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Safeguarding children in the secure estate: 1960-2016

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October 2018

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Contents

Tables

Figures

1. Executive summary

Background and aims of the research

The research for this report was commissioned by the Historical Child Abuse Team of HM Prison & Probation Service (HMPPS), to inform its response to the Independent Inquiry into Child Sexual Abuse (IICSA). Their aim was to enhance HMPPS's institutional memory, and to suggest avenues for improved practice in safeguarding children in custody.

The research set out to review the operation of past safeguarding frameworks within what is now known as 'the secure estate for young people'.

Research methods

The initial research strategy was twofold: to conduct an orienting review of risk factors for institutional abuse using existing research and the reports of child abuse inquiries; and to review which kinds of establishment held children sentenced to custody for criminal offences by the courts, and under what policy and legal frameworks they did so.

These reviews framed our consideration of inspection reports, archival records, and other primary records concerning institutions of interest. The latter were selected according to where known allegations of sexual abuse have been made. All were male-only; to ensure that female custody was included in our analysis, we added the small number known to have held girls to the list.

Systematic catalogue searches were then carried out to identify relevant records in the two principal repositories used for the study (the Radzinowicz Library in Cambridge and The National Archives).

The results of these searches were uneven. Archival records for the earlier period (1960 to the 1990s) were sparse, and some issues and institutions of interest were not well-covered. We therefore adopted a more pragmatic strategy, pursuing 'leads' by browsing the archive catalogues, following cross-references in archival records, drawing inferences about institutions for children using available information (for example, by reviewing how complaints were handled in adult prisons where information was lacking for complaints by children) and turning to academic literature where archival sources lacked information relevant to certain issues. Freedom of Information (FOI) requests were also made to access relevant closed archival records but no files of interest were opened in time for inclusion in the report.

The review of records covering the later period (1990s onwards) faced a contrasting challenge: the volume of documents published on secure institutions for children is enormous. Due to the three-month time limit for the whole project, it was not possible to comprehensively review the available material on specific institutions, and we therefore focused on published reviews of the children's secure estate overall, and on overviews of the running of all establishments (such as annual reports and thematic inspection reports). References to specific institutions were then chased up in inspection reports.

Summary of key developments in safeguarding in the secure estate

Safeguards against abuse from 1960 to the 1990s

Changes in the nature and scope of the secure estate (and the youth justice system more generally) during this period were highly complex. Between 1960 and 1998, there was particular turbulence; since 1998 things have stabilised somewhat. The period as a whole, however, remains one in which there have been frequent revisions of institutional aims, management problems, resourcing pressures and cycles of expansion, reorganisation and decline. This turbulence is part of the context for historical abuse; it has not been uncommon, at different times, for institutions to become detached from their original aims, and instead to 'drift', sometimes with the result that the duty of care was diluted or suspended.

In general, from 1960 until at least the 1980s, policies of all kinds were ill-developed, and often poorly implemented. Responses to abuse were reactive and often failed to recognise or counteract the potential harms which custody might inflict on children. It was common for staff to use their power in irregular ways, and penal institutions often featured violent cultures, in which victimisation of some inmates by others was routine, and sometimes carried out with the tacit consent of staff.

Systems aiming to balance children's interests against those of staff (for example, by enabling them to complain) were often ineffective because they failed to correct the disparities in power that were inherent to institutional life.

In penal institutions, complaints could be dangerous to raise: there were significant formal and informal barriers to raising a complaint, and significant risks of formal or informal reprisal from staff members.

Investigative procedures were also weak, usually relying on investigation within the institution, or (rarely) external investigation by Boards of Visitors. The independence of Boards from prison authorities was not guaranteed.

Arrangements to protect the 'welfare' of children were also hampered by resourcing, and by the narrow definition of the issue: Welfare Officers were, for the majority of this period, probation officers mostly responsible for heavy resettlement caseloads, and with limited time for other tasks.

In the care system, checks and balances against abuse were often weak, left the same people and organisations responsible for the administration and oversight of institutions, and led to serious conflicts of interest.

By the 1970s and 1980s, secure custody within the care system was developing along different lines to that in penal institutions. New justifications for custody were being advanced: that it was not a deterrent, or a training opportunity, but a form of *treatment*. These ideals were not always achieved in practice, but they led to a shift in official thinking whereby secure conditions were reframed as a way of meeting children's needs, rather than compelling their compliance. One result was to increase awareness of the risks that could be posed by inadequate safeguards.

Catalysts for change, 1990-2000

New discourses and practices regarding child protection emerged in the care system during the 1980s and 90s, most particularly as the result of a series of public inquiries which exposed abuses in residential homes. Increasingly, it was recognised that residential institutions possessed their own risks and were particularly vulnerable to certain characteristic risks of abuse.

The new practices were formalised into a single legislative framework by the Children Act 1989, which transformed the regulation of the care system. However, its applicability to children in YOIs was legally uncertain until a High Court ruling in 2002.

Legal ambiguity did not prevent observers of the prison system making strong criticisms of YOIs (and later, STCs) a major plank in their prison reform agenda. These criticisms were powerful because they drew on the general rights and protections which the 1989 Act had created for children and which, it could be argued, they were denied in custody. These calls for reform applied the 1989 Act to child imprisonment in novel ways, leading to a 'new orthodoxy' in safeguarding.

The implementation of a 'new orthodoxy', 2000-2016

Since 2000, there have been further developments in the policy framework for the secure estate, but also new indications that policies have not been perfectly implemented. Imbalances of supply and demand for places in the secure estate, and a gradual shift towards a more vulnerable and damaged population, have been among the factors making implementation challenging.

Even so, some safeguards are undoubtedly more effective than previously. For example, greater controls are applied through staff vetting, and several custodial practices such as restraint and strip-searching have been reassessed in light of children's lived experience of these forms of power.

Yet these new policies have also been circumvented in new ways. Abuses have come to light which possess both new features and others familiar from past inquiries. Most fundamentally, the arrival of new safeguarding policies has led to the recognition of forms of abuse which went unrecognised before. This has had an unforeseen effect: it has expanded the boundaries of what can potentially be considered abusive. The outcome of this shift remains unclear.

Conclusions

The safeguarding of children in secure institutions can only be evaluated fully through close attention to organisational culture, *as well as* the actions and motivations of 'bad' individuals. Cultural beliefs affect day-to-day decision-making and are not always congruent with what is laid down formally in policy; indeed, in some circumstances culture is used to justify the circumvention or relaxation of standards which are officially sanctioned. This is particularly likely in residential institutions for children, which feature inherent disparities of power.

Race and learning difficulties added to vulnerability, though it is unclear whether this resulted in an increased likelihood of sexual abuse. The apparent absence of allegations of sexual abuse in establishments for girls is difficult to explain using the evidence we have reviewed, but does not appear to be because girls in custody were less vulnerable.

New safeguarding policies implemented since the 1990s contain their own vulnerabilities and have generated their own forms of illegitimacy. It is difficult for institutions to recognise these. It is a

consistent pattern, throughout the history we have reviewed, that abusive practices had often seemed unlikely or unthinkable, but later became visible.

Thus while preventive safeguards are, in themselves, important, it is also important that institutions do everything possible to promote trusting, positive relationships between staff members and the children in their care, and to ensure that both staff and children are able to make meaningful challenges to aspects of custodial practice. The size of institutions appears relevant here, as do structures of accountability which avoid excessive formality.

It is also important that institutions are open to outside scrutiny. This is not merely a question of regular inspection: it is clear from the historical record that those responsible for scrutinising the secure estate could become acculturated, so that their ideas about what is 'normal' and acceptable began to reflect those of the culture around them. Contemporary arrangements for inspection and oversight need to retain awareness of this risk.

Abusive cultures develop largely because it is relatively easy for staff, in the context of organisations with steep power differentials, to present certain practices as justifiable means to legitimate ends. Over the long term, the operational context for the secure estate is *always* likely to characterised by fluctuations in resourcing, and imbalances between supply and demand. Shifting priorities (of the sort which have been associated with the development of abusive cultures) are likely *always* to affect provision. In consequence, cultural blind spots will *always* be possible, and identifying them will *always* impinge on the interests of those who hold power. This makes protections for whistleblowers a key measure to protect children against abuse.

In short, despite safeguarding policies and frameworks and inspection regimes, the potential for abusive practices to develop must be viewed as evolving, and thus always possible. This points to three final reflections:

- the use of custody for children should be limited as far as possible, because of the inherent tensions in residential institutions where there is a marked disparity of power and an element of coercion in the allocation of residents;
- there are distinct benefits to historical research in this area, because it enables a long view to be taken on present-day safeguards and abuses, and reveals continuities in the kinds of risks affecting the implementation of safeguards;
- child safeguarding must be understood as an ongoing, iterative process, rather than as the attainment of a defined standard of practice.

2. Introduction

The research on which this report is based was commissioned by the Historical Child Abuse Team of HM Prison & Probation Service (HMPPS), to inform its response to the Independent Inquiry into Child Sexual Abuse (IICSA). Its aim was to enhance HMPPS's own institutional memory, and to suggest avenues for improved practice in safeguarding children in custody. The study's aims were framed by nine orienting questions agreed between the research team and HMPPS, which are listed in the fuller description of our research methods in Appendix 9.1. This report, however, does not follow the structure implied by those questions.

The project set out to review the historical infrastructure of child protection within what is now known as 'the secure estate for young people'. Historically, this comprised different kinds of institutions, overseen by different agencies of government, each of which possessed its own aims, cultures, traditions and custodial practices. The story of how these institutions changed over time is complex and is narrated in greater detail later in the report. Fuller definitions of the terms used in the report can also be found below.

The research undertaken was documentary and historical, drawing mainly on secondary literature held in the Radzinowicz Library in Cambridge (which houses the most comprehensive collection of criminological materials in the UK) and on primary sources in the National Archives in London. Further information about the research methods, including discussion of the limitations of the available documentary evidence, is presented in Appendix 8.1.

The body of policies and practices now gathered under the terms 'child protection' and 'safeguarding' did not exist before the 1980s and did not gain traction in Prison Service establishments until the late 1990s. Institutions in the past did sometimes recognise the possibility that abusive practices could develop in custody. But they framed the issue of abuse differently than today, and official responses were different too. The report focuses on 'safeguarding' as now understood: the body of practices by which organisations aim to guarantee the welfare of children, among which protections from child abuse are a significant aspect. It narrates the development of safeguards over half a century, but with close attention to how safeguarding was thought about at the time. It evaluates the effectiveness of historical safeguards *by today's standards*, using what has since been learned about institutional abuse to point out past shortcomings.

The report addresses these aims by means of a historical narrative, bookended by two chapters of thematic context. Chapter 3 situates the narrative in its wider cultural and institutional context. It first describes how wider cultural discourses around child sexuality and child sexual abuse have changed since the 1960s. It then reviews the findings of UK and international inquiries, which have shed much light on the physical, sexual and emotional abuse and neglect of children in institutional settings, and which can be used to understand the vulnerabilities of children in custodial institutions. Following this review of inquiry findings, there is a descriptive account of change and continuity in the 'secure estate for young people' since 1960. Finally, key terms used in the remainder of the report are defined.

Chapters 4, 5 and 6, taken together, comprise an extended narrative of the development and operation of current discourses of 'child safeguarding' and 'child protection'. Chapter 4 describes responses to abuse in the secure estate between 1960 and the 1990s, identifying important

differences between institutions in the penal and care systems. The argument of this chapter is that the potential for abusive cultures to develop was under-recognised in most institutions, and responses to this possibility were mostly *reactive*. Chapter 5 describes how, from the 1980s onwards, a series of scandals, inquiries, and wider cultural changes led practitioners in the care system to develop a new body of *proactive, preventive* child protection policies. These took time to be reflected in the penal system, gaining traction only from the late 1990s. The chapter's main aim is to describe how and why this happened. Chapter 6 describes the implementation and evolution of a 'new orthodoxy' in custodial safeguarding, and critically reviews its implicit claim to effectiveness. Its argument is that new safeguards have improved the protections for children, but have also created new problems. Despite obvious and important changes since the 1960s, there remain continuities between past and present.

Chapter 7 completes the argument, thematically reviewing evidence for how intersecting factors such as race and ethnicity, gender, and intellectual disability may have affected the extent to which children in the secure estate were vulnerable to abuse.

Chapter 8 draws together this thematic evidence with the narrative presented in chapters 4, 5 and 6, and offers concluding reflections on what lessons the past may offer to contemporary practice.

2.1. Terminology

In this report, **'abuse'** and **'child abuse'** are used in the broad sense: 'any action by another person – adult or child – that causes significant harm to a child. [Abuse] can be physical, sexual or emotional, but can just as often be about a lack of love, care and attention'(NSPCC n.d.). This is a broader definition than that implied by the remit of IICSA, which exclusively considers the *sexual* abuse and exploitation of children. We have selected it because sexual abuse is not highly visible in the archives, meaning that we have had to be alert to the connections between different kinds of practices which children may experience as harmful, and which (as section 3.4 indicates) are linked through institutional culture to a greater likelihood of sexual abuse.

The terminology for residential institutions which receive children sentenced to custody by the courts has changed considerably since 1960. These changes in the institutional landscape are described more fully in section 3.3 (and summarised in Table 1 on page 4). The current term 'secure estate for young people', has been in common usage for a decade or so, and obscures significant differences in culture and traditions between the different kinds of institution which comprise it. Where we wish to highlight these differences, we use the terms **'penal system'** and **'penal institution'** for establishments overseen by the Home Office and its successor the Ministry of Justice. Mainly, these were managed by HM Prison Service, but some (such as approved schools) were commissioned by the Home Office from voluntary sector organisations, and others (such as secure training centres) were managed by for-profit private companies. The defining feature of a 'penal' institution, in our usage, is that it must *only* have held children accused or convicted of a criminal offence.

Other institutions have sometimes been described as part of the **'care system'.** These were overseen by the Department of Health and Social Security (and its successor the Department of Health) between 1970 and the 1991 implementation of the 1989 Children Act. During these two decades, children convicted of an offence could be sentenced using care orders. Because local

authorities were responsible for care, and because children's homes under their oversight *also* held looked-after children *who had not been accused or convicted of an offence*, we use the term 'care system' to recognise their distinct cultures, traditions, and professional structures.

Nevertheless, the boundaries between 'penal' and 'care' systems are blurred. For example, some institutions have been in continuous existence but have moved between the two systems: Red Bank, for example, began as an Approved School, became a 'Special' (i.e. secure) unit in the 1960s, came under the management of its Local Authority as a Community Home during the 1970s (and thus moved into the 'care' system), and has since been a Secure Children's Home. Through each reclassification it would have retained staff and working practices, and unlike the name of the institution these would not have changed overnight. We therefore also use the terms **'penal'** and **'care'** to classify *cultures* and *practices*, as well as *institutions*: those associated with control-oriented and welfare-oriented responses to offending. However, the two approaches are seldom mutually exclusive (Garland 1985) and our use of these terms does not imply that children always experienced them in the way that was intended.

The term **'secure'** – present more recently in current usages such as **'secure setting'** and **'secure home'** – is useful in that it links disparate institutions on the basis of what they share. Yet it too has its difficulties: children's liberty has been restricted illegitimately in some (non-secure) children's homes, effectively resulting in the creation of irregular 'secure' units. We term settings as **'secure'** when they house children who are prevented from leaving by physical security measures such as locks and fences. The current term '**the secure estate**' has the advantage of recognising that the institutions it described are increasingly subject to a harmonised regulatory framework. However, it should not obscure the differences between SCHs, STCs and YOIs.

Changing definitions of the term '**child**' are discussed in some depth in section 3.1. It is, however, important to note that over time, the secure institutions described in this report have held people aged between 14 and 21, and that before the 1990s, different terms were current:

- In the care system:
    - 'child' for under-14s
    - 'young person' for 14- to 17-year-olds
- In the penal system:
    - 'juvenile' for 14- to 17-year-olds
    - 'young offender' for 17- to 21-year-olds.

Teasing these groups apart in documents can be difficult (and sometimes impossible), and it is clear that the terms have not always been applied strictly: under-18s who did not fit in with the dominant expectations of a child (e.g. innocence, helplessness, dependence) were often reclassified, for example when those found to be disruptive or difficult (or who had committed more serious offences) could be held in adult prisons. In the interests of simplicity, therefore, we usually refer to children and young people held in institutions using the catch-all term 'children'. We avoid doing so where we are certain that the institution did *not* hold under-18s, but we do not apply a strict definition, not least because institutions themselves appear not to have done so. We also sometimes use the predominant term used by those institutions to refer to children: 'young prisoners', 'trainees', 'inmates' and so on.

Table 1: Institutions in the 'secure estate' and their functions, 1960-1998

	Held children	Managed by	Custodial function	Prevalent terms for under 18s	Successor
Adult prisons	Until 1999	Prison Service	Remand only (in areas where courts not served by alternatives)	'young prisoners' (used for all under-21s)	-
Borstals	1902-1983	Prison Service	Used for convicted children sentenced to 'borstal training' (indeterminate but no longer than three years)	'trainees'	YCCs
Young Prisoner Centres (YPCs)	1954-1983	Prison Service	Not dedicated institutions, but usually separate accommodation in adult prisons. Used for convicted children sentenced to 'immediate imprisonment' (mostly determinate, some indeterminate).	'young prisoners'	YCCs
Detention Centres (DCs)	1954-1988	Prison Service	Used for short-term 'detention' sentences of up to six months. Divided into 'senior' and 'junior' centres, holding ages 14-17 and 17-20 respectively	'inmates' (though many documents refer to 'trainees')	YOIs
Remand Centres	1961-1999	Prison Service	Dedicated local prisons holding only under-21s on remand, serving courts in large conurbations	-	YOIs
Secure units (aka special units)	1964-1971	Mixed voluntary/LA ownership; oversight by Home Office (to 1970) and DHSS (from 1970)	Short-term facilities holding absconders and disruptive children from Approved Schools	-	Community Homes
Community Homes (with Education)	1971-1989	Mixed voluntary/LA ownership; oversight by DHSS and successors	System of children's homes with wide variations in size and function; some with secure accommodation. A few (including all with secure accommodation) provided education on-site	-	Most now closed; remaining examples are now known as 'secure children's homes' (SCHs)
Youth Treatment Centres	1971-2002	DHSS	Long-term treatment for the most 'disturbed' young people believed a significant risk to themselves/others	-	Adolescent forensic secure units (NHS)
Youth Custody Centres (YCCs)	1983-1988	Prison Service	Consolidation of borstal and YPC populations	'young prisoners'	YOIs
Young Offender Institutions (YOIs)	1988-	Prison Service; some briefly in private sector	Consolidation of YCC and detention centre populations; sometimes (as with YPCs) on same sites as adult prisons, but with separate regimes	'juvenile offenders' (most official reports refer to 'children and young people')	-

	Held children	Managed by	Custodial function	Prevalent terms for under 18s	Successor
Secure Children's Homes	1989-	Mixed: voluntary/LA ownership, private sector; Oversight by DFE.	Secure accommodation for 'vulnerable' children (10-17 yrs.)	'children'	
Secure Training Centres (STCs)	1998-	Private sector; one currently in public sector.	Originally commissioned for short-term custody of mixed 12-14-year-olds. Currently holds children up to 18 yrs.	'trainees' (official reports refer to 'children and young people')	-

3. Contexts and concepts

This chapter provides a broad overview of the changing legal, social and structural contexts within which the safeguarding of children in the secure estate was positioned, and against which they might be better understood. Section 3.1 examines how 'the child' has been defined and conceptualised by law, whilst section 3.2 identifies the dominant discourses surrounding children, abuse, sexuality and child protection in England and Wales across time. We use the term 'dominant discourses' to refer to mindsets and attitudes commonly articulated in the public domain, and the rhetoric used to talk about them. Section 3.3 provides an outline of the complex and shifting institutional landscape through which children have been held in custody since 1960; we identify types of custodial setting, their purposes, and their temporal span. Thus sections 3.1 to 3.3, taken together, highlight broader national influences, factors and trajectories that have shaped responses to abuse within the secure estate.

Section 3.4 moves on to consider international contexts. In recent years many jurisdictions have commissioned extensive investigations of child abuse (including physical, sexual and emotional abuse and neglect) in institutional settings. The reports of these inquiries can help to shed light on the experiences of children in prisons and the factors that make them vulnerable to abuse. We draw on these findings elsewhere in the report, but offer here a general evaluation of the insights they offer relating to the abuse of children in custody.

3.1. Changing definitions of 'the child'

Since around 1800 'the child' has been thought about in terms of innocence, dependency, incapacity and vulnerability, and as requiring protection and full-time education through state intervention (rather than employment in work) (Ariès 1996; Cunningham 2005; Jenks 2005; Hendrick 1994). In contrast, 'the adult' has been associated with knowledge, independence, agency and responsibility (both financial and pastoral). These social attitudes have been embedded within (and enacted by) statute law, which defines both 'the child' and 'the adult' as legal categories. However, precisely what it means to be a child and who exactly is included in the definition – in terms of age – has shifted across time, varying in relation to different areas of law (Davin 1999). There are also subtle differences across the constituent parts of the UK, although this report focuses on England and Wales.

The law operates by ascribing sets of roles, responsibilities and rights to children and to adults (including those in positions of authority in relation to children). It also creates systems of compulsion and protection, enforced through the courts (Goldson 2013). The general trend across the twentieth century has been to extend upwards the age associated with adult roles, responsibilities and rights. For example, in relation to education, the statutory school leaving age in England and Wales (which assumes that children should be in school and not work) rose from 14 in 1918, to 15 in 1947 and 16 in 1972. Participation in education or training was extended to all persons aged under 18 in 2015. In a small number of cases – such as voting age – the age of majority has been reduced (from 21 to 18 in 1969) and, overall, there has been very considerable convergence on 18 within the last 30 years. Most significantly, the Children's Act of 1989 (which to reformed childcare law and practice and came into effect in October 1991) defined the child as a

'person under the age of 18' (s. 115), replacing previous classifications which distinguished between 'children' (under 14 years of age) and 'young persons' (over 14 but under 17).

The legal definition of the child and adult in relation to sexual consent and agency – often predicated on assumptions about innocence/knowledge as well as physical development/maturity – has been framed through gender as well as age, until very recently. This is pertinent here, given the focus of this report on institutional safeguarding, including from sexual abuse. The age of consent to sexual intercourse for females has remained constant at 16 since 1885, with sexual intercourse involving a female under 13 defined as statutory rape, and thus of greater severity. An age of consent relating to 'indecent assault' was set at 16 for both males and females in 1922. For males, however, legal definitions have been profoundly shaped by changing social attitudes towards homosexuality. Sexual acts between males were criminalised as 'gross indecency' in 1885 but then partially legalised though the 1967 Sexual Offences Act, which effectively set an age of consent of 21. In 1994 this was lowered to 18, and in 2001 to 16, the same as for heterosexual relationships (Waites 2005). The Indecency against Children Act of 1960 had also filled a loophole in the law, by making it an offence to commit an act of 'gross indecency' with or towards any child under the age of 14 (whether male or female) or to incite a child to such an act (Jackson 2015).

In summary, this meant that, by the 1960s, girls received different levels of protection (i.e. a sliding scale) depending on the nature of an act and whether they were under 13, 14, or 16. The age of consent for boys increased in the same decade from 14 or 16 (depending on the act committed) to 21, but changed again in the 1990s. Finally, in 2003 the law regarding sexual offences was radically overhauled: the offence of 'abuse of a position of trust' was introduced for the first time, criminalising *any* sexual activity with a 'child' under the age of 18 by a person in a formal position of trust in relation to them. Thus there has been a convergence on 16 (in relation to peers) and 18 (in relation to those in positions of trust, and thus of care/authority), although the contours of this change have been complex and uneven. The law – and the definition of who counts as a child – have thus both been subject to significant reform and change in the years since 1960, reflecting more broadly the profound changes in social attitudes which have taken place.

In the field of justice, the age of criminal responsibility (by which an individual can be held accountable for their actions and thus deemed to have committed an offence) rose from 7 in 1908, to 8 in 1933 and, finally to 10 in 1963. Until 1998, those aged 10-13 were also covered by the doctrine of *doli incapax*, which held that capability to distinguish between right and wrong could not be presumed. Juvenile Courts were initially set up in 1908 to deal with minors through separate processes and principles from adults, following an ethos that had regard to 'the welfare of the child'. In the 1970s there was a shift back towards a model that stressed the principles of justice, punishment and 'individual or parental responsibility' within youth justice (Garland 1985; Gelsthorpe and Morris 1994; Goldson 2002; Newburn 1997).

Nevertheless, whilst the balance between welfare and justice has been subject to fluctuation, separate courts have remained in place throughout, with the upper age limit for the Juvenile Courts (originally 16) raised to 17 in 1933, and then to 18 in 1991 when they were also reconstituted as Youth Courts. The rise to 18 was in part to align it with custody guidelines and, indeed, 16- and 17-year-olds in the Youth Court were to be dealt with as 'near-adults' (Gelsthorpe and Morris 1994, 981). It also meant, however, that custody and court arrangements together aligned with the 1989

Children Act – and to some extent the United Nations Convention on the Rights of the Child (which came into force in the UK in 1992) – through a shared focus on 18 as the age of majority. Thus between 1960 and 2000, the age of the 'child' in the youth justice system shifted from 8-17 to 10-18 (although different age groups within this range have continued to hold different status).

Ultimately, the modern definition of 'the child' is incompatible with the prison institution. Indeed, for over 100 years it has been widely acknowledged that prisons are institutions designed for adults rather than children, and that fundamentally, they contradict the needs and roles of the child (defined through law as welfare/care and education/training). There have been repeated attempts to restrict the use of imprisonment for children, to make it a means of last resort: in the case of sentencing, imprisonment has been reserved in 1948 for those for whom 'no other method' was deemed appropriate, and in 1969, for children deemed so 'unruly' that they could not be 'safely' committed to other forms of care (*Criminal Justice Act* 1948, sec. 17 and 27; *Children and Young Persons Act* 1969, sec. 23).

The 1991 Criminal Justice Act abolished the concept of 'unruliness' and replaced it with assessment of 'the need to protect public from serious harm', as well as setting out the aim of replacing remand in prisons with the use of other secure accommodation (Goldson 2002, 38). Similarly, the minimum age limit for remand in prison, which had been set at 14 in 1948, was raised to 15 for boys in 1991 (16 for girls). In 1997 then Chief Inspector of Prisons David Ramsbotham concluded that 'the Prison Service should relinquish responsibility for all children under the age of 18' because of the child's 'distinct needs in the areas of protection, education and maturation' (HM Chief Inspector of Prisons 1997b, para. 8.07). The problem has remained that, in practice, children who do not easily comply with social expectations of the child are those for whom prison has been seen as the only solution (Jenks 2005). Indeed, children in the secure estate had to wait until 2002 to gain the same legal rights as other children, because it was unclear whether the Children Act of 1989, which provided safeguards for children in other custodial settings, applied to prisons (Munby 2002).

Thus *who* exactly counts as a 'child' has varied across time in terms of age, gender and differing aspects of lived experience; but because those in custodial settings have fitted uneasily into definitions that associate the 'child' with innocence and vulnerability, they have often been the last to be accorded the same protection as peers of the same age.

3.2. Changing discourses of child abuse, child sexuality, and child protection

The term Child Sexual Abuse (CSA) did not become became common within professional and public discourse until the 1980s. As historians and sociologists have shown, this does not mean that it was only 'discovered' as a social problem at that point. Rather, it was known about but often hidden through euphemistic or trivialising language, adding to the difficulties of disclosure. In some periods – such as the 1880s and the 1920s – there were orchestrated and highly visible campaigns to change the ways in which the law and criminal justice responded to what we would now describe as CSA (although these were limited in focusing overwhelmingly on female children). Significantly, too, in other decades – including the 1950s and 1960s – such concerns dissipated; while anxieties about the sexualisation of young people remained, adult responsibility was often sidestepped and adolescents, in particular, were blamed for behaviour (Smart 1999, 2000; Delap 2015; Bingham and Settle 2015; Bingham et al. 2016; Delap 2018; Brown and Barrett 2002; Egan and Hawkes 2008).

Across time, the modern construction of the 'idealised child' in terms of innocence has often resulted in an ambiguous status for children who have been sexually abused, on the grounds that they could no longer be simplistically equated with 'innocence'. This, as we have seen, has also been the case for children in custody. Even if such children were blameless 'victims', their loss of 'innocence' led to adult fears of moral contamination, and consequent threats to other children. As Hendrick (1994) has argued, the dualism of victim/threat was a dominant narrative through which children were thought about within child welfare policy across the twentieth century.

