Medway Safeguarding Children Board

Safeguarding Medway's children together

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Serious Case Review

'Learning for organisations arising from incidents at Medway Secure Training Centre'

Independent Reviewer: Alex Walters

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1. INTRODUCTION

1.1 This Serious Case Review (SCR) was initiated by Medway Local Safeguarding Children Board (MSCB) following the identification of abuse of children by staff at the Medway Secure Training Centre (STC) in the BBC Panorama documentary broadcast in January 2016. The issue was originally referred to the Medway LSCB in February 2016 where it was agreed at the SCR Screening Panel that the operational response needed to take priority and the case reviewed again. Reviews took place in June and October 2016 and in December 2016 the Medway LSCB Independent Chair confirmed the SCR criteria were met and an SCR should be undertaken. This decision was communicated to the Department for Education (DfE) and Ofsted in December 2016. The Independent Chair and senior leaders in the LSCB appointed an independent reviewer and an independent SCR Panel chair. The SCR process commenced following their appointment in July 2017.

1.2 There is a legal requirement, as defined in Statutory Guidance, "Working Together to Safeguard Children 2015", the guidance at the time the SCR was initiated, to undertake a Serious Case Review when abuse or neglect of a child is known or suspected and

- either a child has died; or
- a child has been seriously harmed and there is cause for concern about how organisations or professionals worked together to safeguard the child.

1.3 The purpose of a Serious Case Review, as confirmed in the current statutory guidance, "Working Together to Safeguard Children 2018" is clear that the focus is on learning not holding individuals, organisations or agencies to account.

"*The purpose of reviews of serious child safeguarding cases, at both local and national level, is to identify improvements to be made to safeguard and promote the welfare of children. Learning is relevant locally, but it has a wider importance for all practitioners working with children and families and for the government and policy- makers. Understanding whether there are systemic issues, and whether and how policy and practice need to change, is critical to the system being dynamic and self-improving.*

"Reviews should seek to prevent or reduce the risk of recurrence of similar incidents. They are not conducted to hold individuals, organisations or agencies to account, as there are other processes for that purpose, including through employment law and disciplinary procedures, professional regulation and, in exceptional cases, criminal proceedings".

1.4 The summary of the case is that an undercover BBC reporter was recruited by G4S and filmed his experiences at Medway STC in the autumn of 2015. The programme showed apparent excessive use of force in restraints by staff, inappropriate language, shouting, bullying and aggressive behaviour and the impact this had on some of the children. Following the broadcast of this film by BBC Panorama on the 11th January 2016, the Ministry of Justice (MoJ) established a Medway Improvement Board, which reported in March 2016 and

made a number of recommendations to which the MoJ responded in May 2016. Disciplinary processes and criminal investigations followed and resulted in a number of trials. In April 2016 the decision was made for Medway STC to be transferred to Her Majesty's Prison and Probation Service (HMPPS). HMPPS began to run Medway STC in July 2016. Ofsted subsequently judged the STC 'Inadequate' in its inspections published in August 2016 and June 2017 but it's most recent inspection published in May 2018 recognised overall improvement and provided a judgement of "Requires Improvement".

1.5 In this report I have chosen to refer to the children who were living at the STC as children because they are children first - not trainees, not offenders and not young people. This SCR is not the appropriate mechanism and does not have the remit to make any judgements on the overall national policy of the secure estate and its approach to children who have committed offences. A number of the agencies reports referred to in this SCR report set out these arrangements. However I would wish to state that having met and spoken with many of these children it is clear that this is a highly vulnerable group. Many have had adverse childhood experiences and require the most skilled workforce and interventions to enable them to lead productive lives and become adults who do not continue to cost the state in terms of their future health needs and potential offending.

1.6 This SCR is unusual in that it relates to abuse within an institution and to services that are commissioned and provided both locally and nationally. The process has been complex but has aimed to extract the key issues and areas of learning from the analysis of each of the individual organisations reviews and other processes in the public domain and has additionally been informed by discussions with key partners, practitioners and children who responded to the request for them to contribute to the SCR.

1.7 In summary I have identified that the **three primary areas of focus for learning for this SCR are:**

First - how to create safe working cultures within organisations. This covers areas such as safe recruitment, policies, training and supervision of staff; the creation of transparent and effective arrangements for staff and children to raise their concerns with clear management oversight and whistleblowing procedures.

Second - how to ensure that statutory agencies and their arrangements for responding to allegations/concerns about adults who are in positions of trust or peer abuse are effective in protecting children from abuse and that local monitoring is effective.

Third - how to ensure appropriate and child focussed commissioning practice by national organisations responsible for the contracts for service provision including from the voluntary sector within the secure estate which are informed by local safeguarding arrangements.

2. ARRANGEMENTS FOR THE SERIOUS CASE REVIEW

2.1 Medway LSCB appointed an Independent person, Reg Hooke to chair the SCR Panel and Alex Walters was appointed as the Independent Reviewer. Their biographies are set out in Appendix B.

2.2 Medway LSCB then established an SCR Panel and agreed the representation on this Panel. The Panel then developed comprehensive Terms of Reference (TOR) for this SCR. These are attached at Appendix A. These TOR differentiated the level of information and issues to be addressed by the relevant agencies/organisations in order to be proportionate and focussed in its work.

2.3 The time frame agreed for the Review was September 2014 (Ofsted inspection which judged Medway STC as Good) - September 2017 when the SCR commenced.

2.4 Individual Management Reviews (IMRs) were requested from the following 14 organisations/services who all had involvement with Medway STC either as commissioners of services within the STC, as providers within the STC or as local statutory agencies who had safeguarding responsibilities for the children.

- Barnardos (children's advocacy provider)
- Central and North West London NHS Trust (health provider)
- G4S (STC provider until July 2016)
- Her Majesty Prison and Probation Service (STC provider from July 2016)
- Kent Police (local statutory agency)
- Medway Local Authority - Children's Social Care (local statutory agency)
- Medway Local Authority - Local Authority Designated Officer (local statutory agency for allegation management)
- Medway Local Authority - Youth Offending Team (local statutory agency)
- Medway Safeguarding Children Board (local statutory safeguarding children body)
- Medway NHS Foundation Trust (district hospital provider)
- Nacro (training and resettlement services provider)
- NHS England (health commissioner)
- The Children's Society (provider of services for girls leaving custody)
- Youth Justice Board (STC Commissioner)

In order to support the IMR Authors in their work, a half-day briefing session was held facilitated by the Chair and Independent Reviewer.

2.5 In addition, Information Reports were requested from a further six organisations/services who had had a role/involvement to establish if there was any broader learning.

- Barking and Dagenham Local Authority[1]

[1] *The London Borough of Barking and Dagenham were asked to produce an Information report for two reasons as both their Director of Children's Services and the Chair of their LSCB had pressed the case for a Serious*

- Care Quality Commission (independent regulator of health and social care services)
- Her Majesty's Inspectorate of Prisons
- Ministry of Justice
- Medway Clinical Commissioning Group
- Ofsted

2.6 Individual meetings were also held with:

- BBC
- HMIP
- Office of the Children's Commissioner

2.7 Not all the individual management reviews (IMRs) initially fully addressed the terms of reference and some required further work and revision including responding to new information at the request of the Independent Reviewer and the SCR Panel. There continued to be some factual discrepancies between IMRs such as the transfer of information between providers of the STC. All the IMR authors of the individual management reviews were independent of direct management, and most undertook informal interviews with staff involved. All IMRs were signed off and the content agreed by the senior managers in their organisations.

2.8 It was agreed that, in order to maximise learning and achieve proportionality, the IMRs were divided into two – one focussing on the local agencies and one on the national agencies. Following consideration of the individual management reviews, the IMR Authors were invited to meet with the SCR Panel to discuss their IMRs together and consider the learning identified in December 2017 and January 2018. The IMRs and any further amendments to IMRs were then discussed with the SCR Panel at further meetings in January 2018 and March 2018, which focussed on the key learning and improvements already made by agencies/organisations and those still required.

2.9 **Listening to children:** The SCR Panel agreed in the TOR that it was crucial to hear the voice of the children who had been/remained at Medway STC during the three year timeframe of the SCR. The methodology agreed was for MSCB to contact all Local Authorities who had been involved with the children either because they were looked after, care leavers or through their Youth Offending Team (YOT) responsibilities. They were to be asked if they would be willing to speak with the Independent Reviewer. A leaflet was devised by the Independent Reviewer to explain the process and set out the context and the opportunity to present information to inform the learning from the SCR process.

2.10 As a result 65 Local Authorities were contacted who were responsible for 330 children placed at the STC during this timeframe and 25 of the children indicated

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Case Review and offered to provide insight to the review as the home local authority for some of the children who had lived at the STC during this period. It was not deemed practical to involve all such Councils but the insight of at least one was seen as important.

their wish to speak to the independent reviewer .For those uncomfortable in talking, questions were submitted to their lead professional to discuss with them and in one LA there was already a consultation process with 4 children and the questions incorporated into that process. The Independent Reviewer was finally able to directly speak to 13 of these children by phone; many changed their minds or were unavailable despite repeated contacts.

2.11 In addition the SCR Panel Chair and the Independent Reviewer visited Medway STC in April 2018 and spent time talking with 7 children - two of whom had been identified through their Local Authority contact, two who had been at the STC since 2015 and three who responded to the request offered to all the young people to meet with us. This was 7 from a cohort of 38 children resident at the STC at that time.

2.12 **Listening to staff in the secure estate.** The SCR Panel Chair and Independent Reviewer visited the Medway STC, a Young Offenders Institution and a Secure Children's Home, and spoke with managers and front line staff.

2.13 In addition the SCR Chair and Independent Reviewer wrote to organisations who had offered support services through their helplines – Childline, Office of the Children's Commissioner (OCC) and the Howard League for Penal Reform, and met with the OCC, the Producer of the Panorama programme, and HMIP.

2.14 This report was written with the knowledge that it would be published; therefore the information in the report is deliberately limited in order to:

a) take reasonable precautions not to disclose any identities of individuals not already in the public domain, and to

b) protect the right to an appropriate degree of confidentiality for the children who contributed to the process.

3. METHODOLOGY USED TO DRAW UP THIS REPORT

3.1 This SCR Overview report relies on:

- The agency Individual Management Reviews (IMRs) and Information Reports;
- Minutes and discussions from the SCR Panels;
- Discussions with and views of the IMR Authors with SCR Panel members at five separate meetings;
- Telephone discussions between the Independent Reviewer and 13 children who had been at Medway STC;
- Meeting with 7 children at Medway STC;
- Follow up discussions with individual organisations where appropriate;
- Ofsted/HMIP Inspection reports: December 2014, August 2016, June 2017 and May 2018;
- Medway Improvement Board report March 2016 and MOJ response - May 2016;
- OCC report on STC visits; and
- Meetings with front line staff and managers at the STC and additionally at one YOI and one secure children's home.

3.2 This SCR Overview report consists of:

- A factual context;
- Summaries of learning identified by each agency's IMRs;
- Key messages from Information reports;
- Analysis of key messages from children;
- Analysis of key messages from staff in the secure estate;
- Analysis of key learning issues arising from the review; and
- Conclusions and Recommendations.

3.3 The conduct of this review has not been determined by any particular theoretical model. However, it endeavoured to use an appreciative enquiry approach involving IMR Authors and practitioners in the exploration and learning from the case as well as listening to children and front line staff. It has been carried out in keeping with the underlying principles of the statutory Guidance, set out in Working Together 2015. These are at Appendix C.

3.4 The Independent Reviewer and the Independent SCR Panel Chair would like to record their gratitude for the exemplary support to this complex SCR process provided by the Medway Safeguarding Children Board Manager and his team.

4. CRIMINAL PROCEEDINGS

4.1 Following broadcast of the BBC Panorama programme Kent Police launched a major criminal investigation into the activities at Medway STC, known as Operation Woodley. This was a substantial investigation that initially investigated back to 2015 and was then extended to include the entire period G4S were responsible for the STC that is back to 1998. The investigation utilised 40 officers. 150 statements were taken, 23 nominated suspects were identified and 39 victims identified. Sixteen people were arrested. The Crown Prosecution Service (CPS) judged that there was sufficient evidence to warrant prosecution of 9 people in connection with behaviour towards children in the STC. Offences included misconduct in public office and common assault. All pleaded not guilty. Following trials, juries found 7 of the defendants not guilty. Verdicts were not reached on the remaining 2 and the CPS concluded that a retrial would not be appropriate. In summary, there were no convictions.

5. THE AGENCIES

5.1 Each of these sections below provides the contextual information on the organisation's involvement with the STC and the learning they have identified for their own organisation and they are listed in alphabetical order. All IMRs prepared by the agencies/organisations involved were signed off and agreed by their senior management. The single agency recommendations are listed in Appendix F.

5.2 Barnardo's

5.2.1 A brief summary of contextual information provided by the agency in the IMR

"Barnardo's had been commissioned by the Youth Justice Board to deliver Advocacy services across the young people's secure estate of England and Wales, including Medway STC. This contract started in 2013 and commissioned 17 hours a week, including management time, of advocacy in Medway STC. Barnardo's advocates do not have an office in Medway STC but are based in the adjacent Cookham Wood YOI. Its proximity to Medway STC means that staff visit Medway at regular times each week.

All young people, as part of their induction at Medway, meet an advocate in order to understand how and why they might take up the service. The advocates have made themselves available by being physically present in Medway STC, enabling young people to self-refer. Referrals also come from Medway STC staff. The contract, until 30 June 2017, required Barnardo's to offer advocacy support to all young people as part of post-restraint debriefs. Barnardo's have employed additional staff at times when the service faced challenges in meeting its contract. A significant proportion of the Advocate's activity, until 30 June 2017, involved offering advocacy in person as part of the post- restraint debrief process. This offer was not well used by young people in Medway STC and, at times accounted for approximately 40% – 50% of all the advocacy staff time. Since 1 July 2017, the contract has been changed so that Barnardo's staff do not have to be physically present to offer advocacy if a young person has previously been restrained in Medway STC. This has significantly increased the amount of time that Advocates are available for other forms of advocacy work that have had a higher take up by young people. The new contract, from 1 July 2017, also involved a significant shift from only providing an Advocacy Service to the provision of a Children's Rights and Advocacy Service. This new contract requires Barnardo's to uphold the Department of Health's 2002 Advocacy Standards, and has a stronger emphasis on the independence of the advocacy service from the STC and on young people's right to confidentiality. It also allows Barnardo's to decide, at times, that it should independently advocate on behalf of young people."

