Sexual Abuse of Children in Custodial Institutions: 2009–2017

Investigation Report
February 2019

A report of the Inquiry Panel
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Executive summary

In England and Wales, there are currently three types of institution where children may be detained within the criminal justice system. These are young offender institutions (YOIs), secure training centres (STCs) and secure children’s homes (SCHs). There are five YOIs, one of which is in Wales, for boys aged 15 to 17; three STCs, all in England, for boys and girls aged from 12 to 17; and eight SCHs which accept children detained for criminal justice reasons, one of which is in Wales, for boys and girls aged 10 to 17.

This investigation concentrated on the period from 2009 to 2017.

The numbers of children detained in these institutions have reduced considerably over time, with a current population of around 900. Several witnesses told us how, in the 1950s, 1960s and 1970s, they had been placed in custodial institutions for reasons apparently unconnected with any need for either a punitive or a custodial environment. These included truancy, death of parents, running away from home, being beyond parental control and family breakdown. Children as young as nine were detained in these establishments, some of which were previously designated as 'assessment centres' and 'approved schools'.

Over decades it has continued to be the case that children detained in a custodial or secure setting are among the most vulnerable in society, experiencing unhappy and disrupted childhoods. Many have become involved in regular offending, some of it of a violent or sexual nature.

A further matter of concern regarding the current child population in custody is the proportion of children on remand prior to trial, at around one-third. This number of children exposed to the risks associated with custody seems very high and should be investigated by the Youth Custody Service, with a view to reducing that population in the future.

The accounts from adult survivors of child sexual abuse who were detained in custodial institutions in earlier years were among the worst the Inquiry has heard. One example of this was a witness who as an 11-year-old boy was sexually assaulted by two members of staff at the same time. Another witness detailed at least 35 examples of times when he was raped and sexually assaulted by four members of staff and a former pupil at Stanhope Castle Approved School. On several occasions he was choked unconscious while being abused.

Examples of more recent allegations were that in 2015 a female member of staff at Medway STC had masturbated children there, and that in 2014 members of staff at Rainsbrook STC had permitted two young people to go into a bedroom there together, knowing that one of the young people was going to defecate on the other’s face, and that they observed while this happened.
The combination of challenging behaviour and vulnerability within the current population in custodial settings often presents difficulties in safely managing and caring for these children and young people, some of whom may be violent to staff and other children. Nevertheless, we concluded that children in YOIs and STCs are not safe from harm, either physical or sexual. Recent inspection reports from Ofsted and HM Inspectorate of Prisons also raised serious concerns about the safety of children in several units in the custodial estate.

The culture of these institutions, particularly their closed nature and focus on containment and control, has not provided an environment that protects children from either physical or sexual abuse. Many witnesses supported this view, with a former Chief Inspector of Prisons describing children in custody as “very vulnerable children in a very dangerous place”.

Work carried out by the Inquiry has shown that the number of reported incidents of sexual abuse is much higher than was previously understood. Information obtained directly from the relevant custodial institutions and related authorities has found 1,070 reported incidents of alleged sexual abuse in the period 2009–2017, despite the significant drop in numbers of detained children over that time and the relatively low number overall. These allegations were mostly against staff and were often alleged to have taken place during restraint or body searches. Nor do the numbers show any sign of reducing over time, with allegations in the years 2016 and 2017 running at similar levels, at just over 200 in each year.

Complaints of sexual abuse in YOIs and STCs were rarely investigated properly, with very little evidence of involvement of the statutory authorities, signifying a failure to adhere to normal child protection procedures.

The perception and reality of a habitually violent atmosphere in YOIs and STCs has been made worse by the approach of these institutions to restraint, strip searching and pain compliance techniques. The latter includes such methods as bending of a child’s thumbs and wrists, which are permitted by Ministry of Justice guidance. From March 2016 to March 2017, there were 119 recorded incidents of pain compliance being used on children. This form of control is particularly intimidating to children who have been sexually abused. In itself, this use of pain compliance should be seen as a form of child abuse and must cease.

Throughout this investigation, the differences between the regimes in YOIs and STCs and those in SCHs became increasingly clear. The latter are more child centred, with better staff ratios and training requirements. These institutions are subject to similar standards of care to those applied by Ofsted to children’s homes. Importantly, the environment is one in which it is potentially easier to build trusting relationships with children, where they would feel safer and more likely to disclose sexual abuse. A serious concern is the uneven availability of SCHs which accept children detained for criminal justice reasons, with none in London and the south east of England.

Consideration of these issues led us to examine the context of policy formulation for children in custody at government level. At present, for YOIs and STCs, it lies with the Ministry of Justice, with the Department for Education having ultimate oversight for SCHs. These two departments have distinct but overlapping priorities
in relation to the justice system, education and child welfare. We conclude that the needs of children in custody would be better served by the Ministry of Justice and the Department for Education sharing policy responsibility for managing and safeguarding children in custodial institutions. This is to ensure that standards applied in relation to children in custody are jointly focussed on securing child welfare as well as discipline.

For much of the period under investigation, custodial institutions for children have been very poorly resourced. Staff turnover ran at unacceptable levels in YOIs and STCs, with low morale and inadequate training, including safeguarding training. In 2016, the outsourced contract for operating Medway STC had to be taken back into government control, while the contract for Rainsbrook STC was transferred to another private provider. Few of the recommendations contained in inspection reports of YOIs and STCs have been achieved. There is little doubt that the service was in crisis towards the end of the period under investigation.

In 2017, the Youth Justice Board itself said that the youth secure estate was “on the edge of coping”. In the same year, the Youth Custody Service was set up with a view to making improvements. It has introduced measures to professionalise the workforce in YOIs and STCs, but this falls short of individual workforce regulation, which the Inquiry recommended in its Interim Report for staff working with children in residential care settings. We recommend that arrangements are introduced for the professional registration of staff in roles which involve responsibility for the care of children in YOIs and STCs.

The history of the children’s custodial estate has been marked by structural change and instability, following attempts by various governments to provide an effective model of care and control. These have largely failed. The Youth Custody Service has recently proposed a ‘secure school’ model, which is now in development. While this is welcomed, it must not repeat the weaknesses of current and previous ways of working, and must make child safety a top priority. The secure school should be the final attempt to get it right for every child in custody, to ensure they are free from the risk of sexual abuse and harm. Recent reports indicate that the timetable for tendering for the contract to run the pilot secure school has already slipped. The new system should be brought in with speed and efficiency. If the secure school model does not work, more radical change will be required to ensure the protection of these children, whose safety, welfare and education is the responsibility of the state.

We make a series of recommendations, covering areas such as children on remand, the practice of ‘mixed’ justice and welfare placements, staff training, workforce regulation, pain compliance and the response to allegations of sexual abuse.
‘Pen portraits’ from children in custody

Peter Smith

Peter was placed in care when he was eight because his parents had difficulties looking after him. He was placed in several institutions, including one known as “the black hole of Calcutta”. He spent a few months at Aycliffe Assessment Centre and saw other boys being beaten. In 1963, aged nine, he was moved to Stanhope Castle Approved School. There was a degrading and physically violent atmosphere at Stanhope. Deep bruises from beatings by the staff would stay on the boys’ bodies for weeks and Peter recalled rampant bullying by older boys.¹

Peter was sexually abused many times. The incidents he described were just the "tip of the iceberg". Within a few days of arriving, two older boys made him give oral sex to one, while he masturbated the other. One of the boys tried to anally rape him but he was too small. He told the teachers, who did not believe him and beat him, saying he was lying. For the next two weeks, he was made to wear two boards that read "I am a pig" on the front and "Treat me like a pig" on the back. On numerous occasions older boys attempted to anally rape him, and he was orally raped by other boys. He knew it was wrong but hoped that if he did it, the older boys would take care of him. There was also an ex-pupil in his mid to late 20s who was not a teacher but had returned to the school (CI-F108). He would give Peter chocolates before attempting to masturbate him under the bedclothes.

Peter’s first thought every morning was “How do I get through today without being abused or assaulted?” He lived in constant fear with no-one to help him and felt powerless. He reminded us that there could be a young lad called Peter in custody now, and he urged us to stop and think “How does Peter see the world?”²

Peter Robson

Peter Robson went into care in 1963, when he was 11. He was placed at Stanhope Castle Approved School from 1963 to 1967. It was a strict, "military" place, with regular violence committed by the children and the staff. He was caned across his bare bottom by the headmaster, which he saw as a sexual and sadistic act. In late 1963, an older boy who was in the next bed started to touch his penis and raped him. This type of abuse then started to occur every night. Peter does not know how the prefect and nightwatchman could not have known this was going on. He strongly suspects he suffered further sexual abuse which he has "blocked out". He said there was no opportunity to speak privately to or build a trusting

¹ Smith 9 July 2018 98–113
² Smith 9 July 2018 113–128; 140
relationship with anyone at Stanhope. He did not want to be seen as a “grass”, so did not feel able to report the abuse. Peter said he had become institutionalised and frightened of the outside world by the time he left.³

CI-A17

CI-A17 had experienced a difficult home life and was placed in care because he ran away. He was detained at Aycliffe for four weeks, before being detained at Stanhope Castle from 1963 to 1967. Aycliffe staff were very violent towards the boys on a daily basis. He was slapped, punched and caned regularly. The boys would often need medical treatment, but there was never any investigation as everybody knew what happened and the violence against the boys was seen as "normal".⁴

When CI-A17 was around 10 or 11, a former resident of the school who had returned as an unofficial member of staff (CI-F108) forced his penis into CI-A17’s mouth when he was in the bathroom one night, saying “Don’t say nothing”. He was so shocked he wet the bed and was caned as a result.

CI-A17 told us of a particularly shocking incident of sexual abuse. Around Christmas 1963, when he was about 11, CI-F108 anally raped him in one of the dormitories, while the deputy head (CI-F11) orally raped him at the same time and then anally raped him. CI-A17 collapsed on the floor in tears; there was blood on the floor.⁵

After this incident, CI-A17 lived in constant fear of being raped and started carrying a concealed nail in his sock to enable him to fight back. On one occasion, CI-F108 tried to assault him in the school play area toilets but his screams alerted other boys which caused CI-F108 to leave. He said he never reported the attacks because he did not know who to trust or who to complain to, not least because the people in positions of authority to whom he otherwise might have disclosed the abuse were also his abusers. He also feared reprisals from the teachers.⁶

Colin Watson

Colin Watson was sentenced to an approved school in 1958 and spent short periods in remand homes where he was physically abused. He then was moved to Aycliffe, where he was subjected to significant staff violence and absconded several times. He was moved to Stanhope Castle in 1960, when he was 11. Again he experienced staff violence, including being dragged across the dining hall and slammed into a wall, which broke his nose. Later that day, when he was alone in the sick bay, the head of house (CI-F110) anally raped him and said “Say that I’ve been here and I’ll kill you”. Shortly after this incident, the deputy headteacher (CI-F11) took him to the store rooms at the back of the gym and forced him to masturbate him.⁷

³ Robson 9 July 2018 144; 149; 151; 154–159; 162
⁴ CI-A17 10 July 2018 2; 4–5; 8
⁵ CI-A17 10 July 2018 13; 15
⁶ CI-A17 10 July 2018 16–17
⁷ Watson 10 July 2018
Colin Watson detailed at least 35 examples of times when he was raped and sexually assaulted by four members of staff and a former pupil resident (CI-F108). On several occasions he was choked unconscious while being abused. He also witnessed other boys being abused. He believed there was an organised group who knew of each other’s abuse and abused together. This group included the head of house (CI-F110), the deputy headteacher (CI-F11), a female teacher who lived in the school (CI-F114) who groomed and controlled him and a former pupil of the school (CI-F108). He was also abused by a teacher and Scoutmaster (CI-F116) who forced him to masturbate him. The violence meant he was too frightened to report the abuse, but when he did tell a police officer about the abuse in 1961 the officer’s response was to punch him and tell him “That’s our friends you’re talking about”.8

CI-A34

CI-A34 was placed in a custodial institution due to his family breaking down. He spent time in Aycliffe but did not recall any abuse there. In 1968 he moved to Stanhope Castle, when he was 11 or 12. There was a culture of violence there; he was hit at least once or twice a day by members of staff. A housemaster (CI-F112) offered him cigarettes in return for masturbation and, when CI-A34 initially refused, he threatened to make his life hard in the school. This continued throughout his time at Stanhope Castle. CI-F112 took CI-A34 to his home twice and forced him to masturbate him there. When CI-A34 began to refuse, CI-F112 started hitting him more and more for no reason.9

CI-A34 used to run away, but could not tell his father about the abuse. When he told a female member of staff about the abuse, she apparently reported this to CI-F112 as CI-F112 announced publicly CI-A34 had been spreading lies and then gave him the hardest beating of his life. The consequences of his disclosure taught him to suppress thoughts of the abuse and he did not report it again. When he was 17, CI-A34 was moved to Medomsley Youth Detention Centre, where the violence was worse than at Stanhope and where he knew of other boys being sexually abused.10

CI-A30

In 1970, when he was around eight or nine, CI-A30 was placed in custody due to his parents failing to take him to school and unsatisfactory home conditions. He had previously been sexually abused by a family member. He went to Vinney Green and Kingswood, and then Forde Park from around 1973. There was violence between the boys and the staff would cane the boys publicly at Forde Park.11

One of the older boys tried to sexually attack him, but CI-A30 managed to fight him off. However, there was extensive sexual abuse by staff. CI-A30 was sexually abused by a maintenance worker (CI-F121, who touched CI-A30’s penis inside his shorts while playing with his own penis); another maintenance worker (CI-F122, who touched CI-A30’s penis in the showers and tried to make CI-A30 touch his erect penis); the Scoutmaster (who slapped him, perforating his eardrum, and then put his hands down CI-A30’s trousers and grabbed

8 Watson 10 July 2018 29; 34–36; 40; 47; 52
9 CI-A34 10 July 2018 73–77; 81–83
10 CI-A34 10 July 2018 78; 83–84; 91
11 CI-A30 10 July 2018 106; 109; 113
his penis); a woodwork teacher (CI-F24, who beat him with a piece of wood in the workshop, before touching him in a sexual manner, asking CI-A30 to perform oral sex on him and pulling CI-A30’s head towards his groin); and a gardener (who put his hands down CI-A30’s shorts while he masturbated himself and who anally raped him in the garden shed). One of the PE teachers (CI-F125) also showered with the boys and appeared to show an interest in them, which made CI-A30 feel uncomfortable.\(^\text{12}\)

CI-A30 described Forde Park as a centre for paedophiles who were well cemented within the organisation. He did not report the abuse because he had been threatened by CI-F122; he felt he would not be believed and would be punished. The only people he could have reported it to would have been other paedophiles or their friends.\(^\text{13}\)

**Recent complaints from the Inquiry’s case study material**

**HMYOI Feltham**

- A 17-year-old detainee submitted a written complaint after being searched by a female prisoner officer in September 2009, saying "*She sexually assaulted me by squeezing my penis a couple of times. I have several witnesses who saw the assault*".\(^\text{14}\)

- A detainee at HMYOI Feltham disclosed to his advocate in March 2012 that an officer had come into his cell to hand out lunch and then grabbed him by the genitals.\(^\text{15}\)

- There was a report made to Childline by a child who said he had witnessed other children raping a child in the shower.\(^\text{16}\)

**HMYOI Werrington**

- In April 2013, a detainee stated "*A female officer touches my bum and dick and grabs me during searches on visits*".\(^\text{17}\)

- In August 2014, an unidentified person told Childline he had been informed by a person recently released from HMYOI Werrington that a 16-year-old had been raped while detained there by an inmate from a rival gang.\(^\text{18}\)

**Medway STC**

- In October 2015, a male trainee reported that another detainee had pulled a knife on him, tried to kiss him and inserted his finger into his bottom, then hit him three or four times. He said it had happened in a classroom where there was no CCTV. As a result of the incident, he suffered from pain when he went to the toilet. He complained about not seeing a doctor.\(^\text{19}\)

\(^\text{12}\) CI-A30 10 July 2018 106; 125; 127; 129; 131–132; 136; 138; 139
\(^\text{13}\) CI-A30 10 July 2018 128; 130; 139; 142
\(^\text{14}\) Wood 16 July 2018 58
\(^\text{15}\) Wood 16 July 2018 58
\(^\text{16}\) Wood 16 July 2018 88
\(^\text{17}\) Wood 16 July 2018 132
\(^\text{18}\) Wood 16 July 2018 133
\(^\text{19}\) Wood 17 July 2018 2–3
• In April 2016, a 16-year-old trainee contacted police and described a male member of staff touching him in the groin area.\textsuperscript{20}

• An allegation was made in April 2016 that a female member of staff had formed an inappropriately close relationship with a trainee. Another person had said “He follows her around like a puppy. They sit on the sofa. It appears like something is occurring. It’s uncomfortable to watch. It looked like a physical interaction.”\textsuperscript{21}

• It was reported in April 2016 that a female member of staff had masturbated children there.\textsuperscript{22}

• According to an allegation made in April 2016, a member of staff overheard a child tell another child he had received a love bite to his chest from a member of staff.\textsuperscript{23}

**Rainsbrook STC**

• In November 2010, a male trainee said staff member B had inappropriately touched his genital area while carrying out searches and had then said to another trainee “Get your knob out”.\textsuperscript{24}

• In May 2011, it was alleged that staff member B had restrained a female trainee and touched her inappropriately, trying to remove her top. She said “I’m disgusted by this incident”.\textsuperscript{25}

• On 30 April 2013, a 14-year-old trainee telephoned Childline and reported that people at the institution knew he was “gay”. He said others thought they could do what they wanted with him when he was in the shower. He added he had dropped the soap and someone put their willy in his bum, and that prison guards had laughed at him when he told them. He was worried if he wrote a letter to his solicitor that the guards would read it and not pass it on.\textsuperscript{26}

• In April 2014, it was alleged a staff member had restrained a 16-year-old boy, which was caught on CCTV. The staff member had stood over the boy, who was sitting on a sofa, and put his knee on the boy’s stomach. The boy threw a DVD cover at the staff member, who then tickled and bear-hugged the boy. The boy ended up on all fours with the staff member squatting behind him, thrusting his hips towards the boy, who was crying. The boy said he had found the experience degrading.\textsuperscript{27}

• In July 2014, a child told his mother (and made a written complaint) that a staff member had threatened, if he did not behave and calm down, he would rape him.\textsuperscript{28}

• It was alleged that in October 2014 a female member of staff permitted a male trainee to put his hand on her thigh and also permitted other trainees to touch her in a sexual way. It was also suggested she had kissed at least one trainee.\textsuperscript{29}

\textsuperscript{20} Wood 17 July 2018 3 
\textsuperscript{21} Wood 17 July 2018 3 
\textsuperscript{22} Wood 17 July 2018 5 
\textsuperscript{23} Wood 17 July 2018 5 
\textsuperscript{24} Wood 17 July 2018 30 
\textsuperscript{25} Wood 17 July 2018 31 
\textsuperscript{26} Wood 17 July 2018 31 
\textsuperscript{27} Wood 17 July 2018 31–32 
\textsuperscript{28} Wood 17 July 2018 32 
\textsuperscript{29} Wood 17 July 2018 33
• In December 2014, it was alleged members of staff had permitted two young people to go into a bedroom together, knowing that one of the young people was going to defecate on the other’s face and observed while this happened.\(^\text{30}\)

**Vinney Green SCH**

• It was alleged in February 2010 that a member of staff told a female resident she had a "nice arse" and asked if she would "like to be part of a threesome".\(^\text{31}\)

• In March 2010, a female resident told a social worker that a male staff member had entered her bedroom and then touched her bottom and thigh in a sexual way. She said he would not stop when asked but rather made inappropriate comments such as "You’re just so sexy" and also commented on how her breasts looked.\(^\text{32}\)

**Aycliffe SCH**

• In February 2016, a 15-year-old female resident said a member of staff touched her breasts and vagina during restraint.\(^\text{33}\)
Part A

Introduction
Introduction

1. The Sexual Abuse of Children in Custodial Institutions investigation is an inquiry into the extent of any institutional failures to protect children from sexual abuse and exploitation while in custodial institutions. Children in detention are particularly vulnerable to sexual abuse. However, very little is known about their experiences or the extent to which institutions in England and Wales have discharged their duty of care to protect them. The Inquiry’s work on children in custody seeks to address this gap in public understanding.

2. This phase of the investigation has focussed on recent and current issues relating to the sexual abuse of children in custody. Specifically, we have considered the nature and extent of, and institutional responses to, recent sexual abuse of children in custodial institutions, and the adequacy of current institutional and systemic protections of children in those institutions from sexual abuse. For the purposes of this phase, 'recent' was considered to mean sexual abuse which allegedly occurred on or after 1 January 2009.

3. The process adopted by the Inquiry is set out in Annex 1 to this report. Core participant status was granted under Rule 5 of the Inquiry Rules 2006 to one group of complainants, one individual complainant and four institutions. We held two preliminary hearings in February and June 2018 to open this phase of the investigation and to deal with procedural matters.

4. In March 2018, the Inquiry’s research team published a Rapid Evidence Assessment (REA) on child sexual abuse in custodial institutions. This summarised the existing evidence and provided an invaluable context for the public hearings that followed over nine days in July 2018.

5. The Inquiry’s legal team collated and reviewed a large amount of witness and documentary evidence, which was disclosed to the core participants when relevant.

6. The overarching issues considered in this phase of the investigation, derived from the definition of the scope of the investigation set by the Inquiry and the Terms of Reference for the Inquiry set by the Home Secretary, were:

   a. How much sexual abuse of children in custodial institutions in England and Wales has been alleged to have taken place in recent years (ie since 1 January 2009)? What has been the nature of the sexual abuse alleged?

   b. Has there been recently, and is there now, a culture within custodial institutions which inhibits the proper prevention, exposure and investigation of child sexual abuse?

   c. What are the current institutional or systemic protections for children in custodial institutions in respect of sexual abuse? Are they effective?

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35 [www.iicsa.org.uk/terms-reference](www.iicsa.org.uk/terms-reference)
d. In respect of a sample of allegations of sexual abuse in custodial institutions, what have the institutional responses been? How effective, overall, have these responses been?

7. In order to address the overall culture and systems issues, we heard evidence about a range of factual issues. These included broad questions, such as whether children in custody can ever be fully protected from sexual abuse, whether children are more at risk of sexual abuse in institutions run by private contractors and whether the sexual abuse of children in custody is part of a wider pattern of declining safety in the custodial estate. They also included more specific questions, such as whether the complaints process available to children in custodial institutions is effective, whether they have adequate access to family and friends and whether there should be greater use of CCTV or body-worn cameras to better protect children in custody from sexual abuse.

8. At the public hearings we heard from several complainant core participants, who described being sexually abused while children in custody some years ago. These powerful accounts served as a reminder of how vulnerable children in custody can be and of the need for vigilance to ensure that they are protected from the risk of sexual and other abuse as far as possible. They also reminded us that the sexual abuse of children in custody can be hidden from view. The Inquiry’s own prevalence analysis confirms this.

9. It was not possible for us to hear directly from any complainant who described sexual abuse in the post-2009 period on which this phase of the investigation was focussed. The Inquiry legal team made significant efforts to contact complainants by, for example, publicising the investigation on the website, inviting lawyers and organisations in contact with children in custody to assist, and following up through institutions with some individuals whose experiences were set out in the institutional disclosure, but this was without success. This could be for a number of reasons, such as the transient nature of the youth custodial estate and the inherent vulnerabilities of those who have been abused as children in custody. This makes them particularly hard to reach. However, we ensured the voices of complainants of recent sexual abuse in custody were heard in the hearings as much as possible.

10. We heard from professionals with extensive experience of children in custody:

- Dr Laura Janes (Legal Director of the Howard League for Penal Reform)
- Carolyne Willow (a children’s rights campaigner and founder of Article 39)
- Pam Hibbert OBE (former Chair of the National Association of Youth Justice)
- Professor Nick Hardwick (former Chief Inspector of Prisons)
- Angus Mulready-Jones (a current inspector of prisons)
- Mark Johnson (founder of User Voice)
- Katherine Willison (Director of Children’s Social Care, Practice and Workforce within the Department for Education, DfE)
- Matthew Brazier (Ofsted specialist adviser for looked after children who also has some responsibility for the secure estate)
• Chief Constable Simon Bailey (the National Police Chiefs’ Council’s lead on child protection)
• Albert Heaney (Director of Social Services and Integration, Welsh Government)
• Sara Robinson and Peter Savage (Youth Custody Service – respectively, its Interim Executive Director and Head of Operational Contract Management).

11. Many witnesses addressed the issue of the culture in custodial institutions for children. We were keen to understand whether these cultural elements inhibit the proper prevention, exposure and investigation of child sexual abuse. Cultural factors are considered in Part D of this report.

12. Where we looked at systems issues, the REA provided us with a thorough overview. The witnesses developed this evidence and all, to varying degrees, addressed the question of what reforms are needed to the current systems.

13. We heard evidence from Alan Wood, who was instructed by the Inquiry to act as an independent expert witness. Mr Wood has been a qualified social worker since 1995 and has focussed on child protection and safeguarding practice in both the private and public sectors. His work has included carrying out case file reviews, investigating complaints and performing his own ‘front line’ social work. The Inquiry asked him to provide his opinion on a number of issues and to identify key themes that might have a bearing on the commission, detection and reporting of child sexual abuse in custodial settings.36

14. We conducted a review of a series of recent allegations of sexual abuse made by children at six custodial institutions: HM Young Offender Institutions at Feltham and Werrington; Medway and Rainsbrook Secure Training Centres; Vinney Green Secure Unit; and Aycliffe Secure Centre. We understand this is the first time specific institutional responses to a series of allegations of sexual abuse of children in custody have been subjected to such an analysis. Although we have not made findings about the adequacy of the response in respect of a particular case, the broad themes that emerged from the analysis have given us a clear sense of how these allegations are currently investigated.

15. Further witness statements were read or summarised to us. We also considered a number of further documents obtained by the Inquiry and disclosed to the core participants.

16. Howe and Co made written submissions setting out a series of proposals for reform,37 on which the witnesses were invited to comment.

17. After the hearings, the Inquiry’s research team published its report from primary research in four institutions that hold children.38 Interviews have been carried out with staff and detained children about safeguarding procedures and practices in relation to child sexual abuse. The findings of the primary research support and inform the conclusions we have reached in this investigation.

36 Wood 12 July 2018 2
37 INQ001751
38 Safe inside? Child sexual abuse in the youth secure estate
18. References in this report such as ‘HWL000001’ and ‘HWL000001_001’ are to
documents or specific pages of documents that have been adduced in evidence and that
can be found on the Inquiry website. A reference such as ‘Janes 11 July 2018 5–6’ is to the
hearing transcript (which is also available on the website); that particular reference is to the
evidence of Dr Janes on 11 July 2018 at pages 5–6 of that day’s transcript.
Part B

Context
Context

B.1: The children in custody

1. The age of criminal responsibility in England and Wales is 10. Children aged 10 or over may be charged and detained in custody, both on remand and after being sentenced. In criminal justice legislation, the word ‘child’ sometimes refers to a person under 14 and ‘young person’ to a person who is 14 to 17. However, the Inquiry’s Terms of Reference define a ‘child’ as being any person under 18, which is the terminology we have used throughout this investigation.

2. The number of children in custody has declined considerably since mid-2008, from over 3,000 to fewer than 900 children. At July 2018, there were 883 children in custody.

3. This reduction in numbers has led to significant changes in the characteristics of the population, in that those who have committed less ‘serious’ offences or who have less extensive criminal histories are now less likely to receive a custodial sentence. Changes in the prison demographic mean that there is now a higher proportion of children in custody who have committed a serious crime, in particular a violent or sexual offence. For example, Ministry of Justice statistics show that the proportion of children in custody for sexual offences increased from 5 percent in the year ending March 2011 to 10 percent in the year ending March 2016. However, children can be placed in secure children’s homes (SCHs) on welfare grounds as well as on remand or under sentence, as explained below.

4. Statistics from July 2018 indicate that, of the 883 children in custody, 348 had been sentenced to a Detention and Training Order (DTO), 246 were on remand, 233 had been sentenced under section 91 of the Powers of Criminal Courts (Sentencing) Act 2000 and 56 had been given other sentences.

5. The most recent published figures for sentence length are for the year ending March 2017: 57 percent were up to 3 months, 20 percent were 3–6 months, 9 percent 6–9 months, 6 percent 9–12 months and 8 percent more than 12 months. The median length of time a child spends in custody, whether on remand or in custody, is 90 nights.

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39 See, for example, Children and Young Persons Act 1933, section 107
40 www.iicsa.org.uk/terms-reference
41 REA, figure 4.3
42 www.gov.uk/government/statistics/youth-custody-data
43 REA, section 4.2
44 Mulready-Jones 16 July 2018 7
45 REA, paragraph 4.5
46 A DTO is given to a persistent offender between 12 and 17 years of age, and lasts between 4 months and 2 years. The first half of a DTO is served in custody, the second half is served in the community.
47 A section 91 sentence is given to a child who commits certain serious offences.
48 Youth Custody Data: November 2018
49 Length of time spent in Youth Custody 2016/17, Youth Justice Board, 2018, p10
50 Robinson 13 July 2018 7
6. The changes in the demographic have practical consequences for the youth custodial estate. As indicated in the REA, there are now proportionally more children in custody with 'challenging behaviours’ who may present significant risk to themselves and to others. The literature also suggests children in custody are now typically more vulnerable and disadvantaged. The Howard League and others have pointed out that, as young offender institutions (YOIs) accommodate the majority of children who offend, children deemed more vulnerable may now be in YOIs, rather than the smaller secure training centres (STCs) or SCHs.