Since 1960 a range of narratives have been deployed – through the media but also within social work, policing and other professional discourse – that have framed the problem of young people and sexual danger in ways that have had different effects on perceptions of causation, blame and responsibility. These narratives have developed as follows.

3.2.1. The 1960s

In the 1960s, females aged 13 to 16 were stereotyped through concerns about the 'wayward girl'. Child protection legislation enabled those under 17 who were 'in moral danger' and 'beyond [the] control' of parents to be taken into institutional care (including approved schools). Whilst gender was not specified, these clauses tended to be used in relation to female rather than male children, and to stigmatise girls who were engaging in under-age sex, rather than those whom they were sexually active with, who would now be classified as adult abusers (Cox 2013; Carlen 1988; Gelsthorpe and Worrall 2009). The police focused on cafés, clubs and music venues in large cities as sites of danger for girls who had run away (from home or from institutions). There was also significant focus on girls' associations with black and Asian men, who were stereotyped in terms of 'vice and immorality' (Jackson 2008; Jackson and Bartie 2014). Within this narrative, young females were portrayed as 'precocious' and prematurely adult, rather than as children, and were blamed for placing themselves in danger. They were constructed as 'risky', rather than 'at risk' from others (Gelsthorpe and Worrall 2009). Attention was deflected away from white communities, and from the home or residential institutions as sites of danger. Within the popular music and popular culture of the period there was a tendency to eroticise 'teenage' girls and to trivialise behaviour that would now be seen as abusive. Where newspapers covered sexual violence as a serious issue in the 1960s they tended to focus on the 'sex maniac', public space, and on 'stranger danger' (Bingham and Settle 2015).

3.2.2. The 1970s

Those who opposed the partial decriminalisation of sex between men in 1967 (including socially conservative elements of the tabloid press) had demonised the 'the homosexual' by conflating this figure with that of 'the paedophile' and, in some cases, using the terms interchangeably (Bingham et al. 2016). In the 1970s fear of 'the paedophile' gained prominence as a dominant trope, for a number of reasons. The influence of Freudian ideas, which recognised that sexual feelings in childhood were a normal aspect of development (rather than a corruption of 'innocence'), converged with libertarian viewpoints that opposed state intervention in private (often sexual) life, to create a space in which the removal of age of consent legislation was debated in a number of public arenas. An organisation calling itself the Paedophile Information Exchange (PIE) organised a high-profile conference in Swansea in 1977, attracting press opprobrium; its chair was successfully prosecuted for circulating indecent material (Thomson 2013). Those involved in PIE justified

relationships with children by arguing they were 'natural' and welcomed by those involved, a viewpoint with currency amongst some libertarian constituencies at this significant point in time. However, in the wake of the press condemnation of PIE, and into the 1980s, 'the paedophile' became a staple of public discourse, and major cases received huge publicity; blame was placed on 'evil' individuals who were responsible for their actions, rather than focusing on a broader social responsibility. Discourses of threat further emphasised dangers to children in public spaces, including streets and parks, leading parents to escort children to and from school and other activities.

3.2.3. The 1980s

Significant concerns that familial abuse ('incest') was much more widespread than previously thought surfaced from the late 1970s and into the 1980s in both the USA and UK, as result of the transatlantic publication of key studies by feminist activists and social workers (Armstrong 1978; Finkelhor 1979; Rush 1980; Herman and Hirschman 1981; Mrazek and Kempe 1981; Butler 1985; Miller 1985; Russell 1986). The term 'child abuse' had been used previously, from the 1960s onwards, to describe *physical* abuse (including 'battered baby syndrome') but it was in the 1980s that 'child abuse' came to be thought about in sexual terms: both in that sexual abuse itself dominated public discourse; and in that CSA was recast as intra-familial (Kempe et al. 1985; Helfer and Kempe 1974; Hacking 1991). In the UK, however, following the Cleveland scandal of 1987-88 and further controversial cases in Rochdale (1990) and Orkney (1991), press coverage was contradictory, often critical (of social workers and the state), and defensive of the rights of parents (Bingham 2015; Campbell 1988).

3.2.4. The 1990s

Allegations regarding institutional sexual abuse (and subsequent cover-up) at Kincora boys' home in Belfast first came to media attention in Northern Ireland in 1980 but did not generate significant contemporaneous coverage in other parts of the UK. Where dominant discourses in previous decades had highlighted *public and domestic space* as sites of danger, *institutional* abuse came increasingly to be the focus during the 1990s: the 'first exposure of systematic abuse within a residential home for children' (Thomson 2013, 181; see also Wolmar 2000) surfaced in 1989 in England, in the case of Castle Hill School, a privately-owned children's home in Ludlow, Shropshire which took children from local authorities around the country. The case also highlighted the abuse of teenage boys specifically (in contrast to earlier decades, in which it was assumed that 'victims' were girls or very young children). Investigations followed in North Wales, Staffordshire and Leicestershire, with discussion of the need for safeguarding in residential care settings entering public discourse.

3.2.5. The 2000s

Awareness of institutional abuse has become apparent within the last two decades on an international scale where (very significantly) the testimony and experience of victims and survivors has moved centre-stage. Models of transitional justice – involving recognition/redress in the present for harms done in the past, and recommendations for future security/safeguarding – became the basis for national inquiries in 19 countries, having spread from Australia and New Zealand (where the original focus was on aboriginal children) to Canada, and Europe (Sköld and Swain 2015). Other than in England and Wales, inquiries have focused on residential care settings

('looked after children') and on all forms of abuse. In England and Wales, the Independent Inquiry into Child Sexual Abuse (IICSA) was announced in the summer of 2014.

3.2.6. Summary

In summary, it is very apparent that although concerns about children and sexual danger were voiced in earlier decades, the concept of 'child sexual abuse' – as a broad umbrella term denoting a range of sexual acts and behaviours held to be harmful to children – emerged in the 1980s. Associated initially with girls and young children and the private home, it is only since the 1990s that awareness has developed of residential institutions as potentially abusive settings, and only since around then that teenaged boys have been thought about as potentially vulnerable.

3.3. Changes in the institutional make-up of the secure estate, 1960 to 2016

The historical picture of custodial provision for children sentenced by the courts is rather fragmented and disjointed. Since the inception of the youth justice system at the beginning of the twentieth century, the purpose, form and character of custody for children has been subjected to multiple influences: contrasting political agendas and professional practices; legislative change including to minimum ages of criminal responsibility and criminal majority; and divisions in management responsibility between private and publicly run bodies across state penal, health and welfare sectors.

3.3.1. Institutional developments

At the beginning of the 1960s there were three principal forms of custody for children sentenced by the courts: borstals, detention centres and approved schools.[1] Borstals were the longest-running institution, the first having opened in 1902 near Rochester, Kent. Approved schools had been running since 1933 following the amalgamation of reformatories and industrial schools. Detention centres, meanwhile, were a relatively recent initiative, having been set up in 1952. All three types of custody were under the jurisdiction of the Home Office, but borstals and detention centres were run by the Prison Service, while approved schools were mainly run by local voluntary organisations. These different forms of custody operated quite differently, reflecting the character of their respective managing bodies. Borstals and detention centres drew on the disciplinary regimes of a penal establishment, whereas approved schools were run along similar lines to a boarding school.

In the 1940s and 1950s, approved schools and borstals were subject to increasing criticism. Frequent absconding by young people from approved schools and from open borstals prompted questions about their continued value and effectiveness (Hayden 2007). There was a powerful undercurrent of resistance amongst the young people sent to borstal too, including complaints about the use of corporal punishment and staff treatment (Humphries 1981, 218). Problems with absconding and discipline, and an increasing rate of reconviction, fuelled an official discourse of 'children who could not be trusted'. The similar problems faced by approved schools and borstals did not, however, generate a single policy response. Policies divided according to the perceived problems of the children concerned: welfare and treatment for younger, neglected children who

[1] A smaller number of children were held in remand centres and probation hostels/homes; older children could be sent to Young Prisoner Centres.

were ‘troubled’ and ‘disturbed’; and punishment-oriented approaches for the wilful and persistent ‘young offender’.

Detention centres were the product of the more punitive political and public voice that had been developing towards the older and persistent offender since the late 1940s and which had also led to the development of young prisoner centres (Warder and Wilson 1973). Whereas the primary focus of borstals and approved schools had been on reform through training and education, detention centres aimed to reform through deterrence. They were designed for young people aged between 14 and 21 years, sentenced to 6 months or less (Muncie 1990), and reflected a revival of interest in disciplinary regimes which would instil ‘a right attitude in the individual and in the community to society, to work, to authority, to decency and order, to life’ (Home Office 1953, 138). The centres aimed to give young offenders a ‘short, sharp, shock’ which would deter them from future offending (Hagell and Hazel 2001). Despite controversy over the effectiveness of harsh disciplinary regimes for young offenders, political belief in the value of reform through deterrence revived the harsh custodial approach in the early 1980s. ‘Military-style’ regimes were set up at two centres: Send (for 17- to 21-year-olds) and New Hall (for 14- to 16-year-olds). However, these regimes were abandoned following a Home Office research study which reported negative effects (Newburn 1997; see also Thornton et al. 1984).

Continuing disciplinary problems in approved schools precipitated further discussions about the need for secure accommodation within the younger, welfare-oriented strand of custody. Proposals for closed schools had initially been rejected by the Home Office as retrogressive and likely to alter the fundamentally open and educational focus of the schools. However, the need to address the problem of children who were absconding prompted a review, and the opening of secure units within three of the classifying centres in the mid-1960s: Red Bank, Redhill and Kingswood (Lindsay 1990). The units were originally aimed at absconders and disruptive pupils aged 14 to 16. This mixed intake (children who were perceived to be dangerous to others and children who were considered a risk to themselves) reflected ambiguity about the aims and purpose of the secure units (Harris and Timms 1993). Originally, secure units were intended to run a brisk regime with no home leave and a quick return to an open school. However, there were concerns about the appropriateness of these more punitive regimes in practice, and a more treatment-oriented approach was subsequently adopted (Hagell and Hazel 2001).

The White Paper ‘Children in Trouble’ (Home Office 1968) epitomised this stronger political and professional interest in intervention and treatment. It built on a growing policy orientation towards care and protection, which had instigated the raising of the age of criminal responsibility from eight to ten years in 1963. In the ensuing 1969 Children and Young Person’s Act, approved schools and probation homes were amalgamated into Community Homes to which children would be sent by the courts using newly established ‘care orders’. Responsibility for oversight of the homes was transferred from the Home Office to the Department of Health and Social Security, though the day-to-day management of the homes rested with local authority children’s departments. These homes were known as Community Homes with Education (CHEs), and some operated as secure establishments or had secure units. Secure provision within the care system was designed for children who were considered to need particular treatment because they were highly disturbed. If a young offender received a care order from the courts, it was left to the discretion of local authority

social service departments (SSDs) to decide whether they would receive treatment in their own community or be placed in secure accommodation.

The 1969 Children and Young Person's Act also made provision for two youth treatment centres (YTCs) intended for the long-term care and control of children between the ages of 12 and 19, whose needs could not be met elsewhere within the secure estate. These were the St Charles Youth Treatment Centre in Brentwood in Essex (opened in 1971), and the Glenthorne Youth Treatment Centre in Birmingham (opened in 1978). Both were managed directly by the Department of Health. They thus continued with the mixed intake of children 'suffering from serious personality and behaviour disorder' and others who had committed serious offences (Hoghughi 1973).

CHEs and YTCs steadily declined in popularity in the 1980s as a result of diverging policy interests. There was a preference among some local authorities and social services for community alternatives to custody for young offenders; in contrast to these, secure facilities were seen as violent and disordered places (Bennetto 1994). Furthermore, due to a national shortage of places for girls in CHEs, those who were recommended for referral often had long waits for treatment (Howard League for Penal Reform 1977). In addition, magistrates frustrated by the discretion exercised by SSDs, and who wanted to guarantee a custodial sentence, often directed young people to penal custody rather than issuing them with a care order (Bottoms 2002a).

The division between welfare and penal responses to youth crime and between departments responsible for custodial placements in the 1980s had generated, by default rather than design, a disjointed and inconsistent approach to the provision of custody for young offenders. Children could be sent to CHEs, YTCs, DCs, borstals, YPCs or (sometimes) adult prisons. A research study concluded that

> *'young people with similar problems [were] drifting around different welfare and control systems, whether special education, health, social services or penal establishment. Where problematic people end up seems largely a matter of local as well as national policies and of the resolve and ability of some settings and agencies to hang onto difficult clients rather than transfer them' (Bullock et al. 1990, 205)*.

The need for rationalisation prompted a review of custody for young offenders. In the 1982 Criminal Justice Act, borstals and young prisoner centres were amalgamated into one custodial option – the youth custody centre (YCC) for under-21s. YCCs were intended to provide a longer-term complement for the short-term provision of detention centres. They aimed to run prison-like regimes and staff (unlike in borstals) wore Prison Service uniform. It was envisaged that they would provide a 'constructive training regime' which would link prison work and education in one overall training programme. Although training opportunities were similar to those offered in borstals, YCCs subsequently had to accommodate the introduction of short determinate sentences for children and the resulting higher turnover of the youth custody population (Genders and Player 1986). With declining overall numbers of children in custody through the 1980s (Newburn 1997), and little difference in approach between them in practice, YCCs and DCs were merged into young offender institutions (YOIs) in 1988.

The focus on penal rather than care-oriented custodial options continued in the Children Act 1989, which ended the use of care orders as a disposal for young offenders. Consequently, a large number of children who had previously been placed in CHEs because of their offending, came out of the care system. There was piecemeal closure of CHEs and by 1993 only a few remained. Nevertheless, a small minority of places for very young children who had committed offences were retained. They were still housed in what in 1989 had been renamed Local Authority Secure Children's Homes (SCHs). The successor to the Youth Treatment Centres were adolescent forensic secure units, to which 'mentally disordered' young offenders could be sent under the Mental Health Act of 1983.

From the early 1990s, growing political concerns about youth crime rates and 'misspent youth' resulted in the adoption of a more punitive tone towards young offenders. The mantra of 'no more excuses' and a focus on personal responsibility characterised youth justice policymaking in the 1990s; there was also a renewed belief in the effectiveness of imprisonment (Goldson 2005). The 1994 Criminal Justice and Public Order Act legislated for another new custodial model, the 'secure training centre' (STC); Medway, the first such centre, opened in 1998. STCs were intended for young offenders aged 12 to 14, girls up to the age of 16, and 15 to 16-year-old boys who had been assessed as too vulnerable for YOIs. They were to be exclusively operated by private companies and were to provide 'training' to 'tackle' offending behaviour. With modern buildings reflecting a secure boarding school model, and a high ratio of staff to young people, the STCs were situated midway between the penal and welfare strands of custodial provision. This ambiguous positioning has not been maintained without difficulty. Since their beginning there have been on-going controversy about staff treatment of children in the centres (Hagell, Hazel, and Shaw 2000; Taylor 2016). Of particular concern has been the use of physical restraint, which was linked to the deaths of two children, Gareth Myatt and Adam Rickwood, in STCs in 2004. The overuse of restraint has more recently been linked to allegations of abuse by staff at Medway STC in 2016.

3.3.2. Girls

Secure provision for the small minority of girls in the criminal justice system has tended to mirror that designed for the majority male population with some (often minor) adjustments to reflect the (perceived) specific needs of girls. The first female borstal opened in 1909 in Aylesbury Prison. Borstal regimes focused on training in vocations traditionally associated with women: sewing, cooking and other domestic duties (Gelsthorpe and Worrall 2009). Later, girls were sent to secure units and youth treatment centres; however, this was more commonly done on grounds of disturbed behaviour and risk to themselves than for criminal offences. The tendency to assume that what was suitable for the male population would be equally suitable for girls led to failures in practice: a detention centre was opened in 1962 for girls but closed after 7 years as the 'practice of military drill and physical education was not considered 'appropriate training' for young women (Muncie 1990, 56).

The last borstal for girls, at Bullwood Hall, closed in 1982. However, like many secure establishments, Bullwood Hall then became a YCC and subsequently a YOI. The criticisms of its provisions for girls, which had started during its time as a borstal, continued until its closure as a YOI in 2006 (Kozuba-Kozubska and Turrell 1978; HM Chief Inspector of Prisons 2004). The absence of dedicated provision for the small minority of girls sentenced to youth custody and training orders

often resulted in girls being housed in adult prisons. The gendered assumption was that they would benefit from care by (rather than contamination from) the adult women they resided with. There were some policy restrictions designed not to allow contact with women convicted of sexual offences, but these were not consistently implemented in practice (Genders and Player 1986). The last female YOI units were decommissioned in 2013 (Youth Justice Board and Ministry of Justice 2016) and girls in the secure estate are now housed only in STCs or SCHs.

3.3.3. Future directions in policy

In 2014, the government proposed the creation of secure colleges, 'a new generation of secure educational establishments where learning, vocational training and life skills will be the central pillar of a regime focused on educating and rehabilitating young offenders' (Ministry of Justice 2014, 3). These plans, although legislated for in the Criminal Justice and Courts Act of 2015, were later abandoned. It was argued that the 'nature of the challenge ha[d] changed' because of a decline in the population of young people in custody and a concern about the cost of building the new college. Rising levels of violence and self-harm amongst the population of young people in custody also raised concerns about placing such a large proportion of the youth custody population in the same institution (Hansard 2015)

A review of the youth justice system in 2016 has since re-stated the political interest in prioritising education, although the parameters of the discussion were redrawn. The recommendations were for smaller custodial establishments, presented as a secure version of the 'free school' model with closer links to local education providers. In addition to the persistent remedial focus on 'basic skills' of literacy and numeracy, these new secure schools are envisaged as having a therapeutic dimension – an echo of earlier welfare-oriented interests (Taylor 2016). However, with other issues dominating political attention, these proposals have not yet been enacted.

3.3.4. Summary

This brief review of developments in the children's secure estate since 1960 illustrates a picture of inconsistent practice and ongoing troubles, associated with conflicting views of the aims of custody and fragmented management responsibilities. These have impeded the implementation of a consistent approach to safeguarding, so that the lessons of good practice have not traditionally been shared across the boundaries of criminal justice services and child care agencies (Hagell and Hazel 2001). In their review of secure establishments for children since the 1830s, Hagell and Hazell identify eight recurring themes:

- the establishment and closure of institutions as a result of broader macro swings between welfare and retribution;
- high levels of public interest and critique by press and pressure groups on matters of principle and specific concerns;
- initial enthusiasm for new institutions leading to a quick expansion of facilities before concerns and decline;
- management problems including high staff turnover;
- untrained and inexperienced staff and unsuitable buildings;
- shifts in the nature of regimes, often leading away from that intended in policy planning to one which is considered more manageable in practice;

- problems with residents' behaviour, and associated tightening of selection criteria;
- concerns with poor reconviction rates, welfare and human rights.

Hagell and Hazel published this list in 2001. Many of these themes continue to be relevant to the running of secure institutions for young people 15 years later.

3.4. Inquiries and research findings on institutional abuse

The roots of abuse in institutional culture are difficult to investigate, because much abuse is covert and hidden. One consequence is that academic research tends to concentrate on individual causative factors: in other words, on the abuser. However, it is clear from other evidence that abuse only becomes possible in certain circumstances. Inquiry findings, while not strictly academic research, are recognised as particularly valuable, because they can to shed light on those circumstances, with a view to identifying learning points for organisations.

Recent years have seen extensive investigation of the abuse (including physical, sexual and emotional abuse and neglect) of children in institutional settings. The reports of international inquiries help to shed light on the comparative experiences of children in prisons and their vulnerability to abuse. There are however distinct focuses in the various national inquiries. As Sköld (2016) has argued, inquiries have diverged in how far they provide redress, investigation and public recognition. Some have heard testimony in confidence; others have resembled a civil court of law and have had powers to name perpetrators. Their definitions of abuse have also varied, from narrow legal definitions to broader versions. Despite these differences, the content of reports can suggest areas of concern and standards of child safeguarding in different kinds of secure accommodation for children who have broken the law.

3.4.1. Australia

An Australian inquiry into institutional CSA published its findings in December 2017 (The Royal Commission into Institutional Responses to Child Sexual Abuse 2017). It reviewed abuse experienced by children at children's homes, including those to which children were referred to by Magistrates following court appearances. The inquiry did not look specifically at youth prisons. The Royal Commission found that it was routinely the case that police did not follow up complaints, often because they did not think there was sufficient evidence to prosecute after an abuse allegation was made. It is also clear that procedures to safeguard children were not widely known about by professionals during the period under review, and were often not followed. Children were returned to the care of suspected perpetrators, and caregivers did not consistently (or often) report allegations to police or line managers. The onus was often placed on children or the ex-residents of care homes to pursue complaints; where they did not, no further action was taken, even if other children might be at risk.

The Australian inquiry also published research into how organisational culture might play a role in facilitating or preventing abuse (Palmer, Feldman, and McKibbin 2016). This research focused on the particular vulnerabilities that children face in 'total institutions' and indicated that some secure children's homes (including those with 'maximum security annexes') operated in this fashion. It described the tendency for the moral values of 'total institutions' to diverge from those of wider society into 'alternative moral universes', thus tending to 'insulate perpetrators […] from structures

in civil society that might otherwise inhibit the abuse, speed up its detection and enhance responses to it' (Palmer, Feldman, and McKibbin 2016, 9)

This was exacerbated by racial discrimination and the tendency to 'embrace degrading assumptions about the fundamental nature of inmates', and to 'extinguish the[ir] pre-institutional identities'. In some homes the idolisation of a 'macho culture' and stigmatising attitudes towards homosexuality also played a role. Finally, total institutions tended to withhold information about their operations, which further detracted from the possibility to hold them accountable (ibid.).

3.4.2. Canada and the United States

A Canadian inquiry published *Restoring Dignity: Responding to child abuse in Canadian institutions* in 2000, covering physical and sexual abuse and neglect of children in a range of institutions, including 'correctional facilities' (Law Commission of Canada 2000). Like the Australian Royal Commission, it identified the relevance of discrimination against indigenous populations and the potential for abuse in 'total institutions', where children were cut off from kin and trusted adults, and where external oversight was absent.

A government-commissioned study of sexual victimization in American juvenile criminal justice facilities in 2008-9 suggested that around 12 per cent of youth inmates experienced sexual victimization, of which about 10 per cent involved staff members. Rates for non-heterosexual youth were significantly higher (Beck, Harrison, and Guerino 2010). These data do not indicate what percentage of youth inmates were legally defined as children.

3.4.3. Ireland

The findings of the Irish Commission to Inquire into Child Abuse ('the Ryan report') were published in 2009. The inquiry's remit included St Patrick's Institution, which detained boys aged 16 and 17, and other detention schools for children of younger ages. The report noted confusion over responsibility for institutions, such as the 'anomalous' Marlborough House (1944-72). This was a children's detention school/remand home certified by the Department of Justice, but actually under the management of the Minister of Education. Conflicts over management responsibilities left it virtually uninspected, and since its staff did not have childcare experience, the standard of care was declared 'inexcusably low' in 1944. Conditions did not improve subsequently, and the Commission noted the poor management, inadequate staff and lack of vision. Allegations of physical and sexual abuse and neglect were made, but no action was taken, and complaints were not recorded properly. The 'brutal, harsh regime' was allowed to continue because the 'concern at all times was to protect the Department [of Education] from criticism' (The Commission to Inquire into Child Abuse 2009b, Volume I:756). Similarly, in the detention facility at Letterfrack, run by the Christian Brothers for children on remand or after sentencing, sexual abuse was prolonged and undetected. Where complaints were made, the priorities for the institution suggested 'a policy of protecting [perpetrators], the Community and the Congregation, from the effects of disclosure of abuse. The needs of the victims were not considered' (The Commission to Inquire into Child Abuse 2009c, Volume I:394).

The report concluded overall that childcare institutions had failed to make management accountable for the quality of services, had failed to implement regular reviews, had failed to make child well-being and safeguarding a priority, and had thus fostered abuse and neglect. Sexual abuse

was endemic in Irish boys' institutions, and known abusers were transferred rather than prosecuted. The inquiry found that Irish institutions had served the interests of their adult staff, rather than those of the children in their care (The Commission to Inquire into Child Abuse 2009a).

3.4.4. Northern Ireland

The Northern Irish Institutional Historical Abuse Inquiry, which reported in 2017, conducted a module of work into youth justice institutions, including industrial schools, young offender units, training schools,[2] and borstals, examining the period from 1922 onwards. The final report stated that no allegations of abuse in prisons had been recorded by the Inquiry. The (single) borstal and the training schools were presented as having successfully modernised, with consistent attention to creating more humane approaches. This was surprising because despite the lack of formal complaints made to the Inquiry or the police, transcripts of evidence given to the Inquiry by trainees at Millisle Borstal suggest that senior staff were complacent about sexual abuse allegations there. When a complaint was made by a trainee about repeated indecent assault by another trainee in 1961, the Governor maintained that 'little or no indecency existed at this establishment'. However, he also conceded that:

> *'This problem of indecency is always likely amongst adolescents who are in [a] post-puberty stage and every precaution is taken to obviate incidents of this nature. However, under the conditions of extreme overcrowding, supervision, difficult at any time, becomes vulnerable to breaches such as appear to have occurred.' (Historical Institutional Abuse Inquiry 2016, 133–35)*

The incident was explained by reference to the perpetrator 'lacking suitability' for the borstal regime, and apparently did not generate any reflection on the institutional culture.

3.4.5. United Kingdom

Research commissioned by the NSPCC (Erooga 2009) reviews seventeen official inquiries which published findings on institutional child abuse in the UK between 1985 and 2000. This section presents key points from Erooga's summary.

UK inquiries suggest conclusions similar to the Australian findings described in section 3.4.1, concerning the tendency for 'total' institutions to develop unhealthy cultures that become increasingly remote from mainstream moral norms. Such cultures inhibit disclosure, cause allegations to be heard with incredulity, and incubate further abusive practices; they are particularly likely to develop when the behaviour and welfare of children are evaluated in the new light of changed organisational priorities.

For example, the Pindown inquiry found that abusive practices in children's homes in Staffordshire first developed in 1983, at a time of budgetary constraint and organisational restructuring. Staffing changes left complex tasks, 'many of which required considerable skill, knowledge, and experience, [to] be carried out by inexperienced, untrained and unqualified staff' (Levy and Kahan 1991, 153; see also Harris and Timms 1993, 85). In a climate where managerial priorities lay with reorganisation and restructuring, staff feared that their own interests could be threatened by perceptions that they were incompetent and not in control. Challenging behaviour was therefore

[2] Training schools were the Northern Irish equivalent of Approved Schools.

controlled using practices which (though abusive) achieved a desired outcome for those in power. The 'success' of these practices led them to be formalised as policy and used in other homes for a further five years, *with managerial approval*. A particularly troubling feature noted by this inquiry was the pride with which staff described practices which, to outside eyes, immediately appeared unprofessional and abusive.

Institutional abuse investigations in the UK also demonstrate the importance of power dynamics in institutions, and particularly the interplay of power and powerlessness. This interplay is complex: '[m]ost of those who suffer abuse in these settings are vulnerable and powerless, either to prevent the abuse occurring, or to report it subsequently' (Erooga 2009, 41). Children's vulnerabilities can be exacerbated also by discriminatory attitudes towards gender, learning difficulties and race (On gender issues, see Erooga 2009, 42–43). Conversely, most of those who *perpetrate* abuse possess great power over children, but simultaneously feel relatively powerless in relation to their employers. Staff in residential units often had a low status within their organisations as a whole, often had little or no training, and were usually not very well paid in absolute terms or relative to their managers and social workers who allocated children to their care (Harris and Timms 1993). Regardless, working daily with children in care can be extremely stressful. In institutions where the management, training, supervision, oversight and support of workers are weak, some workers may gain a sense of personal significance by exerting power over children, who themselves 'may be perceived as part of the source of the stress and [are] also the most available outlet for frustration' (Erooga 2009, 43).

Checks and balances on the power of staff are therefore crucial. Many reports on abuse in children's homes describe a process whereby relatively inexpert and unqualified staff members have developed 'effective' methods of control, often under the cover of perceived (and often bogus) 'expertise'. These methods often went unchallenged, even attracting acclaim for their apparent efficacy. If such abusive methods of control are seen as legitimate, and if residential staff are left relatively unconstrained in developing them, then it is easy to see how other forms of abuse (such as sexual abuse) could be perpetrated covertly and with impunity, even though no reasonable interpretation of legitimate organisational aims could possibly have framed them as legitimate. One such example was in children's homes in Leicestershire, where Frank Beck and his accomplices developed reputations as individuals able to control difficult children, and subsequently went on to commit systematic physical and sexual abuse against the children in their care (Kirkwood 1993).

