Medway Safeguarding Children Partnership

Safeguarding Medway's children together

Medway Safeguarding Children Partnership

ANNUAL REVIEW OF RESTRAINT AND SAFEGUARDING IN THE SECURE ESTATE FOR CHILDREN AND YOUNG PEOPLE

2023-2024

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1. INTRODUCTION

1.1 In December 2008 the Government published an Independent Review of Restraint carried out by Peter Smallridge and Andrew Williamson[1]. This examined a wide range of issues in respect of the use of restraint on children in custody. In their review Smallridge and Williamson recommended that:

1.2 *'Local Safeguarding Children Boards with a secure unit(s) in its area should report on its use of restraint annually to the Youth Justice Board or more frequently if they have concerns. They should also report to HM Inspector of Prisons and Ofsted as appropriate to inform inspections.'*

1.3 This recommendation was accepted by the Government and was first incorporated into *Working Together to Safeguard Children*[2] in 2010. The most recent edition of *Working together*, produced in 2023, reiterates this duty.

1.4 For the period 2023-24, Medway Safeguarding Children Partnership (MSCP) was, consequently, responsible for producing an annual review of the use of restraint in HM Young Offender Institution Cookham Wood.

1.5 The MSCP, through the Secure Estate Safeguarding Assurance Subgroup and in conjunction with the Independent Scrutineer for the Secure Estate, has developed over the past three years a process to seek annually the views of a wide range of professionals and organisations with first-hand, expert, experience of this on both safeguarding and the use of restraint. The MSCP had concluded that extension of the remit of this annual report to include safeguarding was a logical and valuable development of the original guidance contained in *Working Together.*

[1] Smallridge and Williamson were former Directors of Social Services, Smallridge in Kent.

[2] *Working together to safeguard children* is HM Government's standing guide to inter-agency working to safeguard and promote the welfare of children. The most recent edition was produced in 2023.

2. ABOUT SECURE ESTATE IN MEDWAY

His Majesty's Young Offender Institution (HMYOI) Cookham Wood

2.1 His Majesty's Young Offender Institution (HMYOI) Cookham Wood was a closed custodial facility for sentenced or remanded boys under the age of 18. The institution had a wide catchment across southern England and could accommodate up to 120 boys. At the point of when HM Chief Inspector of Prisons undertook the Independent Review of Progress in April 2024 the population was 33 children.

2.2 Education was provided by Novus. Health care services were provided by OXLEAS NHS Foundation Trust, Central and Northwest London NHS Foundation Trust and Open Road.

2.3 HMYOI Cookham Wood was inspected by His Majesty's Inspectorate of Prisons in partnership with the CQC, Ofsted and HMIP. An unannounced inspection of HMYOI Cookham Wood took place in April 2023.

2.4 The Chief Inspector of Prisons conducted an unannounced visit to Cookham Wood YOI, in April 2023 resulting in the Urgent Notification process being triggered.

2.5 Whilst the inspection report noted concerns with restraint, the Urgent Notification did not contain mention of it, nor did the action plan created in response to it. However, the Urgent Notification and resulting Action Plan reference steps to 'make HMYOI Cookham Wood a safer place for children and staff.'

Oasis Restore Secure School

2.6 The plan to open a Secure School in the summer of 2024 continued during this reporting period. The Secure School will be located on the site where the Medway Secure Training Centre (STC) was located. The new site will be run by Oasis Restore, working in conjunction with the Ministry of Justice. Oasis Restore, the working name for the arm of Oasis Trust delivering the secure school, aims to become a registered secure children's home (SCH) with Ofsted. The Principal Director of the project joined the MSCP Secure Estate Safeguarding Assurance Group in 2022 and their membership of this group had continued during 2023-2024. Once open, the Secure School will form part of the MSCP annual review of restraint and safeguarding in future years.

2.7 Secure schools are an alternative to youth offending institutions which place child-focused education, health, and resettlement at the very heart of the youth secure estate. The method of intervention will be underpinned by therapeutic principles designed to build on individual strengths and develop life and social skills that support children's transition back into the community. The concept of a Secure School was first proposed by Charlie Taylor, now the Chief Inspector of Prisons, in a report he wrote for the Secretary of State for Justice in 2017.

3. RELATIONSHIP BETWEEN MSCP AND THE SECURE ESTATE

3.1 The MSCP has had a Secure Estate Safeguarding Assurance Group since September 2019. The group met four times in this reporting year in July 2023, October 2023, January 2024, and March 2024. The Secure Estate Independent Scrutineer, John Drew, chairs the meeting. The primary focus of each meeting has been to review the work of the various safeguarding protective mechanisms (Including those operated by the custodial institutions themselves) that operate in the secure estate.

3.2 Engagement in the Secure Estate Safeguarding Assurance Group meetings throughout the year has been good.

3.3 A standing agenda item was created, where Cookham Wood YOI supply a data set for each meeting, covering the overarching theme of safeguarding and use of restraint.

4. SAFEGUARDING REPORTS

Overview by Independent Scrutineer, John Drew CBE.

4.1 The partnership has continued to maintain a Secure Estate Safeguarding Assurance sub-group in recognition of Medway the place's unusual position, last year, as being the site of one of only five children's prisons in the country, HMP Young Offender Institution (YOI) Cookham Wood on the outskirts of Rochester. This was a national resource, and at any one time accommodates about 80 boys out of a total in England and Wales of approximately 430. These are mainly 16- and 17-year-olds.

4.2 There has remained a high level of engagement from members of the partnership in overseeing the safety of children in the prison, work that is powerfully enhanced by the Inspectorate of Prisons (although they are not members of the sub-group, at their choice). However, a high level of engagement is no guarantee that children in custody are kept safe.

4.3 All England's YOIs represent severe challenges in terms of safety, and in no sense is Cookham Wood an exception to this, indeed at many times the Prisons Inspectorate has identified Cookham Wood as the most troubled and troubling children's prison in England.

4.4 When the Inspectors visited Cookham Wood in 2023 they described the prison as being "in crisis after six years of decline". Under a procedure agreed with the Lord Chancellor the inspectorate issued an 'Urgent Notification' requiring the Prison Service to make immediate changes to the prison.

4.5 The Inspectors found "there was widespread weapon making and nearly a quarter of the children felt unsafe. Solitary confinement had become normalised … and some children did not come out of their cells for days at a time". The Chief Inspector criticised the Leadership Team for lacking cohesion and a failure to improve standards and said staff lacked confidence in their managers.

4.6 Safeguarding partners had been well sighted on these problems and several challenges had been presented locally and nationally about specific incidents in the prison. During the reporting year 2023-2024 we have observed the Governing Governors making determined efforts to improve standards in the prison, and they have been very open with safeguarding partners about the challenges they faced, not least due to very high turnover rates and difficulties in filling vacancies. Despite much extra support from the national leadership of the Youth Custody Service, and regular restrictions on new admissions, it was hard to see significant improvement in these and other areas.

