’t they and obviously you don’t feel safe then, but if like them kind of children are out the way, apart from that you are safe.”

Child, SCH

4.4.3 Anxieties about who they were sharing a living space with

Children expressed anxieties which stemmed from the uncertainty of who they were sharing a living space with. They had concerns about sharing with children who were ‘criminals’ and felt they were an unknown entity. Some children expressed concern about how they themselves might be perceived by others.

This was a particularly salient issue in the SCHs which accommodate children placed on welfare grounds as well as those placed on criminal justice grounds. For those children placed on welfare grounds, they felt uncomfortable and worried about who they were sharing their daily life with. As an establishment rule (see section 5.4.8), children were not allowed to discuss their offences with other children. All establishments also considered which unit children were best placed on, although some managed this more carefully than others (see section 5.4.3). However, there were concerns amongst children that they were residing with other children who may have committed offences that they, or others, had been a victim of.
“If you think about it yeah, they’re putting us in here to take us away from drug dealers people like that, violence and that and now they’re mixing us up with all sorts of people like everyone here is violent or is a drug dealer or something like that. It’s mixing up with them so it don’t make sense.”

Child, SCH

Across all establishments, the prospect of sharing with children who had or were alleged to have committed a sexual offence was a particular concern for some children. This was influenced by a wider stigmatisation attached to this specific offence type (rather than feeling at risk of being sexually victimised).

“Like if I was in here with a rapist I’d fucking smash his head in, you know what I mean, and end up being here, and end up being here for longer, I’d end up being here on criminal you know what I mean?”

Child, SCH

The status of having committed a sexual offence, which was often wrongly attributed by others, served to heighten the threat of physical violence and victimisation for children. In the YOI, one boy reported having been physically victimised in an STC for being perceived as a sex offender.

“They think we’re all rapists ... and you do get a little bit anxious if they’re just gonna get up, just start beating you up, um ‘cause I had that before at [an STC] ‘cause I was the new kid, I went onto one unit and got rushed by seven people and pretty bad.”

Child, YOI

While not explicitly reported as a safety concern, there was also some discomfort expressed by boys about mixed-gender establishments or units, amongst those who were currently living with or who had lived with girls in secure settings. Concerns were due to having experienced changes in other boys’ behaviour who were more likely to ‘kick off’ in the presence of girls.
Chapter 5: Prevention measures and protective factors
This chapter sets out the various measures and protective factors intended to keep children safe and how these are viewed from the perspective of both children and staff.

Summary

- There were various prevention measures and protective factors in place intended to contribute to children's sense of safety and wellbeing. We categorised these as individual, interpersonal and operational factors.

- In terms of individual factors, some children were employing self protection strategies to help them feel safe, for example, projecting a sense of confidence to avoid being seen as 'weak'. Many (in the YOI in particular) described being in a constant state of vigilance. Children also had certain perceptions about which children were more or less vulnerable to, or capable of, harm depending on their physical size and strength.

- With interpersonal factors, meaningful positive relationships between children and staff emerged as a critical – and arguably the most important – factor to children feeling and being safe in these environments. Most children had at least one member of staff that they trusted and could talk to. However, a number of issues impeded children and staff from being able to build effective relationships including: a lack of staff continuity, and perceived breaches of trust.

- Operational factors such as staff recruitment processes, staff to child ratios, the allocation of children to units, management of the physical space, and information sharing, together played a critical role in safely managing the wider environment. However, children were not always aware of some of the operational measures in place to keep them safe – and knowing about these may have helped to alleviate some of their concerns.

- There were mixed views between children and staff in relation to some operational measures designed to contribute to safety, especially closed circuit television (CCTV) and body worn video cameras (BWVCs). It was also concerning to see how often restraint appeared as a theme in the accounts of children and staff and that there was no backstop against restraint being used on children with known past experiences of sexual abuse.

5.1 Overview of prevention measures and protective factors

We have grouped prevention measures and protective factors into three overarching categories. These are illustrated in Figure 5.1.
These factors do not operate in isolation but often interact and complement one another, and their effectiveness was influenced by how they combined with other measures. For example, the risk assessments in the initial allocation of children to units is one safeguarding measure in place to protect children but being alert to the changing dynamics between children can be supported by meaningful relationships between staff and children and supported by the use of CCTV. Children’s attitudes towards how staff attempt to de-escalate issues will also be influenced by the relationships they have with staff. Some measures viewed by staff as contributing to keeping children safe, in particular the use of restraint and technology, were not always viewed in the same way by children.

5.2 Individual factors

5.2.1 Self protection strategies

Children were often employing their own techniques to help them feel safe in these environments. Four key techniques were identified:

*Projecting confidence*

Safety for some children was seen as a self-determined state. Having – or at least projecting – a sense of confidence emerged as a self-preservation strategy children were adopting to keep themselves safe. Boys in particular talked about ‘confidence’ and were conscious to not be perceived as ‘weak’. They felt they needed to be seen as being able to ‘hold their own’ to help them stay safe. This could in part be linked to their preconceived ideas about these environments and taking on the responsibility of keeping themselves safe.
"I just think, it’s all in your confidence, you get me. If you’re not confident, you’re not gonna feel safe, innit ... If you’re confident, you’re gonna feel safe."

Child, YOI

**Vigilance**

Despite their initial reporting of feeling safe, many children described a heightened awareness of the environment which required a need to be vigilant at all times. In the YOI, this sense of vigilance was primarily linked to the threat and fear of physical violence.

"I think everywhere I feel on edge so when I’m outside my cell, it’s not a thing about me having nothing to worry about because it’s a jail innit so we always have to be on watch..."

Child, YOI

Linked to notions of ‘confidence’, being in a permanent state of vigilance could also be driven by a child’s personal biography and life experience prior to entering the youth secure estate. Some had simply become habituated to looking out for themselves.

"Obviously I’ve been, before I came in here, obviously I ain’t got a Mum or Dad innit ... I came here ’cause I was at a care home innit, I had a care home for like six months, seven months ... I’ve been on the streets for a long time so I have, so I’ve seen hella shit, I’ve had to look out for myself..."

Child, SCH

**Managing interactions with others**

Some children were consciously distancing themselves from or avoiding other children in order to keep themselves safe, stay out of trouble, and avoid being targeted in some way. Likewise, some children made a conscious effort to be pleasant and respectful to both children and staff as a way of keeping a low profile and not drawing attention to themselves.

**Using clothing as protection**

In establishments where children were allowed to wear their own clothes (STCs and SCHs), there were certain dress code rules in place (see section 5.4.8). However, girls were also themselves being mindful of how they dressed. This was largely in response to sexualised comments by boys, and developing their own strategies to help mitigate against it.

"The only thing that he kept saying and doing was talking about my body figure, not like bad stuff but like yeah you can comment every now and then but don’t go too far ’cause I don’t like it, it makes me feel uncomfortable and I said it to him and he stopped, but that was the only time I thought do you know what, no I’m gonna cover up a bit more now."

Child, SCH

Boys were also sometimes ‘layering up’ in the YOI and STC, which involved multiple layers of clothes for added protection against physical violence.
5.2.2 Physical characteristics

Linked to these self-protection strategies, children had certain perceptions about which children were more or less vulnerable to, or capable of, harm depending on their physical size and strength. This was particularly notable among boys.

“Maybe I did have a bit of a worry because when I came in I was a bit skinny, I was scared if I would get to fight I would lose and I would get beat up.”

Child, STC

“People might have a different opinion right, but me, I’m a big guy for my age and that, I won’t be scared of anyone, no-one, I’m not letting anyone in here affect me, like.”

Child, SCH

The strategies employed by children were in direct response to the environmental stressors which created a heightened sense of vigilance and a constant alertness to perceived threats. Children were taking on the responsibility of keeping themselves safe and created physical and psychological barriers to offset the harms posed by the secure establishment.

5.3 Interpersonal factors

5.3.1 Relationships between children and staff

Meaningful positive relationships between children and staff emerged as a critical – and arguably the most important – factor to children feeling and being safe in these environments. This chimes with research findings of the REA (Mendez Sayer et al., 2018) and the wider context set out in Chapter 2.

“What is it that’s helped you to feel safe?”

– “Um ... A bit of everything really but mostly I would say mostly the staff...”

Child, STC

The importance of meaningful relationships between children and staff

For children, having positive relationships with staff was important for three main reasons:

- Feeling that staff cared about them helped to make them feel at ease in a challenging and often unfamiliar environment.
- Staff knowing and understanding them meant they were alert to any changes in their behaviour (which could be an indicator of victimisation or distress).
- Positive relationships helped to facilitate disclosures if they had at least one member of staff they trusted and could confide in.

Staff too recognised that the quality of relationships between children and staff was key to keeping children safe. Having expertise and knowledge about children, alongside an ongoing commitment to safeguarding, were described as critical to fostering a safe environment and being able to identify and respond to any potential risk. Staff generally felt that they had a good relationship with children. They were using information from external agencies as a starting point for understanding them and
endeavouring to get to know them through ongoing monitoring and interactions. Staff recognised the importance of understanding children in order to monitor changes in behaviour and the underlying reasons behind certain behaviours they may exhibit. They widely acknowledged the difficulties in doing this if they did not know the child well enough. There was a shared consensus among staff on the importance of getting to know children. However, there was some variability within the YOI, with some staff particularly enthusiastic about this and in other cases, it was not mentioned.

Children characterised a meaningful, trusting relationship with a staff member if they were:

- approachable and easy to talk to
- honest
- reliable
- like a friend
- someone they could 'have a laugh with' and who got involved in activities
- someone who treated them in such a way where there was mutual respect
- someone who genuinely cared about their wellbeing, had time for them, listened to and looked out for them
- sympathetic to their background and what they had been through
- someone who was responsive to issues that arose
- someone who 'gets them' and could calm them down if they were angry or upset
- someone they could find common ground with.

“I just get along with them and can actually have a proper conversation, they don’t see me as a prisoner, they see me as a normal person.”

Child, YOI

“He’s Asian as well and he knows how it is innit, like [if] you’re not Asian, you don’t know things about Asian, so he knows everything, and when you get angry.”

Child, SCH

A number of staff also echoed these views.

“It’s about having, I think, a bit of a laugh with them like, ’cause at the end of the day, they’re kids, and it is quite a serious environment, is this, so you’ve just got to try and make them feel relaxed.”

Operational staff, YOI

This highlights the importance of staff being able to strike the right balance of approachability and professionalism, ensuring boundaries are upheld when necessary without undermining building effective relationships.

**Relationships with and attitudes towards staff**

All children reported that they had at least one member of staff they trusted and would confide in if they wanted to raise an issue. This was not always their assigned key worker or named officer – children mentioned unit staff, teachers, psychologists or a social worker. This was largely determined by frequency of contact and children having consistent and regular interactions with particular staff members.
There was, however, some variability in children's attitudes towards staff across the different establishments. Children generally spoke positively about staff in SCHs, but views were noticeably more mixed in the STC and YOI. Some children in these establishments felt that some staff did not care about them and their safety.

“Some of them just ain’t bothered ... Yeah some officers care and some don’t.”

Child, YOI

Overall, children described having a distant relationship with safeguarding staff. They had relatively little (if any) contact with them compared to other staff members. This was not necessarily reported as an issue by children. However, it appeared that greater visibility of and access to safeguarding staff could further improve safeguarding practice when it came to reporting and disclosure (see Chapter 7). This was being proactively addressed in one SCH, which viewed it as important for safeguarding staff to carry out their own independent welfare checks and ensure children were aware of them as another point of contact.

“I do pop down and try and say hello but sometimes it’s a couple of weeks after they come in when I’m able to do that which is why we’ve got [another person] alongside me now so that we can, they need to spend a lot more time down there on the unit, making ourselves known and part of the furniture sort of thing, doing welfare checks down there.”

Non-operational staff, SCH

**Barriers to building effective relationships**

A number of barriers emerged which impeded the ability of staff and children being able to build effective relationships, and hindered the ability of staff to develop an understanding of the children in their care and their individual needs. These are set out in Figure 5.2.
5.3.2 Relationships between children

Children often reported choosing to ‘keep themselves to themselves’ and just get through their time in the establishment.
"I do my best to get along with people ... even if I don't like someone I just try and put up with them and it's ... I just want to serve my time and get out."

Child, YOI

They largely felt that there was no point making friends while in the establishment. This was driven by an acceptance that they would not maintain contact with them when back in the community and for some an acknowledgement that they would not be there long enough to build friendships. A lack of shared commonality, for example a difference in age, and concerns around the criminality of other children were also barriers to forging friendships.

"We don’t really have friends in here, we just call them people we get along with."

Child, SCH

While children did not typically confide in one another, some did discuss feeling safer knowing they had at least some alliances with other children. In the YOI and STC in particular, this helped to reduce their concerns about the perceived risk of physical violence and unpredictability of other children. Having some ‘friends’ made them feel they had an extra layer of protection should they be at risk or experience harm.

5.3.3 Relationships with external agencies and between staff

As highlighted in section 5.3.1, poor information sharing from external agencies posed challenges for children and staff being able to form effective relationships. However, improvements in this area were noted by establishments.

“It’s definitely improved over the last few years ... we’ve set up better lines of communication with the local hospital, so we’ve got passwords and things ... we can ring up and access, you know, what treatment’s occurred, what’s happened to the young person, because two years ago, you know, eighteen months ago, we'd ring up and they wouldn’t exchange information, even though that young person was under our care...”

Non-operational staff, YOI

Good working relationships between staff members within and across different teams also emerged as a protective factor in these establishments. Staff reiterated the importance of having a sense of coherence, teamwork and support between colleagues. This was deemed important for the effectiveness of practical information sharing about children and handover processes, both of which impact on children’s safety. In the SCHs in particular, staff were also positive about the open culture of challenge promoted by management and being encouraged to look after their own wellbeing working in this tough environment. Some newer staff were also positive about drawing on the expertise of more experienced staff in how they went about their work.