3.4.6. Summary

While there is not always specific evidence relating to child abuse in prisons and other forms of secure accommodation in the comparable international inquiries, there are nonetheless some helpful insights. First, several inquiries have concluded that attempting to 'tally' the case files of individuals with their subsequent accounts of abuse were unproductive. Deficiencies in record keeping, which might on occasion have been deliberate, meant that case files were not forthcoming about abusive experiences (Sköld, Foberg, and Hedström 2012). Instead, abuse nearly always became visible through subsequent complaints, the testimony of 'bystanders' such as prison visitors, chaplains or whistleblowers, and occasionally, through later investigations into 'historic abuse'.

Inquiries have also suggested that abuse was rarely experienced by the majority of individuals at an institution, but rather has tended to be limited to children who were particularly vulnerable by virtue of their ethnicity, disability status, mental health status, etc. The prolonged consideration of questions of race and indigeneity in the Canadian and Australian materials indicates how ethnicity could exacerbate experiences of marginalisation, suggesting that IICSA; should remain alert to this factor in examining the secure estate. Similarly, (learning) disabilities have also been a widely noted factor exacerbating vulnerability. Peer-on-peer abuse and bullying are also prominent in inquiry reports as a common feature of hierarchical organisations where safeguarding was not a priority.

More generally, it is possible to use the findings of inquiries to describe a process of the 'corruption of care', whereby in certain circumstances, workers deprioritise the duty of care their organisation has towards children (Erooga 2009, 39–46; Wardhaugh and Wilding 1993). In making this point, it is important to distinguish between two different kinds of abuse. The first is abuse associated with the *unethical pursuit of legitimate aims*, for example cruel or violent practices intended to control children's disruptive behaviour. The second kind is abuse associated with the *pursuit of illegitimate aims* which cannot be justified by any reading of institutional aims. Clearly, sexual abuse falls into the second category; but some instances of emotional and physical abuse fall into the first. Both kinds of abuse, however, become likelier as a result of the corruption of care, and it makes no sense to consider them separately.

Taken together, the inquiries and related research reviewed by Erooga help elucidate factors associated with abuse in institutional settings, some of which are structural features of at least some forms of secure accommodation for children in Britain between 1960 and 2016. These include:

- structures allowing staff to control the distribution of privileges to inmates (which can facilitate grooming);
- excessive or harsh punishment regimes;
- desensitisation to boundary-crossing behaviour such as strip searching, which might make staff less averse to engaging in more questionable forms of boundary-crossing in the future;
- intense pressure on staff resources (which make disclosures less likely to be investigated, or bring the feasibility of institutional aims into question);
- discriminatory attitudes towards race, gender and children with learning difficulties;
- cultures of loyalty and inward-looking moral validation.

4. Official responses to abuse and ill-treatment of children in custody, 1960 to c.1990

This chapter describes responses to abuse in places where children were held in custody from 1960 until the 1990s. It deals separately with Prison Service institutions and those in what became, during this period, the 'care system'. In brief, official responses to child abuse during this period was undifferentiated and reactive. Measures to secure inmate welfare in institutions for children were broadly similar to those in institutions for adults; and despite good intentions, subsequent allegations and investigations have demonstrated their weaknesses. Responses to abuse during this period relied on complaints to bring problems to light, and investigative measures were of dubious effectiveness. We describe the design and implementation of these responses, commenting on possible shortcomings which may have allowed abusive practices to develop, or compromised the ability of reactive measures to detect abuses.

Sections 4.1 to 4.3 describe safeguards in Prison Service custody, starting with a description of relevant sources of policy in 4.1. Since there was significant latitude for the exercise of staff discretion, the practical impact of policy must be considered in the light of wider trends in the nature of custody (and in staff culture) during this period. These trends are reviewed in section 4.2, with comments on what they imply for the lived experience of children in custody. The implementation of relevant safeguards in Prison Service establishments are reviewed and evaluated in section 4.3. In section 4.4, safeguards in the care system are compared and contrasted with those in penal institutions.

4.1. Sources of relevant policy in Prison Service establishments, 1960-c.1990

The statutory foundation of regulations affecting all Prison Service establishments is s.47(1) of the Prison Act 1952, which empowers the Secretary of State to 'make rules for the regulation and management of prisons'. Because Parliament passed (and amended) Rules for different kinds of establishment at different times, the full evolution of the legislative basis of youth custody cannot be given here.[3] This should not obscure the fact that *all* the different Rules have evolved from the same basic model laid down in the 1952 Act, which remains the legislative basis for imprisonment today.

Differences between the Rules in different kinds of institution were subtle and minor and few fundamental differences distinguish those governing adult and child establishments. For example, one form of custody, the Remand Centre, was designed specifically as pre-trial custody for under-20s, but never had its own Rules: the (adult) Prison Rules applied. Interestingly, the scope for corporal punishment was always more limited in Prison Service institutions (where it could only be applied by a magistrate, with the approval of the Secretary of State, and only for serious offences

[3] A simplified example, to illustrate the point: Parliament passed new Prison Rules, Borstal Rules and Detention Centre Rules in 1952. The first two were revised and reissued in 1964; the Borstal Rules were later revoked (but in fact substantially retained, with minor changes) by the YCC Rules 1983. Meanwhile, the 1952 version of the detention centre Rules was not rewritten, receiving only amendments before being revised and reissued in 1983. In 1988, however, both the detention centre Rules and YCC Rules were revoked by the YOI Rules, which nonetheless retained sections from both. Thus the 1988 YOI Rules bear a strong family resemblance to all their predecessors, and to the 1964 Prison Rules. Full versions of both were last passed in 1999, still retain many similarities, and in some sections even preserve wording from the original 1952 Rules.

such as mutiny or assaulting an officer) than in Home Office Approved Schools (where it could be applied by the headteacher and to sanction a wider range of behaviour). In short, the Rules varied according to the ostensible characteristics and needs of establishment, not those of the inmate.

All versions of the various Rules restricted the 'unnecessary' use of force by officers, and regulated and limited the use of punishments (including isolation and restraint) by holding their use to specified procedures. However, the Rules left considerable room for interpretation, and for the exercise of discretion by staff. Against the undiluted power that this discretion granted, Boards of Visitors or Visiting Committees, composed of local laypeople, were relied on as a reactive check against abuses.

Further non-statutory documents aimed guide staff in interpreting the Rules, and thereby to regulate their use of their discretion. Standing Orders and Circular Instructions (SOs and CIs) were usually revised *ad hoc* in response to wider policy and legal developments, although it is clear from archival materials that in many cases, such revisions brought policy into line with practice, not *vice versa*. Before the early 1980s, the existence and content of SOs and CIs were classified as official secrets, and they were gradually published only after litigation at the European Court of Human Rights (ECHR 1980). SOs and CIs were not indexed, and were circulated by the Home Office to governors, who had discretion to determine whether, how, to whom, and in what form they should be disseminated (Plotnikoff 1988, pt. II).

The dissemination of SOs and CIs was therefore haphazard, with the common practice being for governors to circulate edited versions and not the originals. Research conducted in the 1970s and 1980s found that it was not possible, outside the Home Office, to establish how many SOs and CIs were currently in effect. Furthermore, staff received no training on (and often did not understand) the legal status of Rules, SOs and CIs; they were commonly unaware of the content (and often the existence) of specific SOs and CIs relating to their particular roles (Plotnikoff 1988, 19–20; Cohen, Taylor, and Sulman 1978). The consequences could be serious: Inspectorate and inquiry reports documented how the non-implementation of policy contributed to suicides, for example, and high-profile escapes (HM Chief Inspector of Prisons 1984, chap. 6; Woodcock 1994).

Three points can be made in summary. First, in this period, the Prison Service did not make policies which recognised the rights and needs of children as distinct from those of adults; it instead created policies according to the requirements of the kind of institution which held them, often allowing policy to be led by operational practice. In principle, different policies could apply to the same child depending on the institution he or she was allocated to. Second, safeguards against abuse tended to be reactive, not preventive: instead of creating explicit safeguarding policies and earmarking resources for implementation, they relied on complaints to bring problems to light. The sole preventive measure was Boards of Visitors, which also had other duties. Third, even where specific policies existed in relation to child custody, we cannot assume that they would have been implemented consistently, or even that staff would have been familiar with them. It therefore seems likely that the occupational cultures of staff, and the operational exigencies of day-to-day institutional life, were at least as significant as policy in influencing how children in custody were treated.

4.2. Regimes and staff cultures in secure custody, 1960-c.1990

There were complex developments in the use of custody during this period. Most notably, the absolute numbers of children in Prison Service custody increased steadily through the 1960s and 1970s, fell substantially during the 1980s, then grew rapidly again from the early 1990s. These increases reflected the growing use of custody for 'juvenile' offenders aged 14 to 16, mostly boys (statistics in this section come from two academic overviews and official publications, namely Bottoms 2002b; Bottoms and Dignan 2004; Home Office 1983, 1980, 1984).

There were also changes in the *character* and *aims* of custodial establishments, both in the 'penal' and the 'care' system. These can be summarised as a gradual shift, in penal institutions, away from aims of *rehabilitation* and *training*, and towards aims of *secure containment*. In 1960, the Prison Service managed and ran several different kinds of institution, each with its own distinctive aims and practices. By the late 1970s, however, distinctions between them had become less meaningful. A challenging operational environment, a relentlessly rising prison population (of all ages), budgetary constraint, and serious industrial and prisoner unrest all made the fulfilment of rehabilitative ambitions increasingly challenging, so that the more rehabilitatively-oriented establishments became indistinguishable in practice from those with a more punitive orientation. By the 1980s, it was 'difficult to resist the conclusion that the borstal and detention centre [had] evolved into institutions for longer and shorter terms of something similar to imprisonment for the younger offender' (Harding et al. 1985, 249).

Custody in the 'care system', meanwhile, had been re-defined by the 1969 Children and Young Persons Act, and mostly comprised Community Homes. Under the management of Local Authority Social Services Departments (SSDs) they developed markedly different aims, objectives, cultures and practices to those which operated in secure settings in the penal system. This can broadly be described as a 'treatment' model of custody, which framed confinement as a form of stabilisation, used to better address the needs of children. This model found its purest expression in Youth Treatment Centres.

These wider trends are significant because of their links to staff culture. As we have seen from the findings of international enquires (see section 3.4) abuses are more likely to develop where staff lack a clear 'lead' as to the values and aims of the organisation, or where operational circumstances deprioritise their commitment to those values and aims. In such circumstances, staff will tend to operate according to their own values, beliefs and priorities as to the aims of the institution. These are often strongly influenced by occupational culture, which in turn is likely to shape how children in custody are thought about and treated. The following sections therefore review the occupational cultures of the main forms of child custody.

4.2.1. Borstals and prisons

In 1960, the cultural traditions of different forms of penal custody were substantially different. Borstal training was indeterminate but incorporated the possibility of 'remission' (or early release), to incentivise compliance. Borstal regimes incorporated programmes of occupational training, as well as physical and (to a lesser extent) academic education. Arrangements for 'after-care' (i.e. post-release supervision) were also far more extensive than in other forms of custody, and in general the aims of the institutions were framed more explicitly in terms of rehabilitation and

change, rather than punishment and retribution. By contrast, the occupational culture of adult prisons in 1960 was (again with some exceptions) less inclined towards objectives of rehabilitation and reform, more punitive, and more inclined to endorse the use of violence to maintain order. These differences reflected structural features: if the population of a prison was transient, resistant, or comprised many remand prisoners, it was more difficult for staff to imagine themselves as being seriously concerned with meaningful long-term change. Instead, their cultural values tended to be those of security and containment, though even these could find expression in more and less humane practices.

However, in the 1960s and 1970s, amid increasing population pressure on the secure estate as a whole, practices within establishments varied widely, so that the traditional borstal culture degenerated completely in some locations. Closed borstals, especially those designated for the most 'difficult' and 'refractory' inmates, struggled to deliver their regimes: in a 1973 parliamentary debate one MP reported that staff unions at Feltham were complaining it had become 'more or less a psychiatric institution' (Hansard 1973).[4] By the late 1970s, then, the borstal 'tradition', at least in closed borstals, had become little more than a rhetorical rallying point for staff, as is clear from the frequency with which it was invoked by officers disillusioned by penal change when an official inquiry visited their establishments in 1979 ('HO 263/370: Rochester Borstal' 1979; 'HO 263/413: Portland Borstal' 1979). It was not a practical reality on the ground.

Children on remand were held in adult prisons and remand centres throughout this period. From 1961 until 1999, the courts in large urban areas were served by dedicated Remand Centres (e.g. Ashford, Risley, and Low Newton). These held both boys and girls but were governed by the (adult) Prison Rules 1964. Elsewhere, both boys and girls were often placed on remand in adult prisons. Conditions for children were consistently grim, leading to repeated (though unsuccessful) efforts by policymakers to abolish the use of remand for children (For a detailed account of conditions in a remand centre, see 'HO 383/298: Ashford: Inspectors' Reports; Report by Prison Department Inspectorate' 1976; for responses by a Visiting Committee to a spate of suicides at Risley see 'HO 391/138: HM Remand Centre Risley, Warrington, Lancashire: Visiting Committee, 1969-1971' 1972; and also 'HO 391/139: HM Remand Centre Risley, Warrington, Lancashire: Board of Visitors, 1972-1974' 1976; for early policies designed to restrict remand for young people, see Home Office 1968; also *Criminal Justice Act* 1991; for evidence of ongoing difficulties in remand centres, see Howard League for Penal Reform 1993).

From 1954, children aged 15 and over were increasingly concentrated in 'Young Prisoner Centres' (not in fact separate institutions, but designated residential units within adult prisons, with undifferentiated regimes). YPCs were originally intended to hold a small number of 'hard cases' of any age under 21, but sentencers disillusioned by the shortcomings of borstals appear to have increasingly sentenced older children to imprisonment as a YP, rather than to periods of borstal training (Harding et al. 1985, 240–49).

By the mid-1970s an internal Home Office review recognised that most YPs differed little (in terms of their offences or their behaviour in custody) from borstal and detention centre trainees,

[4] Feltham, Rochester, and Reading all had the function of holding the most difficult inmates, at different times; Reading was the scene of major disturbances in 1967, and officers were subsequently prosecuted for brutality – see section 9.3.

although the latter continued to receive fuller and more purposeful regimes. This led eventually to a decision to accommodate some of the burgeoning YP population in specially designated accommodation within borstals; and because it then proved impossible to run separate regimes for them, in practice this meant that the distinctions between young prisoner centres and borstals had effectively collapsed by the late 1970s ('HO 391/216: Young Offenders General: Future Policy on Young Prisoners' 1975; 'HO 391/218: Working Group on Regimes for Young Prisoners: Minutes of Meetings' 1977). Though borstal training and imprisonment remained in law as different *sentences*, the review effectively abolished the distinctions between borstal and YPC *regimes*.

4.2.2. Detention Centres

Detention Centres rapidly evolved away from their original aim in the Criminal Justice Act of 1948 of providing a deterrent 'short sharp shock' for first-time offenders. From the beginning, magistrates sent children to DCs *not only* for first offences, but also for repeated low-level offending not deemed serious enough for an (indefinite) borstal sentence. Such volume offending, while often not particularly serious, is typically associated with complex and entrenched difficulties. The vast majority of DC sentences, however, lasted for three months (Advisory Council on the Treatment of Offenders 1963), and even the maximum sentence of six months left scarce time to address such entrenched difficulties. Annual reports by DC wardens through the mid-1960s abound with references to 'unsuitable' trainees sent by the courts, who they judged unlikely to benefit from the regime.

Some wardens, especially those who had previously worked in borstals, appear to have implemented a broader regime, more oriented around training, albeit with their scope limited by short sentences and rapid population turnover. Regimes with more than forty hours' weekly activity for children (including at weekends) were the norm, and this high 'tempo' was often noted when DCs were investigated by civil society groups or newspapers (Penal Affairs Committee of the Religious Society of Friends (Quakers) 1968; Lacey 1968).

DCs were in rural locations, with staff usually living in nearby staff quarters. This probably reinforced a widespread trend at the time for Prison Service staff to work significant overtime – working weeks in excess of sixty hours were not uncommon (Home Office 1979). Annual reports by DC wardens in the 1960s and 1970s cite the remote location of establishments, and the spartan nature of quarters, as a factor militating against the recruitment and retention of staff, particularly those with families. It was common for new prison officers to begin their career in DCs, to work in them for a short time but then to transfer elsewhere. As a result, DCs often functioned only with a small core of more experienced Senior and Principal Officers.

The response of most was to adapt as best they could, using the available skills and experience in the establishment. This meant that DC regimes were varied and inconsistent, and characterised by varied aims, as a review in 1967 identified:

> *'the original concept of the "short sharp shock" has been gradually modified by the introduction of an increasing element of "training", but the objects and methods of this form of treatment have not been redefined […] the absence of a clear guiding philosophy, and suspicion of the original concept, are reflected in a growing uneasiness about the functions and work of the detention centres'* (Letter

from Home Secretary Roy Jenkins, in 'BN 29/1076: Review of Detention Centres' 1968).

The lack of clarity over the aims and functions of detention centres left space for the abuse of power. An ethnographic study of life at Whatton (Ericson 1975), for which fieldwork was conducted between July and December 1972, describes a culture in which *most* officers routinely resorted to violence to intimidate new trainees, and preferred irregular, discretionary and sometimes collective punishments to the procedures laid down in the Detention Centre Rules. It appears that officers (and many trainees) preferred these informal methods, which though illegitimate and illegal, were less likely to result in the loss of remission (the main sanction applied in formal adjudications).

It is also clear from Ericson's research that officers at Whatton usually delegated some of their power to 'daddies' (i.e. high-status or disruptive boys able to make life difficult for staff), a practice which was also common in borstals. In exchange, 'daddies' maintained order among other boys through their readiness to 'use the knuckle'. 'Daddies' also received privileged jobs in the DC, giving them access to goods which could be used as forms of exchange in the informal economy. Ericson's account suggests that the delegation of power to 'daddies' was hidden by officers from Whatton's liberal Warden, and was exercised with the tacit approval of a harsh, punitive Deputy Warden.

At the other end of the trainees' hierarchy at Whatton lay another group, the 'divs'. 'Divs' were identified by the fact that they sought protection from staff or attempted to isolate themselves from life in the dorms. They were frequently the subject of disdain from staff and from other trainees, who subjected them to humiliation, violence and forms of defilement such as 'potting'. Some of these could certainly have been experienced as abusive, and some crossed boundaries such as nudity: one humiliation inflicted on 'divs' on the sports field by other boys, and described by Ericson, was repeatedly pulling down their shorts to expose their genitals. This was done in front of officers and apparently with impunity.

It appears also that harsh judgments on 'divs' were made by staff openly, routinely, *and officially*, as shown by a discharge report quoted by Ericson, which was written for a 'div' by a Senior Officer: 'This blubbering giant needed an above average amount of staff support at first … he must be made to face up to reality and be less of a cry baby …. A poor prospect indeed.' (Ericson 1975, 96)

Some caution is required in interpreting the evidence offered by this study: the age of the trainees it describes is not stated (some might have been as old as 20), and there is no way to be certain that the culture at Whatton was replicated elsewhere. Nevertheless, as the only ethnographic study of a Prison Service establishment holding children that we have discovered during our review of the literature, it provides a unique form of evidence, which can be used to illustrate three key points about an establishment where sexual abuse has since been alleged. All three points are relevant to our consideration of institutional culture in general.

First, it demonstrates that a 'brisk' or busy regime is not necessarily built upon the legitimate exercise of power by staff. It is too simplistic to equate 'punitive' regimes with abusiveness, or purposeful, 'rehabilitative' regimes with good treatment. At Whatton, the requirement to run a full and 'brisk' regime may actually have *encouraged* the illegitimate delegation of power to 'daddies', leaving officers free to concentrate on priorities other than the maintenance of order.

Second, it shows that in practice, trainees at Whatton were subject to strong (and gendered) cultural expectations about the 'proper' masculine behaviour that was expected of them while in custody. These expectations were enforced *both by staff and by trainees*: they were expected to conform with the environment, to 'look after themselves' using violence if necessary, and were disdained as weak – 'cry-babies' – if they did not. The existence of such a macho culture is hinted at (albeit in lesser depth) by other sources, such as a *Sunday Times Magazine* article which described a visit to Aldington, then a Senior Detention Centre (Lacey 1968). Protecting vulnerable individuals therefore appears to have been a low priority for staff, because vulnerability was seen as blameworthy. Individual staff members might have regulated bullying and victimisation, but in this climate, it is unlikely that *all* did. Such regulation was probably not a concerted effort, nor a matter of policy.

Third, it shows that (at least at Whatton), the routine treatment of trainees at detention centres included practices which (with the benefit of distance and hindsight) can plausibly be understood as humiliating, and which crossed personal boundaries. The practices described by Ericson were unremarkable enough to have been conducted in public, in front of staff and an external researcher, and with impunity. Similarly, the *Sunday Times Magazine* article describes the reception of a new inmate at Aldington, including a description of a strip-search which appears to have been conducted in front of the reporter:

> *'"Now your clothes, lad" [says the officer]. The last traces of civilian identity are peeled off. "Legs apart lad to be searched." The last traces of civilian dignity go too and the pain far deeper than physical hurt begins. The boy stares ahead dumbly, trying perhaps not to cry. "We have to search there, lad, it's prison regulations. Last week a lad had some pound notes on a string. It could have been drugs."'(Lacey 1968, 49)*

If, as has since been alleged, more serious and less acceptable forms of sexual victimisation were also taking place privately at Whatton (and other establishments) in 1972, then it seems unlikely that the institution's culture would have favoured disclosure.

4.2.3. Secure units in the care system

From 1960, the Home Office Children's Department (which oversaw the approved school system) embarked on a lengthy process of commissioning new secure units. These were a response to perceived control problems in (and widespread absconding from) approved schools. Three units opened, one each in 1964, 1965, and 1966. Subsequent research (Cawson and Martell 1979, 36–41) argued that these new units were initially intended as short-term deterrent custody for boys found to be too disruptive in Approved Schools. Instead, however, this aim shifted in practice, so that they became facilities for the long-term detention of children who were seriously disturbed or held indefinitely for very serious offences under s.53 of the 1933 Children Act.[5]

Both groups, and especially the latter, had much more complex and obvious needs, and were held for a much longer period than originally intended. As a result, secure units gradually developed a

[5] A prominent example was Mary Bell, sentenced at 11, in 1968, for the manslaughter of two boys aged 3 and 4. She was allocated to the Red Bank Special Unit, which until that point had held only held boys.

longer-term, more treatment-based set of practices and cultures than their deterrent aims might have implied. Longer periods of custody meant that spaces in secure units were soon in greater demand than had been foreseen, meaning that the early estimates of need (and hence of provision) were soon inadequate. Revised aims, methods and cultures (which emphasised long-term treatment) were reinforced after the secure units were reorganised under the 1969 Children and Young Persons Act, and put under the management of Local Authority Social Service Departments (SSDs) in 1970. Existing secure units were retained.

The 1969 Act foresaw that local authorities would work together in regional groups to create further secure accommodation if they felt this was necessary; some had already committed resources to construct new secure accommodation. However, arrangements for Regional Planning Boards in the 1969 Act were never implemented. Regional planning of secure accommodation therefore did not go ahead. This left councils which already possessed secure units (or which had committed funds to build them) with an expensive resource which they would later discover they could not fill on their own. One consequence was that many did not build accommodation, or cancelled plans to do so. This partly explains why detention centres continued to be necessary into the 1980s: under the original intentions of the 1969 Act, local authority secure units were to have replaced them. By the late 1970s, research into allocations found that the strongest predictor of whether SSDs allocated children in care to secure units was not any characteristic of the child, but whether the council possessed a secure unit in the first place. Put differently, secure units were generating demand, as much as meeting it: the need for them was justified by their use.(Cawson and Martell 1979, 144–46; Harris and Timms 1993, 99–101)

4.3. Checks and balances in the penal system

Although policies and procedures to protect children in penal custody were underdeveloped, this section describes some arrangements which *were* in place, and which might be expected to have acted as indirect safeguards against abuse. Boards of Visitors, which were responsible for visiting penal establishments regularly, and hearing and investigating complaints, are covered in section 4.3.1. Prisons were also visited by an Inspectorate (section 4.3.2), and the prevailing culture of establishments was modified from the 1950 onwards through the gradual introduction of 'welfare officers' and other specialist staff (section 4.3.3). The increasing number of non-prison officer staff in prisons introduced different professional orientations to penal institutions, and may therefore have diluted or altered the overall organisational culture. Finally, there were also various procedures in place for the investigation of complaints (section 4.3.4). We review each check and balance in turn, and note weaknesses in these arrangements which limited their overall effectiveness as safeguards against abuse.

4.3.1. Boards of Visitors

If policy did not proactively safeguard the abuse of children, and staff cultures were relatively unconstrained, then the main protection for children in custody was the Board of Visitors, which was charged with monitoring conditions. The basic duty of Boards was to 'satisfy themselves as to the state of the prison premises, the administration of the prison and the treatment of the prisoners' (*The Prison Rules* 1964). They were to be given free access to the establishment, to meet together there at least eight times annually, to make individual 'rota visits' at least weekly, and to hear prisoners' complaints or requests.

In practice, however, the ability of Boards to conduct their 'watchdog' role was questioned with increasing frequency from the 1970s, leading to unfavourable comment in official inquiries and in research findings (Home Office 1979, 1985b; Jellicoe, Howard League for Penal Reform, and Nacro 1975; Maguire and Vagg 1984). Research commissioned by the Home Office found that prisoners doubted their independence (Maguire and Vagg 1984), and while Boards frequently objected to such criticisms, a close reading of their annual reports suggests that their approach to their task varied considerably.

Some Boards made it their business to *actively defend* their establishments against outside criticism: annual reports by the Board of Risley Remand Centre between 1969 and 1976, for example, document the Board's strenuous efforts to rebut 'irresponsible statements' about high suicide rates and allegations of staff brutality, made variously in press and parliamentary debate ('HO 391/138: HM Remand Centre Risley, Warrington, Lancashire: Visiting Committee, 1969-1971' 1972; 'HO 391/139: HM Remand Centre Risley, Warrington, Lancashire: Board of Visitors, 1972-1974' 1976; 'HO 391/140: HM Remand Centre Risley, Warrington, Lancashire: Board of Visitors, 1975-1976' 1977).

Similarly in 1971, the Board at HMDC New Hall (which had recently conducted an inquiry into allegations of staff brutality) reported that 'a reporter in seeking to make news, quoted […] Prison Statistics [to say] that New Hall [had the] highest *pro rata* number of disciplinary reports of all Detention Centres'. They reported having raised this matter with the Warden, who had replied that dealing with 'acts of misbehaviour in an open [i.e. official] manner inflated the numbers compared with the methods used at some other Detention Centres'. The Board reported that the subject could be 'put in a better perspective' by pointing out that they had only once been asked to adjudicate on a trainee's behaviour during the previous year. Rather than interpreting this as possible evidence of a closed, abusive culture, and *even after the recent brutality inquiry*, the Board at New Hall were reliant on the management for their understanding of institutional life, and lacked an independent basis on which to evaluate the establishment (1971 annual report, in 'HO 391/128: HM Detention Centre New Hall, Wakefield, Yorkshire: Board of Visitors, 1966-1971' 1972).

Other archival evidence suggests conflict between Boards and managers over the aims and purposes of the establishment. One such disagreement occurred at HMDC Medomsley in 1975. The Warden's annual report for that year describes how the Board disagreed so strongly with his plans to introduce new activities to the regime (e.g. swimming and hiking outside the establishment for trainees in their last month of detention) that all but two of its members resigned. One of them is quoted by the Warden as saying, 'boys are sent here for detention not for training'. If accurate, this reveals conflict over aims, and suggests that some Board members may have seen themselves as the guardians of the original, more punitive/deterrent traditions of DC custody. By 1976, a new Board, comprising the two remaining members of the original Board and new members recommended by the Warden, was settling in ('HO 383/327: Medomsley: Annual Reports' 1976). At a time of turbulence in policy and operational reality, this shows that Medomsley's management and the Board were in fundamental conflict regarding institutional aims and the methods to achieve them. This is also an example of the limits to Boards' independence, since the Warden appears to have nominated replacement Board members himself.