7. These themes were confirmed by the witnesses. Sara Robinson described the current youth custody estate as including a "concentration of highly complex, high-needs young people" who pose "a risk of harm to others". Peter Savage similarly referred to the cohort of children in custody as "very challenging and complex young people".

8. We do not underestimate the difficulties of safely managing and caring for this group of challenging yet vulnerable children, some of whom may be violent to staff and other children.

9. As the REA sets out, the profile of the children in custody is varied:

- The population of white children in custody has decreased over the last 10 years disproportionately compared to the black, Asian and minority ethnic (BAME) population. By March 2017, children from a BAME background made up around 43 percent of the population of children under 18 in custody. A figure that had increased to 47 percent according to data from July 2018 (Youth Custody Data: November 2018)
- Prior experience of abuse, including sexual abuse, and neglect is common among children in custody. Around four in 10 children in the youth secure estate have previously been in local authority care. Many come from backgrounds of general social or economic disadvantage.
- The prevalence of mental health problems within the population of the youth secure estate is significant.
- Girls make up a very small proportion of children in custody – around 3 percent in March 2017. However, the health needs of girls in the youth secure estate are more complex than the needs of boys, and girls have higher rates of co-morbidity, self-harm and attempted suicide.

B.2: The custodial institutions

10. Children remanded in custody or detained after sentence are generally detained in a YOI, STC or SCH.

11. When a child is remanded in custody or sentenced to youth detention, the Youth Custody Service placement team will decide on the type of establishment to which the child will be sent. There are no fixed criteria, except that boys cannot be accommodated in YOIs
unless they are aged 15 or over, and there is no YOI accommodation for girls. The Youth Custody Service will consider a range of factors in deciding on the appropriate placement. The Youth Custody Service’s placement procedures indicate, for example, if the child is young, immature or requires a high level of support that a SCH or STC may be more suitable. A YOI might be suitable for someone who is emotionally mature and resilient.57

Young offender institutions

12. Most children detained are in YOIs, which were created by the Criminal Justice Act 1998 and operate under the Young Offender Institution Rules 1988 and 2000.58 There are currently five YOIs that hold children operating in England and Wales: Cookham Wood, Feltham, Werrington, Wetherby and Parc.

13. These institutions hold boys aged from 15 to 17. YOIs can accommodate 40 to 440 children, usually split into smaller units of 30 to 60. They typically hold children considered to be more resilient, who may be older and who “externalise their risk”. There is a relatively low staff to offender ratio of around 1:10. Places currently cost around £81,000 each per annum. As at December 2017, there were 641 boys detained in YOIs across England and Wales, approximately 70 percent of the total number of children detained. Only Parc is privately run.

57 INQ001808, paragraphs 14–36
58 REA, section 4.1 and appendix E; Savage 13 July 2018 14
14. Secure training centres were created by the Criminal Justice and Public Order Act 1994 and operate under the Secure Training Centre Rules 1998. There are three STCs operating in England: Medway, Rainsbrook and Oakhill. There are none in Wales. The STCs accommodate boys and girls aged from 12 to 17. One STC is male only and Rainsbrook has a separate mother and baby unit. Each STC accommodates 50 to 80 children, with accommodation usually split into smaller units of five to eight. They typically hold those children assessed as more independent, who are motivated to attend school or who have risk factors which make it inappropriate for them to be placed in a YOI. There is a higher staff to offender
ratio than is present in YOIs, of between 2:5 and 3:8. Places cost around £178,000 each per annum in 2014. At December 2017, there were 169 children held in STCs across England, approximately 18 percent of the total number of children detained. Medway was privately run by G4S until 2016, when it returned to the public sector. Rainsbrook was also run by G4S until 2016 but the contract was then transferred to MTC Novo. Oakhill is still run by G4S.59

59 REA, section 4.1 and appendix E
15. Secure children’s homes were created by the Children Act 1989 and operate under Part 2 of the Care Standards Act 2000 and applicable regulations. There are currently seven SCHs in operation in England which accept children detained for criminal justice reasons: Adel Beck, Aldine, Aycliffe, Barton Moss, Clayfields, Lincolnshire and Vinney Green. There is one in Wales: Hillside. SCHs accommodate boys and girls aged from 10 to 17. Uniquely, SCHs detain children who are on remand or convicted (on ‘justice placements’) and also children placed there for the protection of themselves or others (on ‘welfare placements’). Welfare placements can be arranged by a local authority if it considers that a child who it is looking after is likely to abscond in any other form of accommodation and may cause harm to themselves or others.

16. SCHs accommodate eight to 40 children, with accommodation usually split into smaller units. They typically hold those considered to be the most vulnerable, who have more complex needs and who are younger. Of the three types of institution, SCHs have the highest staff to offender ratio of between 1:2 and 6:8. Places currently cost around £231,000 each per annum. At December 2017, there were 114 children detained in SCHs on justice placements, approximately 12 percent of the total number of children detained. All SCHs are run by local authorities.

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60 Under the Children Act 1989, section 25
61 Under the Children Act 1989, section 22
62 REA; section 4.1 and appendix E; Savage 13 July 2018 14
Adolescent Secure Estate in the UK map from NHS England - commissioned research

This includes all SCHs, including those which do not detain children for criminal justice reasons.
B.3: Management and inspection

17. In 2017, the Youth Custody Service was created as a distinct service for youth custody within Her Majesty’s Prison and Probation Service (HMPPS), taking over many of the previous functions of the Youth Justice Board.\(^{64}\)

18. The secure estate for children and young people is subject to various inspection processes: \(^{65}\)

- YOIs are inspected annually by HM Inspectorate of Prisons (HMIP) alongside Ofsted or Estyn (Wales), and the Care Quality Commission or Healthcare Inspectorate Wales. In YOIs, Ofsted and Estyn inspect only education, skills and purposeful activity.

- Inspections of STCs are led by Ofsted or Estyn (Wales) and are carried out alongside HMIP and the Care Quality Commission or Healthcare Inspectorate Wales. Individuals acting as monitors are also placed on site in each STC.

- Ofsted regulates and inspects children’s social care services, including SCHs. SCHs have a minimum of two inspections a year and both are unannounced.

19. Each YOI has an independent monitoring board. Its purpose is to provide independent oversight of treatment and care in prisons, including YOIs. (STCs and SCHs do not have such boards.) The board has to satisfy itself as to the humane and just treatment of those held there. Its members must inform the Secretary of State of any concern and report annually to the Secretary of State on how well the prison had met the standards and requirements placed on it and what impact these had on those in custody. Board members have the right of access to every prisoner and every part of the prison and also to the prison’s records. \(^{66}\)

20. The Prisons and Probation Ombudsman (PPO) carries out independent investigations into deaths and complaints in custody. Its terms of reference include a duty to investigate complaints made by children in YOIs and STCs, to understand what happened, to correct injustices and to identify learning. \(^{67}\) The PPO’s role in complaints applies once an internal complaints process has been exhausted. \(^{68}\)

21. The role of the Children’s Commissioner is to promote and protect the wellbeing and safety of children, particularly vulnerable children, and give them the opportunity to have their voices heard. This includes those in the secure estate. The Children’s Commissioner and her team undertake regular visits to YOIs, STCs and SCHs, although there is no agreed timescale for the visits. During their visits, they have informal conversations in open settings with the children, ranging from 5–10 minutes to 30 minutes. There is no formal policy about what is discussed. Between September 2017 and April 2018, the Commissioner and her team undertook four such visits. They do not publish a report of the visit but can share observations and insights with the institution. \(^{69}\)

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\(^{63}\) Formerly the National Offender Management Service.

\(^{64}\) Savage 13 July 2018 2–3

\(^{65}\) REA, table 8.1

\(^{66}\) IMB000001, paragraphs 3, 4 and 7

\(^{67}\) PPO000001, PPO000003

\(^{68}\) www.ppo.gov.uk/investigations/make-complaint/how-to-make-a-complaint-dvd

\(^{69}\) INQ001175
22. Alan Wood summarised the role of local authorities with respect to children in custody. All children on remand are treated as being 'looked after' within the meaning of the Children Act 1989.\textsuperscript{70}

### B.4: Safeguarding policies and procedures

23. The overall policy and legislative framework for YOIs and STCs is set by the Ministry of Justice. Operational oversight of the institutions is carried out by the Youth Custody Service, part of HMPPS, an executive agency of the Ministry of Justice. The DfE has responsibility for setting the overall policy and legislative framework for SCHs but not YOIs or STCs.\textsuperscript{71}

24. The Secretary of State for Education has a duty to promote the wellbeing of all children but the Children Act 1989 gives statutory responsibilities to local authorities, which carry out the Secretary of State's responsibilities in practice.\textsuperscript{72} The Children Act 2004 puts local authorities, and directors and governors of YOIs and STCs, under a statutory duty to make arrangements for ensuring that their functions are discharged having regard to the need to safeguard and promote the welfare of children.\textsuperscript{73}

25. Section 47 of the Children Act 1989 requires local authorities to make inquiries when they have reasonable cause to suspect that a detained child is suffering, or is likely to suffer, significant harm. If allegations of abuse are staff-related, they may be referred to a local authority designated officer.

26. The recently updated *Working Together to Safeguard Children* guidance\textsuperscript{74} is a statutory document to which local authorities and all other bodies working with children must have regard in carrying out their functions. The guidance applies across YOIs, STCs and SCHs. It provides overarching guidance on topics including section 47 enquiries and how to carry out assessments. It also sets out the overall responsibilities of individual organisations. The guidance seeks to put in place a protective environment with specific rules around training and safeguarding. One of the common issues it addresses is the response to a disclosure of abuse.\textsuperscript{75}

27. The National Health Service also has a role in custodial institutions for children. NHS England does not directly provide health services but commissions them. This includes both primary care (general practice services) and secondary care services (hospital services)\textsuperscript{76} and facilities for children detained in the secure estate.

28. In December 2016 the report of the Taylor review into youth justice was published.\textsuperscript{77} The Youth Custody Service has commissioned *A Review of Safeguarding in the Secure Estate* (June 2018) led by Sonia Brooks OBE, which will encompass safeguarding from sexual abuse. This will be completed by April 2019. The review will take into account the Inquiry’s analysis of the case studies and the material that the Inquiry has produced. The terms of

\begin{itemize}
\item Under the *Legal Aid, Sentencing and Punishment of Offenders Act 2012*, section 104
\item Willison 12 July 2018 140; 141; 146
\item Willison 12 July 2018 141; 142
\item Under the *Children Act 2004*, section 11
\item DFE000876
\item Willison 12 July 2018 141-146
\item NHS000027
\item Review of the Youth Justice System in England and Wales, Ministry of Justice, December 2016 (INQ001422)
\end{itemize}
reference include a review of current operational policies for safeguarding and the processes for handling allegations and complaints (including the responses, investigation and support offered to children), corporate governance of safeguarding, and training.\textsuperscript{78}

\textsuperscript{78} Robinson 13 July 2018 46–49; HMP000427.005, paragraph 12; HMP000426.006
Part C

The prevalence of sexual abuse of children in custody
The prevalence of sexual abuse of children in custody

C.1: The REA’s findings on prevalence

1. Relatively little has been known historically about the prevalence of sexual abuse of children in custody in England and Wales. As set out in the Inquiry’s Rapid Evidence Assessment (REA):79

   - There are significant challenges in collecting accurate data on child sexual abuse in custody, and there are very limited data available.

   - The best available source of information on child sexual abuse in young offender institutions (YOIs) and secure training centres (STCs) in England and Wales is the HM Inspectorate of Prisons (HMIP) Children in Custody annual survey. This survey asks a number of children at each YOI and STC (it does not cover secure children’s homes (SCHs)) a series of questions, including whether they have experienced sexual abuse from young people or staff.

   - The HMIP survey has consistently reported relatively low levels of sexual abuse in YOIs and STCs. In the 2015/16 survey, sexual abuse by staff was reported by 1 percent of children in YOIs and 2 percent in STCs; and sexual abuse by peers was reported by 1 percent of children in YOIs and 3 percent in STCs.80

2. As identified in the REA, there are some limitations to the data available from the HMIP survey. It is a sample conducted once each year and not all detained children are surveyed. The questionnaire does not include a definition of the term ‘sexual abuse’ (so children may omit reporting incidents of sexual abuse due to a lack of understanding, or report incidents which do not amount to sexual abuse for the same reason). The questions in the STC survey may be confusing to children because of its structure. It is also unclear whether those who may require assistance in completing the surveys for literacy or other reasons adequately take up the support that is offered. Children may not feel comfortable disclosing being sexually abused on a survey to someone they do not know, and may be concerned about who will hear about what they say.81

3. Unlike the youth survey carried out by the American Bureau of Justice, the HMIP survey does not collect data on the circumstances surrounding the allegation of sexual abuse.82

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79 REA, section 5.2.2
80 YJB000125
81 Brazier 18 July 2018 25; Hardwick 11 July 2018 141
82 REA, section 5.2.2
C.2:  Barriers to disclosure

4. When approaching the issue of prevalence, it is important to note barriers to the disclosure of sexual abuse may mean that abuse is not reported for many years, or at all. The National Society for the Prevention of Cruelty to Children (NSPCC) told us that a high number of incidents of sexual abuse might go unreported, undetected, unprosecuted and untreated.\textsuperscript{83} There is also research indicating that up to two-thirds of children are not able to disclose abuse during childhood.\textsuperscript{84}

5. The Australian Royal Commission identified general barriers to disclosure:

- Barriers for the victim: feelings of shame and embarrassment; fear or experience of a negative response to disclosure; attitudes to sexuality, masculinity and gender; uncertainty about what is abusive; and difficulty communicating child sexual abuse.

- Perpetrator behaviours that create barriers to identifying and disclosing: grooming behaviours and tactics; perpetrators’ position and authority; threatening the victim or others; isolating the child; and making victims feel complicit or responsible.

- Institutional barriers to identifying and disclosing child sexual abuse: cultures of child sexual abuse, punishment and violence; inadequate avenues for disclosure; the nature of relationships within institutions; and inadequate record-keeping and information-sharing.\textsuperscript{85}

6. Of these, the Commission considered the following were of particular application to contemporary detention environments:

- children not understanding what sexual abuse is;
- children not feeling safe to disclose abuse; and
- issues around the avenues for disclosure.\textsuperscript{86}

7. Many witnesses reflected these themes. We heard that children in custody may withhold information about abuse because they:

- do not have someone they trust fully;
- have insufficient emotional support;
- fear they will be blamed, doubted or not believed;
- fear of reprisal or victimisation, particularly because of the power staff have over almost every aspect of the child’s life;
- feel shame and fear of the stigma associated with sexual abuse;

\textsuperscript{83} Noyes 12 July 2018 85
\textsuperscript{84} Australian Royal Commission into Institutional Responses to Child Sexual Abuse: Final Report, Volume 4 Identifying and disclosing child sexual abuse, paragraph 2.3.3
\textsuperscript{85} Australian Royal Commission into Institutional Responses to Child Sexual Abuse: Final Report, Volume 4 Identifying and disclosing child sexual abuse, sections 4–6
\textsuperscript{86} Australian Royal Commission into Institutional Responses to Child Sexual Abuse: Final Report, Volume 15 Contemporary detention environments, section 3.6
• feel unsafe;
• fear being labelled a ‘grass’;
• are isolated from family and friends;
• are concerned that the disclosure may not be confidential;
• are concerned that the investigation or response to the disclosure will be poor, because in order for children to have confidence in reporting something as significant as sexual abuse, they need to have confidence that staff will take their allegations seriously and will respond effectively;
• do not fully understand that the abuse is wrong, or do not fully understand how to complain and what the response will be; and
• have difficulty understanding or communicating.\textsuperscript{87}

8. A key theme Dr Laura Janes (Legal Director of the Howard League for Penal Reform) took from speaking to children in custody was their feeling that they will not be believed. When they are offered help to make a complaint, they say “There's no point. It's not going to make any difference.” Against the overarching power imbalance, Dr Janes said it was not surprising that children think their word stands for little, especially when many children in custody have low self-esteem to start with. In her view, if children are in a fearful state, the chances of them disclosing something as sensitive as being sexually abused are very low.\textsuperscript{88}

9. Alan Wood, the Inquiry’s independent expert, said the creation of a safe environment for disclosure starts with the child’s cultural experience. While confidentiality is hard to achieve in custodial settings, a child’s experience of disclosures will be passed on to other children and a cultural view will emerge about what happens if children talk about abuse. Carolyne Willow, a children’s rights campaigner and founder of Article 39, agreed children ‘test’ how staff respond to general complaints they make; if they see a poor response, they are unlikely to be confident to disclose abuse.\textsuperscript{89}

10. Disclosing abuse is likely to be very complex and difficult for children, especially those in custody, as they may feel isolated and may not have a complete understanding of why they are being detained. Mr Wood told us it requires a “leap of faith” for children to disclose abuse and trust is an essential element to this. He also noted further barriers to reporting abuse for children in custody, including that 33 percent of children in custodial institutions have mental health disorders, 11 percent have attempted suicide, 60 percent have communication difficulties and 25 percent have a learning disability. While there are a multitude of reasons why a child may not disclose abuse, these are “enhanced to a greater extent if the child ... is in the custodial arena.”\textsuperscript{90}

\textsuperscript{87} Janes 11 July 2018 11–12; HWL000001, sections 5 and 6; Hardwick, 11 July 2018 45; NHK000003, paragraphs 42–51; Hibbert 11 July 2018 112–115; Wood 12 July 2018 11–22; Noyes 12 July 2018 85–88, NSP000025, paragraph 17; No one noticed, no one heard: a study of disclosures of childhood abuse, Alnack and Miller, NSPCC, 2013, pp24–31 (INQ001489); Willow 12 July 2018 115–116; INQ001073, paragraphs 16 and 41–46; Johnson 17 July 2018 185–187 and 193, referring to “Why are they going to listen to me?” Young people’s perspectives on the complaints system in the youth justice system and secure estate, Children’s Commissioner, July 2012 (INQ001607); USV000001, paragraphs 3.1–3.2; Brazier 18 July 2018 25; Whellans 18 July 2018 164; Newcomen 16 July 2018 171; Why do women and young people in custody not make formal complaints?, PPO, March 2015 (INQ001560). See also Commission on Sex in Prisons, Coercive Sex, Howard League, 2014
\textsuperscript{88} Janes 11 July 2018 36–37, 48–49
\textsuperscript{89}INQ001073_013, paragraph 46
\textsuperscript{90}Wood 12 July 2018 5; 11–12; 15, 74
11. Many institutional and other witnesses told us they had received very few reports of sexual abuse. Having analysed more than 800 enquiries and case files within the Howard League over the last 10 years, Dr Janes identified only a “small handful” of instances where children have reported any form of sexual abuse. She listed six such cases, and in only three of those instances had the child reported the sexual abuse themselves. She was clear that a range of cultural factors explained the reluctance of children to report sexual abuse and was likely to provide the context for these figures.\(^91\) The Prisons and Probation Ombudsman (PPO) received two complaints of sexual abuse of a child detained in a YOI or STC between 2006 and 31 December 2017.\(^92\) The Independent Monitoring Board\(^93\) and Children’s Commissioner\(^94\) received respectively eight and no disclosures of sexual abuse between 2009 and 2017. Rosamond Roughton said that, since 2013, NHS England has not received any formal notification of child sexual assault in the youth justice secure estate involving healthcare provider staff or occurring while under the care of such staff.\(^95\)

12. As historical examples show, the sexual abuse of children in custody may be hidden for many years.

- Durham Constabulary received allegations of sexual abuse against 229 children detained at Medomsley Detention Centre between 1962 and 1987. Only nine of those children (4 percent) are recorded as reporting sexual abuse to the authorities while they were in custody or shortly after being released.\(^96\)

- West Yorkshire Police received a considerable number of allegations of sexual assault against 28 different children who had been resident at Thorpe Arch Grange (a home where children were detained on remand, and also held under care orders). The alleged assaults occurred between 1971 and 1989. West Yorkshire Police report that two of the allegations were reported in 2001, and the remainder between 2008 and 2018. A number of prosecutions have resulted and 21 convictions.\(^97\)

### C.3: The Inquiry’s work on prevalence

**Methodology**

13. The Inquiry has carried out extensive work on the prevalence issue:

- Reviewing the overall prevalence figures for different types of institution in the HMIP Children in Custody series reports.\(^98\)

- Reviewing HMIP and Ofsted surveys at each institution between 1 January 2009 and 31 December 2017, and other information provided by HMIP.

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\(^{91}\) HWL000001, paragraphs 3.2, 3.6 and 5.1–5.2; Janes 11 July 2018 11–22

\(^{92}\) 16 July 2018 171; 18 July 2018 185; 20 July 2018 3; PPO000001; PPO000003

\(^{93}\) Stuart 16 July 2018 171; IMB000001, paragraph 18; 20 July 2018 3

\(^{94}\) Longfield 16 July 2018 171–172; INQ001175; 20 July 2018 3

\(^{95}\) NHS000027, paragraph 13

\(^{96}\) OHY003832; OHY003943

\(^{97}\) OHY003945; OHY003947

• Using its powers under Rule 9 of the Inquiry Rules 2006, obtaining information about disclosures of child sexual abuse received by custodial institutions, local authorities, police forces and the bodies who inspect or visit these institutions, covering incidents said to have occurred between 1 January 2009 and 31 December 2017.99

14. This material has now been analysed by the Inquiry and, for the first time, provides a clearer picture of: (i) the total number of reported incidents, including by category; (ii) the rate of incidents per year; (iii) the different types of abuse; and (iv) the alleged perpetrators, each of which can be broken down by type of institution.100

15. This analysis, together with the underlying material, was disclosed to the core participants and their observations sought. No core participants disagreed with the analysis.101

Analysis

16. We are aware of the limitations on the data described above. However, despite those limitations, we can conclude that there has been even more sexual abuse of children than is disclosed by the evidence we have seen.

Total number of allegations

17. For the period between 1 January 2009 and 31 December 2017, the Inquiry’s analysis shows:

• There were 1,070102 alleged incidents103 of child sexual abuse within custodial institutions.

• Of these, 578 alleged incidents were described in terms equating to sexual assault or rape.

99 The requests asked for, in respect of any allegation or report of child sexual abuse occurring at a custodial institution:
(a) a brief description of the alleged incident;
(b) the number of victims;
(c) the date(s) of the incident(s);
(d) the type of investigation undertaken;
(e) the outcome of the investigation; and
(f) whether the alleged perpetrator was a member of staff, detainee or someone else.
The requests also asked, in respect of incidents in SCs, whether the victim had a justice or a welfare placement at the institution.

100 See Annex 2 to Inquiry Counsel’s analysis, summarised at 10 July 2018 168–180

101 See Note from Inquiry Counsel dated 11 June 2018 at INQ001709 and Addendum to Note from Inquiry Counsel dated 5 July 2018 at INQ001769 and accompanying Annexes, as summarised at 10 July 2018 168–180 and 20 July 2018 4–7

102 There were, in addition, two alleged sexual assaults of children resident in custodial institutions where the incident happened at court, and one by a manager of a custodial institution while the victim was on licence. In any case where it can be inferred from the date, description and/or action taken that different records are likely to be referring to the same incident, the Inquiry has counted it as a single incident for the purpose of the analysis. In most cases, the position is reasonably clear. However, in relation to 26 incidents, it is unclear whether they are duplicated in other records. In relation to those cases the analysis has rounded ‘down’ rather than ‘up’. It is possible therefore that there are 26 more alleged incidents of abuse, above those recorded here.

103 Each act of abuse has been counted as an incident. Sometimes several incidents of abuse were recorded as part of the same case, ie in the same allegation, complaint or report. This was usually where a group of incidents occurred on the same date and close in time, involving the same parties, but sometimes where there were series of similar incidents for which only the date of the last incident was recorded in material provided to the Inquiry. Each case is recorded in a single row of data, and the number of incidents is reflected in the ‘incidents’ column. There were in total 990 such cases of abuse, the explanation for the difference between this figure and the total number of incidents being that some cases were recorded as a group of incidents of the types described.
Around 1,109 children were alleged victims of sexual abuse.

There were more alleged incidents per year in 2016 and 2017 than in any previous reporting year. Between 2009 and 2015, there were never more than 114 incidents per year. However, in 2016 and 2017 there were 203 and 205 alleged incidents respectively.

For reasons that were not always clear, the vast majority of these allegations were not found to be substantiated.

In 10 cases where the alleged perpetrator was a member of staff, he or she was issued with a warning, reprimand or had a letter placed on his or her file. In a further nine cases, the alleged perpetrator was dismissed for reasons connected to the alleged incidents. Some other action was taken against the alleged perpetrator in another 120 cases (including suspension, monitoring, words of advice, supervision or being moved to a different location).

Only nine alleged incidents resulted in criminal charges, of which four resulted in conviction.

18. We have identified a significant number of complaints of child sexual abuse in custody which have not otherwise come to light. For example, there is no published survey of children at Feltham in 2016, and the January 2017 survey revealed no sexual abuse. However, the evidence provided to the Inquiry refers to five allegations in 2016, and a further allegation in January 2017 before the survey. Again, despite alleged incidents of sexual abuse being recorded elsewhere prior to January 2017, no child took the opportunity to refer to it in the survey. Similarly, in surveys undertaken between October 2012 and February 2017 at Medway, it was in only one year – 2014 – that any sexual abuse was reported and only by 2 percent of respondents, which equates to one child. This compares with 44 alleged incidents revealed in the Inquiry’s evidence during the same period of time. Finally, in the October 2016 survey of Rainsbrook STC, only one child reported having been sexually abused, whereas the Inquiry’s evidence has revealed 20 alleged incidents of sexual abuse in 2016 prior to the survey.

\[104\] This is an estimate because although the figures have been adjusted where it is clear that the same victim was involved in two or more incidents, the material did not indicate in every case whether two or more incidents involved the same victim, or the exact number of victims for some incidents involving multiple victims.

\[105\] The figure of 139 for ‘Count of action against perpetrator’ in the third sheet of Annex 2 includes the 19 cases where action as specified in this paragraph was taken.

\[106\] However, in many cases it is unclear whether the action was taken only temporarily during the investigation, or at the end of it.

\[107\] Albeit that one of the incidents which resulted in conviction, and possibly a further incident which resulted in charge only, occurred outside the relevant custodial institution: the perpetrators paid for sexual activity with a child, the child having been moved from the institution to other premises.

\[108\] INQ001125

\[109\] INQ001481

\[110\] INQ001571

\[111\] This pattern is reflected in other establishments. For example, the July 2014 survey at Hassockfield STC disclosed no complaints of sexual abuse but the Inquiry’s evidence shows that there were a total of five alleged incidents in 2014. Similarly, the June 2014 and August 2017 surveys of Cookham Wood revealed no reports of sexual abuse. However, the Inquiry’s evidence found 12 alleged incidents recorded or occurring between May 2013 (when the previous survey of Cookham Wood had been undertaken) and June 2014; and 10 alleged incidents of sexual abuse between September 2016 (when a survey was undertaken) and August 2017 (when a survey revealed no sexual abuse).
19. In all of the surveys referred to in which respondents reported no sexual abuse, or where only one respondent reported such abuse, survey questionnaires were offered to the vast majority or all of the children within the institution at that time. While some children may choose not to return questionnaires and some may leave before the next survey is undertaken, it seems children who do complete the surveys are not taking up the opportunity to report sexual abuse that may have been recorded elsewhere.

**Trends by institution**

20. There were more alleged incidents in 2016 and also 2017 than in any previous period. When the figures are broken down by institution type, on the data currently available, incidents in STCs account for most of the increase: in 2015, there were only 19 alleged incidents but this figure rose to 79 in 2016 and 110 in 2017. This increase is of more concern when the population size of the STC is taken into account; when incidents are expressed as a percentage of the average under-18 population for the year, the increase from 2015 to 2016 rises from 9.1 percent to 54.9 percent.\(^\text{112}\)

**Types of abuse**

21. Based on the information to the Inquiry, the types of abuse alleged for each case\(^\text{113}\) of alleged child sexual abuse can be broken down as follows:

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\(^{112}\)It is important to note that the percentages show rate of incidents (which, for the avoidance of doubt, is the number of incidents expressed as a percentage of the average population of the institution for the same year) and not the percentage of detainees who have been sexually abused. The latter is impossible to ascertain from data available because in many cases no victim identifier was used by evidence providers.