“There’s people that have been here for such a long time that they are a fountain of knowledge which helps as well ’cause they can say well actually you know this may be the case or this is what I’ve experienced and sometimes you can, you can benefit from that.”

Operational staff, SCH

Across all establishment types, however, staff implied there could also be tensions between colleagues and a lack of consensus in how they worked together to safeguard children. In contrast to some newer
staff valuing the experience of longer serving staff, others expressed more negative attitudes which are explored in the subsequent chapters.

5.3.4 Family ties

Children reported that contact with specific family members generally increased their sense of safety and wellbeing. This was particularly pertinent given many of the children we spoke to were living many miles from home, or from where they had been living previously, so family visits were relatively rare.

“Yeah because if I know my family are coming, I know I can chat to them like about serious things but as ... I can speak to staff on a level but not the level I can speak to my family.”

Child, YOI

Staff in the SCHs also described the importance of children having contact with their families (where it was safe for them to do so) and for them to keep parents and carers updated on how they were getting on.

“I think it’s very important when somebody gives your child to know that uh you’re doing everything to, to keep them safe so I always like to keep them informed uh and aware of any kind of behaviour, good or bad.”

Operational staff, SCH

5.4 Operational factors

5.4.1 Staff recruitment

Across all establishments staff had various safeguarding processes in place in terms of how they recruited new staff. Safeguarding was considered at various points from an invitation to interview, during the course of an interview and throughout a probationary period upon appointment.

All establishments had the necessary Disclosure and Barring Service (DBS) checks as standard practice. Relevant qualifications, professional experience, and softer skills of candidates were reportedly assessed. Senior management recognised the requirement of candidates having a good understanding of child protection and being able to work effectively with particularly vulnerable children. Various scenarios were also being tested with candidates to ascertain how they would respond to certain situations, with some specifically intended to gauge an individual's propensity to report abuse. When appointed, new staff were monitored and attended various training sessions.

Greater importance was being placed on a more rigorous recruitment process. For example, staff in the YOI described a recruitment drive that was now more focused on ensuring staff had the right skills to work with children in secure environments. Likewise, staff in the STC recognised that, at present, staff did not necessarily have the right skills and aptitude to effectively work with children and keep units under control. They accepted that their recruitment process was something that needed greater attention and scrutiny, and that more work was required to retain staff.

5.4.2 Staff to child ratio

Having a high number of staff visibly present was another factor which helped children feel safe. Although children did not particularly like being constantly observed by staff, greater staffing numbers
provided them with reassurance, particularly given their concerns around other children’s backgrounds and behaviour.

“Well at first there’s, it’s not that nice because it’s just someone there 24/7 but at the same time it’s for your own safety as well because there’s mixing with criminal and welfare in here so, I dunno.”

Child, SCH

There was a much higher staff to child ratio in the SCHs. Staff in one SCH reported the ratio had increased from three to four staff for every nine children to four staff for every eight children. It was explained that the ratio could at times be one to one or even two members of staff to one child if there was a particular risk they were trying to manage.

By contrast, staff in the other establishments expressed the need for more staff on the units and recognised that staffing levels were not always adequate. As highlighted in section 5.4.1, staff retention and turnover also appeared to be more of an issue in the STC, and in particular, the YOI. In the YOI, it was acknowledged by some that having a full team on a unit also presented an opportunity to get to know children better, since staff could spend more time with children and provide more targeted support. More staff also enabled children to have more time out of their rooms, which is necessary for building positive relationships and increasing wellbeing.

“So that enables the young people to have more time with staff … [it means] slightly more time out their cells. The staff can, can talk to them more about their issues, can understand their issues a bit more.”

Non-operational staff, YOI

Children in the YOI reported feeling that there were generally enough staff around them ‘most of the time’ and this was reported as always two officers on a single unit. Given YOIs in general were made up of individual units that could accommodate 30–60 children (Mendez Sayer et al., 2018), this was a significantly lower staff to child ratio compared to SCHs. Children with experience of different establishments also reported feeling happier about the greater number of staff on the units in STCs and SCHs compared to YOIs.

“I’ve been here for four months on Friday, so I think this place is better than [YOI] because you’ve got more staff to look after you, if you get into a fight they do protect you...”

Child, STC

Across all establishments, staff were also trying to increase the visibility of other professionals on the units. This included safeguarding, education and social work staff. It was recognised that having multidisciplinary staff around was crucial to keeping children safe as children may interact differently to different staff.

5.4.3 Allocation of children to units

The dynamics of units was something that establishments were constantly managing in terms of the profile of children housed together on a single unit. Staff in the SCHs described in detail the range of considerations given to the intake of new children and in determining which unit they were best suited to. These factors included the child’s age, gender, physical characteristics, needs and vulnerabilities, offence type (if being placed on criminal justice grounds), and the current profile and dynamics of each
unit. Staff reported that unit allocation was revisited on a regular basis through ongoing observation and staff meetings.

“I’d be concerned about some of the mixes, so if we knew a new young person was coming in who was kind of a [child sexual exploitation] risk and was going onto a unit and we know the bedroom’s next door to someone in for a sexual offence you know that would kind of trigger things for me.”

Non-operational staff, SCH

It is important to acknowledge the unique risks that some establishments in the youth secure estate had to manage. The challenges of managing a population which is mixed in gender and/or status (welfare and criminal justice cases) should not be underestimated. Children in two mixed sites spoke to us about their concerns in mixing with other children, particularly in relation to the type of offences committed by other children of a sexual nature. There were several instances described by children who felt uncomfortable in the presence of the opposite sex.

Staff were reliant on information from external agencies about individual children to inform their decisions about unit allocation and it was again highlighted that this was often inaccurate.

“...’Cause we’re having children in here as you know um five foot and they’re only ten stone or something like that and we think oh he’s a bit slight, there’s some big boys on that unit, he’s been bullied before, we’ll put him over there and they come in six foot and 13 stone, so it makes a difference, it does make a difference so we start saying is it true, the description.”

Non-operational staff, SCH

Decisions about which establishment children are placed in are centrally managed by the Youth Custody Service. However, establishments also appeared to have some freedom in relation to which children they took in. Staff in SCHs for example, told how in some cases they had chosen not to accept children into the establishment where it was deemed that they posed a high risk to other children. They might also reduce their intake of children to ensure that those already living there were adequately staffed. In this sense, staff in these establishments were balancing individual and aggregate safety and wellbeing in their decision making.

“...and it’s realistically who we can keep safe ... if we had a 17 year old horrific sex offender 17 and a half making a referral here and we’ve got 12, 13 year olds, where are we gonna put that 17 year old?”

Non-operational staff, SCH

Careful consideration of risk and managing unit dynamics differed across the establishments. In the YOI and STC, the management of risk focused on fights and mixing issues (the biggest issue they were dealing with on a daily basis). Where specific individual needs were being considered in the unit allocations process, children (across all establishments) were not always aware of the diligence exercised by staff in relation to this. More assurances and communication around this may have helped to alleviate some of their concerns.

Children across establishments did report that they would ask staff to move units if they felt uncomfortable about living with a particular child. While they recognised this would not always be possible, there was a belief that staff would do their best to meet their request.
“Two young people, again it’s not necessarily related to sexual abuse but two young people just got, got switched units because neither of them were feeling safe on their units and they’re both now are feeling more settled on the units.”

Non-operational staff, SCH

While this could be seen as a positive, simply removing children from situations arguably does not necessarily address issues at their root. Furthermore (as highlighted in section 5.3.1), it could also result in children being removed from members of staff they had positive relationships with.

5.4.4 The physical space

Design of the physical space

There were several features of the physical space designed to protect children from harm and which contributed to children’s feelings of safety. For children who considered the secure environment as a ‘safe space’, doors being physically locked increased their sense of safety. More broadly, private rooms and private shower cubicles also helped children to feel safe. Many reported having felt anxious about the prospect of shared rooms and communal shower areas before they arrived. While the shower area was communal in the YOI, individual lockable cubicles had been installed. Staff also reported recent improvements to the physical space including the removal of ligature points (to reduce the risk of suicide and self-harm).

“We spent months and months making sure we’ve got the safest rooms we could possibly have. There’s no ligature points. We even took off the battens over the windows and put velcro on for their curtains.”

Non-operational staff, YOI

In terms of increasing wellbeing, some establishments offered children the opportunity to personalise their own space – albeit to varying degrees. The principle of normality was promoted most noticeably in the SCHs where children were encouraged to personalise their rooms with their own duvet covers and posters on the walls. Staff assisted in making communal rooms and outside spaces pleasant for children to be in.

Management of the physical space

There was an acute awareness amongst both children and staff that management of the physical space and dynamic security was key to keeping children safe. In particular, the movement of children around the establishment, for example walking from their rooms to education, was something that needed careful management and coordination. Linked to staff to child ratios, having enough staff on duty throughout movement was critical to preventing and responding to issues arising. Managed movements were put in place, for example, when a child or group of children were known to have a problem with one another and required ongoing separation. As discussed in section 4.4.1, this was a particular issue in the YOI and STC. Similarly, managed movements were put in place if a child made some form of allegation against another child. In some cases, children were managed as ‘lone movers’, moving around the establishment on their own and at different times to other children.

Staff across establishments described how such issues would be communicated and revisited via scheduled staff meetings and daily briefings as well as through ongoing risk assessment of the children concerned. It required staff members more widely to be vigilant and aware of potential risk. Children relied on staff being aware of which other children they needed to be kept away from. Overall they
were positive about the responsiveness of staff to prevent issues and intervene when needed, although recognised that improvements could still be made to further minimise the risk of incidents.

“Sometimes like the staff that are in the classrooms are quite good and they know who’s in their class or not, so they say don’t open the door or they run to the door and stand there, then sometimes a fight happens, but it gets stopped pretty much within like two minutes maximum.”

Child, STC

The management and risk assessment of movements appeared to be particularly challenging in the YOI and STC compared to SCHs. Their relatively large size meant that a greater number of movement interventions were needed, making the logistics of movement more complex in these establishments. There was some variability in terms of the confidence and trust children had in staff to keep them safe. This was driven by three things:

● Children perceiving that members of staff were not physically strong enough to separate children if needed.

● A perception that new members of staff were not fully informed about mixing issues or did not have the confidence to intervene if they needed to. There was a perception that staff who had been there for longer or were more senior were more proactive and ‘hands on’ in terms of preventing fights from happening.

● As raised in section 5.3.1, there was the perception that some staff simply did not care enough to intervene and just ‘let fights happen’.

5.4.5 Technology

Closed circuit television (CCTV)

CCTV was present across all of the establishments and had become a ‘normalised’ part of the secure environment. Children perceived it as offering some protection from potential harm by staff, believing that staff would not ‘try anything’ knowing they were on camera. CCTV was perceived to be far less of a deterrent in relation to other children’s behaviour, which was the prominent safety issue for children. Children would still initiate or participate in fights and the presence of CCTV had little impact on their behaviour. This was reinforced in the levels of violence seen across the youth secure estate – particularly in the YOI and STC.

Staff were using CCTV for general monitoring and surveillance of both children and staff. It allowed staff to dynamically monitor hot spots and ‘risky’ areas within the establishment from a central location. For example, in the YOI, staff were aware of the key times and places when a fight was more likely to happen. CCTV as a surveillance tool enabled staff to monitor interactions and intervene quickly to defuse situations.

The use of CCTV for monitoring staff was more commonplace in SCHs (which were much smaller in size). In one SCH for example, it was valued by safeguarding staff who would utilise CCTV for carrying out ‘spot checks’ on staff doing the nightly checks of children in their rooms.
“So we are in a bit of a privileged position I suppose because I go and view CCTV footage and it’s mainly around staff members checking young people in their bedrooms then I could possibly see some inappropriate interaction then I would have to um report it, I haven’t as of yet thank goodness and I hope that I never do but the fact that we do those spot checks on people means that things could be picked up and people are aware that we do the spot checks as well.”

Non-operational staff, SCH

It was recognised however that CCTV should not be relied upon too heavily and that it did not always deter and influence behaviour in the ways in which it was expected. The normalisation of constant and heightened levels of surveillance and monitoring of staff and children in secure settings was arguably not ‘normal’ or indicative of a safe and rehabilitative environment. An over-reliance on CCTV could undermine communication and erode trust between staff and with children. Likewise, a reliance on cameras could mean children become less likely to report incidents where they are aware there is no footage to support it (see section on body worn video cameras below).

While there were CCTV blindspots across all establishments, children in the YOI and the STC reported that there were more blindspots in these particular establishments that could be exploited. This is perhaps unsurprising due to their larger size and populations. In the STC, for example, there were no cameras in classrooms, and there were blindspots in the laundry room and gym areas. The children we spoke to did not report feeling unsafe in these areas, but were reliant on staff keeping them safe in these spaces. This suggests that children wanted and expected some alternative form of protection in spaces not covered by CCTV.

CCTV was perceived to be a valuable tool in capturing evidence, and was of most value post incident, rather than acting as a deterrent and preventing incidents. This is discussed further in the context of reporting safeguarding concerns in Chapter 7.

**Body worn video cameras (BWVCs)**

BWVCs had been introduced in three out of the four establishments and were a relatively recent or ongoing investment for some. Staff generally praised their introduction, seeing them as being able to evidence how situations were de-escalated and, where children were physically restrained, that the procedure was managed and carried out correctly and without causing physical harm to the child. They were also positive about the added value of BWVCs being able to record sound (which CCTV does not). This was viewed as helpful for those watching the footage to understand the fuller context of situations and better support the process of recording and reporting restraint incidents.

“When a young person is in the room being restrained there’s no video to support it and that’s where the document is used with the footage to say does the document match the footage and within the bedrooms you can’t do that, so the body worn cameras were bought for that reason alone.”

Non-operational staff, SCH

Staff also valued BWVCs for filling some of the CCTV blindspots and protecting themselves from any allegations made against them by a child.
"If like a young person goes to do their washing and they don't know how to use the washing machine, we would switch our cameras on and step in... so that at least we've got evidence, like we were just helping with the washing machine or something in case they made any allegations."