4.7 At the same time the Prison Service came under increasing pressure to find prison accommodation for adult prisoners, and these two pressures, apparently taken together, led the Prison Service to announce in March 2024 that they were going to re-roll Cookham Wood as a prison for adults and move all children elsewhere. This decision was made shortly before the next scheduled inspection by the Prison Inspectorate.

4.8 At the same time steady if not rapid progress has been made towards the opening of Oasis Restore. During 2023/2024 no children were admitted but, out of the period of this annual report, the first children did arrive in July 2024. The plan is that there should be a gradual build up in numbers of children placed at Oasis Restore through the year. In essence the Secure School is seen by the Ministry of Justice as being a complete replacement for Young Offender Institutions.

4.9 The Safeguarding Partnership and others have been in detailed discussions with the leadership of Oasis Restore and are putting a series of arrangements in place, drawing on experience elsewhere including the old Medway Secure Training Centre, to secure safe care for the children at the Secure School.

Average Population

4.10 The average number of children held at Cookham Wood has halved since 2017.

Violence Breakdown: 2023-2024

4.11 In the period of this annual report there were approximately **170** '**child-on-child' acts of violence**, this is down on the previous year's returns of approx. 200, although to note that there was a reducing number of children held in the prison.

4.12 Violence that was deemed 'serious' never arose above 7 incidents per month, lower than last reporting year and was usually below 5 a month.

4.13 There was no consistent pattern to the proportions of violence that took place between children and children, and those between children and adult.

4.14 In the period there were approximately **104 assaults on staff**. Some of these assaults occurred during use of force incidents, others were direct acts of violence against members of staff. Spikes in assaults coincided with staff annual leave periods resulting in children having less time out of their rooms.

Use of Force Breakdown: 2023-2024

4.15 The phrase 'use of force' is used by the Prison Service to mean "the use of force by a member of staff in an establishment" and Prison Service Order 1600 further defines when such use of force will be justified. In many reported

circumstances, force is used spontaneously to prevent or end violent incidents. Children convicted, or remanded, for offences of violence continue to be over-represented in use of force incidents.

There were approximately 386 'use of force' incidents in 2023-2024.

4.16 During 'use of force' incidents Minimising and Managing Physical Restraint (MMPR) techniques, the nationally approved syllabus for prison staff that aims to provide guidance on de-escalation and diversion strategies as well as to describe permissible systems of physical restraint, were used. This included pain distraction techniques.

Feedback from HM Chief Inspectors of Prisons on Restraint

4.17 In respect of specific feedback regarding restraint HM Chief Inspector of Prisons reported the following regarding use of force:

- In the six months prior to inspection 307 incidents of Use of Force were recorded.

- Use of pain-inducing techniques, a high level of intervention for children, was higher than at other establishments.

- Most incidents of force occurred because of risk of harm to others. The incidents that Inspectors viewed seemed justified and proportionate but lacked evidence of attempts to deescalate.

- Inspectors reported being concerned that staff did not respond quickly to a child making a serious injury or warning sign. During the unannounced inspection children had to make repeated communications to staff before action was taken to ensure situations did not deteriorate further.

- The quality of use of force reports varied greatly; some included a thorough account of the incident and what lead up to it, whilst others did not contain any detail about the incident. Too many reports had not been completed which was concerning.

- Oversight of the use of force was reasonable, with all incidents screened for safeguarding concerns and to establish if full quality assurance was required. Whilst this quality assurance had identified issues, this had not yet been addressed at the point of inspection.

- Debriefs with children who had been restraint were not timely. Some took place more than a month after the incident and the child often did not take part.

- Restraint management plans, which alert staff to injuries or conditions such as asthma, were of adequate quality and readily available to staff.

5. LOCAL AUTHORITY DESIGNATED OFFICER (LADO)

5.1 The role of the LADO was defined in statutory guidance Working Together to Safeguard Children (HM GOVT) 2010 and is referenced in subsequent revisions. The MSCP procedures 'Managing Allegations Against Staff Practice Guidance' is reflective of the statutory guidance.

5.2 Referrals received by the LADO are divided into three categories, 'Duty Enquiry', 'Consultation and Advice' and 'Referral Pathway' as not all the referrals received require the same level of LADO intervention.

Duty Enquiry – A contact with the LADO, which after consideration, is not deemed to meet the definition of an allegation.

Consultation – The concerns raised within a referral meet threshold for LADO intervention, however, are not of such concern that they require a full LADO investigation. LADO consultations mainly relate to staff conduct issues which overall tend to be passed back to employers to manage as practice or competence issues rather than formal allegations. Some of these consultations will have an internal investigation or disciplinary process. They are no less important than allegations and can often take as much time as allegation investigations.

Referral - The referral to the LADO service, clearly meets the threshold for a full investigation by the LADO which is most likely to result in a Joint Evaluation Meeting.

5.3 During 2023-2024 the Medway LADO Service received a total of 68 contacts from or about members of youth custody service staff working at Cookham Wood. 41 of these contacts were LADO referrals regarding Cookham Wood staff.

5.4 20 were progressed as duty enquiries, 11 were managed as LADO Consultation and Advice Pathway and 10 met the LADO threshold and were progressed via the LADO Referral Pathway.

5.5 In comparison to 22/23 this was nearly a third down in terms of contacts.

5.6 94% of these contacts were related at least in part to the use of force within the setting.

5.7 Reviewing the year, there are two key reasons for this number of contacts. In the first part of the 23/24 reporting year, there was an experienced Head of Safeguarding in post and alongside the DSW team, lower-level concerns and allegations against staff that were clearly unfounded from the outset were managed via the internal Cookham Wood triage process, with oversight via the LADO clinic and this meant that LADO referrals were then not required for these cases.

5.8 In addition, following the Cookham Wood Urgent Notification, there was a gradual decrease in the population of children in the setting which would likely gradually reduce the number of incidents that could result in allegations.

5.9 In the second part of the reporting year, the Head of Safeguarding changed in the setting and there were also several changes within the senior leadership and management team. There needed to be a focus on the new Head of Safeguarding developing their knowledge and experience in the role and the internal triage process was halted during this time, with additional LADO clinic consultation instead.

5.10 There was also a need to seek and gain assurance in relation to the senior leadership engagement with wider safeguarding themes and patterns as well as specific safeguarding issues. This continue to be a challenge during this period up to the notification of the setting closure as a YOI.

5.11 It should be noted that this was a particularly challenging context for the setting, with a wide range of areas of concern and requirements for improvement and over this period, it became increasingly apparent that these developments were not able to gather traction in timely and consistent manner.