\(^{113}\)Here, ‘case’ refers to an incident or group of incidents, within the same allegation, complaint or report, either occurring on the same date at around the same time between the same parties, or forming part of a series of similar incidents where only the last incident date is recorded. The total number of such ‘cases’, 990, is lower than the total number of incidents, 1,070, because some cases involved a group of similar incidents.
### Table 1  Type of abuse by institution and in total

<table>
<thead>
<tr>
<th>Type of abuse (main event)</th>
<th>Type of institution</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>YOI</td>
</tr>
<tr>
<td>Rape</td>
<td>28</td>
</tr>
<tr>
<td>Attempted rape</td>
<td>2</td>
</tr>
<tr>
<td>Sexual assault</td>
<td>219</td>
</tr>
<tr>
<td>Attempted sexual assault</td>
<td>5</td>
</tr>
<tr>
<td>Exposure</td>
<td>12</td>
</tr>
<tr>
<td>Sexual acts between</td>
<td>8</td>
</tr>
<tr>
<td>detainees possibly</td>
<td></td>
</tr>
<tr>
<td>consensual</td>
<td></td>
</tr>
<tr>
<td>Sexual/inappropriate</td>
<td>15</td>
</tr>
<tr>
<td>relationship between</td>
<td></td>
</tr>
<tr>
<td>staff and detainee</td>
<td></td>
</tr>
<tr>
<td>Threat of sexual abuse</td>
<td>10</td>
</tr>
<tr>
<td>Other‡</td>
<td>96</td>
</tr>
<tr>
<td>Insufficient detail</td>
<td>45</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>440</td>
</tr>
</tbody>
</table>

*SCH* refers to SCHs holding children on both justice and welfare placements, whereas ‘SCH W’ refers to SCHs only holding children on welfare placements.

†The ‘Other’ column includes the three incidents of abuse which occurred outside a custodial institution, referred to above.

‡This includes, for example, sexual comments, voyeurism, grooming behaviour and sexual gestures.

§This refers to the 990 cases of abuses: see explanation for ‘case’.
Perpetrators

22. Based on the information to the Inquiry, the perpetrators for each case of alleged child sexual abuse can be summarised as follows:

Table 2  Type of abuse by perpetrator and in total

<table>
<thead>
<tr>
<th>Perpetrator</th>
<th>Type of institution</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>YOI</td>
</tr>
<tr>
<td>Detainee</td>
<td>113</td>
</tr>
<tr>
<td>Staff</td>
<td>240</td>
</tr>
<tr>
<td>Staff member and detainee together</td>
<td>1</td>
</tr>
<tr>
<td>Religious figure</td>
<td>4</td>
</tr>
<tr>
<td>Teacher</td>
<td>34</td>
</tr>
<tr>
<td>Ex-teacher</td>
<td>1</td>
</tr>
<tr>
<td>Other type of perpetrator</td>
<td>9</td>
</tr>
<tr>
<td>Not stated</td>
<td>38</td>
</tr>
<tr>
<td>Total</td>
<td>440</td>
</tr>
</tbody>
</table>

*SCH* refers to SCHs holding children on both justice and welfare placements, whereas ‘SCH W’ refers to SCHs only holding children on welfare placements.
† The ‘Other’ column includes the three incidents of abuse which occurred outside a custodial institution, referred to above.
‡ This refers to the 990 cases of abuses: see explanation for ‘case’.

23. Of the 990 cases, 385 (38.9 percent) related to other detainees and 461 in total (46.6 percent) involved a staff member acting alone or with a detainee.

24. There were 121 cases involving abuse allegedly perpetrated by detainees in SCHs (including those on welfare placements), 143 in STCs and only 113 in YOIs. This is despite the overall population of YOIs being several times higher than the populations of SCHs and STCs at any given time. It raises the question of whether the higher ratio of staff per detainee in the SCHs and STCs compared with YOIs may make it more likely that abuse between detainees is identified, recorded and reported to agencies by staff.

Circumstances of abuse

25. Some patterns have emerged in the circumstances of the reported abuse:

- 92 incidents were alleged to have taken place during search or restraint. The percentage was highest in YOIs. Of the 469 alleged incidents occurring in YOIs, 57 (11.1 percent) occurred during search or restraint.
- 53 alleged incidents happened in the showers or bathrooms. Again, the percentage was highest in YOIs. Of the 469 alleged incidents occurring in YOIs, 40 (8.5 percent) happened in the showers or bathroom.
• 27 incidents were alleged to have happened in a cell. This raises the question of whether the absence of CCTV in these areas may increase risk of sexual abuse.\textsuperscript{114}

26. The figures which the Inquiry’s analysis gives for incidents in each category may be lower than the actual numbers. This is because the precise details of each allegation were not always apparent from the material provided, and so there may be further incidents falling within the above categories which have not been counted above.

**How incidents were reported and responded to**

27. Many allegations (where such information is available) were disclosed to someone within the institution by the alleged victim, a witness or fellow detainee. A small number of incidents (19) were not reported at the institution where the alleged abuse took place, but rather at another custodial institution by a witness or victim. Some were reported after release.

28. In 166 allegations, it was recorded that the alleged victim withdrew, retracted or was unwilling to pursue the allegation. Investigators described 49 allegations as malicious or similar. Many other complaints were found not to be substantiated for other reasons, though those reasons were not always clear.

**Limitations and issues**

29. The Inquiry has identified a number of limitations in relation to the data obtained from the published surveys:

• The sample group included 18-year-olds, i.e., adult not child victims.

• The survey results give the percentages of respondents who have been sexually abused, but not the total number of incidents of abuse.

• Prior to October 2012, children in STCs did not take part in surveys in which a question about sexual abuse was asked.

• Children in SCHs have never been asked specifically about sexual abuse.\textsuperscript{115}

30. The further data obtained by the Inquiry may also have limitations:

• A number of respondents, including the PPO, the Youth Justice Board, HM Prison and Probation Service (HMPPS), Ofsted, police forces and at least six local authorities, highlighted shortcomings in the data provided or the methods used to search for it, which may mean those bodies received more allegations of sexual abuse than those they have provided to the Inquiry.

• Similarly, there are significant levels of incomplete records held by the various bodies, including some YOIs, some STCs (and some STCs’ records have not been made available to the Inquiry), and some local authorities, although we note there might be various reasons for this.

\textsuperscript{114} Where figures are higher than the number of incidents in the third sheet of Annex 2, this is to take account of where more than one incident was recorded in a case.

\textsuperscript{115} See Annex 1 to Note from Inquiry Counsel at INQ001710
• Using existing systems, it is not possible to categorise an incident as sexual abuse of a child in custody, so as to allow records to be retrieved easily and thus to distinguish custody-related abuse from other categories.

• We have also seen incidents recorded in one place but not in others as we would have expected.\textsuperscript{116} There were 130 occasions on which police were said to have been informed about an incident which the relevant police force did not refer to when responding to requests. Similarly, there were 211 occasions on which a local authority was informed about incidents, but which were not included in local authority evidence.

• There were also issues with inaccurate recording or missing details.\textsuperscript{117}

\textsuperscript{116} For example: (i) In February 2015, Ofsted received from the Youth Justice Board a spreadsheet of alleged incidents at Rainsbrook recorded on the Youth Justice Board’s IARMS system. This spreadsheet has been compared to IARMS records provided directly to the Inquiry investigation team from the Youth Justice Board. There are four incidents referred to on the former but not on the latter. (ii) Several allegations of sexual abuse were not recorded on child protection logs but instead in other places such as on security information reports or complaint forms. (iii) The NSPCC’s Childline service received eight disclosures of sexual abuse from detainees in 2015 regarding children in YOI Werrington which do not appear to have been recorded by any state body (INQ001709; INQ001769).

\textsuperscript{117} For example (i) the date of incident is not always given; (ii) the location of abuse may not always have been recorded accurately, such as where different custodial institutions are geographically close to each other; (iii) the categorisation of abuse may not always be consistent, such as in respect of incidents of alleged sexual abuse being recorded by an evidence provider as physical abuse, and so the relevant information was not provided until further queries by the investigation were made; and (iv) in just over 10 percent of the PPO’s records, the age of the victim is missing and so it is impossible to know whether the alleged victim is a child or adult (INQ001709; INQ001769).
Part D

The role of culture
The role of culture

1. A key issue for this investigation was whether the culture within custodial institutions from 2009 onwards has inhibited the prevention, exposure and investigation of child sexual abuse.

D.1: The REA’s observations on culture

2. As set out in the Inquiry’s Rapid Evidence Assessment (REA), there are a number of potentially relevant cultural factors:

- Punitive rather than rehabilitative cultures are said in some of the research to lead to environments where sexual abuse is more likely to occur. Young offender institutions (YOIs) in particular have a culture focussed on punishment. There is also research suggesting that control can take priority over care or rehabilitation in secure training centres (STCs). By contrast, a number of reports indicate the culture in secure children’s homes (SCHs) is more focussed on safeguarding and supportive relationships.\(^\text{118}\)

- ‘Closed’ and hierarchical environments have been associated with instances of abuse of power within institutions for children. Some argue that YOIs and STCs, and even some SCHs, have elements of ‘defensive’ practice, such as referring to children by their surnames, over-reliance on procedures and inflexible application of the rules, rather than ‘child-centred’ practices.\(^\text{119}\)

- The ‘macho’ culture identified by some within the youth secure estate has also been a factor in a number of inquiries into child abuse in residential settings, particularly in relation to identification and reporting. (This ‘macho’ culture might be evident through an inability to express feelings or emotional vulnerability, a denial of feelings or an inability to recognise them in other children or staff.) Most children in custody and the vast majority of staff are male, leading to a male-dominated environment, which has also been identified as relevant. For example, one study – which looked at how the needs of children are met in secure accommodation in Scotland (the equivalent of SCHs) – suggested a ‘macho culture’ and a fear of being labelled as gay may have inhibited young boys from revealing involvement in or discussing circumstances related to child sexual exploitation.\(^\text{120}\)

- Trusting relationships between staff and children are important to enable children to raise concerns or problems, and staff members to identify victimisation. However, surveys and inspections have highlighted differences in the quality of these relationships, and of children’s perceptions of staff both between institutions of the same type, between different establishment types and

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\(^{118}\) REA, sections 6.1.1 and 8.4.7

\(^{119}\) REA, section 6.1.2

\(^{120}\) REA, section 6.1.3
between individuals. While it is obviously important that staff can identify potential victims of abuse (including sexual assault), they find this difficult. This may be due partly to cuts in staffing levels and the consequent reduction in contact time. Detained children are also often seen as lacking credibility because of their backgrounds, offending behaviour and age.

- There is a significant power imbalance between detainees and staff, but this is further exaggerated when those detained are children. The nature of secure units also gives staff power and the opportunity for the exercise of this power to become abusive.121

**D.2: The Inquiry’s findings on culture**

**The current culture within custodial institutions**

3. From all the evidence we heard, there are a number of cultural factors within custodial institutions which inhibit the proper prevention, exposure and investigation of child sexual abuse.

4. The position was summarised by Professor Nick Hardwick, formerly HM Chief Inspector of Prisons, that there are very serious risks that children in custody may be subject to sexual or other forms of abuse, and that the reasons for this are linked with the following cultural factors within custodial institutions:

- These are closed institutions, where the normal scrutiny of parents, friends and visitors is not possible. It is very difficult for a person from outside to see what is actually happening, other than what they are shown. As an example, abusive behaviour by staff at Medway STC was hidden from inspectors and official visitors in some cases.

- There is a power imbalance between staff and children. Staff are trained to use force, including pain compliance techniques. In addition, the child is dependent on staff for every part of day-to-day life, including access to privileges, status, food, unlock, visits and more.

- Children in detention often lack credibility because of their offending behaviour, mental health or age.

- If staff are encouraged to create an ‘unpleasant experience’, this makes poor behaviour normal. In Professor Hardwick’s view, there was likely to have been a direct link between the policy to create an ‘unpleasant experience’ and the brutality and sexual abuse that followed at HMP Medomsley, echoed in some of the language of juvenile custody. He thought there was a similar subculture between staff at HMP Medomsley to that at Medway STC.

Overall he described children in custody as “very vulnerable children in a very dangerous place”.122

121 REA, sections 6.1.4 and 8.4.3
122 Hardwick 11 July 2018 128–130; 133; NHK000003, paragraphs 44–51
5. There was a focus on achieving a closed and controlled environment rather than welfare in YOIs and STCs. The Medway Improvement Board (established after the January 2016 Panorama documentary regarding Medway STC, discussed below in greater detail) had concluded that the culture at Medway was focussed on control and contract compliance at the expense of child welfare.⁵¹ Pam Hibbert, a social worker and former Chair of the National Association for Youth Justice,⁵² believed that children in custody have become more vulnerable because institutions have become more closed and the protective factor of contact with the outside world has reduced.⁵³ Dr Laura Janes, Legal Director of the Howard League for Penal Reform,⁵⁴ described the culture in custody as a generally punitive one.⁵⁵ Matthew Brazier, an Ofsted special adviser on looked-after children, said the key difference between SCHs and STCs/YOIs is that SCHs tend to be much more child-centred.⁵ These characterisations of the secure estate were borne out by the evidence concerning how SCHs operate compared to YOIs and STCs.

6. Complainants regarded physical and sexual abuse as inextricably linked. Witnesses described physical violence making them so frightened they submitted to sexual abuse and were too afraid to complain about it. Effectively the culture of violence contributed to the opportunities for sexual abuse to occur and go undetected.⁵⁷ Angus Mulready-Jones, the lead inspector for children in detention for HM Inspectorate of Prisons, agreed that today there remains a link between violence and sexual abuse. One consequence may be that children are less likely to trust the institution to protect them if they report sexual abuse.⁵⁸

7. There seems to be a perception of detained children as somehow “undeserving” and not reliable historians. In Pam Hibbert’s experience, children in custodial institutions are considered offenders first and children second; they are seen as malicious or different from other children. Her examples included a member of STC staff saying it was okay to refer to children in custody as “animals”, and other staff expressing the view that children made false allegations. To disclose abuse, a child must feel they will be believed and that something would happen as a result; however, the children Pam Hibbert had spoken with did not believe the staff who looked after them would put their interests before those of the establishment.⁵⁹ As Carolyne Willow, a social worker and founder of Article 39,⁶⁰ highlighted, a child in custody has a “tarnished” reputation before they even enter an institution.⁶¹

8. This is exacerbated by feelings of powerlessness experienced by the child in custody, which are made worse still by practices such as strip searching and pain compliance. As Dr Janes explained, it is a fact of detention that children often are in positions where they feel vulnerable, lonely and afraid. This, coupled with the acute and inherent power imbalance, puts them at greater risk of abuse.⁶² Pam Hibbert also suggested there is a link between power dynamics and abuse. Many children in custody have already

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⁵¹ Medway Improvement Board: Final Report, 30 March 2017, vii (MED000003_006); Petherick 17 July 2018 51–60
⁵² http://thenayj.org.uk
⁵³ Hibbert 11 July 2018 104–107; 112–113; 115; INQ001637; INQ001750
⁵⁴ https://howardleague.org
⁵⁵ Janes 11 July 2018 3–6; 13–16
⁵⁶ Brazier 19 July 2018 21
⁵⁷ Smith 9 July 2018 131; CI-A17 10 July 2018 18; Watson 10 July 2018 41; CI-A34 10 July 2018 86
⁵⁸ Mulready-Jones 16 July 2018 5–6 and 30–31
⁵⁹ Hibbert 11 July 2018 104–107; 112–113; 115; INQ001637; INQ001750
⁶⁰ http://article39.org.uk
⁶¹ Willow 12 July 2018 99–100
⁶² Janes 11 July 2018 3–6; 13–16
experienced neglect, abuse and chaotic lifestyles, and some have been involved in gangs. As a consequence, the dynamic in which "the strongest person wins" might be replicated in custody. In Carolyne Willow’s view, practices such as strip searching and pain techniques to induce compliance or facilitate restraint are the antithesis of what children need to feel safe and cared for.

9. These broad themes were reflected by others. Mark Johnson, founder and CEO of User Voice, explained the power imbalance between adults and children in the community was amplified in custody and children are reliant on the systems and people within the institution to protect them. Angus Mulready-Jones said staff need to take positive action in many aspects of how detainees are treated. For example, only 25 percent of children in YOIs said their emergency cell bell was answered within 5 minutes. If the institution cannot guarantee basics, it will undermine the child’s confidence in reporting, including incidents of abuse. Such an approach is also likely, in our view, to make a child feel powerless.

10. The friendships, intimacy and sexual activity that would be normal in the community are likely to be absent from the custodial environment. Dr Janes noted there were no authorised sexual outlets and no opportunities to develop relationships in custody. Parents not being allowed to hug their children during visits and teenagers in detention being punished for masturbating creates an artificial state of “untouchedness”, as well as a secretive and unhealthy atmosphere around sexuality. These factors make it harder for children to know what is normal and what is abusive. Mark Johnson commented that the very nature of excluding people from normal sexual activity, the volatility and social immaturity of children in custody, and gang or other peer pressures all increase the risk of sexual abuse occurring. They also reduce the likelihood of a child disclosing abuse in custody.

11. Finally, according to Steve Gillan, General Secretary of the POA, there are a number of matters which limit the time staff can spend building trusting, professional relationships with children, leading to fear that they might be deterred from coming forward to discuss concerns.

12. Alan Wood, the independent expert appointed to advise the Inquiry, considered these cultural issues at some length.

- He described various potential risk factors for the occurrence of sexual abuse in custody, including the use of drugs, gang membership and violence committed by other children, although there are many variables that could cause a child to become isolated and at risk.

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135 Hibbert 11 July 2018 104–107; 112–113; 115; INQ001637; INQ001750
136 Willow 12 July 2018 101
137 www.uservoice.org
138 Johnson 17 July 2018 182-184
139 Mulready-Jones 16 July 2018 30–31
140 Janes 11 July 2018 3–6; 13–16
141 Johnson 17 July 2018 182-184
142 Professional Trades Union for Prison, Correctional & Secure Psychiatric Workers
143 POA0000001_001_Q1
144 Wood 12 July 2018 44. More generally, the evidence from the National Society for the Prevention of Cruelty to Children (NSPCC) was that there were a number of factors which could increase a child’s risk of sexual abuse, including a history of previous sexual abuse or other forms of neglect, having a disrupted home life and social isolation. Young or disabled children may not be able to tell someone what is happening or may not understand they are being abused (Noyes 12 July 2018 84–85)
He noted that in the community the possible symptoms and signs of abuse may be detected by a wide range of people with whom a child interacts, whereas children in custody are dependent on the professionals they come into contact with to recognise those signs. In a custodial environment, some of the signs associated with past or current abuse may be present because the child is reacting to custody.

One of the strongest protective factors for children is having a positive educational experience, which feeds into their self-esteem, self-awareness, positive peer contact and ability to build trusting relationships with adults. Despite the importance of education, he noted from the Review of the Youth Justice System in England and Wales by Charlie Taylor in 2016 (Taylor Review) that children were only accessing 17 hours of education per week, rather than the expected 30 hours. He explained that children need to be given information about what is abusive or neglectful behaviour so they can identify it, as they might not realise they are being harmed or their prior experiences may have skewed their idea of what constitutes consensual activity. He thought children should be given practical information in an age-appropriate way about what would happen if they made a disclosure.

In Mr Wood’s experience, the most successful ways to enable children to disclose abuse have involved creating a culture where there is access to a trusted and close professional (e.g. social worker) as well as other independent people. However, his view was that once a disclosure is made, achieving the necessary multi-agency response is more complicated in custody than in the community.

In the context of the case studies analysis relating to Medway, he described an incident when staff members failed to protect another child who was being assaulted and having his clothes removed by other detainees. He expressed concern about the effect this would have had on children’s expectations of the protection they would receive from members of staff.

Chief Constable Simon Bailey, the National Police Chiefs’ Council lead on child protection, was more optimistic. He thought that while the culture within custodial institutions may well be such as to operate as a barrier to disclosure, the culture and working relationship between the police and prison service is improving, and there is now a greater understanding about how to meet the current challenges.
14. On behalf of the Youth Custody Service, Sara Robinson recognised that the environment in custodial environments is not always conducive to staff being able to create a culture of enabling children to have positive outcomes and not re-offend, albeit there were many staff who worked hard and wanted to make a difference.\textsuperscript{151}

**Proposals to reform culture**

15. Various witnesses gave their views as to what cultural change is needed within custodial institutions for children.

16. Dr Janes suggested a common set of rules and standards based on the rights of children is required.\textsuperscript{152} Children in custody need to be treated with great care but, in her view, they also need to be empowered to take responsibility for their own futures and to demand to be treated with respect and dignity.\textsuperscript{153} Recommendations to this end have been made by a number of experts. For example, the Bach Commission report *The Right to Justice* (2017)\textsuperscript{154} recommended that “all matters involving children should be brought back into the scope of funded legal aid”.\textsuperscript{155}

17. Experts in this area, including Pam Hibbert and Dr Tim Bateman,\textsuperscript{156} have expressed disappointment that the government rejected the recommendation of the Taylor Review\textsuperscript{157} that the focus should be on the child first and offending second. Pam Hibbert considered that there needed to be a “fundamental rethink” about children in custody, and that they should be removed from Prison Service responsibility.\textsuperscript{158}

18. Professor Hardwick told us “the most important factors in reducing risk are sufficient well trained professional staff, a child-centred culture and a management culture which encourages challenge and discussion”. He shared the view that child detainees should not be the responsibility of the Ministry of Justice but rather of the Department for Education or Department of Health or somewhere else. Overall the protection of children should be at the top of the list of important aims; the bedrock has to be safety and protection of children from abuse.\textsuperscript{159}

19. Of the key themes Mr Wood identified, those relating most directly to the reform of culture were that the need for a child-centred approach and that issues of trust are key.\textsuperscript{160}

20. Phillip Noyes of the NSPCC indicated there were a number of ways that professionals and non-professionals could make it easier for children to disclose abuse, including:

- being aware of, recognising and responding appropriately to emotional distress, behavioural changes and other signs;
- asking sensitive questions;

\textsuperscript{151} Robinson 13 July 2018 174–175
\textsuperscript{152} Janes 11 July 2018 60
\textsuperscript{153} Janes 11 July 2018 61
\textsuperscript{156} The state of youth justice 2017: An overview of trends and developments, Dr Tim Bateman/National Association for Youth Justice, September 2017 (INQ001598_003-055)
\textsuperscript{157} Review of the Youth Justice System in England and Wales, Charlie Taylor, Ministry of Justice, December 2016 (INQ001422)
\textsuperscript{158} Hibbert 11 July 2018 120–123
\textsuperscript{159} Hardwick 11 July 2018 157–159; 162; 164; 166; INQ001757_002
\textsuperscript{160} Wood 12 July 2018 74
• using age and developmentally appropriate words and communication styles;
• giving children a safe space to talk and tell;
• giving children a sense of control over the process of disclosure;
• taking prompt action to protect children; and
• giving children better information.

To help children disclose sexual abuse sooner, Phillip Noyes thought cultural change in organisations was needed; in summary, the key change needed is “kindness”.161

21. Sara Robinson said that the Youth Custody Service was looking at developing a code of practice on the management of behaviour across the sectors. She agreed they ought to consider whether the clear quality standards relating to children that apply in the SCH context162 can be carried over to YOIs and STCs.163 Sara Robinson said, generally, all the steps the Youth Custody Service is undertaking are aimed at creating an improved and more child-centred culture in custodial institutions.164

22. Peter Savage, formerly of the Youth Justice Board, stressed the importance of “porous boundaries” in youth custody, where a range of different organisations and individuals come into the establishment who are independent of HMPPS. He thought this was an area where HMPPS needed to continue to do more.165

23. Jonathan French, governor of Medway, told us about the attempts he has made to change the culture at Medway STC since taking over in early 2017. He has, for example, introduced a “rewards-based approach”, as a foundation for the behaviour management policy. The previous regime had been overly punitive and was ineffective. The new scheme gives children points for positive behaviour.166

24. Likewise, Peter Gormley, the former governor of HMYOI Werrington, told us that at the institution they had tried to create a reward culture for good behaviour, rather than a punitive one for poor behaviour.167

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161 Noyes 12 July 2018 87–88
162 These include that staff engage and develop positive relationships with children and provide them with support: the Children’s Homes (England) Regulations 2015, regulations 7 and 11 ([INQ001426]).
163 Robinson 13 July 2018 95–96
164 Robinson 13 July 2018 175. Since the hearings, we have been provided with some further information about the Youth Custody Service’s new programme entitled ‘Building Bridges: The Positive Behaviour Framework for Children and Young People in the Secure Estate’. This is being implemented in the early part of 2019 and is a further initiative intended to address some of these cultural issues.
165 Savage 13 July 2018 176
166 French 17 July 2018 140–141
167 Gormley 16 July 2018 165
Part E

The institutional response to child sexual abuse in custody
The institutional response to child sexual abuse in custody

E.1: The fact of custody

1. Beyond the cultural issues discussed in Part D, some experts have argued that children can never be safe from sexual abuse in custody, and that the best way to protect children from abuse is not to detain them at all.  

2. Some complainants gave evidence on this issue. Peter Smith said imprisoning children should be a last resort. CI-A30 said consideration should be given to whether some children really needed to be in custody, or whether they were troubled children from poor backgrounds who had done "lots of small things that build up into a prison sentence". He questioned whether for some children the money would be better spent on intensive support rather than custody.

3. Institutional witnesses also addressed this.

4. The written evidence from Dr Laura Janes, Legal Director of the Howard League for Penal Reform, was that "the starting point is that prison is inherently risky and it will be impossible to eradicate the risk of sexual abuse for children in penal detention". The Howard League has long advocated for a penal policy that detains only a very small number of children who genuinely cannot be managed safely in the community. Its position is that the population of children in custody should continue to fall. It has concerns that children in care are criminalised for minor incidents (which police consider care homes should be able to deal with) and placed there to punish and control them. Efforts should be made to reduce criminalisation of children in care.

5. Dr Janes’ understanding is that of the one-third of children in custody who are on remand, over half will not receive a custodial sentence. This suggests they ought not to be there. Her view is that many children are remanded into custody simply because there is not appropriate provision available for them in the community and that greater caution should be taken before remanding a child in custody. She thought research into any regional variations in local authority provision would be very worthwhile.

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168 See, for example, Carolyne Willow’s book, Children Behind Bars: Why the Abuse of Child Imprisonment Must End, 2015.
169 Smith 9 July 2018 138–139
170 CI-A30 10 July 2018 105, 161-163; INQ001743, paragraphs 7-9
171 HWL000001, paragraph 3.1
172 Janes 11 July 2018 6
173 HWL000003_005-007, paragraphs 3.3 and 4.4
174 Review of the Youth Justice System in England and Wales, Charlie Taylor, Ministry of Justice, December 2016 (INQ001422, paragraphs 122 and 123) concluded that too many children are securely remanded by the courts when alternative arrangements could be made, and made some recommendations about this issue.
175 Janes 11 July 2018 6, 7 and 71
6. Dr Janes’ experience was that short Detention and Training Orders (DTOs) were inappropriate for children (noting that the disruption can be particularly difficult for them). She considered that DTOs should be abolished. At the other end of the spectrum, she had observed an increase in the average length of custodial sentences for children. She considered that, under the current guidance, sentences often gravitate towards being offence-specific rather than being focussed on the specific child.176

7. Carolyne Willow, a children’s rights campaigner and founder of Article 39, considers that penal institutions are fundamentally unsafe for children and that the only way of preventing sexual abuse in child prisons is to stop incarcerating children.177 In short, prison is no place for a child.178

8. On behalf of the Youth Custody Service, Sara Robinson, Interim Executive Director, said children can never be entirely protected from abuse in any setting. There are always going to be individuals who will take an opportunity to abuse children; all that can be done is to try and minimise the risk as far as possible. She stressed that custody is seen as very much a last resort and that the Youth Custody Service works closely with the Youth Justice Board and Youth Offending Teams to try and prevent the need for custody. While there was a significant reduction in the number of children in detention between 2006/07 and 2017/18, numbers have reached “a kind of steady state” and may have reached their lowest point. She accepted the remand population was quite high, around a quarter of the children in detention,179 with children being remanded in custody due to limited specialist provision in the community. The Youth Custody Service’s policy unit is examining whether there are other things that can be done to reduce the number of children in detention further, particularly in the remand population.180

9. We considered whether the mechanisms for sentencing children effectively leave magistrates and judges with limited choices for children. At present:

- A DTO is a type of custodial sentence imposed on children aged 12–17. It would only be imposed if the offence is so serious that neither a fine nor a community sentence is justified, or certain other conditions are met, and a custodial sentence of longer than two years is not warranted. The Secretary of State for Justice has not appointed a date from which DTOs may be imposed on children aged 10 or 11. In the case of children aged 12–14, the court must be of the opinion that the child is a ‘persistent offender’ before it may impose a DTO. Half the sentence is spent in custody and the other half is spent under the supervision of the Youth Offending Team in the community. The minimum period of a DTO is four months and the maximum is two years. There is no power to suspend a DTO.181

- Referral Orders may be imposed by the Youth Court or Magistrates’ Court, as well as by the Crown Court on appeal. When a child without any previous finding of guilt pleads guilty to an offence which is punishable with imprisonment in the

176 Janes 11 July 2018 8, 9
177 INQ001073, paragraph 11
178 Willow 12 July 2018 98
179 In fact, the latest figures from July 2018 show 268 out of 883 detained children, or about 30 percent, were on remand (www.gov.uk/government/statistics/youth-custody-data)
180 Robinson 13 July 2018 6–9
181 Powers of Criminal Courts (Sentencing) Act 2000, ss.100 and 101; Criminal Justice Act 2003, s.152
case of someone aged 21 or over, the court must impose a Referral Order unless the offence carries a sentence which is fixed by law (for example, murder) or the court is proposing to impose a custodial sentence, hospital order, absolute discharge or conditional discharge. If the child has previously been found guilty of an offence, the court may impose a Referral Order. Under a Referral Order, the child meets with the youth offender panel and agrees to undertake activities aimed at preventing reoffending. If the child fails to agree to this or does not comply, the youth offending panel may refer the case back to the court.  