5.2.2 Learning and improvements identified from the IMR process

5.2.3 In their role as advocates, which included being available to all young people in advance of their post restraint debrief, staff had not been made aware by young people of the behaviours that Panorama exposed. The IMR suggests young people's low expectations and adverse childhood experiences (ACE) may well

have led to a tolerance of poor staff behaviour in Medway STC that was simply not communicated to Barnardo's advocates. This may indicate there was a cultural problem within the institution, with many STC staff unaware of the impact that the young people's adverse childhood experiences had on them.

5.2.4 Although this work did involve complaints over how staff acted during restraints, no complaints had been received that involved the staff that Panorama caught on camera abusing young people. Additionally, the complaints did not relate to the level of abuse exposed by Panorama. There were records of Barnardo's staff escalating their Safeguarding concerns to the staff with responsibility in the STC, in line with the contract's requirements.

5.2.5 However, there was not a requirement for Medway STC to update Barnardo's of the outcome of these escalations. In addition, the contract expressly did not allow Barnardo's to independently contact the Local Authority Designated Officer (LADO) who has the statutory responsibility for responding to allegations made by children against adults who work with children. Changes have subsequently been made to the new contract extension to ensure more transparency and the right to contact the LADO independently. The contract that runs from July 2017 does allow Barnardo's to contact the LADO directly if it has concerns about a member of staff.

5.2.6 **Additional learning identified by the Independent Reviewer**

5.2.7 The contract between the YJB and Barnardo's was a barrier to independent scrutiny. In addition, children have described the barrier of visibility and identification i.e. of being seen by STC staff talking to an advocate or having to refer via a request through the STC staff. Consideration needs to be given to ensure the advocacy service is fully accessible and there are no barriers to children raising their concerns.

5.3 Central and North West London NHS Foundation Trust (CNWL)

5.3.1 **A brief summary of contextual information provided by the agency in the IMR**

"Health care provision at the STC is commissioned by NHS England (NHS E) and has been provided by CNWL since April 2015. CNWL provide an integrated health provision at Medway STC, which includes primary care, substance misuse and child and adolescent mental health service (CAMHS). Following the Panorama screening and to provide assurance to the CNWL Board of Directors and external stakeholders, a wider review into healthcare provision at Medway STC was commissioned to seek evidence of the practices of the health care team at the STC and their impact on the safe and appropriate delivery of care to the service users residing there. It was also undertaken to better understand the culture of the STC, both within the health care team with G4S and the impact of this, if any, on the experiences of the service users. The review was undertaken in February and March of 2016 and comprised a series of site visits, interviews, including with young people, scrutiny of the process and documentation available

at the STC, a series of case note audits, an audit on capacity and consent and a CQC Key Lines of Enquiry review."

5.3.2 **Learning and improvements identified from the IMR process**

5.3.3 The internal review undertaken in 2016 made a number of recommendations around improving the visibility and response to complaints, a review of the recruitment process of staff to include financial incentives and skill mix, a review of all care plans and improvement to the physical location of the services at the STC.

5.3.4 **Additional learning identified by the Independent Reviewer**

5.3.5 It does not appear that this internal review and the resulting action plan was shared with NHS E as the commissioner or the MSCB and this should have been required by NHS E.

5.4 G4S

5.4.1 **A brief summary of contextual information provided by the agency in the IMR**

"Medway Secure Training Centre offers secure provision for young people aged between 12 and 18 years old. During G4S Management it could offer accommodation for up to 76[2] male and female young people; who have been either sentenced or remanded to custody. Medway secure training centre was opened in 1998 and operated under a 15 year PFI[3] contract. This contract had been extended on two occasions, pending a retender, latterly for a one year term, which expired on the 31st March 2016.
G4S was successful in the re-tender and was contracted to operate Medway STC under a new five year PFI contract, branded as 'Inspiring Futures' from 1st April 2016.
On 31st March 2016, G4S and the Ministry of Justice (MoJ) agreed that the mobilisation of the new contract be postponed and the existing contract be extended in its current form for a period of up to four months whilst the work of the Improvement Board, which was appointed by the MoJ in January 2016, was completed".

The decision was subsequently taken in April 2016 by MoJ to terminate the contract and bring the service under HMPPS from July 2016.

5.4.2 **Learning and improvements identified from the IMR process for G4S**

5.4.3 **Staffing** Medway STC had experienced an increasing level of vacancies and the IMR identified contributing factors to the high levels of staff attrition and leavers, such as; a challenging work environment, shift patterns and a lack of or perceived lack of support. It should be noted there was also high level of employment within

[2] An additional 22 beds were added in 2002
[3] Private Finance Initiative

Kent during the scope period of the review. Reasons for leavers also include medical capability, early retirement, retirement or a change in career.

5.4.4 The IMR notes that it is appropriate to consider whether the training provided by G4S to new staff prepared them for the environment in which they were going to work. The training took 7 weeks, which is considered an appropriate length of time. Some staff employed have never worked with young people before, had no or limited experience working with customers or clients. Classroom based activities can support, but cannot provide all the skills required to manage challenging behaviour. Inevitably without experience of the environment prior it can be a challenging and for some an anxious setting.

5.4.5 **Recruitment and training of staff.** The IMR Author reviewed training records for those subject to the allegations and all had undertaken relevant training in statutory and mandatory modules. Refresher training was also undertaken where necessary. Other training was also undertaken specific to their roles. The vetting of those subject to the allegations had also been reviewed. All individuals were Enhanced Disclosure and Barring Service (DBS) cleared and renewals were in place where applicable. All individuals had been approved and clearance granted by the YJB, following the submission of the relevant 'bundles of documentation,' to the YJB.

5.4.6 **Whistleblowing** Medway STC had an operational whistleblowing policy in place, one which was owned by G4S Central Services, and there was an individual Policy for Medway STC. According to the IMR Author both demonstrate an organisation that strived to create an environment and culture that is one of openness and honesty. The 'Speak Out' facility came into effect in September 2015 and is therefore not detailed in the G4S central services policy (November 2014) that was in place for the majority of the time covered by the SCR; it is in the revised policy in 2015. A communication was sent to all staff informing them of the 'Speak Out' process. Prior to the speak out line, Expolink provided a service as an external company and were a completely independent specialist organisation that provided a 24 hour free to call phone number and a confidential service to enable the reporting of concerns. It guaranteed individuals reporting concerns anonymity. However the Medway Improvement Board state that some of the staff they had spoken to had raised concerns about the anonymity of the whistleblowing line as they had been asked to provide their contact details. Based on the information shared by a minority of staff, without any additional evidence otherwise, the Board concluded that "at the very least there is evidence of a lack of trust … in the whistleblowing process" [4] from a small amount of staff.

5.4.7 **Behaviour management** .The application of sanctions required improvement as identified in the 2016 Ofsted report, which would reinforce the view that the policy was not being utilised effectively. Ofsted cited that the very high staff attrition rate of 67% over the previous 12 months meant that most staff were very inexperienced and concluded that this was likely to be a contributing factor to the inconsistent application and enforcement of the scheme. The Inspectors concluded that the inconsistent application of rewards and sanctions, coupled

[4] Holden, G, Allen, B, Gray, S, Thomas, E, Medway Improvement Board, Final Report, March 2016, Page 41

with inadequate oversight and governance resulted in weak management of behaviour. There were frequent instances where young people were allowed to misbehave and were not dealt with appropriately.

5.4.8 There were whistleblowing concerns considered as part of an internal review in the identified scope period. Staff were interviewed and these interviews were utilised in making an assessment of reporting practices and culture across the G4S STC. The allegations are listed below:

- *"Mixed messaging from management; including Senior Management, on reporting, rewriting of statements at the request of Duty Operational Manager's (DOMs) and that the splitting down of incidents being commonplace.*
- *It was reaffirmed in interview post Panorama that a staff member had been asked to split down incidents where more than two young people were involved on two occasions, and that this was established practice.*
- *Duty Operations Managers were under pressure not to have incidents on their shifts due to KPIs (Key performance Indicators), and that messaging was given from the DOMS to classify some incidents as de-escalations."*

5.4.9 The great majority of managers interviewed at the time maintained that reporting was thorough and transparent and there was not a culture of misreporting or under reporting. The staff involved in the above disclosures, one of which worked at a different STC establishment to Medway, could not provide G4S any evidence to support their allegations or any acceptance that these practices exist in a general sense. "This does not take away from the seriousness of the allegations and the need to address the concerns"- Internal G4S review 2016.

5.4.10 The IMR Author makes the following point: *"Whilst on the surface; there are appropriate policies and procedures and a full complement of management, it can at times mean little if the staff implementing and carrying out the policies and procedures are not the right, fit and proper staff to be caring for our most vulnerable young people. Training can be incredibly helpful and fruitful for some staff but what it cannot teach is empathy, understanding and compassion for the lives the young people are leading. Inevitably, particularly in an environment that can be unpredictable and challenging, some new staff will learn from the established, confident staff. Without direct contact with all the staff and their training records, who were working at Medway STC it is impossible to reflect on if the establishment had a fully effective, 'knowledgeable and confident workforce'. This would have needed to be regularly reviewed through robust, effective and supportive supervisions with staff, where actions are followed through and staff are both praised and held to account when appropriate."*

5.4.11 **Contractual issues.** Quarterly contract review monitoring minutes evidence that there were some challenges and perceived restrictions for G4S within the contract, an example; young people accessing services during education time. This issue which restricted children accessing health care for example such as substance misuse, psychiatry or psychology during school hours appeared to be a systemic view that became embedded over time and impacted on practice and on the children.

5.4.12 As G4S is no longer providing services to Medway, there were no recommendations in the IMR. There is however an overall recommendation from the Independent Reviewer that G4S should consider the learning from their own IMR process and the overall learning in this SCR and consider implementation in its other service provision in the secure estate.

5.4.13 **Additional learning identified by the Independent Reviewer**

5.4.14 The IMR author has recognised a number of issues, which could have led to some of the concerns identified i.e. that staff were recruited to the STC without previous experience of working with children or with the necessary behaviours/values/attitudes and this was exacerbated by the high turnover. The training and induction was primarily classroom based and did not enable staff to test out the skills needed in real life situations and that without formal supervision to support and enable staff to learn and improve this could lead to poor operational practice. Some of these issues still resonated for the workforce operating in the secure sector today and were raised in discussions had with practitioners /managers in the secure estate and will result in a recommendation.

5.4.15 There is also clearly a difference of opinion between G4S and the YJB over aspects of the contract and differing perceptions of how requirements to comply with children attending education were interpreted and the impact this had on children accessing other services. The key learning issue is that any contract monitoring arrangements need to ensure these practice issues and the impact on children are identified and addressed.

5.5 Her Majesty's Prison and Probation Service (HMPPS)

5.5.1 **A brief summary of contextual information provided by the agency in the IMR**

"In April 2016, the MoJ agreed with G4S to terminate the new contract and bring the Medway service under HMPPS for a period of up to two years, pending a further decision on the future of Medway once the Youth Justice Review is published. By that point, HMPPS will need to consider Medway STC as part of the response to the wider changes in the youth secure estate. 0n 1st July 2016 HMPPS takes over the running of Medway STC from G4S.A clear governance framework oversaw the transition. Whilst this approach established a robust framework to manage the transition, there were areas out of scope from the project board -the principal issue being that HMPPS would have no involvement in the delivery of the service prior to the agreed transition date.

Some of the concerns highlighted were around the uncertainty of staff and that there could be no communication between the new provider and the existing on site staff, this did increase the risk of staff leaving to compound what was already a high turnover rate.

Infrastructure changes were identified, particularly around IT, but again there could be no actual delivery, until after the commencement of the contract with HMPPS"

5.5.2 **Learning and improvements identified from the IMR process for HMPPS**

5.5.3 The IMR Author identifies the amount of work required on taking over the STC had perhaps been underestimated and the challenges were greater than expected. Although new practices and policies had been implemented in line with HMPPS guidance, there were still significant gaps around staff culture, skills shortages and the challenges of speedy and safe recruitment.

5.5.4 There were national arrangements in place in relation to the 'Transfer of Undertakings (Protection of Employment) Regulations 2006 (TUPE) of existing staff to HMPPS and high-level staff information was shared to enable this process. But some locally stored staff records were removed by G4S and therefore some information was not handed over e.g. local supervision records. Overall there appear to have been difficulties in both establishing and sharing information between the implementation board and the site.

5.5.5 The IMR Author has summarised a range of improvements implemented since 2016 in response to the learning:

- Body Worn Video Cameras are now in use across the site and there has been an increase in the CCTV provision, including the areas that were highlighted as blind spots in previous reports.
- The referral process to the LADO for safeguarding concerns has been changed to provide greater assurance.
- There are weekly restraint minimisation meetings, which look at all incidents of Use of Force, to highlight concerns, learning and where appropriate good practice. The LADO is invited to the meeting and attends regularly.
- There are established MMPR (Managing and Minimising Physical Restraint) co-coordinators on site. These staff will de-brief young people after any incident and will take forward any learning points that are required.
- The Barnardo's contract has been reviewed and as well as focusing on advocacy, there is now a stronger emphasis on ensuring the rights of the child are understood and observed. This role effectively establishes the Barnardo's workers on site with the benefit of having quarterly meetings with the Governor.
- The STC now has a youth council which allows all young people to have a voice and to allow concerns to be brought directly to senior managers and therefore allaying potential fears of the children in raising concerns to staff directly.
- Medway STC has implemented a complaints procedure – this allows all children to raise concerns directly and by following the guidance allows young people to submit complaints through the confidential access
- Quality is assured and monitored within the YCS through scheduled performance and assurance returns. These are completed monthly and any data returns are also quality assured to maintain integrity.