5.12 During this period the Designated Safeguarding Service and the Medway LADO Service, along with the wider Safeguarding and Quality Assurance Service sought to provide clear advice, guidance and direction to support safeguarding within the setting as set out below:

Assurance & scrutiny arrangements:

- Fortnightly LADO Referral clinics (allocated CW LADO)
- Monthly Head of Service assurance meetings with the Governing Governor
- The training and supervision of the Designated Social Work Team
- Quarterly allegation management triage audit dip sampling
- Membership of the Safeguarding and Quality Assurance Secure Estate Meeting
- Safeguarding escalations to the Governing Governor and Deputy Governor
- Quarterly YCS LADO Meeting
- Monthly check ins with the YCS Head of Safeguarding

5.13 In respect of how the establishment has discharged their responsibilities in relation to safeguarding children the golden thread of safeguarding had slowly began to be embedded at Cookham Wood during the earliest part of the reporting period. The key ingredients were prison staff, DSW and the role of the LADO service as set out as follows.

5.14 Prison Staff: There was a stable safeguarding team and an experienced safeguarding governor who had worked closely with the LADO service previously. There was also a sense that the governing governor was demonstrating a commitment to working with the local authority and who articulated that safeguarding child was a key priority.

5.15 DSW Team: The DSW team were becoming more established during this period and evidenced a strong commitment to promoting safeguarding children within the setting. This was evidenced through consistent challenge and seeking escalation where needed to seek to focus on safeguarding whilst navigating institutional and organisational structures within the setting. The DSW team were a key part of the internal triage system within the setting with the added oversight and scrutiny provided by the LADO service.

5.16 The role of the Medway LADO Service: There continued to be a focus on strong partnership working between the Medway LADO Service and the Cookham Wood Safeguarding Team. The role of the LADO Service was clearly understood by the experienced Head of Safeguarding and with the support of the DSW team, and the structure of LADO multi-agency clinic meetings, there was assurance that allegations were identified appropriately, referred to LADO and there was a focus on the safeguarding of children as well as providing a proportionate response in relation to the member of staff, alongside employer support for them. There was a consistent process of the home local authorities being kept informed and up to date in relation to the allegations management process and a growing focus on seeking the voice of the child. There was also a focus on seeking timely internal reviews of restraint and internal investigations.

5.17 Alongside this partnership approach through the year, there were developing concerns regarding the setting's capacity to fully and consistently discharge their safeguarding duties and this required more frequent and focussed LADO clinics and then regular assurance meetings with the setting and the safeguarding service manager and the head of safeguarding and quality assurance. Despite this focus, there continued to be safeguarding issues that required escalation within the setting and the YCS and a concern that the required safeguarding service development was not being embedded in the setting at the pace and consistency required.

5.18 On review, there are several themes impacting this situation including there were staffing changes within the safeguarding and safety team and the senior management team within the setting. This led to transitional processes and a challenge to ensuring a consistent engagement with the safeguarding processes and support that had been established and developed previously. Whilst there was a high level of local authority support and challenge, this situation did not clearly improve on a reliable basis.

5.19 The internal triage process was not operational following staffing changes, and the plan was for this to be reintroduced as key staff settled in their safeguarding roles. However, this did not come to fruition.

5.20 There were also challenges in the safeguarding team and particularly the DSW team in gaining access to CCTV for review and significant delays in internal restraint reviews (MMPR QAs).

5.21 From a local authority perspective for a period of time extending over this reporting period there were concerns regarding a cohort of youth custody officers who indicated significant risks in terms of their safeguarding practice in the setting. There was a concern that governing governors who often came from the adult estate did not fully engage with the level of risk, and it was not clear that effective employer actions were taken to mitigate future risk.

5.22 Risk assessments were a key issue, with advice and guidance provided by the LADO Service, confirmation of risk assessments requested and then indications that risk assessments were not fully implemented or changed without consultation or update to the LADO. This led to some staff returning to fully operational, child facing duties when the allegations had not been fully reviewed from a safeguarding perspective and the appropriate measures being taken. It was noted that there was a number of staff (in comparison with other settings) who continued to work with children whilst having three or more substantiated LADO outcomes.

5.23 There was a developing increase in peer-on-peer violence, including the use of improvised weapons and multi-agency partners including Kent Police and commissioned health services needed to escalate their concerns around this issue and the importance of using all strategic and operational tools to address these concerns.

5.24 There were also continuing issues around the dynamic between safeguarding and corruption and security processes within the setting. The perspective of the local authority was that the setting prioritised security operations in terms of corruption and did not ensure effective information sharing with the safeguarding team and the local authority to ensure that the individual and contextual safeguarding strands were robustly addressed.

5.25 In light of the ongoing picture, the local authority continued to be concerned that the setting was struggling to consistently and robustly exercise their safeguarding responsibilities and as such there was an increase in risk of harm to children.

5.26 It should be noted that there was a complex wider context to this challenging situation including that Youth Custody Service staff not subject to full safer recruitment processes and there is no pre-requisite expectation for staff to

have had experience of working with children presenting with a high level of trauma and risk to themselves and others.

5.27 These raised questions about the skills, knowledge and experience of operational staff in the setting and how this impacted on their responses to the children, particularly in heightened and challenging situations.

5.28 Whilst a wide range of multi-agency training and support was available via the MSCP for senior managers and staff at the setting, there does not seem to have been effective engagement with the local authority or safeguarding partnership offer. This did lead to concerns about the skills and experience within the setting to ensure that there was a committed focus on the safeguarding lens.

5.29 As set out in this report, the local authority provided a range of measures to provide safeguarding advice and guidance and seek safeguarding assurance both in terms of allegations management and wider safeguarding themes and patterns. However, there does seem to have been inconsistent engagement with these measures and this assurance was not consistently provided.

5.30 Overall, from the Urgent Notification in 2023 through to the notice of closure as a YOI and repurposing the setting for the adult estate, there remained ongoing concerns regarding the capacity of the setting to respond to the identified concerns including key safeguarding concerns and develop and embed effective and consistent safeguarding practice improvements.

5.31 In respect of specific concerns relating to the use of restraint officers who were subject to live LADO referrals regarding use of force were often made non-operational, at the point of referral.

5.32 Staffing pressures sometimes meant though that these officers returned to duty, without the allegations management process being fully completed and without consultation with the LADO Service or an effective risk assessment.

5.33 Swearing at children and calling them names was a theme within a number of LADO referrals and also a wider practice issue, that appeared to have been culturally accepted by the setting. Whilst recognising the impact of significant operational stress, there was not clear assurance that this practice was consistently and robustly challenged and where required the appropriate employer action taken.