Operational staff, STC

For children, BWVCs had little, if any, impact on how safe they felt in these environments. Given that children's main concern about their safety related to potential harm from other children, it was perhaps unsurprising that children held this view as they perceived BWVCs as solely serving the interests of staff.

"That's for their safety innit."

Child, YOI

These attitudes were underpinned by the knowledge that staff have control over the cameras and when they choose to turn them on. There was a sense that their usage was generally low and inconsistent and that they were not always turned on during restraints.

"They're just not turned on."

Child, YOI

Children's scepticism was at times reinforced by their own negative experiences of when BWVCs had not been turned on. One boy described an experience in the establishment he had been in previously, of being beaten by staff in his room during restraint but that his claim was disregarded because there was no evidence. Negativity towards BWVCs was more notable amongst children in the YOI and STC. This is likely due to them being larger sites, where fights and physical violence, and thus the use of restraint, appeared to be more common. The discretionary nature of BWVCs can increase levels of mistrust and undermine relationships, and establishments must ensure a fair and consistent approach to their use.

5.4.6 Restraint

The use of restraint as a mechanism for managing children's behaviour and de-escalating incidents to prevent harm was mentioned by staff across all establishments. The Minimising and Managing Physical Restraint (MMPR) system and the Management of Actual or Potential Aggression (MAPA) system were the two methods of restraint mentioned by staff, both of which are built on the premise that the physical restraint of children, and use of force, should only be used as a last resort. This aligns with international standards which state that restraint and force may only be used when the child poses an imminent threat of injury to themselves or others and that restraint must never be used as a means of punishment or as a disciplinary measure.

MMPR was in use in the YOI and STC and included two pain inducing techniques. The MAPA system – based on hospital methods and designed to avoid pain compliance – was advocated by SCH staff for being the safest approach when working with children. SCH staff were insistent about using restraint as a very last resort when other techniques had failed to calm children down. Where restraint was deemed necessary, children were automatically checked for injuries by health staff. One girl in a SCH did however report feeling distressed at having witnessed another child being restrained in an extreme situation, and had complained to staff about it.

In the YOI and STC, the likelihood of restraint appeared high and during interviews children readily described the possibility of being restrained. For example, they accepted that if they were involved in a
fight that staff were struggling to defuse, restraint was a likely outcome. For some children, the possibility of restraint served as a disincentive from getting involved in fights. In describing their experiences of living in an SCH compared to other types of establishments, one child also described having witnessed and experienced more restraint in other types of establishments.

“Like other [sites] like they will restrain you to your room, these lot they try to talk to you first. They said come out when you’ve calmed down.”

Child, SCH

One boy believed that in some establishments, there were staff who actually wanted to hurt children during the restraint process, but this view was not shared by children in the other establishments.

“No [it depends where you go like], they wanna hurt you, they’re gonna hurt you.”

– “Do you think that ever happens, people actually want to hurt the young people?”

“Yeah.”

Child, SCH

However, children in the STC did say that staff needed more training on how to restrain. Likewise in the YOI, staff thought that children's complaints in relation to restraint sometimes reflected a lack of understanding of MMPR as a practice. Across all establishments, children were checked for injuries following restraint, although healthcare staff sought more training on MMPR in order to be able to accurately assess any injuries.

The REA highlighted that where children had previously experienced sexual abuse, the use of restraint could be a highly traumatic experience (Mendez Sayer et al., 2018) and this issue emerged during our fieldwork. In the YOI, staff described a scenario of a child reacting particularly badly to being restrained because of their prior experience of sexual abuse. Similarly, there were challenges around some children wanting to be restrained for reasons linked to previous experience of abuse, and the need to question if there were children being repeatedly restrained. These issues draw attention to the importance of restraint as a last resort but also being mindful of (and having sufficient information about) children’s individual backgrounds when restraint was deemed necessary.

“There was a young person who was restrained and the staff were really upset after the restraint because of how he reacted and I wasn’t here, so they got another social worker to go and see him and the whole staff team was distraught…”

Non-operational staff, YOI

5.4.7 Monitoring and information sharing

The constant monitoring of children was another way in which they were being kept safe in these environments. Children and staff in the STC and SCH in particular had more to say on this particular method of keeping children safe, although staff in the YOI were vigilant about ensuring children did not go into each other’s rooms and monitoring mixing issues. In the STC and SCH, the risk of harm was minimised by the fact staff were around children and monitoring them more heavily.

Staff were monitoring children’s conversations with one another and intervened if they veered into topics deemed inappropriate – including if these were sexual in nature. This also included monitoring verbal and
non-verbal interactions and exchanges between children, changes in mood and behaviour and – in mixed
gender settings – physical closeness of boys and girls in communal spaces. Interactions between staff
and children were also closely monitored, with staff in one SCH describing nightly checks on units always
being carried out by staff in pairs.

Staff utilised their knowledge about children to inform their monitoring, for example, keeping a
particularly watchful eye or ‘shadowing’ children in relation to known risks and vulnerabilities. Staff
also kept their own records of children’s behaviours and updated daily logs to track them and ensure
any issues were shared with staff coming in for the next shift. Children’s behaviours, interactions and
needs were also assessed through daily centre briefings and assessment forms. Overall, information
sharing in relation to monitoring children was reported to be working relatively well and staff attributed
detailed recording and post incident review as helpful in learning lessons. However, it was noted that
improvements in communicating and sharing information, particularly between different teams with
external agencies when concerns were raised were required. These issues are discussed further in
Chapter 7 in relation to the reporting process and management of safeguarding issues. It was also evident
that more needed to be done to tackle certain behaviours, for example problematic sexualised behaviours
between children – a particular challenge staff were facing in the STC. They were utilising daily logs as
well as a separate sexual behaviour log to monitor this. However, there were concerns that more needed
to be done to properly address this issue above and beyond tracking behaviours through monitoring and
record keeping. This issue is also explored more fully in Chapter 6.

5.4.8 Establishment rules and incentive schemes

There were a number of ‘establishment rules’ in place intended to keep children safe. For example,
children placed on criminal justice grounds in SCHs were not allowed to disclose their offences to other
children. This was designed to reduce any potential prejudices against other children, and mitigate against
targeted victimisation. As described in earlier sections of the report, however, it was evident that the
uncertainty of who children were sharing with could also lead to misattribution of offence types and
general anxieties about the unknown.

As part of establishment rules, children were given incentives for ‘good’ behaviour and were sanctioned
for ‘bad’ behaviour. For example, if children are involved in fights, their television may be taken away.
Children could also have points awarded or deducted in accordance with their behaviour, which
determined the level of privileges they received. At the top end of the scale children may receive
more time out of their room, more activities, more or longer phone calls, or access to a games room.
Unsurprisingly, these privileges had real currency for children who were locked behind closed doors and
seemed to contribute to their overall wellbeing. Many endeavoured to get to – and stay – on the top tier
of the system. Some children also reported feeling relatively safer on ‘gold’ or ‘platinum’ units amongst
other children also on that level.

Staff recognised that some establishment rules, and the loss of privileges and sanctioning of behaviour
were not always helpful and could do more harm than good. For example, removing a child’s television
could actually put them at risk of harm.

“After doing the adjudication, we give them the telly back, ‘cause it ... if you’ve got a kid with mental health
problems or is worrying about so-and-so or ... or is self-harming or ... why take away the only distraction
they’ve got?”

Non-operational staff, YOI
Staff in the SCH in particular discussed the importance of children having the opportunity to behave ‘how a child should’. They were conscious about children’s reintegration back into the community and, as part of this, wanted children to have the opportunity to do normal activities such as playing games and watching television.

Across all establishments, staff spoke about the different rules designed to promote safety, both in relation to children’s interactions between each other and with staff. For example, children were not allowed to touch each other and, in the STC and SCHs (where children were allowed to wear their own clothes), certain dress code rules were enforced.

“They have to wear sleeves, no vest tops, no cut-off t-shirts like that any shorts have to be to the knee, there’s no belly tops like that, so the girls are not allowed to wear leggings of the sort like they’re see through, they have to have proper quality, they can’t wear any you know explicit things.”

Non-operational staff, SCH

In this sense, children were not always able to behave in ways that may be ‘normal’ in the community. These boundaries and rules concerning behavioural interactions emerged as the most complex area in managing children’s safety, presenting a range of challenges which are discussed in Chapter 6.
Chapter 6: Perceived risk of child sexual abuse in establishments
This chapter presents the research findings relating to the perceived risk of child sexual abuse occurring in the various establishments visited. It explores current levels of knowledge and awareness of child sexual abuse among children and staff and also draws attention to wider challenges around behavioural norms and determining appropriate and inappropriate behaviour in these settings.

**Summary**

- **Child sexual abuse did not emerge as a significant issue or concern for the children that were interviewed.** Both staff and children perceived that the risk and opportunity for child sexual abuse to occur in their respective establishments was low. There was a widely accepted belief among children that child sexual abuse 'couldn't happen here' or 'wouldn't happen to me'. This was due to the range of prevention measures and protective factors in place – most notably meaningful positive relationships between children and staff. However, a number of issues emerged in relation to this that were critical to keeping children safe.

- **Children had a limited understanding of child sexual abuse and the range of behaviours constituting it.** Education on this topic was not offered to children as standard in establishments and was instead limited to targeted interventions for those who have been identified as needing particular support in this area. Children were therefore not always able to identify abusive behaviours.

- **Levels of knowledge and understanding of child sexual abuse amongst staff also varied.** More emphasis was being placed on training by senior management but the extent to which staff had received training was inconsistent and varied by role.

- **Managing appropriate and inappropriate behaviour in the specific context of the youth secure estate was challenging.** The rules and boundaries around behaviour were different to those in the community and it could be difficult for both children and staff to decipher and negotiate what was and was not appropriate in this setting. The impact of being in a secure environment also had certain negative implications for children whereby behaviours that were identified as inappropriate came to be seen as acceptable in this environment.

### 6.1 Perceived risk of child sexual abuse: children's perspectives

Child sexual abuse did not emerge as a significant issue or concern for the children that were interviewed. Chiming with recent HMIP survey results (as set out in section 2.3.4), there was a prevailing belief that child sexual abuse simply ‘could not happen here’ or ‘wouldn’t happen to me’. This response was consistent across all establishments and was driven by a number of the individual, interpersonal and operational factors set out in Chapter 5. These are discussed below.

#### 6.1.1 Individual experiences and perceptions about themselves and other children

Children reported feeling safe from sexual abuse because they had not directly experienced or witnessed sexual abuse since they had been living in the establishment.

“I don’t think sexual’s our problem in here. I think it’s more violence and that, you get me.”

Child, YOI

They also had certain beliefs about which children would be more likely to experience sexual abuse, if it were to occur. For many, there was a belief that ‘it wouldn’t happen to me’. This was linked to the self-
protection strategies they were adopting (see section 5.2.1) such as ‘keeping themselves to themselves’ and the perceptions they held about other children. They perceived that children who were younger, ‘small’ and ‘quiet’ were more likely to be sexually victimised. This view was predicated on the belief that these children would be more easy to manipulate; would likely not fully understand what was happening to them and would be less likely to report it. Children recognised that an imbalance of power could exist between two children as well as between an adult and a child. Interestingly, however, no children reported that they themselves felt more at risk of sexual abuse than their older or ‘bigger’ peers, despite some feeling this way in relation to physical violence and bullying.

“No-one on our units would be like, like vulnerable like that...”

Child, SCH

Children also believed that being well behaved would make them less likely to be victimised by a staff member, compared with other children who ‘misbehaved’ more. Similarly, complying with establishment rules that children could not have sexual relationships with each other, was also perceived as a protective factor. One girl held the view that not being ‘in a relationship’ with another child minimised the risk of being sexually abused because they would not be putting themselves in a position where they could be taken advantage of.

6.1.2 Confidence in staff

There was some acknowledgement of the power imbalance between staff and children in the secure environment and that it was always a possibility that a child could be sexually abused by staff while in their care. Overall, however, children reported feeling that staff were professional, took their jobs seriously and cared about their wellbeing. Children stated that staff were simply ‘not like that’ and that the stakes would be too high for staff to ‘try anything’ in terms of putting their jobs and careers at risk. Children felt that staff were ‘on top of things’ and would not allow sexual abuse perpetrated by staff or other children to happen, and if it did they would take action immediately.

6.1.3 Confidence in prevention measures

Children believed that the various measures in place to keep them safe would inhibit the opportunities for sexual abuse. Children’s perceptions of safety from sexual abuse were largely influenced by: the presence of CCTV (in relation to potential sexual harm perpetrated by an adult or staff member); the number and presence of staff (in SCHs particularly); the general monitoring of both children and staff; design of the physical space (such as private rather than communal showers); and rules of the establishment (specifically that children were prohibited from having a sexual relationship with another child whilst living there). Children recognised that there were certain places in the establishment where there was more opportunity for sexual abuse to occur, for example, places where CCTV was not present. However, overall, it was felt that the various mechanisms in place did a good job of keeping children safe from sexual abuse.

“No like sexual abuse happens here because it just can’t, everything is monitored 24/7.”

Child, SCH
6.2 Children’s awareness and understanding of child sexual abuse

While children perceived the risk of child sexual abuse to be low in their respective establishments it is important that these perceptions are considered within the context of:

- their understanding and awareness of child sexual abuse and exploitation
- their understanding of healthy relationships and sexual behaviours more broadly
- the contextual ‘norms’ that manifest in the youth secure estate.

6.2.1 Level of understanding

All the children we talked to had a very limited understanding of child sexual abuse, its nuances, and the continuum of behaviours that constitute it. This is not to say that they were at an increased risk of child sexual abuse, but it highlighted the risk that they may not necessarily recognise behaviours that are harmful or abusive.

“I wouldn’t really know what to look for to be honest.”
Child, STC

Some children had a greater understanding of child sexual abuse than others, referring to concepts of consent, and a recognition that child sexual abuse could constitute abuse by both an adult or another child. However, child sexual abuse was commonly understood in the ‘extreme’ form of rape. Likewise when children were asked about child sexual exploitation specifically, there was some reference to notions of power, grooming, manipulation and sharing images. However, children’s understanding of child sexual exploitation as a particular form of sexual abuse appeared to again be patchy and narrow – or lacking altogether.