Until at least the 1980s, recruitment to Boards was not by advertisement, but usually relied on existing Board chairmen (or prison governors) recommending appointments to the Secretary of State. One consequence was that Boards lacked diversity: in general, their members were white, retired, and often magistrates. They were significantly older than those whose custody they oversaw, and generational differences are sometimes evident in baffled (and occasionally contemptuous) references to youth culture. For example, the Board at Eastwood Park, in its 1970 report, attributed violence at the Centre to 'bigger intakes and the overlap of the "long haired" and "skinhead" elements' ('HO 391/101: Boards of Visitors: Replacement of Visiting Committees at Local Prisons and Remand Centres; Courts Act 1971 and Amendment to Prisons Act 1952; Draft Letters to Organisations and Prison Governors' 1971; 'HO 391/99: Visiting Committees: Replacement by Boards of Visitors; Explanation of Distinction between Both Groups; Historical Backgrounds' 1973; see also Jellicoe, Howard League for Penal Reform, and Nacro 1975).

Annual reports by Boards in the 1960s and 1970s also demonstrate that they tended to see vulnerability in inmates as evidence they were ill-suited to the regime, rather than that the institution was failing to meet individual needs. The 1966 annual report for Haslar DC, for example, reports that 'a number of attempted and feigned attempted suicides […] endorsed the absolute necessity for careful selection when sending lads to Detention' ('HO 391/121: HM Detention Centre Haslar, Gosport, Hampshire: Board of Visitors, 1966' 1967, emphasis added). In general, it was common for reports by Boards, like those by wardens and governors, to frame self-harm and suicide as manipulative and thus a disciplinary matter, or as evidence that unsuitable trainees were being sentenced to detention ('HO 391/116: HM Detention Centre Eastwood Park, Wotton-under-Edge, Gloucestershire: Board of Visitors, 1968-1971' 1971). Boards generally expected inmates to adapt and get on with their sentences, not to pursue complaints: the Board at HMDC New Hall described trainees' legal appeals as being 'motivated solely as being means of getting out of the day to day routine of the Centre rather than out of a genuine feeling of grievance against the sentence' ('HO 391/128: HM Detention Centre New Hall, Wakefield, Yorkshire: Board of Visitors, 1966-1971' 1972). The criterion used to judge a grievance 'genuine' is not clear.

4.3.2. Prisons Inspectorate

Before 1980, HM Inspectorate of Prisons was an internal department of the Home Office. Rather than independently developing its own inspection methodology and performance benchmarks (as it does now), it inspected for adherence to policy. It had no responsibility to hear individual prisoner grievances and thus was not, strictly speaking, a reactive safeguard in the same way as the Boards. Such a role was held to be unnecessary on the grounds that prisoners could use the courts and the Boards of Visitors if they had complaints ('HO 263/47: Prison Department Inspectorate' 1979).

Inspectorate reports were not published before the 1980s, and only two files that we reviewed at the National Archives preserve full reports on specific institutions : Ashford RC in 1971 and Medomsley Detention Centre in April 1977 ('HO 383/298: Ashford: Inspectors' Reports; Report by Prison Department Inspectorate' 1976; 'HO 383/329: Medomsley: Inspectors' Reports; Report by Prison Department Inspectorate' 1977). While both documents sometimes contain comments on the *culture* and *atmosphere* of these establishments, these are mostly found in introductory remarks preceding the main body of the report, and they do not appear to inform any of the inspectors' recommendations. Neither report offers evidence that any systematic attempt was

made to collect the opinions of inmates, and the inspectors' interactions with them are reported only in summary. The bulk of both reports concerns the extent to which the establishment is operating smoothly, including the effectiveness of management and the use of resources.

The 1977 report on Medomsley is of particular interest because sexual abuse is known to have been perpetrated there during that time. Yet under the heading 'General Impressions', the report states: 'the detention centre has never hit the headlines and within the Prison Department has apparently been accepted as a place where nothing of any import ever occurs and one which is unlikely to cause any problems' ('HO 383/329: Medomsley: Inspectors' Reports; Report by Prison Department Inspectorate' 1977, para. 01.02). Despite this picture of apparently smooth operation, subsequent paragraphs go on to suggest that institutional drift and internal conflict were particularly apparent at Medomsley: recent spates of industrial action are described,[6] with a staff representative quoted as having described the Warden to the inspectors with 'both venom and acrimony in a manner which the Senior Inspector had not previously encountered'. Conflict at Medomsley appears to have been rooted in divergent views over the aims and methods of the institution:

> *'the Medomsley tradition has long been for trainees to jump to attention and to stand as robots when an official passes by. The excessive marching, exaggerated drill, "skin-head" haircuts, endless kit changes, perpetual motion, "spit and polish" and so on, of former times have now disappeared. The atmosphere of the Centre is relaxed. Staff are caring. Trainees are polite, although not particularly communicative. They are, indeed, very manageable, perhaps more so than most other trainees in the detention centre system. But neither they nor the staff seem to know what the purpose of the centre really is...'* ('HO 383/329: Medomsley: Inspectors' Reports; Report by Prison Department Inspectorate' 1977, para. 01.04)

In an environment lacking a clear purpose, where safeguards against abuse were weak, and where staff operated with discretion, there was great potential for things to go wrong. The report by inspectors on 'Catering' gives a glimpse of working conditions for trainees working in the kitchen at Medomsley:

> *'A labour force of 13 trainees cover the daily requirements from 06:45 to 18:00 weekdays and from 07:00 to 17:00 weekends. Four trainees on a rota basis remain in the kitchen to 19:30 weekdays to clean the kitchen […] the kitchen party work a 7-day week, although provision is made for one hour's PE each weekday […] Trainees who are considered medically fit for work in the kitchen are selected by the Officer Caterer'* ('HO 383/329: Medomsley: Inspectors' Reports; Report by Prison Department Inspectorate' 1977, para. 11.01 to 11.08).

This 'brisk' regime, featuring a great deal of time performing what is now understood as 'purposeful activity', was very far from a guarantee of the safe or legitimate exercise of power. These trainees spent practically the whole week in the kitchens, supervised by a single member of staff who hand-

[6] These are also mentioned in the Warden's annual reports for 1975-77.

picked them to work there. It is now known that this member of staff had, by 1977, been sexually assaulting trainees for some time with impunity.

It is striking that the inspectors appeared to lack the concepts and language to think about this situation as risky or potentially abusive. The kitchen, like other parts of the establishment, was evaluated by other priorities: the inspectors' recommendations all concerned specific matters of cleanliness and administration, and their overall judgment was that 'Medomsley possesse[d] a well-organised and efficient catering department'.

In brief, inspections *were* conducted by staff from outside the institution, but tended to be specifically concerned with checking compliance with policies and procedures, and not with more reflective thinking as to whether these were fit for purpose. Moreover, inspectors (like Boards of Visitors) were familiar with prisons and with what appeared normal in this peculiar social setting. This was so until at least the mid-1980s, by which time the Inspectorate of Prisons had been re-established on a more independent basis, and had begun to publish its reports. Yet as we will see in chapter 5, it was not until the 1990s, when the Inspectorate called in outside expertise to inform its thinking on child imprisonment, that it began to ask more fundamental questions regarding conditions experienced by children in custody.

4.3.3. 'Welfare Officers' and other non-discipline staff

Arrangements to protect the 'welfare' of children in Prison Service custody had a common structure throughout this period and were strongly associated with arrangements for 'after-care'. From 1955, all Prison Service establishments employed Welfare Officers in what was in theory a social work role. From 1965, some Welfare Officers were seconded from the local probation service (usually for a two-year period), and from 1969 these secondment arrangements were adopted as the norm. Like chaplains, doctors, psychiatrists and teachers, who were not in residence and usually came into establishments part-time during the week, Welfare Officers were part of growing body of professionals offering social, emotional, medical, spiritual and educational services in prisons.

In reality, however, their role was limited, and establishments found it difficult to fill posts with suitably qualified staff. It was common until 1965 for Welfare Officers to lack formal training or qualifications. Although there was a requirement that they should have a background in social work (Advisory Council on the Treatment of Offenders 1963), governors' and wardens' annual reports make clear that this was often difficult to achieve, with posts remaining vacant for up to a year, and the remote location of some institutions a significant factor. Retaining staff (except in the role of chaplain) often appears to have been difficult.

Nevertheless, the individuals who filled Welfare Officer roles were very different from the 'discipline staff' (i.e. prison officers) in terms of gender and ethos, given that their roles were explicitly organised around aims of care and support. Wardens of male DCs often stated in their annual reports that they preferred to employ women Welfare Officers, contrasting their 'softer' manner with that of the male discipline staff. At Bullwood Hall girls' borstal, on the other hand, the governor's preference by the late 1960s was for one of the two Welfare Officers to be male (and thus for the team to be mixed), to complement the (female) discipline and management staff ('HO 383/257: Bullwood Hall Borstal: Inspectors' Reports 1969-1975' 1975). Annual reports suggest cultural differences between the probation officers who filled most of the welfare posts, and the

discipline staff upon whom they relied for access to their 'clients'. Indeed, probation staff often struggled to integrate themselves, and reported having to learn to 'speak the language' of borstal and detention centre officers in order to carry out their roles. This included performing a certain harshness and cynicism towards trainees, but also adapting their own aims and objectives to fit in with what was possible within the operational constraints of a custodial setting ('HO 391/213: Joint Committee on Young Offender Treatment and Training (Replaced Neighbourhood Borstal Steering Committee): Minutes of Meetings February-June 1977' 1977; 'HO 391/215: Joint Committee on Young Offender Treatment and Training (Replaced Neighbourhood Borstal Steering Committee): Minutes of Meetings February-June 1977' 1977).

In policy terms, the Welfare Officer was required to interview inmates on arrival and (throughout the sentence) to 'advise, assist, and befriend'; this was the ostensible central aim of all probation work (Vanstone 2004). Towards the end of the sentence, it was the Welfare Officer's role to contact family, local probation staff, and relevant local agencies to plan for release and (occasionally) supervise the released prisoner. In borstals, longer sentences meant there was more time to work with and build relationships with individuals, and 'after-care' work had deeper roots, because the borstal sentence had always included a period of supervision after release. In detention centres, the rapid population turnover meant that the one (or at best two) Welfare Officers worked under greater pressures, each handling a caseload of between 500 and 1,000 inmates annually. The Warden's report from Kirklevington in 1975, for example, noted that with 98 per cent of the DC's population turning over every three months, the caseload for the one welfare officer exceeded 600 per year:

> *'[The welfare] department makes a very real and valuable contribution to the trainees, who being the children they are, need much more support and care than would be the case with adults. The fact that they are only with us for eight weeks means that Welfare problems become urgent problems by virtue of the time available in which to resolve them […] The inadequacy of the staffing […] particularly in junior D.C's is so bad that much valuable help cannot be given because of pressure of numbers'* ('HO 383/325: Kirklevington Grange: Annual Reports' 1975).

A similar assessment of the Welfare Officer's caseload carried out at Medomsley in 1971 supports the Warden's contention that this was not an isolated problem ('HO 383/328: Medomsley: Welfare Arrangements; Experimental Scheme with Student Volunteers Offering Personal Contact and Help for Detainees during Detention and after Release' 1975). Even at Bullwood Hall – a borstal with a more stable population – welfare officers struggled with heavy workloads, finding in 1970 that they were 'unable to give much time to talk with girls except on a crisis basis and in relation to discharge plans' ('HO 383/257: Bullwood Hall Borstal: Inspectors' Reports 1969-1975' 1975). Given their view that 'girls in custody needed more welfare work than did men', there was continued frustration within the local probation service that it had diminished to a skeletal role at Bullwood Hall by 1973. (This comment is also revealing in its unspoken assumption that male trainees were more resilient and able to cope with less welfare support.)

Thus, for a variety of reasons, the role of Welfare Officers – who in theory provided a social work service and might have been expected to be at the frontline in identifying abuse, receiving

disclosures, or acting as whistleblowers in relation to institutions – was significantly curtailed in practice. Children had, at best, limited access to them. Furthermore, their work was often restricted to making practical arrangements for release, and they were sometimes forced by institutional circumstance to compromise on their own priorities in order to work effectively with discipline staff.

4.3.4. Complaints and staff disciplinary procedures

At the start of this period, prisoners who wished to make complaints could do so in various ways: orally, via petition to see the governor or the Board of Visitors, or via a letter to an MP, the Secretary of State, or the European Court of Human Rights. In practice, however, the expectation was that most such complaints would be rejected unless they had first been handled within the prison *and* unless the complaints were serious ones concerning the conduct of members of staff. Additionally, *all* prisoner correspondence was read by staff, as a matter of course and in accordance with the Prison/Borstal/DC Rules. There were not, as there are today, any forms of protected correspondence.

If a complaint did make an allegation against a member of staff, Circular Instruction 88/61 (issued in 1961) offered guidance on the procedure to be followed. It stated that *however the complaint came to light* the complaint should go no further before a warning regarding false allegations had been read to the complainant:

> *'The following form of warning shall be used. This […] should not be made to sound a threat to compel [the prisoner] to drop the complaint: "If you wish to make a complaint against an officer I shall hear it and it will be fully investigated. You know that it is an offence against discipline to make false and malicious allegations against an officer. You should consider carefully whether you wish your complaint to go forward, and if you do you should make a full written statement, giving the names of any witnesses you wish to call."'*(From 'Allegations agianst officers by inmates', CI 88/61, in 'HO 413/6: Guidelines for New Procedures for Investigating Complaints against Prison Officer Staff: Complainant and Complainee's Rights' 1978)

The Circular Instruction went on to say that if a written complaint *was* made, it should be investigated internally by the Governor (or Warden). Prisoners dissatisfied with the outcome could raise the matter with the Board of Visitors, or by writing to their MP, the Secretary of State, or the European Court (although all such letters would first have been read by prison staff). Attempts to raise the matter with these external actors before they had been handled in the prison would usually be passed back to the governor. On occasion, the Home Office Prisons Department appointed a more senior member of staff such as an area manager (i.e. not working at the establishment concerned) to investigate complaints. Such investigations were known as 'superior investigations', but records of these, and of complaints in general, were not kept centrally before the 1990s, so it is impossible to estimate how many complaints were investigated in this way or how they were resolved.

The main archival evidence we have found giving detailed information on complaint handling is a Home Office file concerning the review of CI 88/61; the file was opened in 1974 and closed in 1978.

Certain facts stated in the file underline the difficulties involved today in estimating the prevalence of complaints in general, or describe how they were typically investigated. No central monitoring statistics on complaints, whether relating to 'internal' or 'superior' investigations, were routinely compiled. The overall frequency of complaints can therefore only be a matter for speculation, along with the thoroughness and independence of their investigation. Indeed, the review of CI 88/61 itself appears to have drawn mostly upon consultation with governing governors; the implication here is that the Home Office lacked sources of independent data with which to evaluate the operation of the complaints system.

Although the handling of the vast majority of complaints is therefore invisible in the archives, the file does refer, in some depth, to eight complaints which had been subject to 'external investigation' in the nearly two decades between 1956 and the review, which was initiated in 1974 and resulted in a new Circular Instruction issued in 1978. An undated table, drawn up for the review, summarises key aspects of these eight investigations, and is reproduced in full in Appendix 9.3 ('HO 413/6: Guidelines for New Procedures for Investigating Complaints against Prison Officer Staff: Complainant and Complainee's Rights' 1978).

Although the eight probably represent only a handful of all prisoner complaints during this period, some key points about them can be drawn out which may shed light on complaint handling in general. The evidence they provide should nevertheless be interpreted cautiously: far from being typical, external investigations probably represent the peak of independent scrutiny for prisoner complaints during this period.

- The source of seven of the eight complaints was an ex-prisoner, who raised the matter (sometimes on behalf of peers still imprisoned) via an outside channel, usually a newspaper. This suggests that it was very nearly impossible for serving prisoners to raise complaints externally through the 'proper' channels, without outside support, probably because of censorship. Indeed, the only complaint raised by serving prisoners with no external assistance, and subsequently investigated externally was made in a letter to a newspaper, signed by 120 inmates at Parkhurst, which had been smuggled out of the prison in 1969.
- Just one of the eight complaints received a preliminary investigation within the prison. This has two implications: first, that the procedure in CI 88/61 was not always followed (i.e. complaints raised externally were *not* always passed back to the governor for internal investigation); and second, that adverse publicity was probably the key factor causing the Home Secretary to order an external investigation in each case.
- Four of the eight complaints concerned staff brutality in establishments which routinely held children. Two of these were partly upheld. Given the formidable obstacles to raising effective complaints, it is very unlikely that these four represented the only instances of staff brutality against children during this period; if brutality was more widespread, it probably failed to generate effective complaints. Because no complaint relates to allegations of a sexual nature, we can only speculate as to how such allegations might have been handled in prisons at that time.
- Seven of the eight external investigations were conducted by Boards of Visitors. The Home Office review comments on the reasons for this: the only exception was the first of the eight (an inquiry held at HMP Liverpool in 1956). This had been conducted by a QC, and was

'universally condemned' at the time, with 'effects [that] were felt in the service for many years afterwards'. A paper in the file states that this was because its terms of reference were 'too widely drawn', inmates were promised that there would be no disciplinary proceedings if their allegations were 'proved to be unfounded', and the inquiry generated 'disciplinary proceedings against some officers [which] arose from complaints unconnected with the original allegations'. Memories of this had lingered, and 'any attempt to revive this form of inquiry would have no chance of carrying staff confidence. Indeed, the same could be said of any inquiry by a person or body without knowledge or experience of the prison service *and the facts of institutional life*' ('Investigating Allegations', undated paper in 'HO 413/6: Guidelines for New Procedures for Investigating Complaints against Prison Officer Staff: Complainant and Complainee's Rights' 1978, paras 29–30 Emphasis added) The official preference after 1956 was therefore to rely on Boards of Visitors to conduct external investigations, and this was formalised as policy by the revised 1978 Circular Instruction.

- In none of the eight external investigations did any prisoner receive any form of legal representation. Staff were represented by lawyers in all cases but one.
- Finally, only the first two inquiries (in 1956 and 1963) published their findings; thereafter, it was normal practice for summaries to be released via arranged questions in Parliament, and later by press releases.

We have only been able to trace a more detailed account of one of these eight external investigations: the published report of an inquiry at HMP Durham (Home Office 1963). It permits only a tentative evaluation of how allegations were handled and does not definitely concern allegations made about the treatment of children. Even so, as the only available documentary evidence we have uncovered which relates to the handling of specified complaints, a summary of key points is appropriate.

- First, since the allegations had been raised by an ex-prisoner, it was difficult for the inquiry to make confident conclusions regarding alleged incidents which had, in some cases, occurred a year or more beforehand.
- The the conduct of the inquiry bears the imprint of lessons learned from the 1956 Liverpool inquiry: the report states that the hearings were informal and procedurally *ad hoc*, witnesses could not be compelled to attend and were not questioned under oath, and some who had since been released could not be traced.
- Prisoner witnesses were read a warning about making false allegations before giving their evidence, and two members of Prison Service staff (one from headquarters, and one from Durham) were present throughout the hearings, as clerical support to the Board.Although the report does not make clear what standard of proof the Board applied, it is clear that a presumption of innocence framed its consideration of staff conduct.
- In relation to one complaint, the report records the Board's distrust of two officers accused of brutality, stating that they were suspected of collusion. Nevertheless, because there was no *conclusive* evidence to the contrary, the Board's adjudication was that the complaint was unfounded. No action against the officers was recommended despite the suspicions about their evidence, and it is unclear from the Board's report whether any was taken.

- Finally, some of the complaints alleged that the prison had failed to prevent specified cases of suicide or self-harm. None of these complaints were upheld, and commenting on this finding the inquiry's report drew attention to what it described as a 'general consideration': that self-harm and suicide attempts are often 'simply a gesture or [a] means of attracting attention […] this is a well-known feature of prison life' (Home Office 1963, 26). This is evidence that the Board considered the complaints using its prior understanding of what was 'normal' in the penal environment. This, as the 1978 Home Office review had stated, was seen as a definite advantage when it came to handling external inquiries in a manner which commanded staff confidence.

Although the available archival evidence is therefore partial, it is very difficult to avoid the conclusion that the system for handling prisoner complaints had grave shortcomings, as did the ability of Boards of Visitors to provide independent oversight of custody. Indeed, this was clear to outside observers: shortcomings in both the complaints system and Boards featured prominently in materials published by campaigning groups during the 1970s and 1980s. By the 1980s concerns were serious enough for the Home Office to commission research into the effectiveness of Boards (Maguire and Vagg 1984), and the inability of the complaints system to counteract the great disparities of power between prisoners and staff was a matter of consensus in official sources by the late 1980s (HM Chief Inspector of Prisons 1987; Prison Reform Trust 1988; Nacro 1989, 1988).

The available archival evidence relating to staff disciplinary proceedings consists of a single Home Office file from 1980, which reviews the policy to be followed if allegations were made against an officer (whether as a result of non-criminal disciplinary charges, police investigation of conduct at work, or a non-work-related charge or summons). It is clear from the file that some offences by staff were, if proven, seen as grounds for automatic dismissal, and that officers accused of these would have been suspended from duty during any investigation. The nature of the accusations, and the action to be taken in each case, is given in Table 2. It is unclear whether this 1980 review resulted in a new Circular Instruction, and therefore impossible to state whether this policy was followed in practice. It is, nonetheless, remarkable that the table demonstrates a limited but definite level of tolerance, within headquarters, towards those accused of 'minor' acts of violence committed off duty. It is also remarkable that an alleged sexual offence committed off duty was not considered automatic grounds for dismissal (or suspension). Table 2 overleaf demonstrates that offences which interfered with the smooth running of the prison were dealt with more severely, and that allegations concerning a staff member's actions outside prison were subject to a (qualified) presumption of innocence, rather than a preoccupation with the risks they might signal.

Table 2: Offences liable to result in the suspension/dismissal of prison officers in 1979 ('HO 413/38: Suspension from Duty of Prison Officers. Decision to Take Prison Officers off Duty after a Complaint Made against Them. List of Offences for Which Prison Officers May Be Suspended' 1979).

Offences automatically liable to suspension while investigated and dismissal if proven	**Offences possibly liable to suspension while investigated and dismissal if proven (to be reviewed by HQ)**	**Offences not liable to suspension or dismissal**
• Theft (on or off duty)	• Off-duty sexual offences	• Driving offences

• Assaults on inmates • Serious off-duty offences (e.g. rape, GBH) • Other serious off-duty offences (burglary, robbery, etc.) • Sexual offences committed while on duty • Trafficking	• Second/third minor offence of violence committed while off duty • Off-duty minor frauds (e.g. not paying railway fare)	• First offence of common assault or ABH committed while off-duty

Despite gaps in the available evidence, it is still possible to draw some reasonably confident inferences from this review of complaints and staff disciplinary procedures.

- Given how difficult it was for adult prisoners who lacked outside assistance to raise complaints and have them considered externally, it must have been much more difficult for children.
- Investigations were hampered by a number of factors: it was difficult to raise complaints; investigations were seldom independent; investigations lacked transparency; and they were preceded by considerable formal (and probably informal) disincentives to pursuing the complaint.
- External investigations were rare, were conducted without legal representation for prisoners, and were rarely more than minimally independent or transparent.

Taken together, these findings suggest the overall conclusion that formal checks on staff power were nearly non-existent, and those that did exist were mostly ineffectual, until at least the 1990s. This means that prisoners (both adults and children) would mostly have been reliant on informal and illicit methods of resistance, or on private strategies of coping with problems generated by their confinement.

Finally, children generally are less aware of their rights than adults and less inclined to complain, unless specific efforts are made to remedy this. Table 3 supports this view, showing that children were massively less likely than adults to apply to see the Board of Visitors. The overall conclusion of this section can only be that if children *were* being abused, they were not only very unlikely to complain, but also very unlikely to be heard. Care for the vulnerable in Prison Service establishments can only have been haphazard; it was not assured by clear and well-implemented policies.

Table 3: Annual recorded applications to the Board of Visitors in 11 establishments sampled for Home Office research in the early 1980s. Establishments which held a majority of under-21s are asterisked (Maguire and Vagg 1984, 80).

Establishment	**Recorded applications**
Local 1	340
Local 2	334

Local 3	230
Female local	174
Dispersal	140
Training	72
YP Training*	34*
Remand Centre*	16*
Open	8
Borstal*	3*
Detention Centre*	2*

4.4. Checks and balances on institutional power in the care system

4.4.1. The institutional landscape

Arrangements to limit the power of secure accommodation in the care system differed considerably from those in prisons. Systems of control and regulation were much more localised and reflected considerable variation in the ownership and management of Community Homes. Specifically, they reflected the fact that many homes (especially smaller ones) were owned and run by voluntary organisations.

Before the consolidation of 'the care system' during the early 1970s, the institutions which became Community Homes had been run by a patchwork of local, regional and national providers, and were regulated differently, chiefly according to whether they were Approved Schools or voluntary children's homes. The process of redefining their powers and the limits upon them was long and complicated; far from the centralised 'command and control' structure of the Prison Service, the structures involved were localised and highly decentralised.

Local authority Social Services Departments (SSDs) were created by the Local Authority Social Services Act of 1970. Forming these, planning the local and regional provision of accommodation, and negotiating new agreements with private and voluntary homes to bring them under the oversight of SSDs took considerable time. The task also had to be accomplished against the background of a major reorganisation of local authorities generally under the 1972 Local Government Act. It is no overstatement to describe the early 1970s as a significant period of 'turmoil', organisationally speaking (Waterhouse 2000, 25).

4.4.2. Regulations and checks on staff power

Regulations for the new Community Homes drew on basic principles established by the 1969 Children and Young People Act. This provided SSDs with considerable latitude to shape provision in their respective areas: they could own and establish homes on their own premises and under their own management, but could also buy in accommodation from other providers. 'Voluntary homes' were run by voluntary organisations but were not designated as 'specialist' accommodation; places

in them were for general usage and commissioned *ad hoc*, and they were usually relatively small. They did not include units with secure accommodation, and therefore play no further part in this section.

Where specialist provision of any sort (such as secure accommodation) was required, it could be built and managed directly by the SSD or commissioned from a third party. Regardless of which arrangement applied, the organisation responsible for the home had to provide for *both* its day-to-day management *and* for its governance and oversight. In the case of homes under the control of the SSD, oversight was carried out by such persons as the local authority considered appropriate. In homes in the voluntary sector, a board of volunteer 'Managers' was appointed by the organisation, on terms agreed with the SSD and specified in an Instrument of Management.

This system was formalised and elaborated by the 1972 Community Homes Regulations, which created a single system of checks and balances, but left different authorities responsible for implementing it depending on the ownership of the home. Key to both was the concept of the 'responsible body', namely the organisation accountable for governance and oversight. This body was to appoint a 'person in charge' to be accountable for certain key operational decisions, but also responsible for the 'conduct' of the home – that is, whether it was making 'proper provision for the care, treatment and control of the children who are accommodated therein' (*The Community Homes Regulations* 1972, sec. 3(2)). The Regulations required responsible bodies to arrange for homes to be visited at least once a month for this purpose, and to submit a written report to the responsible body. Where there was a board of Managers, this visit was done by one of their number; and where it was the SSD, the local authority could appoint whomever it considered appropriate.

In both cases, therefore, the Regulations made the same body responsible both for the day-to-day management of the home, and for its inspection. This created the potential for conflicts of interest. In addition, where the responsible body was a board of volunteer Managers, there was no guarantee that visits would be undertaken in different homes by someone with relevant training or specific qualifications: Managers were volunteers and the quality of oversight provided by their visits was down to the qualities of the individual. A similar picture applied in homes controlled by SSDs. The Act and the Regulations left local authorities largely free to devise their own methods of quality assurance for children's homes. A handful set up their own inspectorates, either locally or regionally in partnership with other SSDs, but most arranged for the statutory monthly visits to be carried out by senior managers within the SSD, many of whom (as inquiries have shown) had no specific prior experience or training in work with children or in residential care (Waterhouse 2000, 33–34).

Throughout the 1970s, there was also no direct system through which Community Homes received regular outside inspections, other than by the bodies responsible for their day-to-day operation. Approved Schools had been subject to regular inspection by the Home Office Children's Department. However, the reorganisation of the care system under the 1969 Act was explicitly intended to shift responsibility for inspection to the local level, effectively redefining the relationship between local and central government. Thus section 58 of the 1969 Act still allowed the Secretary of State to appoint inspectors to inspect homes 'from time to time', but this power was not used to create a regular programme of central government inspection until the 1980s.

Instead, in the words of section 7(1) of the 1970 Local Authority Social Services Act (which implemented their creation) the new SSDs were to 'act under the general guidance of the Secretary of State', but to have considerable discretion to run their activities as they saw fit.