5.34 Minimal or absence of de-escalatory practice was a key theme in LADO referrals in relation to use of force.

5.35 During the reporting period, whilst there were substantiated LADO outcomes in relation to unjustified or disproportionate use of force, there was no further actions identified by the police for these incidents as they were not deemed to meet the criminal threshold. With these cases, where disciplinary hearings

were held, the follow up was generally informal around advice, guidance and retraining rather than more formal disciplinary processes.

5.36 Within the reporting period, there were occasions where the safeguarding concerns in relation to specific officers who had been subject to an allegations management process were escalated to seek further clarification and assurance of the employer follow up actions. This was not always in evidence and on one occasion the Medway LADO service exercised their power to refer to Disclosure and Baring Service (DBS).

5.37 During the reporting period it was clear to the LADO Service and the wider Safeguarding and Quality Assurance service how to raise safeguarding concerns in relation to the setting and how to raise specific concerns regarding the use of restraint.

5.38 As set out above, there was DSW involvement in the internal safeguarding triage process and the restraint review processes. The LADO Service provided a fortnightly clinic where concerns could be raised, and restraints could be reviewed alongside specific case escalation processes and the regular meetings held with the senior leadership team.

5.39 During the reporting period these channels were part of the regular framework of working together and used consistently to review safeguarding issues and specific allegations management cases.

5.40 Alongside this there were also formally escalated safeguarding issues. One regarded the use of restraint, one regarded peer on peer violence and the use of weapons and one related to the number of children accessing cannabis and other substances within the setting.

5.41 On review of the results of this escalation, it was not clear that the issues escalated were clearly resolved with a positive impact for children.

5.42 During the reporting period, the organisational culture was experienced by the LADO service as quite closed and defensive. Whilst the safeguarding team was seeking to engage with the local authority, there was a wider culture and context which made it difficult to progress significant developments in terms of building an effective safeguarding culture.

5.43 As an example, there were significant staffing pressures at times, staff members had been seriously injured because of incidents with children, inspection feedback was concerning and the overarching message from children was that they did not feel safe in the setting. There was concern that the setting had not been able to take on the collective responsibility for

safeguarding children, with the focus remaining on the safeguarding team within a setting under significant pressure.

5.44 There was a whistleblowing policy in place in the setting, however, the local authority records do not indicate that this was utilised by any members of Cookham Wood staff during the reporting period.

5.45 On identification of certain safeguarding concerns, multi-agency partners took the opportunity to raise concerns and escalate these.

5.46 In respect of ways in which additional safeguarding oversight the framework for the local authority safeguarding oversight and support has been set out in this report as above.

5.47 On reviewing the reporting period and the subsequent closure of Cookham Wood as a YOI and repurposing as part of the adult estate, 2023-2024 was one of significant challenge within the setting and one where organisational safeguarding concern were not consistently and effectively addressed at a senior level. This should not diminish the efforts of the safeguarding team and the DSW team to seek to promote the safety and welfare of the children in the setting, but there do seem to have been persistent barriers to establishing the organisational and practice changes required.

5.48 Alongside this challenging context and noting that closure of the YOI, there were some positive developments during the reporting period including that the YCS published the national safeguarding policy framework in 2023, and the next steps are for each YCS setting to develop their safeguarding practices and processes in line with this framework. This sets out the centrality of children's voices and right to be safeguarded and supported.

5.49 In addition the YCS is progressing a review of safer recruitment of staff within the youth secure estate which should impact the quality and suitability of staff within the sector to work with children who have a high level of vulnerability and risk.

5.50 The YCS have also subsequently commissioned the MSCP to provide safeguarding training to YOI Governors within England.

6. VIEWS OF PROFESSIONALS WITH EXPERIENCE OF WORKING WITH THE ESTABLISHMENTS

6.1 As part of the annual review of restraint and safeguarding in the Secure Estate for children 2023-24, the MSCP Independent Scrutineer for the Secure Estate wrote to several professionals and organisations with first-hand, expert, experience of HMYOI Cookham Wood. As in previous years we invited the professionals/agencies to submit comments on their experiences with the establishment in the way they considered most appropriate but provided them with six questions as guides. We wrote to the following:

- HM Chief Inspector of Prisons
- His Majesty's Prison and Probation Service
- Youth Justice Board
- Barnardo's
- Chair, Cookham Wood Independent Monitoring Board
- The Howard League for Penal Reform
- Medway Youth Offending Team
- Croydon Youth Justice Service
- Brent Youth Justice Service
- Royal Borough of Greenwich Youth Offending Service
- Essex Youth Justice Service
- East Sussex Youth Offending Team
- Kent Youth Justice Service
- Lewisham Youth Offending Team
- Milton Keynes Youth Justice Service
- Surrey Youth Offending Team
- Barking and Dagenham Youth Offending Team
- Bexley Youth Offending Team
- Bromley Youth Offending Team
- Birmingham Youth Justice Service
- Nottingham Youth Justice Service
- Harrow Youth Justice Service
- Redbridge Youth Justice and Targeted Prevention Service
- Hackney Youth Justice Service
- Islington Youth Offending Team
- Lewisham Youth Offending Team
- Southend City Council
- Norfolk County Council
- Suffolk County Council
- Waltham Forest Council
- Wandsworth Council
- Southampton Council
- Newham Council
- Sutton Council
- Southwark Council
- Kingston and Richmond Council

- Central and North West London NHS Foundation Trust, Health Service for Cookham Wood
- Oxleas
- Kent and Medway NHS
- Open Road
- NHS England
- Medway NHS Foundation Trust
- The social workers embedded in Cookham Wood YOI
- The Local Authority Designated Officer
- Novus – Education Service
- Kent Police

6.2 From the letters sent out 12 responses from partners were received, 4 confirming they would not be responding this year. Requests were sent out in June 2024 and a second deadline for September 2024 was set to encourage uptake from agencies involved.

HM Chief Inspector of Prisons

6.3 HM Chief Inspector of Prisons inspected Cookham Wood YOI from 4 April to 20 April 2024. Whilst this is outside of the reporting period, it is being included as the last report on restraint for the establishment. To note feedback from HM Chief Inspector of Prisons relating to restraint and use of force is in Section 4.

6.4 In respect of the establishment discharging their responsibilities in relation to safeguarding children the HM Chief Inspector of Prisons view was that this was not well enough reported. It was known that internal child protection arrangements had deteriorated with the challenge for leaders to embed safeguarding in all areas of work.

6.5 HM Chief Inspector of Prisons noted their concerns relating to the breakdown of behaviour management within the establishment, leading to escalations in 'poor' behaviour, widespread weapon making and nearly a quarter of the children reporting they felt unsafe.