“I don’t even know what [child sexual exploitation] is.”
Child, YOI

One boy understood child sexual exploitation to mean ‘child porn’ and others reported having never heard the term before the interview. Girls who were known to have experienced child sexual exploitation were unsurprisingly better able to talk about what this meant. For example, one girl referenced elements of exchange by way of gifts and of having understood one of the perpetrators to be her boyfriend at the time (consistent with the child sexual exploitation ‘boyfriend model’).

Similarly, one boy used his experience of criminal exploitation as a proxy for understanding that sexual exploitation must be about children being ‘used’. However, children were generally open and upfront about the fact they knew very little about these topics, often giving the explanation of ‘I don’t know because it never happened to me’.

6.2.2 Basis of understanding

In the community

Some children had vague recollections of having covered topics such as child sexual abuse in school (as part of Personal, Social, Health and Economic Education lessons). However, the limited understanding they had was more typically credited to the media through news, documentaries and recent campaigns
around sexual harassment. In general, children had not received any formal education about child sexual abuse unless they had been provided with or were currently undertaking a targeted intervention. This was usually in response to a specific vulnerability or following known incidents of sexual exploitation in the community.

**In the youth secure estate**

Education about healthy relationships in the different establishments was infrequent and children were not currently offered, as standard, education about child sexual abuse or healthy sexual behaviours.

Children who received education on this topic were those who had been identified as needing particular support around child sexual abuse or harmful sexual behaviour. Amongst children in one SCH for example, some had been specifically allocated a child sexual exploitation worker (either before and/or since they had arrived in the establishment) – someone who worked with that individual to help them better understand and make sense of recent experiences. This was typically arranged and facilitated by the establishment and often provided by external agencies such as Barnardos, Child and Adolescent Mental Health Services (CAMHS) and Blast.

Children who were or had received targeted support were surprised by the numerous different ways child sexual abuse can manifest and reinforced the value of what they had learnt. They praised the education they had received in having helped them understand sexual exploitation as they had not previously recognised their experience as abuse. Some felt that if they had been given this knowledge earlier, it may have prevented them from being victimised in this way.

> “I learnt a lot from there obviously I had sessions where I was really emotional, I was always crying, I didn’t realise what happened to me, I didn’t realise what was happening to me and it put me down really like quite a lot, really badly because I thought like wow, I thought that would never happen to me and it did so it was, it was quite, I was really shocked, really shocked.”

Child, SCH

**6.2.3 Behavioural boundaries and contextual norms: challenges for children**

Children found it challenging to determine what sexual behaviours were appropriate or inappropriate. This was in relation to behaviours between children and was not just in the context of the secure environment but also in the community. Children reported that in the community they would often rely on their peers to help them determine whether something was acceptable or not. In the outside world, peers appeared to be particularly influential in helping them make sense of what was ‘normal’. This was perhaps unsurprising given the lack of education children had reportedly received on sexual abuse and healthy relationships.

The secure environment presented even more confusion for children. The boundaries of what behaviours were appropriate or not were different in the youth secure estate versus the community. Many behaviours that would be deemed ‘normal’ in the community were considered inappropriate in this environment. For example, being tactile with a peer. Having to decipher and negotiate appropriateness of behaviour within this context – and the culture and rules an establishment enforced – was incredibly challenging for children. Sometimes children only learn when they or someone else has behaved inappropriately when they are reprimanded for it. The secure environment demanded a rigorous and consistent approach to managing risk and challenging behaviours but needed to support children in their understanding of what was normal behaviour in an abnormal environment.
Children told us that they found it difficult to distinguish appropriate or inappropriate behaviours between children in this environment. This was compounded by a lack of education in this area. Children were not typically able to recall any information about establishment rules on arrival. As in the community, children reported that they would sometimes confer with other children to help them determine what is acceptable behaviour. However, most children negotiated these boundaries themselves given they did not necessarily have ‘friends’ in this environment. Staff recognised the difficulties children faced in knowing what was and was not appropriate, attributed in part to the limited education they received. They also recognised that they were adolescents and in an environment which operated a very different set of behaviour rules.

“I don’t know if the young people necessarily know what is right or wrong and it is a confusing time for them generally anyway but given that they have hormones flying all over the place … it’s just a testing time in general but I do feel they at least know how to ask the question on whether it’s right or wrong.”
Non-operational staff, STC

Further compounding this issue was the impact of the secure environment on children’s (arrested) sexual development and identity. A number of children (boys in particular) expressed frustration with being behind locked doors with no sexual outlet or opportunity for sexual development.

“All the [young people] here are sexually frustrated.”
Child, SCH

This appears to engender certain attitudes and perspectives whereby behaviours that are unacceptable can come to be seen as acceptable and ‘normal’ in the context of a closed environment. One striking theme to emerge from interviews with children was that even if they were to identify certain sexual behaviours (of other children or staff) as inappropriate, this did not necessarily mean that they would render it unacceptable.

In particular, a recurring theme in our interviews with boys related to how they would respond if a female member of staff were to act in a sexually inappropriate way towards them. Boys found it difficult to imagine situations when this would be unwanted by them or other boys. This attitude was held by boys in all establishments, although most pronounced in the YOI, likely because of its male-dominated environment and the fact that overall they were a slightly older group of boys.

“I think any [young person] here yeah, to have a sexual conversation with a lady, would be over the fucking moon…”
Child, SCH

These ‘norms’ in the secure environment had implications for how children would respond to sexual abuse and sexually inappropriate behaviour experienced by themselves or others in these settings, and their propensity to report. Disclosure and reporting are discussed in more detail in Chapter 7 in the context of wider safeguarding processes.

While we did not explicitly ask this question, none of the boys reported having had any inappropriate sexual behaviours directed at them by staff in their respective establishments and felt that the opportunity for this was minimal. Some children did however share negative experiences relating to their time in previous secure environments in relation to how they or another child had been treated by staff. For example, one child reported having been touched inappropriately by a member of staff during
a restraint and another reported hearing a member of staff talking in a sexualised way to another child. However, these incidents were not considered by children in relation to sexual abuse.

As a wider point about the youth secure estate environment, violent behaviour was also described by some children as an expression of frustration of being locked up for long periods of time. This was interesting to consider in light of physical violence being one of children's main concerns about their safety in this context.

“...So like young people who've got ADHD, whatever problems, whatever, they're stuck in their pad for what, twenty-three hours, even longer, you get me ... So I mean, when you do come out, you're already pissed-off, you get me ... When you got all this stress in you and that, [fighting] releases your stress innit.”

Child, YOI

For children, negotiating the appropriateness and acceptability of behaviour in this setting was underpinned by a dominant discourse of 'it's only inappropriate if the person feels uncomfortable with it'.

“It's whatever the kid feels innit.”

Child, SCH

Sexual behaviours of other boys were often understood as ‘banter', 'boys being boys' or was put down to 'being gay'. Boys found it hard to envisage that sexual abuse could happen in 'all male' environments. That being said, children did share instances of feeling uncomfortable with certain behaviours that had been directed at them from other children. Despite 'child sexual abuse' not being a concern for children, they did share experiences of sexual behaviours that made them feel uncomfortable, but were not identifying and labelling them as harmful or potentially abusive. This is interesting to consider in the context of HMIP data described in section 2.3.4 and the picture of low prevalence rates they indicate.

“There's a boy in here that’s very, he's 13 but he is very sexual and he makes me feel quite scared when he looks at me, he looks at me sexually and it's making me feel scared ... and he tells me stuff to do to him and other stuff like.”

Child, SCH

Sexualised behaviour was a particularly pertinent issue in the STC, compared to the other establishments, with several children sharing their experiences of this.

“There was a boy when I was here last time ... he would, the night staff I came to him because he was doing sexual things or trying to do sexual things to me like trying to kiss my neck and stuff and kept getting his penis out.”

Child, STC

In discussing sexualised behaviours between boys and girls specifically, children had mixed views about a preference for single-sex establishments or units, recognising that it was part of 'normal life' for males and females to be around each other. Interestingly, children shared the staff’s view that there seemed to be a higher proportion of girls in secure environments than previously. With this was an acknowledgement that it may not always be practically possible to have or maintain single-sex units.
6.2.4 Appetite for more education

**Children’s appetite for education on child sexual abuse**

There was a clear need to better educate all children about child sexual abuse and healthy sexual behaviours. Some children were more sceptical about the value of more education on child sexual abuse. This linked back to the individual factors outlined in section 6.1 and the perception that ‘it couldn’t happen here’ or ‘it wouldn’t happen to me’. However, most were generally open to receiving more education on these topics while in the youth secure estate. They felt it would improve their general knowledge, and enable them to identify sexual abuse and sexually harmful or abusive behaviours.

“I’m open to understanding and learning more about it innit, because I don’t know that much about it.”

Child, YOI

Children were not always clear or confident about the appropriateness of behaviours between children and could therefore see the value of having more education about what healthy sexual relationships looked like to help them to develop and maintain safe and healthy relationships when they leave the establishment. Children specifically expressed interest in learning more about consent.

The youth secure estate was felt to be an opportune time for children to learn more about these topics. Children themselves identified that it was the only real opportunity they had to learn about it, due to daily educational regimes which were more difficult to avoid than in the community. They saw themselves as a captive audience and were engaged in learning and education because it gave them something to do, occupying their time and mind.

“Yeah because when you’re in here you’re ... oh I don’t know how to say it ... you concentrate more on listening to ‘em and stuff like that.”

Child, YOI

**Staff’s perspectives on children’s education on child sexual abuse**

Staff shared the same views as children and identified a gap in education for them on sexual abuse and healthy sexual behaviours and relationships. This included more specific work and support for children who had experienced or perpetrated sexual abuse prior to entering the youth secure estate. Staff in one SCH described how children had limited knowledge and understanding of child sexual abuse when they arrived and it was acknowledged that even those who had experienced sexual abuse (and sexual exploitation specifically) did not necessarily realise or accept that they had been victimised. Staff recognised that keeping children safe from sexual abuse in the establishment was only one part of a much bigger picture and that more education would help children stay safe in the community too.

Staff in the YOI felt the education provision for children on these topics was poor. This included both general provision for all children on healthy relationships and child sexual abuse as well as specific targeted provision. Previous provision had been decommissioned, and staff felt this specialist body of work was now in a state of disarray with limited staff and resources attending to it. Staff also felt the boys in their care needed more support and education particularly around child sexual exploitation and other areas because they would not have been (formally or informally) educated in the community.

Staff in the STC recognised the need for more specialist training delivered by external agencies, in light of the sexualised behaviours occurring between children. They believed more education on these topics...
could help tackle the behaviours currently being exhibited by children in the establishment. Staff in all establishments shared the view that external agencies were better placed to deliver specialist education of this kind. Staff did not always have the necessary confidence, knowledge and expertise to be able to deliver this training in-house. A programme of regular and up to date training is needed to ensure relevant staff are equipped to cascade learning to others (see also section 6.4.3).

“So if they had proper lessons, proper education on like sexual – what’s it called, it’s sexual education – sexual education like the sexual comments they say and things like that. I think if they got more educated on it, I don’t think it would be as common as it is.”

Operational staff, STC

Staff in SCHs were positive about the tailored intervention work that children in their care received. This could be provision delivered by external agencies, arranging specific key worker sessions, or targeted one to one work with psychologists. However, staff felt that all children would benefit from routine education on these topics. In terms of arranging tailored provision, they also noted that this could be problematic if children were only being held in the establishment for a short time. This may particularly be the case with those children on welfare placements. As highlighted in section 4.3.4, staff expressed frustration around the lack of continuity of care when children left the establishment, expressing concerns about their potential vulnerability to sexual abuse. Some YOI staff were also keen to ensure that provision around sexually harmful behaviour was continued in the community, both to address the lack of provision on offer within the YOI and the limited time a child might spend in the establishment.

6.3 Perceived risk of child sexual abuse: staff’s perspectives

Staff shared similar views to children and perceived the risk of child sexual abuse to be low in their respective establishments. For them, the factors described below were considered to be key in protecting children against sexual abuse in this environment – with quality of relationships, regular interaction and ongoing assessment of children being of utmost importance.

6.3.1 Understanding children's needs and vulnerabilities

Staff being able to understand and assess a child’s needs and vulnerabilities both in relation to sexual abuse and more generally was deemed to be vital in keeping them safe from sexual abuse while in their care. Staff were reliant on receiving detailed and accurate multidisciplinary assessments from external agencies in order to do this. Asset Plus assessments were completed by Youth Offending Teams (YOTs) for criminal justice placements and risk assessment forms were completed by local authorities for children placed on welfare grounds (in SCHs only). This could include information on how they liked to be communicated with and things they might find hard to talk about. Staff used this information to target interventions and support services for child sexual abuse and exploitation. These assessments also helped to tailor specific one to one work, including about sexually harmful behaviours. Staff were not always satisfied with the information they received from external agencies. Staff in the STC and SCHs stated that a history of sexual abuse should be one of the first things they are made aware of, yet the onus was often on them to seek out and chase information. One child in a SCH reported feeling that staff were not as sensitive to his needs and vulnerabilities as he would like and expressed wanting to talk more about his past, reinforcing the need for the necessary information to be shared with staff to ensure support was tailored to the needs of each individual child.
“There are some things that have happened in my past that maybe some people aren’t aware of and they might, and they’re not as sensitive to me as they should be because I’m very, not breakable but I’m very sensitive.”

Child, SCH

6.3.2 Ongoing interactions with children and behaviour assessments

Staff in STCs and in particular SCHs recounted their ongoing development of local practices, including how they carry out needs assessments of all children, generating care plans, and continuing to monitor these and children’s behaviours through regular meetings. As highlighted in section 5.3.1, positive, meaningful relationships between children and staff were critical to children’s safety and wellbeing in secure settings. Staff from across all establishments recognised the importance of proactively spending time with children to better understand them and their needs and be alert to any changes in behaviour. Staff identified triggers and changes in behaviour, which included children being unusually quiet or self-isolating from others.