5.5.6 **Additional learning identified by the Independent Reviewer**

5.5.7 In discussions with children who had been/were still at the STC, they identified many positive improvements and changes in attitude by senior managers and staff. These are set out in more detail in Section 6 but they identified issues about potential barriers to accessing advocacy and their relationships with their allocated Custody Support Plan (CuSP) workers and the need to be involved in choosing these staff to establish meaningful trusting relationships. Other issues raised were raised directly with the Governor to address.

5.6 Kent Police

5.6.1 **A brief summary of contextual information provided by the agency in the IMR**

"On 30/12/15, Kent Police received information that the BBC had gathered information and documentation relating to alleged assaults by staff on the children at the Medway STC. The incidents ranged from assaults, shouting, bullying and aggressive behaviour. A Senior Investigating Officer was appointed and an investigation commenced with partners under "Operation Woodley". The investigation was set up with an appropriate management structure, dedicated and trained staff, supported by an IT system named HOLMES. (Home Office Large Major Enquiry System).

5.6.2 **Learning and improvements identified from the IMR process for Kent Police**

5.6.3 The IMR Author concludes that prior to the commencement of Operation Woodley, the reporting of crimes committed against children at Medway STC can be described as "stymied" in that their progress had been prevented/hindered. This is evidenced by the number of crimes, which were reported retrospectively into the investigation process.

5.6.4 The IMR Author has accepted that evidence provided from other IMRs over concerns regarding the joint working between the Local Authority, the STC and in particular that of the interaction and lack of escalation by the Police about any concerns regarding the LADO.

5.6.5 The IMR Author identifies improvements that Kent Police at Medway have initiated including a dedicated team to manage reported crime set against an SLA and a Crime Clinic. In September 2017, Kent Police enhanced its ability to manage incidents and crimes committed against vulnerable people including Children and Young persons. The LSCB document, Medway Council - A Guide to Managing Allegations against Members of Staff, has been adopted by Medway police.

5.6.6 **Additional learning identified by the Independent Reviewer**

5.6.7 It is clear that the limited Police response to previous allegations from or about children at the STC combined with an ineffective Local Authority Designated Officer (LADO) function (see section 5.8 below) resulted in an ineffective

response and crucially this was not identified by any internal police management/governance oversight, inspection activity or multi-agency oversight or scrutiny. Concerns about the functioning of the LADO role were not escalated by the Police to the Local Authority. It is recognised that many of the children chose not to pursue an allegation and there needs to be reflection and understanding as to the reasons children do not pursue an allegation against someone where they are living permanently and an attitude and approach by the investigating agencies that supports them.

5.7 Local Authority- Medway Children's Social Care

5.7.1 Learning and improvements identified from the IMR process for Local Authority Children's Social Care

5.7.2 The IMR Author found it difficult to draw conclusions about the overall effectiveness or the consistency of the quality of children's social care function in responding to the concerns about children or allegations regarding staff coming from the STC as during the timeframe of the review there were only three Medway children's cases where there was intervention by Children's Services workers. As identified in the LADO report, referrals into the front door were dealt with by the LADO not Children's Social Care "front door" social workers. Children's social care involvement demonstrate the statutory duties typical for children in the secure estate: two children who were already looked after prior to sentencing. The evidence shows that there appeared to be a good understanding of the duties by all: care planning and reviewing was all up to date, timely and appears to be of a good quality.

5.8 Local Authority Designated Officer function (LADO) - management of allegations.

5.8.1 A brief summary of contextual Information from the agency in the IMR

"Working Together 2015 states that Local Authorities should have designated a particular officer, or team of officers to be involved in the management and oversight of allegations against people that work with children as set out in the Allegations against People who Work with Children Procedure. Any new appointments to such a role, other than current or former designated officers moving between local authorities, should be qualified social workers. Their role is to give advice and guidance to employers and voluntary organisations; liaise with the Police and other agencies, and monitor the progress of cases to ensure that they are dealt with as quickly as possible consistent with a thorough and fair process".

5.8.2 Learning and improvements identified from the IMR process for the Local Authority

5.8.3 The IMR Author describes how the period under review from September 2014 to August 2017 saw significant change and improvement in how the LADO service responded to allegations from the secure estate in Medway. These changes include a complete change in personnel from the Head of Safeguarding and Quality Assurance to the officers in the LADO roles to those who provide

administrative support to the service. Processes and the implementation of that role have changed; in summary, the service has moved from a service that was described by the IMR Author as " erratic and ineffective" to something which fulfils the function of the role of LADO and supports the staff to try to ensure that children in the secure estate in Medway are safeguarded.

5.8.4 An audit of the LADO service was undertaken in 2016 and the scope was to cover all cases referred from Medway STC and YOI Cookham Wood. The audit identified some considerable risks in the service and how it was safeguarding children in the secure estate. Inspections in 2014 and 2015 had also raised concerns about the LADO function.

5.8.5 The IMR notes that due to the secure estate being significant in the work of the LADO service, the 'Medway way' of delivering that service until 2017 was different from other LADO responses. The different roles of 'threshold decision-maker' i.e. about whether the LADO should be involved in co-ordinating the investigations; the LADO role of 'co-ordinator and manager' of the response to allegations; and the combining with the role of 'investigating social worker' in one role – that of the assistant LADO were all different to other responses. The assistant LADOs were self-allocating cases from duty and then going out to see the child as the S47 (statutory child protection investigation) investigation social worker. The three strands of response to any allegation must be clear (criminal; employment/ disciplinary; safeguarding children's needs) and the concepts of the suitability of the adult to work with children should be the focus of those involved. The resultant confusion may have been a factor in the failure of some challenges by the assistant LADOs when trying to affect the co-ordinator and manager role. Another consequence, arising partly from the multiple roles held within the post of assistant LADO, as well as from the style of management of the Senior LADO, was the lack of a strategy meeting to plan the management of the allegation by the LADO.

5.8.6 In the practice seen from 2014-2016, the priority for the LADO service appeared to be proving if the allegation could be substantiated or not, rather than understanding the behaviour of the adult as possibly harmful, criminal or suitable and managing the potential future risk of that behaviour towards children re-occurring and causing harm. It is also clear that there were many delays in response and follow up to the incidents by Medway STC itself and there were examples of escalation by the LADO but with no positive outcome.

5.8.7 **Additional learning identified by the Independent Reviewer**

5.8.8 It is clear from the IMR, and acknowledged by the Local Authority, that the LADO function had been acting in an ineffective manner throughout most of the period of this review until a detailed audit was undertaken in 2016 and the findings and changes implemented in late 2016/2017. The LADO function had operated in a way not seen in most other Local Authorities –the result was that there were few strategy discussions, interviews with children were not undertaken by those professionals who best knew the child from their home authorities, management oversight and supervision were poor, policies were not followed, regular liaison meetings were not held and responses were slow and did not provide sufficient

challenge to the staff and management at Medway STC. There was no operational practice guidance on the management of allegations in the procedures and the approach to the line management of the LADO who may have a specific expertise unfamiliar to most other staff including the line manager appears to have contributed to some serious and undetected deficiencies in the delivery and the management of the LADO response to allegations from the STC. It was not until 2016 that these began to be detected.

5.8.9. There was also no escalation by any other agency/organisation. The key learning point is how ineffective cultures can develop within services where there is no effective quality assurance of the arrangements. There was little quality assurance activity and no audits of LADO practice and no apparent challenge to this function by more senior management. Ofsted inspections raised issues but these were not apparently followed up in a timely manner and the Medway Safeguarding Children Board did not challenge the quality of the LADO Annual reports or other performance information it received as outlined in the MSCB section. The Reviewer will be recommending robust quality assurance arrangements are implemented and monitored by the MSCB and the LA including the outcomes of all disciplinary processes at the STC.

5.9 Medway Youth Offending Team (YOT)

5.9.1 **A brief summary of contextual Information provided by the agency in the IMR**

"The Medway YOT work with young people from Medway on the range of custodial options available to the court when sentencing. During the period under review there were only 6 young people from Medway who were placed in the Secure Training Centre. All of these young people appeared as very vulnerable. The IMR author saw evidence of a robust performance management/ quality assurance framework with regular reporting and monitoring to the internal Medway Youth Offending Management Board and the outcome of a positive peer review undertaken in 2017."

5.9.2 **Learning and improvements identified from the IMR process for Local Authority YOT**

5.9.3 The YOT staff reported that Medway STC caseworkers appeared committed, proactively making contact with YOT staff, ensuring regular sentence planning meetings took place, and ensuring that information was shared about vulnerability, for example increases in self-harming behaviours. The YOT staff described a difference in the approach of the skilled case/ key working staff and the clinicians working at the STC from that of those working on the units, supervising the young people. Their reflection was that those staff did not appear as professional in their approach. The IMR Author identifies that YOT staff had not been told about the allegations by the children they were working with and suggested that staff needed to understand that children do not always recognise their treatment as being abusive.

5.9.4 In summary the IMR Report found that the focus and the direct work by the YOT with the children was of a high standard and would suggest that the service is effective in working to reduce the risk of re-offending through sensitive and respectful practice with this cohort of children. However there is clearly more to do in the future to develop working relationships between the departments and agencies working with the same children as this IMR suggests 'silo' working across what should be a safeguarding system.

5.9.5 **Additional learning identified by the Independent Reviewer**

5.9.6 Other agencies working with the STC should ensure they have the same expectations with regard to the attitude and skills of STC unit staff as the caseworker staff employed at the STC. The expectation of the level of skill and understanding of children should be the same given the significant amount of contact which takes place with the children by unit staff and should be escalated if it is felt to be not reflecting a child focussed approach. This issue is reflected in the conclusion section.

5.10 Medway Safeguarding Children Board (MSCB)

5.10.1 **A brief summary of contextual information provided by the agency in the IMR**

"Working Together to Safeguard Children 2015 states that Local Safeguarding Children Boards (LSCBs) with a secure establishment within their area are required to include a review of the use of restraint within that establishment in the LSCB's annual report on the effectiveness of child safeguarding. Furthermore, a report on the findings of the review on restraint should be sent to the Youth Justice Board (YJB). MSCB have undertaken this specific function and their broader function around ensuring effectiveness of organisations/services in a number of ways:

- *Annual Reports to MSCB - 2014/15; 2015/16 and 2016/17*
- *Completion of quarterly returns to the MSCB dataset scrutinised by the Performance Management and Quality Assurance (PMQA) sub group*
- *Section 11 bi annual returns - 2014/15 and 2016/17*
- *Annual report to the PMQA sub group*
- *Annual reports on restraint"*

5.10.2 **Learning and improvements identified from the IMR process for Medway Safeguarding Children Board (MSCB)**

5.10.3 The IMR author identifies the lack of proper analysis of allegations being presented to the MSCB was a missed opportunity for challenge. Further analysis would be able to identify if it was the same young people repeatedly making allegations, or if the professionals that are subject of the allegations have had allegations made against them before with the STC or previous roles in the secure estate. This information would need to be contextualised but would give greater insight into the nature of allegations and their resolutions. Figures relating to assaults of staff should also be included in future reports. In the most recent

Section 11 it was recognised that there needed to be more challenge around the Section 11 returns. Section 11 champions were invited to attend a forum to share challenges and examples of best practice. The MSCB also used their youth panel to review some services' responses to the area concerning contact with children and service users. The STC and YOI were not part of the challenge from the young persons panel as it was a pilot process, which will be repeated and widened in the 2018 section 11. There is no evidence to demonstrate that the lack of data relating to training has been challenged appropriately.

5.10.4 It is clearer now that previous reports to the MSCB were not as in depth as they could have been to demonstrate what life is like for the staff and young people at the STC. This identifies a need to review the template used by the MSCB for partner's annual reports. The MSCB already monitors the changes within the STC in regards to their improvement plan. Plans are already in place to ensure annual reporting of restraint is more robust and considers safeguarding in a wider context. This will apply to both the STC and YOI.

5.10.5 MSCB have proposed changes to the way they conduct their annual review of restraint. Instead of the narrowly focused review of restraint from limited sources the proposed changes are to:

- Extend the annual review to include the broader range of safeguarding issues.
- Extend the range of organisations from whom the MSCB seek views so as to collect a wider range of comments on safeguarding and the use of restraint. This will include seeking the views of children at the two establishments via the consultative forums in place for them, as well as the advocacy service run by Barnardo's.
- Follow best practice established by Milton Keynes LSCB by discussing this range of views with the Governors of both institutions, together with the government's new director of Youth Custody Operations, or their chosen representative.

5.10.6 MSCB has also established a Secure Estate task and finish group now called the Secure Estate Quality Assurance Group which first met in November 2016 to consider the specific safeguarding needs of children in the secure estate given that Medway is unique in having both the STC and YOI. The group is chaired by the current Governor of the STC and attended by both secure estates, and representatives from police, health, youth offending, Medway Council Quality Assurance and Safeguarding and the MSCB with both the Business Manager and Independent Chair .The aim of the group is to manage the reporting mechanism for the annual review of restraint in the secure estate, to consider learning and support better outcomes for the young people in the secure estates.

5.10.7 **Additional Learning identified by the Independent Reviewer**

5.10.8 The LSCB probably relied disproportionately on the positive inspection reports of the STC from Ofsted to provide assurance. The LSCB has a unique responsibility and opportunity to ensure that they bring together all information and data- both quantitative and qualitative to monitor the effectiveness of safeguarding arrangements at Medway STC. The planned arrangements for the Annual Report

will support this but should also include information from the national helplines and whistle blowing arrangements. The LSCB should therefore consider establishing a permanent sub group of the LSCB to bring together quantitative and qualitative information and data to monitor the safeguarding arrangements and for this to involve those organisations that have a commissioning and provider arrangement with the STC.

5.11 Medway NHS Foundation Trust

5.11.1 **A brief summary of contextual information provided by the agency in the IMR**

"Medway Foundation Trust provides both acute and community services to the residents of Medway and Swale areas. Acute service provision includes all attendance in Accident and Emergency (A&E); in-patient active and Outpatient follow up services. Community services include all services for children and young people with long term medical support, such as ADHD (Attention Deficit Hyperactivity Disorder) and Development delay, looked after children medical reviews, and ongoing medical support for existing conditions. During the specified time frame of the SCR, the main point of contact with young people from STC was through the Accident and Emergency department. Throughout the given period there were 90 unplanned presentations to Accident and Emergency."