6.6 Staff told Inspectors there was a reluctance to search children thoroughly or challenge threatening or intimidating behaviour as they did not feel supported by colleagues or managers.

6.7 As noted above such was the concern HM Chief Inspectors of Prisons wrote to the Secretary of State for Justice issuing an Urgent Notification about the establishment.

Medway Children's Services, Designated Social Worker Team (DSW) Manager, Based within Cookham Wood YOI

6.8 The DSW has oversight of safeguarding children and young people and the use of restraint within HMYOI Cookham Wood via a range of methods and experiences, including:

- Internal triage process, which can include the use of restraint.
- Oversight of complaints submitted by the children and young people in the establishment.
- Review use of force footage, daily/ dip sample.
- Access to body worn and CCTV footage.
- Access to MMPR debriefs.
- Close working relationship with Barnardo's, advocacy service. Also, complete review for all children who have experienced their first restraint in custody.
- Attendance at the fortnightly LADO referral clinic

6.9 A further method of oversight from the time frame outlined, is of 'planned interventions' as well as the use of national resources, specifically when children or young people are 'at height' due to their being no approved Minimising and Managing Physical Restraint (MMPR) intervention to safely remove children at height.

6.10 As DSWs employed by Medway Children's Services their place of work is within Cookham Wood YOI. The service level agreement between Medway Children's Services and the Youth Custody Services (YCS) outlines that there should be a Designated Social Worker on site 5 days a week.

6.11 Until the point of closure the DSW Team Manager predominantly worked with the Cookham Wood Safeguarding/Child Protection team alongside the Child Protection Coordinator and Head of Safeguarding. The DSW Team Manager formed part of the Senior Leadership Team and on a day-to-day basis worked closely with the MMPR team.

6.12 From being part of the establishments safeguarding team the DSW Team Manager reports multiple Heads of Safeguarding and Child Protection Coordinators, whilst at the point of closure the Safeguarding team were at a stage of stronger collaboration, with a shared drive to shift the narrative around safeguarding. This included becoming more open, with a drive to ensure everyone was aware of their safeguarding responsibilities towards the children and for themselves.

6.13 It was noted that the governing Governor was curious about the establishments safeguarding position.

6.14 Whilst the DSW reports that there were examples of the safeguarding network within the establishment working hard to safeguard children, the balance of promoting safeguarding remained a challenge, particularly when children displayed violent or harmful behaviours

6.15 In relation to restraint during the reporting period the DSW team noted that the internal triage process and LADO referrals were often linked to the use of restraint.

6.16 The Safeguarding teams' own CCTV and access to body worn cameras were disabled for a period.

6.17 Safeguarding, MMPR and Health daily review of footage was trailed during this time to overcome barriers and promote closer working. The strengths included those staff not trained to use MMPR were able to ask questions regarding holds and techniques. The DSM though report that the level of engagement by MMPR staff varied and when there was professional engagement this structure provided the opportunity to have a multi-agency overview of restraint and allowed actions to happen more quickly.

6.18 The DSW report concerns regarding members of operational staff regularly coming to the attention of the Safeguarding team for what could be described as lower-level concerns, but with a risk of a cumulative impact. Linking to the Signs of Safety framework the restraints that fell into the 'grey areas' or had 'complicated factors' where more challenging to evidence or progress to triage/LADO.

6.19 They report having specific concerns relating to full searches under restraint, noting significant variations between practice. This was an area that the DSW team were reviewing and alongside the MMPR driving messages of positive practice, demonstrations and refreshers for staff. Audio quality assurance took place after every full search, whether under restraint or not, but often the driver was in relation to being informed of the search rather than as a true quality assurance process.

6.20 Members of operational staff from the adult estate did not always have the full MMPR training.

6.21 As in the 2022-2023 the DSW team have identified concerns regarding the use of force when a child is at height, incidents at height and the lack of consistency across all operational staff grades remained a concern.

6.22 The DSW is clear how to raise safeguarding concerns in relation to the Cookham Wood YOI, especially to the Safeguarding Governor, Deputy Governor, and Governing Governor. As the DSW Team Manager, processes were in place for concerns to be raised and reported directly to the YCS Head of Safeguarding.

6.23 It was noted that weekly safety/safeguarding meetings did not feel like the appropriate forum to raise concerns relating to safeguarding and restraint. There were meeting structures designed to discuss safeguarding and restraint that did not always feel confidential or appropriate spaces.

6.24 The DSW Team Manager had started to trail a monthly mock Independent Restraint and Review Panel (IRRP) with the governing Governor and department to review cases from the previous month which met the IRRP criteria. The model was productive, providing increased levels of oversight and quality assurance.

6.25 At times there were delays in commencing triage or completing a LADO referral despite the DSM Team Manager stating that an incident had met threshold for either or both.

6.26 The 2022-2023 annual report noted a recommendation for the Senior Leadership team to drive forward staff's confidence is exercising the whistleblowing process; staff needed to receive the message that they are safe to whistle blow. The DSW Team Manager raised concerns during the 2023-2024 period at not being able to the find the establishments Whistleblowing Policy.

6.27 The DSW noted a culture that lacked a drive to work together, coupled with an ongoing lack of understanding by MMPR on their safeguarding responsibilities.

Milton Keynes Youth Justice Service

6.28 Milton Keynes Youth Justice Service confirmed they would not be submitting a response to the review as they had no children placed at Cookham Wood during the time.

Royal Borough of Greenwich Youth Justice Service (YJS)

6.29 During this reporting period two children from the Royal Borough of Greenwich were remanded to Cookham Wood YOI.

6.30 Royal Borough of Greenwich YJS reported experiencing good communication with Health and Case Workers, including Managers.

6.31 Appropriate referrals for support were made by Cookham Wood YOI staff in respect of the children from their borough during this time.

6.32 The Royal Borough of Greenwich YJS were not aware of any known instances in which the use of restraint was used for children from their borough.

6.33 They report being clear on how to raise safeguarding concerns in relation to the establishment stating they were provided with contact details of all relevant staff members. Also, they received the Youth Custody Service Safeguarding Pack which included relevant staff details, details of escalation via the Safeguarding hotline.

6.34 The Royal Borough of Greenwich YJS reported that the escalation policy had been provided.

6.35 They held Child in Care reviews for additional oversight of safeguarding.

6.36 In respect of other representations in relation to safeguarding and/or restraint the Royal Borough of Greenwich YJS noted:

- Clarity about instances in which restraint was required and used
- Medical assessment being provided to all young people following use of restraint.
- Notification to the Local Authority when restraint has been used with opportunities to review CCTV/body worn cameras.
- Careful and compassionate consideration of how parents are notified following use of restraint.

Kent Youth Justice Service (YJS)

6.37 The role of Kent YJS is to support those who have come to the attention of police and receive either an out of court disposal or a sentence.