“If there’s] a young person that doesn’t really get involved in incidents and things I’d be like – and then all of a sudden they are, I’d be like ‘So why are you getting involved in all these incidents?’ Or for someone that’s very withdrawn that’s not coming out of their room and things like that, but they’re normally active on the unit, I’d question that…”

Non-operational staff, STC

6.3.3 Surveillance and monitoring

Staff stated that the opportunity for sexual abuse to occur was minimised by the presence of CCTV, the close monitoring of both children and staff and, particularly in the SCHs, that children were accompanied by staff most of the time. As highlighted in Chapter 5, CCTV was perceived to be more of a deterrent for abuse perpetrated by staff but less of a deterrent in minimising behaviours between children. Staff in SCHs believed that due to their smaller size and high staff to child ratio, they were able to monitor individual behaviours and whereabouts more easily. An open and supportive culture of challenge and communication between staff members here also contributed to staff’s perceptions of a low risk of sexual abuse.

6.4 Staff’s awareness and understanding of child sexual abuse

6.4.1 Level of understanding and where understanding had come from

Staff’s current levels of knowledge and understanding of child sexual abuse, exploitation and harmful sexual behaviours varied within and across the establishments. This was dependent on several factors: the role of the individual (and whether they were directly employed by the establishment or externally contracted, for example, by the NHS); their professional experience; the qualifications they hold; any training undertaken as part of their current or a previous role; and their levels of interaction with children in the establishment. Knowledge and understanding was also informed by learning from colleagues with specialist experience (such as social workers, case workers, CAMHS, psychologists) as well as media articles and programmes, and their own personal biographies.

However, there was disparity in the training that had been received both within and across establishments – and therefore variability in staff understanding and awareness of and engagement with
the issue. Some staff found it hard to articulate how they understood the concept of child sexual abuse. When asked about their understanding, one member of staff in a SCH declined to answer the question. Similarly, a staff member in the YOI when specifically asked about child sexual exploitation, simply responded, “I don’t know”. It appeared that, in particular, front line staff such as unit staff were relatively less cognisant of child sexual abuse and its different forms. Some staff, in sharing their views with us, used language and descriptions that were at times somewhat derogatory. For example, the terms ‘attention seeking’, ‘risky behaviours’, and – in particular – ‘promiscuous’ all formed part of the staff’s narrative in relation to girls who had experienced child sexual exploitation. It was clear that the use of such language was not intentional – rather, that it was an implicit bias. However, it highlighted the need for continued learning and development of knowledge in this area to promote a non-judgemental narrative.

6.4.2 Behavioural boundaries and contextual norms: challenges for staff

In addition to children, staff also found it difficult to know what was and was not appropriate behaviour (both in the secure setting and more generally). They recognised that behaviours that were ‘normal’ in the community were less acceptable in the context of the youth secure estate, which was much more cautious and did not reflect ‘reality’. Staff found it challenging to manage the balance of children in their care being ‘normal adolescents’ but also ensuring they were kept safe. They acknowledged it was hard to get right all of the time and there was recognition of a level of subjectivity in whether or not individual staff members deemed something appropriate or inappropriate in these settings.

There were various frameworks in place to help staff determine whether or not behaviours between children were appropriate. For example, in the STC (where sexualised behaviour between children was a particular issue), staff used a ‘traffic light’ system to determine whether behaviour was age-appropriate, inappropriate and/or sexually harmful. However, it was clear that in and of themselves such frameworks were not particularly effective. There was still a lack of clarity among staff in all establishments on which behaviours were a cause for concern. They were often drawing on the advice of other colleagues (for example, psychology staff) about what should be seen as an issue. Children also perceived staff as not always knowing what behaviour was a cause for concern or not and were not always able to provide a clear explanation as to why certain behaviours were deemed inappropriate. Children did not therefore always know what they had done ‘wrong’.

Furthermore, there was no equivalent frameworks concerning the appropriateness of behaviours between children and staff. For example, actions such as a child plaiting a member of staff’s hair was considered inappropriate and challenged by some staff and not by others. Staff’s interactions with children also varied between establishments. For example, staff in SCHs reported hugging a child if they were feeling upset in line with their culture of modelling parental behaviours. In the YOI, however, this behaviour would not be deemed appropriate by staff.

Some staff perceived there to be differing levels of confidence among their peers to challenge certain behaviours – between both children and staff and children. Some shared the view that newer staff in particular needed more support and guidance in relation to this. Some staff were much more likely to challenge behaviours than others.

“They shouldn’t be coming out with the comments given the environment where we are and it being a secure children’s home you’ve got to constantly keep reminding yourself that we’re not in the community here.”

Operational staff, SCH
These findings echo that of the REA, which suggested that staff working in YOIs and STCs in particular did not always have the skills and experience needed to manage the most vulnerable children in these settings, and did not receive sufficient training (Mendez Sayer et al., 2018). This also provides helpful context for understanding the process and effectiveness of raising and managing safeguarding concerns, which are discussed further in Chapter 7.

6.4.3 Staff training

Staff described a greater emphasis and shift towards needing more training on child sexual abuse and healthy sexual behaviours in the youth secure estate. Staff described a greater focus had been put on these issues in recent years in society more generally. They perceived child sexual exploitation in particular to be a growing area of concern – driven by, for example, media coverage on ‘grooming gangs’ as well as a perceived growth in the number of children (particularly girls) entering the youth secure estate who had experienced child sexual exploitation.

In SCHs, staff reported training on child sexual exploitation had become mandatory for all staff (with further optional training available), to ensure staff were aware of, and alert to the signs of previous or current abuse. While some staff had not yet undertaken this training (for example, education staff), senior staff described this as a notable shift from previous training on child sexual abuse which had been offered on a voluntary basis. Some staff within SCHs also reported having undertaken (non-mandatory) training around harmful sexual behaviours. They were also drawing on external expertise to develop their knowledge. For example, Barnardos were reported to come in regularly to offer staff training and advice. Newer staff drew on the expertise of those more experienced, and staff were also utilising clinical teams to ensure a trauma-informed approach was being taken.

Staff in SCHs stated a need for more training, in part due to an increase in the number of children arriving who had experienced sexual exploitation (particularly among girls being placed on welfare grounds). More broadly, however, staff recognised it as a dynamic area where the spectrum and nature of behaviours constituting child sexual abuse was evolving. They recognised that they did not always know how to deal with children who had been sexually abused before they arrived at the establishment, and very much saw this as part of their duty of care.

“I think yes, what I learnt was OK but I need like more, you know, because there are a lot of things that are changing, especially nowadays, things are changing so quick and sometimes you don't realise.”

Operational staff, SCH

Similarly, in the STC there was recognition of the need to better understand a range of vulnerabilities of children in their care (see also Chapter 2). Staff reported having recently undertaken training on mental health, suicide and self-harm, and sexually harmful behaviour – all of which were relatively new. This was in part due to the establishment recognising it needed to update the policies and practices it had in place to reflect the range of vulnerabilities and how they were dealt with. No staff in the STC reported having undertaken training on child sexual abuse. There was a specific desire in the STC to increase training for staff to be better able to manage sexual behaviours between children. They reported already being in the process of setting up drop-in clinics for staff – led by psychologists who could help to advise on matters relating to children's behaviours, including sexually harmful behaviours.

The disparity in staff knowledge and engagement with the issue of child sexual abuse was more notable in the YOI. This could in part be explained by a larger population of children and lower staff to child ratio when compared to the other two types of establishments. Staff referred to an awareness course
undertaken by all upon joining, which covered some content around child sexual abuse, child sexual exploitation specifically, and harmful sexual behaviours. However, there was a perception amongst some staff that operational staff were less knowledgeable about this issue compared to more senior colleagues or those working in other non-operational roles such as social work. This resonated in the responses of operational staff themselves.

“I think like, the first induction, you might get trained for it, but I don’t think we ... I don’t remember doing any training about it.”

Operational staff, YOI

Some staff in the YOI also perceived that there was a need for more ongoing and refresher training, particularly for members of staff who had been working at the establishment for a relatively long time.

“...the older staff sometimes are a ... their training needs are a little bit more because it’s like anything, you get complacent and you need to constantly retrain staff, but I think the older staff – to flip that onto a positive, the older staff have got that in-depth knowledge of working with children. They’ve worked with children a long time...”

Non-operational staff, YOI

Staff in all establishments demonstrated that child sexual abuse and healthy sexual behaviours more broadly were important issues to be aware of, and this was reinforced by senior management teams. Staff expressed a desire to increase their understanding and knowledge of these issues in order to effectively support the children in their care who may have experienced previous sexual abuse, and in protecting them from any current and future harm.
Chapter 7: Reporting safeguarding concerns
This chapter explores the process of reporting safeguarding concerns and how inappropriate behaviour and sexual abuse would be managed and reported, from the perspective of children and staff. It also looks at how establishments respond to concerns raised by staff.

**Summary**

- Children were not always aware of the formal process to report a safeguarding concern, but they reported they could talk to a member of staff if they had a problem.

- Children had different ‘rules’ about what they would and would not report and were unlikely to report incidents of child sexual abuse. This was due to a number of factors including: a lack of understanding of what constituted child sexual abuse; not wanting to get involved in other people’s business; not wanting to get themselves or others in trouble; and not wanting to be labelled a ‘snitch’ by other children.

- Staff generally had a good understanding of safeguarding. They were able to describe various behaviours that would be a concern. Views became more wide ranging and subjective when considering the more nuanced sexual behaviours.

- There was no clear articulation of the official safeguarding process. Rather, staff members reported an individualised process that they would personally follow which included a variety of routes. They believed any issues raised would be adequately addressed, but there was room for improvement. In general, they lacked knowledge on the wider safeguarding vision of the establishment. Staff’s confidence in the referral process was being undermined as they were rarely notified of the final outcome after reporting an incident. Operational staff at the YOI were perceived, at times, to prioritise establishment rules over the welfare of the child in responding to safeguarding concerns.

- Responding appropriately to safeguarding concerns relied on clear, open and timely communication between staff within an establishment as well as with external agencies. Good working relationships with the local safeguarding teams and the Local Authority Designated Officer (LADO) were a vital part of the safeguarding process. Staff reported that communication with external agencies was difficult at times although they did note some recent improvements.

### 7.1 Children’s views on reporting safeguarding concerns

#### 7.1.1 Understanding of the safeguarding process

None of the children we spoke to had been involved in, or had witnessed, an incident they deemed to be a safeguarding concern in their respective establishments. They reported having no direct experience of the safeguarding process. They typically struggled to recall receiving any information on how to report a safeguarding concern. A number referred to information on the complaints system or safeguarding team being provided on admission into the establishment, while some children described figuring out the process as they went along. Children referred to several ways of reporting a concern, which included telling a member of staff, submitting a complaints form or asking staff to check CCTV footage.
Overall children had limited understanding of the formal process by which the establishment addressed their concerns. Children were unable to clearly articulate how and when to raise a concern, which indicated more work is required to improve communication with children. This would be critical in both the early days of arriving into the establishment and continued throughout their time in the secure estate, so that they were fully aware of, and confident in the steps they could take to raise a concern.

### 7.1.2 Reporting inappropriate behaviour

The majority of children had a member of staff they trusted and would confide in if they were concerned about something, be that unit staff, key workers, social workers or the establishment manager. Very few children would talk directly to staff in the safeguarding team. As highlighted in section 5.3.1, awareness of designated safeguarding staff across establishments was poor, and they were not always easily accessible to children, with access being facilitated by unit staff. This raised concerns for some children who were worried that the unit staff would not take the request to see the safeguarding staff seriously. Despite some staff believing that the safeguarding team were visible and accessible, children were not always aware of which staff members had a designated safeguarding role, which impacted on their relationship with them and their likelihood to report a concern. The existence of a trusting relationship with staff was fundamental for children in raising a concern, a consequence of which would be waiting to report a concern until a specific staff member was available, which could potentially put them at greater risk.

> "Obviously safeguarding they don’t like – they don’t work on the wing, so if you want them you would have to either ask an officer to call them for you, and they might say, ‘Oh, what’s the issue like, what do you need them for?’ But that depends what officer’s asking me like, ‘What do you need them for?’ because I might just say, ‘Oh, it’s confidential’, and then he might not take me serious.”

Child, YOI

In general children believed that staff would help them if they raised a concern and would take it seriously. They hoped that staff would action the concern appropriately, gather evidence and conduct an investigation, which could involve reallocation of a child to a different unit, a staff member’s suspension, and police involvement if deemed necessary. There were concerns that some staff would not handle information correctly, which determined which member of staff children would choose to confide in. As highlighted in Chapter 5, a minority of children believed that staff (particularly in the YOI and STC) simply did not care enough about their safety and wellbeing. They lacked any trust in some staff to address their concerns or to have their best interests at heart. They believed staff would think they were lying so were reluctant to raise any concerns.

> "They all have each other’s backs, they all look, staff they all look out for each other innit.”

Child, SCH

There was variability in children's response to reporting, dependent on the type of inappropriate behaviour. Fights, the biggest factor associated with feeling unsafe, were seen as a normal part of being in the youth secure estate, in particular for children in the STC and YOI. Fights would rarely be reported...
to staff, though staff would likely be aware of incidents requiring immediate intervention. There was a strong anti-bullying stance amongst the children, and this type of behaviour was generally not tolerated. Several children stated they would intervene if they witnessed any bullying and would try to stop it directly rather than reporting it to staff. This reluctance to involve staff and take on the responsibility of intervening and managing this type of behaviour themselves suggested a normalising of some behaviours whereby children did not deem it necessary to routinely involve staff.