Nevertheless, these new organisations still required considerable support to get to grips with their new task. To this end, the Home Office Children's Department Inspectorate was transferred to the Department of Health and Social Security and given a new name and new tasks. The new Social Work Service Development Group (later renamed the Social Work Advisory Service) was 'not so much regulatory as promotional, educational and consultative' (Waterhouse 2000, 27). This may have reflected cultural differences between Whitehall departments, and it certainly left some Home Office staff uneasy ('BN 29/999: Transfer of Inspectorate to DHSS' 1971).[7] It also, however, reflected a more general desire within the DHSS to redesign the aims of the care system, and specifically those of secure units. The DHSS's guidance materials to local authorities were influential in framing policies which were nonetheless still decided at the local level.

The powers of staff in homes (and specifically their power to place children in secure accommodation) were nevertheless still set by the same Community Homes Regulations. These created a general framework in which staff power was to be limited, but which allowed exceptions to be made where circumstances required. Thus, for example, Regulation 10(1) required that the control of children in the home was usually to be achieved through good relationships, but 10(2) allowed the Managers of the home or the SSD (as the case may be) to approve 'such additional measures as they consider necessary […] and the conditions under which such measures may be taken'. The Regulations made no mention of corporal punishment, but nor did they forbid its use: again, this was down to decisions by the responsible body, which, in considering additional control measures, was required to consider the 'purpose and character of the home and the categories of children for which it is provided'. In similar fashion, there were stringent regulations concerning the provision of, and allocation of children to, secure accommodation.

The creation of new secure accommodation, and the recertification of existing provision, had to be approved by the Secretary of State (e.g. 'MH 152/27: Bedfordshire Non-Metropolitan County: Oxendon House; Approval of Secure Unit; Visits and Inspection' 1985). This was achieved in practice through inspection under section 58 of the 1969 Act, demonstrating again the advisory role envisaged for central government inspectors. Regulation 11 of the 1972 Community Homes Regulations also limited the power of the 'person in charge' of a home to place children into secure accommodation on his or her own authority: this was allowed for a maximum of 24 hours continuously, and 48 hours in any consecutive seven-day period. However, the person in charge could apply to the 'responsible body' (i.e. the Managers or the SSD) at the expiry of this period to extend the placement to 14 days, and again at the end of that period to extend it to 28 days. Moreover, with the permission of the 'care authority' (i.e. the body legally responsible for the care of the child, often *also* a voluntary organisation, or a named social worker within the SSD), permission could be granted to extend the child's placement in secure accommodation over a

[7] The change was later reversed, as a result of perceived shortcomings in the oversight of Community Homes. In 1985, the Social Work Advisory Service was reformed into the Social Services Inspectorate, with the explicit aim of establishing a more rigorous quantitative regime of centralised inspection. The SSI is therefore a distant ancestor of Ofsted, which has inherited its responsibility of inspecting SCHs. See Harris and Timms (1993).

specified *or even an indefinite* period, provided that this was reviewed every three months. 'Care authorities' could also request the placement of a given child into secure accommodation if they deemed it justified by his or her risk of harm to self or others.

Community Homes had no direct equivalent of the Boards of Visitors in penal establishments; section 24(5) of the 1969 Act required independent persons to be appointed to visit children who had little or no contact with their families, but not for those who did. In any case, it was common in practice for children to be held far from home and moved frequently, according to available provision, especially if their behaviour was challenging and a decision was taken to place them in (scarce) secure accommodation. As a result, even where they were in contact with families (or an independent visitor) such contact could be limited by distance and the expense of travel (Harris and Timms 1993).

4.4.3. Summary

In effect, therefore, checks and balances on the power to place children in secure accommodation (like limitations on the power of homes to punish) were only guaranteed to be effective if those responsible for overseeing them were able and willing to put welfare above institutional priorities without fearing the consequences. While the Regulations *appeared* stringent, particularly concerning secure accommodation, arrangements for oversight were subject to multiple and sometimes overlapping conflicts of interest. Different personnel from the same organisations, presumably affected by the same organisational pressures and priorities, were responsible for overseeing each other's decision-making, generating a risk that safeguards could be circumvented. Additionally, there were no effective arrangements to protect children's voice. It would be scarcely surprising if such a system of oversight diluted the protections for children deemed 'difficult' or 'disruptive', allowing them to be treated more harshly if this served institutional needs. One effect was that the intention of Regulation 10 (that behaviour should be controlled, in the main, by good relationships) could be watered down in localised pockets of quasi-secure (but unregulated) accommodation. This was effectively the finding of the Pindown inquiry (Levy and Kahan 1991).

4.4.4. New thinking about the purposes of custody

A final point relates to changes in how custody in secure units was thought about, after they came under the management of SSDs. The reframed custodial aims promoted by the new DHSS advisory bodies, perhaps influenced by the developing practices in the secure units and the new Youth Treatment Centres, tended to suggest new justifications for placing children into secure accommodation. Custody was framed *not as a form of punishment but as a form of care*. Rather than being a short-term deterrent measure, these justifications emphasised the potential for custody to stabilise 'disturbed' children, the better to understand and treat their needs. This partly helps to explain how the 1972 Regulations attempted to limit the use of placement in secure accommodation, while simultaneously creating welfare-based exceptions which allowed it to be used for longer, even indefinite, periods. The implication was that adults in the relevant positions of responsibility were competent to define a child's needs on their behalf. Instead, a professional judgment about their behaviour took precedence over any requirement to consult the child. The potential is obvious for such decisions to be shaped by organisational, rather than individual, needs.

Such new ways of thinking did, however, also result in new thinking within the DHSS about the causes of disorder in institutions. If children could be held in custody over a long period, not for

punishment but so that their needs might be identified and provided for, then it was possible for non-compliance to be taken as evidence not of *resistance*, but rather of *unmet need*. This in turn implied fundamental changes to the model of authority by which 'difficult' children should be controlled. Accordingly, DHSS working papers issued to the Community Homes (including secure units) and YTCs in the early 1970s also recognised, *for the first time in this narrative*, that 'incidents of aggression or hysteria' were not *necessarily* caused by children being 'difficult' but could instead be 'unwittingly' provoked by staff. Implicit here is a different (and less trusting) view of institutional power *per se*: the working papers 'discussed the possibility [that] abuses of closed provision might arise through staff shortages or lack of adequately trained or experienced staff', and suggested ways that homes could prevent these outcomes (Cawson and Martell 1979, 35).

This opened a new possibility: as well as being a consequence of the *overuse* of power beyond legitimate limits, abuse of children in custody could also be a consequence of the *underuse* of power, if responsible authorities failed to guarantee minimal conditions of safety. As we shall see in chapter 5, this understanding was extremely important to custodial change during the 1980s, 1990s and 2000s.

5. Catalysts for change, c.1980 to c.2004

Chapter 4 reviewed responses to abuse prior to the development of contemporary forms of 'child protection' and 'safeguarding'. This chapter reviews and summarises changes in two key areas of policy and practice during the 1980s and 1990s. Section 5.1 concerns how discourses of 'safeguarding' and 'child protection' – new forms of professional knowledge – developed in the care system during the 1980s and 1990s. These developing discourses included new understandings of how sexual abuse and other abusive practices could develop in institutional settings, as well as new policies and practices aimed at preventing it. Section 5.2 describes how this thinking and these practices spread into the penal field, where they were promoted as part of a more general policy agenda of prison reform. The focus throughout this chapter is on *changes in policy*. What these policies achieved *in practice* is the focus of chapter 6.

5.1. The development of preventive practice, c.1980-c.2004

Policy and legislative changes during this period were rapid and led to the body of practices now known as 'safeguarding' and 'child protection', which emphasised cooperation between different agencies of the state to identify and investigate abuse. They can be argued to have begun with guidance on multi-agency work issued by the DHSS in the mid-1980s (Cobley 1995, 39–72; Ryan 1994, 59–73), culminating in the 1989 Children Act. This comprehensive legislation came into force in 1991 and has remained the basis of child protection arrangements ever since, with all subsequent legislation and statutory guidance building on its foundation. It codified three significant shifts in official thinking.

First, the 1989 Act enshrined in law the principle that the child's welfare was *the paramount consideration* for all decisions relating to the child by courts and government agencies. This represented a significant change from the regime created by the 1933 Children and Young Persons Act, which had simply required courts to 'have regard' to the child's welfare. Although the 1989 Act did not define 'welfare', courts subsequently interpreted it broadly, and later legislation confirmed this interpretation, to the extent that the Children Act 2004 imposed a general duty on *all* state agencies providing services to children to safeguard their 'well-being' (also broadly defined).

Second, the 1989 Act continued a longer-term trend which had been apparent since the 1948 Children and Young Persons Act: a gradual move away from the use of institutional care (Hendrick 1994). It formalised the principle that the best option was usually for children to be left in the care of their parents, with whom the social services should work 'in partnership' as far as possible. This was, effectively, a presumption against taking children into the care of the state. Where such care orders were made, fostering was preferred. One consequence has been that the number of children in homes has shrunk, and that the population of children's homes, while shrinking, has also tended to become increasingly troubled. This is because children are usually sent to residential homes having first been found too 'difficult' or 'disturbed' in fostering or other forms of care.

Finally, the 1989 Act put in place a framework of policies and procedures, developed and built upon by subsequent legislation, which aimed to protect children from abuse (See, for example, Department of Health 1991; Home Office et al. 1991). For the secure estate, the key elements in this protective framework were that the local authority was responsible for investigating possible cases of abuse and deciding how to respond. Because it was unable to discharge this responsibility

alone, however, there was a very strong emphasis on multi-agency coordination, with the local authority again in the lead.

Since the child's welfare was enshrined as *the paramount consideration* for all agencies and courts within the scope of the Act, there was now also a strong basis on which to challenge practices, *howsoever justified by institutional priorities*, which appeared *not* to comply with this principle. The pressure on organisations to change was not only a matter of legal principle, however: it was also a practical necessity. Agencies of government were now required, in cases where children had come to harm, to provide clear information to the Area Child Protection Committee (ACPC). An additional driver of compliance was the growing body of audit and inspectorial procedures which blossomed in response to the Act. Thus, for example, child protection arrangements became a specific focus in the inspection of a wide range of organisations (e.g. Social Services Inspectorate 1993).

These arrangements aimed to address a significant problem (apparent since at least the 1960s and a significant finding in multiple 1980s inquiries): that child abuse might become evident to (or be disclosed to) any number of professional and non-professional actors, and that not all of these might recognise it as such, think similarly about the appropriate response, or understand how to report concerns to the relevant authorities. Such failures were not only consequential for the children involved: they could be catastrophic for the professionals and organisations excoriated by inquiry reports (e.g. Corby, Doig, and Roberts 2001, chap. 9). The effect (at least in theory) has generally been to promote compliance with a framework of regulation within which professionals are expected and required to recognise and report their concerns about potential abuse. Thus the 1989 Act, while imposing direct statutory duties on relatively few organisations, indirectly and gradually caused major changes to the governance of a *much wider* range of others.

In practice, however, although the *principle* of working together has been relatively uncontroversial, the history of multi-agency work has been troubled. Many subsequent inquiries have documented, in painful detail, the failure of different agencies to *actually* coordinate their responses to abuse, to train staff, to write policies, to implement those that have been written, and so on (e.g. Laming 2003). In short, it has proven more challenging to create a *genuinely* integrated framework for child protection than to imagine the need for one (Broadhurst, Grover, and Jamieson 2009).

Despite gaps between policy and implementation, there can be no question that one consequence of the 1989 Act has been to discipline organisations of all kinds into introducing new aims and practices which draw on discourses about children's individual rights that had little purchase before. Even where they are ineffectively implemented, organisations have had to redefine *their own stated aims and policies* in response to the principle that the child's welfare is paramount. This in turn has opened them to outside criticism of their practices, based on these redefined aims. Put differently, there are now more legal and discursive resources available with which to scrutinise and critique specific custodial practices than ever existed before. Challenges of this kind were mounted throughout the care system in the 1980s and 1990s.

5.2. Child custody in a climate of penal reform, c.1990-2002

There was, however, significant ambiguity over whether penal establishments were subject to this process of redefinition. The 1989 Children Act did not list them as within its scope, and legal advice

taken during the 1990s reassured the Prison Service that Young Offender Institutions were not regulated by the Act. However, the Act *did* create a *general duty* on ACPCs to investigate cases where children had come to harm, including in residential care. Suicides by young people in YOIs were a clear anomaly: the increasingly strong legal protections for children, alongside an increasing tendency to view institutions *per se* with mistrust, made those who committed suicide in YOIs appear particularly vulnerable, in spite of their offending.

The anomalous status of children in Prison Service custody was to become a major plank of reformist discourse. The *official* discourse of the late 1990s and early 2000s is, by today's standards, striking in its language. It evaluated the 'performance' of penal institutions not simply by reference to outcomes for offenders and the efficient use of resources, but in explicitly moral terms, emphasising carelessness and negligence. In 2001, at the Prison Service's annual conference, its Director General declared:

> *'I am not prepared to continue to apologise for failing prison after failing prison […] We have to decide, as a Service, whether this litany of failure and moral neglect continues indefinitely […] It's a matter of caring, a matter of determination, and, I accept, not a little courage in taking on a culture in all too many places which we have allowed to decay….' (Narey 2001, quoted in Liebling and Arnold 2005, 39)*

Following a major public inquiry into prison riots, and high-profile political rows concerning escapes from maximum-security prisons (Woolf and Tumim 1991; Learmont 1995; Woodcock 1994), by the mid-1990s the Prison Service was beleaguered. Many of the 'failures' referred to in the quotation above related to problems in adult prisons. However, problems in institutions for children were also a significant focus of attention and were the subject of campaigns by pressure groups, who often focused on unsafe conditions in places of child custody. Suicides and self-harm by young people were prominent themes, and were often found to have occurred in institutions where bullying and violence were rife, and sexual assaults were not unknown (e.g. Howard League for Penal Reform 1993, 1997; O'Donnell and Edgar 1998; McGurk, Forde, and Barnes 2000).

These concerns increasingly penetrated official thinking, influencing how prisons were inspected during this period. A case study can be made using reports published by the Chief Inspector of Prisons. The default position in those published soon after the Inspectorate was re-established in 1981 was to evaluate youth custody according to institutional priorities. For example, the entire discussion of youth custody in the 1984 Chief Inspector's Annual Report concerns whether changes in sentencing law and the new Youth Custody Centres would result in better or worse behaviour by young prisoners (Home Office 1985a, 11). Thematic reports from around the same time, however, do offer a slightly different framing, discussing children and young people as particularly vulnerable when it came to the issue of prison suicide (HM Chief Inspector of Prisons 1984).

In the late 1980s and early 1990s, however, inspection reports for YOIs began to consider issues like order and control within a wider context. For example, they no longer discuss misbehaviour by young people *as a control problem*, but instead frame it as something which *undermines their healthy development* by creating an unsafe environment. This reflects, perhaps, a greater aspiration towards the *treatment* aims of custody. Inspections in the early 1990s do not comment on 'child

protection' arrangements *in those terms*, but there are trenchant criticisms (for example) of how bullying makes for an unsafe environment and increases the likelihood of self-harm and suicide (HM Chief Inspector of Prisons 1989, 1993). However, in the mid-1990s there was a shift in language: the term 'child protection' began to appear in reports, and annual reports describe deliberate steps to recruit Inspectors with relevant professional expertise in this area. Reports on individual establishments also began routinely to audit child protection as an area of practice (e.g. HM Chief Inspector of Prisons 1997a). Thus there was a gradual shift, in which the discourse of child protection moved from the periphery to the core of official evaluative thinking.

The culmination of these developments was a major thematic report published in 1997. Among its many findings and recommendations, it identified an underlying assumption common among most staff in most institutions for children: that 'young people needed to survive by their own devices'. Staff did not always 'understand their responsibility for active involvement in identifying and assisting the more vulnerable'. This was a problem, to which the answer was better management and 'a multi-agency approach', with closer links to local authority child protection teams (HM Chief Inspector of Prisons 1997b, 35).

Such arrangements were already standard practice in Secure Training Centres (the first of which, Medway, opened in 1998). Indeed, working together with ACPCs was a statutory requirement in STCs (Department of Health 1991, 30–33; *The Secure Training Centre Rules* 1998, sec. 43). In effect, YOIs were being expected to develop a new model of imprisonment which (in theory at least) was better adapted to the individual needs of their residents. This can be seen as a process of coordination, in which they were brought into closer line with what was, by the late 1990s, already a statutory requirement in SCHs and the new STCs. Implicit here is a changing understanding of what custody for children was *for*, and a distinct de-emphasising of punishment.

Concerns about the treatment of children in custody were nothing new; in fact, similar concerns had been voiced in public, for example through media coverage, for many years (*The Guardian* 1967; *The Guardian* 1968; Cook 1981; Ballantyne 1985). However, the significance of these developments was that child protection discourse provided a means to express these concerns *within an established statutory framework*, and to do so regarding institutions which were not originally expected to fall within its scope.

These concerns about youth custody were expressed by influential civil society groups, but also increasingly by the Inspectorate and other official sources: . By the late 1990s, child protection discourse offered those who were already concerned about children in custody a powerful new language in which to make their criticisms. This can be seen, for example, in a major review of safeguards for children in the care of institutions of all kinds – children's homes, foster families, boarding schools, as well as prisons (Utting et al. 1997). The report collapsed a long-standing conceptual distinction between penal and care institutions, treating YOIs *not* as special cases, but as simply one institution among others in which children 'lived away from home'. The same terminology was also used in Inspectorate reports (Compare, for example, how consistently criticisms of custodial institutions for children are framed, using the language of child protection, in Utting et al. 1997; Utting 1998; HM Chief Inspector of Prisons 1997b, 1999).

By implication, YOIs were no longer *just* penal establishments: they were one of a *range* of institutions which possessed a *duty of care* towards children. Long-standing issues like suicide and self-harm could be reframed in terms of vulnerability and unmet need as *failures of care*. In the 1960s and 1970s, by contrast, the Inspectorate had largely remained silent on these issues, while governors (and Boards of Visitors) tended to describe them as tragic or manipulative behaviours, for which institutions were ultimately blameless ('HO 391/138: HM Remand Centre Risley, Warrington, Lancashire: Visiting Committee, 1969-1971' 1972; 'HO 391/128: HM Detention Centre New Hall, Wakefield, Yorkshire: Board of Visitors, 1966-1971' 1972; 'HO 383/340: Whatton: Annual Reports' 1977). Thus the official rationales for Prison Service custody began to shift along very similar lines as those for secure accommodation in the care system had during the early 1970s, implying that abuse might *both* be associated with the illegitimate overuse of power, *and* with its irresponsible underuse (see section 4.4.4). The logic of this understanding has generated ever more specialised and elaborate regulations governing custodial practice.

Inspection reports are not always implemented in full, of course, and changes in practice were not immediate. The Prison Service maintained throughout the 1990s that the 1989 Children Act did not apply in its establishments, acknowledging all the same that this had not yet been tested in the courts. Even so, there was significant and rapid change from the mid-1990s onwards, especially under a Labour government which came to power in 1997 and made the reform of public services and the protection of rights a central component of its legislative programme.

By 1997, it appears that a handful of YOIs had voluntarily implemented safety-focused regimes informed by child protection practice (e.g. Sparks 1997), but these were cases of 'best practice', with most establishments lagging behind. However, following major reforms to the youth justice system more generally in 1998, YOIs were *required* to implement their own child protection and safeguarding arrangements by Prison Service Order 4950 (HM Prison Service 1999), and also by similar requirements issued by the new Youth Justice Board. Neither constituted a *statutory* requirement. This was an anomaly, because child protection *was* a statutory requirement in SCHs (by virtue of s.47 of the 1989 Act) and STCs (by virtue of rule 43 in the 1998 STC Rules). However, statutory child protection in YOIs followed soon afterwards: in the High Court, Mr Justice Munby ruled that the 1989 Act *did* apply to YOIs.

Despite clarifying the law in this way, Munby argued that the significant change had already happened with PSO 4950, which he said *already* represented a 'revolution in official attitudes within the Prison Service to the treatment of children in YOIs' which had been 'driven in significant measure by the recommendations of Sir David Ramsbotham and Sir William Utting' (Munby 2002, para. 95). Munby's summary of the impact of PSO 4950 nevertheless sounded a note of caution:

> *'[PSO 4950's] aspirations are noble. Humanity and regard for the dignity of the children in YOIs shines through on every page. **If** its policies, plans, protocols and procedures can be implemented as its authors hope and intend then children in YOIs will have small cause for complaint.' (Munby 2002, para. 135, emphasis in original.)*

Further reforms followed to strengthen the safeguarding framework, requiring YOI governors and STC directors to participate in Local Safeguarding Children Boards (*The Children Act* 2004).

By the end of this period, then, *all* forms of youth custody were subject to specific governance arrangements which had three significant features. First, they had originated to regulate institutions in the care system, not the penal system, and harmonised the regulation and official thinking covering the two. Second, they formalised the legal principle of the paramountcy of the child's welfare. Third, by enshrining these principles in the legal regulatory frameworks for youh custody, they created the tools for compelling critiques of existing custodial practices which appeared incongruent with the welfare principle.

6. The 'new orthodoxy' in safeguarding, c.2000 to 2016

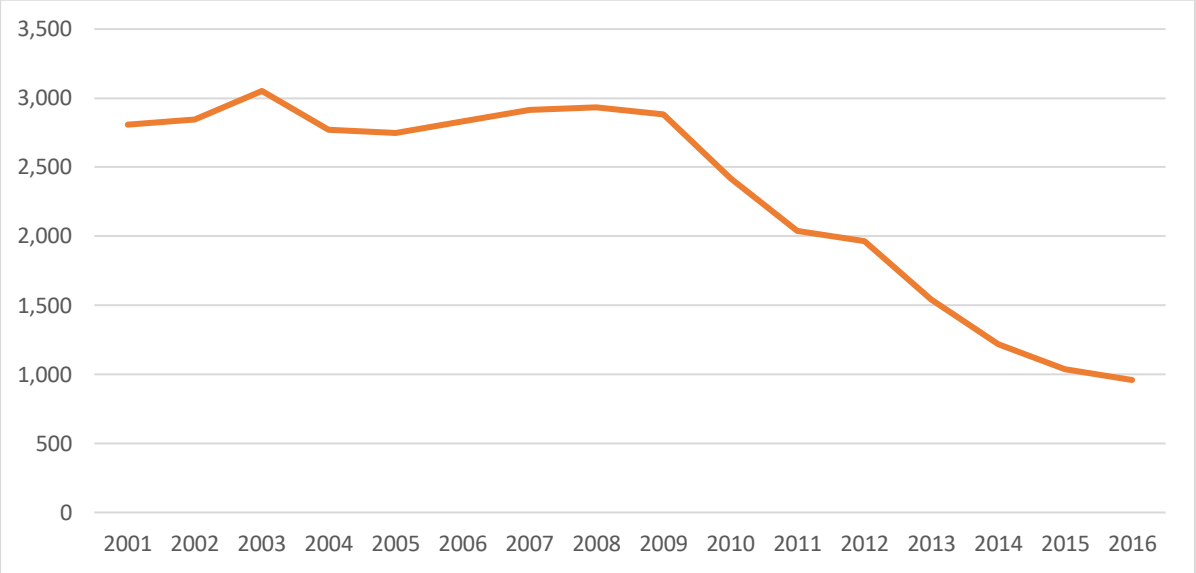
The 1998 reforms to the youth justice system saw YOIs and SCHs joined by a third custodial institution, the STC; the first, Medway, opened in 1998. Safeguarding requirements were written into the STC Rules from the start, marking an initial difference from the YOIs, for example. However, with the introduction of the Youth Justice Board (YJB) in 1998, the policies governing all three were harmonised, with the different institutions (and their varied cultures and traditions) re-imagined as a single 'secure estate'. Places in them would be commissioned centrally and would have to meet the requirements of common (and harmonised) National Standards (Youth Justice Board 2000). These framed custody *not* as a punitive measure, but as one exercised reformatively, in the child's best interests: '[Our objective is] that detention in custody becomes an effective means of correcting offending behaviour, improving the life skills of young people detained and reducing reoffending on release' (Youth Justice Board 2001). The move away from punitive and deterrent justifications for custody implied a greater departure from the existing traditions and cultures of the Prison Service than it did for SCHs.

Reforms to the youth justice system also led to significant changes in its scale. The numbers of children in contact with it, and of those sentenced to custody, increased rapidly after 1998, remaining relatively stable until around 2010. After that time the number of children in custody declined dramatically, a trend which has continued to the present day.[8] Figure 1 (overleaf) charts these changes. It is also relevant that in both the adult and youth estates, there have been significant financial constraints since 2007/8: 'economy and efficiency are prioritized [...] the emphasis on performance targets has become stronger while the resources allocated to meet [them] have reduced' (Liebling and Crewe 2013).

As a consequence, we might expect to see a weakening of the safeguards developed since 2000, in favour of the pursuit of institutional efficiency and economy. However, the picture is more complex. The reform of safeguarding in custody began as a high political priority and remained so because of a series of high-profile failures which undermined the legitimacy of custodial practices (such as restraint) which had previously gone relatively unquestioned. One consequence was that the 'new orthodoxy' in policy was not static, but instead continued to evolve through application. The full implications were only beginning to become clear when financial constraints and the overall shrinkage of the secure estate began, and their effects have continued to play out since then. As a result, the overall picture remains complex: safeguards have been strengthened, have evolved, and have been called into question by actual custodial practices.

[8] The adult prison population increased without any corresponding decline.

Figure 1: Under-18s held in YOIs, STCs and SCHs at end of YJB reporting year, 2001 to 2016 (Ministry of Justice and Youth Justice Board 2018).



The argument of this chapter is that the improved safeguards implemented since 2000 *have* made the abuse of children, and particularly their sexual abuse, less likely. This argument is made in three stages. First, in section 6.1, the content and implementation of the new safeguards is reviewed, alongside a brief narrative of how the extent and nature of youth custody has changed during this short period. Second, in section 6.2, their effectiveness is reviewed, with a focus on inspection reports and inquiries into known problems and failures in the duty of care. Finally, in section 6.3, conclusions are offered regarding this most recent period in the narrative.

6.1. Reform and compliance: the early implementation of the 'new orthodoxy'

In 1997, the Chief Inspector of Prisons described youth custody within the Prison Service as 'chaos' and 'not a system at all', despite the 'excellent work [of some staff] against the general culture of the organisation' (HM Chief Inspector of Prisons 1997b, 69). Safeguards in SCHs were held up as more effective than in YOIs, and the report asked whether YOIs could be considered suitable establishments in which to hold children *at all*. Pressure on the Prison Service to improve safeguarding and conditions for children in YOIs was therefore intense, and became a major plank in the Every Child Matters policy agenda (HM Treasury 2003); new statutory duties for YOI governors were also created by the 2004 Children Act. The progress of implementing these reforms in the 2000s can be traced in a series of three triennial joint inspectorate reports, which continued to make comparisons (often highly unfavourable) between places of custody and other institutions.

Safeguarding in YOIs began from a low base, and progress was slow: individual institutions had not implemented PSO 4950 immediately, nor got to grips with what it implied. In 2002, although three years had passed since the PSO, the safeguarding of children in YOIs remained 'a major concern'. Basic failures to implement child protection frameworks were prominent in inspectorial reports: most institutions had failed to forge links with Area Child Protection Committees (ACPCs), or to develop a 'safeguarding culture' in which matters like bullying, self-harm, and the complaints of the victimised were taken seriously (Chief Inspector of Social Services et al. 2002, 69–81).

At HMYOI Feltham in 2002, for example, there existed no child protection log, no links with the local ACPC, no anti-bullying programme, no training for night staff in suicide and self-harm prevention, and no adaptations to complaints procedures to make them accessible to children with poor literacy skills or learning disabilities. Moreover, children were routinely being required to squat while being strip-searched, a policy discontinued immediately when inspectors raised it as an urgent concern. Even this, according to the Chief Inspector, represented 'steady progress' from the 'unacceptable' conditions seen during the previous inspection (HM Chief Inspector of Prisons 2002, 1–2, 14–17). Such comments reflect a delicate balance, whereby inspectors must publish their criticisms but also protect staff morale. Feltham's inspection reports during the late 1990s had affected morale so badly that some staff members considered efforts at reform to be futile, one factor in Feltham's 'degeneration into crisis' before the racist murder of Zahid Mubarek in 2000 (The Zahid Mubarek Inquiry 2006, chaps 38–40). Negative findings tend now to be framed not as unacceptable failures, but as fixable snags in an overall meta-narrative of gradual improvement.