5.11.2 **Learning and improvements identified from the IMR process for Medway NHS Foundation Trust**

5.11.3 The IMR Author notes that since the SCR was initiated, the introduction of a safeguarding care plan is now being utilised within Accident and Emergency and the Children's Ward. This closes the gap highlighted with regards to clear documentation and communication with other agencies. However, its use is limited if this information is not shared with the hospital from partner agencies and should therefore be audited. A new safeguarding assessment tool has recently been implemented within the children's accident and emergency department, this tool is designed to prompt clinicians to explore safeguarding wider and recognise the voice of the child. This tool is currently on trial and will be audited within the next few months.

5.11.4 In the cases included within this IMR limited information was gained about the child and limited information passed back to the receiving carer post treatment. In order to safeguard all children from Medway STC, information sharing between agencies is crucial; in order to fill this gap in information sharing the idea of having a transfer of care form has been discussed but has yet to be actioned.

5.11.5 **Additional learning identified by the Independent Reviewer**

5.11.6 There are some key issues with regards to children from the STC presenting at A&E. First, children were presenting at A&E without any information about their past medical history as custodial staff accompanying the child did not routinely have this information. Secondly, staff in A&E were not notifying the children's next of kin of their attendance but relying on the STC custodial staff to undertake this

task. Thirdly, it would appear that follow up outpatient appointments were often not kept. In the Independent Reviewer's view, children's families or their Local Authority if they have looked after status should be notified. The children from the STC needing medical intervention should be responded to with the same quality standard and in the same way as any other child presenting at A&E and outpatient appointments in relation to ensuring follow up appointments are kept.

5.12 Nacro - a social justice charity

5.12.1 **A brief summary of contextual information provided by the agency in the IMR**

"Nacro took responsibility for vocational training and resettlement services from 01 April 2016 under contract with G4S. No staff transferred to Nacro under TUPE. Following the Ministry of Justice (MoJ) decision to take direct management responsibility for the Medway STC from 1 July 2016, Nacro was invited to deliver a second contract for delivery of the full education service including delivery of the curriculum, enrichment activities and the management of three subcontractors - Medway Youth Trust providing Information, Advice and Guidance (IAG) to young people, Medway Mediation Services providing training to staff on family mediation, and Heart of England Training providing external verification and continuous professional development support for the hair & beauty teachers and this began from 1 August 2016"

5.12.2 **Learning and improvements identified from the IMR process for Nacro**

5.12.3 Nacro commissioned an external independent review in 2016/2017, with an action plan to support improvement, and have developed safeguarding procedures for their staff including ensuring escalation is effective. In addition, the NACRO IMR has identified further single agency recommendations.

5.13 NHS ENGLAND (NHS E)

5.13.1 **A brief summary of contextual information provided by the agency in the IMR**

"Responsibility for commissioning health services in secure settings transferred from the YJB to NHS England in April 2013, with responsibility for commissioning health services within the Secure Training Centres (that fell within NHS regulations) transferring in April 2015. In preparation for the transition of commissioning arrangements, NHS England served notice on G4S for provision of the Healthcare services within the STC. A competitive tender process was undertaken to procure Healthcare, Substance Misuse and Mental Health services for the STC, with a service commencement date of 1st April 2015. The procurement was unsuccessful with no bidders meeting the expectations set out in the tender notice. In line with procurement practice, NHS E contracted a provider (Central and North West London NHS Foundation Trust (CNWL)) to provide healthcare services on an interim basis from April 2015 while a full re-procurement exercise was undertaken. Following the second procurement exercise, CNWL were identified as the winning bidder and a 5 year contract was

awarded which commenced 1st October 2015. In compliance with the NHS Standard Contract, Regular Quarterly Contract Meetings commenced in October 2015 and continue to present day. Reports produced by CNWL are reviewed at contract meetings and form the basis for monitoring performance of the contract. The meeting structure and reports conform to national guidance for overview and are in line with specification requirements."

5.13.2 **Learning and improvements identified from the IMR process for NHS E**

5.13.3 The IMR Author's report recognised some limitations in effective commissioning practice and monitoring arrangements and additionally identified that in October 2015 a formal letter was sent from NHS E to the Youth Justice Board (YJB) regarding lack of access to children during the school day and detailing the limitations this placed on providing a healthcare service in-line with national frameworks and equitable to that available in the community. The author could not find a specific response. However, when reviewing the contract meetings notes, it is clear that access to health for children has since improved.

5.13.4 **Additional learning identified by the Independent Reviewer**

NHS E did not request the provider to undertake a review of their practice following the allegations, which would have been expected. Although this was undertaken by the provider CNWL, this was not requested by NHS E as part of their commissioning and oversight role. Additionally national commissioning organisations who are commissioning services in the same setting need to ensure their performance management arrangements are aligned.

5.14 The Children's Society (TCS)

5.14.1 **A brief summary of contextual Information from the agency in the IMR**

"The Children's Society (TCS) worked in Medway STC from early 2014 to 31st of March 2016. The Children's Society service was called Safe Choices which was commissioned by Big Lottery to specifically work with young women leaving care or custody.TCS undertook two types of service provision at Medway STC during the IMR period. A member of staff was employed as a case support worker, working 1.1 with female clients in the centre, and another worked as a group worker with female clients. Both staff worked as part of The Children's Society's Safe Choices services which was particularly focused on girls who had experienced sexual exploitation where this was gang related. TCS staff worked predominately with the resettlement staff covering the female units in the STC."

5.14.2 **Learning and improvements identified from the IMR process for TCS**

5.14.3 The Children's Society staff noted eight incidents in the two years operating in Medway STC. The common issue in these incidents was that residential staff in particular, but also other staff, were not prepared or trained to offer a supportive or caring environment for the girls, some of whom were severely traumatised or exploited. These concerns were escalated. The Children's Society staff reported that on the whole they felt their concerns and complaints, and the complaints of

the children, were taken seriously although there does not seem to have been a culture of feeding back the outcome of complaints and concerns.

5.15 Youth Justice Board

5.15.1 **A brief summary of contextual information provided by the agency in the IMR**

"In September 2015 the Government announced a full review of youth justice to be led by Charlie Taylor[5]. In December 2016, the Government set out its plans to reform youth justice and help drive forward improved outcomes for children in the justice system both in custody and when supervised in the community. Specifically, this included changes to the functions performed by the Youth Justice Board (YJB), the creation of the Youth Custody Service (YCS) and responsibility and accountability for commissioning youth custody services being brought into the Ministry of Justice (MoJ).

The role of the YJB prior to this date of 1/9/17 and over the timeframe of the SCR was:

a. *Commissioner of the youth secure estate and therefore the provision delivered by G4S at Medway STC. As such the YJB had a contract management process in place (alongside the MoJ) to allow for oversight of the delivery of this contract.*
b. *Body responsible for monitoring the youth justice system. As a privately run Secure Training Centre (STC) Medway had an STC Monitor in place at the establishment, in line with legislation, who provided an onsite Monitoring role. This Monitor was a YJB employee and therefore carried out their monitoring function within the wider statutory function of the YJBs to monitor the youth justice system.*
c. *Placing authority for children remanded or sentenced to custody – and therefore was the decision maker for all placement and transfer decisions relating to children accommodated at Medway STC.*
d. *Responsible authority for providing advice to Ministers on the operation of the Youth Justice System."*

5.15.2 **Learning and improvements identified by the IMR process for the YJB.**

5.15.3 The following learning is a summary by the independent reviewer of the learning identified in the IMR. The focus on contract compliance and STC rules did not, as has already been identified by other investigations, enable judgements to be focused primarily on children's safety. In addition, it appears that the granularity of the monitoring activity, which was often focused on resolving individual issues in daily events did not enable the identification of trends or patterns over a longer period.

5.15.4 The conflict that appears to have taken place here presents a point of learning; co-commissioners need to take steps to make sure that their individual

[5] Who was later announced (February 2017) as the new Chair of the Youth Justice Board

requirements do not clash with one another and where this happens that the problem is resolved before the commission is made.

5.15.5 It is apparent from the evidence available that before December 2015, both internal monitoring and external reports on Medway STC had not signaled concerns about the treatment of children by staff. It was not at that time considered a high-risk establishment by the YJB and Medway's most recent inspection, prior to the airing of the Panorama programme, rated it as 'good with outstanding features'. Therefore the reduced performance information available for STCs, relative to that for Young Offender Institutions (YOIs), was in line with the risk-based approach adopted by the YJB. This suggests that information going to the YJB's Secure Estate Governing Body (SEGB) about STCs had already been risk assessed prior to reaching the SEGB.

5.15.6 What is noted from the review is the absence of recorded evidence that decisions taken were sensitive to the needs of children. Through the informal conversations that have been had as part of this IMR process, it can be concluded that discussions on the needs of the child were a strong focus of the YJB's approach. However, it is not evident from the written material reviewed that the impact that those significant decisions[6] would have on the children they affected was communicated through governance chains and within advice to Ministers by the MoJ and its agencies.

5.15.7One of the key points of learning has been with regard to the monitoring approach undertaken by the YJB. As was found by the Medway Improvement Board the balance of monitoring weighed too far in the direction of contract compliance as opposed to the safety and welfare of children.

5.15.8 The YJB undertook a Review of Secure Monitoring (RSM) initiated in July 2016 with the key objective to '*review the YJB's approach to monitoring in the secure estate and implement change*'. This was in line with a renewed focus on keeping children safe, helping them to access their rights, meet their needs and support them to find positive ways back into society. The project was overseen by an Implementation Board, and was introduced fully in April 2017, following a month's pilot period. The RSM project included workstreams to develop and improve advocacy services for children, children's participation, a new performance framework across the secure estate, and incorporating multi-agency input to monitoring activities and the upskilling of monitors. The IMR highlights the progress made by the RSM but in addition highlights additional recommendations.

5.15.9 **Additional Learning identified by the Independent Reviewer**

5.15.10 There were clear challenges in monitoring a contract by more than one function nationally and, as the IMR recognises, the focus was too heavily on contract compliance and less on children's safeguarding and ensuring sufficient access to their voices. There was insufficient alignment of both the national commissioner's

[6] Such as the transfer of Medway to NOMS, and the impact that caps on placement were having on children across the estate

performance management arrangements and ensuring the joining up of national and local monitoring arrangements to ensure a clear and full overview of performance.

6. KEY LEARNING FROM THE INFORMATION REPORTS

6.1.1 The Information reports from the three inspectorates – CQC, Ofsted and HMIP and from the Ministry of Justice provided contextual information to support the Serious Case Review process and this information has been used to inform the analysis and recommendations of the Independent Reviewer.

6.1.2 **Learning from Inspection visits**:

6.1.3 The Ofsted inspection of Medway STC in 2014 stated *"Since the last inspection, the centre has revised its child protection procedures in conjunction with the local authority. The procedures require child protection concerns to be referred to the local authority designated officer (LADO) for consideration. The local authority receives referrals from the centre in a timely manner, usually within 24 hours. There has been delay from the local authority in the progression of some referred matters. Inspectors remain concerned that a number of referrals have not led to the consideration of instigation of Section 47 enquiries. Local authority representatives are aware of these findings and report that structural changes including greater resource will accelerate a review of practice in this area. The centres records do not evidence that there is proactive communication with the local authority to determine action they are taking. Neither are all records kept by the centre of all child protection incidents sufficiently detailed to show decisions made, actions taken and by whom. Work in this area is a priority."*

6.1.4 The Ofsted inspection of the Local Authority in October 2015 contains the following regarding the LADO response: *"Where allegations are received regarding professionals working with children, a specialist team of social work qualified designated officers undertakes strategy discussions and investigations. The team has seen a significant increase in referrals over the last year, prompting additional investment. Despite this, management capacity has been affected. The initial response to allegations is appropriate to ensure children are safeguarded. However, during the inspection two cases sampled by inspectors had not been effectively tracked or progressed. The oversight of referral and investigation outcomes has not been robust in all cases". This resulted in the following recommendation "Take steps to ensure that the progress of all investigations concerning allegations about professionals is robustly monitored until investigations are concluded and outcomes are confirmed".*

6.1.5 **Learning identified by the Independent Reviewer**

6.1.6 Despite this being an area of priority identified in the STC 2014 report and raised again in the October 2015 inspection report about the Local Authority this does not appear to have been given sufficient and timely attention given the operational risk presented.

6.1.7 The information report from Barking and Dagenham Local Authority involved discussions with practitioners involved with the 14 children who were at the STC in the SCR timeframe. The overall theme is one of inconsistency of practice and on occasions a degree of chaos at the STC. There have been examples of good practice, with vulnerable young people being identified and offered appropriate

support and supervision. However, there have also been examples of concerning practice and delay in sharing information as well as one example of the STC refusing to allow a child to be seen alone by their social worker. However there were no concerns escalated.

6.1.8 The Information report from the Ministry of Justice (MoJ) provided some helpful context to the governance and commissioning arrangements, which were put in place in September 2017. The newly created Youth Custody Service (YCS) was established as a distinct arm of HM Prisons and Probation Service (HMPPS). HMPPS is an executive agency of the MoJ (prior to 1st. April 2017, HMPPS was known as The National Offender Management Service or NOMS); the YCS has a dedicated Director directly accountable to HMPPS's Chief Executive. The YCS has operational responsibility for the day to day running of the custodial services for children that are the youth secure estate, and secure escorts; this includes the placement of children remanded or sentenced to custody and the management of performance across the secure estate. The YCS's Director is a board-level member of HMPPS. Alongside the creation of the YCS, responsibility and accountability for commissioning youth secure services is now a function performed by the MoJ. The MoJ, is also responsible for setting clear standards for the provision of youth justice (with advice from the YJB) and for intervening decisively to address poor performance. These changes will enable the Youth Justice Board to focus on its statutory function of providing vital independent advice on, and scrutiny of, the whole system, advising the government on what standards to set for the youth justice system and monitoring delivery of those standards. At the time of the announced changes, the government set out its intention that the YJB should continue to work closely with Youth Offending Teams to promote early intervention in the community and share best practice across the system.