- The length of any custodial sentence imposed must be the shortest term commensurate with the seriousness of the offence, regardless of whether the offender is an adult or a child.  
- When sentencing children, the court must consider the welfare of a child.  
- Current sentencing guidelines applicable to child offenders emphasise that custody is a measure of last resort and that the younger the child, the shorter the custodial sentence should be.

E.2: Different types of institution

Young offender institutions, secure training centres and secure children’s homes

10. The Inquiry’s REA directed us to evidence from a range of sources that children are generally safer in secure children’s homes (SCHs) as compared to young offender institutions (YOIs) and secure training centres (STCs). The witnesses we heard from agreed, and generally suggested that children were also safer from sexual abuse in SCHs. For example:

- Dr Janes told us that the Howard League’s position has long been that SCHs are a safer environment for children. For the very small number of children who genuinely cannot be managed safely in the community, they should only be detained in small local SCHs.

- Pam Hibbert, a social worker and former Chair of the National Association for Youth Justice, thought SCHs were better at safeguarding than YOIs and STCs because their ethos was rooted in a social care tradition rather than criminal justice, and staff in SCHs were more aware that children may be both victims and abusers.

- Carolyne Willow, a social worker and founder of Article 39, considered that children in SCHs are much better protected from sexual abuse than those in YOIs and STCs, because the law, policy, staffing ratio, professional expertise, size,
physical environment, education, health, culture and respect generally afforded to children in those homes is far superior. She said that when detention of children is required, this should be in a SCH.190

11. Matthew Brazier, an Ofsted special adviser on looked-after children, referred to Ofsted’s most recent annual report, dated 13 December 2017, which noted a “marked contrast” between the inspection outcomes for SCHs and STCs. While 86 percent of SCHs were judged good or outstanding, the three STCs were judged less than good.

- Inspectors of SCHs noted strengths in matters such as the ability of the staff to develop positive and effective relationships with young people who are disaffected.191

- In contrast, inspectors of STCs had "serious concerns" about “poor behaviour management ... the safety of children and staff ... rising levels of violence between children and young people and assaults on staff ... rules and sanctions being inconsistently applied ... difficulties in recruiting and retaining staff”. Overall, Ofsted considered that although there were some “pockets of better practice”, the STCs’ staff “often did not have the skills and experience to respond to children’s needs with the necessary sensitivity and care”.192

12. Mr Brazier said the reasons for these problems within the STCs were instability of leadership, at certain points very high staff turnover and high levels of violence. The report had concluded that outcomes for children and young people in YOIs and STCs were much less good and sometimes extremely poor. The report said: “lessons need to be learned urgently about how best to educate and take care of children in the secure estate”.193

13. Alison Sykes, Head of Secure and Emergency Services for South Gloucestershire Council and the registered manager for Vinney Green SCH, gave us a practical insight into the different establishments. She told us that at Vinney Green there are 150 staff for 24 children. She knew all of the children personally, but it would be impossible for her to do this when looking after 70, 100 or more young people. By comparison with YOIs and STCs, children in SCHs have much greater private contact with their families. Unlike the other contexts, there are clear, published child safety standards governing SCHs, which make child welfare a primary aim. A person working in a care role in a SCH must have minimum childcare qualifications and there is regular supervision of staff.194

14. On behalf of the Youth Custody Service, Sara Robinson accepted the evidence from the inspectorates that the SCHs generally provide a safer environment.195

15. However, SCH places form a relatively small part of the child custody estate. By March 2017, the number of children in SCHs had dropped to 210, of which 49 percent (or around 102) were on justice placements.196
16. Some children who should be in SCHs are in fact in YOIs or STCs. Matthew Brazier told us of children in “very, very difficult and upsetting situations” in STCs who should be in “a nurturing environment” in a SCH.\(^{197}\)

### Smaller establishments

17. The Inquiry’s REA cited evidence that children are generally safer in smaller establishments\(^{198}\) because they are more likely to facilitate positive staff/child relationships.

18. Many witnesses considered that children were better protected from sexual abuse in smaller institutions:

- Pam Hibbert agreed with Dr Tim Bateman, an expert in this area, who suggested the size of the establishment and the staff-to-child ratios in combination with a care-based ethos were fundamental.\(^{199}\)

- Professor Hardwick, former Chief Inspector of Prisons, said that detained children were at risk from the closed nature of the establishments, whether they were big or small, but that smaller establishments, closer to a child’s home, would get many better outcomes.\(^{200}\)

- Carolyne Willow considered children feel safer in smaller establishments.\(^{201}\)

- Angus Mulready-Jones, the lead inspector for children in detention for HM Inspectorate of Prisons (HMIP), agreed with the recommendations from Martin Lomas (the Deputy Chief Inspector of Prisons) that custodial units holding children should be smaller to facilitate positive relationships between staff and children.\(^{202}\)

19. However, Sara Robinson said that one has to be careful not to think simplistically that small is best. It is not necessarily about the size of the operation, it is more about the culture of the leadership, the interventions and the processes that are in place to safeguard children.\(^{203}\)

### Privately run establishments

20. Prior to the hearings we were aware of the allegations of serious abuse of children by staff at Medway STC, when it was run by G4S, as featured in a Panorama programme broadcast in January 2016. In particular:

- HMIP’s Advice Note on Medway,\(^{204}\) produced shortly after the allegations emerged, noted concerns that staff had carried out ‘poor practice’ in areas not covered by CCTV, that there was a very high rate of staff turnover, and that

\(^{197}\) Brazier 18 July 2018 35–37
\(^{198}\) REA, p72, section 6.2.2
\(^{199}\) Hibbert 11 July 2018 121–122; The State of Youth Justice 2017: An Overview of Trends and Developments, Tim Bateman/National Association for Youth Justice, September 2017 (INQ0001598_055)
\(^{200}\) Hardwick 11 July 2018 156–157
\(^{201}\) Willow 12 July 2018 136
\(^{202}\) Mulready-Jones 16 July 2018 33–34
\(^{203}\) Robinson 13 July 2018 17
\(^{204}\) INQ001478
managerial oversight had failed to protect young people from harm. The final report of the Medway Improvement Board concluded there had been a focus on contract delivery at the expense of the welfare of the children.\textsuperscript{205}

- The Secretary of State for Justice responded to the Medway Improvement Board report by saying that the fundamental problem was "those running Medway conceived it as a place of coercion, where the culture and incentives – as they were designed in the contracts – were centred around corralling and control of children, rather than their full rehabilitation".\textsuperscript{206}

- The Youth Custody Improvement Board report in February 2017 concluded: "The appalling situation at Medway and the decision of G4S to sell its remaining STC contract indicate that these arrangements have not played out as intended. It raises questions as to the capacity to manage contracts and suggests the contracting arrangements are insufficiently flexible to deal with underperformance, ensure high-quality provision and effective recruitment and retention of skilled staff".\textsuperscript{207}

21. A press release from the Prison Governors Association in January 2018 stated that contracts for prisons and other services had not been fit for purpose, and running the contracts had diverted managers from running prisons.\textsuperscript{208}

22. In light of this evidence, we addressed the question of whether children are generally safer in establishments that are run by state bodies rather than by private contractors, and if so whether this means they are likely to be better protected from sexual abuse in establishments run by state bodies.

23. Some witnesses remained concerned about private custody providers:

- Pam Hibbert considered that the state should be responsible for the care of detained children and that problems were exacerbated when the focus was on contract compliance and profit.\textsuperscript{209}

- Carolyne Willow expressed concern that financial considerations and reputational risk may get in the way of protecting children in privately run institutions.\textsuperscript{210}

- Steve Gillan, the General Secretary of the POA, said the POA's position is that the Government should be responsible for all custodial care, because public-sector staff are more likely to have broader experience and publicly run establishments have improved security and vetting procedures.\textsuperscript{211}

24. However:

- Angus Mulready-Jones said there was no evidence that links private companies to poor outcomes; there are very poor outcomes in some public provision as well as private provision. He referred to an internal report by Her Majesty's Prison and Probation Service (HMPPS) which raised concerns that too much reliance was
placed on information provided by the contractor, so that inaccurate reporting was hard to detect. The report also noted that the focus is on process rather than the quality of service.\footnote{Mulready-Jones 16 July 2018 14–15}

- Professor Hardwick stressed that children were at risk from being detained, whether the establishment was privately or publicly run.\footnote{Hardwick 11 July 2018 156}

- Sara Robinson said there were polarised views about whether private provision should be used, but there are examples of where private provision has been successful. She said the evidence does not show children are safer in publicly run institutions compared to those run by the private sector.\footnote{Robinson 13 July 2018 20–24}

25. We heard directly from those involved in providing custodial services on a private basis.

26. G4S had run Medway and Rainsbrook STCs until 2016. Medway had been taken over by HMPPS and Rainsbrook by MTC Novo. Jerry Petherick, managing director of G4S Custodial and Detention Services, acknowledged the concerns raised by the Medway Improvement Board and HMIP about Medway in 2016, specifically in HMIP’s case that safety, and the institution as a whole, was inadequate.\footnote{Petherick 17 July 2018 52; 56; 61–74; 90–92; 98; 103–105; 114} He accepted that the 2015 HMIP report on Rainsbrook had also found that safety was inadequate,\footnote{Petherick 17 July 2018 95–98} but other reports had not been so critical. He explained that, since the issues that had arisen at Medway, significant efforts had been made by G4S with respect to whistleblowing, safeguarding processes, CCTV, body-worn cameras, shower viewing panels and the introduction of an additional layer of leadership at the chief operating officer level.\footnote{Petherick 17 July 2018 99} Nearly all of the personnel who worked at Medway and Rainsbrook are no longer employed by G4S.\footnote{Petherick 17 July 2018 52; 61–64; 75; 79–80; 83–88; 90–91}

27. In terms of other G4S-run institutions:

- The June 2017 Ofsted report for Oakhill STC found safety to be inadequate, raised several concerns about safeguarding and management of it, and noted there were still areas where children did not feel safe due to an ongoing lack of CCTV coverage.\footnote{Petherick 17 July 2018 95–98}

- The December 2017 HMIP report for HMYOI Parc\footnote{INQ001697} concluded that although safety had been a challenge and violence remained too high, it was encouraging to see many previous recommendations attended to, which was said to be to the great credit of the Director and her staff.\footnote{Petherick 17 July 2018 99}

28. Jerry Petherick was asked about the May 2018 Independent Monitoring Board’s report on the Brook House detention centre run by G4S (although children are not detained there).\footnote{INQ001798} A further Panorama programme had revealed disturbing scenes of ill-treatment of detainees by some staff. Mr Petherick accepted this reflected some serious
concerns. He said there is risk in every custodial situation worldwide of some staff behaving inappropriately and referred to “small pockets of very negative behaviour” that were “well hidden”. 223

29. Stuart Jessup of MTC Novo is the current Director of Rainsbrook Secure Training Centre. Mr Jessup was involved in the transition of Rainsbrook, following the transfer from G4S. He explained that after the 2017 Ofsted score of ‘inadequate’ an action plan was implemented to address the recommendations. 224 Mr Jessup told us about MTC Novo’s improvements. These included the early implementation of the SECURE STAIRS framework, the changes it has made to enable children to have better contact with the outside world, improvements to the company’s recruitment processes, its staff training programme, the system of supervision for staff, increases to its senior management team, its systems with respect to body-worn cameras, shower viewing panels and night staff rotas. 225 We are aware that the most recent Ofsted report on Rainsbrook noted the improvements that had been made in the four areas of the inspection. 226

30. Jonathan French of HMPPS has been the governor of Medway since January 2017. The number of children at Medway was very low when he arrived (14) but gradually increased. Since taking over, he has prioritised staff training because many staff indicated they had had very little training at Medway and did not feel equipped to deal with the children they were looking after. He had also initiated training around sexual abuse for some staff. A comparatively high proportion of staff are enrolled on the youth justice foundation degree. The Custody Support Plan (CuSP) scheme was rolled out 12 months ago. Medway is now fully staffed. The Ofsted report in March 2017 227 rated the establishment as ‘inadequate’. However, by March 2018 228 the overall grade had improved to ‘requires improvement’ and the report stated “Medway had improved in all areas since the last inspection”. 229

31. In terms of the future, Sara Robinson explained there are currently no plans within the Youth Custody Service to put more children in publicly run establishments. Instead the Youth Custody Service intends to follow the recommendation from the Review of the Youth Justice System in England and Wales by Charlie Taylor in 2016 to develop “a secure school, which is built on a principle of smaller provision, looking at 60/70 beds, it’s more geographically based, that is led by a culture that is more akin to education and health and security being secondary, although it is a primary factor in terms of safety for children”. She said these schools would use the approach set out in the Department for Education legislation currently applicable to SCHs. The main differences between secure schools and SCHs is that the former will be run by an education authority and will be bigger. 230

E.3: Potential environmental risk factors

32. We heard evidence about issues arising from the physical environment of custodial institutions.

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223 Petherick 17 July 2018 100–102; 115–116
224 Jessup 17 July 2018 159; 176
225 Jessup 17 July 2018 164; 168–169; 171–174
226 https://files.api.ofsted.gov.uk/v1/file/50040904
227 INQ001480
228 https://files.api.ofsted.gov.uk/v1/file/50004467
229 French 17 July 2018 51; 126; 134–136; 139
230 Robinson 13 July 2018 25–28
Access to children's cells and rooms

33. As explained in Part C, there is some evidence from the Inquiry’s prevalence analysis of abuse occurring in a cell, but it was not always clear whether the alleged perpetrator was another child or a member of staff.

34. *Children sharing cells*: Peter Savage, formerly of the Youth Justice Board, explained that the only place in the secure estate where children may now share cells is HMYOI Parc. This reflects the Youth Custody Service gradually moving away from cell sharing as a policy, partly driven by capacity issues rather than safety concerns.\(^{231}\) Before a child shares a cell, a Cell Sharing Risk Assessment is carried out, following PSI 20/2015.\(^{232}\) Peter Savage said the assessment was a detailed process, looking at the risk of violence and sexual abuse both as a victim and as a perpetrator. However, we note that the wording of PSI 20/2015 – which appears to have expired in June 2017 – focusses on identifying whether a child was “at risk of murdering or very seriously assaulting another prisoner in a closed space”. It does not mention sexual abuse or any lower threshold of violence. Overall, insofar as children do share cells, Peter Savage considered there was a sufficiently effective system in place to minimise the risk of children engaging in sexually harmful behaviour with each other.\(^{233}\)

35. *The ability of staff to enter cells and rooms*: Peter Savage said that in YOIs and STCs a member of staff may enter a child’s cell if it is thought to be necessary to do so, even if the young person does not consent. He thought the position in SCHs is the same in practice.\(^{234}\) Steve Gillan, General Secretary of the POA, said the POA considers that two staff members should always be present when entering an occupied room.\(^{235}\) Alison Sykes, Head of Secure and Emergency Services for South Gloucestershire Council and the registered manager for Vinney Green SCH, explained that staff are encouraged not to go into bedrooms at Vinney Green “for obvious reasons”. However, there are exceptions; for example, if the child is self-harming.\(^{236}\)

36. We note there are some policies and procedures for staff working alone,\(^{237}\) but it seems these are not of general application.

CCTV and body-worn cameras

37. As set out in the Inquiry’s REA, there is evidence indicating that the presence of CCTV in custodial environments has had some positive impacts (but there is a risk of over-reliance on CCTV in investigations).\(^{238}\) The Youth Custody Service said CCTV is now “routinely used”\(^{239}\) in child custody and is being extended to reduce ‘blind spots’.\(^{240}\) HMIP and Ofsted reports...
indicate that CCTV in communal areas generally improves safety.\textsuperscript{241} Body-worn cameras are now in "widespread use",\textsuperscript{242} and they have the additional benefit of audio coverage, unlike CCTV.\textsuperscript{243}

38. The witnesses expressed mixed views about the benefits of CCTV and body-worn cameras:

- Dr Janes, Legal Director of the Howard League, said some children feel safer with CCTV present, while others say it is intrusive. Similarly, some young people feel safer in the presence of an officer using a body-worn camera, whereas others see the operation of it by the person in charge turning it on and off as another power dynamic.\textsuperscript{244}

- Steve Gillan of the POA observed that the use of CCTV and body-worn cameras has increased dramatically, but acknowledged that abuse by its nature would be perpetrated covertly.\textsuperscript{245}

- Katherine Willison, Director of Children’s Social Care, Practice and Workforce within the Department for Education, suggested there is a balance to be struck between safeguarding on the one hand and recording everything inside a children’s home, if we are to encourage the development of positive relationships, mutual trust and respect.\textsuperscript{246}

- Sara Robinson, Interim Executive Director of the Youth Custody Service, described CCTV as being "incredibly helpful", but both she and Peter Savage, Head of Operational Contract Management, Youth Custody Service, were concerned that widespread body-worn camera use could inhibit the personal relationship between a child and a staff member.\textsuperscript{247}

- The experience of Chief Constable Bailey (the National Police Chiefs’ Council’s lead on child protection) was that the use of body-worn cameras may make a difference but comes with unresolved issues about turning devices on or off and the volumes of data generated.\textsuperscript{248}

- Jonathan French, of HMPPS, told us that Medway STC has invested heavily in CCTV and put over 70 cameras into the centre so that it now covers all classrooms, stairwells and kitchen areas on the residential units. Body-worn cameras are now in optional use at Medway, and staff have been positive about them.\textsuperscript{249}

39. The retention policies for such footage seem to vary. For example, MTC Novo’s policy states that footage is normally deleted after 31 days, except if it will be required later for evidence or for some other specific reason.\textsuperscript{250}

\textsuperscript{241} See, for example, 8 August 2017 report on Rainsbrook (INQ001569_006)
\textsuperscript{242} HMP000398, paragraph 20
\textsuperscript{243} January 17 July 2018 59–73
\textsuperscript{244} Janes 11 July 2018 59–73
\textsuperscript{245} Willison 12 July 2018 177
\textsuperscript{246} Willison 12 July 2018 177
\textsuperscript{247} Savage 13 July 2018 43, 50–55; Robinson 13 July 2018 54–55
\textsuperscript{248} Bailey 11 July 2018 97
\textsuperscript{249} French 17 July 2018 144–145
\textsuperscript{250} MTC000094_028-029, paragraph 6.1
Placing children for justice and welfare reasons together in secure children’s homes

40. As set out in the Inquiry’s REA, some research from the USA suggests that juvenile sexual offending can be a predictor of sexual misconduct in secure institutions. The REA noted that this raises concerns about the policy in England and Wales of accommodating children who have been found guilty of sexual offences with other children, especially with those who have been abused prior to custody. This is particularly the case in SCHs when some of the children have been placed there on welfare grounds. We explored how the potential safeguarding challenges presented by this practice are being addressed.

41. Katherine Willison told us all children in SCHs are sent there by a court order, and the regulations and quality standards apply equally, regardless of the route by which the child came to be there. While the children may have arrived by different routes, their needs are often not vastly different. She said combining welfare and justice placements in SCHs appeared to be working reasonably well.

42. Sara Robinson said a judgement is made about whether a new entrant to a SCH is appropriate but that, in reality, children coming in from both welfare and justice placements are often similar.

E.4: Safety

43. A series of recent reports have been highly critical of the levels of safety in institutions detaining children.

- The 2016/17 HMIP report described the lack of safety in establishments which hold children as “dire” and noted a “staggering decline” in safety. It said that there was “not a single establishment that we inspected in England and Wales in which it was safe to hold children and young people”.

- The 2017 Youth Custody Improvement Board report concluded that “the youth estate was on the edge of coping”.

- The 2017 Ofsted annual report said its inspection findings reflected serious concerns held nationally about, among other things, the safety of children in STCs.

44. It appears the level of physical violence is higher in custodial institutions holding children than those holding adults, but also that it is increasing:

- Ministry of Justice figures from 2014 suggest that, despite comprising just 1 percent of the prison population, 11 percent of recorded prison assault victims were children.

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251 REA, pp58–59
252 Willison 12 July 2018 160; 162; 182
253 Robinson 13 July 2018 56–58
255 Findings and recommendations of the Youth Custody Improvement Board, 24 February 2017 (INQ001618_001)
256 The Annual Report of Her Majesty’s Chief Inspector of Education, Children’s Services and Skills 2016/17, Ofsted, 13 December 2017 (INQ001492)
Youth Justice Board data from 2016 indicated there were 1,294 recorded assaults in custody, equivalent to 18.9 assaults per 100 children in 2016, up from 9.7 in 2011.

The HMIP report from 2016/17 also indicates that levels of violence in the youth secure estate have increased. Of the four YOIs inspected, levels of violence had risen at three and there were concerns about under-reporting at the fourth. Levels of the use of force by staff were high at the YOIs and STCs, and the latter were found to be insufficiently safe overall.257

45. Dr Janes referred to a wider pattern of data from the five years leading up to 2015/16. For this period she explained that Ministry of Justice figures indicate the use of force by staff had increased by 36 percent, assaults had increased by 95 percent and self-harm by 120 percent.258

46. There is also evidence of increased reports of children feeling unsafe. The Inquiry’s REA noted that, within YOIs in England and Wales in 2015/16, 18 percent of boys reported they felt unsafe. The proportion who reported ever having felt unsafe was 46 percent, the highest recorded figure. Children reported feeling least safe in YOIs and most safe in SChs, with STCs in between.259 Dr Janes told us that from April 2016 to March 2017 HMIP figures suggest that 39 percent of boys in YOIs and more than one in five in STCs reported that they did not feel safe.260

47. We explored the safety issue with several witnesses in order to understand what had led to these findings on declining safety and whether this pattern of decline was related to sexual abuse of children in custody.261

48. Although Dr Janes did not explicitly link declining safety to child sexual abuse, she was of the opinion that child abuse in custody should be considered in the context of the wider environment of violence and power imbalance. There is of course a very low chance of children disclosing abuse if they are too afraid to speak out.262

49. Angus Mulready-Jones, the lead inspector for children in detention for HMIP, considered the causes of the decline in safety included children being held further from home; there being a higher proportion of those in custody who have committed a violent or sexual offence; instability in management in some institutions, particularly in STCs; and instability in staffing at all levels, including senior leadership. He said the HMIP report for 2017/18, published during our hearings, concluded there had been some improvement. Three YOIs received the ‘reasonably good’ rating in respect of safety in their most recent reports. However, safety in YOIs had declined in as many places as it had improved; the remaining three YOIs and all STCs received the lowest two ratings in all respects. Levels of violence in STCs were the highest in any type of institution inspected. For example, in Oakhill STC, an institution holding 75 children, there were 110 incidents involving the use of force each

257 REA, pp52–53
258 Janes 11 July 2018 36–37
259 REA, p62
260 Janes 11 July 2018 36–37
261 Janes 11 July 2018 36–37
262 Janes 11 July 2018 36–37
263 HIP000022
month. Angus Mulready-Jones considered there is a link between violence and sexual abuse. One reason was that children are less likely to trust the institution to protect them if they were to report sexual abuse.\textsuperscript{264}

\textbf{E.5: Resources}

50. There is evidence from several sources that limited funding and low staff to child ratios in YOIs have in the recent past made it difficult for staff to provide for the needs of detained children and to ensure their safety.\textsuperscript{265} Others had also pointed to a potential link between the decline in safety in the custodial estate and reductions in resourcing and staff.\textsuperscript{266} We therefore considered whether there is a link between the reductions in the custody budget since 2010 and child sexual abuse in custodial institutions, and more generally whether resourcing is adequate to protect children in custody from sexual abuse.

51. The evidence heard was summarised below:

- Professor Hardwick, former Chief Inspector of Prisons, understood there is some evidence of the spending per child in YOIs having increased in recent years. There is also evidence of recent increases in staffing levels, including at Medway STC, which might imply staffing levels had fallen too far, and that there was a link between this and the widespread concerns about the safety of these institutions.\textsuperscript{267}

- Dr Janes noted that in February 2018 the Ministry of Justice announced it had £64m to invest in the reform of the youth custody estate. Overall she did not consider that funding and resources were a major issue in the children’s estate.\textsuperscript{268}

- Angus Mulready-Jones agreed staffing levels have been too low at times. This has had an impact on the regime in YOIs because a child is locked up for longer, the response to issues is not as swift or as good and children may be unable to use a telephone. This can also mean staff are relocated, which causes the same problems.\textsuperscript{269}

- Steve Gillan told us budget cuts from 2010 have had a serious impact on safety. He also referred to problems in relation to the recruitment and retention of staff, commenting that staffing levels have fallen to an all-time low, with vast numbers of experienced staff leaving the Prison Service and a new recruitment programme encountering difficulties, resulting in the recruitment of inexperienced staff.\textsuperscript{270}

- Pam Hibbert, a social worker and former Chair of the National Association for Youth Justice, said it was difficult to see how reductions in staffing and funding of YOIs have not impacted on their ability to safeguard children. When she visited

\textsuperscript{264} Mulready-Jones 16 July 2018 4–6; 29
\textsuperscript{265} REA, section 6.2.3
\textsuperscript{266} See, for example, Review of the Youth Justice System in England and Wales, Charlie Taylor, Ministry of Justice, December 2016, paragraphs 127–128 (INQ001422) and The Government’s austerity measures have left our prisons in meltdown, POA General Secretary, August 2016 (INQ001554)
\textsuperscript{267} See the letter from Professor Nick Hardwick dated 29 June 2018, pp3–5 (INQ001757)
\textsuperscript{268} Janes 11 July 2018 33–34
\textsuperscript{269} Mulready-Jones 16 July 2018 10–11
\textsuperscript{270} POA000001, Q2 and POA000003, Q3
a YOI in April 2018, she was told by a prison officer that routinely there was one member of staff per 40 children.271 (In contrast, we note that Vinney Green has a staff ratio of no more than four young people to one member of staff).272

52. On behalf of the Youth Custody Service, Sara Robinson said the reasons for safety figures in recent years included low staff numbers and the quality of staff. However, efforts are currently being made to increase the ratio of staff to children, back to the levels they were in 2013. Sara Robinson made clear that the HMPPS had the money to pay for staff, but the difficulty was recruiting and retaining good quality staff.273 As an example, Glenn Knight, Governor of HMYOI Feltham until May 2018, told us that in June 2018 Feltham A was fully staffed for the first time. He added that attrition rates had been high, due to job opportunities at Heathrow Airport nearby, but a pay rise had since been implemented in line with the local labour market to address this.274

E.6: Potential staff risk factors

53. We acknowledge that the very challenging, and sometimes violent and sexually harmful, behaviour of children in custody requires great skill and experience to manage. This is especially so given that children in custody have some of the most complex needs of any children in the country.275 However, staffing issues are plainly integral to the institutional response to child sexual abuse. We therefore considered staff recruitment, diversity, training, supervision, retention and whistleblowing.

Recruitment

54. The Inquiry’s REA highlighted concerns that have been raised historically about the skills and experience of those recruited to work in youth custody. In 2016, for example, the Taylor review276 concluded:

“many staff working in YOIs and STCs do not have the skills and experience to manage the most vulnerable and challenging young people in their care, nor have they had sufficient training to fulfil these difficult roles.”

There were particular concerns about YOIs, where staff are drawn from the Prison Service more generally and therefore may not have a specific motivation to work with children, or experience of doing so. More recently, the 2017 Youth Custody Improvement Board report277 (which reviewed the state of YOIs and STCs) repeated issues of poor behaviour management of children and stated that staff lacked the skills to meet the needs of some of the children in their care. In responding to the Taylor review, the Government committed to introducing a new Youth Justice Officer role. These officers would be recruited with experience of youth work, social work or teaching, or would be trained on the job.278

271 Hibbert 11 July 2018 112
272 Sykes 18 July 2018 115-116
273 Robinson 13 July 2018 65-70
274 Knight 16 July 2018 106; 124
275 Hardwick 11 July 2018 135-136
276 INQ001422
277 INQ001618
278 REA, section 8.2.1
55. We agree with the National Society for the Prevention of Cruelty to Children (NSPCC) that no single test or screening process can identify an individual who poses a risk. Recruitment procedures should evaluate an individual’s values, motives and behaviour in certain situations.279

56. All staff recruited to work with children in public or private institutions are vetted through the Disclosure and Barring Service.280

57. Every person working in a care role in a SCH is required by regulations281 to hold a Level 3 Diploma for Residential Childcare or equivalent.282 By contrast, even though working with children in custody is a highly skilled and demanding job,283 there is in general no requirement that staff who are recruited to STCs or YOIs have any prior experience of working with challenging children, or any childcare qualifications. A number of witnesses – including Dr Laura Janes, Legal Director of the Howard League for Penal Reform,284 Steve Gillan, General Secretary of the POA285 and Angus Mulready-Jones, a current HMIP inspector286 – considered a minimum qualification should be a prerequisite for all those working with children in the secure estate. This is expected in other environments involving children.

