

Safe inside?

**Child sexual abuse in the youth
secure estate**

Summary report

Independent Inquiry into Child Sexual Abuse

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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Summary report

Claire Soares, Rachel George, Laura Pope, Dr Verena Brähler

IICSA Research Team

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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.

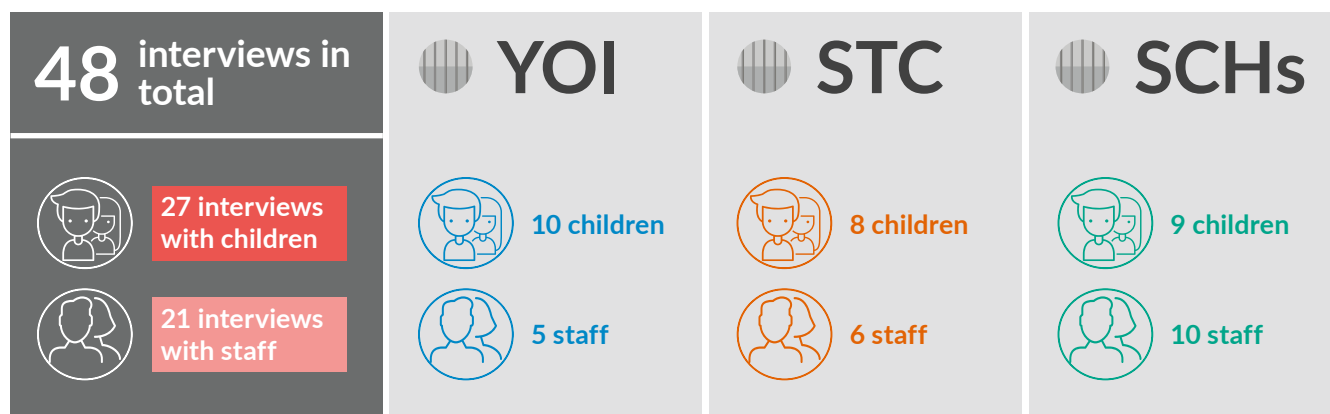
Methodology, ethics and limitations

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



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

<p>1) Some practices in the youth secure estate do not seem to serve the best interests of the child</p>	<p>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.</p> <p>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.</p>
<p>2) More work is needed to ensure safeguarding and embedding a culture of safety is seen as everyone's concern</p>	<p>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.</p> <p>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.</p>
<p>3) Children in the youth secure estate do not always feel safe or are kept free from harm</p>	<p>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.</p> <p>Children had several concerns about their safety, particularly in relation to violence from other children.</p>

<p>4) Prevention measures in place to keep children safe do not always reduce risk or promote a safe environment</p>	<p>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.</p> <p>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.</p>
<p>5) Children in the youth secure estate are not well equipped to have healthy sexual relationships</p>	<p>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.</p> <p>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.</p>
<p>6) Children and staff struggle knowing what constitutes abuse and inappropriate sexual behaviour</p>	<p>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.</p> <p>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.</p>
<p>7) More work is needed to ensure staff in the youth secure estate are equipped to deal with safeguarding issues</p>	<p>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.</p> <p>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.</p>
<p>8) Fostering good relationships and multidisciplinary working is a challenge</p>	<p>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.</p> <p>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.</p>

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