6.1.9 The information report identified the following learning summarised by the Independent Reviewer. There needs to be clear Terms of Reference when groups are established particularly where there may be overlapping areas of focus to clarify roles and facilitate the management of dependencies. There can be no complacency about the systems and structures in place and previous issues around accountability/governance have been strengthened by the new operating model for the youth justice system which is intended to provide clearer, stronger governance and accountability for performance.

6.2 The SCR process requested information in relation to the use of helplines by children at the STC from the Office of the Children's Commissioner (OCC), NSPCC Childline, and the Howard League for Penal Reform.

6.2.1 The Howard League legal service confirmed that during the three year period, it received over 50 calls in respect of around 40 children. Their analysis was limited but their view is that the calls received from the centre during that time related to issues such as resettlement needs on release that staff were largely willing to facilitate (and therefore less likely to relate to criticisms of the child's treatment at Medway) but they did have cause to make a number of safeguarding referrals in respect of children at Medway during that period. No other concerns were raised.

6.2.2 NSPCC - Childline. Their detailed response indicated they had had contact with 21 children during the period of the SCR and identified one had not been referred on appropriately but raised no other safeguarding concerns.

6.2.3 Office of the Children's Commissioner (OCC) - Their response indicated they had been contacted by 3 children and these had raised no issues or safeguarding concerns.

7. KEY LEARNING FROM THE DISCUSSIONS WITH CHILDREN

7.1. The Independent Reviewer had detailed telephone discussions with thirteen children (some are now over 18) who contacted the LSCB in response to the contact made with Local Authorities. Face to face discussions were also undertaken with the Independent Reviewer and the SCR Panel Chair with seven children currently at Medway STC.

7.2 The Independent Reviewer of this SCR would want to recognise the courage of all of these children to make contact and share their experiences and their learning. There was considerable learning for this SCR gained from this process. Key messages for the SCR:

- Unsurprisingly, there was not an overall consensus from discussions with the twenty children. Inevitably most of their experiences were different – some had been at Medway STC for years and some for only a couple of months and at different times before and after the Panorama screening.
- There was universal positivity about the use of “freeflow” introduced by the current governor at Medway STC, which enables children from different units to mix together socially/at meal times etc., and about the range of activities open to them after the school day and at weekends.
- There was universal negativity about the use of lock down due to staff shortages, which results in children being locked in their rooms for differing periods of time at the weekend/after school.
- The introduction of Custody Support Plan (CuSP) officers (1-1 identified personal officer) in 2017 was welcomed although not universally popular if there was a poor relationship.
- The majority of children had experienced restraints - there was a theme that some STC officers are more “heavy handed” than others and more likely to use restraint, and some caused pain. There were certainly examples provided by the young people of perceived excessive restraints in 2014/2015.
- There was a view that historically prior to 2016 staff had picked on children who appeared vulnerable. This included children who did not speak English or were comparatively young or withdrawn or had no external family support.
- Children did describe historical incidents by staff (prior to 2016) deliberately taking place out of sight i.e. under CCTV cameras/where there were no cameras.
- There was a view that response to complaints received a quicker response if the children’s family/external organisation also raised complaints on their behalf.
- There was also a view that physical and verbal bullying between children themselves had been a significant issue historically, which was not addressed but was not raised by current children at Medway STC.
- There was also a view that staff were often disrespectful and inappropriate to each other as well as to the children.
- There was also a powerful view that staff were “mates” who came from the same areas/background and therefore would find it difficult to challenge each other/not support each other.

- There was also a shared view from those currently at Medway STC that was generally positive about most staff and about their genuine interest in them
- Most children were aware of how to make complaints/allegations and were aware of the helplines available to them on the phones in their rooms. Some felt their complaints had been responded to well including direct discussion with the governor in 2017 but some struggled to give examples of any changes as a result.
- The advocacy service provided by Barnardo's was known about by the children but currently appeared to the children at the STC to be less visible.
- One child was particularly clear that there needs to be an independent person who should have a visible presence at least every other day who attends every block and talks to every child to provide the opportunity for discussion. It should not be dependent on the child completing a form given to STC staff or visiting an onsite office.
- Many of the children spoken to were positive about the "education offer" at Medway STC - both in terms of the staff and of the range of learning opportunities - both academic/vocation based.

7.3 All of these key learning messages were welcomed and have been incorporated into the conclusions and recommendations made by the Overview Author. There were no further disclosures made by children. Some specific issues which were raised in the meeting with children currently at the STC, which were formally referred verbally and in writing to the STC Governor who is addressing these.

8. KEY LEARNING from discussions with Managers and practitioners at the STC, a Young Offenders Institution, and a Secure Children's Home

8.1.1 On reflection and discussion with the SCR Panel, it was felt it would be helpful to the SCR learning to meet with practitioners and managers not just at the STC but in a sample of the two other types of secure provision operating in the custodial estate. As a result, the Independent Reviewer and SCR Panel Chair met with 20 practitioners and managers at Medway STC**,** a Young Offenders Institution, and a Secure Children's Home. The discussions focussed on their recruitment, induction, training, and use of restraint and their experiences of working with this group of children. The Independent Reviewer would wish to thank those who gave up their time to engage so constructively in this process and to share their views on improvement.

8.1.2 Key messages for the SCR:

- Practitioners were positive about improvements they have seen in the induction and training offers for staff and the increase and encouragement of arrangements and services to support staff.
- Practitioners at the STC were positive about the changed approach to sanctions for children – i.e. positive points scheme and the increase in out of school activities for the children and the use of "free flow".
- Practitioners were universally positive about the impact of body worn cameras and CCTV.
- There was recognition in the STC of the impact of the visibility of senior leaders and the change in organisational culture.
- There was recognition of the increasing child focussed approach.
- There were some concerns that the initial induction training was primarily "classroom based" and did not enable practitioners to test out their learning/skills in "real life" situations with children.
- There was concern that the new Youth Justice qualification is primarily online and doesn't provide sufficient opportunity to reflect with other practitioners or have direct observation of work with children and also whether this was currently available to all the operational staff.
- There was recognition that there is still no formal supervision process in place at the STC or YOI to enable practitioners to share and reflect on their practice.
- There was concern raised by YOI practitioners that new staff tended to be very young without prior work experience, and that the continued high turnover of staff resulted in a reduction of effective staff role models.
- Restraint is used in secure children's homes but their models do not allow the deliberate infliction of pain. Staff report this as an effective method for managing incidents.

9. CONCLUSIONS, ANALYSIS AND KEY LEARNING ISSUES IDENTIFIED THROUGH THE OVERALL SCR PROCESS

9.1.1 This Serious Case Review recognises that had a number of arrangements been more effective there were opportunities to prevent the abuse of children. The analysis and conclusion reinforce many of the messages about abuse in institutions that have previously been identified through other SCRs and national research. What is indisputable is the importance of safe organisational cultures, which adopt all the required features and are vigilant in their ongoing monitoring and scrutiny, and which can and do protect children. The absence of this culture combined with the fact that the local and national agencies and the multi-agency processes to monitor the STC were not effective in identifying and responding and monitoring allegations of abuse meant children were not kept safe.

9.1.2 The culture of listening to, consulting with and giving children a voice is crucial to developing safe cultures within organisations. This requires organisations to be proactive in enabling opportunities for children to raise issues and concerns in an environment where any potential barriers preventing this are recognised and removed. These include physical barriers enabling identification and an absolute understanding within the workforce that many children will find it difficult to raise issues as a result of their previous life experiences and inability to recognise their entitlement to complain. Even more importantly when children do raise concerns, adults must actively listen, really hear and take protective action, which keeps children at the centre of their thinking and safeguarding practice.

9.1.3 This SCR has also highlighted the overwhelming need for those commissioning contracts and performance managing those contracts involving services to children to ensure that these are developed and are child focussed and to ensure that there are no perverse incentives. The monitoring of these contracts should be aligned with the local monitoring arrangements and services so that the full range of information and data is available to provide a complete overview of performance.

9.1.4 No individual organisation or system ever deliberately sets out not to protect children. Organisations involved in the SCR have responded and welcomed the opportunity to learn and improve safeguarding arrangements. Many organisations in the last three years since the Panorama screening in January 2016 have undertaken extensive independent audits/reviews and implemented significant changes to improve practice. The STC itself has evidenced improvement in culture and practice through inspection and the views of children.

9.1.5 **LEARNING**

9.1.6 The three primary areas of focus of learning for this SCR were:

A. First, how to create safe working cultures within organisations. This covers areas such as safe recruitment, policies and training for staff, the creation of transparent arrangements for staff and children to raise their concerns with effective management oversight and whistleblowing procedures.

B. Secondly, how to ensure statutory agencies and commissioning/contracting arrangements for responding to allegations/concerns about adults who are in positions of trust are effective in protecting children from abuse.

C. Thirdly, how to ensure appropriate and child focussed commissioning practice by national organisations responsible for the contracts for service provision including from the voluntary sector within the secure estate which are informed by local safeguarding arrangements.

9.1.7 The following are the main organisational learning themes identified for the system in keeping children safe in the secure estate with the associated recommendation.

9.1.8 **A. How to create safe working cultures within organisations. This covers areas such as safe recruitment, policies and training for staff, the creation of transparent arrangements for staff and children to raise their concerns with effective management oversight and whistleblowing procedures.**

9.1.9 **Safe cultures for children.** The children in Medway STC over the early period covered by the SCR frequently did not see they had a right, nor that it was safe for them, to complain /make allegations, and the prevailing culture did not support them to do so**.** In addition, children were at times unable to differentiate between appropriate and inappropriate staff behaviour i.e. use of play fighting. Their perspective on the behaviours of staff in the STC can be witnessed as confused and distorted due to their own disorganised attachment behaviours or communication disorders. Children attending the STC presented as increasingly troubled and challenging both to each other and staff, and some staff were unable to manage this appropriately for the child, focusing only on containment. Comparatively low level concerns voiced by children about bullying, racist and sexist remarks and intimidation were not heard and responded to.

9.1.10 There was evidence over the period of this SCR of occasions when low level concerns/complaints about individuals were not recorded or acted upon, discussed or escalated and were seen in isolation. This frequently resulted in the full understanding of concerns/previous behaviours not being available to strategy discussions and not informing the assessment of risk.

9.1.11 This issue was apparent within the STC where the role of the individual in organisations had an impact on children feeling able to raise concerns, and feeling that there was no point in doing so as they had no expectation that engagement with the STC or the LADO or the Police would change their experience.

9.1.12 Custodial staff felt disempowered and accepting of the cultural norm that children need to be contained. Staff at the STC historically were not required to have the skill set or training to work with this client group of children. There appeared to be a difference in attitude and in skill set between STC staff groups acting as case workers, and those officers providing custodial day to day care of children

9.1.13 Staff did not challenge each other/escalate or apparently whistle blow about their concerns. A clear learning from this SCR, and reflected by a number of organisations, is that all STC staff need to be appropriately trained, well supported and supervised to deal with this highly vulnerable group of children- particularly those who have the most contact with the children. The approach and use of supervision and reflective practice used by some of the more effective Secure Children's Homes should be considered and any learning applied and implemented in the STC, as this group of practitioners are part of the wider children's workforce as opposed to part of an adult prison workforce.

9.1.14 The impact of the three different types of secure provision currently operating within the secure estate cannot be underestimated in terms of the resource and capacity to provide a quality offer to these children. It is the view of the Independent Reviewer, based on the evidence from practitioners and children that the three different types of provision are working with children who have very similar levels of complexity and levels of need. Secure Children's Homes (SCHs) work with a significantly smaller group of children and are resourced to provide a staff ratio that enables children to receive high levels of support and for issues such as a child's bedtime to be age appropriate and not one determined time for all children. The opportunity for staff in SCHs to receive regular consistent and quality supervision to reflect on their practice and to improve is embedded in the culture.

Recommendation 1 **Medway LSCB** to re-launch a programme of awareness and training on safer recruitment processes and safe organisational cultures and audit to ensure these messages are embedded.

Recommendation 2 **HMPPS/STC** to consider if the current arrangements for listening to children in the secure estate could be further enhanced and to ensure that there is no confusion for children on who/how to raise their complaints/allegations including with national organisations.

Recommendation 3 **HMPPS/STC** to consider how the role of the Custody Support Plan Officers could be enhanced and responsive to the views of the children.

Recommendation 4 **HMPPS/STC** to consider STC staff undertaking training in Adverse Childhood Experiences (ACE) to better understand children's needs and behaviour.

Recommendation 5 **HMPPS/STC** to consider the implementation of regular formal supervision processes for their staff.

Recommendation 6 **HMPPS/STC** to consider how to better integrate practitioners at the STC within the wider children's workforce in Medway in terms of full opportunities for shared training.

Recommendation 7 **G4S** to ensure that the learning identified in this SCR in terms of developing safe organisational cultures in their provision of services to children in the secure estate is actively considered and disseminated.

Recommendation 8 **YCS** to consider the learning and publish evidence from all the current behaviour management approaches used in the secure estate, reinforced by ongoing training, supervision and modelled throughout the organisation to ensure that there is a consistent best practice offer used with all children.

Recommendation 9 **YCS** to consider how formal supervision arrangements can be implemented within the entire secure estate so that staff are able to reflect and learn on their practice and be held to account if this practice is not improved over time.

Recommendation 10 **YCS** to consider how recruitment of the workforce has a consistent clear expectation of the previous experience of working with children or the values/attitudes required and that children's panels are routinely included in the recruitment process.

Recommendation 11 **YCS** to consider how the new Youth Justice Officer qualification for those in the secure estate can be informed by the best practice used in residential childcare and specific training in adverse child experiences and impact on the behaviour of children and be more integrated with supervised practice experience.

Recommendation 12 **YCS** to consider how the current induction and training programme can better integrate practical experience with children into the programme so that practitioners have the opportunity to reflect and improve on their practice.

Recommendation 13 **Kent Police** to ensure that in all cases involving child victims, the police need to be especially sensitive to the impact on those children of the abuse and their ability to engage in the criminal process.