“It would be different because see with like just a fight, a normal fight, when I say it’s normal but it’s just, it happens, just it’s not sexual or anything.”
Child, STC

7.1.3 Reporting sexual abuse

Children’s accounts of how they would handle incidents of sexual abuse were less clear. Many children could not articulate how they would respond to sexual abuse and why their response might differ from other types of incident. Children described handling different types of sexual abuse and sexual behaviours in different ways. This was influenced by the different ‘rules’ and thresholds they prescribed for specific circumstances. For example, any abuse against a younger child, by either a staff member or an older child, was seen as wrong and would be reported whereas sexual behaviour involving older children or children of the same age was not perceived in the same way. This is likely to be a result of both the lack of experience with this type of incident, and, as discussed in Chapter 6, their limited understanding of what constitutes sexual abuse and the appropriateness of behaviours in secure settings. It is likely that the blurred lines surrounding the types of sexual behaviour that were lawful in the community affect how a child may view and respond to an incident. They may regard sexual activity that would be legal, or at least acceptable, in the community as also being appropriate in a secure setting despite relationships and sexual activity of any kind being prohibited in the youth secure estate. It was likely that this lack of clarity was also a reflection of children’s unease in discussing topics of a sexual nature with adults. Other factors that would influence children’s views of, and response to, incidents of sexual behaviour included; who the perpetrator was, their gender, and whether they were directly involved in the incident.

“if I saw a grown man touching a young woman, that’s out of order innit, but if like well if I saw a woman touching a young vulnerable kid I’d put that out there, but if a kid my age and a woman was doing it, boy, I don’t think I would say anything.”
Child, SCH

Abuse perpetrated by other children

Children described their initial response to another child behaving in a sexual inappropriate way towards them would be to handle this directly. They shared a common perception that behaviour of this kind from other children would simply be a joke and that it could be handled directly, responding with a joke, telling a child to stop, and for some children resorting to violence. Sexualised banter and joking was seen by the children as a normal part of teenage behaviour that could be easily managed without the involvement of staff. This response was heavily influenced by the types of behaviours children deemed to be inappropriate or acceptable. There was no clear and consistent message from staff, and more worryingly a lack of consistency in staff challenging behaviour of this kind, skewing children’s perceptions of, and response to abuse and unhealthy sexualised behaviours. However there were some children who said if the behaviour began to make them feel uncomfortable then this would normally be reported to staff.
"Obviously the lads joke about the lads in here, like just mess about, but you can tell it’s messing about, because they just they say that they are messing about.”
Child, STC

In situations where two other children were involved in sexual activity, be that consensual or not, the overwhelming reaction reported by children was to not get involved. Children perceived it as not being their business. As highlighted in section 5.3.2, the majority of children wanted to keep to themselves, and simply do their time without getting involved in anything that could cause them trouble. This could account for their reluctance to intervene in situations, which could potentially place children at greater risk of abuse or harmful behaviours occurring on a regular basis. Situations where it was not clear if something was inappropriate or whether it was consensual made it difficult for children to determine if there was a cause for concern. Children were worried that they could disrupt a relationship or get themselves or other children in trouble if they raised a concern, so the common response was to not get involved and leave staff to identify if there was a cause for concern.

"If there were two trainees I don't know probably to be honest, I'm not gonna lie I'd walk away it's not any of my business.”
Child, STC

As noted in section 6.2.3, some boys found it hard to envisage that sexual abuse could happen in ‘all male’ environments. Some stated that they would not want to get involved in any sexual behaviour between two males and referred to this as ‘gay behaviour’. They were fearful of also being perceived to be homosexual if they did become involved in such a situation. It was unclear whether these attitudes were homophobic beliefs or a reflection of immature teenage views on masculinity and sexual banter, exaggerated by the often hypermasculine culture found within all-male establishments. However it was clear that their views on sexuality, combined with the self protection strategy of keeping their distance, impacted on children's ability to recognise potentially harmful or abusive situations, and was a barrier to reporting.

"I would probably ask them, 'Are you gay or something?' You get me ... 'Don't come near me,' innit. I'm not gay.”
Child, YOI

There were a number of children who stated they would report sexual activity between children to staff, if it was clear that a child was being forced to participate in something and was clearly not ‘enjoying themselves’. However for the majority of children one of the barriers to reporting was fear of being labelled a 'snitch'. As highlighted in section 2.3.4, fear around being given this label was one of the main barriers to reporting victimisation and would affect relationships with other children on the unit – often leading to fights as a way of retaliating for breaking trust between children. For some this was deemed to be more important than reporting something inappropriate. As highlighted in section 5.3.2, positive relationships with other children, particularly in the YOI and STC, could help to increase children's sense of safety. Unsurprisingly, children's first priority was their own safety. However, the reluctance of children to report certain behaviours to staff may indirectly place other children at risk.

"I would say something but I would be a snitch, everyone will know about that. All the centre.”
Child, STC
Abuse perpetrated by staff

Children were more confident in their response to sexual behaviour involving staff and clearly understood this to be wrong. Most of the children we talked to stated they would report this directly to another member of staff, often someone senior given the severity of the incident. Several children stated they would challenge a staff member directly. Children reiterated the need to report to someone they could trust so that a complaint was taken seriously and if necessary escalated to someone external, such as their social worker, to ensure it was dealt with appropriately. There were still some children, however, who would not want to get involved in these situations for fear of getting into trouble or being labelled a snitch.

“I’ve seen like some people go up to officers and say something, that’s quite serious and they’re just like ‘Oh no, no. We don’t think that’s… we don’t think that happened, and they don’t take it too seriously, so you have to move on and speak to someone else.”

Child, YOI

The perceived inappropriateness of sexual behaviour from staff was heavily influenced by gender, of both the staff member and the child. There was consensus among children in all establishments that any incident involving a male member of staff was wrong and would need to be reported, regardless of the gender of the child involved, which was in direct contrast to situations involving a female member of staff and boys. Boys could generally not comprehend this type of incident being reported, especially if they had been sexually active in the community. It was seen as something that would be actively welcomed by some.

“Well, a lot of people in here want something to happen with an officer, they’ve been here a long time, you know like … um, I don’t know, it’s just something that they want, because obviously they’re just disconnected from the outside world. So I, I don’t really know. A lot of people see it as a positive.”

Child, YOI

The perceived acceptability of this behaviour was determined largely by the issue of consent – in that if boys were consenting, which they would do, then this would not be abusive or inappropriate. As described in section 6.2.3, this acceptance of a sexual interaction with a female member of staff highlighted the poor understanding amongst children of what constituted abuse, in particular, in relation to age of consent and abuse of power. This also highlights the harms of the secure environment and the adverse effects it has on a child’s sexual development. It places children at greater risk, potentially encouraging behaviours from female staff members with little to no understanding of the serious implications of the abuse of power.

“It’d probably be easier for a woman to sexually abuse you in a place like this than a … like a male officer.”

Child, YOI

7.1.4 Children’s perceptions of how staff respond to concerns

Despite the range of responses about when and how children would respond to inappropriate behaviour, they all shared the view that staff would challenge any behaviour they deemed unacceptable. Children felt sexualised behaviour was taken seriously by staff, and they would not allow this type of behaviour to continue, but there was variation across the responses from staff in relation to what they deemed to be
inappropriate behaviour. There was inconsistency from staff in both what behaviour they would challenge and the form that it would take.

“Yeah the staff deal with it in their own ways, so one member of staff might not tolerate that conversation or another might just give a sanction for it, another might just say to change the subject before it goes any further without getting in any trouble for it, so they do deal with it in their own ways.”

Child, SCH

Children had witnessed staff challenging inappropriate behaviour, but none of the children we spoke to had reported something of a sexual nature in their establishment and had limited knowledge on what they thought the outcome might be of making such a complaint. Children who had made a complaint relating to other matters had mixed views towards the response they received and felt that the outcome of the complaint was inadequate. Children attributed the inadequacy of responses to delays in receiving one, if receiving one at all, and felt the content of a response would often blame them for the incident. Children were also concerned that complaints made about a staff member were being viewed and managed by the staff member in question. As a result they had little confidence in the complaints system, it was not confidential or impartial, and was not an avenue they would use to raise a concern or report sexual abuse.

7.2 Staff’s knowledge and experience of the safeguarding process

7.2.1 Understanding of safeguarding

Staff in all establishments described safeguarding as the means to keep children safe and to minimise the risk of harm posed to themselves and others. This included the collation and sharing of information, management of behaviours to maintain a safe environment as well as providing a safe space for children to disclose information. Safeguarding encompassed responding appropriately to any risks identified or information obtained either through disclosures from the children or via other routes. Safeguarding was also seen as the process by which to keep staff safe, protecting them against physical harm but also in the case of any allegations made against them. Staff at the YOI were particularly aware of the importance of safeguarding practices for staff as well as children, which may be a reflection of the high rate of assaults on staff in these establishments in recent years (see for example MoJ, 2018a).

“Staff safety historically here has ... well from a staff point of view has not been good enough.”

Non-operational staff, YOI

Staff perceived safeguarding as an intrinsic part of their role. Staff from all professional backgrounds understood the part they played in the safeguarding process, and the importance of following the required policies to protect children and staff from harm. As highlighted in section 4.1, senior management in some sites were actively promoting safeguarding and there had been notable and ongoing change, for example in the creation of additional safeguarding roles to strengthen the presence of safeguarding teams and accompanying policies. Whilst efforts were made by senior management to promote safeguarding, some staff were not always clear on the overall safeguarding vision or narrative within their respective establishments. Staff could benefit from greater clarity and steer from senior management to help them embed and implement a consistent safeguarding approach, particularly in how they manage difficult behaviours, the processes in place to help them do so and the way in which they communicate a healthy narrative to children.
Staff identified a range of behaviours that could trigger a safeguarding referral, including bullying, abuse (sexual or other), self harm, and hurting staff or other children. Some staff acknowledged the wide range of behaviours that could be exhibited by vulnerable children in their care and believed safeguarding encompassed more than simply challenging inappropriate behaviour but also educating and teaching children about why those actions were inappropriate and how they could be better managed. This was encouraging to hear given the lack of understanding reported by some staff around the complex nature of child sexual abuse, the different types and its impact (see section 6.4). It was emphasised that action needed to be proportionate so safeguarding did not impinge too heavily on the child’s daily life nor be impractical for when the child was released back into the community, for example allowing children with a history of knife crime and violence to safely use knives in an educational cooking class. If staff were unsure about whether a certain behaviour was a safeguarding concern they would seek advice from the safeguarding team who were generally described as approachable. Some staff at the YOI however described a more negative relationship with the safeguarding team. They felt the team would be unsupportive if they sought advice, which potentially impacted on staff’s ability to recognise safeguarding issues.

Despite staff recognising that sexual abuse would be a safeguarding concern it was clear that not all staff were able to identify sexualised behaviours (particularly prominent in the STC) as being a cause for concern. Staff had varying tolerance levels and the threshold for what type of behaviour should be reported as a concern was unclear. This was in part due to a lack of understanding amongst staff as to the types of sexualised behaviours that were normal for this age group, compounded by the types of behaviours that were prohibited in secure settings as highlighted in Chapter 6. Staff could not be expected to recognise and address concerning sexual behaviours without first having the necessary training and support to develop a detailed understanding.

As indicated in earlier sections, there was a concern amongst some staff about the varying and subjective reporting behaviour amongst staff. For example, there was a perception that more experienced staff could become too complacent in their views about what sexual behaviours were ‘normal teenage behaviour’ or normal behaviour for that custodial environment rather than recognising it as a potential safeguarding issue. It is possible more experienced staff had developed other ways to manage these risks, however the perception amongst some newer staff members was that they did not treat these incidents with the required severity. Where sexual behaviours become normalised in this context, there may be a risk that staff no longer deem certain behaviours as inappropriate. This could result in fewer safeguarding concerns of this nature being reported. The normalisation of sexual behaviours could also mean that staff who do wish to challenge them may be criticised by their colleagues. For newer and less confident staff, this could result in them adapting their views and behaviours to fit in with those more experienced. There was a perception that newer or younger staff were more on top of safeguarding and, given they had received training more recently, were more aware of the behaviours that would need to be flagged as
concerning. This normalisation of certain behaviours could not only lead to an increased risk of harmful
sexual behaviours still exhibited by children but could result in it being unclear to children whether their
behaviour was or was not acceptable both whilst in the youth secure estate but also upon release in the
community.

“I guess um that people kind of be here for such a long time and they’re like oh well it’s only a wink, or it’s only
a, it’s only a kiss, or it’s only a touch ’cause that’s not the case.”
Operational staff, SCH

7.2.3 Reporting a safeguarding concern

Despite the fact that staff understood what safeguarding meant and the importance of promoting safety,
this did not always translate into a clear articulation of what the formal safeguarding process was. Staff
recounted the personal steps they would follow when reporting a safeguarding concern, rather than a
description of the formal process set out in the policy and procedures. Despite staff not reporting the
official establishment processes, they felt confident they could respond appropriately to safeguarding
concerns and keep children safe.

Staff would raise a concern with a senior member of staff, be that their line manager or senior
management, and would make a referral to the safeguarding team, which was described as a key step in
the safeguarding process. How this referral was made varied across sites and staff members however.
Staff understood the importance of recording and documenting concerns so that there was an audit trail.
This was done in a variety of ways, including email, a written statement or through one of a number of
referral forms. Whilst staff were confident that any one of the referral forms would ultimately reach the
safeguarding team, it was not clear whether using a form with a different intended purpose, such as a
security form rather than a safeguarding concern, would cause a delay in responding to a safeguarding
concern or trigger any unintended consequences. Staff found the range of forms available confusing as
it created uncertainty of the official processes. The variation in process across establishments was in
part due to differences in the types of establishment and local policies at each, however both across and
within establishments there was very little coherence among staff’s accounts. This highlighted the need
for further work on internal processes to ensure that all staff were aware of, and understood the formal
processes in place.

“I don’t think it’s like a set in stone process.”
Non-operational staff, STC

Challenging inappropriate behaviour from staff members was considered just as important as challenging
behaviour between children. Staff felt confident that they could raise a concern about a colleagues’
behaviour directly with them, regardless of grade or experience. They felt this culture of challenge was
supported and promoted by senior management, although it had to be done in an appropriate way and
not in the presence of children, so as to not undermine the authority of staff. Staff were emphatic in their
views that protecting children was more important than maintaining friendships with colleagues.