58. Professor Hardwick, former Chief Inspector of Prisons, noted that the roles are not well paid and are not high status.287 Alan Wood agreed that the worth placed on the role of custody officers, in light of the stresses and demands on them, is not always reflected in the pay received.288 While the current background checks and references are required, he also considered the current recruitment process does not always establish why people want to work with children. In any event, he stressed the recruitment process should be compliant with the Bichard Inquiry recommendations, as set out in London Safeguarding Children Board Child Protection Procedures.289

59. The Youth Custody Service recognises that working with children requires specialist knowledge and skills, and is actively seeking to recruit people with a background in working with young people, such as those with experience of probation and social work.290 The Youth Custody Service accepts that it is ”vital to continue with the drive to professionalis(e) the workforce in YOIs, STCs and SCHs”.291 However, Youth Custody Service Interim Executive Director Sara Robinson said there is no proposal to require staff to have a minimum level of qualification or experience. In her view, a statutory requirement that staff working in custody have specific child-related training, as is in place in the SCHs, would create difficulties for recruitment.292

279 NSP000025, paragraph 12
280 HMP000397, paragraph 29
281 The Children’s Home (England) Regulations 2015, regulations 32(3 and 4) (INQ001426)
282 Willison 12 July 2018 164; Sykes 18 July 2018 146
283 Willow 12 July 2018 128
284 Janes 11 July 2018 39
285 POA000000, Q2
286 Mulready-Jones 16 July 2019 18; 20
287 Hardwick 11 July 2018 135–136
288 Wood 12 July 2018 44
289 www.londoncp.co.uk
290 HMP000397, paragraph 31
291 HMP000397, paragraph 70
292 Robinson 13 July 2018 65–70; 80–81; 89


**Diversity**

60. There is overrepresentation of black, Asian and minority ethnic (BAME) children in custody. Dr Janes did not see any positive action being taken over this. She felt correlations between ethnicity, sexual orientation and the likelihood of abuse are areas that should be looked at more carefully. In respect of the divergence between the diversity of staff and the children detained, she said while there is no evidence to suggest this inhibits children speaking to staff, logically it could be a factor.293

61. Professor Hardwick pointed out that only 9 percent of staff are from a BAME background,294 whereas July 2018 figures indicate around 47 percent of children in the youth secure estate are from a BAME background.295 His view was that the lack of ethnic diversity among staff has an impact on trust, and trust is critical in this sort of institution.296

62. Chief Constable Simon Bailey, the National Police Chiefs’ Council’s lead on child protection, thought it was important to understand the profile of BAME groups in the youth justice system and to obtain more data on why some groups were overrepresented.297

63. Sara Robinson referred to the Ministry of Justice diversity strategy,298 which showed 9 percent of staff were from a BAME background, although the ethnicity of 35 percent of staff was unknown. She explained the current aim is that 14 percent of new recruits will be from a BAME background, and noted that 21 percent of new starter prison officers since January 2017 are from a BAME background.299

**Training**

64. Several issues relating to staff training are noted in the Inquiry’s REA. In the past recommendations have been made that all staff working in custodial settings, especially those in YOIs, should receive specialist training on working with children. The Juvenile Awareness for Staff Programme (JASP) – a seven ‑day training course covering safeguarding, mental health, substance misuse and behaviour management – was criticised by some commentators as being too brief, basic and lacking in appropriate content. Some 2011 research indicated that staff themselves did not feel they were properly trained, equipped or supported to work effectively with children and young people. The REA also noted:

- evidence that delivery of the training was ‘patchy’ and in some settings few people had been trained;
- significant variability in the training provided between establishment types, individual establishments, roles and members of staff; and
- some of the literature had raised specific issues about a lack of training in dealing with children with sexually harmful behaviour.

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293 Janes 11 July 2018 10; 20; 23: 46
294 Letter from Professor Nick Hardwick, dated 29 June 2018 (INQ001757)
296 Hardwick 11 July 2018 159
297 Bailey 11 July 2018 96
299 Robinson 13 July 2018 99
Although some concerns had been expressed about the staff training available in SCHs, generally the range of training had been described as wider than that available in YOIs.  

65. The Taylor review in 2016 also concluded that many staff working in YOIs and STCs had not had sufficient training to fulfil their difficult roles.  

66. Several complainants stressed the need for staff training. Peter Smith told us staff should be trained to spot signs of abuse, like changes in behaviour, and that bad behaviour can be a sign of abuse. Colin Watson said staff should be trained to see changes in children’s behaviour and to be trained to see the world through children’s eyes. CI-A34 felt there should be strong training on caring for children’s emotional needs. CI-A30 said staff should be trained to think about things the way a child does.  

67. The institutional witnesses also identified various training issues:  

- Professor Hardwick’s view was that specialist and ongoing training is required for staff working with children in custody to equip them to identify and deal with abuse appropriately; having sufficient well-trained professional staff is one of the most important factors in reducing risk.  
- Steve Gillan said questions remain as to whether the JASP training is adequate. He recommended there should be specific safeguarding training with regular updates and refresher training.  
- Angus Mulready-Jones noted that the new safeguarding training is valuable but is only a day in length.  

68. Improvements have been made to training in the youth custody estate. We heard about various Youth Custody Service training initiatives, including the Prison Officer Entry Level Training (POELT) course, externally provided courses available on the Youth Justice Resource Hub, the Working with Young People in Custody training programme, the three-year refresh cycle for the Child Protection and Safeguarding element of the course, and the ‘tiering structure’ to support establishments in identifying the correct level of child protection and safeguarding training for their staff. However, significant proportions of staff do not receive the mandatory child safeguarding training: between 12 percent and 23 percent of staff working in Feltham and Werrington YOIs had not received this training in 2014 and 2015. By contrast, in Vinney Green SCH all staff received all mandatory training in both years, and all current staff have received it.
69. Sara Robinson also explained HMPPS’s Youth Justice Foundation degree, which is available to all frontline staff. It is currently voluntary and 243 officers have volunteered so far, but it is intended that – over five years – the first year will become mandatory, with staff being given time off to complete the course, although they will not need to complete it before starting work with children. HMPPS is also developing a specific version of the POELT, focused on young people.313

70. Alan Wood considered that professional development and training must be firmly embedded further into the role of custodial care officers as part of professionalising the role. He gave examples of areas that staff should be trained in: child-centred communication; safeguarding in a secure setting; the impact of abuse on child development and communication; whistleblowing policy and practice; communication in conflict settings; professional roles and responsibilities when responding to allegations of abuse; exercising care within secure settings; and moving children into and from custodial settings. Practitioners need to participate in relevant skills and practice-based training in order to remain focussed on ensuring that the needs of children and young people remain central.314

71. In our Nottinghamshire hearings, Professor Hackett, Professor of Child Abuse and Neglect in the Department of Sociology at Durham University, said that all staff working in children’s services should be trained in how to respond to allegations of sexual abuse, including the question of confidentiality. He explained standard practice in this respect.315

Supervision

72. The Inquiry’s REA noted several issues with respect to staff supervision, which is recognised as part of good safeguarding practice, as well as a variability in the supervision provided.

73. In an SCH, under the Children’s Home (England) Regulations 2015 and the DfE’s related guide, supervision and performance management of staff helps safeguard children and minimise potential risks.316 As an example, at Aycliffe SCH, staff have a nominated supervisor who ensures supervision takes place on a monthly basis for each staff member, with arrangements set out clearly in guidance. In addition, any allegation of sexual abuse is referred to a senior manager, who is responsible for reflecting on and learning from experience as well as addressing practice concerns.317

74. By contrast, the National Children’s Bureau concluded in 2008 that, unlike in STCs and SCHs, the prison service “does not have a culture of individual supervision or learning from peers”.318 In 2016, the Medway Improvement Board found there was insufficient oversight of the work of operational staff in the STC.

313 Robinson 13 July 2018 5. After the hearing we were provided with more information about this programme and were told it has now been introduced.
314 Wood 12 July 2018 47, 74
315 INQ002045_078, paragraphs 9.5 and 9.7–9.12
317 Whellans 18 July 2018 169
318 A Review of Safeguarding in the Secure Estate, Youth Justice Board and National Children’s Bureau, 2008 (YJB000009_036)
75. A number of witnesses (including Dr Janes, Professor Hardwick, Steve Gillan and Alan Wood) said that staff and detainees would benefit from proactive and reflective supervision and support. As Angus Mulready-Jones said, supervision is an important tool to promote good-quality childcare practice; it is difficult to see how custodial officers will maintain a child-centred focus without this, or how poor performance by staff is dealt with. Staff need guidance from management and supervision to explain how to do this.

76. ‘Mainstream’ custody staff do not receive regular supervision. In the hearings, Ms Robinson confirmed that inYOIs and STCs there is no standard minimum requirement or a model for staff supervision, but indicated that the Youth Custody Service intends to develop a system of staff supervision. Whether this will include the necessary elements of accountability, personal development and support remains unclear.

Retention

77. The issue of high staff turnover in the youth secure estate has also been raised previously. For example, one of the concerns identified by the Medway Improvement Board final report included the rapid turnover of staff. This is a concern to us because a lack of continuity in staff is of course likely to hamper the ability of children to form meaningful relationships with staff, and so protect them from sexual abuse.

78. Professor Hardwick referred us to HMPPS workforce statistics to the effect that the leaving rate for Band 3–5 Officers (the main operational grades) increased from 2.8 percent in 2009/10 to 11.2 percent in 2017/18. Difficulties caused by high staff turnover contribute to staff being poorly equipped to face the challenges of the environment, as well as impacts on children’s feelings of safety and their ability to form relationships with staff.

79. By contrast, SCHs have a much smaller turnover of staff and therefore good, consistent relationships and adult role models are more likely.

80. Ms Robinson said remedies for recent high staff turnover rates may include higher pay (and pay has been increased recently), a better culture and better support for staff. She explained the youth justice reform programme is looking to make youth custody a place of safety and to create a professional and stable workforce.
Whistleblowing

81. Working Together to Safeguard Children requires organisations to have clear whistleblowing procedures (reflecting the principles in Sir Robert Francis’ Freedom to Speak Up review), which should be suitably referenced in staff training and codes of conduct, and to have a culture that enables issues about safeguarding and promoting the welfare of children to be addressed.  

82. Both the YOI and STC Rules state "an officer shall inform the governor promptly of any abuse or impropriety which comes to his knowledge". There are also Prison Service Instructions (PSIs) in place to cover whistleblowing in YOIs and STCs. A staff member with a concern can complete an intelligence report or a corruption prevention intelligence report, either of which would be actioned by the security team within the institution. Staff can also refer immediate concerns directly to the local safeguarding manager or duty governor. All sites operate current and site-specific whistleblowing policies.

83. However, there is evidence that these rules, PSIs and policies have not been working effectively in practice.

84. The Medway Improvement Board final report noted there had been a history of similar concerns being raised in letters from whistleblowers and former members of staff, and that action was needed to ensure that whistleblowers and children inside the STC feel safe to raise concerns and complaints.

85. Angus Mulready-Jones said that, in common with a range of other settings, there is evidence to suggest that staff rarely blow the whistle on poor practice and abuse carried out by colleagues. Carolyne Willow said it is uncommon for staff in prisons to “break rank” and support a child’s version of events. Pam Hibbert said organisations which have an open learning culture and operate on a reasonably ‘flat’ hierarchy are those where disclosure of concerns by staff are more likely. Professor Hardwick was clear that what was important was the development of a culture where staff feel if they have concerns about anything they can talk about them openly, which he linked with the issue of staff supervision.

86. Some complainants gave evidence about the importance of this issue. Peter Smith said staff should be trained not to ‘trust’ other staff, but should question and monitor each other. CI-A30 said policies need to be introduced that protect the identities of whistleblowing staff. Alan Wood felt whistleblowing should be an element of safeguarding

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332 Working Together to Safeguard Children, April 2018 (DFE000876)
333 Namely the Young Offender Institution Rules 2000, rule 67(2) (INQ001617) and the Secure Training Centre Rules 1998, rule 39(2) (INQ001599)
334 There are a number of rules, regulations and guidelines by which prisons are run. These are outlined in Prison Service Instructions (PSIs) and Prison Service Orders (PSOs).
335 Namely PSI 21/2013 Reporting Wrongdoing (HMP000152) and PSI 01/2016 Corruption Prevention (INQ001563); NOM000008, paragraphs 24, 44 and 65
336 Medway Improvement Board: Final Report, 30 March 2017 (MED000003)
337 Mulready-Jones 16 July 2018 35
338 Willow 12 July 2018 115
339 InQ001750, Q7
340 Hardwick 11 July 2018 147
341 Smith 9 July 2018 136
342 CI-A30 10 July 2018 162
training; merely having a whistleblowing procedure was not enough. He explained that because it was difficult for staff to go above the management structure, whistleblowing needs to be embedded into the culture.\textsuperscript{344}

87. On behalf of the Youth Custody Service, Sara Robinson explained that the whistleblowing procedures had been reviewed after the Medway issues arose. She indicated referrals were being made and the systems were there; the issue was whether or not they were being used. She said the Youth Custody Service uses different intelligence methodologies to assist with this, and that HMPPS is introducing an 'annual thematic review' across the sector, whereby each provider will submit a thematic review of their locally managed whistleblowing matters (and other issues) to the Youth Custody Service. Central teams, including an audit team which sits outside the Youth Custody Service, will review this information so that lessons can be learned.\textsuperscript{345}

E.7: Restraint, strip searching and pain compliance

88. There are occasions when staff in custodial institutions consider it necessary to physically restrain or strip search children. Force may be used to achieve 'good order and discipline' in children. Pain compliance techniques are also used on children in custody: the Youth Custody Service confirmed they were used in 119 incidents in STCs and YOIs in the year to March 2017.\textsuperscript{346}

89. We were concerned to understand whether there are appropriate safeguards in place around this kind of physical contact with children, not least because 92 of the complaints of sexual abuse in our prevalence analysis involved situations of restraint. In addition, as noted in the Inquiry’s REA, there is evidence of a growing understanding of the adverse impact that restraint and strip searching can have on children who have been abused previously.\textsuperscript{347} As Peter Gormley, former Governor of HMYOI Werrington, said, it is also likely that a violent and unsafe environment will discourage children from reporting abuse.\textsuperscript{348}

90. The Minimising and Managing Physical Restraint (MMPR) programme is the framework within which restraint is used in child custody. It requires staff to ensure that physical restraint is only ever used as a last resort, and there should be a de-escalation of incidents and the prevention of the use of force, as well as a process of review and learning from incidents.\textsuperscript{349}

91. Strip searching can be extremely intrusive and distressing. Peter Savage, Head of Operational Contract Management, explained on behalf of the Youth Custody Service that it is ‘risk-led’, ie there has to be a good reason why it is necessary. It must be authorised by a senior person and there must be at least two members of staff present.\textsuperscript{350} (The same approach is taken, for example, at Vinney Green SCH.\textsuperscript{351} Dr Janes, Legal Director of the Howard League for Penal Reform, raised concerns over the use of strip searching, particularly in relation to children who have had previous negative sexual experiences or girls

\textsuperscript{344} Wood 17 July 2018 7
\textsuperscript{345} Robinson 13 July 2018 150–152; 164–166
\textsuperscript{346} Savage 13 July 2018 114–115; 122–123; 180–181; HMP000427.005, paragraphs 13–16
\textsuperscript{347} REA, sections 6.3.1–6.3.2
\textsuperscript{348} Gormley 16 July 2018 150, 166
\textsuperscript{349} HMP000321, paragraphs 5–6; HMP000398, paragraphs 25 and 38–40; HMP000321.005, Q6
\textsuperscript{350} Savage 13 July 2018 114–116; 119–121
\textsuperscript{351} Sykes 18 July 2018 106
who are pregnant.\textsuperscript{352} Angus Mulready-Jones, the lead inspector for children in detention for HM Inspectorate of Prisons (HMIP), told us HMIP has noted that the required forms for strip searching are not completed appropriately at times.\textsuperscript{353}

\textbf{92.} Professor Hardwick, former Chief Inspector of Prisons, referred to the HMIP 2015 report about restraint in YOIs and STCs,\textsuperscript{354} including examples of how children experience restraint. He was very concerned about the use of pain compliance techniques, and considered their use starts to pervade the culture, normalises pain for staff and for children, and is contrary to staff building trusting relationships with children. As a result, he considered this practice should be stopped.\textsuperscript{355}

\textbf{93.} Dr Janes agreed with the abolition of pain compliance techniques. She also discussed the relationship between the use of restraint and allegations of sexual abuse, including the sexualised nature of some restraint. She said the use of restraint for 'good order and discipline' reasons has been ruled unlawful in STCs\textsuperscript{356} but is still permitted in YOIs. More generally, Dr Janes commented that, whatever was recorded as the reason for the restraint, children often perceived that they had been subjected to force for not doing what they were told. If children in custody are deliberately subjected to pain by staff, that is also likely to seriously impact on their ability to trust staff or report other concerns. In Dr Janes' experience, the sense of injustice and powerlessness experienced by children as a result of the use of force is compounded by the fact it is often followed by disciplinary processes.\textsuperscript{357}

\textbf{94.} Other witnesses shared these concerns about the impact of pain compliance techniques:

- Both CI-A17\textsuperscript{358} and CI-A34\textsuperscript{359} thought that pain compliance or force techniques should not be allowed.

- Pam Hibbert, a social worker and former Chair of the National Association for Youth Justice, said that while some children exhibited very challenging behaviour, the response to such behaviour should be increased confinement, control and restraint.\textsuperscript{360}

- Carolyne Willow, a social worker and founder of Article 39, agreed that pain-inducing restraint should be prohibited.\textsuperscript{361}
Phillip Noyes, NSPCC, considered there were no circumstances in which pain compliance techniques should be used. The NSPCC considers physical restraint of children should only ever be used as a measure of last resort, and there were no circumstances which warranted the use of pain or distraction techniques on children.

Angus Mulready-Jones said that reducing restraint requires better conflict resolution and pain-infliction techniques should not be used.

95. The Youth Custody Service witnesses told us that a review of whether pain-inducing techniques should remain authorised in YOIs and STCs, and in the MMPR syllabus, is in progress. A review of the updated behaviour management code of practice was expected in autumn 2018.

96. Alan Wood’s view was that the child’s perception of restraint and what it means to them must be considered, particularly given the impact on children who have been abused. This is supported by the experience at Feltham, where a clear focus on reducing violence with a new behaviour management strategy and restraint minimisation plan has led to a reduction in violence.

E.8: Mental health, drugs and gangs

97. We explored with witnesses whether (i) psychiatric disorders, mental health conditions or other psychological factors, (ii) the use of drugs and synthetic substances, and (iii) gang membership and culture have an impact on the prevalence and reporting of child sexual abuse in custody.

98. Angus Mulready-Jones indicated that HMIP has various expectations relating to mental health. We understand that the SECURE STAIRS programme is intended to help staff understand where emerging mental health issues might create a challenge in working with a young person. It also hoped to assist them on a day-to-day basis to better build better relationships.
99. HMIP also requires establishments to have in place an effective strategy to reduce the prevalence of drugs. Peter Savage told us that drug issues in child custodial institutions were not on the same scale as in the adult estate; it was not a major factor. His view was that typically teenage detainees are experimenting rather than dependent, and some recent work by User Voice suggests they had limited interest in psychoactive substances which might be more of a risk.

100. The Youth Custody Service does work to identify gangs and is building on its understanding from the police of the potential conflict between gangs to consider how to keep people safe from gang-related conflict in custody.

E.9: Identifying ‘warning signs’

101. A number of factors are associated with an increased risk of child sexual abuse in custody. These include gender, ethnicity, sexual orientation, history of experiencing sexual assault prior to custody, and having been convicted of a sexual offence prior to custody. It has also been suggested that children who have committed sexual offences may be at greater risk of being victimised themselves in custody as well as victimising others.

102. Alan Wood said that all members of staff should be trained appropriately to recognise and respond to sexual abuse.

103. SCH staff are directed to continually monitor and actively assess the risks to each child and the arrangements in place to protect them. Staff skills should include being able to identify signs that children may be at risk and to support children in strategies to manage and reduce any risks.

104. We were told that the Comprehensive Health Assessment Tool (CHAT) system, together with the Youth Custody Service’s ASSETPlus system, would adequately identify those children most at risk of sexual abuse in custody. However, the Inquiry’s REA noted evidence that CHAT assessments in YOIs and STCs are not always completed consistently, and that children’s health records are often unavailable so establishments may not always be aware of children’s pre-existing health conditions.

105. PSI 08/2012, Care and Management of Young People, recognises that young people held in custody are inherently at risk of harm. It provides that staff must be able to recognise, and know how to act upon, evidence that a child is suffering or is at risk of suffering serious harm.

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371 HIP000023_004-5
372 Savage 13 July 2018 101
373 Savage 13 July 2018 101-102
374 REA, section 5.3
375 Wood 12 July 2018 20–22
376 Willison 12 July 2018 161–165; Guide to the Children’s Homes Regulations including the Quality Standards, Department for Education, paragraphs 9.5 and 9.10 (INQ001439)
377 Rosamond Roughton from the NHS told us the Comprehensive Health Assessment Tool (CHAT), used in secure settings, was designed to provide a comprehensive picture of the needs of each child, resulting in the development of a specific care plan with appropriate care and interventions indicated. If a child was vulnerable, or at risk of harm to themselves or others, this would be referenced on the CHAT care plan, and risk management discussed in the wider setting (NH5000027_005).
378 ASSETPlus includes a section on the young person’s safety and wellbeing, which asks whether he or she is at risk of sexual exploitation. It mentions familial child sexual abuse as a factor indicating vulnerability to exploitation (Savage 13 July 2018 126; HMP000340_143–149, paragraph 8.3.3.1).
379 NOM000008, paragraph 33; HMP000398, paragraphs 18 and 48
380 REA, section 7.1
381 PSI 08/2012 (NOM000003)
harm. It recommends that staff report concerns to the relevant safeguarding manager. This policy is supported by mandatory training on safeguarding in YOIs and STCs, which includes how to identify signs of sexual abuse and recommends that staff report concerns to the relevant safeguarding manager.\footnote{382}

106. However, as set out above, the safeguarding training is only a day in length and there is evidence that, although it is mandatory, not all staff have received it.\footnote{383} HMPPS has recently commissioned a Review of Safeguarding in the Secure Estate (June 2018) by Sonia Brooks OBE. The terms of reference include a review of safeguarding training.\footnote{384}

107. Dr Janes told us that therapeutic interventions for children who have engaged in harmful sexual behaviour used to be provided in custodial institutions by groups such as the Lucy Faithfull Foundation and GMP, but these stopped some years ago. There is now no standardised service.\footnote{385} Stuart Jessup of MTC Novo told us about one specialist psychology-led harmful sexual behaviour service, led by Northamptonshire Health Foundation Trust.\footnote{386}

### E.10: Enabling children to disclose sexual abuse

108. It is clearly important that children being sexually abused have available to them a range of routes to disclose what is happening to them. Regular contact with family and friends is a safeguarding measure. Given how difficult it is to disclose abuse, a child must trust the person they tell. In Pam Hibbert’s experience as former Chair of the National Association of Youth Justice, children would rarely disclose abuse to someone within an establishment but would rather disclose it to a relative, a friend or sometimes a social worker if they had a good relationship with them.\footnote{387} Other witnesses went further and said that initial disclosures are most often made to a parent or friend.\footnote{388} Similarly, surveys in STCs show if children had a problem they were most likely to turn to family.\footnote{389} We have therefore considered the various ways in which children can disclose sexual abuse in custody.

#### Family, friends and peers

109. Several complainants told us about the need for children to access their family, friends and peers. Peter Smith stressed the difficulties caused by children being detained at a distance from their families.\footnote{390} CI-A17 said it might be easier to trust people who are closer in age to the children so they can understand the children's needs.\footnote{391}

\begin{footnotes}
\footnotetext[382]{HMP000321_012, paragraph 14; HMP000325; HMP000381; HMP000390; HMP000392}
\footnotetext[383]{Mulready-Jones 16 July 2018 17–18; HMP000001, paragraph 13; HMP000176; HMP000184, paragraph 13}
\footnotetext[384]{HMP000427_005, paragraph 12; HMP000426}
\footnotetext[385]{Janes 11 July 2018 16–17}
\footnotetext[386]{Jessup 17 July 2018 161–164; 166; 170; 174}
\footnotetext[387]{Hibbert 11 July 2018 109–110, 115}
\footnotetext[388]{Noyes 12 July 2018 91, referring to No one noticed, no one heard, NSPCC, 2013 (INQ001489_006)}
\footnotetext[389]{Mulready-Jones 16 July 2018 31–34; HIP000023_003}
\footnotetext[390]{INQ001746_003}
\footnotetext[391]{CI-A17 10 July 2018, 24}
\end{footnotes}
110. To this end, the rules for YOIs\(^{392}\) and STCs,\(^{393}\) and PSI 08/2012,\(^{394}\) make provision for children to have contact with the outside world. The SCH framework is more generous.\(^{395}\) In all STCs, children have telephones in their rooms, and they can have as many incoming phone calls outside of the school day as they want. This has also been established in Cookham Wood YOI and the Keppel Unit in Wetherby YOI, and the intention is to ensure children have free access to telephone calls from their family in all YOIs.\(^{396}\)

111. However, as Dr Janes, Legal Director of the Howard League for Penal Reform, explained, the length of time a child can spend on the phone is often limited to 10 minutes before it cuts off automatically. There are limits on a child’s phone credit, and calling mobiles phones is extremely expensive. For the children in YOIs without in-cell phones, their calls are not likely to be private. The children also know their calls will be monitored and recorded.\(^{397}\)

112. In YOIs and STCs, family visits do not take place in private and so children’s conversations may be overheard by detainees or staff.\(^{398}\)

113. Witnesses also told us of problems associated with children being placed further away from their families and communities, which had resulted from the closure of some YOIs and SCHs.\(^{399}\) For example, Professor Nick Hardwick, former Chief Inspector of Prisons, Angus Mulready-Jones, HMIP inspector, and Martin Lomas, Deputy Inspector of Prisons all agreed that children should be held closer to home, to facilitate positive, protective external relationships with family, friends and community-based professionals.\(^{400}\) We were troubled to be told that there is no SCH in the Greater London area.\(^{401}\)

114. However, we recognise there may also be other ways to facilitate this kind of support. For example, at Aycliffe Secure Centre, a bookable room has been set up for Skype and video conferencing facilities are available.\(^{402}\) At Rainsbrook STC, MTC Novo has provided tablets with secure messaging functions so children have improved contact with the outside world, can request a visit from Barnardo’s or make confidential complaints; they also have peer mentors to assist young people.\(^{403}\) Children in STCs can send and receive as many letters as they wish.\(^{404}\) We also understand the intention is to ensure children have free access to telephone calls from their family in all YOIs.\(^{405}\)

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392 Under the Young Offender Institution Rules 2000, rules 9–11 (INQ001617), a young person’s entitlement to communication with the outside world is restricted to sending and receiving a letter once a week, and receiving a visit twice every four weeks, and letters other than communications with lawyers are capable of being randomly opened by the Governor.

393 Under the Secure Training Centre Rules 1998, rule 9 (INQ001599), arrangements must be made for children to receive visits, taking account of the importance of contact by a trainee with his family, and the need to keep to a minimum any disruption of his or her education and training. In all STCs children have telephones in their rooms, and they can have as many incoming phone calls outside of the school day as they want.

394 PSI 08/2012 on the Care and Management of Young People requires arrangements to be put in place to promote the positive contact and involvement of the family with every child where appropriate (NOM000008, paragraph 64).

395 Under the Children’s Home (England) Regulations 2015, regulations 22 and 23 (INQ001426). In SCHs, under the applicable regulations, “visits should be permitted as freely as possible”. There must also be suitable facilities for a child to meet privately at any reasonable time with family, friends and certain others; the child must normally be able at all reasonable times to make and receive telephone calls, emails, and post, in private, without reference to persons working in the home.