9.1.15 **Escalation and challenge**. There is evidence from most of the agencies in this SCR that issues around either individuals or processes were not always escalated either within organisations or between organisations. Safe cultures rely on transparent clear procedures and active encouragement by senior managers for practitioners to raise and escalate their concerns within their organisations through whistle blowing and between organisations.

Recommendation 14 **Medway LSCB** to undertake an audit across partner organisations to ensure that all staff whistleblowing procedures are in place and audit their use and outcomes.

9.1.16 **B. How to ensure statutory agencies and commissioning/contracting arrangements for responding to allegations/concerns about adults who are in positions of trust are effective in protecting children from abuse**

9.1.17 **Role of the Local Authority Designated Officer (LADO) in allegation management**

9.1.18 There is a need to ensure there is sufficient LADO capacity to undertake clear recording of concerns and of challenges made by partner agencies during strategy discussions.

9.1.19 There is a need to be clear that the current arrangements allow LADOs sufficient capacity to pro-actively follow up the outcomes of individual agencies disciplinary processes to ensure that they have been undertaken with rigour and to the appropriate standard and to escalate if that isn't achieved.

9.1.20 As with all organisations, LADOs need to be supported in raising challenges and escalation with organisations and this needs to be reviewed and endorsed in procedures and reported into the quality assurance arrangements of the LSCB.

Recommendation 15 **Medway LSCB** to raise awareness of the LADO function through their multi-agency MSCB training and single agency training programmes, and monitor agency engagement/referrals to LADO.

Recommendation 16 **Medway Local Authority** to develop/integrate regular single agency audit/quality assurance activity on the work of the LADO function, and to report this routinely into the Performance Management and Quality Assurance (PMQA) sub group of the LSCB. (9.3)

Recommendation 17 **Kent Police** to ensure all cases referred to Kent Police are discussed with the LADO.

Recommendation 18 **Kent Police** to develop regular single agency auditing activity of the Police response to complaints/investigations from the secure estate which is reported into the LSCB PMQA sub group.

Recommendation 19 **Medway LSCB** to ensure regular multi-agency quality assurance activity of the response to allegations and complaints from the STC and YOI by LADO and the Police.

Recommendation 20 **Medway LSCB** to recommend to all LSCB partner and relevant agencies that their individual disciplinary procedures are undertaken to their conclusion irrespective of the employment status of the individual and whether or not the individual has left employment in the interim.

Recommendation 21 **Medway LSCB** to review the S.11[7] audit tool and process by all partner organisations to request further areas of scrutiny and require evidence of compliance including outcomes of disciplinary processes. (9.3)

9.1.21 **Lack of escalation and challenge of operational practice by statutory agencies and their response to allegations against staff and children**

9.1.22 The LADO service itself and the interface with Police and STC, were not always effective and not undertaking the required management oversight of allegation management. As a result, LADO and Police investigations were limited and many resulted in frequent refusals by children to provide evidence. The overarching function of the management of risk was not well understood by the LADO function itself or communicated effectively and pro-actively with partner organisations/agencies. The Police response was not supported by the LADO

[7] This recommendation refers to s.11 of the Children Act 2006.

function and was hindered by the children's refusal to provide evidence. There was little strategic oversight by both organisations of the data and analysis of individual staff members as responses were generally incident based.

Recommendation 22 **Medway LSCB** to continue to raise awareness of the Escalation Policy to ensure evidence of challenge in all organisations is explicitly encouraged and undertake an audit of dissemination by partner organisations.

Recommendation 23 **Kent Police** To ensure all police practitioners are appropriately trained around issues of safeguarding and particularly around allegations made by children in the secure estate and how to ensure an appropriate and informed approach is undertaken which recognises the particular vulnerabilities of this group of children.

9.1.23 **C. How to ensure appropriate and child focussed commissioning practice by national organisations responsible for the contracts for service provision including from the voluntary sector within the secure estate which are informed by local safeguarding arrangements.**

9.1.24 **Lack of effective local and national monitoring arrangements:**

9.1.25 The SCR has found evidence of silos existing between organisations/within organisations that hindered the sharing of information and did not contribute to a holistic understanding of issues for children in Medway STC. The fragmented analysis of information/evidence provided into different quality assurance systems, both at a national and local level, resulted in fragmented accountability. A number of national bilateral monitoring meetings were being held and are still being held that could become more aligned to minimise duplication, provide more informed overview and thus greater impact of scrutiny. The national monitoring arrangements appeared to have focused on the perceived highest risk sector i.e. children in YOIs not STCs and therefore STCs received a lower level of performance management.

9.1.26 The overarching national contract monitoring arrangements were not informed by the full range of other quality assurance processes that existed locally i.e. the MSCB, and focused on compliance and less on impact to the child.

9.1.27 Some responses to inspection recommendations were not robustly followed/monitored by all agencies. The Local Authority Single Inspection Framework (SIF) Inspection did not identify the severity of concerns re LADO function in 2015 or follow up the STC inspection issues from 2014 re STC/ LA interface.

Recommendation 24 **Medway LSCB** to consider establishing a permanent sub group of the LSCB to bring together quantitative and qualitative information and data to monitor the safeguarding arrangements and for this to involve those organisations who have a contractual arrangement with the STC.

Recommendation 25 **The Inspectorates**- Ofsted, HMIP and CQC to ensure that recommendations made for the Local Authority functions and those in inspections of the secure estate are cross referenced.

9.2 National Contractual arrangements between Commissioners and Providers:

9.2.1 Contracts negotiated at a national level were developed using a standard national contracting arrangement that was not primarily child focused and different functions within the MoJ had different monitoring functions in relation to the contract/provision.

9.2.2 Contracts appeared to include some potentially perverse incentives and were potentially open to interpretation by the provider i.e. financial penalties on the amount of education hours made available and the numbers of children involved in incidents. Contractually advocacy services at that time were unable to refer directly to the LADO but through the STC, which potentially reduced a layer of independence.

9.2.3 Commissioners did not always require oversight of internal provider reviews/audits undertaken to support their monitoring of contracts.

9.2.4 Discussion between different national commissioners was not always effective to ensure that all contracts were child focused.

Recommendation 26 **NHS E** to ensure that any reviews of the quality of safeguarding practice undertaken by providers of health services are scrutinised as part of contract management.

Recommendation 27 **NHS E** to ensure any provision, which is commissioned by another national body and NHS E aligns its performance management arrangements.

Recommendation 28 **MOJ/YCS** and **NHS E** to consider how the contract monitoring arrangements are child focused and informed by the local quantitative and qualitative information/data to ensure a full picture of the effectiveness of safeguarding arrangements is included.

Recommendation 29 **YCS** to ensure that there is robust oversight and reduction in the use of “Lock down” when children are locked in their rooms during times they should normally be outside which measures the impact of low staffing levels/sickness on the care for children

9.2.5 **Transfer of contracts between different providers**

9.2.6 There is some debate and lack of clarity about whether electronic information held by G4S on staff was transferred in full to the new provider, the Prison Service (NOMS at that time). The impact was that the new provider took some time to understand and did not have access to data and information to support the transition process. Additionally communication with existing staff was not allowed prior to take up of contract and given the speed of this transfer was not helpful to support a fully robust transfer. The oversight of the staff TUPE arrangements between G4S and HMPPS by the MOJ/YJB did not effectively anticipate the potential risk in sufficient staffing at the point of transfer given the numbers of staff who left during this time although remedial action was taken by reducing the

cohort of children in the STC. However, identifying a new provider NOMS in a timely manner did take place within a very limited timeframe.

Recommendation 30 – **MOJ/YCS** to consider the learning identified in this SCR for future contracting arrangements including the transfer of arrangements for providers.

9.2.7 **GENERAL LEARNING**

9.2.8 **Organisational knowledge/memory**

9.2.9 As a result of the significant churn in staffing, restructuring within organisations, governance arrangements and changing policy landscape over the period of the SCR, there were numerous examples of changes in staffing/ personnel resulting in a lack of organisational memory and inadequate documents to explain/provide evidence for the evidence base for decisions.

Recommendation 31 - **All organisations** to ensure they retain a clear and cohesive organisational memory by the appropriate level of detailed recording particularly around the rationale for decisions.

9.2.10 **Professional curiosity by all organisations**

9.2.11 Overall there was a lack of professional curiosity demonstrated by practitioners in a number of organisations in relation to these children's lived experience and a lack of response to low level concerns.

9.2.12 There is evidence that A&E /Outpatient staff have provided a limited response to children and were unaware of their medical history and were not notifying next of kin or the LADO directly. Voluntary sector staff operating in the STC, the statutory YJB Monitor, and health staff, as well as visiting professionals from other Local Authorities did not always pro-actively identify or raise low level concerns or did not pursue those concerns.

9.2.13 In addition to the need for staff to be encouraged and empowered to escalate their concerns, staff, volunteers and practitioners need to be encouraged to continually demonstrate professional curiosity in every situation to ensure that they ask and pursue questions, voice their concerns and to "think the unthinkable".

Recommendation 32 **All Local Authorities** who have children placed in the secure estate or host the secure estate to ensure that they engage with a high level of professional curiosity and ensure they ask and understand the child's lived experience.

Recommendation 33 **Medway LSCB** Consider how to raise awareness amongst all practitioners and organisations involved with the STC of the need for vigilance and professional curiosity.

Recommendation 34 **Medway NHS Foundation Trust** to ensure the proposed changes to responding to children presenting at A+E should be implemented immediately and an audit undertaken within 3 months to review progress. This ongoing audit should be routinely reported into the LSCB.

9.2.14 **Use of restraint**

9.2.15 The use of restraint techniques (Minimising and Managing Physical Restraint) that include a final stage allowing infliction of pain on children are the standard practice in STCs and YOIs. The use of such techniques features strongly in the BBC Panorama programme and appeared to enable an environment of increased risk of abuse to children. Children reported that having pain inflicted on them was a highly unpleasant experience. Information from them included inconsistency of its application, often between different officers dealing with the same incident. Children also commented that there were some staff who were quicker to resort to such techniques than others. Restraint practice at, for example, some Secure Children's Homes (SCH), where the stage allowing pain inflicting techniques are not used, showed the successful management with equally challenging children and circumstances as those found in STCs and YOIs, without the need for the use of pain infliction. Her Majesty's Inspector of Prisons have, more than once, made recommendations to the MoJ that the use of pain inflicting techniques on children in STc and YOIs should be stopped.

Recommendation 35 **MoJ** to consider the approach taken by the Secure Children's Home sector in its review of the authorisation of pain inducing restraint on children detained in young offender institutions and secure training centres, and during escort to these prisons and secure children's homes currently taking place.

9.2.16 **Inspection of the secure estate**

9.2.17 The fact that the three elements of the secure estate are subject to statutory inspections under different methodologies and differing legislative frameworks with different standards is difficult to reconcile and provides an inconsistent offer.

Recommendation 36 **Ministry of Justice, Department for Education and Department of Health, and the Inspectorates** to consider how the current different inspection regimes operating within the secure estate can be aligned and operate under a single consistent methodology and grading system.

9.2.18 Future monitoring arrangements

Recommendation 37 **Medway LSCB** to consider the most effective way to provide support and challenge to those organisations involved with this SCR who have clear improvements to make to their safeguarding arrangements identified in the SCR process.

Recommendation 38 **Medway LSCB** to undertake a wide dissemination of the learning from this SCR as it is of relevance to all LSCB partner organisations and national organisations.

APPENDIX A: Terms of Reference

Contents

1. Introduction

Medway Local Safeguarding Children Board (MSCB) has decided to undertake a Serious Case Review following the identification of abuse by staff of children at the Medway Secure Training Centre (STC), which came to light following the broadcast of a BBC Panorama documentary in January 2016. In December 2016 the Medway LSCB Independent Chair confirmed the decision to undertake the SCR and has appointed an independent reviewer and an independent SCR Panel chair.

The review was agreed under guidelines within Chapter 4, Working Together (2015) and regulation 5 of the safeguarding children board regulations 2006.

2. Purpose of the Review

The purpose of the Serious Case Review will be to cover the key areas of inquiry as set out in Working Together (2015) and to follow these principles and those of the Welsh model (2013) guidance for arrangements for multi-agency practice reviews. This is to identify improvements that may be needed and to consolidate areas of good practice

Any findings from the review should be translated into programmes of action leading to sustainable improvements.

The SCR should be conducted in a way which:

- Seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did
- Seeks to understand practice from the viewpoint of the individuals and organisations involved at the time, rather than just using hindsight
- Is transparent about the way data is collected and analysed and
- Makes use of relevant research and case evidence to inform the findings

The SCR will seek to:

- determine why children in the care of Medway STC were abused.
- determine why this had not been identified and acted on by any of the multi-agency processes locally and nationally and by those agencies who hold statutory responsibilities to keep children safe.

3. Scope of the Review

Review Timescale

The relevant time for the review will be from the point immediately before commencement of the 2014 Ofsted inspection of Medway STC which will cover the period from September 2014 to September 2017 when the SCR commenced.

Contributing agencies to the Serious Case Review

This SCR will require contributing information from:

- Barking & Dagenham Local Authority Children's Social Care and YOT
- Barnardos
- Office of the Children's Commissioner (OCC)
- Care Quality Commission (CQC)
- Central and North West London NHS Trust
- G4S
- Ministry of Justice
- Her Majesty's Prison and Probation Service (HMPPS) -previously National Offender Management Service (NOMS)
- Her Majesty's Inspectorate of Prisons (HMIP)
- Kent Police
- National Association for Care and Resettlement of Offenders (NACRO)
- Medway Clinical Commissioning Group (CCG)
- Medway NHS Foundation Trust (MFT) (Acute Hospital)
- NHS England
- Ofsted
- Medway Secure Training Centre
- Medway Council Local Authority Designated Officer (LADO) service
- Medway Council Childrens Social Care
- Medway Council Youth Offending Team (YOT)
- Medway Local Safeguarding Children Board
- Youth Justice Board
- The Children's Society
- Other Local Authorities involved with children placed at Medway STC

This list of contributing agencies will be regularly reviewed and if in the course of the review additional partner agencies are identified to contribute to the process, they will be invited to contribute.