“As long as I took it that the young person is safe that, that for me is the main thing, even though he is a
member of staff it might be my friend doesn’t matter.”
Operational staff, SCH
The whistleblowing policy was never cited as an avenue used to raise and challenge staff wrongdoing or to raise safeguarding concerns. Some staff did not know what was set out in their local establishment whistleblowing policy and some establishments did not have a local policy and adopted that of their local authority. There was an accepted culture within establishments that any wrongdoing could be dealt with openly with colleagues and that being a bystander and not taking action was not acceptable. Staff were still required to formally report any behaviour to senior management and safeguarding teams in addition to directly addressing it with the colleague concerned. There was a recognition that some establishments were doing more to promote the whistleblowing policy, through posters or information cards with the relevant phone numbers, following the number of recent high profile cases reported in the media.

“There is a whistleblowing but I won’t whistleblow in my position, I’d just say, I’d report it straight away.”
Non-operational staff, SCH

Handling allegations about staff misconduct could be challenging for establishments, and could impact on staff morale. The way in which investigations into staff misconduct were managed shaped staff’s views on whether the process would ensure allegations were responded to and investigated fairly and robustly. There was a view amongst some front line staff that any staff member involved in an incident would be suspended for ‘no reason’ or that the Local Authority Designated Officer (LADO) was simply looking to get staff sacked. This was a particularly prominent view at the YOI. These concerns around suspension and dismissal could potentially result in incidents only being addressed through internal measures without the involvement of the LADO or, in some cases, not reported at all. Addressing these negative perceptions and the associated fear of reprisals was critical to increasing trust and confidence in a process which was meant to protect both children and staff and encourage a culture of open challenge.

“LADO referrals were going out about members of staff, the prison didn’t understand what it meant and that actually the social work team didn’t want people to get sacked; they wanted people to be supported.”
Non-operational staff, YOI

7.2.4 Establishment responses to safeguarding referrals raised by staff

Whilst staff could explain how they would make a safeguarding referral, there was less certainty as to the next steps in the safeguarding process once that referral had been made. Staff who raised the initial referral were rarely made aware of the final outcome so had limited understanding of the end to end safeguarding process. Despite not always knowing the final outcome, staff were confident safeguarding referrals would be taken seriously by senior management with immediate action taken to safeguard those involved, and a full and confidential investigation would take place regardless of the severity of the concern.

Designated safeguarding staff and senior management across all four establishments described the end to end safeguarding process once a referral was made. There were two key components: the internal response from establishments and referral out to external agencies.

Internal response from establishments to safeguarding referrals

After a referral was made to the safeguarding team, immediate action would be taken by establishments to ensure that any children and staff involved in any incident were kept safe, this included moving children to a different unit or removing staff from front line duties. The emphasis on immediate action was particularly apparent with allegations involving a member of staff to minimise any further risk to any
child within the establishment and to protect that staff member from any further allegations. An internal investigation would be undertaken with evidence gathered through witness statements as well as CCTV and BWVC footage, if available, which allowed staff to investigate and corroborate the different accounts of a given situation, and helped inform and manage their response.

For allegations of abuse perpetrated by a child, further consideration would be given in relation to the establishment’s response to the alleged perpetrator. Establishments put in place measures to manage and address any ongoing inappropriate behaviour. This included one to one sessions with a key worker, targeted behaviour work with psychology staff or the use of a ‘sexually inappropriate behaviour log’ which could track incidents of recurring sexualised behaviour. Where there was an understanding of child sexual exploitation amongst staff, the importance of having tailored interventions for these children was also discussed.

Whilst those members of staff in safeguarding roles were able to articulate what the internal establishment response would be to a safeguarding referral, other staff were less confident. Safeguarding teams were not always seen as being proactive in sharing information on the outcome of referrals. Whilst the importance of confidentiality was understood, non-operational staff in particular were often not included in the discussions and investigations carried out by the establishment. As a consequence, staff were not aware of the potential implications on their own work with that child or able to provide professional advice on the proposed outcome. On occasion, the final outcome of a referral was shared with some front line staff, which helped to increase their understanding and trust in the management of the referral. The inconsistency in communication hindered staff’s understanding of the process and their trust to handle referrals properly. Staff might not have the necessary information needed to appropriately manage their ongoing work with a child involved, which could prevent any future incidents from arising. Regular and relevant feedback following a referral would help to foster a whole-establishment approach to safeguarding, and increase both staff’s confidence in, and use of the process.

“You know what goes on after they’ve made that first step ... I don’t know. I can’t say.”

Operational staff, STC

There was also a concern amongst some non-operational staff at the YOI that the needs of the establishment were put first in responding to safeguarding concerns, above the welfare of the child. Balancing the ‘prison rules’ with child welfare requirements was difficult, with establishment policies sometimes being deemed to be the priority despite international and national standards stating the welfare of the child should be the primary consideration. At times operational staff were perceived by some non-operational staff to prioritise establishment processes by making decisions about a child’s welfare before any safeguarding investigations had been properly completed. This might be because YOIs tend to favour a more punitive approach in management of the regime, in part due to the use of some policies originally designed for and in use in adult prisons. Therefore YOIs may be less able to adopt a child-centric approach which promotes child welfare in the same way as other establishments in the youth secure estate. This perception signifies further work was required to ensure that all establishments were prioritising safeguarding practices and policies as required.

Referrals to external agencies

External agencies play a key role in the safeguarding process in their ability to share information with different agencies, which is critical to an effective safeguarding process. If an incident involved an allegation against a staff member, referrals would be made to the LADO or, with incidents relating to abuse perpetrated by a child, other relevant local authority contacts so that external investigations could
be undertaken and appropriate actions and support determined. In addition to the required referrals to the LADO, safeguarding staff explained how information pertaining to a safeguarding concern would be shared with the Youth Offending Team (YOT) or social worker to ensure that they were kept fully informed of any incident, and any implications on the welfare of the child. Staff at the SCHs would also involve the child’s home local authority if they were located in an establishment far from home. This was not raised by staff at the YOI or STC and it was unclear whether this information would be shared to ensure a joined up response across all agencies involved in the care of the child. Relationships with YOTs and social workers were vital for establishments to ensure they had the relevant background information on children, and appropriately address any safeguarding concerns. If needed, given the severity of the incident, referrals would also be made to the police, and staff would be suspended pending the outcome of any investigations.

“I think good communication with referral teams, CAMHS service, social workers, YOT workers, that’s absolutely I think the most vital thing in being able to keep a young person safe.”

Operational staff, SCH

Consistent and timely communication with these external agencies was key to an effective safeguarding process and ensured that an investigation was carried out quickly, with involvement from the relevant agencies to ensure the child could access the right support from the appropriate services. However, staff reported that communication with external agencies was difficult and the flow of information stalled after an initial safeguarding concern had first been raised with the necessary agency. Staff found it difficult to get timely and detailed information from external agencies on the progress of investigations. They found the lack of communication frustrating and were not able to provide children with up to date information. While it was noted that relationships with LADOs, for example, had improved, there was a desire across all establishments to develop better, more consistent working relationships with external agencies. This was to share the necessary information and to provide training and education on safeguarding, healthy relationships and child sexual abuse or exploitation. Further work was needed across all establishments to facilitate the timely and relevant sharing of information to ensure a quick resolution and to keep children updated on progress.

“We have to pick up the pieces so we, the young person is being aggravated at that point, he doesn't know, she doesn't know where they're going, where she's going. We don't know because it’s all up to the other agency.”

Operational staff, SCH

It was not possible to determine how well establishments were following the key components of the safeguarding process, but for most staff they were only aware of a small part of the process that they had been directly involved in and lacked understanding of a wider safeguarding approach.

7.2.5 Safeguarding training

Staff's knowledge of the safeguarding process came from a mixture of both formal and on-the-job training. Based on the variation in staff's understanding of the process, safeguarding training may not have been sufficient in providing staff with the required knowledge and skills. Most staff recalled receiving training as part of their induction alongside regular refresher training offered by the establishment. However for some staff their induction was many years ago and others reported not receiving any refresher training. Those with limited or out of date formal training were reliant on their
practical on-the-job experience to guide them in their decision making and handling of safeguarding concerns. Training for non-operational staff was even less consistent, and some staff described relying purely on their professional training, in particular healthcare staff or social workers; others had received some level of establishment specific training, normally online; while others did not recall receiving any formal safeguarding training when they first joined the establishment. A lack of formal training for all staff disciplines might explain the variation in how staff would identify, respond and raise a concern, and for non-operational staff feeling excluded from a process that everyone had a part in.

“Is there safeguarding training here for staff?”
- “Don’t think so... Not that I’m aware of.”
Operational staff, YOI

As highlighted in section 6.4.3, staff expressed a desire to increase their understanding and knowledge of the types of behaviours to be alert to, and how to manage and respond to these. When combined with a programme of regular training on both national and local safeguarding practices, staff would be aware of the necessary tools and processes available to help them effectively support the children in their care, safeguarding them from any current and future harm.
Chapter 8: Eight key findings from the research
This chapter concludes the report by highlighting eight key findings from the research in the youth secure estate. These research findings do not constitute formal recommendations by the Inquiry’s Chair and Panel and are separate from legal evidence obtained in investigations and hearings.

1. Some practices in the youth secure estate do not seem to serve the best interests of the child

The aim of this research was to examine the extent to which children feel safe from sexual abuse in the youth secure estate and the role of staff, systems and processes within this. In doing so, it was essential to consider the broader question of whether the best interests of the child were put at the heart of safeguarding considerations in these settings.

International and national human rights and juvenile justice standards stipulate that the best interests of the child should be the primary consideration when any decision is made in relation to a child in these secure settings. The ‘best interests’ test requires establishments to take a rehabilitative approach and promote the reintegration of children into the community. Children deprived of their liberty must be treated with humanity and dignity, and establishments must take appropriate steps to protect children from all forms of abuse and ill-treatment.

Against this background, a number of practice areas emerged which did not seem to serve the best interests of the child.

For example, there were challenges for children and staff to form positive, meaningful relationships. Staff from across the different establishments saw themselves as playing a role in rehabilitating, educating, and generally improving the lives of children in their care. Indeed, children typically reported having at least one member of staff they trusted and could turn to for help. However, a number of issues impeded children and staff from being able to build quality relationships, hindering staff’s understanding of children and their needs. In the YOI and STC in particular, a lack of staff continuity was an issue and some children felt that staff simply did not care about them and their safety. Across establishments, some children had experienced what they perceived as breaches of trust with staff, and felt that staff used information about them against them.

Another example was the lack of understanding about child sexual abuse amongst staff. Some staff – particularly operational staff working on the front line – found it hard to articulate how they understood child sexual abuse. Some of the language and descriptions used by staff in varying roles to describe children in their care was also, at times, somewhat derogatory. For example, girls who had experienced child sexual exploitation being described as ‘promiscuous’, ‘attention seeking’, and showing ‘risky behaviours’.

For some staff in the YOI, there was also a perception that other colleagues placed more importance on upholding ‘prison rules’ than on safeguarding the child. Operational staff were sometimes seen as prioritising establishment processes, making decisions about a child’s welfare before any safeguarding investigations were properly completed.

2. More work is needed to ensure safeguarding and embedding a culture of safety is seen as everyone’s concern

Staff described some notable changes to safeguarding practices and a commitment from establishments to learn lessons and embed change. Establishments recognised the importance of safeguarding as everyone’s concern but were not always alert to the significant challenges of bringing about cultural change. The role of leadership was critical in championing and embedding a clear and consistent whole-establishment approach to safeguarding, underpinned by a culture of safety.
Staff described a renewed focus on safeguarding, and a continued commitment to improving and strengthening their safeguarding arrangements and creating a safe environment for children. Recent inspection findings have noted improvements and provided a clear steer for what is needed in the future. Some establishments were further ahead in creating and embedding a culture of safety. Those with a more established vision promoted through senior leadership came through in staff responses. For example, staff were more alert to, and understood their own role as a parental one, supporting the establishment’s wider aim of emulating the family structure within its workforce.

There were views that this renewed focus on safeguarding and cultural change was not always shared by all staff, or reinforced through the existing culture of an establishment. A common theme that arose was the continually evolving and ever-changing profile of the children who lived there and the staff who cared for them. Retaining a full and steady complement of staff was identified as fundamental to creating and embedding a culture of safety but was particularly problematic for the YOI and STC.

Insights shared by children and staff suggested cultural change could be supported by leadership which:

- set a clear vision of safeguarding and all it encompasses
- actively promoted and championed safeguarding using a consistent and clear narrative that was communicated to staff and children
- established clear practices which facilitated effective multidisciplinary working across all teams and encouraged greater collective responsibility for safeguarding
- invested in a comprehensive package of skills-based training and education for staff to build their capability and experience to effectively safeguard and protect children and respond to their individual needs
- consulted children in how their lives in an establishment could be made safer.

3. Children in the youth secure estate do not always feel safe or are kept free from harm

The youth secure estate is entrusted with the care of children, many of whom are vulnerable and have complex behavioural needs. Establishments have a duty to take reasonable steps to keep children in their care free from harm, and children should feel safe at all times while in the youth secure estate. Feeling safe is a precondition to children being able to prosper in the youth secure estate, overcome any previous trauma they might have experienced, and prepare themselves for their reintegration into society.

Children initially reported feeling safe in their respective establishments and believed the necessary measures were in place to protect them. However, when safety was explored in more detail with them, it was clear they did not feel as safe as they initially indicated and had concerns about their safety in relation to other children. In particular, they worried about physical violence and bullying, the general unpredictability of how other children would behave, and who they were sharing a living space with. Children’s initial reporting of feeling safe was relative – rather than absolute. For example, they reported feeling relatively safe where they were compared to other secure establishments they had been to before. Children were employing self protection strategies to help them feel safe, with many operating on the basis they needed to be vigilant at all times.