396 Savage 13 July 2018 147–148

397 Janes 11 July 2018 32; HWL000001_024, paragraph 6.17

398 See, for example, HMIP’s 2017 report on HMYOI Feltham (INQ001125), paragraph 2.6

399 Hibbert 11 July 2018 109–110, 115

400 Hardwick 11 July 2018 161; HIP000017_004, paragraphs 19–26; Mulready-Jones 16 July 2018 31–34; HIP000023_003

401 Hibbert 11 July 2018 110

402 Whellans 18 July 2018 164; 170

403 Jessup 17 July 2018 161–162; 168; 171

404 YJB000101, paragraph 63

405 Savage 13 July 2018 147–148
The complaints process

115. The Inquiry’s REA set out a range of well-recognised issues with the complaints process for children in custody, including children’s lack of satisfaction with it, concerns over its credibility, accessibility and formality, and fears of ‘grassing’ and reprisals.\(^{406}\)

116. It is clear that these issues persist. During Professor Hardwick’s tenure as Chief Inspector of Prisons, survey results about complaints indicated that only 26 percent of children in YOIs felt their complaint had been dealt with fairly.\(^{407}\) Pam Hibbert agreed that children had very little faith in the complaints system: it tends to be used for minor matters such as requesting an extra pillow, rather than to report that someone had abused them.\(^{408}\) Dr Janes also identified issues with the complaints process, such as computers being situated on communal landings, confidentiality, and literacy barriers. If the Prisons and Probation Ombudsman (PPO) becomes involved, delays mean that children are often released by the time the PPO has made a decision.\(^{409}\) Some children had also expressed a view that there might be retaliation against someone who made a complaint.\(^{410}\)

117. Consideration is being given to improvements, such as to making provision across the secure estate for children to use tablets on which they can make complaints.\(^{411}\) We agree with Alan Wood that the complaints process should be age and developmentally appropriate.\(^{412}\)

Personal officers, external professionals and advocates

118. Several complainants stressed the need for children in custody to have access to independent professionals. Peter Smith said children should have access to ‘outside’, independent people.\(^{413}\) CI-A17 agreed independent lines of communication should exist between children and trained youth and social workers.\(^{414}\) Colin Watson said telephones should be available to children to call Childline or someone completely independent, and that social workers should visit children at least once per week and speak to them on the phone on other occasions.\(^{415}\) CI-A30 thought children should be able to report problems anonymously to someone outside the institution.\(^{416}\) Peter Robson said there should be independent people available at all times who the young person can talk to in private.\(^{417}\)

119. Legislation and statutory guidance states children who are on remand, but not those who have been sentenced, are treated as being ‘looked after’.\(^{418}\) For children in custody who are ‘looked after’, the home local authority must visit roughly once every six weeks, and also

\(^{406}\) REA, pp99–105
\(^{407}\) Hardwick 11 July 2018 160
\(^{408}\) Hibbert 11 July 2018 116–117
\(^{409}\) Janes 11 July 2018 49–50
\(^{410}\) Hibbert 11 July 2018 113–114
\(^{411}\) Robinson 13 July 2018 136–137
\(^{412}\) Wood 12 July 2018 20: 51
\(^{413}\) Smith 9 July 2018 133; INQ001174_009
\(^{414}\) INQ001744_002
\(^{415}\) INQ001745_003
\(^{416}\) CI-A30 10 July 2018 150; INQ001743_003
\(^{417}\) INQ001761, paragraph 117.11
\(^{418}\) Legal Aid, Sentencing and Punishment of Offenders Act 2012, section 104
if requested by the child or others.\textsuperscript{419} Social workers have been based in YOIs since a review in 2003.\textsuperscript{420} However, for the majority of children given a custodial sentence, an English home local authority will not visit them regularly.

120. Dr Janes considered there is overall a shortage of permanent external adults, such as advocates or social workers, in these institutions. A number of children on remand, who are treated as being ‘looked after’, did not receive regular visits from their social workers. Her experience was that there are normally only one or two general social workers based in each establishment, which may hold well over 100 young people, and they are not required to meet regularly with each child. She also observed that, at times, independent professionals may not have a private space to talk to children about sensitive issues.\textsuperscript{421}

121. Several witnesses, including Professor Hardwick,\textsuperscript{422} Carolyne Willow, a children’s rights campaigner and founder of Article 39,\textsuperscript{423} and our expert Alan Wood,\textsuperscript{424} considered that access to advocacy workers and other independent people was important. Mark Johnson, founder of User Voice, referred to a User Voice report which found that young people would use independent advocacy services if they were available; comments from young people included that it would be good to have someone independent to visit once a week.\textsuperscript{425}

122. However, there are also problems with advocacy. For example, Medway Improvement Board found the Barnardo’s advocacy service was not fit for purpose\textsuperscript{426} and raised concerns about the effectiveness of the role of the Youth Justice Board Monitors in STCs.\textsuperscript{427} The child may also be responsible for approaching the advocate who then relays and represents what the child has told them but, as Pam Hibbert noted, a child might say for example “I want another pillow” when they really want to talk about something else.\textsuperscript{428}

123. We note that in Wales an advocate is proactive. He or she approaches the child and makes direct contact, rather than passively waiting for a child who may be struggling to articulate a concern or raise a complaint. Developing a relationship with a trusted adult in this way is important for them to be able to speak out and have support and assistance.\textsuperscript{429} Albert Heaney, Director of Social Services and Integration, Welsh Government, also told us that in Wales the home local authority is required to visit all children in detention; for many children, a visit must take place once within the first 10 days and after that if the child, parent, staff or Youth Offending Team worker requests it.\textsuperscript{430}

124. However, it is important to note that advocates are only one possible option for detained children. In a survey in STCs, children were asked “If you had a problem, who would you turn to?”:

\textsuperscript{419} Legal Aid, Sentencing and Punishment of Offenders Act 2012, section 104
\textsuperscript{420} REA 8.5.3; Gormley 16 July 2018 147
\textsuperscript{421} Janes 11 July 2018 32; 53–54; HWL000001_025, paragraph 6.18; HWL000004_007, paragraph 2.14
\textsuperscript{422} Hardwick 11 July 2018 162
\textsuperscript{423} Willow, 12 July 2018 124; INQ001412_011-012
\textsuperscript{424} Wood 16 July 2018 127–128; HOU000018_009-010
\textsuperscript{425} Johnson 17 July 2018 193; ‘Why are they going to listen to me?’, User Voice, July 2012 (INQ001607_029)
\textsuperscript{426} REA, paragraph 8.4.8
\textsuperscript{427} HMP000398, paragraph 46
\textsuperscript{428} Hibbert 11 July 2018 116–117
\textsuperscript{429} Heaney 13 July 2018 106–107
\textsuperscript{430} Heaney 13 July 2018 112–113; WGT000003_011, paragraph 8
<table>
<thead>
<tr>
<th>Role</th>
<th>2015–16*</th>
<th>2016–17†</th>
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<tbody>
<tr>
<td>Advocate</td>
<td>11%</td>
<td>9%</td>
</tr>
<tr>
<td>Another young person here</td>
<td>19%</td>
<td>19%</td>
</tr>
<tr>
<td>Key worker</td>
<td>35%</td>
<td>25%</td>
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<tr>
<td>Case worker</td>
<td>43%</td>
<td>34%</td>
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<tr>
<td>Staff on the unit</td>
<td>51%</td>
<td>41%</td>
</tr>
<tr>
<td>Family</td>
<td>54%</td>
<td>43%</td>
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*INQ001199
†INQ001200

125. This may reflect the irregular contact with current advocacy services. It may also reflect, as Sara Robinson, Interim Executive Director, Youth Custody Service, pointed out, that a child might turn to other staff within the establishment, including education and healthcare staff, social workers, Youth Offending Team workers and probation offender managers. A child is able to see an Independent Monitoring Board member at any time in confidence, and can access chaplaincy services, legal helplines from children’s rights groups such as the Howard League, and confidential helplines run by Childline and the Samaritans. They can also access the PPO if they lodge a complaint and this has been dealt with internally.

126. Whatever the range of people available, the critical question is whether the child trusts one of them enough to disclose. As Professor Hackett commented, it is the availability of an accessible and trusted adult that is vital and these relationships take time to develop. Children are not likely to spontaneously disclose abuse, but are more likely to talk about their experiences when invited to do so and this means they should be given frequent opportunities, in private, to discuss any concerns.\(^{431}\)

127. The Youth Custody Service therefore needs to build young people’s confidence in the available staff, to show there will be support mechanisms when they disclose, and to demonstrate that their concerns are being taken forward, addressed and investigated.\(^{432}\)

128. At Medway STC, the Custody Support Plan (CuSP) officer has replaced the personal officer and will spend one hour per week with their allocated child. The intention is to foster positive relationships, motivate the young person, identify unmet needs and set goals.\(^{433}\) Sara Robinson said it is hoped that, by the end of this financial year, every child across the estate will have a CuSP officer.\(^{434}\) This appears to be a positive step.

129. Peter Savage, Head of Operational Contract Management, Youth Custody Service, stressed that there needs to be a range of different organisations and individuals available who are independent of HMPPS.\(^{435}\)

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\(^{431}\)INQ002045_074, paragraph 8.23, 8.25
\(^{432}\)Robinson 13 July 2018 141; 173–174; YJB0000101, paragraph 68; HMP000397, paragraph 47; HMP000398, paragraphs 40, 44, 47
\(^{433}\)HMP000398, paragraph 45
\(^{434}\)Robinson 13 July 2018 138–139
\(^{435}\)Savage 13 July 2018 176
Legal advice

130. Dr Janes considered the best way to protect any child from the risk of abuse is to empower them to understand and enforce their rights. She noted that a number of recommendations have been made to that end by a range of experts. For example, the Bach Commission (2017)\(^{436}\) recommended that "all matters involving children should be brought back into the scope of funded legal aid".\(^{437}\) We note the concerns expressed by the Joint Committee on Human Rights that the reductions in legal aid will increase the vulnerability of children in custody.\(^{438}\)

131. More generally, we note that legal visits are held in sight but out of hearing of a member of staff\(^{439}\) which may inhibit a child’s willingness to disclose abuse.

General steps to build trust

132. As discussed above, it is important that staff and children are able to form positive relationships; this is crucial to gain the child’s trust and confidence and to enable a child to disclose sexual abuse.

133. We recognise that building relationships in the context of a custodial institution may be extremely challenging. Staff need guidance, experience, qualifications, training and supervision to explain how to do this.\(^{440}\) As the DfE 2015 Guide\(^{441}\) for SCHs states, children should be loved, valued and nurtured, and "staff should strive to build positive relationships with children in the home and develop a culture of openness and trust that encourages them to be able to tell someone if they have concerns or worries about their safety".\(^{442}\) However, the regulations, policy and contracts governing YOIs and STCs contain very much less about building positive relationships, trust and confidence. For example, in YOIs, PSI 08/2012 briefly mentions positive relationships\(^{443}\) and the STC contract states "young people will develop positive relationships with adults...".\(^{444}\) We recognise that several elements of the Youth Custody Service reform programme aim to address this.

134. In our Nottinghamshire hearing, Professor Hackett explained that he considered that the availability of an accessible and trusted adult is vital. The essential point is that these relationships take time to develop, and consistency is important. He said that children are not likely to spontaneously disclose abuse, but are more likely to talk about their experiences when invited to do so. This means children should be given frequent opportunities (in private) to discuss any concerns.\(^{445}\)

\(^{437}\) HWL000003_003, paragraphs 2.4–2.5
\(^{438}\) The UK’s Compliance with the UN Convention on the Rights of the Child – Eighth Report of Session 2014–15, House of Lords and House of Commons Joint Committee on Human Rights, 24 March 2015, paragraph 125 (INQ001465)
\(^{439}\) NOM000008, paragraph 60
\(^{440}\) Mulready-Jones 16 July 2018 12–13, 21–22 and HIP000017_004, paragraph 20
\(^{441}\) Guide to Children’s Homes Regulations including the Quality Standards, Department for Education, April 2015 (INQ001439)
\(^{442}\) Guide to Children’s Homes Regulations including the Quality Standards, Department for Education, April 2015, paragraph 9.11 (INQ001439)
\(^{443}\) YJB0000068, paragraph 2.9 and Annex B, paragraph 23
\(^{444}\) YJB000030_031, p33, paragraph 6.1
\(^{445}\) INQ002045_074, paragraphs 8.23, 8.25
E.11: Education and information given to children

135. The Inquiry’s REA referred to:

- the Howard League’s position that there is a need for greater sex education for children in custody, and a greater recognition of the need to acknowledge normal sexual experimentation\(^{446}\) and
  
- concerns that have been raised about the quality of induction processes used when a child arrives in custody, and the potential link between a lack of information that sexual abuse is prohibited and its prevalence.\(^{447}\)

Sex and relationships education

136. Dr Laura Janes rightly stressed the importance of sex and relationships education, because if children do not recognise abuse this will be a barrier to reporting it.\(^{448}\)

137. Peter Savage understood sex and relationships education is being widely taught in most of HMPPS’s establishments.\(^{449}\)

138. However, Dr Laura Janes noted that the curriculum in YOIs and STCs is different from that in the community; her opinion was that some of the sex education in some STCs was very good but it needs to be on a rolling basis in custody because of the transient population. There are also gaps. For example, children do not routinely receive education about the relationship between sex and the law.\(^{450}\) Children need to understand what abusive behaviour is as well as about their own sexual development and identity.\(^{451}\) Staff also do not get routine training about talking to children about sexual behaviour, sexual identity, the law around sex and healthy sexual relationships. However, when Dr Janes spoke to staff about this, they have found it very helpful particularly when facing complex situations that require supporting children without crossing boundaries.\(^{452}\)

139. Following DfE guidance, SCHs must produce a ‘Children’s Guide’ in ‘age appropriate’ language, through which children "must be supported by staff to understand what abuse is and what constitutes inappropriate behaviour".\(^{453}\) Margaret Whellans took us through the Aycliffe sex education materials which give guidance to children about appropriate boundaries, including that overtly sexual behaviour is not acceptable.\(^{454}\)

140. Statistics suggest harmful sexual behaviour between children has increased. Alan Wood thought this risk might be reduced through training, sending a consistent message to children about bullying and sexually harmful behaviour in a clear and unambiguous way, proper sex education, proper risk assessment processes, and making support available to victims and alleged perpetrators.\(^{455}\)

\(^{446}\) REA, section 7.4
\(^{447}\) REA, p108
\(^{448}\) Janes 11 July 2018 12
\(^{449}\) Savage 13 July 2018 129
\(^{450}\) Janes 11 July 2018 16–17
\(^{451}\) Johnson 17 July 2018 187
\(^{452}\) Janes 11 July 2018 40–41
\(^{453}\) The Children’s Home (England) Regulations 2015, regulation 7 (INQ001426) and Guide to Children’s Homes Regulations including the Quality Standards, Department for Education, April 2015, paragraphs 4.20–4.23 and 9.8–9.18 (INQ001439)
\(^{454}\) Whellans 18 July 2018 167–169
\(^{455}\) Wood 12 July 2018 27; 35
Professor Hackett said that factors which helped children disclose abuse include children being provided with information about sexual abuse that is developmentally appropriate, and frequent opportunities to talk about their concerns.  

Sara Robinson confirmed she had asked the Brooks review to consider whether key principles around sex education should be developed and provided to children.

### Information about procedures and rights

The SCHs ‘Children’s Guide’ explains how children can report concerns to the Office of the Children’s Commissioner, and provides details of helplines such as the NSPCC’s Childline. It also explains how to make a complaint and how the complaint will be dealt with. The policies for the protection of children from abuse and neglect must be available and explained to children and their families.

In terms of more general information being given to children about their rights, Peter Savage and Sara Robinson accepted the SCH model described above could well be applied in YOIs and STCs.

### E.12: Responding to allegations

A key part of this investigation was the issue of how custodial institutions respond to allegations of child sexual abuse when they are made. We therefore obtained evidence on this issue from a range of sources, both at a general systems level and in our review of a series of ‘case studies’.

### The REA’s observations on response issues

The Inquiry’s REA set out what was known about how custodial institutions respond or are likely to respond to allegations of child sexual abuse, and similarly about failings in that response. For example, in 2008 the National Children’s Bureau’s safeguarding review noted:

- safeguarding practice was hindered by the lack of clear definitions about what constituted a child protection concern;
- examples of child protection matters being overlooked in YOIs;
- evidence of unfair pressure being put on young people;
- in YOIs children were not always provided with independent support; and
- there were delays and poor communication with children in some cases.

In 2014, the Association of Independent LSCB (Local Safeguarding Children Board) Chairs noted that in the previous year YOI and STC inspections found several cases where child protection referrals had not been made by the establishments when they should have been.
147. HM Inspectorate of Prisons (HMIP) has also been critical of the way certain institutions have responded to child protection issues, including in 2015 at HMYOI Cookham Wood and in 2016 at Medway STC.461

148. More recently, in 2016, the European Committee for the Prevention of Torture visited HMYOI Cookham Wood. Its report, published in April 2017, indicated that in several cases where children had alleged violence or abusive behaviour by staff, there had been no referral to the police or local authority. It recommended staff members allegedly involved in ill-treatment should be allocated duties that do not bring them into contact with the alleged victim until the results of the disciplinary proceedings are clear.462

149. The Youth Justice Board Review of child protection in Secure Training Centres (2016) raised a series of concerns about child protection. It found between 2014 and 2016 only 6 percent of child protection referrals from STCs were substantiated. The Youth Justice Board recommended there should be a new national policy on how to manage allegations against adults who work in the secure estate. It considered a dedicated, qualified and independent social worker should be more involved in responding to safeguarding issues.463

**Responding to a disclosure of child sexual abuse in custody**

*Best practice*

150. Alan Wood, who was instructed by the Inquiry to act as an independent expert witness, provided us with an overview of the recognised best practice in responding to a disclosure of child sexual abuse. The immediate response by staff to a disclosure of sexual abuse should include:

- listen carefully to the child;
- let them know they have done the right thing;
- tell them it is not their fault;
- explain that the allegation will be taken seriously;
- explain to the child what will be done next;
- do not talk to the alleged abuser; and
- do not delay reporting the abuse.

He also said the response can have an impact on whether children have confidence in the procedure and whether they subsequently withdraw their allegation.464 Carolyne Willow, a children’s rights campaigner and founder of Article 39, also reflected on this, saying that children ‘test’ how staff respond to general complaints they make. If children see a poor response, they are unlikely to be confident to disclose abuse.465

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461 HIP000017, paragraph 8
462 Report to the Government of the United Kingdom on the visit to the United Kingdom carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment from 30 March to 12 April 2016, 19 April 2017, pp53–55 (INQ001182_053-055)
463 Review of Child Protection in Secure Training Centres, 2016, paragraphs 37, 40, 43, 49–51, 86–88 and 95–98 (YJB000141)
464 Wood 12 July 2018 19; 54; 58–59; INQ001652_028, paragraph 6.32(a)(3); INQ001764_012, paragraph 4
465 INQ001073_013, paragraph 46
151. As to the immediate response, Phillip Noyes, NSPCC, and Pam Hibbert, a social worker and former Chair of the National Association for Youth Justice, explained disclosures are often veiled and subtle, and so may not be recognised or understood. At times, children do not willingly report abuse but would do if a trusted adult asked them if something was wrong and explored their answers. Adults should create opportunities for disclosure. The professional should be vigilant about whether something is wrong, be able to recognise the signs of abuse and of a veiled disclosure, and ask sensitive questions to explore what is wrong.

152. As to the further stages of the response, Alan Wood said the person investigating the allegation should be totally independent of the agency or geographical area where the alleged perpetrator is employed. Independence is important to ensure children have confidence in the process. Confidentiality is also central. His opinion was that the default position should be that an allegation against a member of staff is subject to a section 47 inquiry by the local authority. The investigation should be fair and transparent to the child. He noted that Working Together to Safeguard Children is clear that the process should be child-centred: children want vigilance, understanding, respect, information, engagement, support and protection. He told us support for the child within the process is essential. At the end of an investigation, children should be supported regardless of the outcome, even if the disclosure is retracted.

153. Alan Wood stated, in his experience, it was “quite rare” for a child to lie completely about an allegation of sexual abuse. There are a range of possible pressures which may lead to a child retracting an allegation, and a retraction should not be taken at face value. He said there is a likelihood of retraction or refusal to comment further if the child’s experience of disclosure is a negative one. He noted that in the case studies the child often had to explain the same allegation over and over to different people, and this could undermine their willingness to pursue the allegation.

154. Similarly, the Australian Royal Commission concluded an allegation may be retracted for a variety of reasons, and adults should not assume that a retraction means the abuse did not occur or is not occurring. It said research consistently shows that false allegations of child sexual abuse are rare.

155. Chief Constable Simon Bailey, the National Police Chiefs’ Council’s lead on child protection, explained that detailed guidance is given to police about how to investigate an allegation of abuse against a child. Subject to the best interests of the child, following an allegation of a sexual offence against a child, it would normally be expected that the child would be interviewed using an ‘Achieving Best Evidence’ interview. Statements would be taken from all eyewitnesses, and video or photographic evidence would be preserved and viewed. A medical examination would often be expected if there are any marks or injuries.

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466 Working Together to Safeguard Children, 2018 (DFE000876) indicates establishments should have in place arrangements which instil “a culture of listening to children and taking account of their wishes and feelings, both in individual decisions and the development of service”.

467 Noyes 12 July 2018 81; 86–87 and 90; NSP000025_006, paragraph 15, referring to No one noticed, no one heard, NSPCC (INQ001489_006); Hibbert 11 July 2018 117–118

468 DFE000876

469 Wood 12 July 2018 57; 60–67; 75; Wood 17 July 2018 18–19; INQ001652_029-30; INQ001652_033

470 Wood 17 July 2018 38

471 Wood 12 July 2018 26–28, 59 and 75; Wood 16 July 2018 63; INQ001652_028, paragraph 6.32(a)(2)

472 Australian Royal Commission into Institutional Responses to Child Sexual Abuse: Final Report, Volume 4 Identifying and disclosing child sexual abuse, pp53–54 and footnote 28
To investigate a crime in a custodial institution, police must have the permission of the governor or manager; it may be therefore that staff within the custodial institution would take initial investigative steps.473

Current procedures

156. There are several areas of concern about the current procedures for responding to an allegation of child sexual abuse in custody.

157. Chief Constable Simon Bailey referred to The appropriate handling of crimes in prison,474 a protocol between the National Offender Management Service, the Association of Chief Police Officers and the Crown Prosecution Service. This states that any sexual offence should be reported "to the police for investigation". He expected the police to investigate all sexual offences committed against a child in custody, at least by an adult in a position of trust. There appears to be a conflict between that protocol and national Her Majesty’s Prison and Probation Service (HMPPS) policy, which states that allegations of ‘serious’ sexual assault are referred to the police.475 He could not draw any reliable conclusions from the high number of alleged incidents of child sexual abuse within custodial institutions between 1 January 2009 and 31 December 2017 compared to the low number of convictions, as revealed in the Inquiry’s prevalence analysis. He thought that it was a “really worrying statistic”.476

158. Although local policies or procedures may be in place, the main written guidance or policy on responding to an allegation of sexual abuse against a child in a YOI is contained in Prison Service Instruction (PSI) 08/2012, Care and Management of Young People. (This also appears to apply in STCs.) It indicates that, when investigation by the police or social services does not occur, the procedures set out in Prison Service Order (PSO) 1300, Investigations, must be followed. However, PSO 1300 does not contain any specific guidance about how an allegation of sexual abuse of a child in custody should be responded to. In addition, PSI 08/2012 expired on 31 March 2016 and does not appear to have been updated.

159. The documents provided indicate that in YOIs and STCs an allegation of sexual abuse against a child will often be referred to a member of staff working within the same establishment, even if it is against another member of staff. There is no provision to prevent this from happening, nor any requirement that the alleged should be kept confidential so far as possible from the alleged abuser or their associates. Generally each allegation will be referred to the child protection coordinator, safeguarding manager and/or deputy governor, who may discuss the matter with any member of staff he or she considers appropriate. In those cases which are not subject to a section 47 inquiry or full investigation by the police, the establishment conducts the response and investigation, with assistance from the local authority designated officer (LADO), even if the allegation is against a current member of staff. There is no requirement for allegations against staff to be investigated and responded to by someone independent of the establishment.477

473 Bailey 11 July 2018 77; 82–83; 84–91; OHY004799_002, paragraphs 3.5–4.1
474 OHY004800
475 Bailey 11 July 2018 84–87; Savage and Robinson 13 July 2018 160–161; YJB000068_048, Annex C, paragraph 4
476 Bailey 11 July 2018 93–94
477 Robinson 13 July 2018 156–159; PSI 08/2012, Annexes B and C (YJB000068); see Review of Child Protection in Secure Training Centres, Youth Justice Board, paragraphs 95–98 (YJB000141_014-015)
160. It also appears that, in contrast to the detailed guidance available for police, there is no guidance for staff working in YOIs or STCs who are conducting an investigation into an allegation of child abuse on how the complainant should be interviewed or what evidence to seek. National policy for YOIs and STCs is also not clear about what support should be offered to a child who has alleged abuse when the case is not referred to the local authority.\(^{478}\)

161. The LADO’s role is somewhat unclear. In the community, the LADO should coordinate the safeguarding and investigative processes for allegations against adults.\(^{479}\) However, PSI 08/2012 states that when an allegation is made against a member of staff, Appendix 5 of the Working Together to Safeguard Children guidance 2010 must be followed, and when allegations meet the criteria in paragraph 1, the LADO must be contacted.\(^{480}\) The role of the LADO described by PSI 08/2012 appears to be one of monitoring and discussing the progress of an investigation carried out by the establishment.\(^{481}\) However, in any event, this guidance is out of date: Appendix 5 and paragraph 1 no longer exist and the Working Together to Safeguard Children guidance\(^{482}\) has been superseded three times.

162. Procedures in SCHs for responding to allegations of abuse were generally better. For example, the Aycliffe Child Protection Policy contains guidance on how any member of staff should respond to a child who discloses abuse.\(^{483}\)

Current practice

163. We heard substantial evidence that the current procedures for responding to allegations of child sexual abuse in YOIs and STCs do not work effectively.

164. Dr Janes, Legal Director of the Howard League for Penal Reform, told us that an increasing part of the work of the Howard League legal team is making child protection referrals and that they receive a varied response from local authorities and prisons. This included a referral being refused on technical grounds by a LADO, who would have a role to perform if there were an allegation of sexual abuse. Young people have also said they “don’t see the point” in a referral being made to the LADO, which has been a concern. Dr Janes has experienced social services suggesting issues referred to them were for the establishment to deal with. She suggested that it would assist if LADOs dealing with children in custody were given specialist information, training and guidance about the particular vulnerabilities of children in custody. She said overall when she had seen child protection referrals made, she rarely saw “responses dealt with rigorously or urgently”.\(^{484}\)

165. Carolyne Willow understood that HMIP would refer concerns of sexual abuse of a child in custody to the prison rather than to the local authority. Research she conducted using freedom of information indicated that a low proportion (24 percent) of child protection referrals from an establishment to the local authority result in a section 47 inquiry. She pointed out there is no requirement for LADOs to be registered social workers or to have professional child protection training or experience. That is one of the reasons why she

\(^{478}\) YJB000068_050, paragraphs 14 and 22
\(^{479}\) Wood 12 July 2018 65–67; INQ001752_003, paragraph 1.9(a)
\(^{480}\) YJB000068_048, paragraph 6; YJB000068_051, paragraphs 24–28
\(^{481}\) YJB000068_052, paragraphs 28–29
\(^{482}\) DFE0000876
\(^{483}\) Whellans 18 July 2018 167; DUC000423, pp2–3
\(^{484}\) Janes 11 July 2018 1; 43–47; INQ001766, paragraph 3.8
considered all institutional abuse allegations should be referred directly to children's social services in the local authority; there is insufficient involvement of social services with children in custody. She explained that Article 39 is pressing for the introduction of statutory guidance on the response to a disclosure of sexual abuse against a child in custody. All abuse allegations should be investigated by child protection professionals independent of the establishment, and the child should receive support from an independent advocate.\textsuperscript{485}

166. Angus Mulready-Jones, the lead inspector for children in detention for HM Inspectorate of Prisons, told us there are concerns about the response to child protection referrals in some institutions. It is not unusual to see delays in the process.\textsuperscript{486}

167. Mark Johnson, the founder of User Voice, said that when a child disclosed abuse there was often no therapeutic intervention when there should have been. Other factors affecting the response included the skill level of staff in the environment and their relationship with the child. A child who had seen a number of different Youth Offending Team workers over a short space of time would not be likely to perceive that any one of them was particularly interested in him or her.\textsuperscript{487}

168. Matthew Brazier noted that ordinarily if a child makes an allegation of sexual abuse in a survey it will be passed back to the establishment, not to an independent person.\textsuperscript{488}

169. The Inquiry’s case studies analysis supports these concerns regarding the response to allegations.

170. Sara Robinson, Interim Executive Director of the Youth Custody Service, said the principles of good practice for responding to child sexual abuse that are applied in the community (as described by Alan Wood) should also apply in custody. The Review of Safeguarding in the Secure Estate (June 2018), led by Sonia Brooks OBE, will look into some of the issues raised by Alan Wood, such as the extent to which allegations are referred to social services. She said there are clear procedures in place but it is the application of those procedures which needs to be looked at. It is the process of auditing and assurance which needs improving. She accepted there is still work to be done about how evidence is gathered and how children are interviewed when police do not investigate.\textsuperscript{489}

The Inquiry’s case studies analysis

Introduction

171. The Inquiry instructed Alan Wood to conduct a detailed review of recent allegations of sexual abuse made by children at six custodial institutions: HM Young Offender Institutions at Feltham and Werrington; Medway and Rainsbrook STCs; and Vinney Green and Aycliffe SCHs. In total, Alan Wood reviewed 72 cases, and examples of cases from each of the six establishments appear in the pen portraits at the start of this report.

\textsuperscript{485}Willow 12 July 2018 104–106; 117–119; 121–122; INQ001073_014, paragraph 47
\textsuperscript{486}Mulready-Jones 16 July 2018 36–37; INQ001479
\textsuperscript{487}Johnson 17 July 2018 187–188
\textsuperscript{488}Brazier 18 July 2018 26–28
\textsuperscript{489}Robinson 13 July 2018 153; 159-162
172. The case studies were selected in order to illustrate a range of themes or issues, including sexual abuse by institutional staff or other children, allegations involving restraint or searching, the role of CCTV, the involvement of the local authority, and investigations by the police.

173. The Inquiry asked relevant bodies to disclose all documentary records relating to the 72 cases, their investigation and the outcome of the investigation. Alan Wood then reviewed the material to identify key or recurring themes in the institutional responses. All of the underlying documentary evidence from the case studies was made available to the Inquiry and in part formed the basis of its conclusions.