The 2005 Joint Chief Inspectors report, unlike its 2002 predecessor, made direct comparisons between STCs, SCHs and YOIs, emphasising the complex needs and vulnerabilities of children resident in all three, but suggesting that the higher staff to child ratios in STCs and SCHs made these needs easier to identify, and difficulties easier to address. This, for example, was associated with 'young people's view that bullying [was] identified at an early stage [in STCs and SCHs] and there [were] robust policies and procedures in place [to deal with it]' (Commission for Social Care Inspection et al. 2005, 48). The report also makes clear that secure institutions (like many others) were struggling to get to grips with new vetting arrangements for staff, though again such concerns were usually framed as 'teething difficulties' within longer narratives of positive change. Regardless of the changes in policy, the second report suggests that some organisations were not making deliberate efforts to change staff cultures through training: here again, YOIs were compared unfavourably with STCs and SCHs.

These findings in the Joint Chief Inspectors' reports suggest two distinct phases in the implementation of the new orthodoxy. At first, reform (and monitoring) efforts had focused on basic compliance with policy: the bulk of recommendations in the first report concern institutions' failures to write policies, appoint staff to safeguarding roles, and satisfy basic duties such as multi-agency child protection work. Subsequently, however, once these measures were in place, a shift in the inspectorial gaze can be detected: from the relatively simple question of compliance, to more fundamental questions of whether certain mainstream custodial practices might be tantamount to abuse. Also crucial in shifting the focus in this way was the fact that there had been, by 2005, high-profile institutional failures to guarantee the welfare of children: most specifically, in 2004 two young people had died in STCs following incidences of restraint. This put restraint (and other practices) under the microscope, shifting the discourse on abuse to the legitimacy *of custodial practices themselves*, rather than their misapplication or corruption by staff.

6.2. The evolution of the new orthodoxy and the shifting definitions of 'abuse'

The 2005 joint Chief Inspectors' report described a mistaken but widespread assumption which it said was hampering the progress of the safeguarding agenda. The assumption was 'that [children who are] already in care or under supervision [must] be safe, despite the fact that *the extent to which they themselves feel safe* varies considerably' (Commission for Social Care Inspection et al.

2005, 68, emphasis added). This finding reflects the extent to which safeguarding discourse generates new ways of thinking about custodial performance, and about how and where abuse might occur. It has also generated new critiques of custodial practice, and new definitions of what can be considered abusive. What these share in common is that they invoke the notion of child protection to critique the core practices of custodial provision.

One way to chart this process is through the case study of strip-searching. This practice is near-invisible in the documentary record before the 1990s: we can presume that it was practised routinely, but it appears to have been fairly unremarkable, and such regulations as governed its use generally related to who should be present: at Feltham in 1989, for example, inspectors criticised the conduct of routine strip-searches in Reception while other young people were in the room. Strip-searching, however, was seen mainly as a practice justified by the need for security (HM Chief Inspector of Prisons 1989). As late as 1995, inspectors at HMYOI Deerbolt reported security concerns, and quoted without comment the belief of staff that *not enough* routine strip-searches were being conducted following visits (HM Chief Inspector of Prisons 1995, 28). However, nearly-contemporaneous research conducted by the Howard League identifies strip-searching as particularly humiliating and problematic *for girls* who have experienced sexual abuse before custody, indicating perhaps that gender made vulnerability more visible (Howard League for Penal Reform 1997). By 2002, PSO 4950 was in effect, the potential vulnerabilities of children were more apparent, and strip searches appeared to be viewed with increasing concern: at HMYOI Warren Hill, for example, inspectors found that the routine strip-searching of boys was incompatible with 'best practice' in child protection (HM Chief Inspector of Prisons 2003, 3, 86), and other inspection reports recommended reining in certain practices (such as squatting during searches) which were understood to be especially problematic. Shortly afterwards, inspection reports were describing routine, non-targeted strip-searches as *fundamentally illegitimate*: the 2005 inspection of Feltham, for example, described it as 'degrading' (HM Chief Inspector of Prisons 2005, 36). Other sources went further: this was not merely a question of 'best practice', but potentially tantamount to abuse, one of a range of practices which 'would, in any other circumstance, trigger a child protection investigation and could even result in criminal charges' (Carlile 2006, 9).

Another case study of how child protection and safeguarding discourses have been used to critique and reform custodial practice can be found in the case of restraint. Widespread concern over restraint began in 2004 with investigations into the deaths of Adam Rickwood and Gareth Myatt in different STCs. Such concerns moved from consideration of the techniques used, to more fundamental questions regarding the use of force and separation, and how far these have a legitimate place in managing and control the behaviour of children in secure settings. Concerns about restraint were very prominent in the third triennial Chief Inspectors' report on safeguarding, published in 2008, and have remained so since then (Ofsted et al. 2008, 47–52). In the 2008 report, comparisons between different institutions were again explicit, and again the SCHs were presented as the least problematic: recommendations about restraint in SCHs mostly related not to inappropriate *methods* of restraint, nor to its *overuse*, but instead to irregularities in how incidences of restraint were being recorded. The implication is that restraint was used legitimately in SCHs, albeit that it still required careful monitoring. In STCs, by contrast, the overuse of restraint and separation, and the high levels of force used by staff, were described as worrying and potentially unsafe, even though safety in three of the four STCs had been judged (at the most

recent inspection) to be 'adequate' or better. This reflects ambiguity in institutional thinking on restraint: as in the SCHs, it is seen as a legitimate practice which is justified in some circumstances, but one which should nevertheless be regulated, especially where there was reason to believe that it might not be used as a last resort. Similar concerns are voiced about YOIs, which the 2008 report covered in much greater depth than either STCs or SCHs. YOIs still appeared to offer the greatest cause for concern: the use of restraint techniques designed for adults, the persistence of strip-searching (sometimes by force), the overuse of separation, and the overuse of overly formal, non-child-friendly procedures to resolve disciplinary matters were all subject to considerable criticism.

Changes to policy to reflect these issues lagged some way behind the criticisms. Even so, criticisms of restraint (such as those raised by the Inspectorate) *have* resulted in changes to policy, first in the independent review of restraint, and later in the redesign, repackaging and republication of policies relating both to restraint and searching (Smallbridge and Williamson 2008; National Offender Management Service 2014b, 2014a; National Offender Management Service, Ministry of Justice, and Youth Justice Board 2015). It is notable that reforms have *not* aimed to eliminate these practices, but instead to review and re-present them as compliant with safeguarding children's welfare.

What is apparent here is that the 'revolution in official attitudes' towards children in custody that Mr Justice Munby described in 2002 has not necessarily been matched by a revolution in custodial practices. Instead, several changes of emphasis have resulted in the re-evaluation and problematisation of practices (like restraint) which, in the official view, remained necessary. Practices once regulated by trust in the professional discretion of staff, and by comparatively weak complaints procedures, are now subject to multiple layers of regulation, record-keeping and monitoring. Ostensibly, these regulations safeguard children and hold staff members to a higher standard of discipline, but they also create new resources with which individual staff can be held responsible for what in fact may be widespread institutional practice. They may also force non-compliance with policy 'underground'.

6.3. A safeguarding culture?

Before the development of new safeguarding practices, the opinions of children regarding their conditions of custody appear not to have been systematically monitored or attended to, and the idea that the voices of the excluded and vulnerable required particular attention was not prominent. As we have seen, in institutions which possessed 'penal' traditions and cultures in the 1960s and 1970s, the general expectation appears to have been that the task of criminal children in custody was to toughen up. Individual vulnerability was read as evidence of individual weakness. We saw this, for example, in section 4.2.2, when officers at Whatton derided the 'blubbering' of 'divs', or in section 4.3.1, when Boards of Visitors framed suicide and self-harm as evidence of individual (rather than institutional) failure.

By contrast, a striking recent feature of orthodox safeguarding practice has been an official concern with the 'voice' of children in custody. To some extent, this can be seen as the result of high-profile failures to consider how custodial practices affect children; the 2004 death of Adam Rickwood (who was found hanged after staff used force to retrain him) offers a particularly sharp example. The growing tendency towards arrangements to give children 'voice', however, relates more fundamentally to the (re)framed official aims of secure institutions. Since custody had been

redefined as an intervention exercised in the best interests of the child, then it could be thought of *as a service*, with children as its consumers or 'service users'. Their opinions about their treatment were a legitimate matter for organisations to consider, and to some extent organisations could not present their use of custody as legitimate unless they could demonstrate respect for the 'voice' of service users. This was in marked contrast to the 1960s, when the Home Office position was that prisons could not be seen as the provider of *any kind* of service to the public or to their residents (see section 7.1).

As a result, inspectorates, institutions and the Youth Justice Board alike now make systematic efforts to understand how children themselves experience custody. This is apparent (for example) in the collection and compilation of survey data, in specialist research projects to access 'user voice', and in measures (such as revised complaints procedures and advocacy schemes) which aim to guarantee children an effective voice within the institution. Data of this sort have fed into the reform agenda, sometimes providing challenge, sometimes assurance that institutional power is being exercised legitimately. Often, assurance is well-founded: for example, children's lived experiences of restraint, separation and strip-searching have contributed to the re-evaluation and re-regulation (though not the abolition) of these practices. Research of this sort has also suggested that under certain circumstances, children recognise searching and restraint as unpleasant but necessary components of institutional life, suggesting that it may be *how* they are practised rather than their mere existence which makes them legitimate (For example, see the discussion of restraint in Prisons and Probation Ombudsman 2017; see also the discussion of when separation and restraint are justified in User Voice 2011).

Arguably, however, an over-reliance on the 'voice' of children to bring problems to light can lead to problems again becoming invisible. One example of this can be read into the contemporary framing of sexual abuse. Extensive survey data, as well as research into the views of 'service users', consistently suggest that the sexual abuse of children in custody is very uncommon: less than one per cent of children surveyed in most custodial institutions have alleged sexual abuse by adults or other children (thus compare reported rates of sexual victimisation in HM Inspectorate of Prisons 2004; HM Inspectorate of Prisons and Youth Justice Board 2013, 2017).

Indeed, it is very striking *how little* the available documentation on sexual abuse in the secure estate since 2000 (i.e. non-historical abuse) dwells on the possibility that abuses are *still* being committed by staff. This is especially surprising given that historical allegations at sites like Medomsley had begun to come to light during the early 2000s, and given also that there have been occasional revelations regarding inappropriate relationships between prison staff and (female, young adult) prisoners, for example at HMP/YOI Downview. These revelations cannot be examined closely using the documentary evidence available to us: investigations into them, such as serious case reviews and the Prison Service's internal investigation regarding allegations at Downview, have not been published. It is difficult, therefore, to evaluate whether the lessons of the past have been learned.

It is possible, even so, to find evidence that sexual abuse *by staff* has been seen as inherently unlikely, with young people themselves seen as more likely perpetrators. In 2000, for example, Home Office researchers argued that sexual abuse by staff was inherently unlikely in prisons, on account of the tightly controlled nature of the institutions:

'[r]eports into abuse in children's homes have frequently concluded that guilty staff were not sufficiently well vetted when applying for their posts […] The picture with prison staff is somewhat different, as procedures for selecting suitable staff, vetting [and] training them, are well established. Any history of previous convictions is also investigated as a matter of course, partly because staff may be employed anywhere in the system, and security considerations are of paramount importance.' (McGurk, Forde, and Barnes 2000, 18)

In short, concerns about the sexual abuse of children in custody during the last fifteen years have tended to hinge on whether specific custodial practices could be experienced as harmful, rather than on the possibility that custodial staff, in certain climates, might circumvent or manipulate safeguards in order to pursue their own, illegitimate, aims. The implication has been that if institutions take proper account of safeguarding policies, including through attentiveness to children's voices, then safeguards against abuse will be effective.

This situation is similar to the one which pertained in the 1960s and 1970s. Both then and now, regulatory frameworks existed, were believed to operate effectively, and relied, to a very great extent, on serious problems coming to light through complaints. Yet now as then, there are serious risks in this approach: children, while often willing and capable of contributing their 'voice' if asked, are less likely to use formal systems to disclose more serious problems. Recent research suggests that this reluctance is grounded in several factors, including the fear of reprisals by staff; children's feeling that any ill-treatment they receive is deserved; and their feeling that internal and external complaints procedures, *including those which aim to make complaining easier*, are slow, unwieldy and unreliable. Moreover, children are *less likely* to use official procedures to disclose *more serious* problems, and *more likely* to use them for relatively minor matters such as concerns over property (Prisons and Probation Ombudsman 2015). Comparative research, even so, finds that children in SCHs perceive all of these problems to be less pronounced than those held in STCs or YOIs, probably because of the smaller overall size of the institutions. In SCHs, the lesser organisational distance between children and the staff who hear their complaints results in speedier and more personalised responses, meaning that the procedures themselves can be legitimate if applied in certain ways (User Voice 2011).

The key issue here is that arrangements to reflect children's 'voice' can alter custodial practices for the better; but it is dangerous for institutions to expect that these arrangements will definitely bring more serious problems to light, something that is particularly unlikely if there is collusion or other illicit conduct by staff. Indeed, they can only be relied upon to do so if the culture of the institution *also* promotes the kind of positive, trusting relationships which make problems less likely to develop in the first place. Without such a culture, complaints by children are not certain to bring abuse to light *even where specific safeguards exist*. This is because if they complain about behaviour by staff, their complaints will be evaluated not against what is 'normal' or acceptable behaviour outside the secure estate, nor even necessarily against the contents of relevant policies, but instead by reference to what is considered 'normal' and justifiable *in the specific cultural context of that institution*. These cultural standards, as we saw in chapter 5, also tend to 'spread', so that what seems normal and acceptable to an institution's staff, over time, risks becoming normal to outsiders as well, and also to children themselves. This is why outside scrutiny – whether

obtained through prisoners' letters to newspapers in the 1960s and 1970s, through new inspectorial thinking in the 1990s and 2000s, or through covert filming by the BBC in 2016 – has always played such a key role in uncovering abuse.

Put differently: *the institutions most likely to be abusive are also those least likely to recognise abuse for what it is*. This limits the effectiveness of formal safeguards. Indeed, the safeguards developed since 2000 may themselves be vulnerable to *new kinds* of illegitimacy. This troubling conclusion – consistent with the 'corruption of care' in children's homes – pervades the report of the most recent inquiry to publish in-depth findings into abuse allegations at an individual institution (Medway Improvement Board 2016). The report documented the development of an abusive culture which was similar, in many respects, to those described by earlier abuse inquiries. These included:

- A lack of clarity regarding the purpose and aims of the institution, contributing to a 'culture of control and contract compliance' detached from the achievement of any particular aim;
- Gaps between stated policies and actual custodial practice;
- Inadequate staff training on safeguarding, especially among a layer of middle managers most responsible for overseeing the translation of policy into practice;
- The failure of safeguarding and child protection arrangements to detect abuse, *despite their compliance with procedure*;
- The failure of multiple layers of inspection and oversight to detect what was going on.

All of these points echo the findings of the Pindown inquiry into children's homes in Staffordshire, where an illicit and abusive culture of control also facilitated the smooth accomplishment of institutional goals such as order and efficiency (Levy and Kahan 1991). However, there were also some new features, reflecting specific features of the 'new orthodoxy':

- The falsification of records by junior staff, to circumvent safeguards and create the impression among powerful middle managers that the institution was running smoothly;
- The circumvention of situational controls such as CCTV;
- The reinforcement of this culture by perverse financial incentives arising from the contract.

The first two points in particular suggest significant differences from the Pindown inquiry, where staff were openly proud of an abusive regime. At Medway, the existence of safeguards seems to have driven abusive staff to go to some lengths to conceal their behaviour, despite the same underlying judgment that children's welfare was subordinate to other priorities. It may be, therefore, that the new orthodoxy has incubated similar behaviour elsewhere; the Medway Improvement Board stated its concern that this was likely to be the case in other STCs.

The 'corruption of care' is as relevant a concern now as it ever was, and the new orthodoxy leaves no room for complacency. Formal safeguards do not guarantee a safeguarding culture. If safeguarding lapses into mere compliance with policy, or becomes detached from critical evaluation *by staff and managers alike* of whether policy is meeting the aims it was created to address, then instances of abuse will continue to develop – and be missed.

7. The effects of intersecting disadvantages

It is now well-established that minority race, ethnicity, and disability status can all disadvantage people in the criminal justice system (See, for example, Young et al. 2014; Lammy 2017; Talbot 2008). It has also been suggested that women and girls are at a disadvantage because their needs, which in many cases may be different, tend to be subordinated to those of the men and boys who predominate in criminal justice statistics and for whom services were often designed (Corston 2007; Carlen and Worrall 2004; Cox 2013; Gelsthorpe and Worrall 2009). We discuss these issues collectively as 'intersecting disadvantages', in recognition that their impact may be altered and amplified for individuals who possess more than one of these characteristics.

Extant reviews and research have tended to identify inequalities at two scales: first, in the criminal justice system as a whole, where members of particular groups suffer disproportionately negative outcomes; and second, at the individual level, where people with these characteristics experience unfavourable treatment. In society generally, the minority status of a particular group can lead to their particular needs and vulnerabilities being misunderstood or missed altogether, and the applicability to secure settings is obvious. In some cases, this is alleged to be the result of outright prejudice on the part of the powerful. It can, however, also result from insensitivity, cultural misunderstanding, 'unconscious bias', and the tendency for those who hold power in institutions to assert that their own position represents the needs of the majority.

On a systemic scale, such intersecting disadvantages were not visible before the routine collection of monitoring data brought them into focus. Nor is it clear from archival materials that they particularly preoccupied officials or shaped their thinking. As a consequence, tracing their influence on the issue of safeguarding is difficult: the available evidence is fragmentary, and requires considerable inference and interpretation. This chapter therefore has two principal aims. First, in sections 7.1, 7.2, and 7.3, it will outline how race, gender and ill health, disability and learning difficulties *might* have been thought about in the earlier period covered by this report, by describing the few official documents from the 1960s and 1970s which enable us to make inferences. It then briefly concludes, in section 7.4, by reviewing what these findings might have meant for the incidence of and response to abuse.

7.1. Race and ethnicity

During the period covered by this report, all published large-scale investigations of systemic racial inequality in the criminal justice system have been conducted since the 1980s. It is tempting to conclude that racial bias only came into official focus around that time, but the first pieces of legislation addressing racial discrimination were the 1965 and 1968 Race Relations Acts, which created a series of civil and criminal offences forbidding discrimination on the grounds of race in the provision of a service. The 1965 Act created the Race Relations Board (RRB) to hear complaints on these grounds, and the 1968 Act strengthened its provisions, as well as abolishing the Crown Immunity under which public services were exempted from the 1965 Act.

There is archival evidence that the Prison Service saw the RRB as a threat to its own complaints system and its control over prisons, and sought to neutralise it. A Home Office file shows that the RRB did receive complaints from prisoners who alleged discriminatory treatment in prisons. The Home Office argued in response that imprisonment was not in any form a service to the public or to

prisoners, and that on that basis the RRB should not take up the complaint ('HO 391/141: Race Relations Act 1968: Memorandum by HM Treasury; Complaints of Discrimination Concerning Government Departments; Complaints by Prisoners; Drafting of Circular Instruction to Prison Establishments' 1973). Following this, the Prison Service issued a new Circular Instruction to establishments (CI 64/1969) which adopted new guidelines: that future complaints made by prisoners to the RRB were to be returned to the prisoner and made subject to the normal complaints procedure (see section 4.3.4). If the prisoner went ahead and remained dissatisfied with the outcome of an internal investigation, then he or she should be permitted to send the complaint to the RRB, which would then make its own decision whether to investigate. CI 64/1969 stated that any interview between an RRB staff member and a complainant must take place with an officer present. In practice, however, two later complaint letters (dated 1971 and 1973) were rejected by the RRB on the same basis as the first – that the complaint was out of its scope. This suggests that the RRB may not have pursued complaints from prisoners; instead, they forwarded the letters to the Prison Service, which appended them to the file but took no further action.

In itself, this is only of tangential relevance to the handling of complaints by children in custody: the age of the prisoners whose letters feature in the file is not clear, and the complaints themselves do not relate to allegations of abuse. The file does, however, reveal something of the way that very senior Prison Department officials considered complaints from black and minority ethnic people. The Director of Prison Administration, in a memo dated 3rd January 1969, made a generalisation suggesting that such complaints might have been dismissed out of hand:

> *'The place for dealing with false and malicious complaints is at their source […] Coloured immigrants who are often poorly educated and generally paranoid about attitudes towards them often express themselves violently and with little accuracy.'* ('HO 391/141: Race Relations Act 1968: Memorandum by HM Treasury; Complaints of Discrimination Concerning Government Departments; Complaints by Prisoners; Drafting of Circular Instruction to Prison Establishments' 1973)

The file also suggests that attitudes to people in penal custody more generally were conditioned by the underlying assumption of a loss of full citizenship: one memo in the same file, dated 29th August 1968, states simply that 'a prisoner is not a member of the public.' We may infer from these two quotes that senior civil servants in the Prison Department did not consider prisoners' complaints as having been made by equal citizens. They may have carried still less weight if they came from 'coloured immigrants', with their supposed tendency to 'paranoid' and 'inaccurate' grievances. We can only speculate how similar attitudes might have affected the consideration of complaints and disclosures by children, but it is unlikely that they would have led to more serious consideration.

The first comprehensive review of racial disproportionality in the criminal justice system was published in 1986 (Nacro 1986). A file recording the Home Office's deliberations on this report suggests that the key turning point had been the findings of the Scarman report into inner-city riots in 1981 ('HO 383/460: National Association for the Care and Resettlement of Offenders (NACRO): Black People in the Criminal Justice System' 1988; Scarman 1981). Since then much more comprehensive information on racial disproportionality has been collected, allowing more systematic comparisons to be made between different groups based on their ethnicity. There have

also been inquiries which have found race (and in particular, prison staff's lack of sensitivity and awareness of the risks some prisoners face because of it) to be a factor in some institutions, including those holding children (The Zahid Mubarek Inquiry 2006). Of particular relevance is how complaints and disclosures may have been handled; there is some evidence that children who are from racial minorities are less likely to use complaints procedures and more likely to distrust staff, in both STCs and YOIs (Childrens Rights Alliance for England 2002, 89–92; HM Inspectorate of Prisons and Youth Justice Board 2017; Prisons and Probation Ombudsman 2017).

7.2. Gender

One striking fact about historical allegations of sexual abuse in the secure estate is that all of them to date have been made by boys. To investigate possible reasons for this, we specifically included institutions for girls and women in the sample of documents that we reviewed, finding neither evidence of undisclosed sexual abuse of girls (this is not surprising, given that abuse in general does not generally show up in documents), nor a conclusive explanation for why the victimisation of girls has not been alleged.

The available evidence is partial: the archival records on specific girls' establishments for this period consist only of a handful of reports on Moor Court (the sole DC for girls during a short period before its 1969 closure), and a small number of Welfare Department reports on Bullwood Hall, the only girls' borstal ('HO 383/257: Bullwood Hall Borstal: Inspectors' Reports 1969-1975' 1975; 'HO 383/213: Moor Court Detention Centre: Inspectors' Reports' 1967; 'HO 383/215: Moor Court Detention Centre: Annual Reports' 1969). These records suggest that these establishments were, in the 1960s at least, staffed mainly by women: the only male staff referred to were chaplains, doctors, psychiatrists and probation/welfare officers, who would have constituted a minority, and (with the exception of the probation/welfare officers, who at Bullwood Hall were usually a mixed team of one man and one woman) would not have worked full-time at the establishment. This does not preclude the possibility of sexual abuse by staff, but it makes it less likely, both because most perpetrators of sexual abuse are male, and because of the comparative rarity of custodial establishments for girls.

Even so, the available evidence from these files does suggest that these institutions thought about girls and young women in custody differently than their male counterparts. Comments in reports on Moor Court suggest a tendency to inquire about the degree to which the girls held there were sexually active, to a degree not evident in reports on male establishments. For example, the medical officer's report for 1967 reports in detail on the number who had children, were married, and had been referred to the 'special clinic'; this may be a reference to a VD clinic since other kinds of treatment are more clearly labelled.

At Bullwood Hall, meanwhile, a 1973 report described 'problems' such as self-harm which are familiar from accounts of male institutions, but which in Bullwood Hall are associated with gender: such behaviour is routinely described as 'hysterical', and self-harm (such as tattooing and causing friction burns) is said to be caused by 'attention-seeking' and 'boredom but possibly depression'. As at Moor Court, there is also a tendency to describe domestic arrangements, and associate these with gender: in July 1973 a report stated, 'many of the girls are homeless [i.e. they had no address on admittance and/or had run away from home] and display hysterical symptoms'. In September of the same year, again, another report describes a 'large proportion of homeless girls and disturbed

girls'. What is not stated, but is suggested by these different sources, is that some girls at Bullwood Hall were very likely to have been sexually abused and exploited, although their 'homelessness' and running away are not being framed in this way. Similarly, it is possible that some of those described as 'prostitutes' could in fact have been children being sexually exploited by adult men. In these reports, child sexual exploitation and abuse, though not described in these terms, appear as a 'problem' that existed outside the institution, rather than within its walls. This is consistent with the later tendency for the Prison Service to frame relationships between adult women and girls in prison as 'maternal', rather than potentially abusive (Howard League for Penal Reform 1997, 29–30).

Gendered expectations did not only affect the treatment of women. It was stated in September 1973 by one of the Welfare Officers at Bullwood Hall that 'girls in custody need more welfare than men' ('HO 383/257: Bullwood Hall Borstal: Inspectors' Reports 1969-1975' 1975). Behind such comments lie a strongly gendered assumption about 'proper' forms of behaviour for males and females in custody: men and boys are expected to be stoical, self-sufficient and tough, and women and girls vulnerable, sociable, and in need of help. Some of these expectations find echoes in recent research evidence, for example that girls are much more likely than boys to make complaints or seek advice from advice lines, and to turn to a teacher or member of staff if they have a problem (User Voice 2011; HM Inspectorate of Prisons and Youth Justice Board 2017). Meanwhile, inquiries in Australia and elsewhere have found that boys are less likely to disclose abuse where there are macho cultural norms encouraging them to remain quiet, particularly when disclosure might bring with it the implied taint of homosexuality (Palmer, Feldman, and McKibbin 2016, 53–55).

The lesson for institutions here should be in considering individual children who do not 'fit the norm'. Just as it appeared at Whatton that 'divs' lacked the ability to fit in with dominant cultural assumptions about properly 'masculine' behaviour (see section 4.2.2), so the supposed 'promiscuity' and homelessness of trainees at Bullwood Hall may have served to obscure the abuses they might have been suffering. Children isolated by reason of their lack of gender conformity would have been more vulnerable to abuse, either by other children or by staff.

7.3. Ill-health, disability and learning difficulties

Similarly to race and ethnicity, the extent to which the earlier archival sources offer a clear view of disability is limited, because the terminology used at the time to discuss it was different, and because systematic information about these contemporary categories were not always collected in the past. Relevant information is therefore fragmentary and dispersed in the historical record. Most of the material in this section draws from archival sources on the provision of education and training in secure establishments, or from sections of reports where the authors of reports discuss the 'suitability' of individuals to the establishment, using terms such as 'inadequacy' to refer to what might now be understood as ill-health, disability or learning difficulties. Once again, because the available evidence is partial, this section relies on inference from the few available materials, and presents what can be gleaned from the archival record rather than making a review of the academic literature or the more plentiful recent published materials on this topic.

There is some evidence that disability was construed as something which made children 'unsuitable' to be detained in certain kinds of institution. There appears to have been an assumption that DCs were *only* suitable for young, healthy boys who required the 'brisk tempo' of

the regime to shake them out of bad habits; by extension, those who did not meet these expectations were liable to be considered beyond help. This perception seems to have rested on the degree to which the DC regime was founded on physical education: references are common to the fact that trainees have put on weight as a result of all the sport, drill, and exercise, both in annual reports, reports by Boards of Visitors, and in occasional media coverage (Lacey 1968).

We have seen already that at Whatton, boys unable or unwilling to comply with this expectation were often disdained by the staff and by other boys (Ericson 1975). Such treatment cannot usually be linked to an identifiable disability, but on occasion there are references to these, and the language used usually relates to the individual's 'inadequacy'. At Medomsley, for example, the Warden's annual report commented approvingly that 'doubtful allocations' from courts had reduced in 1967, and that as a consequence it had been easier to deliver the regime without the need for disruptive adaptations:

> *'Courts have sent, for the most part, suitable allocations to Detention – amongst the doubtful allocations were:- a diabetic, an epileptic, two lads with a past history of epilepsy, a lad with a detached retina and an old poliomyelitis. We were able to absorb these exceptions and I believe they profited from the sentence, but if we were to receive such lads in large numbers it would reduce the tempo of the Establishment.'* ('HO 383/327: Medomsley: Annual Reports' 1976)

In 1968, it is clear that Medomsley would, on occasion, send 'inadequate' trainees away rather than accommodate them in the establishment: the same report states that 'one boy, who was quite inadequate, was released on Bail to Appeal. He did not return.' The underlying assumption here is normative: that the detention centre regime creates (and is for) healthy, able and 'normal' boys, and those who are none of these things must conform, for example by settling into the 'brisk' tempo and becoming fitter. Implicitly, the smooth delivery of the regime (rather than the needs of the individual) takes priority.