Relationships with staff were a key factor in helping children feel safe. All establishments needed to continue to ensure that they were developing and maintaining good, open relationships with the children to help them feel supported and provide opportunities for the identification or disclosure of sexual abuse. Most children had at least one member of staff that they trusted and could talk to. The importance of this
A trusting relationship was recognised by both children and staff, not only to help children feel protected but also to provide staff with a space in which they could identify any changes in behaviour that might signify a problem.

Other areas that could be improved to allow children to feel safe were: more communication with children about the processes in place to keep them safe; explanations of how and why information about them was recorded and shared; more training and support for newer staff members to increase their ability and confidence to intervene and manage conflicts between children; and ongoing and refresher training for staff who have worked in an establishment for a relatively long time.

4. Prevention measures in place to keep children safe do not always reduce risk or promote a safe environment

Establishments were improving their safeguarding practices to help children feel at ease about their safety and wellbeing. A wide range of operational safeguarding measures were in place intended to keep children free from harm. For example, ongoing improvements to staff recruitment processes and training, the management of the physical space, considerations around staff to child ratios and unit allocation, monitoring of children's behaviour and the use of establishment rules.

There were mixed views between children and staff in relation to the use of technology to manage the operational environment and contribute to safety, especially CCTV and BWVCs. CCTV was present across all of the establishments and had become a ‘normalised’ part of their environment. Children perceived it to offer some protection against potential harm by staff but it did little to alter the behaviour of other children. This normalisation of constant and heightened level of surveillance and monitoring of staff and children in secure settings was arguably not ‘normal’ or indicative of a safe and rehabilitative environment. It was recognised that CCTV should not be relied upon too heavily and that it did not always deter and influence behaviour in the ways in which it was perhaps expected. An over-reliance on CCTV could also undermine communication and trusting relationships between staff, and with children.

Careful consideration of risk and managing unit dynamics differed across the establishments. In the YOI and STC, the management of risk focused on fights and mixing issues (the biggest issue they were dealing with on a daily basis). SCHs were faced with the challenge of managing a mixed population, in both gender and status (welfare and criminal justice cases).

It is important to acknowledge the unique risks that some establishments in the youth secure estate have to manage in a careful and dynamic way. The challenges of managing a mixed population should not be underestimated. Children in two mixed sites spoke to us about their concerns in mixing with other children, particularly in relation to the type of offences committed by other children including offences of a sexual nature. There were also several instances described by children who felt uncomfortable in the presence of the opposite sex.

Restraint should only be used when a child poses an imminent threat of injury to themselves or others and must never be used as a means of punishment or as a disciplinary measure. It was concerning to see how often restraint appeared as a theme in the accounts of children and staff. It was also concerning that there was no backstop against restraint being used on children with known past experiences of sexual abuse.

5. Children in the youth secure estate are not well equipped to have healthy sexual relationships

While in the care of the youth secure state, children need to develop the skills that will allow them to have healthy sexual relationships when back in the community. This includes more education about
sexual abuse that is offered to all children in the care of the youth secure estate – and not limited to those few children identified as needing particular support.

The few children who had received specific education on this topic spoke positively about the fact it had given them a better understanding of how to recognise abusive behaviours. It had helped to prepare them for having healthy relationships in the community while enabling them to identify potentially abusive behaviours they might experience in the youth secure estate. For the majority of children, however, knowledge and understanding of child sexual abuse was very limited. They typically understood it in ‘extreme’ physical forms of rape and were not aware of its nuances and the different manifestations it could take. Some children had no awareness of child sexual exploitation at all. Knowledge of child sexual abuse and what types of behaviours are acceptable often came from peers in the community rather than formal mainstream education, which many may have missed. The secure environment could provide an opportunity to educate children on healthy sexual relationships when combined with a rehabilitative culture and skilled workforce.

6. Children and staff struggle knowing what constitutes abuse and inappropriate sexual behaviour

Managing sexual behaviour is challenging for staff. More guidance and support on what constitutes normal sexual development for children and which behaviours signify a cause for concern was needed for staff to feel confident to identify sexual abuse and harmful sexual behaviours. This in turn would improve the understanding and behaviour of the children. A consistent approach from staff, combined with the introduction of education on healthy sexual relationships (and ongoing targeted interventions) would also allow children to develop their understanding of what types of behaviour they should not be exhibiting or tolerating from others.

Children and staff could find it challenging to decipher what behaviours were appropriate in these settings. Amongst staff, this led to inconsistent practice in challenging sexualised behaviours – reported as being a cause for concern in establishments, particularly in the STC. There did not seem to be a set threshold for which behaviours to report as a safeguarding concern. Staff talked about the subjective nature of identifying and responding to this type of behaviour which was influenced by staff’s experience, professional training and their length of service. This was also noticed by the children who reported variability in staff’s responses and if, how and when they would intervene. For children experiencing potentially harmful sexual behaviours, they were not always identified as such. Behaviours deemed inappropriate could also come to be seen by children as acceptable in this environment and there were various barriers to children reporting sexualised behaviours to staff. This further contextualised and highlighted the difficulties that children and staff had in conceptualising what was appropriate and ‘normal’ within a secure setting.

7. More work is needed to ensure staff in the youth secure estate are equipped to deal with safeguarding issues

It is essential that staff have a detailed understanding of safeguarding practices and implementation, and are adequately trained and supported to raise concerns and respond to disclosures. Senior management need to cascade relevant information and rigorous monitoring should be in place to ensure safeguarding practices are being applied in a timely, consistent, safe and proportionate way.

Staff raised several factors that could influence the successful translation of policy and process into effective practice including: a more streamlined and simplified safeguarding process which facilitates comprehensive and timely information sharing and communication between teams and external agencies; a clear steer from senior leaders reinforcing a child-centred approach to safeguarding; greater clarity on what to expect from the safeguarding process for both children and staff; and regular safeguarding
training which is timely and responsive to the current challenges faced within the secure estate, including child sexual abuse. Regular supervision in relation to safeguarding as well as support for those staff responding to safeguarding concerns should also be provided to ensure staff are receiving adequate monitoring and assistance.

Staff generally understood what safeguarding meant and saw it as an all encompassing concept in keeping children safe. They were able to describe various behaviours that would be a concern although there were varied and subjective views towards the nuances of certain (including sexual) behaviours. Staff were confident in the steps they would take in raising or reporting a safeguarding concern. However, this did not always mirror the formal safeguarding process by which to report, which was perceived to be overly complex and confusing in certain establishments. Staff described a culture in which they could and would openly challenge behaviours of both children and colleagues although, with colleagues, they would not typically use the formal whistleblowing route to do this. Despite staff feeling confident and capable of responding to and raising any safeguarding concerns, the wide variation in their lack of knowledge and application of the formal processes was concerning.

8. Fostering good relationships and multidisciplinary working is a challenge

Relationships with external partners and multidisciplinary working are key aspects of the safeguarding process. Establishments need to improve the relationship with key internal and external partners such as the safeguarding team and the LADO in order to improve the effectiveness of the overall safeguarding process. Improving staff’s understanding of the different roles involved in the process and the importance of these relationships may help to achieve a more coordinated, cohesive and effective safeguarding process.

All establishments highlighted problems with their relationships with key stakeholders in the safeguarding process. While some improvements were noted, staff described a lack of joined up working and poor information sharing with both internal and external colleagues and not always being fully informed about the processes or cases relating to individual children. Information sharing with external agencies was often described as being poor, leaving staff frustrated that they did not have all the required information. Perceptions of the safeguarding team and the LADO were not always positive. In the YOI particularly, the safeguarding team were not always deemed to be visible or helpful, affecting the degree to which staff (and children) would utilise them as a resource. Staff’s understanding of the LADO was also patchy, resulting in some staff members perceiving them as a tool to have staff suspended or dismissed – rather than a support in the safeguarding process.
## Acronyms and glossary

### Table A.1: Key acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
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</thead>
<tbody>
<tr>
<td>BAME</td>
<td>Black, Asian and Minority Ethnic</td>
</tr>
<tr>
<td>HMIP</td>
<td>Her Majesty’s Inspectorate of Prisons for England and Wales</td>
</tr>
<tr>
<td>HMPSS</td>
<td>Her Majesty’s Prison and Probation Service</td>
</tr>
<tr>
<td>LADO</td>
<td>Local Authority Designated Officer</td>
</tr>
<tr>
<td>REA</td>
<td>Rapid Evidence Assessment</td>
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<tr>
<td>SCH</td>
<td>Secure Children’s Home</td>
</tr>
<tr>
<td>STC</td>
<td>Secure Training Centre</td>
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<tr>
<td>YCS</td>
<td>Youth Custody Service</td>
</tr>
<tr>
<td>YJB</td>
<td>Youth Justice Board</td>
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<tr>
<td>YOI</td>
<td>Young Offender Institution</td>
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</tbody>
</table>

### Table A.2: Glossary

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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</thead>
<tbody>
<tr>
<td>Child</td>
<td>A person under the age of 18.</td>
</tr>
<tr>
<td>Child placed on welfare grounds</td>
<td>Children entering SCHs who have been admitted via a welfare order (as per Section 25 of the Children Act 1989) rather than because they have committed an offence.</td>
</tr>
<tr>
<td>Child sexual abuse</td>
<td>Sexual abuse of children involves forcing or enticing a child or young person to take part in sexual activities. The activities may involve physical contact, and non-contact activities such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse including via the internet. Child sexual abuse includes child sexual exploitation.</td>
</tr>
<tr>
<td>Child sexual exploitation</td>
<td>Sexual exploitation of children is a form of child sexual abuse. It involves exploitative situations, contexts and relationships where a child receives something, as a result of them performing, and/or another or others performing on them, sexual activities. Child sexual exploitation can occur through the use of technology.</td>
</tr>
<tr>
<td>Custodial institution</td>
<td>Umbrella term to describe the establishments in operation for children and young people in the England and Wales youth justice system. See also ‘youth secure estate’.</td>
</tr>
<tr>
<td>Detached duty staff</td>
<td>Staff attached to one establishment but who are temporarily re-deployed to a different establishment for operational reasons, for example staff shortages.</td>
</tr>
<tr>
<td>Grassing</td>
<td>Informing the police or someone in authority about an incident.</td>
</tr>
<tr>
<td>Individual convicted of a sexual offence</td>
<td>A person who commits a crime involving a sexual act.</td>
</tr>
<tr>
<td>Institution</td>
<td>Means the same as ‘organisation’. That is, a group of people who work together in an organised way for a particular shared purpose. For example, a business, a government department, a school or a church.</td>
</tr>
<tr>
<td>Juvenile</td>
<td>A person under the age of 18. See also ‘child’ and ‘young person’.</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
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<tr>
<td>Non-operational staff</td>
<td>For the purpose of this report, non-operational staff are those whose primary role does not involve working on the residential units with the children. They will still have some contact with the children but are in specialist roles such as education, healthcare, support roles or management.</td>
</tr>
<tr>
<td>Operational staff</td>
<td>For the purpose of this report, operational staff are those whose primary role is working on the residential units with the children rather than in specialist roles such as education, healthcare, support roles or management.</td>
</tr>
<tr>
<td>Perpetrator</td>
<td>A person who has committed a harmful, illegal or immoral act.</td>
</tr>
<tr>
<td>Prevalence</td>
<td>The proportion of a population who has experienced a particular event, such as child sexual abuse.</td>
</tr>
<tr>
<td>Qualitative research</td>
<td>Qualitative research uses words and themes, rather than numbers, to answer research questions. Qualitative social research seeks to observe and understand social situations without measuring them using numbers, for example, through interviews with people involved.</td>
</tr>
<tr>
<td>Rapid evidence assessment (REA)</td>
<td>A research methodology used in the identification, quality assessment and synthesis of existing literature on a particular topic. More structured and rigorous than a standard literature review, it is not as exhaustive as a systematic review.</td>
</tr>
<tr>
<td>Rehabilitation</td>
<td>The reintegration into society of a convicted person, with the aim of preventing further offending.</td>
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<tr>
<td>Remand</td>
<td>'On remand' refers to those individuals who are placed in the youth secure estate, awaiting conviction or sentence.</td>
</tr>
<tr>
<td>Safeguarding</td>
<td>Can be defined as: protecting children from maltreatment; preventing impairment of children's health or development; ensuring that children are growing up in circumstances consistent with the provision of safe and effective care; and taking action to enable all children to have the best life chances.</td>
</tr>
<tr>
<td>Secure Children's Home (SCH)</td>
<td>Secure custodial institution run by the local authority for children convicted or on remand for a criminal charge, and for those admitted via a welfare order. Accommodates males and females aged 10–17.</td>
</tr>
<tr>
<td>Secure Training Centre (STC)</td>
<td>Secure custodial institution for children convicted or on remand. Accommodates males and females aged 12–17.</td>
</tr>
<tr>
<td>Unit</td>
<td>The particular section or building in the establishment where an individual child’s room is located. Children's rooms are typically located in one of several units. Units are sometimes referred to as 'wings'.</td>
</tr>
<tr>
<td>Young Offender Institution (YOI)</td>
<td>In the context of this report, this is used to describe a secure custodial institution for male children convicted or on remand, aged 15–18.</td>
</tr>
<tr>
<td>Young people/young person</td>
<td>In the context of this report, where this is used when referencing literature, legislation or guidance, it describes someone aged 18 or over who is held in the youth secure estate. However, during interviews children and staff often referred to anyone held in the establishment as a young person. Therefore where it is used in verbatim quotes, it describes anyone currently living in that particular establishment.</td>
</tr>
<tr>
<td>Youth secure estate</td>
<td>Umbrella term to describe the establishments in operation for children and young people in the England and Wales youth justice system. See also 'custodial institution'.</td>
</tr>
</tbody>
</table>


Council of Europe (2009). Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), Report to the Government of the UK on the visit to the UK from 18 November to 1 December 2008. [Online]. Available at: https://rm.coe.int/1680698700 [Accessed 5 December 2018].


