

## **'Eve' Learning Review Recommendations**

### **Learning Placement decision making process**

#### **Recommendation 1**

The YCS progress the recommendations to address the delay in the complaints system and to establish a Task and Finish Group as set out in the YCS internal review 2020 and ensure the learning from this Learning Review is fed into the Working Group on Asset Plus.

#### **Recommendation 2**

In the interim, whilst recognising that the information provided by the child's YOT worker/asset needs to be thorough and updated, a telephone discussion initiated by the YCS and the child's YOT worker at the point of placement would at least enable a more informed discussion about a child's needs/risks and history of previous placements.

### **Child's Eve's Experience at Medway STC**

#### **Recommendation 3**

When children move and transition to new secure arrangements, the most recent assessment(s) and plans for the child need to be handed over through good case management often described as case formulation.

#### **Recommendation 4**

The YCS Internal review described the development of a Partnership agreement to address the issue of improved working relationships between Health services and the STC staff, but this has not yet been updated. It is therefore suggested that ORSS and the HMPYOI work with the health provider (if externally commissioned) to develop a local agreement to agree operationally how information sharing, relationships and trust can be established to maximise the collective and consistent response to children.

#### **Recommendation 5**

That a review/audit is undertaken of System 1 Post Restraint Healthcare Assessments in HMPYOI to ensure they contains helpful, accurate and up to date information on a child's physical and mental health and needs.

#### **Recommendation 6**

Wider understanding of access to the national Forensic Psychology service needs to be communicated clearly to all Health and HMPYOI and ORSS staff to enable a swift referral for advice/ support to staff in managing a child. The key issue is that the child does not need a formal mental health diagnosis, but their behaviour is predicated on their trauma experience.

**Recommendation 7**

MSCP has an existing escalation process but this needs to be reviewed to ensure it is clear and specifically considers arrangements in the secure estate and is made available to LA staff in the home LA.

**Safe organisational cultures****Recommendation 8**

The issue of completion of safe recruitment checks needs to be escalated and resolved as a matter of urgency by the YJB/YCS. MOJ to ensure organisations that lead on managing the work for recruiting the prison officer workforce in the secure estate that houses children need to embrace and embed safer recruitment practices.

**Recommendation 9**

MSCP to consider how it is reassured that safe recruitment practices are being undertaken by HMPYOI and MSCP to ensure their training for agencies continues and an audit is programmed to quality assure safe recruitment processes.

**Recommendation 10**

The Secure Stairs framework model has been externally evaluated by the Anna Freud National Centre for Children and Families and its findings are due to be published in the Autumn of 2021. It is recommended that the learning from this evaluation is discussed by the Secure Estate subgroup to measure the impact on establishing and maintaining safe cultures and to monitor any recommendations which impact on HMPYOI.

**Recommendation 11**

It would be helpful for the evaluation of the behaviour management framework for HMPYOI and the developing "Restorative Policy" in ORSS and how it applies to the management of self-harm are requested by the Secure Estate subgroup to consider how the beliefs underpinning the policies are reflected and lived out in the behaviour of their staff.

**Recommendation 12**

In addition to routine quarterly performance data on restraints/assaults/self-harm, the Secure Estate subgroup to routinely request assurance from ORSS and HMPYOI on the effectiveness of the QA oversight arrangements of restraints.

**Recommendation 13**

It is suggested that evidence of whistleblowing by all agencies involved with the secure estate is included in the routine performance information submitted to the Secure Estate subgroup.

**Responses to Female Children in the Secure Estate****Recommendation 14**

It is suggested that this report and the Girls Care strategy developed in response is shared with ORSS, HMPYOI and the MSCP Secure Estate subgroup to consider the learning and implement/ monitor as appropriate.

## **Voice of the Child**

### **Recommendation 15**

HMPYOI to consider their complaints system in the light of Ofsted 2019 findings at the STC and both ORSS and HMPYOI to undertake regular auditing /QA activity which is reported routinely into the Secure Estate subgroup.

### **Recommendation 16**

The Secure Estate subgroup should routinely receive performance data from the HMPYOI and ORSS on the engagement of advocates and specific issues arising from their engagement including referrals to the LADO and responses.

### **Recommendation 17**

MSCP to ensure the role of the LADO function continues to be reinforced to all partner agencies involved with the Secure Estate as it is operating a pivotal independent scrutiny role.

### **Recommendation 18**

ORSS and HMPYOI to ensure the Youth Council arrangement in both settings is properly supported including independent evaluation and engagement of children encouraged.

### **Recommendation 19**

MSCP Secure Estate sub group to consider and agree which are the key elements of the Quality Assurance and Performance activity to be reported into MSCP to avoid duplication but ensure sufficient scrutiny to fulfil the SCP's statutory requirements.