6.38 In addition to its statutory duties, the Kent YJS also

- Fulfils duties to victims of crime

- Provides restorative justice opportunities for both victims and for offenders.

6.39 Kent YJS attended Cookham Wood on multiple occasions during the reporting to support Kent children in custody. This included planning meetings, reviews pre-release and welfare visits and across the roles of youth justice practitioners, social workers and independent reviewing officers.

6.40 Kent YJS had a Transitions Practitioner who worked at Cookham Wood approximately 2 days per week, who had access to most areas of the establishment.

6.41 The Kent YJS Service Manager attended monthly virtual Head of Service meetings with the Governor senior management team focused on the improvement plan.

6.42 Safeguarding concerns identified in the HMIP Inspection resonated with the Kent YJS experience of Cookham Wood over this time period. These included increase in “makeshift” weapons, lack of access to external support services, length of time children were kept in their rooms and limited access to education. Kent YJS state that several children they had supported within the prison had either been perpetrators or victims of knife incidents in Cookham Wood. The carer was not notified of this incident.

6.43 Kent YJS reported that during the period Kent children were subject to assaults by other children due to “gate slips” resulting in the mixing of children from different landings.

6.44 They report that responses were received when raising safeguarding concerns, however, were not always followed to a satisfactory resolution.

6.45 Section 47 enquires were appropriately actioned by Medway Children Social Care.

6.46 Kent YJS stated that there were no specific concerns in relation to the use of restraint.

6.47 The Transition Practitioner had regular contact with all Kent children to enabled additional oversight of safeguarding concerns. This contact also enabled children to communicate any concerns they may have had.

6.48 Kent YJS staff know how to raise safeguarding concerns in relation to the establishment and the escalation process.

6.49 Kent YJS confirm they have whistleblowing arrangements in place, but staff have not used these.

Brent Youth Justice Service (YJS)

6.50 During the period pertaining to this review, Brent YJS had 4 children detained in HMYOI Cookham Wood on remand.

6.51 They report Cookham Wood discharging their responsibilities well in relation to safeguarding children known to Brent YJS.

6.52 Brent YJS report no concerns related to restraint and children known to their service.

6.53 Brent YJS report that it was clear to all staff as to how to raise concerns relating to safeguarding and restraint via the Safeguarding Lead for Cookham Wood as outlined in the Youth Custody Safeguarding Contact pack.

6.54 They report that they have whistleblowing arrangements in place but have not used them.

6.55 Brent YJS report that Multi Agency Resettlement and Aftercare meetings were held to discuss remanded or sentenced children within the secure estate included safeguarding concerns are an agenda item. The allocated case manager from Cookham Wood was invited to all meetings for children within the establishment.

The Howard League for Penal Reform

6.56 The Howard League for Penal Reform confirmed that they would not be submitting a response to the review.

Croydon Youth Justice Service (YJS)

6.57 Croydon YJS had seven children sentenced or subject to remand during the reporting period.

6.58 Croydon YJS reported that Cookham Wood YOI were inadequate in how they discharged their safeguarding responsibilities. They noted staffing issues, linked to poor staff retention, sickness and inexperience having a negative impact on the support offered and the establishments ability to deliver a safe, productive regime.

6.59 They noted that many children spent too long in their cells and could not access education or other rehabilitative programmes. Noting, that children were frustrated to not be given access to programmes, education or gym use due to staffing issues.

6.60 At least half of children said that they did not feel safe, citing assaults by other children as a concern.

6.61 Croydon YJS reported being clear on who to report safeguarding concerns within the establishment, via Resettlement Worker and HMP Safeguarding teams.

6.62 They note that all Croydon YJS staff and the Resettlement Practitioner had contact details and were aware of the escalation process, with Resettlement and Safeguarding manager to be contacted as required.

6.63 Croydon YJS report using these channels to raise safeguarding concerns, who generally responded to enquiries in a timely manner and provided feedback.

6.64 Croydon YJS confirmed they had whistleblowing arrangements in place within the local authority and were not used.

6.65 In respect of other representations in relation to safeguarding and/or use of restraint Croydon YJS noted:

- Adequate staffing levels
- Stable staff, low retention rate, too many changes of staff
- More experienced staff

Nottingham Youth Justice Service (YJS

6.66 Nottingham YJS confirmed they would not be submitting a response to the review as no children from their area were placed at Cookham Wood YOI during this reporting period.

Redbridge Youth Justice and Targeted Prevention Service

6.67 Redbridge Youth Justice (YJS) had two children placed at Cookham Wood YOI during the reporting period.

6.68 Redbridge YJS Bail and Remand Worker attended Remand Management Review and subsequent three-monthly Sentence Planning meetings.

6.69 In addition the Case Manager attended several EST meetings during the period when one child was withdrawing from interacting with others and needed enhanced support.

6.70 Redbridge Mentors and Social Workers also kept in contact with the children.

6.71 Redbridge YJS described the children as both victims and perpetrators of violence and that safeguarding measures were taken to reduce the risks of both children becoming victims and being involved in further incidents.

6.72 One child was the victim of assault twice and Redbridge YJS made email contact was made with the Head of Resettlement and Head of Safeguarding in relation to this.

6.73 They also note raising concern around the delay in booking initial planning meetings and legal visits. Providing an example of staff being turned away from the establishment due Cookham Woods YOI administrative error.

6.74 Redbridge YJS did not have concerns in relation to the level of restraint.

6.75 With regarding to how staff would raise safeguarding concerns in relation to the establishment Redbridge YJS noted that it would depend on the situation, describing how they would first speak to the Resettlement Practitioners within Cookham Wood YOI. Also, they would and have on occasion contacted the Head of Resettlement and Head of Safeguarding.

6.76 Redbridge YJS noted that they would escalate to the Youth Justice Board and make a referral to the Local Authority Designated Officer if necessary.

6.77 When Redbridge YJS contacted the Head of Safeguarding and Head of Resettlement to raise safeguarding concerns regarding one child responses were slow due to changes of staff.

6.78 Redbridge YJS confirmed they have whistleblowing procedures in place but have not used them in relation to the establishment.

6.79 Additional ways that they had oversight of safeguarding included ensuring meetings were taking place for the children, encouraging correspondence with the children through workers/mentors and discussing with other YJSs.

6.80 In respect of other representations in relation to safeguarding and/or use of restraint Redbridge YJS noted that the findings from the review are disseminated to all Youth Justice Services with clear recommendations on keeping children safe, up to date safeguarding points of contact and whistleblowing policies.

Birmingham Youth Justice Service (YJS)

6.81 Birmingham YJS confirmed they would not be submitting a response to the review as no children from their area were placed at Cookham Wood YOI during this reporting period.