174. The following key themes arose and apply to both YOIs and STCs:

- In some cases staff appeared to pre-judge the allegation, indicating suspicion that the child was making it up. In some cases, Mr Wood was surprised that a child’s statement that he did not want to pursue the allegation was taken at face value.

- In case studies from several establishments, children or others appeared to be concerned about the confidentiality of their allegations. Mr Wood observed that allegations could become “overexposed” whereby a number of members of staff within the establishment would become aware of it, including at times the alleged abuser or their close associates. There was little evidence of how the risk of doing so would be managed.

- In many allegations against staff, other members of staff from within the establishment were involved in the investigation, for example by interviewing the child or witnesses and gathering evidence. In a significant proportion of those cases, there appear to have been flaws in the investigation of the allegation. Obvious investigative opportunities were missed, or the decision not to pursue the allegation or find it substantiated was made on an inadequate basis. A number of allegations were retracted or denied after the child was spoken to by a member of staff at the establishment.

- A focus on the support needs of the children in the investigation was “universally absent”.

- Very few cases were subject to an investigation by the police. Only one allegation out of 53 in YOIs and STCs led to a section 47 inquiry. In YOIs, the LADO often had little significant input.490

175. As Mr Wood said, the highest levels of safeguarding should be expected of members of staff working in YOIs and STCs because the children detained there are so vulnerable. These high levels of safeguarding were not routinely evident in the case studies material. We agree with his overall conclusion that the key elements of the Working Together to Safeguard Children guidance on investigations were absent in the records from the case studies.491

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490 Wood 16 July 2018 82–85; Wood 17 July 2018 41–42; INQ001764_009-012, paragraphs 1.45–1.57; Wood 17 July 2018 10: 36–37; INQ001210, paragraphs 2.1.8, 7.1.5 and 8.1.2; INQ001764_002, paragraphs 1.1–1.2; Wood 16 July 2018 63–69: 138
491 Wood 12 July 2018 75; Wood 16 July 2018 56; 142; INQ001764_009, paragraph 1.44; Wood 16 July 2018 56
The responses by SCHs appear to be generally of a higher standard. Investigations were more extensive, outside agencies were better involved, the process was more child-centred, the child’s credibility was not doubted, and more support was offered. He noted the higher staff to child ratio gave a greater opportunity for children to build trusting relationships and that it is easier to spot safeguarding issues when they arise.492

Case studies from YOIs

HMYOI Feltham

We examined 14 allegations of sexual abuse at HMYOI Feltham, including a number against staff. These covered the period 2009 to 2015.

Alan Wood considered there was a wide variation in the standard of the initial response. The records reflected a lack of understanding of the complications caused by the child being in custody and of their fear of reporting. It was difficult to keep track of issues across various different methods of recording. Having a system which tracked how many allegations were made, against whom and with what results was a “fundamental keystone”.493

Alan Wood had particular concerns about the investigation by staff of allegations against other staff from the establishment. Some decisions not to pursue allegations were made on apparently flawed grounds. Alan Wood had concerns about the substantive involvement of the LADO, for example when an allegation of sexual assault by a member of staff was not referred to the LADO, or the LADO did not attend a key strategy meeting. He also had concerns that the threshold being applied in respect of section 47 investigations was too high. He noted that there were no substantive police investigations in respect of the allegations he considered. Finally, none of the allegations were substantiated.494

Glenn Knight, Governor of HMYOI Feltham until May 2018, gave evidence in response to concerns raised by Alan Wood. He pointed to improved versions of Feltham’s child protection policy and procedure, which were reviewed annually and would be reviewed again in light of the 2018 Working Together to Safeguard Children guidance. This included Feltham’s safeguarding strategy dated September 2017, which post-dated the allegations of sexual abuse reviewed by Alan Wood. He also referred to a new local protocol agreed between Feltham and the London Borough of Hounslow, which applied when a member staff was the subject of an allegation of sexual abuse. He also identified a risk assessment matrix designed in 2018, which was used to document the decision-making process and could also be used to track how many safeguarding referrals had been made against a particular staff member. Finally, he referred to a draft service level agreement, the purpose of which was “to standardise the interagency response to sexual offences within prison establishments in London”. He would like to see more social workers, ideally five or six, and more staff at Feltham.495

Lara Wood, Head of Safeguarding and Quality Assurance at the London Borough of Hounslow (the relevant local authority for Feltham), gave evidence to respond to the issues Alan Wood raised. She explained that when a young person discloses abuse, the social work
team should refer the young person to the appropriate services such as Hounslow Youth Counselling, Barnardo's wellbeing team and psychological interventions. She also referred to the new local protocol agreed between Feltham and the London Borough of Hounslow. The number of referrals to the LADO from Feltham increased from 6 in 2015/16 to 25 in 2016/17, which Alan Wood thought showed improvements in recognising, reporting and recording abuse allegations.496

**HMYOI Werrington**

182. We examined 10 allegations at HMYOI Werrington, covering the period from 2011 to 2016.

183. With the exception of one allegation, Alan Wood felt that Werrington responded to allegations in a timely and structurally appropriate way. However, he observed that some allegations were regarded with suspicion from the outset and that a complainant’s past use of the complaints procedure sometimes framed the approach to the current allegation. One complaint was regarded as potentially not being genuine prior to any investigation of what the allegation actually was. Further examples included a suggestion there were doubts over the credibility of multiple allegations as the boys submitted them on the same day, and that an allegation of rape by a rival gang was a malicious referral.497

184. In a few cases, there was a lack of full investigation, such as CCTV not being checked, eyewitnesses not being questioned, or other investigative opportunities being missed. In some cases the reasons given by staff for a decision not to pursue an investigation were flawed. Alan Wood found examples of allegations against staff, including of sexual assaults, either not being reported to social services or being reported to social services but not being deemed to have reached the threshold for investigation. The police were only involved in a very small minority of investigations. Allegations were investigated largely by staff from the establishment.498

185. Peter Gormley, the Governor at Werrington until April 2018, responded to Alan Wood. He observed that Alan Wood’s comments were based on a small sample size and that seven years is a long time in the life of an establishment. He felt the latest HMIP report was a more helpful indicator of Werrington’s performance, although he welcomed Alan Wood’s view that Werrington generally responded in a timely and structurally appropriate way.499

186. In response to Alan Wood’s observations about the support offered to children after they have made a disclosure, Peter Gormley suggested there was other evidence of support outside the papers reviewed by Alan Wood. He told us that any child who makes an allegation will be seen by one of the social workers, who will stay with that child in terms of support until the investigation is concluded. Peter Gormley also said that every child who makes a serious allegation will be seen by the duty governor or the orderly officer for an initial assessment of needs to be undertaken. This assessment will consider whether there is any vulnerability arising from the making of the allegation and the requirement for any immediate steps such as enhanced observations.500
187. Peter Gormley told us the local authority independently scrutinises incidents at Werrington as part of the multidisciplinary approach. Members of the local authority also chair a quarterly board meeting in relation to the use of force. In reply to Alan Wood’s observation about allegations being approached with suspicion, Peter Gormley stated this was one example and, irrespective of the initial response, the same process is followed for all allegations, including the independent rigour of a multidisciplinary meeting. He was conscious of the need to ensure staff were aware of the importance of approaching allegations with an open mind and recording them in a neutral and objective way. However, Peter Gormley accepted there may have been variability of practice. 501

188. We also considered evidence from Yvonne Gordon, the Strategic Lead for Specialist Safeguarding Delivery at Staffordshire County Council, the relevant local authority. This provides an overview of the local authority involvement at Werrington, including the training of Werrington staff on child protection matters from the Staffordshire Safeguarding Children Board. 502

Case studies from STCs

Medway STC

189. In respect of Medway, we examined 11 allegations, which spanned a relatively narrow period503 from May 2015 to December 2016. 504

190. Alan Wood had an overarching concern about themes of grooming, abusive and inappropriate behaviour by staff, and that other staff who were aware of this did not report it until one relatively young member of staff acted as a whistleblower. He expressed surprise at the wide range of allegations and the responses to them. For example, he was concerned staff alleged to be involved in these incidents were allowed to have continued contact with the children. 505

191. Alan Wood found there was an unhealthy culture of control and a perception of controlling children from a “security guard type point of view”. He raised concerns about the lack of confidentiality of a child’s complaint within the staff group. He identified a repeated theme of there being a lack of documented support to children who had made disclosures. However, he noted that, compared to other institutions, Medway had a higher level of LADO involvement. 506

192. Sharron Rollinson performed the role of LADO at Medway STC until April 2017. She said that the policies at Medway were woefully inadequate and the approach to safeguarding inexperienced. Staff and managers appeared to prioritise protection of staff over the protection of young people. The room she used for meeting with children was not private, and staff were able to hear any disclosures the children might be making. New staff often lacked experience of working with children who were highly vulnerable, and training was not robust enough. Children had told her about being given oral sex by staff in the kitchen area.

501 Gormley 16 July 2018 159–161
502 Gordon 16 July 2018 170; SFC000023
503 This covered the period of time during which responsibility for running Medway passed from G4S back to HMPPS, the Medway Improvement Board having reported in early 2016.
504 Wood 17 July 2018 2
505 Wood 17 July 2018 5–8, 21–25
506 Wood 17 July 2018 9–13; 20
She referred to an allegation that a member of staff had given a child a love bite. She recalled that this was discussed internally, and when she visited the complainant he seemed fearful and withdrawn. Sharron Rollinson told us that the uncut footage from *Panorama* showed a staff member describing to other staff in the smoking area how children could be moved out of view of camera to be assaulted. The reaction of a manager (Jonathan French) to this was that staff were letting off steam.\(^{507}\)

193. Jerry Petherick of G4S addressed Alan Wood’s evidence regarding Medway, commenting that the report read as if the allegations were substantiated but in fact some of them were not. He said that there might have been other documents which might have shown that support was given to children. However, he did agree with a number of the comments made by Alan Wood, for example that a medical examination referred to in one particular case should have taken place but did not.\(^{508}\)

194. We also heard from Jonathan French, Governor of Medway since January 2017. He noted the majority of the alleged incidents referred to by Alan Wood occurred before Medway was transferred back to HMPPS. He described several changes made since that time, as discussed above. Broadly Jonathan French did not take issue with Alan Wood’s observations as to the adequacy of the response on the basis of the documents he had. He indicated that there might be additional material available that showed support having been given to a child that had not been provided to the Inquiry.\(^{509}\)

195. Jonathan French denied having told Sharron Rollinson that staff were just “letting off steam”. He said he took the footage very seriously, noting “The officer did allude, although not explicitly, to blind spots in the CCTV coverage”. The officer was suspended and a formal disciplinary investigation was conducted into the matter. Jonathan French noted he did not have access to the full unedited footage of the conversation between the officer and journalist. After the hearing, Jonathan French produced a new statement dated 19 July 2018. He said that on the footage, the officer did not mention assaulting young people. Jonathan French believed that Sharron Rollinson may have confused the footage of the smoking area with footage of staff during induction training (which Jonathan French did not receive until April 2017). He said “The comments of the then training manager on the footage were particularly inappropriate … I immediately suspended him and a disciplinary investigation was commenced”.\(^{510}\)

Rainsbrook STC

196. We considered 18 allegations in relation to Rainsbrook, spanning from 2010 through to 2016.\(^{511}\) They related to the period when G4S was running Rainsbrook.

197. There were cases in which the staff’s initial response to a disclosure appeared inappropriate, such as when staff were said to have laughed at a boy who disclosed that another detainee had "put his willy in my bum”. Alan Wood told us there was an apparent disparity between the support given to the alleged victims and the support given to the alleged perpetrator staff members. He did not think that children were

\(^{507}\) Rollinson 18 July 2018 44–52, 57, 62
\(^{508}\) Petherick 17 July 2018 77
\(^{509}\) French 17 July 2018 127–128
\(^{510}\) HMP000431
\(^{511}\) Wood 17 July 2018 30
appropriately informed about the investigation and its outcome. Overall he did not feel that the expectations within the Working Together guidelines had been met in the cases he examined.  

198. Jerry Petherick also gave evidence on the Rainsbrook case studies. He expressed surprise at the use of the word “malicious”, and thought some of the tone of letters to the children was inappropriate. Whilst he thought there might have been more material available showing the support given to the child, he broadly agreed with Alan Wood’s observations.

199. We also heard from Stuart Jessup, current Director of Rainsbrook Secure Training Centre. He could not respond to the specific allegations within Alan Wood’s evidence because MTC Novo took over Rainsbrook STC after the last of those allegations. However, he explained a number of changes which have been made at Rainsbrook STC since MTC Novo took over, which are set out in Part E2 where we consider privately run institutions more generally.

200. We received evidence on behalf of Northamptonshire County Council from Lesley Hagger and Alex Hopkins, who have both held the role of Director for Children, Families and Education. Lesley Hagger accepted the response in some of the case studies fell below the standards she expects for safeguarding. However, she offered reassurance that the local authority is aware of the issues and working hard to ensure improvements are sustained through service redesign and development. For example, they are making changes to their multi-agency safeguarding hub arrangements. She also informed us that the review undertaken by Northamptonshire Children’s Safeguarding Board Assurance Group found there was a significant staff shortage during the transition from G4S to MTC Novo, but that MTC Novo reported that Rainsbrook had been fully staffed since November 2016.

Case studies from SChs

Vinney Green SCh

201. We examined six allegations from Vinney Green, dating from 2010 to 2015.

202. Alan Wood felt the information given to children in response to an allegation being received was not appropriate and the outcome notifications were unduly formalistic. Overall, Alan Wood felt there was evidence of a child-focused approach from the minutes of the strategy meetings but that the associated actions connected to those meetings did not always match. He observed good evidence that staff were aware of children’s previous experiences and their likely reaction to being restrained, but there was a gap when it came to translating this knowledge into practice. He noted the paperwork was not always clear in relation to the outcome of the investigation.

203. Alison Sykes, Head of Secure and Emergency Services for South Gloucestershire Council and the registered manager for Vinney Green SCh, explained in more detail the process that would be followed after a disclosure of sexual abuse. For example, a nurse would be contacted as would the mental health team; steps would be taken to see if the

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512 Wood 17 July 2018 43
513 Petherick 17 July 2018 87-90
514 Jessup 17 July 2018 159-179
515 NTC000026; NTC000029
516 Wood 18 July 2018 93-94; 98
member of staff should have contact with the young person; Alison Sykes would attend and view the CCTV; and relevant professionals would be involved. A child would also be able to request a transfer to another unit if they felt it appropriate to do so. Alison Sykes responds to every allegation made by a child. She said great care in Vinney Green is taken to what support will be given to the young person. The problem was a lack of recording of this, rather than a lack of it happening; she agreed the lack of recording of outcomes was surprising and concerning and assured the Inquiry that this does not happen now. She noted that the three recent reports by Ofsted about Vinney Green all rated the home as ‘good’.  

Aycliffe SCH

204. Finally, we looked into 13 allegations at Aycliffe, which were said to have occurred between 2009 and 2016.  

205. Alan Wood said the themes at Aycliffe were similar to those at Vinney Green. He commented that some of the language recorded was inappropriate. He gave an example of a record stating that a young person had made “flirtatious comments” towards a member of staff. Whilst there was good evidence of recording the allegations, this was not matched by evidence of planning post-disclosure.  

206. We heard evidence from Margaret Whellans from Durham County Council, who spoke to written evidence provided by her colleague Carol Payne. Margaret Whellans noted the June 2017 Ofsted report judged Aycliffe to be good, and said a range of positive things about the centre. For example, staff built close and trusting relationships with young people. There were some concerns, such as about restraint and recording of searches. The January 2018 inspection again rated the centre as good. Margaret Whellans observed that some of the material evidencing support for the children might be in case files, and may not have been seen by Alan Wood. She explained that, in respect of Alan Wood’s concern about “flirtatious comments”, she has had direct discussions with management about ensuring that a child’s comments are appropriately recorded and described, so there will be a better description of behaviours going forward. Work has been done to improve the layout of the investigation pro forma.  

E.13: Recording and auditing

Recording by individual establishments, local authorities and the Youth Custody Service

207. Her Majesty’s Prison and Probation Service (HMPPS) explained that allegations are logged by safeguarding leads in particular establishments, who complete “referral documentation and ... logs” to track actions and progress. We were told these can be viewed

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517 Sykes 18 July 2018 122–125; 133–134; 137–140  
518 Wood 18 July 2018 149  
519 Wood 18 July 2018 149–152  
520 DUC000269  
521 OFS007930  
522 OFS007931  
523 Whellans 18 July 2018 155–156; 171–174
by Youth Custody Service staff and inspectorates at visits. Mention was also made of Security Information/Intelligence Reports, and of child protection files being opened on individual cases.524

208. However, it is unclear whether these systems are effective in practice. Many institutions found it difficult to access some of the prevalence data the Inquiry sought, or to provide it to us with ease or in an accurate and accessible way.

209. Carolyne Willow, a children’s rights campaigner and founder of Article 39, had also found it difficult to obtain data from local authorities and from the National Offender Management Service (as it then was) about the numbers of sexual abuse allegations in custody.525

210. Angus Mulready-Jones, HMIP, considered that if there was to be a duty to collect data on sexual abuse in custodial establishments, this should be a duty on central government, because it is the government which has an obligation to detain children safely. These data would also ensure that government had an accurate and complete understanding of child sexual abuse occurring in custody.526

211. Peter Savage, Head of Operational Contract Management, Youth Custody Service, accepted that improvements are needed to the way in which the Youth Custody Service keeps records of disclosures of abuse, and how they are investigated. This will be considered in the current safeguarding review.527

Recording by national surveys

212. As we explained in the summary of the Inquiry’s prevalence analysis in Part C, several issues concerning how the HMIP survey records allegations of abuse have been identified.

213. Dr Janes, Legal Director of the Howard League for Penal Reform, considered the way the HMIP survey is carried out and the challenges of collecting information of this nature may affect how accurately it represents the scale of child sexual abuse in custody. In her view:

“there is a big gap in the evidence base as to the prevalence of sexual abuse among children in custody ... any enhanced monitoring and scrutiny of the nature, prevalence and response to sexual abuse in custody is likely to be helpful in preventing it from occurring in future and to assist the authorities to deal with it effectively.”528

Recording by the police

214. Chief Constable Simon Bailey, the National Police Chiefs’ Council’s lead on child protection, said that although there had been improvements, the accurate recording of crime presented challenges for the police. He considered there would be merit in requiring police forces to record that an allegation of sexual abuse had taken place in custody.529

524 NOM000008, paragraph 66; NOM000011, paragraphs 20–22; HMP000398, paragraph 35
525 Willow 12 July 2018 104–109
526 Mulready-Jones 16 July 2018 44–45; HIP000023_001
527 Savage 13 July 2018 47
528 HWL000004_002, paragraphs 2.2–2.3
529 Bailey 11 July 2018 94–96
Auditing and sharing information

215. In 2014, the Association of Independent LSCB Chairs concluded that there was limited scrutiny of the outcomes of abuse and neglect allegations in custody.530

216. Alan Wood, the Inquiry’s independent expert witness, stressed the importance of auditing. To make progress towards reducing child sexual abuse and allowing it to be detected and investigated, it is essential that there is a collection of consistent, accurate, trackable, quantitative and qualitative data available in relation to allegations.531

217. Sara Robinson explained that HMPPS has introduced an annual thematic review across the sector. Each provider will submit a thematic review of their locally managed complaints, safeguarding and whistleblowing matters to the Youth Custody Service. Central teams, including an audit team which sits outside the Youth Custody Service, will review this information so that lessons can be learned. It is also considering whether information about allegations of sexual abuse can be collected at a central level, to enable HMPPS to address difficulties.532 It could also be enhanced, at an institutional level, by adopting something like the quarterly meetings and monthly safeguarding meetings put in place by Medway STC, to look at trends and developing issues.533

218. Katherine Willison, Director of Children’s Social Care, Practice and Workforce within the Department for Education (DfE), described two processes for information sharing:

- The Children and Social Work Act 2017 introduced a new arrangement whereby local authorities are under a duty to notify the National Safeguarding Panel within five working days of a serious incident. The local authority will then decide whether to carry out a serious case review and the national panel will decide whether any type of learning review is required.534 This means the national panel will have oversight of all incidents of serious harm across a range of institutions and therefore has the ability to identify any trends.

- The second process specifically related to SCHs and requires registered managers of SCHs to notify Ofsted if there has been a serious event in the home. Ofsted will collate this information and use it to form lines of enquiry in relation to the regulation and inspection of those homes.535

E.14: Inspection and child protection standards

Inspection

219. Professor Hardwick stressed that independent inspection is an important safeguard with a crucial role to play in protecting children, including from sexual abuse.536

220. The regimes for inspection differ across the child custody estate:

530 REA, p17
531 Wood 18 July 2018 181
532 Robinson 13 July 2018 164–166; 172; HMP0000397_015, paragraph 64
533 French 17 July 2018 148
534 Willison 12 July 2018 157
535 Willison 12 July 2018 156–159
536 Hardwick 11 July 2018 136–137
In YOIs, inspections are led by HMIP and carried out alongside Ofsted or Estyn (Wales) and the Care Quality Commission or Healthcare Inspectorate Wales. HMIP inspects all YOIs against the criteria in a document called _Expectations – Criteria for assessing the treatment of children and conditions in prisons_ (2012). This is being reviewed, but it currently includes that staff receive sufficient training on child safety. In YOIs, Ofsted/Estyn inspect only education and skills/purposeful activity.

Inspections of STCs are led by Ofsted or Estyn (Wales) and carried out alongside HMIP and the Care Quality Commission or Healthcare Inspectorate Wales.

Ofsted regulates and inspects children’s social care services, including SCHs. The regulatory and inspection framework covering SCHs is effectively the same as the framework covering non-secure children’s homes. The framework is geared towards creating a therapeutic and supportive environment for the children. In Katherine Willison’s view, it is important that SCHs sit within the general framework for children’s homes.

221. The Inquiry’s REA identified an uncoordinated approach between the various bodies responsible for monitoring child custody establishments, which was unhelpful and increased the risk of safeguarding issues being unidentified. It also cited evidence that many issues raised by the joint inspectorates have not been addressed.

222. Angus Mulready-Jones also expressed the view that the differing inspection regimes hide comparisons between the three sectors. We note that HMIP is reviewing the surveys in YOIs and STCs, with the aim of producing a combined, single survey for both settings, to achieve greater consistency in approach.

223. At a more general level, Dr Janes observed that it is difficult to conclude the inspection regime is effective when HM Inspector of Prisons said no child prison he visited was safe.

224. As to whether the inspection regimes have ‘teeth’, Mr Mulready-Jones referred to the 2017–18 HMIP annual report, which noted that of all the previous recommendations made in the area of safety, in YOIs only 34 percent had been achieved, 15 percent had been partially achieved and 51 percent had not been achieved. (Similar figures appeared in the reports for the previous two years.) It is of course proven that if one takes the inspection and recommendations seriously then positive outcomes can be achieved if the resources are made available.

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538 HIP000023_001-2
539 REA, table 8.1
540 Willison 12 July 2018 171-172
541 REA, section 8.1
542 For example, it noted that for the first time in 2016/17 HMIP reported that the number of recommendations that had been fully achieved was lower than the number not achieved (REA, p94)
543 Mulready-Jones 16 July 2018 27-29; 37-40; 46-47; 50-51; HMIP press release dated 16 February 2018 (INQ001580); HIP000022_063; HIP000017_004, paragraph 25; INQ001200; INQ001442_061
544 Mulready-Jones 16 July 2018, 27–29
545 Janes 11 July 2018 62
546 Gormley 16 July 2018 151-152
Where Ofsted has serious concerns over the way an SCH is being run, it has robust powers at its disposal. This includes the power to suspend the registration of the home, provide detailed recommendations for improvement and set a fairly limited timetable for these to be implemented. If concerns remain, Ofsted may close the home and cancel its registration.  

Looking forward, Professor Hardwick expressed concern that the proposals for secure schools contain a section on inspections which does not include inspection of safety, as well as that the government is trying to set the inspection standards and criteria.

Child protection standards

The Australian Royal Commission recommended that detention institutions should implement their Child Safe Standards – clear, simple and accessible child protection standards – for staff, as an important protective factor. The safety standards should be publicly available and regularly promoted, including by leaders of the institutions concerned, for example during recruitment. The Commission noted that "risk is higher in institutional care settings where children's welfare and wellbeing are not at the heart of the institution".

We have considered the regulations, policy and contracts which set out the child protection standards in the three types of custodial institution in England and Wales. There is a stark difference between the framework for SCHs and those in YOIs and STCs.

The regulations and DfE Guide for SCHs are clear, comparatively simple, detailed and publicly available. The SCH regulations contain, at the forefront, a series of quality standards which must be met. Responsibility for achieving them is clearly placed on the registered person. The quality standards include a number of measures relevant to the protection of children from abuse. For example, regulation 12 contains the ‘protection of children standard’, which sets out a number of particular standards for staff relating to child safety and welfare. Those standards include that staff must assess whether each child is at risk of harm; have the skills to identify and act upon signs that a child is at risk of harm; and take effective action whenever there is a serious concern about child welfare. The need to secure child safety and welfare is central to the regulations and related national policy in SCHs.

By contrast, the regulations governing YOIs and STCs contain no quality standards relevant to the protection of children. The principal aim of YOI detention is rehabilitation.

There is no specific provision regarding child safety in the YOI Rules, yet there are 30 separate rules devoted to discipline. The STC Rules include a statement of purpose to accommodate trainees in safe conditions, but they contain no further specific provision for ensuring safety.

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547 Willison 12 July 2018 173
548 Hardwick 11 July 2018 166-169
549 Robinson 13 July 2018 95-96; Australian Royal Commission into Institutional Responses to Child Sexual Abuse: Final Report, Volume 15 Contemporary detention environments, sections 2.4.2 and Appendix A
550 Australian Royal Commission into Institutional Responses to Child Sexual Abuse: Final Report, Volume 15 Contemporary detention environments, sections 2.3 and 2.4
551 The Children’s Home (England) Regulations 2015 (INQ001426), regulations 4-14 and the Care Standards Act 2000, section 22
552 The Children’s Home (England) Regulations 2015 (INQ001426), regulations 6, 12, 13, 32–34 and Guide to the Children’s Homes Regulations including the quality standards, Department for Education, Introduction, Key Principles and Chapters 3 and 9 (INQ001439)
553 The Young Offender Institution Rules 2000, rule 3 (INQ001617)
231. As to policy, for YOIs, much is left to Prison Service Instructions (PSIs). These are not as simple, comprehensive or clear as the SCH equivalent. The central policy on child protection, PSI 08/2012,\textsuperscript{554} was due for review on 31 March 2016 but has not yet been updated. There is a list of general professional standards for staff working in YOIs, in PSI 06/2010.\textsuperscript{555} However, none of the professional standards specifically involve keeping children safe or securing child welfare.

232. The contracts with private custody providers are not routinely published, making it difficult to understand what child protection standards apply.

233. Sara Robinson said HMPPS is looking at developing a code of practice in relation to the management of behaviour generally across the whole estate. She agreed they ought to consider whether the clear quality standards relating to children that apply in the SCH context can be carried over into YOIs and STCs.\textsuperscript{556}

E.15: Leadership and governance

234. Prior to our hearings we were aware that the Youth Custody Improvement Board had concluded that roles and responsibilities within the youth secure estate need to be “crystal clear.”\textsuperscript{557} Sara Robinson explained that the Youth Custody Service was designed with this in mind:

- There is a single point of responsibility for the day-to-day running of the youth estate in the director of youth custody, with direct accountability through the line management chain for those sites.
- In the public sector there is a direct line of responsibility from governors, to a group director, to her. In private establishments the line of accountability is different; the establishment’s director (the equivalent of a governor) is accountable to the board of its private company; HMPPS manages the contract, and holds the board accountable.
- HMPPS can dismiss or move governors who are not performing effectively. In private companies it can impose fines and service credits, and in extreme cases (such as G4S’s Medway STC and HMP Birmingham) can take over the contract.