Reports from other DCs echo this underlying assumption, and offer occasional evidence that attempts were made to send 'unsuitable' individuals somewhere else, rather than try to cater to them. Thus, for example, the warden's annual report reveals that four trainees arrived at HMDC Foston Hall in 1969 in a state of such 'high emotional stress' that there was 'doubt about their mental state'. They were therefore transferred to HMP Manchester (an adult prison) 'for observation'. It is unlikely that, in the case of trainees with disabilities, wardens would have seen it as their role to 'soften' institutional demands ('HO 383/321: Foston Hall: Annual Reports' 1976). Records we consulted on male borstals do not tend to dwell on the physical 'adequacy' of receptions in this way. This might reflect a lesser emphasis on 'tempo' in borstal regimes than in DCs, where 'brisk' discipline appears to have been a key component in the deterrent aspirations of the institution.

In the case of *learning* disabilities, it is again difficult to find evidence about identifiable conditions, but clear that discourses of 'adequacy' and 'inadequacy' were used to categorise individual children, subsequently affecting the degree to which individualised help was (or more often, was not) made available to them. It *is* clear from education reports that establishments made efforts on receiving new trainees to assess their academic ability, but comparisons are difficult because the

basis of classification appears to have varied between institutions. 'Tutor organisers' (i.e. teachers) in both DCs and borstals usually employ at least the categories 'illiterate', 'semi-illiterate' and 'literate' in their reports, and some employ terms like 'backward', 'above average', 'below average' and 'retarded'. The hearings of the Northern Irish Historical Institutional Abuse Inquiry offer some suggestive indications of how this might have reduced the effectiveness of complaints policies for those judged 'backward'. A 1963 complaint about physical abuse revealed an instruction from the Governor of Millisle Borstal, regarding a complainant: 'The evidence of [anon.] must be treated with the greatest reserve. He is without doubt slightly subnormal mentally' (Historical Institutional Abuse Inquiry 2016, 151).

Whether categories such as 'backwardness' were employed in any systematic way is not clear from the reports alone. The commissioning of educational provision in penal establishments during the 1960s and 1970s was the responsibility of the governor or warden, but inspection was the responsibility of both the Prison Department Inspectorate and of inspectors from local authorities' education departments ('HO 391/150: Prisons and Borstals Panel (Sub-Panel of the Department of Education and Science): Minutes of Meetings Held by Her Majesty's Inspectors (HMI); Prison Department Represented' 1971). As a consequence, it is likely that there was substantial local variation (reflecting local practices in the community) and no consistent pattern.

In general, the attitude towards children who may have suffered from learning difficulties appears again to have been shaped by the length of the sentence, and consequent calculations about what it might be possible to do for them. In DCs, where sentences were seldom longer than three months, it was common for staff to feel that there was little they could do to help: for example, the warden of Kirklevington Grange in 1968 reported:

> *'We occasionally (not often) get an illiterate; and when this happens we have no means of helping him, for the tutor organiser is fully occupied with the other schoolboys, and we do not get enough of them to make it worth while [sic] employing someone on an irregular basis. In any case I feel little could be done in the space of eight weeks'* ('HO 383/325: Kirklevington Grange: Annual Reports' 1975)

7.4. The effects of intersecting disadvantage on the risk of abuse

The effects of these issues on abuse and the responses to it, then, can be the subject of some educated guesswork. It is known from both academic research and the historical record that children with (learning) difficulties and disabilities are particularly vulnerable to all forms of abuse, including sexual abuse and exploitation. This is because their behaviour and emotions may be less likely to be recognised by others as legitimate, so that they are easier than other children for abusers to isolate and manipulate, and less likely to be believed if they make disclosures (Stuart and Baines 2004; Delap 2018).

It does appear from the documentary record that children who were physically unable to meet the exacting standards of custody were sometimes regarded by staff as an inconvenience. While there appears to have been more attempt to identify children with learning difficulties and disabilities, the recognition of any impact that these might have on their life in the institution seems mostly to have been confined to the educational sphere; it did not result in the identification of more general

kinds of vulnerability, except in extreme cases where children presented with very obvious signs of distress. Instead, as in the case of physical disability, the expectation seems to have been that the children in question would eventually need to 'measure up' to the requirements of the institution, and not the other way around. This is very unlikely to have increased the effectiveness of safeguards such as the complaints system.

8. Concluding reflections

The safeguarding of children in secure institutions can only be evaluated fully through close attention to organisational culture. Culture affects day-to-day decision-making, and is not always congruent with the beliefs and practices laid down formally in policy. Indeed, in some circumstances culture is used to justify the sidelining, deprioritisation or relaxation of standards which are officially sanctioned. This means that considerations of abuse have to focus on institutional culture *as well as* on the actions and motivations of 'bad' individuals. Culture frames what kinds of behaviour towards children are possible: sexual abuse is likelier where 'normal' rules of conduct which regulate behaviour in the community are believed not to apply. This in turn is more likely where there are sizeable and persistent disparities of power, or other institutional priorities which impinge upon children's interests and welfare. Such disparities, and alterations of the rules of 'normal' conduct, are arguably *an inherent feature* of secure institutions.

The evidence reviewed throughout this report has demonstrated that during the earlier period from 1960 until the 1990s, safeguards against abuse were weak, ineffective, and in some cases nearly non-existent. Some of these shortcomings were apparent: by the early 1980s, for example, serious questions about the Boards of Visitors and the handling of prisoner complaints had been raised by independent observers of the prison system (e.g. Home Office 1979; Jellicoe, Howard League for Penal Reform, and Nacro 1975; Maguire and Vagg 1984). Yet reforms took many years to accomplish, perhaps because of their low political priority.

The historical sexual abuse currently under investigation by IICSA must be seen against this backdrop. It was possible *not only* because individuals acted in ways that were illegitimate and definite abuses of power, but *also* because the absence of clear aims and standards of behaviour allowed the abuse of power to become, in some circumstances, the norm and not the exception. This did not always result in *sexual* abuse, which was nonetheless the most harmful, illegitimate and problematic of a range of staff behaviours which (with the benefit of hindsight) appear abusive. Cultures where bullying among inmates went unchallenged likewise appear to have left space for sexual victimisation *among* inmates, although the documentary record only hints at the existence of this kind of abuse. Even so, both forms of abuse – by staff and by inmates – were possible because contemporary safeguards were ineffective. The institutions under review here tended in practice to leave children in custody to fend for themselves, and set very little store by the aim of protecting those most vulnerable who were least able to protect themselves.

It is clear that race and intellectual disability combined to add to vulnerability, though unclear whether this resulted in an increased likelihood of sexual abuse. The apparent absence of allegations of sexual abuse in establishments for girls is difficult to explain using the evidence we have reviewed, but does not appear to be because of a lack of vulnerability on the part of those girls who were held in custody.

The implementation and subsequent evolution of a new orthodoxy in safeguarding policies has had several effects. First, it has led to the recognition of abuse where it was not recognisable before, including in certain core security practices such as restraint and routine strip-searching. These have, in many cases, resulted in changes to policy. Second, however, a more proactive and preventive body of policies has raised barriers to certain forms of abuse, *although without rendering them*

impossible. Third, if anything, the task of prevention is arguably fraught with greater difficulty than ever before, precisely because what can be considered abusive is so broad and includes some more coercive practices such as restraint which many working in (and managing) the secure estate regard as unavoidable. One risk is that new regulations covering these practices may come to staff to seem an unrealistic bureaucratic imposition, rather than a legitimate constraint on their power. Fourth, and relatedly, new safeguards can in practice still be circumvented. A final consequence is that safeguards can become detached from their original aims. Amid ambiguity and uncertainty, custodial staff may feel more comfortable complying with procedure than they do with interpreting it to reflect changing circumstances and practices. The tendency for child protection to turn into a 'tick box culture' detached from its aims has been documented outside the secure estate (Munro 2011).

Indeed, the lesson of Medway might be that rendering practices like restraint and searching 'safeguarding-compliant' has taken policymakers' focus away from the risk that even the best policies might be circumvented. Abusive practices *can* be malign and collusive, as when care home staff in the 1970s sexually abused children, or when staff members at Medway falsified records and attacked children where they could not (or so they thought) be seen by cameras. But abuses also occur when imbalances of power combine with specific organisational cultures. As with care homes in the 1970s and 1980s, the circumvention of safeguards need not always be characterised by collusive or malign intent; rather, it can be the result of an operating environment which incentivises staff and managers to prioritise institutional goals above children's welfare. Staff at Medway were under pressure to achieve contractual targets. This may have led them to consider 'performance' narrowly (by reference to the targets) rather than broadly (by reference to the outcomes the targets were created to secure). There is a parallel here with the findings of the Pindown inquiry, where abusive staff *did not appear to understand that what they were doing was wrong*.

These are not abstract or unimportant questions. The Chief Inspector of Prisons recently reported that 'there was not a single establishment that we inspected in England and Wales in which it was safe to hold children and young people', representing a 'speed of decline [that] had been staggering' (HM Chief Inspector of Prisons 2017, 9). It is particularly troubling that this decline took place while the overall number of children in custody has been falling steeply. How, then, should we evaluate the possibility that abuses may be taking place in the secure estate today which may only to come to light in years to come?

It is important not to underplay the effectiveness of the safeguards which have been put in place since the 1980s. This research has focused on their failures, but there will have been instances in which they performed as intended and prevented abuse, and (like abuse itself) such instances are unlikely to show up in the records we have consulted. Nonetheless, any given set of regulations will contain its own vulnerabilities and entail its own forms of illegitimacy, some of which may not be apparent to those who are perpetrating abuses. It is, in fact, difficult for institutions to recognise these problems, because doing so requires openness and debate in settings where these are often not easy to practice. It is a consistent pattern, throughout the history we have reviewed, that abusive practices had often seemed unlikely or unthinkable, or were invisible using the conceptual

framework of the time but later became visible after institutional commitments to child welfare were rethought and renewed.

Thus while preventive safeguards are, in themselves, important, it is also important that staff feel confident and supported in their work, and that institutions do everything possible to promote trusting, positive relationships between staff members and the children in their care. There is an extensive research literature on this subject relating to the adult prison estate, the findings of which suggest that it is 'right' relationships based on the legitimate and responsive use of power (rather than 'good' relationships based on informality and the pretence that power disparities do not exist) which 'feel' legitimate to prisoners, and attract their consent (Liebling 2011; Crewe, Liebling, and Hulley 2014).

How far these findings can be applied to the secure estate for children is unclear, though some empirical research has been conducted by Dutch prison authorities (van der Laan and Eichelsheim 2013). However, it is likely that the small size of institutions may be a key factor here, because children are less likely to experience institutional power as legitimate if it feels distant, bureaucratic or unresponsive. This is consistent with the finding that complaints procedures and arrangements to give children a 'voice' appear more effective in SCHs than in STCs and YOIs. The desirability of smaller establishments has been a consistent feature of inspection reports over the last fifteen years (compare, for example, Chief Inspector of Social Services et al. 2002; Commission for Social Care Inspection et al. 2005; Ofsted et al. 2008; Ofsted 2017, 78). It suggests that trust is easier to build in smaller units with flatter management structures, where problems and conflicts can be resolved quickly, directly and without recourse to formal procedure. Excessive formality appears not to gain children's confidence.

Another finding suggested by this report is that the effective evaluation of organisational cultures usually involves opening them up to outside scrutiny. This may be easier at some distance: a point evident, for example, in how obvious it seems today that inspectors at Medomsley in 1977 were blind to what (with hindsight) appear to have been risky working practices in the kitchen. The very fact that problems are easier to perceive from a distance raises a further question: how should monitoring bodies and inspectorates respond to the failures of past safeguards against abuse?

What the past suggests is that there is a very important tension, which will continue to be at play in the work of inspection and monitoring. On the one hand, it is vital (as the Home Office recognised when reviewing complaints procedures in the 1970s) that inspections and complaints investigations retain the confidence of staff, by demonstrating understanding of the peculiar features of the custodial environment. On the other hand, if inspectorates, Independent Monitoring Boards and the like become *too* acculturated to the places they monitor, then their ideas about what is 'normal' and acceptable may begin to reflect those of the culture around them. This suggests, perhaps, that one important principle for those who monitor and inspect the secure estate is to regularly involve new 'eyes' in the task. Some custodial problems, including problematic cultures, may be more apparent to newcomers than to other, more experienced observers. Inspection and oversight must retain awareness of this tension, and must be undertaken with a critical mindset.

Unhealthy cultures in custody develop largely because it is easy to present abusive practices as justifiable means to legitimate ends. Over the long term, the operational context for the secure

estate is *always* likely to be affected by fluctuations in resourcing and imbalances between supply and demand for places. Thus shifting priorities (of the sort which risk the development of abusive cultures) will *always* affect provision. In consequence, cultural blind spots will *always* be possible, and identifying them will *always* impinge on the interests of those who hold power. This makes protections for whistleblowers a key measure to protect children against abuse.

In short, despite safeguarding policies and frameworks and inspection regimes, the potential for abusive practices and cultures in custodial institutions for children must be viewed as evolving and thus always possible. This points to three final reflections:

- that the use of custody for children should be limited as far as possible, because of the inherent tensions in residential institutions where there is a marked disparity of power and an element of coercion in the allocation of residents;
- that there are distinct benefits to historical research in this area, because it offers a long-term perspective on present-day safeguards and abuses, and because past shortcomings in the successful implementation of safeguarding frameworks may suggest where to look for present-day gaps;
- that child safeguarding needs to be understood as an ongoing, iterative process, rather than as the attainment of a defined standard of practice.

9. Appendices

9.1. Research methods

The research carried out for this report was framed by nine orienting research questions agreed between the research team and HMPPS. These were as follows:

1. How has the definition of a child changed over time, in legal terms and within the secure estate?
2. What broad changes have taken place across time in the nature of the secure estate and custodial responses to children?
3. How consistently were under-18-year-olds identified as children within the secure estate? What forms of care and custody did they experience?
4. What are the dominant discourses around child sexuality, child abuse and child protection since 1960 and how have they changed over time?
5. When was the term 'child safeguarding' first used in the custodial estate? What are the key points of change over time in relation to child safeguarding in the secure estate, and who or what has catalysed change? How effectively have external bodies such as local authorities and inspectors worked with custodial institutions to protect children?
6. What can international scandals and inquiries in relation to child sexual abuse in institutional settings tell us about the experiences of children and the organisation of institutions that made for varying levels of safeguarding outside of the United Kingdom? What relevance for custodial settings can be identified from institutional failings in these other types of institution?
7. Are there, historically and in the present day, gaps between policy and implementation with regards to safeguarding children against CSA?
8. What systems of whistleblowing, disclosure and reporting have existed in relation to child abuse within the secure estate?
9. What kind of investigations and discipline systems have existed in relation to staff and child safeguarding concerns?

The research carried out for this report has adopted a mixture of systematic and pragmatic methods. The initial strategy was twofold: to conduct an orienting review of risk factors for institutional abuse using existing research and the reports of child abuse inquiries; and to review academic histories of the youth justice system and of different forms of youth custody. The focus in this second review was upon the kinds of establishment that, at different times, held children sentenced to custody for criminal offences by the courts, and under what policy and legal frameworks they did so.

The intention was that these reviews would then frame our consideration of inspection reports, archival records, and other primary records concerning individual institutions. The principal focus of the research was on Prison Service establishments, and we therefore identified a list of sites of interest where historic child abuse allegations have been made. All the institutions on the list generated by this method were male-only; rather than leave female custody out of the study altogether, we added the small number of borstals, DCs, prisons and YOIs known to have held girls to the list.

Systematic catalogue searches were then carried out to identify relevant records in the two principal repositories used for the study, the Radzinowicz Library in Cambridge and The National Archives (TNA) in London. The searches were thematic and by institutions of interest. Thematic searches were carried out using the following terms:[9]

- child* AND protect* AND prison
- child* AND abuse AND prison
- child* AND safeguard* AND prison
- staff AND complain* AND prison
- remand centre AND complaint
- detention centre AND complaint
- borstal AND complaint
- staff AND discipl* AND prison
- disclos* AND prison

Searches by institution were carried out using the following procedure:

- search catalogues for names of all institutions on the 'establishments of interest' list
- identify all available records which overlap with periods when known allegations of sexual abuse have been made

The results of these searches were uneven, with a plethora of records for the later period of the study (since the 1990s), and far sparser records for the earlier period (1960 to the 1990s). This may reflect changing public and policy discourses around children and child sexuality, particularly the fact that the terms 'child abuse', 'child protection', 'safeguarding', and 'child sexual abuse' only entered widespread usage during the period under study.

The available archival records reflect these changes in thinking and terminology. As described in chapter 6, child safeguarding policies and practices became relevant to institutional practice only during the 1980s (in the local authority care system) and the late 1990s (in the penal system). Archives therefore offer a relatively small pool of relevant records for the earlier period, hardly any of which were created to collate information on abuse, safeguarding or child protection. In addition, for reasons of space and resources, the National Archives retain only a sample of government records which are lodged with them, and by default these are closed for 30 years after the record's creation. This has a significant impact on the evidence available for recent historical research. According to one recent informed estimate (based on archival research using Home Office records covering the same period as we have researched):

- fewer than 10 per cent of records have been retained;
- the overall proportion is probably much lower than that, and for some collections may be as low as 1 per cent;
- selection criteria intended to ensure the survival of historically important records have often failed to do so;

[9] Further searches were carried out using terms such as 'misconduct' and 'indecency' that were commonly used before the 1980s to refer to sexual abuse in other institutions, including approved schools. These searches generated no results relevant to institutions within our scope for this report.

- the extent to which records in any given collection survive is unknown, because '[p]apers from time to time have been destroyed *en masse* and without proper oversight [and m]any files have been "lost in the system", "booked out" to officials who did not return them because they had left their post, mislaid [records] or elected informally to dispose of them' (Rock 2017, 22).

This mixture of policy and accident has several implications for the survival of records relevant to historical abuse. It suggests that few will have been retained, and of those which have, none will be available for thirty years following the closure of the file. An additional factor encountered during initial document searches was that of records which have been retained and are thus listed in the National Archives catalogue. Some such records remain closed after the usual 30-year period, usually because they contain information deemed likely to harm or embarrass living individuals who are named in the file. Typically, these are not opened for 100 years, and thus cannot yet be viewed. It is possible under the Freedom of Information Act to request that a record's continued closure be reviewed. If the review results in the opening of the file, it may be redacted; but reviews can also be rejected. It follows that records relating to the investigation of unproven allegations of any form of child abuse are much likelier to remain closed on these grounds. A final reason some records cannot be viewed at The National Archives is if they have been loaned to a government department.

Given these limitations, we discovered that some issues and institutions of interest were not well-covered by the records generated by our searches. We therefore adopted a more pragmatic strategy, pursuing leads by browsing the TNA catalogue, following cross-references in files, drawing inferences about institutions for children using available information (for example, by reviewing how complaints were handled in adult prisons where information on complaints by children was lacking) and turning to academic secondary literatures where archival sources were in short supply or lacked information relevant to certain issues.

Freedom of Information (FOI) requests were also made to access relevant closed records. A handful resulted in files being opened, but this occurred as we were finalising this report in late January 2018, too late in the research process for us to be able to review and include them in this report. These files related to allegations of 'indecency' – usually a euphemism for sexual misconduct – against a member of staff at a remand home in London, in the mid-1960s, and appear to contain papers relating to the handling of this issue. As such they were not directly relevant to the institutions which have formed the main focus of this report, but they might have provided new material on how complaints of sexual misconduct were thought about and investigated. A number of other files remain unavailable for various reasons, including a few which, for the time being, appear to have been lost. Most of these files concern how specific allegations by young people against staff were handled, and access to them would have significantly enhanced the quality of evidence available for this report. The lost files in question are listed in appendix 9.2.

Methodologically, the later period (1990s onwards) faced a contrasting challenge. The lack of archival records has already been noted, leaving us mostly reliant on secondary sources. Over the past thirty years, there has been a general move towards greater transparency in government, and the volume of documents now published on secure institutions for children is enormous. Due to the three-month time limit for the project, it was not possible to comprehensively review the available

material on specific institutions. In the case of Secure Children's Homes, it was also difficult to match recent inspection reports to individual homes, as the reports are written so as to disguise the identity of the establishment (the reasons for this are unclear, and the same is not done for YOIs or STCs). Our search strategy for this later period therefore focused on published reviews of the children's secure estate overall, and on annual reports which provided overviews of the running of all establishments (such as thematic inspection reports). References to particular institutions were then chased up in specific inspection reports where possible. The availability of records means that in the later parts of the narrative, covering the period since the late 1980s, we have tended to use documents giving an overview of the secure estate more than detailed evidence on particular institutions. In-depth evidence on recent organisational cultures has been hard to obtain, though there are significant exceptions, for example the report of the Medway Improvement Board.

A final point relates to the way that available records shape the writing of history. Put simply, the account we can present of what caused historical change reflects the kinds of evidence that we could consult. One example is chapter 6. Prisons are closed institutions and obtaining information about them is difficult. Much of the available published information since 1980 consists of Inspectorate reports, and even organisations like the Howard League and the Prison Reform Trust are often reliant on these (and on official statistics) for their research. The account we give of change during the 1990s and early 2000s, which draws in large part on Inspectorate reports, might underplay factors which drove change but are only hinted at by Inspectorate reports (such as the thinking of key politicians and policymakers). Such matters will only become clear when the relevant archival records are opened under the 30-year rule.

Another example relates to Secure Children's Homes. As section 4.4 makes clear, the governance of these institutions was very decentralised. One consequence is that documentary records are not usually held at the National Archives, but by whichever organisations ran each home. Some might be available at local record offices. These too would be subject to the 30-year rule; more importantly, however, the gigantic enterprise of identifying what might be available in such dispersed locations was far beyond the scope of this project. We have therefore again been reliant on inquiries and other secondary sources for much of our commentary on SCHs – and academic research in this field is sparse. As a result, we have not been able to attempt such close scrutiny of institutional life in the care system as was possible using the records generated by penal institutions, which happen to be centrally held.

This underlines the importance of making the records of past investigations and inquiries (such as those itemised in Appendix 9.2) available to historical researchers. Currently, most such records cannot be viewed for reasons connected with the Data Protection Act. Even redacted versions would make it far easier to identify problems in institutional culture. If secure institutions now recognise that they are responsible (and may be called to account) for their past actions, then it is imperative that documents are retained in accessible formats. Within organisations, documents constitute institutional memory; they are, further, a crucial matter of public record.

Throughout the report we provide as much information as practicable regarding the sources we have used to build our argument. Our hope is that users of the report will read critically and remain mindful that historical accounts are shaped by the circumstances of their production. They can be, at best, a representation of the past, and never its facsimile.

9.2. Archival records which may be relevant but were unavailable

Table 4: Records we were unable to consult at the National Archives, along with details of why

Number	Title	Status (as per TNA catalogue)	Outcome of FOI review request	Notes & subsequent actions
BN 29/2614	Branch A aspects: individual case note; correspondence, memoranda, comments and drafts	Closed	Refused - exempt under s.40 DPA 1998	File relates to provision of secure accommodation in Community Homes. Relevance uncertain.
BN 29/2615	Remand home provision: note of a meeting with Renee Short 23.3.72; press extracts; individual case notes; correspondence, memoranda and drafts	"	"	"
BN 62/1592	Stamford House Remand Home and Classifying Centre, Shepherd Bush London: special inspection	"	"	Appears to relate to same complaints of sexual misconduct by staff as BN 62/1595 below
BN 62/1594	Stamford House Remand Home and Classifying Centre, Shepherd Bush London: complaint by Juvenile Court magistrate	"	"	"
BN 62/1595	Stamford House Remand Home and Classifying Centre, Shepherd Bush London: complaint about indecency by staff	"	To be opened with redactions	Opened 25.1.18 – too late for inclusion in this report
BN 62/3274	Stamford House Remand Home and Classifying Centre, Shepherd's Bush, Hammersmith, London: complaint regarding staff conduct and subsequent enquiry	"	Refused - exempt under s.40 DPA 1998	

Number	Title	Status (as per TNA catalogue)	Outcome of FOI review request	Notes & subsequent actions
HO 391/104	Governors' annual reports: collection of annexes relating to confidential issues	Closed and retained[10]	TNA catalogue states records with 'creating department or successor'	FOI requests made to MoJ and Home Office. Both say they do not have the files.
HO 391/209	Allegations by prisoners against prison staff: appropriate procedures to be followed by headquarters; discussion papers	Closed and retained	"	"
HO 391/210	Allegations by former inmates against staff at Ashford Remand Centre, Middlesex: arrangements for inquiry	"	Catalogue states record is closed but not that it is with another dept.; TNA FOI team state records are with MoJ	"
HO 391/211	Allegations by former inmates against staff at Ashford Remand Centre, Middlesex: organisation and progress of inquiry	"	"	"
HO 391/212	Allegations by former inmates against staff at Ashford Remand Centre, Middlesex: organisation and progress of inquiry	"	"	"

[10] i.e. retained by another government department.

Number	Title	Status (as per TNA catalogue)	Outcome of FOI review request	Notes & subsequent actions
HO 391/250	Discipline at HM Borstal Feltham, Middlesex: meeting of Board of Visitors with senior staff and Prison Officers' Association	"	TNA catalogue states records with 'creating department or successor'	FOI requests made to MoJ and Home Office. Both say they do not have the files.
HO 391/259	[Medical] Examination of prisoners: policy	"	"	"
HO 391/262	Prisoners' correspondence: disclosure of information to police; review and drafting of prison rules	Closed and retained	"	"
HO 391/263	Disclosure of information: consideration given to approaching inmates for useful knowledge	"	"	"
HO 391/67	Complaint by inmate at HM Prison Styal, Wilmslow, Cheshire	"	TNA FOI team state records are with MoJ	"
HO 391/74	Arrangements for after-care following release: Children and Young Person's Act 1969	"	TNA catalogue states records with 'creating department or successor'	"
HO 391/83	Inquiry: allegations of ill treatment at New Hall Detention Centre, Wakefield, West Yorkshire by two former inmates, made to BBC Radio Teesside; Board of Visitors concluded that complaints not justifiable	Closed and FOI request refused	Refused - exempt under s.40 DPA 1998	

9.3. Prisoner complaints investigated externally, 1956-1978

Table 5: Summary table describing external inquiries held to investigate complaints made by prisoners, 1956-1978. Reproduced with minor clarifications from a hand-drawn table in the original archive file('HO 413/6: Guidelines for New Procedures for Investigating Complaints against Prison Officer Staff: Complainant and Complainee's Rights' 1978)

Location	Nature of allegations	Source	Channels	Preliminary investigation	Type of inquiry	Parties legally represented	Duration	Findings	Report published?	Method of reporting findings	Unusual features
Liverpool (1956) [Adult prison with Young Prisoner Centre]	Brutality	Former & serving prisoners and relatives	MP; petitions	Some allegations investigated by Governor	QC in camera, witnesses examined by counsel instructed by Treasury Solicitor	Governors, officers	?	?	Yes (as Parl'tary paper in 1956)	Arranged parl'tary question	-
Durham (1963) [Local prison]	Ill-treatment of prisoners	One ex-prisoner	MP; TV and media	-	5 members of Visiting Committee	Officers, prison medical officers	2 months	No substance in 8 cases; one possibly had substance but not serious; one suggested that unnecessary force perhaps used	Yes (as Parl'tary paper in June 1963)	Arranged parl'tary question	Complainant allowed to hear and question witnesses
Durham (1967) [Local prison]	Brutality	Several serving prisoners, one ex-prisoner	Visiting Committee (at adjudications)	-	5 members of Visiting Committee	Governor, deputy governor, officers	7 weeks	No evidence to substantiate	No	Arranged parl'tary question (written reply)	Chair of local POA invited to give evidence
Buckley Hall (1967) [Senior Detention Centre]	Brutality, oppressive unofficial punishment	Several ex-trainees	Newspaper (Guardian)	-	3 members of Board of Visitors	Officers	5 weeks	Serious allegations unfounded but substance in one alleged incident	No	Arranged parl'tary question (written reply)	Journalist gave evidence and allowed copy of transcript

Location	Nature of allegations	Source	Channels	Preliminary investigation	Type of inquiry	Parties legally represented	Duration	Findings	Report published?	Method of reporting findings	Unusual features
Reading (1967) [Borstal]	Brutality	Ex-trainees	Newspaper (People)	-	5 members of Board of Visitors	Officers	4 months	Disciplinary action required in respect of 2 officers	No	Arranged parl'tary question (written reply)	108 witnesses heard
Parkhurst (1969) [Dispersal prison]	Ill-treatment, various abuses	120 serving prisoners	Smuggled letter to newspaper (People)	-	Member of Prisons Board (2 Governors assisted in taking statements)	None, but representative of local POA present	1 month	Prima facie evidence of unlawful force in one case. Another possibly meriting further investigation	No	Press statement	-
New Hall (1971) [Senior Detention Centre]	Brutality	2 ex-trainees	BBC local radio	Yes (by DRD)[11]	Chairman and one member of Board of Visitors and Chairman of another Board	Officers	7 weeks	No substance	No	Press notice, arranged parl'tary question (written reply)	-
Ashford (1971) [Remand Centre]	Brutality and irregular practices	3 ex-trainees	Newspaper (Sunday Times)	-	Chairman and 1 member of Visiting Committee and one member of another VC	Governor, officers	7 months	No substance	No	Press notice, arranged parl'tary question (written reply)	Inquiry requested broader terms of reference

[11] It is not stated what these initials stand for.