Hackney Youth Justice Service (YJS)

6.82 Hackney YJS confirmed they had 3 children remanded to Cookham Wood YOI during this reporting period. One child was remanded and sentenced to Cookham Wood YOI.

6.83 They described their usual processes of organising remand planning meetings within 5 working days and monthly reviews thereafter. Legal visits would be arranged to children by their practitioner and ad hoc bases the YJS practitioners liaise with the Resettlement Case Workers for each child.

6.84 In respect of how well Cookham Wood YOI discharged their safeguarding responsibilities, Hackey YJS noted that from observation of staff and processes in place the emphasis and blame was placed on the child, not the staff. Understanding the difficulties the children face will help in the responses of how conflict is escalated. Restrain teams seemed to not always have a clear understanding of trauma.

6.85 Hackney YJS noted that YJSs operate on a trauma informed model and restorative model to ease conflict and encourage a better understanding, and this was not witnessed in many Cookham Wood YOI staff.

6.86 In respect of specific concerns regarding restraint Hackney YJS noted one incident, the lack of detail and limited information relayed on what the restraint looked like, the impact, any harm caused leaving professionals needing to follow up with the establishment. It was also noted that often the Resettlement Officers where relaying information where they did not know the detail as was second hand information, with no information for example of the context for the restraint.

6.87 As with other YJSs Hackney noted the Youth Custody Safeguarding, noting whilst it was useful as it names staff in each establishment it does not outline the process for raising safeguarding concerns.

6.88 Hackney YJS reported that ordinary practitioners and managers would escalate concerns first via the Resettlement Workers, then to safeguarding leads and/or governors, then finally YCS.

6.88 They also note that most safeguarding issues are dealt with via the Resettlement Workers who answer question which may prevent escalation. Hackney YJS are also of the view though that restraints should all be considered from a ‘different light’.

6.89 Hackney YJS confirmed they had not used the escalation channels in this reporting period.

6.90 They confirmed they had an internal process for whistleblowing and would report directly to the LADO.

6.91 In respect of additional safeguarding oversight Hackney YJS reported a concern was around information sharing and timely responses to the use of restraint or when a young person is involved in conflict. Information came from Resettlement Workers or from parents, rather reported formally via the secure estate.

6.92 Hackney YJS also notes that a child was involved in an incident the information is very vague and sometimes appeared negative towards a child and with minimal clarity on what happened before and after.

6.93 Hackney YJS provided the following in terms of other representations and/or recommendations in relation to safeguarding and restraint:

- Clear reports to be written up highlighting what happened, how a child was feeling prior, how they were presenting, words to describe what restraint was used and a plan moving forwards. Much more detail is required for us to support prevention and understanding
- The member of staff involved in the restraint to be the author of the statement which is shared with the child and have the child agree and sign documents. If a child sometimes disagrees with what was written and then the staff chairing the meeting is unable to help or clarity
- Should a restraint be used- senior staff or preferably independent staff to scrutinise the restraint and provide advice to staff on how better to restrain young people.
- Escalations in restraint – for example four staff restraining a child should have a staggered response and a justification as to why four staff were required. Restraints should be a step-down process not, step-up.

7. THE VOICE OF THE CHILD – THE VIEWS OF THE CHILDREN AND YOUNG PEOPLE AT HMYOI COOKHAM WOOD

Methodology:

7.1 As with the 202—2023 process it was agreed that approaching representatives who are on the Junior Leadership Team (JLT) overseen by Kinetics would be a good starting point of who to interview. This would be around 6 young people.

7.2 It was agreed that the MSCP Business Unti Learning and Development Officer would arrange a visit to meet them individually and would focus on broader safeguarding alongside restraint:

- Time out of room
- Education sessions
- Experiences of the type of force and restraint
- Reported injuries following force or restraint
- Debrief with Barnardo's following restraint
- Who can I talk to?

7.3 An Information sheet on the MSCP was provided. Accessible and visual activities accompanied these topics to prompt discussion including a body map to show how restraint had been used on them, a traffic light activity to indicate if following restraint Barnardo's has debriefed them, and other postcards to record their views.

7.4 **Visit and interviews – 10th October 2023**

On 10th October 2023 the Learning and Development Officer visited and met two Designated social workers (DSW) at HMYOI Cookham Wood. The DSW's enabled the planned interviews to go ahead in the best way possible on the day. The original plan of Kinetics supporting the interviews did not occur on the day due to staffing absence/communication. It was agreed that the DSW would select representatives based on their availability on the day. On the day of the visit there were no young people from Medway residing at Cookham Wood.

6 young people were involved, due to time constraints this led to 1 full in person interview, 4 telephone interviews and 1 declined. The in-person interview was the most informative, telephone calls less so. One young person declined to take part stating, "*I haven't been restrained so I can't help".*

Young person 1 (YP1) – full interview with 2 duty social workers present:

This young person had recently turned 18 years of age and had been at Cookham Wood for over a year. They had recently joined the Junior Leadership Team and were self-separating when they took part in the interview. When shown the activities, the young person said, "I don't read or write very well" and instead notes were taken. The following provides a summary of the interview with YP1

- **Time out of room: What do you enjoy doing?**

YP1 shared they spend have 30 minutes per day for exercise. Wanting more time each day for exercise, education 'dine out', 'associate' and 'community' whilst trying to manage avoiding trouble - "*I am staying in my room a lot to avoid trouble. There have been groups on the landing and weapons, I want to avoid this".*

- **Education sessions**

YP1 shared the aspects of education that they liked and didn't like. They reflected on their previous education experiences and how this impacts now - "*I've been opting out – I missed a lot of primary school and I was kicked out of secondary school, I've been opting out of going"*

YP1 talked about the impact of staffing and choices in terms of education opportunities - *" I can't do barbering – I don't think there are any staff. The pathways are limited, my future ambitious are care work or music.*

- **Experiences of force or restraint**

YP1 reported being subject to 10 or more restraints and that "*being restrained is stressful".* They shared their first experience of being restrained, suffering an asthma attack and passing out. It is important share this experience in their own words –

"They took me to my room and they sat me up and I had my inhaler. A healthcare worker came to see me, my cuffs had been removed. There were a lot of staff around when I was restrained, they restrained my wrists and ankles"

YP1 described how on occasion they have had their head held down so that they did not spite as staff and sharing "*but I won't spit"*

They also talked about how they avoid trouble – "*I can feel it coming and get away".* How they observe behaviour of other children and flags like "m*ostly it starts with people doing petty wind ups, saying things to you, petty things".*

YP1 also talked through their coping strategies such as "*I have ear plugs if they are getting noisy and shouting. I am spending more time in my room; I can manage better"*

Do staff talk to you to try and calm situations down?