Overall this structure is intended to simplify performance within the estate, and establish new routes of scrutiny for the youth estate.\textsuperscript{558}

235. We were also aware that the Taylor Review\textsuperscript{559} had recommended that the focus of the child justice system should be on the child first and the offender second.\textsuperscript{560} Several witnesses picked up this theme. Professor Hardwick said the bedrock should be a child-centred culture with a focus on safety and protecting children from abuse, and that this is

\textsuperscript{554} Robinson 13 July 2018 95–96; Review of Child Protection in Secure Training Centres, Youth Justice Board, 2017, paragraphs 31–33 (YJB000143)
\textsuperscript{555} Findings and Recommendations of the Youth Custody Improvement Board, 24 February 2017, paragraphs 8, 14 and 20 (INQ0001618)
\textsuperscript{556} Robinson 13 July 2018 169–171
\textsuperscript{557} Robinson 13 July 2018 169–171
\textsuperscript{558} Robinson 13 July 2018 169–171
\textsuperscript{559} INQ001422
\textsuperscript{560} Hibbert 11 July 2018 120–121
one of the most important factors in reducing risk.\textsuperscript{561} Angus Mulready-Jones considered that the role of residential staff should be primarily one of care.\textsuperscript{562} Matthew Brazier said the key difference between SCHs and STCs is that the former tend to be much more child-focussed.\textsuperscript{563}

236. In terms of reform:

- Professor Hardwick and Pam Hibbert said that the Ministry of Justice should not be responsible for custodial institutions holding children, but another department such as the Department for Education should take over. The aim was said to be to focus the ethos of youth custody on care and welfare, rather than punishment and control.\textsuperscript{564}

- Dr Janes thought it was unlikely that there is sufficient leadership and governance to guard against the risk of child sexual abuse in many custodial institutions. In her view, the creation of a child custodial safeguarding authority would at least ensure a recognition within current structures of the need to have special regard to the risk of abuse in custody, and would assist in reducing that risk.\textsuperscript{565}

- Although he felt there are risks in creating one authority, Angus Mulready-Jones agreed the quality of leadership is not good enough to address the many and complex issues at stake.\textsuperscript{566}
Part F

Conclusions and recommendations
Conclusions and recommendations

Conclusions

1. Children detained in a custodial or secure setting are often the most vulnerable children in our society. Some are detained for their own welfare (unconnected to criminal activity) and others because they are on remand or have been found guilty of crimes and sentenced by a court. Serious criminal activity may, understandably, not always attract public sympathy but behaviours giving rise to these kinds of state intervention tend to reflect unhappy and disruptive childhoods, caused by others, and over which these children have had little control.

2. Children are particularly vulnerable when placed in a closed institution where access to the outside world is necessarily restricted and those in authority are distrusted by the children themselves. It is all the more difficult to escape an abuser when there is nowhere to hide.

3. The problem of child sexual abuse is by no means uncommon across the secure estate, which encompasses young offender institutions (YOIs), secure training centres (STCs) and secure children’s homes (SCHs). The Inquiry’s analysis reveals 1,070 alleged incidents of child sexual abuse from 1 January 2009 to 31 December 2017. There were more alleged incidents per year in 2016 and 2017 (203 and 205 incidents respectively) than in any other reporting year. The majority of allegations related to members of staff. It was troubling that the institutions had less reliable data than the Inquiry.

4. The barriers to reporting an incident of sexual abuse for a child are strikingly similar across all institutions on which the Inquiry has reported. The prevalence of violence, the power imbalance between staff and children, a prevailing culture of disbelief when a child complains and the child’s distrust of authority figures all feature significantly. These elements are exacerbated in custodial and secure settings by the absence of normal friendships and intimacy, and the risk factors arising in a confined environment connected to drug use, gang cultures and violence committed by children.

5. In order to report sexual abuse to someone who can take the appropriate action, a child must feel safe. There has been a shocking decline in safety in the secure estate in recent years. This has been caused by management instability and staffing losses. There is some evidence that these have been linked to budget cuts. Inspectorate reports by HM Inspectorate of Prisons have been critical of YOIs and STCs and improvements have been slow to materialise. There is little doubt that YOIs and STCs were in crisis by the end of the Inquiry’s investigation period.
6. The Youth Custody Service is taking action to professionalise the workforce in YOIs and STCs and there are clear signs of progress. There are no requirements, however, for minimum qualifications or levels of experience before staff are recruited. In contrast, SCH staff are normally required to have qualifications specified by the Children’s Home Regulations 2015. Similarly staff supervision is not subjected to minimum requirements in YOIs and STCs and again compares unfavourably with SChs.

7. Staff turnover for operational officers in YOIs and STCs was high, at 11.2 percent in 2017/18, compromising the ability of the workforce to meet the challenges of the environment and having a negative effect on the children’s feelings of safety and ability to form positive relationships with staff members. A culture of respect for whistleblowers has not yet been embedded across all the institutions. The Youth Custody Service is working to tackle these issues.

8. Understanding the child’s history is an important factor in ensuring the child feels safe and is properly protected. The Comprehensive Health Assessment Tool (CHAT) and the Youth Custody Service’s ASSETPlus systems are designed to identify children most at risk of sexual abuse in custody. CHAT assessments, however, are not always completed in YOIs and STCs. These issues are compounded by missing health records, depriving the institution of a full health history of the child. New IT systems are intended to correct these problems but it is difficult to underestimate the importance of ensuring that the right information is available at the right time to support decision-making about the best interests of the child.

9. Knowing the history of the child and their particular vulnerabilities is important when force is applied in a custodial setting. Custodial institutions are authorised, in certain circumstances, to apply physical restraint or strip search children. Force may be authorised to impose ‘good order and discipline’. Force and strip searches, however, should only be used when absolutely necessary. Greater awareness is needed of children who have been sexually abused so that staff understand the impacts of these techniques and manage the consequences effectively. The problem is compounded when there are failures to document these events properly, making it difficult for custodial institutions to account for their use.

10. In addition to the application of restraint and strip searching, pain compliance techniques are currently permitted in YOIs and STCs (but not in SChs). The use of these techniques, however challenging the behaviour of the child, normalises pain for staff and children. This, in turn, prevents staff from building trusting relationships and inhibits a child from reporting sexual abuse. The use of pain compliance, although authorised as a last resort, has attracted criticism from a number of informed commentators. Pain compliance contributes to a culture of fear and has the effect of silencing the child at a time when it is important that the child feels safe to speak out about aspects of their lives, including sexual abuse.

11. Environmental factors play an important part in developing a safe place for a child. Evidence about room-sharing, CCTV cameras and body-worn cameras for staff painted a mixed picture about the potential benefits of these initiatives and illustrated the difficulties of balancing the child’s right to privacy and potential risk of harm in unmonitored situations. A greater understanding is required of the advantages and disadvantages of these issues, particularly in relation to body-worn cameras. The use of CCTV cameras is well-established, particularly in areas of common access. When properly located to achieve the maximum coverage of these areas, they are regarded by some as helpful.
12. Evidence that children who had engaged in sexually harmful behaviour were placed alongside children who were in SCHs for welfare reasons gave rise to concern.

13. In YOIs and STCs, investigations into child sexual abuse were undertaken without the involvement of a social worker within the institution. The allegation was rarely referred to the police or the local authority. The lack of involvement of independent institutions gives rise to concerns about the rigour of the investigation and the expertise of the investigator, who may not have had relevant training or experience in dealing with these types of cases. When considered alongside the Inquiry’s prevalence analysis, the institutions would find it difficult to provide an adequate account of their performance in responding to sexual abuse. The absence of data about allegations and limited auditing obscures the true picture.

14. There are a number of ways children can report sexual abuse: in writing, externally to friends or family (suitably modified mobile phones have been provided), and to members of staff (where positive relationships have been developed). Not enough social workers are involved with children in YOIs and STCs to provide an alternative trusted adult to whom children could disclose sexual abuse. It is notable, however, that the Department for Education 2015 guide, which applies to SCHs, states that children should be loved, valued and nurtured, and "staff should strive to build positive relationships with children in the home and develop a culture of openness and trust that encourages them to be able to tell someone if they have any concerns or worries about their safety". The regulations, policy and contracts governing YOIs and STCs contain less about building positive relationships, trust and confidence, although the Youth Custody Service is seeking to address these issues.

15. Throughout this investigation, the differences between the YOIs and STCs, and SCHs became increasingly obvious. SCHs were more focussed on the interests of the child and adopted a less punitive approach. Staff training was subject to regulation and use of pain compliance was prohibited. The cultural barriers to disclosure were less apparent in SCHs. Such an environment creates a better climate in which a child potentially will feel safer and more able to disclose sexual abuse. In SCHs the staff/child ratio is higher than the ratio in YOIs and STCs, with more opportunities to build positive relationships with children.

16. The underlying reasons for the differences in regimes almost certainly lie with the departments of state involved. The Department for Education has responsibility for setting the overall policy and legislative framework and ultimate oversight for SCHs; the Ministry of Justice has ultimate oversight for STCs and YOIs. These departments have very distinct roles in serving the public interest, the former focussing on education and social care and the latter on the justice system.

17. Inevitably the cost of keeping a child in a SCH is much higher than other custodial institutions, principally because of the higher staffing ratios. Cost alone, however, cannot be the main factor determining where a child is placed, particularly when the child custody population has considerably reduced over the years.

18. The Youth Custody Service proposes to develop secure schools as an alternative model for child custody. The development of this initiative is welcome but it is important to ensure that secure schools are not an exercise in relabelling. A genuine child-centred focus must be

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567 Guide to the Children's Homes Regulations including the quality standards, DfE, April 2015
introduced with comprehensive education standards and effective safeguards. Greater local authority involvement for these ‘looked after’ children is essential. The new system should be brought in with speed and efficiency.

19. Finally, the number of children who were remanded in custody prior to trial, and were therefore unconvicted, comprised around one-third of the child custody population. This number of children exposed to the risks associated with custody seemed very high.

**Recommendations**

These recommendations reflect the Chair and Panel’s view that the culture and ethos of young offender institutions (YOIs) and secure training centres (STCs) must change, with a child-centred approach to care and support replacing regimes currently focussed on control and discipline. Since these principles underpin the operation of secure children’s homes (SCHs) there is no reason why this cannot be achieved within YOIs and STCs.

The Chair and Panel were concerned that the Inquiry’s prevalence analysis indicates that the risk of sexual abuse faced by children in custody is greater than was previously understood. On that basis, these recommendations are intended to reduce the risk of sexual abuse faced by all children in custody.

The safeguarding review currently being undertaken by Sonia Brooks OBE for the Youth Custody Service provides an opportunity to respond positively to many of these recommendations.

The Chair and Panel ask that these recommendations be applied to the new secure schools model, as appropriate.

The Chair and Panel ask those to whom its recommendations apply publish their response, including the timetable involved. This should be done within six months of the publication of this report unless stated otherwise.

**Recommendation 1**

The Inquiry was told that children should only be placed in custody as a last resort. However, it was concerned to hear evidence that some children are remanded in custody because of a lack of appropriate community provision. Given that the proportion of children in custody on remand is so high, this is an issue of significant concern.

The Chair and Panel recommend that the Youth Custody Service commissions research into why the child remand population is as high as it is. If the reason is a lack of appropriate community provision (nationally or in certain areas), or otherwise unrelated to a genuine need for those children to be remanded in custody, the Chair and Panel recommend that the Youth Custody Service, with appropriate partner agencies, puts an action plan in place to address this.

**Recommendation 2**

The Chair and Panel recommend that the Department for Education and the Youth Custody Service conduct a full review of the practice of placing children for justice and welfare reasons together in SCHs to establish whether it increases the risk of sexual abuse to
children. If so, appropriate action should be taken, including consideration of alternative models. The review should be completed within three months, and an action plan should be published within six months.

**Recommendation 3**

The Chair and Panel recommend that the Youth Custody Service takes steps to ensure that its training provides staff with an appropriate understanding of safeguarding in the context of the secure estate, and that this is regularly reviewed and updated.

**Recommendation 4**

As the Inquiry set out in its Interim Report, professional registration of the workforce in settings responsible for the care of vulnerable children complements regulation of institutions by a separate, independent regulator.\(^{568}\)

The Government has agreed in principle that professional regulation of staff in children’s homes in England could provide an effective additional means of protecting children. It has indicated that it will be conducting an evidence-gathering exercise to inform further action.\(^{569}\)

The Chair and Panel now recommend that the Ministry of Justice introduces arrangements for the professional registration of staff in roles responsible for the care of children in YOIs and STCs. The Interim Report recommendation already applies to staff working with children in SCHs.

**Recommendation 5**

The Chair and Panel consider that the use of pain compliance techniques should be seen as a form of child abuse, and that it is likely to contribute to a culture of violence, which may increase the risk of child sexual abuse.

The Chair and Panel recommend that the Ministry of Justice prohibits the use of pain compliance techniques by withdrawing all policy permitting its use, and setting out that this practice is prohibited by way of regulation.

**Recommendation 6**

The Chair and Panel note that Prison Service Instruction (PSI) 08/2012, which sets out the mandatory actions for YOIs and STCs for ‘maintaining a safe and secure environment’, has expired. The Chair and Panel recommend that the Ministry of Justice revises and publishes this PSI to provide clear guidance on how custodial institutions must respond to allegations of child sexual abuse. This should include a requirement for all allegations to be referred to a child protection professional who is independent of the institution.

The Chair and Panel also recommend that all institutions, including those which are privately run, publish their safeguarding local procedures in full as well as regular reports about their use, to aid scrutiny and increase transparency.

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\(^{568}\) *Interim Report of the Independent Inquiry into Child Sexual Abuse*, IICSA, April 2018, section 6.3

\(^{569}\) *Government response to the Interim Report by the Independent Inquiry into Child Sexual Abuse*, HM Government, December 2018, paragraph 56
Recommendation 7

The Chair and Panel recommend that the Ministry of Justice and the Department for Education share policy responsibility for managing and safeguarding children in custodial institutions. This is to ensure that standards applied in relation to children in custody are jointly focussed on discipline and securing child welfare.
Annexes
Annex 1

Overview of process and evidence obtained by the Inquiry

1. Definition of Scope for the Case Study

1.1. The Sexual Abuse of Children in Custodial Institutions investigation is an inquiry into the extent of any institutional failures to protect children from sexual abuse and exploitation while in custodial institutions.

1.2. The Inquiry recognises that children in detention are particularly vulnerable to sexual abuse, but that very little is known about their experiences or the extent to which institutions in England and Wales have discharged their duty of care to protect them.⁵⁷⁰

1.3. The scope of this investigation⁵⁷¹ is:

“1. The Inquiry will investigate the nature and extent of, and institutional responses to, the sexual abuse of children in custodial institutions, including Secure Children’s Homes, Secure Training Centres, Young Offender Institutions, and their precursor institutions (‘custodial institutions’). The investigation shall incorporate case specific investigations and a review of information available from published and unpublished reports and reviews, court cases, and previous investigations in relation to the abuse of children in custodial institutions.

2. In conducting the investigation, the Inquiry will consider the experiences of victims and survivors of child sexual abuse while in custodial institutions, and investigate:

2.1. the prevalence of the sexual abuse of children in custodial institutions;

2.2. the adequacy of the safeguarding and child protection policies and practices of the range of institutions responsible for the detention of children, including the Youth Justice Board, the Prison Service and individual Secure Children’s Homes, Secure Training Centres and Youth Offender Institutions. In examining the adequacy of these policies the Inquiry will consider issues of governance, training, recruitment, leadership, reporting and investigation of child sexual abuse, disciplinary procedures, information sharing and interagency working, and approach to reparations;

2.3. the extent to which there was or is a culture within custodial institutions which inhibits the proper investigation, exposure and prevention of child sexual abuse;

2.4. the adequacy of the law enforcement and criminal justice response to allegations of the sexual abuse of children in custodial institutions; and

2.5. The adequacy of the inspection and regulatory regimes applicable to children in custodial institutions.

3. As an initial case study, the Inquiry will investigate allegations of child sexual abuse at Medomsley Detention Centre...

4. Other case studies may be identified by the Inquiry as the investigation progresses.

5. In light of the investigations set out above, the Inquiry will publish a report setting out its findings, lessons learned, and recommendations to improve child protection and safeguarding in England and Wales.”

1.4. As is clear above, the Inquiry identified Medomsley Detention Centre, County Durham as an initial case study in the investigation. The apparent scale of abuse at Medomsley demands a rigorous investigation into how multiple allegations, if true, could have gone uninvestigated and the offending undetected for so long. However, at this stage, the Inquiry is not progressing its investigation in issues relating to Medomsley, due to ongoing criminal proceedings.

1.5. Instead, the Inquiry focussed this phase of the investigation (as described in the Update Note published on its website in November 2017\(^{572}\) on:

“the nature and extent of, and institutional responses to, recent sexual abuse of children in custodial institutions; and of the adequacy of current institutional and systemic protections of children in those institutions from sexual abuse.”

2. Core participants and legal representatives

**Complainant core participants:**

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<tr>
<th>F20, F27, F32, Colin Watson and Peter Smith</th>
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<td><strong>Counsel</strong></td>
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<td><strong>Solicitor</strong></td>
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<th>Peter Robson</th>
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<td><strong>Counsel</strong></td>
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Institutional core participants:

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<td>Secretary of State for Education</td>
<td>Cathryn McGahey QC</td>
<td>William Barclay (Treasury Solicitor)</td>
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<td>Commissioner of the Police of the Metropolis</td>
<td>Jonathan Dixey</td>
<td>Sarah Heron (Metropolitan Police Services’ legal services directorate)</td>
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<td>The Ministry of Justice</td>
<td>Neil Sheldon</td>
<td>Kathryn Hennessy (Government Legal Department)</td>
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<td>Ofsted</td>
<td>Sarah Hannett and Zoe McCallum</td>
<td>James Fawcett (Ofsted Legal Services)</td>
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3. Evidence received by the Inquiry

<p>| Number of witness statements obtained:                  | 332 (includes witness statements marked as not relevant) |
| Organisations and individuals to which requests for documentation or witness statements were sent: | Alan Wood (independent expert instructed by the Inquiry) |
|                                                      | Avon and Somerset Constabulary                                                       |
|                                                      | Barnardo’s                                                                      |
|                                                      | BBC                                                                            |
|                                                      | Bridgend County Council                                                          |
|                                                      | Cambridgeshire Constabulary                                                       |
|                                                      | Care and Social Services Inspectorate Wales                                     |
|                                                      | Carolyne Willow (children’s rights campaigner and director of Article 39)         |
|                                                      | Children’s Commissioner for England                                              |
|                                                      | Cleveland Police                                                                |
|                                                      | Coram Voice                                                                     |
|                                                      | Criminal Injuries Compensation Authority                                        |
|                                                      | Crown Prosecution Service                                                       |
|                                                      | Department for Education                                                        |
|                                                      | Derbyshire County Council                                                        |
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|                                                      | Devon and Cornwall Police                                                        |</p>
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<td>Pam Hibbert OBE (specialist in the area of youth justice and looked after children)</td>
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<td>Peterborough City Council</td>
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<td>Professor Nick Hardwick (former Chief Inspector of Prisons for England and Wales)</td>
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<td>Sharron Rollinson (former assistant Local Authority Designated Officer)</td>
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4. Disclosure of documents

**Total number of pages disclosed: 25,590**

<table>
<thead>
<tr>
<th>Investigation material</th>
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5. Public hearings including preliminary hearings

<table>
<thead>
<tr>
<th>Preliminary hearings</th>
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<tr>
<td>1</td>
<td>1 February 2018</td>
</tr>
<tr>
<td>2</td>
<td>7 June 2018</td>
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<table>
<thead>
<tr>
<th>Public hearings</th>
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<tr>
<td>Days 1–5</td>
<td>9–13 July 2018</td>
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<tr>
<td>Days 6–8</td>
<td>16–18 July 2018</td>
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<td>Day 9</td>
<td>20 July 2018</td>
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### 6. List of witnesses

<table>
<thead>
<tr>
<th>Surname</th>
<th>Forename</th>
<th>Title</th>
<th>Called, read or adduced</th>
<th>Hearing day</th>
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<tr>
<td>Smith</td>
<td>Peter</td>
<td>Mr</td>
<td>Called</td>
<td>1</td>
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<tr>
<td>Robson</td>
<td>Peter</td>
<td>Mr</td>
<td>Read</td>
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<tr>
<td>CI-A17 (F27)</td>
<td></td>
<td></td>
<td>Called</td>
<td>2</td>
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<tr>
<td>Watson</td>
<td>Colin</td>
<td>Mr</td>
<td>Read</td>
<td>2</td>
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<tr>
<td>CI-A30 (F20)</td>
<td></td>
<td></td>
<td>Called</td>
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<tr>
<td>CI-A34 (F32)</td>
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<td>Read</td>
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<tr>
<td>Janes</td>
<td>Laura</td>
<td>Dr</td>
<td>Called</td>
<td>3</td>
</tr>
<tr>
<td>Bailey</td>
<td>Simon</td>
<td>Chief Constable</td>
<td>Called</td>
<td>3</td>
</tr>
<tr>
<td>Hibbert</td>
<td>Pam</td>
<td>Ms</td>
<td>Called</td>
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<tr>
<td>Hardwick</td>
<td>Nick</td>
<td>Professor</td>
<td>Called</td>
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<tr>
<td>Gillan</td>
<td>Steve</td>
<td>Mr</td>
<td>Read</td>
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<tr>
<td>Wood</td>
<td>Alan</td>
<td>Mr</td>
<td>Called</td>
<td>4, 6, 7 &amp; 8</td>
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<tr>
<td>Noyes</td>
<td>Phillip</td>
<td>Mr</td>
<td>Read</td>
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<td>Willow</td>
<td>Carolyne</td>
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<tr>
<td>Willison</td>
<td>Katherine</td>
<td>Ms</td>
<td>Called</td>
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</tr>
<tr>
<td>Savage</td>
<td>Peter</td>
<td>Mr</td>
<td>Called</td>
<td>5</td>
</tr>
<tr>
<td>Robinson</td>
<td>Sara</td>
<td>Ms</td>
<td>Called</td>
<td>5</td>
</tr>
<tr>
<td>Heaney</td>
<td>Albert</td>
<td>Mr</td>
<td>Called</td>
<td>5</td>
</tr>
<tr>
<td>Mulready-Jones</td>
<td>Angus</td>
<td>Mr</td>
<td>Called</td>
<td>6</td>
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<tr>
<td>Knight</td>
<td>Glenn</td>
<td>Mr</td>
<td>Called</td>
<td>6</td>
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<tr>
<td>Gormley</td>
<td>Peter</td>
<td>Mr</td>
<td>Called</td>
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</tr>
<tr>
<td>Clackson</td>
<td>Saffron</td>
<td>Ms</td>
<td>Adduced</td>
<td>6</td>
</tr>
<tr>
<td>Stuart</td>
<td>Rachel</td>
<td>Ms</td>
<td>Adduced</td>
<td>6</td>
</tr>
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<td>Newcomen</td>
<td>Nigel</td>
<td>Mr</td>
<td>Adduced</td>
<td>6</td>
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<tr>
<td>Moody</td>
<td>Elizabeth</td>
<td>Ms</td>
<td>Adduced</td>
<td>6</td>
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<td>Longfield</td>
<td>Anne</td>
<td>Ms</td>
<td>Adduced</td>
<td>6</td>
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<tr>
<td>Roughton</td>
<td>Rosamond</td>
<td>Ms</td>
<td>Adduced</td>
<td>6</td>
</tr>
<tr>
<td>Good</td>
<td>Nadine</td>
<td>Ms</td>
<td>Adduced</td>
<td>6</td>
</tr>
<tr>
<td>Wood</td>
<td>Lara</td>
<td>Ms</td>
<td>Adduced</td>
<td>6</td>
</tr>
<tr>
<td>Gordon</td>
<td>Yvonne</td>
<td>Ms</td>
<td>Adduced</td>
<td>6</td>
</tr>
<tr>
<td>Petherick</td>
<td>Jerry</td>
<td>Mr</td>
<td>Called</td>
<td>7</td>
</tr>
<tr>
<td>French</td>
<td>Jonathan</td>
<td>Mr</td>
<td>Called</td>
<td>7</td>
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<tr>
<td>Jessup</td>
<td>Stuart</td>
<td>Mr</td>
<td>Called</td>
<td>7</td>
</tr>
<tr>
<td>Johnson</td>
<td>Mark</td>
<td>Mr</td>
<td>Called</td>
<td>7</td>
</tr>
<tr>
<td>--------------</td>
<td>------------</td>
<td>----</td>
<td>--------</td>
<td>----</td>
</tr>
<tr>
<td>Drew</td>
<td>John</td>
<td>Mr</td>
<td>Adduced</td>
<td>7</td>
</tr>
<tr>
<td>Hagger</td>
<td>Lesley</td>
<td>Ms</td>
<td>Adduced</td>
<td>7</td>
</tr>
<tr>
<td>Brazier</td>
<td>Matthew</td>
<td>Mr</td>
<td>Called</td>
<td>8</td>
</tr>
<tr>
<td>Rollinson</td>
<td>Sharron</td>
<td>Ms</td>
<td>Called</td>
<td>8</td>
</tr>
<tr>
<td>Sykes</td>
<td>Alison</td>
<td>Ms</td>
<td>Called</td>
<td>8</td>
</tr>
<tr>
<td>Whellans</td>
<td>Margaret</td>
<td>Ms</td>
<td>Called</td>
<td>8</td>
</tr>
</tbody>
</table>

7. Restriction orders

On 15 August 2016, the Chair issued a restriction order under section 19(2)(b) of the Inquiries Act 2005, granting general anonymity to all core participants who allege they are the victim and survivor of sexual offences (referred to as 'complainant CPs'). The order prohibited (i) the disclosure or publication of any information that identifies, names or gives the address of a complainant who is a core participant and (ii) the disclosure or publication of any still or moving image of a complainant CP. The order meant that any complainant CP within this investigation was granted anonymity, unless they did not wish to remain anonymous. That order was amended on 23 March 2018 but only to vary the circumstances in which a complainant CP may themselves disclose their own CP status.573

8. Broadcasting

The Chair directed that the proceedings would be broadcast, as has occurred in respect of public hearings in other investigations. For anonymous witnesses, all that was 'live streamed' was the audio sound of their voice.

9. Redactions and ciphering

The material obtained for this Case Study was redacted, and where appropriate, ciphers applied, in accordance with the Inquiry's Protocol on the Redaction of Documents (the Protocol).574 This meant that (in accordance with Annex A of the Protocol), for example, absent specific consent to the contrary, the identities of complainants and victims and survivors of child sexual abuse and other children have been redacted. If the Inquiry considered that their identity appeared to be sufficiently relevant to the investigation a cipher was applied.

Pursuant to the Protocol, the identities of individuals convicted of child sexual abuse (including those who have accepted a police caution for offences related to child sexual abuse) will not generally be redacted unless the naming of the individual would risk the identification of their victim, in which case a cipher would be applied.

The Protocol also addresses the position in respect of individuals accused, but not convicted, of child sexual abuse or other physical abuse against a child, and provides that their identities should be redacted and a cipher applied. However, where the allegations against an individual are so widely known that redaction would serve no

meaningful purpose (for example where the individual’s name has been published in the regulated media in connection with allegations of abuse), the Protocol provides that the Inquiry may decide not to redact their identity.

Finally, the Protocol recognises that while the Inquiry will not distinguish as a matter of course between individuals who are known or believed to be deceased and those who are, or are believed to be, alive, the Inquiry may take the fact that an individual is deceased into account when considering whether or not to apply redactions in a particular instance.

The Protocol anticipates that it may be necessary for core participants to be aware of the identity of individuals whose identity has been redacted and in respect of whom a cipher has been applied, if the same is relevant to their interest in the Case Study. Accordingly, the Inquiry varied the restriction order and circulated to certain core participants a key to some of the ciphers.

10. Warning letters

Rule 13 of the Inquiry Rules 2006 provides:

“(1) The chairman may send a warning letter to any person –

a. he considers may be, or who has been, subject to criticism in the inquiry proceedings; or

b. about whom criticism may be inferred from evidence that has been given during the inquiry proceedings; or

c. who may be subject to criticism in the report, or any interim report.

(2) The recipient of a warning letter may disclose it to his recognised legal representative.

(3) The inquiry panel must not include any explicit or significant criticism of a person in the report, or in any interim report, unless –

a. the chairman has sent that person a warning letter; and

b. the person has been given a reasonable opportunity to respond to the warning letter.”

In accordance with rule 13, warning letters were sent as appropriate to those who were covered by the provisions of rule 13 and the Chair and Panel considered the responses to those letters before finalising the report.
**Annex 2**

## Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
</tr>
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<tbody>
<tr>
<td>CHAT</td>
<td>Comprehensive Health Assessment Tool</td>
</tr>
<tr>
<td>CuSP</td>
<td>Custody Support Plan</td>
</tr>
<tr>
<td>DfE</td>
<td>Department for Education</td>
</tr>
<tr>
<td>DTO</td>
<td>Detention and Training Order</td>
</tr>
<tr>
<td>HMIP</td>
<td>Her Majesty’s Inspectorate of Prisons</td>
</tr>
<tr>
<td>HMPPS</td>
<td>Her Majesty’s Prison and Probation Service</td>
</tr>
<tr>
<td>IMB</td>
<td>Independent Monitoring Boards</td>
</tr>
<tr>
<td>JASP</td>
<td>Juvenile Awareness for Staff Programme</td>
</tr>
<tr>
<td>LADO</td>
<td>Local authority designated officer</td>
</tr>
<tr>
<td>LSCB</td>
<td>Local Safeguarding Children Board</td>
</tr>
<tr>
<td>MMPR</td>
<td>Minimising and Managing Physical Restraint</td>
</tr>
<tr>
<td>NHS</td>
<td>National Health Service</td>
</tr>
<tr>
<td>POELT</td>
<td>Prison Officer Entry Level Training</td>
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<tr>
<td>PPO</td>
<td>Prisons and Probation Ombudsman</td>
</tr>
<tr>
<td>PSI</td>
<td>Prison Service Instruction</td>
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<td>PSO</td>
<td>Prison Service Order</td>
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<td>Rapid Evidence Assessment</td>
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<td>Secure children’s home</td>
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<tr>
<td>STC</td>
<td>Secure training centre</td>
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<tr>
<td>YOI</td>
<td>Young offender institution</td>
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