All contributing agencies will be expected to:

- Openly and critically examine their single agency practice; and multi-agency information sharing arising from the lines of enquiry of this SCR; Openly and honestly identify lessons learnt and proposed areas of improvement for their single agency practice.

Individual Management Reviews (IMR) will be required from the following:

Providers

- Barnardos
- Central North West London NHS Trust
- G4S
- HMPPS (previously NOMS)
- NACRO
- The Children's Society

Local agencies

- Kent Police
- Medway Council Local Authority Designated Officer (LADO) service
- Medway Council Childrens Social Care
- Medway Council Youth Offending Team (YOT)
- Medway NHS Foundation Trust (MFT) (Acute Hospital)/ GP provision in Medway- (if appropriate)
- Medway LSCB

Commissioners

- NHS England
- Youth Justice Board
- Medway Clinical Commissioning Group (CCG)

Information reports will be required from:

- Ofsted
- Her Majesty's Inspectorate of Prisons (HMIP)
- Care Quality Commission (CQC)
- Barking & Dagenham Local Authority Children's Social Care/YOT
- MoJ

Additional information gathering will be sought by interviews or letter, with the following:

- Office of the Children's Commissioner (OCC)
- BBC
- Children's Social Care in Local Authorities, YOT and LADO nationwide (process to be confirmed)
- Ministry of Justice

Engaging with Children, Families and professionals

A key part of the review will include seeking the views of:

- Children living at Medway STC during the relevant time
- Professionals who have been involved with the STC

This part of the review will require a separate protocol to ensure appropriate management of potential disclosures, the maintenance of confidentiality and to ensure appropriate welfare support.

Key Lines of Enquiry

The objective is to produce a clear set of recommendations for improvement to both current and any future planned changes to national and local arrangements for management and scrutiny to ensure this vulnerable group of children are adequately protected. Whilst focussing on Medway STC the review will consider the national implications for safeguarding children in STCs.

Individual Management Reviews:

(i) **Key lines and specific focus for IMRs provided by G4S, HMPPS, NACRO, CNWL Health Trust, Barnardos ,The Children's Society as providers of STC services**

- To consider what features of safe organisational cultures were present in Medway STC
    - Safe recruitment
    - Safe workforce policies and practices – staff supervision
    - Whistle blowing and escalation/challenge processes
    - Disciplinary and capability procedures
    - Behaviour management procedures
    - Restraint procedures and incidents
    - Management of allegations
    - Arrangements for children's views and staff engagement
    - Recording of incidents and management oversight
    - Child protection referral processes and practices
    - Visiting arrangements for professionals
    - Equality and diversity

- To consider in the light of their involvement any relevant issues and identified areas of learning

(ii) **Specific focus for IMRs from Commissioners: YJB, NHSE and Medway CCG**

- To determine what National Governance arrangements were in place to manage the performance of provider services at Medway STC and identify any areas for learning and development

(iii) **Specific focus for IMRs from Medway LA- CSC, LADO and YOT, Kent Police and MFT (Acute Hospital)**

- To set out the arrangements for responding to concerns about staff and children at the STC and identify any areas for learning and development

(iv) **Specific focus for IMR from Medway LSCB**

- To set out the arrangements for oversight and scrutiny of the STC and local agency responses and consider any areas for learning and development.

(v) **Specific focus for Information reports from the Inspectorates**

- To consider the effectiveness of oversight and scrutiny undertaken through inspection of Medway STC and identify any areas for learning and development.

4. Serious Case Review (SCR) Model

Methodology

The Serious Case Review will work within Working Together (2015) and the principles of the Welsh model (2013) guidance for arrangements for multi-agency practice reviews, alongside a hybrid approach. Involved agencies will provide either Individual Management Reviews or Information reports or will respond to specific questions set by the panel.

The reports will be factual and based on evidence from agency records and interviews with relevant staff.

Engagement with children, their families, staff at the STC and other professionals to support the learning will be offered through the SCR process. This will be subject to the advice of the Police, and other organisations and the Serious Case Review Panel. One aspect requiring caution is the ongoing prosecution of STC staff. The Panel Chair and report author will ensure no actions occur that could compromise either criminal prosecutions or the review itself and will have access to legal advice throughout.

5. Operational Learning

If at any stage a need for urgent operational action is identified, Medway STC Serious Case Review Panel, through the LSCB Chair, will ensure that the appropriate partner agency (ies) responds immediately.

If at any stage concerns about the welfare of a child(ren) are identified Medway Local Authority/Constabulary will take all necessary action to ensure the child(ren) are safeguarded and protected, in the context of the Kent and Medway Child Protection Procedures.

If at any stage concerns about staff arise, Medway Local Authority Designated Officer (LADO) in partnership with Kent Police and Medway Children Social Care will ensure all necessary action is taken, in the context of the Kent and Medway Child Protection Procedures.

6. Governance

The Medway STC Serious Case Review is commissioned by Medway Local Safeguarding Children Board (LSCB) Independent Chair.

The Medway Secure Training Centre SCR will be overseen by Medway Serious Case Review Panel

The SCR Panel will be chaired by Reg Hooke, an experienced child safeguarding professional who is independent of Medway and is a LSCB Chair in other local authority areas in England.

The Panel will be supported by Alex Walters, an Independent Reviewer, who will produce the final SCR Report. Alex is an experienced child safeguarding professional who is independent of Medway and is a LSCB Chair in other local authority areas in England.

Medway STC Serious Case Review Panel membership

Chair of the SCR Panel	Reg Hooke
SCR Independent Reviewer	Alex Walters
Barking & Dagenham Local Authority	Head of Service, Care Management Service Children's Care and Support
Clinical Commissioning Group, Medway	Designated Nurse
Kent Constabulary	Detective Chief Inspector
Medway Local Authority	Deputy Director Children and Adults' Services
Medway Local Authority	Head of Safeguarding and Quality Assurance
Medway LSCB	Business Manager
NHS England	Director Nursing & Health & Justice Commissioning
Youth Justice Board	Chief Executive Officer
SCR Legal Adviser	Solicitor, Medway Council
Ministry of Justice	Director Youth Justice Policy

The SCR Panel will be responsible for:

- Overseeing the Terms of Reference of the SCR.
- Analysing the themes and trends emerging from the Individual Management Reviews and the Information reports
- Quality assuring the Individual Management Reviews (IMRs) and the Overview Report and ensuring they are completed in a timely way.
- Addressing any immediate safeguarding concerns
- To identify lessons and recommendations emerging from the SCR process either for individual agencies (additional to those identified in their own report), or for the Medway LSCB to improve the multi-agency process; these recommendations and actions will be consolidated in the final overview report.
- The SCR Panel Chair and Independent Author will present the final SCR overview report and associated action plans to Medway LSCB Board,

The panel will meet at critical points in the review to ensure that the Terms of Reference are appropriate and are being met by the work of the agency authors and the overview author.

A minute taker from the LSCB will attend and where required, the Head of Legal Services, Medway, will provide legal advice.

The SCR Panel will draw on any additional expert advice, as appropriate.

Medway LSCB will approve the final findings, recommendations and action plan arising from the review.

7. Time line

The Chair of the Medway LSCB notified the following organisations or individuals of the Medway STC SCR on 22/12/16

- Department for Education
- Ofsted
- National Panel of Independent experts on SCRs

The completed overview report will be presented at an extraordinary Medway LSCB meeting for all Board members to attend.

8. Publication

The final Overview Report will be published on the Medway LSCB website, following endorsement by the Medway LSCB and following conclusion of any criminal proceedings and expiry of relevant appeal periods. The report will be anonymised regarding victims and the professionals involved. A communications and media strategy will be agreed by the Medway LSCB prior to publication.

APPENDIX B: Biography of the Independent Reviewer and Independent Chair of this SCR report

Alex Walters is a qualified social worker with 36 years' experience in children's services and currently works independently as a consultant for improvement work across children's services. Alex has been a Children's Services Adviser for the DfE and was part of the Children's Improvement Board team working with LAs in need of improvement for their safeguarding and adoption performance. Before these national roles she had a range of management roles in local authorities, including 8 years as Assistant Director, Children's Social Care. She has been the Independent Chair of Surrey LSCB 2011-15, Bracknell Forest LSCB since 2011, Swindon LSCB 2015-18, West Berkshire LSCB, Wokingham LSCB and Reading LSCB since 2017. She is the SE Regional Director of the Association of Independent LSCB Chairs and has published 15 SCRs, chaired 10 and authored 2 previous SCRs.

Reg Hooke spent 30 years as a police officer. From 2008 - 2013 he was deputy, then head, of the Metropolitan Police Child Abuse Investigation Command with responsibility for the police child safeguarding function across London.

Since April 2013 Reg has worked independently in the Child Safeguarding field. He has been Independent Chair for two Local Safeguarding Children Boards and currently chairs East Sussex LSCB.

Reg delivers the child safeguarding Multi-Agency Critical Incident training (MACIE) for LSCBs and has conducted numerous Peer Reviews into LSCBs, police and Local Authorities on safeguarding arrangements. He is a trained intermediary for young people and is a trainer in the forensic questioning of child victims. He sits on several national and academic advisory safeguarding bodies and is a trainer in child trafficking and online investigations for the UNDP.

APPENDIX C: Principles Underpinning this Serious Case Review

The conduct of this review has not been determined by any particular theoretical model. It has been carried out in keeping with the underlying principles, set out in the statutory Guidance, Working Together to Safeguard Children 2015:

- There should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the welfare of children, identifying opportunities to draw on what works and promote good practice;
- The approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined;
- Reviews of serious cases should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed;
- Professionals should be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith;
- Families, including surviving children, should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively. This is important for ensuring that the child is at the centre of the process;
- Final reports of SCRs must be published, including the LSCB's response to the review findings, in order to achieve transparency. The impact of SCRs and other reviews on improving services to children and families and on reducing the incidence of deaths or serious harm to children must also be described in LSCB annual reports and will inform inspections;
- The review will recognise the complexity of safeguarding children and seek to understand not only what happened but why individuals and organisations acted as they did.

APPENDIX D: References

This report has been generally informed by the following publications:

- Working Together to Safeguard Children (Department for Education 2015 and 2018)
- CEOP “The Foundations of Abuse: A thematic assessment of the risk of child sexual abuse by adults in institutions” - 2013
- Triennial Analysis of Serious Case Reviews 2011-14 (Sidebotham et al 2016)
- Medway Improvement Board Report- Final Report March 2016
- IICSA - literature review of children in custodial settings.
- 2014 - A Review of Restraint Systems Commissioned for Use with Children who are Resident In Secure Children’s Homes

APPENDIX E: List of Recommendations from the Independent Reviewer

In addition to the large number of individual agency recommendations in Appendix F, the Independent Reviewer makes the following recommendations informed by the analysis of the key issues and areas of learning.

LOCAL LEARNING and RECOMMENDATIONS

MEDWAY LSCB

- Re-launch a programme of awareness and training on safer recruitment processes and safe organisational cultures and audit to ensure these messages are embedded.

- Review the S.11 audit tool and process by all partner organisations to request further areas of scrutiny and require evidence of compliance including outcomes of disciplinary processes.

- To recommend to all LSCB partner and relevant agencies that their individual disciplinary procedures are undertaken to their conclusion irrespective of the employment status of the individual and whether or not the individual has left employment in the interim.

- Continue to raise awareness of the Escalation Policy to ensure evidence of challenge in all organisations is explicitly encouraged and undertake an audit of dissemination by partner organisations.

- Undertake an audit across partner organisations to ensure that all staff whistleblowing procedures are in place and audit their use and outcomes.

- Raise awareness of the LADO function through their Multi-agency MSCB and single agency training programmes and monitor agency engagement/referrals to the LADO.

Professional curiosity

- Consider how to raise awareness amongst all practitioners and organisations involved with the STC of the need for vigilance and professional curiosity.

Quality Assurance

- For the LSCB to consider establishing a permanent sub group of the LSCB to bring together quantitative and qualitative information and data to monitor the safeguarding arrangements and for this to involve those organisations who have a contractual arrangement with the STC.
- For the LSCB to ensure regular multi-agency quality assurance activity of the response to allegations and complaints from the STC and YOI by LADO and the Police.

- For the LSCB to consider the most effective way to provide support and challenge to those organisations involved with this SCR who have clear improvements to make to their safeguarding arrangements identified in the SCR process.
- For the LSCB to undertake a wide dissemination of the learning from this SCR as it is of relevance to all LSCB partner organisations and national organisations.

MEDWAY LOCAL AUTHORITY

- To develop/integrate regular single agency audit/quality assurance activity on the work of the LADO function and to report this routinely into the Performance Management and Quality Assurance (PMQA) sub group of the LSCB.

KENT POLICE

- To ensure all cases referred to Kent Police are discussed with the LADO.

- To develop regular single agency auditing activity of the Police response to complaints/investigations from the secure estate which is reported into the LSCB PMQA sub group.

- To ensure all police practitioners are appropriately trained around issues of safeguarding and particularly around allegations made by children in the secure estate and how to ensure an appropriate and informed approach is undertaken which recognises the particular vulnerabilities of this group of children.

- To ensure that in all cases involving child victims, the police need to be especially sensitive to the impact on those children of the abuse and their ability to engage in the criminal process.

MEDWAY NHS Foundation Trust

- The proposed changes to responding to children presenting at A+E should be implemented immediately and an audit undertaken within 3 months to review progress. This ongoing audit should be routinely reported into the LSCB.

MEDWAY STC/HMPPS

- To consider if the current arrangements for listening to children in the secure estate could be further enhanced and to ensure that there is no confusion for children on who/how to raise their complaints/allegations including with national organisations.

- To consider how the role of the CUSP Officers could be enhanced and responsive to the views of the children.

- To consider STC staff undertaking training in Adverse Childhood Experiences (ACE) to better understand children's needs and behaviour.

- To consider the implementation of regular formal supervision processes.

- To consider how to better integrate practitioners at the STC within the wider children's workforce in Medway in terms of full opportunities for shared training.