YP1 named officers and described how they helped – "*yes if you are calming down they notice that and tell staff to back off. Other officers are quick to restrain you. I will go to my room if I feel trouble is coming".*

Experience of injuries from force or restraint:

YP1 shared how being restrained impacted on their pre-existing health need – "*I have had 2 asthma attacks when restrained, I had medical care, I have my inhaler".* They shared that they had not been injured as a result of being restrained, which was taken to mean physical injury*. I have an epi pen too – I'm allergic to shellfish. No- I haven't had injuries after being restrained.*

- **Debrief with Barnardo's following restraint**

YP1 had experience of a debrief following restraint and that "*I have been in contact with them more often".*

- **Who can I talk to?**

YP1 shared that their Dad wasn't "*answering my calls at the moment".* They noted there were staff they could talk to, other family members and family friends. They also shared the services they had been talking to including the drug and alcohol team. Importantly "f*amily visits are good – I think it is once a month".*

7.5 Telephone interviews with four young people:

Due to the daily regime and staffing levels after lunch time we attempted telephone interviews as all young people were in their rooms at this time. At the start of the phone call the purpose of the telephone interview was explained and they were offered the opportunity to take part (voluntarily) or decline.

YP – Young person

The interviewees shared the following:

Time out of room: What do you enjoy doing? Young person's views	
YP2	*I'm locked up most of the time, all day in my cell. There are not enough staff. I go to the exercise yard once a day, 30 minutes on a weekday and 1 hour on a weekend. Once a week I go to the gym. I like the gym and exercise. . Once for 2 days I had no exercise. Education is not happening. I've got a TV, phone, laptop in my room. I am meant to self-study – but there's no work on there.*
YP3	*I haven't been to education today – I can't because of a 'keep apart' issue. I do get some exercise but I am on my own 23 hours a day. I have a phone, laptop and TV.*
YP4	*I have done some construction – but I'm not getting exercise or other education.*
YP5	*Yes I have been to education but it is s**t, staff are s**t and unqualified. I like gym and exercise.*

Experiences of force or restraint Young person's views	
YP2	*Yes, I have been restrained three times. It wasn't major – I can't complain. They restrained my arms, crossed my legs and lay me on the floor in my room and then leave.*
YP3	*Yes I have been restrained two times., holding by my arms, legs and back of the neck, they take me to my cell and lay me down.*
YP4	*Yes I have been restrained twice, by my arms and returned to my cell.*
YP6	*No I have never been restrained.*

Debrief with Barnardo's following restraint Young person's views

YP2	*No I don't remember speaking to a Barnardo's person. Once though when I had no lunch in room I asked for help and they gave me a sorry card. I didn't understand this. I didn't get any lunch that day.*
YP3	*No*
YP4	Telephone call ended

Who can I talk to? Young person's views	
YP2	*If I have phone credit I can speak to family, my sister. There are no staff I talk to here. There is no rehab. I know we have done wrong, but some people's mental health is going down and they are getting lonely.*
YP3	*Family – telephone call ended*
YP5	*Yes I talk to my family*

7.6 Wider views of Cookham Wood:

YP2 asked that his views be shared regarding the day-to-day regime. He said that when inspectors are in the building the regime and activities run, when they leave "*we are all locked up most of the time*". The YP referred to it as being "corrupt". They expanded saying that "*we are told there are not enough staff to move us around, then there is an incident and loads of staff appear."*

7.7 Findings:

This is a small sample of the population at HMYOI Cookham Wood so this may not be fully representative. YP1 appeared to be speaking openly and honestly about their experience.

One young person had not been restrained and five had. The five who had experience restraint all consistently said they were restrained primarily by their wrists/arms and ankles and taken to their cells. No one reported any injuries following restraint. One reported an asthma attack, and that medical assistance was provided. In one young person's words "I can't complain".

The full interview with YP1 was the most informative and for future annual visits, 1:1 interviews are more personal and a sensitive way of gaining the views of restraint. Whilst this approach is more time consuming and is unlikely to involve all those at Cookham Wood, a survey could also be offered alongside an interview.

7.8 Concerns:

On the day the views of YP2 and YP5 were shared with DSW and those whose phone calls were ended prematurely, to follow up.

Overall, there was dissatisfaction about the day-to-day regime and lack of activities.

8 CONCLUSIONS AND RECOMMEDNATIONS

8.1 The 2023-24 MSCP Annual Review of Restraint and Safeguarding has enabled the MSCP to seek the views from other agencies with experience of HMYOI Cookham Wood. Whilst it is acknowledged that the establishment is now closed it was disappointing that for a second year there was a lack of engagement from some agencies.

8.2 Whilst HMYOI Cookham Wood has now closed a new secure school opened in the Medway local authority area in July 2024 and it is imperative that the experiences of children and staff illuminated in this report inform the care of this new service and other secure estates.

8.3 As in the 2022-2023 report, in general, agencies reported to the MSCP that they knew how to raise concerns in relation to secure estates and that their staff feel able to raise any safeguarding concerns in relation to the establishment. In addition, as with the 2022-2023 report all agencies reported that they have whistleblowing arrangements in place, however, they had not been used during the period.

8.4 In respect of HMYOI Cookham Wood discharging their safeguarding responsibilities most of the agencies who responded assessed this as inadequate, with one agency noted that the establishment did this well.

8.5 For those agencies who responded to the request for input into the report one reported a specific concern relating to restraint.

8.6 In light of the gaps in staff MMPR training identified in this report we **recommend** the Youth Custody Service (YCS) review how often staff on temporary or permanent deployment to a Under 18's Youth Offending Institution do not have full MMPR training. It would be helpful to receive a reply to the MSCP on this issue within 3 months of YCS's receipt of this report.

8.7 We **recommend** that the YCS produces a clear statement as to how interested bodies can escalate safeguarding concerns beyond an individual establishment when it is appropriate so to do. This should be circulated widely.

8.8 We **recommend** that Barnardo's consider the comments about their service made to YP2, YP3 and YP4 and invite them to comment on these to the MSCP.

8.8 We draw attention to The Children Act 2004 and the specific duties it places on leaders in youth justice establishments to safeguard and promote the welfare of children, further emphasised in Working Together to Safeguarding 2023. Leaders at all levels within the secure estate have a duty to promote

and role model a culture where safeguarding is not only seen as ‘everyone’s responsibility’ but is embedded in policy, procedure and critically experienced by the children. HMIP Chief Inspector noted how internal systems had deteriorate, children continued to report not feeling safe and staff unsupported within the establishment.

8.9 We draw attention to evidence of the direct impact of lack of staff and inconsistency of staff had on the children’s day to day lives. Agencies also attributed these staffing issues to the children’s limited access to education and other programmes that would support improved outcomes.