NATIONAL LEARNING and RECOMMENDATIONS

Ministry of Justice –Youth Custody Service

- For YCS to consider how the new Youth Justice Officer qualification for those in the secure estate can be informed by the best practice used in residential childcare and specific training in adverse child experiences and impact on the behaviour of children and be more integrated with supervised practice experience.

- For YCS to consider how the current induction and training programme can better integrate practical experience with children into the course so that practitioners have the opportunity to reflect and improve on their practice.

- For YCS to consider the learning and evidence from all the current behaviour management approaches used in the secure estate reinforced by ongoing training, supervision and modelled throughout the organisation to ensure that there is a consistent best practice offer used with all children

- For YCS to consider how formal supervision arrangements can be implemented within the entire secure estate so that staff are able to reflect and learn on their practice and be held to account if this practice is not improved over time

- For YCS to consider how recruitment of the workforce has a consistent clear expectation of the previous experience of working with children or the values/attitudes required and that children's panels are routinely included in the recruitment process.

- For YCS to ensure that there is robust oversight and reduction on the use of "Lock down" as a clear performance measure of the impact of low staffing levels/sickness to provide adequate care for children

- For YCS to consider the learning identified in this SCR for future contracting arrangements including the transfer of arrangements for providers.

MoJ

- For MoJ to consider the approach taken by the Secure Children's Home sector in its review of the authorisation of pain inducing restraint on children detained in young offender institutions and secure training centres, and during escort to these prisons and secure children's homes currently taking place.

- For MoJ to consider how to consider the approach taken by the Secure Children's Home sector in its review of restraint currently taking place.

- For MoJ and NHS E to consider how the contract monitoring arrangements are child focused and informed by the local quantitative and qualitative information/data to ensure a full picture of the effectiveness of safeguarding arrangements is included.

MOJ /DfE and CQC

- For MoJ ,DfE and CQC to consider with the inspectorates the integration of the inspection regimes for the whole secure estate including a consistent methodology and grading system.

NHS E

- To ensure that any reviews of the quality of safeguarding practice undertaken by providers of health services are scrutinised as part of contract management.

- To ensure any provision which is commissioned by another national body and NHS E aligns its performance management arrangements.

INSPECTORATES - Ofsted; HMIP; CQC

- To ensure that recommendations made for the Local Authority functions and those in inspections of the secure estate are cross-referenced.

- To consider with DfE and MoJ the integration of the inspection regimes for the whole secure estate including a consistent methodology and grading system.

G4S

- To ensure that the learning identified in this SCR in terms of developing safe organisational cultures in their provision of services to children in the secure estate is actively considered and disseminated.

General recommendations

- For all organisations to ensure they retain a clear and cohesive organisational memory by the appropriate level of detailed recording particularly around the rationale for decisions.

- For all Local Authorities who have children placed in the secure estate or host the secure estate to ensure that they engage with a high level of professional curiosity and ensure they ask and understand the child's lived experience.

APPENDIX F: Single agency recommendations for their own organisations

Barnardos

1. The internal Advocacy Service Action Plan actions, set following a quality assurance audit in November 2016 have been largely completed. However, there are elements of this plan that can be usefully updated.

2. An opportunity is made for all advocacy and children's rights staff to come together to learn about the Advocacy Standards. Barnardo's will support the improvement of practice across the STCs and YOIs covered by this contract. The monitoring of the take up of advocacy shows an improvement by 300% over the last months of the SCR.

3. The service sets new targets which include service take up and Equality, Diversity and Inclusion targets. The targets should be carefully considered, taking into account the demography of young people in Medway STC. They should be realistic but identify any groups of young people whose use of the service is low and a plan should be developed as to how the target will be met.

4. Barnardo's service reports to MOJ have a strong focus on how well the key intended outcomes that underpin the service have been met and what difference the service has made. These outcomes are:
    - Children in STCs and YOIs are able to identify and freely access Independent Children's Rights and Advocacy Services
    - Children in STCs and YOIs are provided with the skills to enable them to advocate for themselves and are supported at every opportunity to do so
    - Children in STCs and YOIs, who have complex needs and are unable or not wishing to represent themselves are supported
    - The voice of children in STCs and YOIs is heard in particular at key periods where Barnardo's have been made aware of those who are vulnerable and in crisis, through access to proactive Independent Children's Rights and Advocacy Services
    - Raising awareness of the issues facing Children in custody in order to promote resolution and prevention at a local and systemic level.

5. Barnardo's commissions an independent audit of the service in summer 2018 to help evaluate the service impact against these intended outcomes. Following this audit, a new action plan should be created to support ongoing improvement.

Central and North West London NHS Trust (CNWL)

1. Multi-agency partners need to provide CNWL health care staff with updates on safeguarding processes being completed by them. This recommendation also covers better liaison with the LADO and with Medway SCB.

2. The STC health care team should have a visible process for advertising the CNWL complaints process as well as having a clear process for collecting complaints from YP or partner agencies and for feeding these back on completion. Complaints and compliments should be tracked via the local quality governance forum.

3. A bespoke recruitment plan for the STC should be implemented and include specific advertising for the STC, recruitment events that reflect location and consideration needs to be given to financial incentives for joining the nursing team such as golden hellos and or golden handcuffs as well as guarantees of development opportunities whilst in post i.e. non-medical prescribing, minor injury or physical assessment courses. The recruitment plan should also consider a skill mix review of nursing staffing to ascertain if there could be better or different ways to address the needs of the YPs, i.e. the use of band 4 staff.

4. All care plans should be reviewed to ensure that they are consistent with the YP risk assessment and clinical needs.

5. Additional clinical accommodation agreed needs to be in place by the contractual time scale of April 2016. (CAMHS and the Substance Misuse Team are now in the new Health and Wellbeing Centre, while other teams await refurbishment of clinical areas by the HMPPS)

6. A further CQC peer review against the Key Lines of Enquiry (KLOEs) is to be completed in August 2016 to seek assurance that the recommendations within this review are being implemented. The STC will devise an action plan to address areas of weakness in the KLOE evidence files and progress against this will be reviewed in August 2016 and a visit from the quality team is being arranged for December 2017 to review progress of the action plan.

HMPPS/ STC

1. All staff who are transferring under TUPE terms should go through a bespoke initial training programme in order to embed the culture and values of the new organisation from the very outset and support staff in move away from the culture of the previous provider.

2. A bespoke initial training course for staff working in an STC should be developed, as the environment is so fundamentally different to that of a prison or a YOI. This would have allowed for staff to be up-skilled more quickly.

3. Governance and assurance mechanisms, including monitoring arrangements in contracted out sites, should be robust, and focused on safeguarding issues, not just contract compliance.

4. Information sharing process should be improved for transition between providers.

Kent Police

1. Training to ensure the role of the LADO is clearly understood by police in investigations involving Children and Young persons.

2. A review is undertaken at Kent Police to ensure the embedding of the new teams set against the Guidance on managing allegations produced by Medway Council is

effective and supportive in the investigation of allegations against children at Medway STC.

3. Where allegations of crimes made by Young Persons at Medway STC cannot be proceeded with; any repeat suspects must be highlighted to the LADO.

4. A review of the Operation Woodley investigation model should be undertaken to identify both good practice and learning which may assist in preventing future abuse and any learning from setting up this type of enquiry.

Medway Children's Social Care

Rather than a recommendation, the IMR Author suggested a reminder of how important it is to gain the child's experience of the STC, which is evidenced in the good and committed practice undertaken by Children's Services.

Medway Local Authority

1. That Medway Council reviews and relaunches its Supervision policy so that is supports good quality reflective case supervision as well as defining the standards required around the other functions of supervision: competent performance, professional development, support and mediation

2. That the LADO service fully participate in a new joint operational group which focuses on reflective conversations on cases where there are allegations as well as negotiating and agreeing practice standards which define good practice. These will provide a measure against which multi-agency audits and case reviewing can take place, as well as supporting professional challenge and the resolution of differences.

3. That there is a practice standard, which can be implemented immediately. When a child or young person makes an allegation and their experience is examined as part of the safeguarding evaluation, that their experience of any bullying, racism or prejudicial behaviour arising from difference or vulnerability is explicitly considered and understood.

4. The senior management team ensure that their processes for the monitoring of action plans in their area of practice are robust, especially where an action that is not completed may present a real risk to operational delivery and to the outcomes for children. This is particularly key during times of significant organisational change. They may wish to assure the MSCB that their management of this is robust

5. Medway Council should assure itself that where line managers do not hold the same level of expertise or knowledge in a particular specialism as those they are managing, that extra opportunities to understand the business they are managing and to be curious about that business are afforded to the manager and their supervisees. This is particularly and increasing relevant in the climate of increasing austerity.

6. That the LADO service supports, contributes to as well as learns from a multi-agency training and development offer around understanding harmful sexual

behaviour and safer practice for staff working with children in the secure estate that exhibit these behaviours.

Medway Youth Offending Team (YOT)

1. That the YOT contribute and are significant partners in establishing a new joint operational group which focuses on reflective conversations on cases where there are allegations as well as negotiating and agreeing practice standards which define good practice with young people in the secure estate. These will provide a measure against which multi-agency audits and case reviewing can take place, as well as supporting professional challenge and the resolution of differences

2. That the YOT ensure that they challenge and support all professionals and staff within the secure estate to offer consistency in the specialist interventions being made to change offending behaviour and in the approaches to care and supervision offered by staff on the units.

3. That the YOT continue to ensure that they focus on understanding the experience of the young people by working directly as much as possible with them whilst they are in the secure estate.

4. That a working protocol between the Youth Offending team and Children's Services is agreed and embedded so that the expectations around roles and responsibilities in joint practice are clear and can be measured in performance monitoring processes.

Medway Safeguarding Children Board (MSCB)

1. Individual annual reports from the secure estate should routinely include;

    - Statistics in relation the use of restraints, allegations made, consultations and referral to the LADO service and assaults on staff.
    - Include an analysis of allegations management; of allegations outcomes; use of restraints; assaults on staff and general complaints of young people

2. An MSCB representative to attend secure estate review meeting periodically rather than as a standing member, as appropriate.

3. STC to provide quarterly data in relation to training levels and to increase staff engagement with MSCB learning events as appropriate to their required competencies.

4. Implementation of agreed annual report of restraint model, with publication by March 2018.

5. MSCB to review the annual report template for partners.

6. PMQA subgroup to demonstrate appropriate challenge of the STC regarding their submission of data and their analysis.

Medway NHS Foundation Trust

Following completion of this IMR it is evident that there are gaps in delivering services to this vulnerable group of young people and the single agency recommendations are as follows:

1. Liaise with STC health team with reference to implementing an information sharing form to be transferred with child to any attendance with an aim at improving information sharing between agencies.

2. Highlight the need to notify services when children are placed at the STC from other areas- for instance notifying looked after children team of placement so agencies are aware of their placement.

3. Continue to monitor the newly implemented safeguarding care plan and assessment and adjust as needed.

4. Highlight escalation policy in relation to concerns surrounding other agencies.

5. Highlight escalation policy in relation to repeat attendance.

Nacro

1. To promote/identify an evidence base of good practice for scrutiny by external regulators

2. To review and assess progress against action plans in place as part of last year's review

3. Through pre-employment and performance management processes encourage and support behaviours in staff that lead to a safe and encouraging environment for disclosure of the experiences and concerns of children.

NHS England

1. Terms of Reference for all Healthcare related meetings should be established and based on National Guidance and Governance Expectations with review dates.

2. Partnership Agreements should be developed, signed, dated and review dated

3. Action plans from CQC or National Bodies should be detailed and monitored by NHS E as commissioners. Action plans to be updated with progress and closed when completed.

4. NHS England should undertake evidence based quality visits in line with national expectations

5. NHS E commissioners should review internal filing systems to ensure that key documents relating to contracts and contract management, partnership boards, procurements and key event documents are easily accessible and identifiable.

6. NHS E should review contract meetings and their frequency allowing adequate for review of detailed reports and paper submissions to be reviewed and note good practice and lessons learnt.

The Children's Society

1. That for TCS services working in residential settings (and with high need young people) there needs to be a development of the Risk Quality Governance/ Clinical Governance monitoring policy so that incidents of concern are reported and logged, and patterns and a sense of an organisational culture can be assessed.

2. That there needs to be a greater emphasis and regular auditing of whether complaints made by TCS about external agencies, have been followed up, and where outcomes of complaints are recorded in supervision and in Mosaic.

3. That TCS staff receive training on recognising and responding to concerns of institutional failure both within the organisation and when working with partners, including ensuring that matters are escalated appropriately, formally and resolved or escalated further as appropriate.

4. That where TCS staff are working with another organisation as a cooperative arrangement and there is no formal contract in place, it is good practice to have a formal agreement on the nature of the work, the mutual accountability and how concerns and complaints are managed, and tracked

Youth Justice Board (YJB)

1. Where a risk based approach to monitoring performance is in place it should be accompanied by an expected minimum standard of safety for children in the secure estate against which judgements on performance can be made.

2. All central Youth Justice organisations with responsibilities for national governance, and in advising Senior Officials and Ministers should include an '*impact on the child'* analysis within these functions.

APPENDIX G: List of Local Authorities contacted as part of the SCR

Barking & Dagenham
Barnet
Bedfordshire
Bexley
Brent
Brighton & Hove Council
Bromley
Buckinghamshire
Camden
City of London
Croydon
Cwm Taf
Derby
Dorset
Dudley
Ealing
East Sussex
Enfield
Essex
Greenwich
Hackney
Hammersmith & Fulham
Hampshire
Haringey
Harrow
Hartlepool
Havering
Hertfordshire
Hillingdon
Hounslow
Isle of Wight
Islington
Kent
Kingston & Richmond
Lambeth
Lewisham
Lincolnshire
Medway
Merton
Newham
Norfolk
Northamptonshire
Oxfordshire
Peterborough
Plymouth
Portsmouth
Reading
Redbridge

Sandwell
Slough
Southampton
Southend-on-Sea
Southwark
Stoke-on-Trent
Suffolk
Surrey
Sutton
Swindon
Thurrock
Tower Hamlets and City of London
Waltham Forest
Wandsworth
West Sussex
Westminster
Wolverhampton