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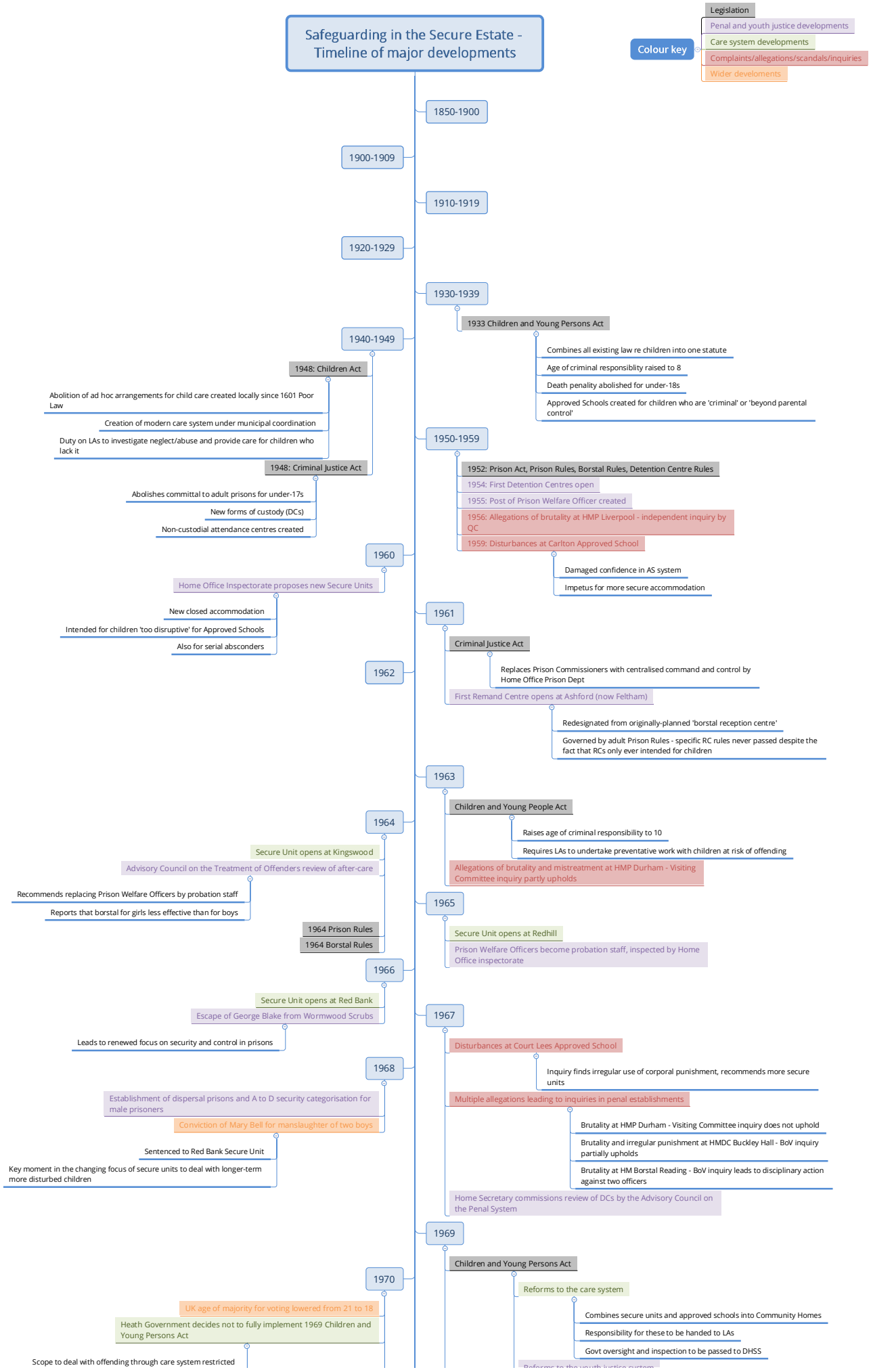
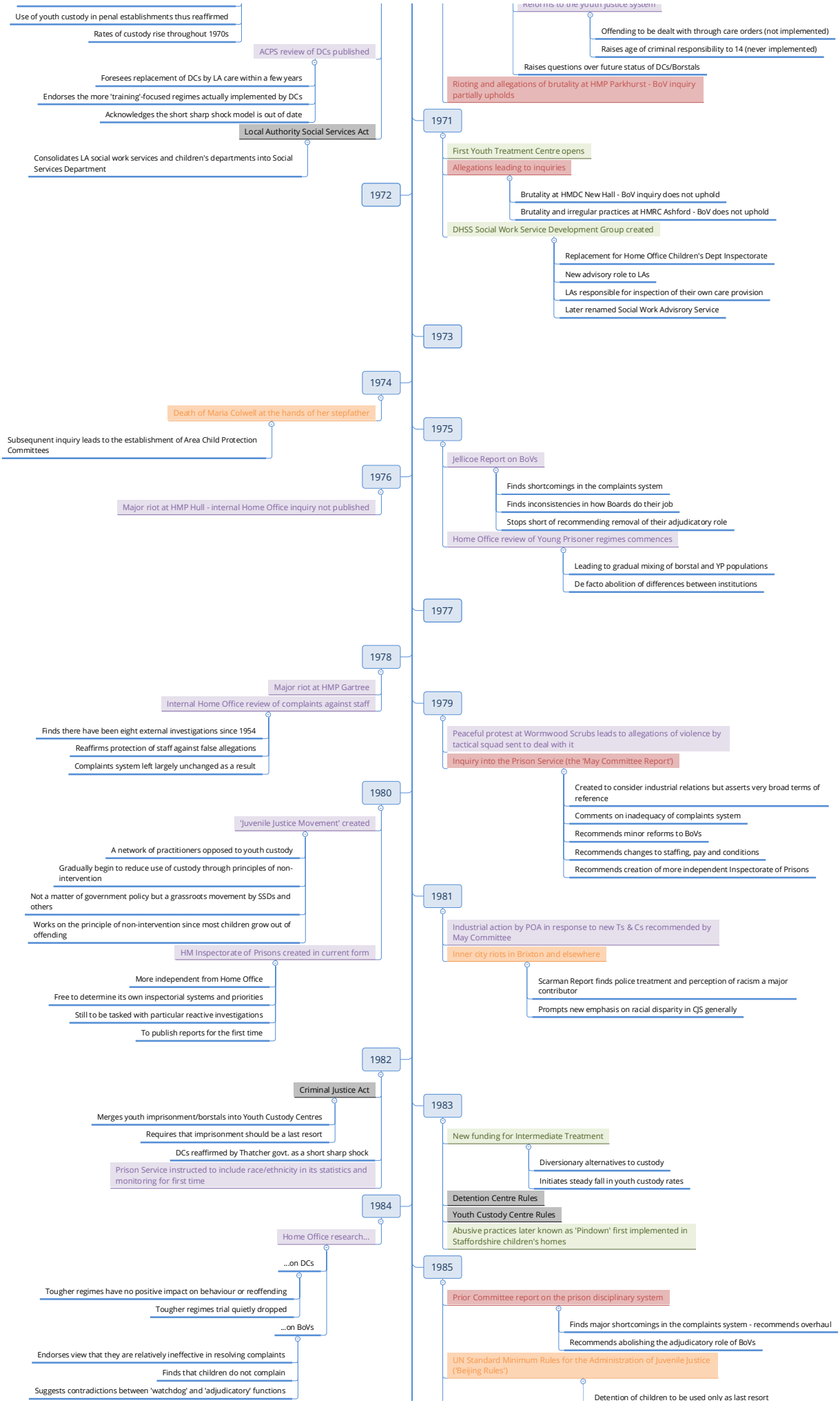
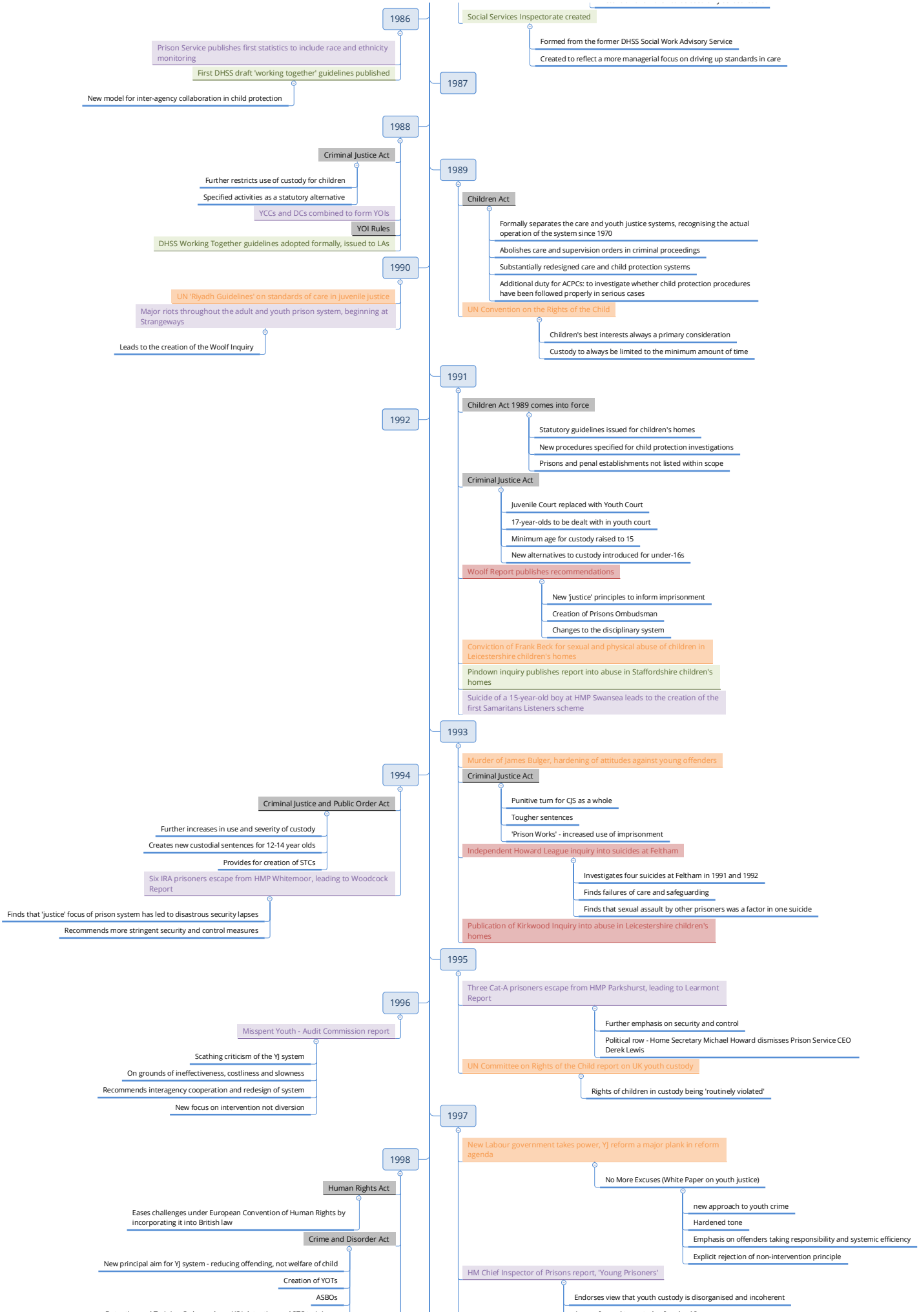
9.5. Timeline of developments in youth justice and child safeguarding

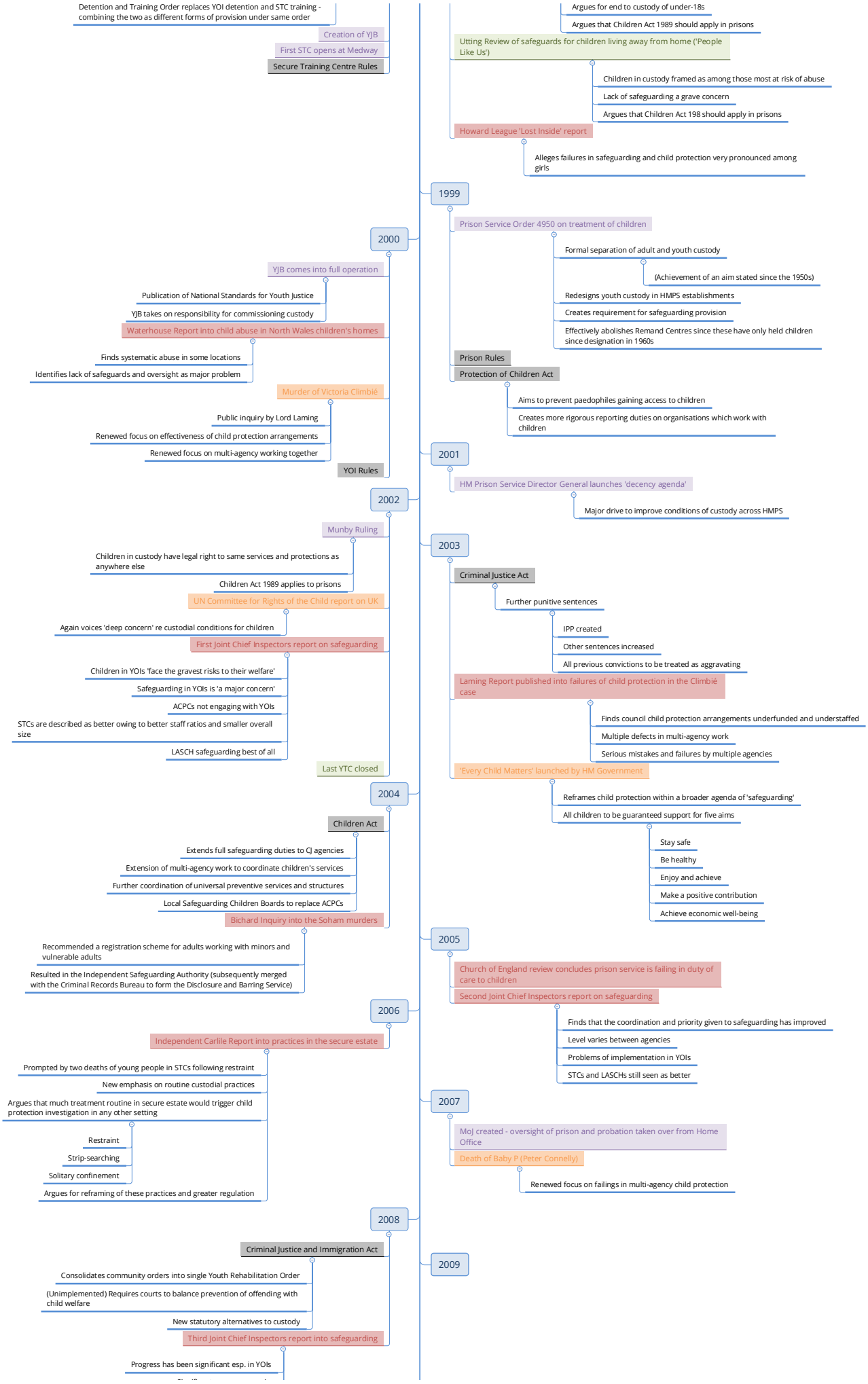
A timeline has been produced to assist readers in visualising the main developments covered by this report, and as a reference resource. This covers several pages and is provided as a separate file.

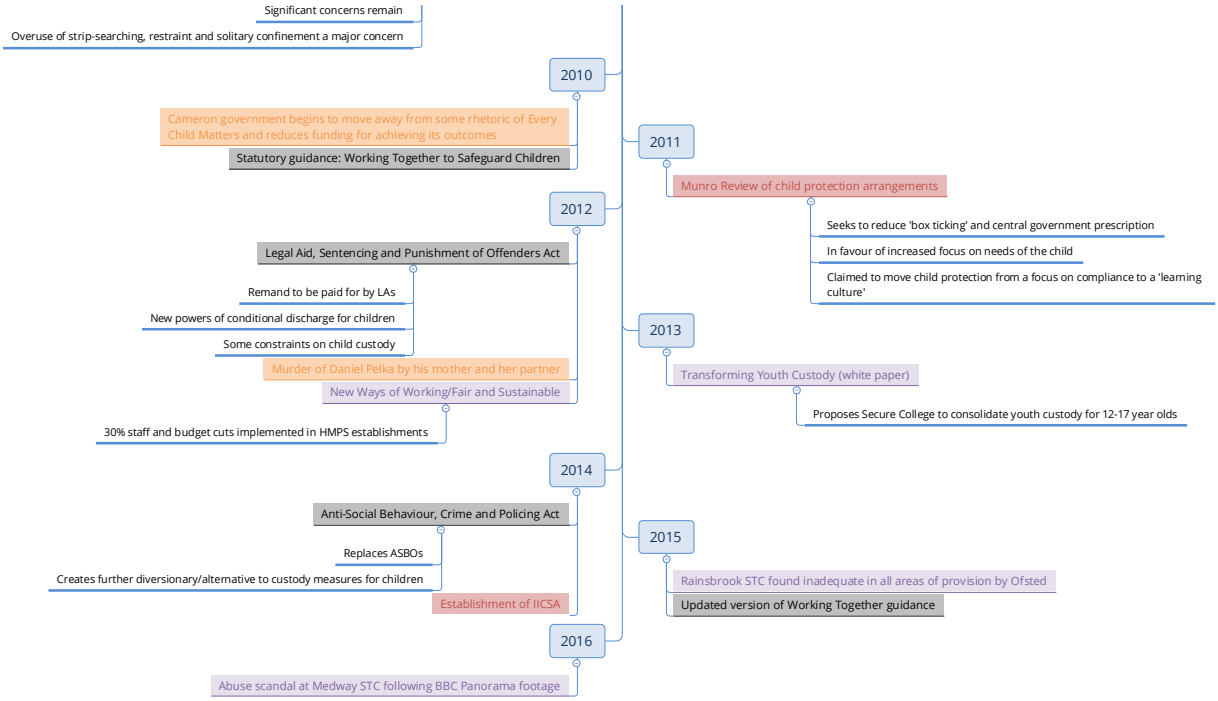
Safeguarding in the Secure Estate - Timeline of major developments




Use of youth custody in penal establishments thus reaffirmed
Rates of custody rise throughout 1970s
ACPS review of DCs published
Foresees replacement of DCs by LA care within a few years
Endorses the more 'training'-focused regimes actually implemented by DCs
Acknowledges the short sharp shock model is out of date
Local Authority Social Services Act
Consolidates LA social work services and children's departments into Social Services Department
1972
Death of Maria Colwell at the hands of her stepfather
Subsequnent inquiry leads to the establishment of Area Child Protection Committees
1974
Major riot at HMP Hull - internal Home Office inquiry not published
1976
Internal Home Office review of complaints against staff
Finds there have been eight external investigations since 1954
Reaffirms protection of staff against false allegations
Complaints system left largely unchanged as a result
Major riot at HMP Gartree
1978
'Juvenile Justice Movement' created
A network of practitioners opposed to youth custody
Gradually begin to reduce use of custody through principles of non-intervention
Not a matter of government policy but a grassroots movement by SSDs and others
Works on the principle of non-intervention since most children grow out of offending
HM Inspectorate of Prisons created in current form
More independent from Home Office
Free to determine its own inspectorial systems and priorities
Still to be tasked with particular reactive investigations
To publish reports for the first time
1980
Criminal Justice Act
Merges youth imprisonment/borstals into Youth Custody Centres
Requires that imprisonment should be a last resort
DCs reaffirmed by Thatcher govt. as a short sharp shock
Prison Service instructed to include race/ethnicity in its statistics and monitoring for first time
1982
Home Office research...
...on DCs
Tougher regimes have no positive impact on behaviour or reoffending
Tougher regimes trial quietly dropped
...on BoVs
Endorses view that they are relatively ineffective in resolving complaints
Finds that children do not complain
Suggests contradictions between 'watchdog' and 'adjudicatory' functions
1984
Reforms to the youth justice system
Offending to be dealt with through care orders (not implemented)
Raises age of criminal responsibility to 14 (never implemented)
Raises questions over future status of DCs/Borstals
Rioting and allegations of brutality at HMP Parkhurst - BoV inquiry partially upholds
1971
First Youth Treatment Centre opens
Allegations leading to inquiries
Brutality at HMDC New Hall - BoV inquiry does not uphold
Brutality and irregular practices at HMRC Ashford - BoV does not uphold
DHSS Social Work Service Development Group created
Replacement for Home Office Children's Dept Inspectorate
New advisory role to LAs
LAs responsible for inspection of their own care provision
Later renamed Social Work Advisrory Service
1973
1975
Jellicoe Report on BoVs
Finds shortcomings in the complaints system
Finds inconsistencies in how Boards do their job
Stops short of recommending removal of their adjudicatory role
Home Office review of Young Prisoner regimes commences
Leading to gradual mixing of borstal and YP populations
De facto abolition of differences between institutions
1977
1979
Peaceful protest at Wormwood Scrubs leads to allegations of violence by tactical squad sent to deal with it
Inquiry into the Prison Service (the 'May Committee Report')
Created to consider industrial relations but asserts very broad terms of reference
Comments on inadequacy of complaints system
Recommends minor reforms to BoVs
Recommends changes to staffing, pay and conditions
Recommends creation of more independent Inspectorate of Prisons
1981
Industrial action by POA in response to new Ts & Cs recommended by May Committee
Inner city riots in Brixton and elsewhere
Scarman Report finds police treatment and perception of racism a major contributor
Prompts new emphasis on racial disparity in CJS generally
1983
New funding for Intermediate Treatment
Diversionary alternatives to custody
Initiates steady fall in youth custody rates
Detention Centre Rules
Youth Custody Centre Rules
Abusive practices later known as 'Pindown' first implemented in Staffordshire children's homes
1985
Prior Committee report on the prison disciplinary system
Finds major shortcomings in the complaints system - recommends overhaul
Recommends abolishing the adjudicatory role of BoVs
UN Standard Minimum Rules for the Administration of Juvenile Justice ('Beijing Rules')
Detention of children to be used only as last resort


1986
Prison Service publishes first statistics to include race and ethnicity monitoring
First DHSS draft 'working together' guidelines published
New model for inter-agency collaboration in child protection
1987
Social Services Inspectorate created
Formed from the former DHSS Social Work Advisory Service
Created to reflect a more managerial focus on driving up standards in care
1988
Criminal Justice Act
Further restricts use of custody for children
Specified activities as a statutory alternative
YCCs and DCs combined to form YOIs
YOI Rules
DHSS Working Together guidelines adopted formally, issued to LAs
1989
Children Act
Formally separates the care and youth justice systems, recognising the actual operation of the system since 1970
Abolishes care and supervision orders in criminal proceedings
Substantially redesigned care and child protection systems
Additional duty for ACPCs: to investigate whether child protection procedures have been followed properly in serious cases
UN Convention on the Rights of the Child
Children's best interests always a primary consideration
Custody to always be limited to the minimum amount of time
1990
UN 'Riyadh Guidelines' on standards of care in juvenile justice
Major riots throughout the adult and youth prison system, beginning at Strangeways
Leads to the creation of the Woolf Inquiry
1991
1992
Children Act 1989 comes into force
Statutory guidelines issued for children's homes
New procedures specified for child protection investigations
Prisons and penal establishments not listed within scope
Criminal Justice Act
Juvenile Court replaced with Youth Court
17-year-olds to be dealt with in youth court
Minimum age for custody raised to 15
New alternatives to custody introduced for under-16s
Woolf Report publishes recommendations
New 'justice' principles to inform imprisonment
Creation of Prisons Ombudsman
Changes to the disciplinary system
Conviction of Frank Beck for sexual and physical abuse of children in Leicestershire children's homes
Pindown inquiry publishes report into abuse in Staffordshire children's homes
Suicide of a 15-year-old boy at HMP Swansea leads to the creation of the first Samaritans Listeners scheme
1993
Murder of James Bulger, hardening of attitudes against young offenders
1994
Criminal Justice Act
Punitive turn for CJS as a whole
Tougher sentences
'Prison Works' - increased use of imprisonment
Criminal Justice and Public Order Act
Further increases in use and severity of custody
Creates new custodial sentences for 12-14 year olds
Provides for creation of STCs
Independent Howard League inquiry into suicides at Feltham
Investigates four suicides at Feltham in 1991 and 1992
Finds failures of care and safeguarding
Finds that sexual assault by other prisoners was a factor in one suicide
Six IRA prisoners escape from HMP Whitemoor, leading to Woodcock Report
Finds that 'justice' focus of prison system has led to disastrous security lapses
Recommends more stringent security and control measures
Publication of Kirkwood Inquiry into abuse in Leicestershire children's homes
1995
Three Cat-A prisoners escape from HMP Parkshurst, leading to Learmont Report
Further emphasis on security and control
Political row - Home Secretary Michael Howard dismisses Prison Service CEO Derek Lewis
1996
Misspent Youth - Audit Commission report
Scathing criticism of the YJ system
On grounds of ineffectiveness, costliness and slowness
Recommends interagency cooperation and redesign of system
New focus on intervention not diversion
UN Committee on Rights of the Child report on UK youth custody
Rights of children in custody being 'routinely violated'
1997
New Labour government takes power, YJ reform a major plank in reform agenda
No More Excuses (White Paper on youth justice)
new approach to youth crime
Hardened tone
Emphasis on offenders taking responsibility and systemic efficiency
Explicit rejection of non-intervention principle
1998
Human Rights Act
Eases challenges under European Convention of Human Rights by incorporating it into British law
Crime and Disorder Act
New principal aim for YJ system - reducing offending, not welfare of child
Creation of YOTs
ASBOs
HM Chief Inspector of Prisons report, 'Young Prisoners'
Endorses view that youth custody is disorganised and incoherent


Detention and Training Order replaces YOI detention and STC training - combining the two as different forms of provision under same order
Creation of YJB
First STC opens at Medway
Secure Training Centre Rules
Argues for end to custody of under-18s
Argues that Children Act 1989 should apply in prisons
Utting Review of safeguards for children living away from home ('People Like Us')
Children in custody framed as among those most at risk of abuse
Lack of safeguarding a grave concern
Argues that Children Act 198 should apply in prisons
Howard League 'Lost Inside' report
Alleges failures in safeguarding and child protection very pronounced among girls
1999
Prison Service Order 4950 on treatment of children
Formal separation of adult and youth custody
(Achievement of an aim stated since the 1950s)
Redesigns youth custody in HMPS establishments
Creates requirement for safeguarding provision
Effectively abolishes Remand Centres since these have only held children since designation in 1960s
Prison Rules
Protection of Children Act
Aims to prevent paedophiles gaining access to children
Creates more rigorous reporting duties on organisations which work with children
2000
YJB comes into full operation
Publication of National Standards for Youth Justice
YJB takes on responsibility for commissioning custody
Waterhouse Report into child abuse in North Wales children's homes
Finds systematic abuse in some locations
Identifies lack of safeguards and oversight as major problem
Murder of Victoria Climbié
Public inquiry by Lord Laming
Renewed focus on effectiveness of child protection arrangements
Renewed focus on multi-agency working together
YOI Rules
2001
HM Prison Service Director General launches 'decency agenda'
Major drive to improve conditions of custody across HMPS
2002
Munby Ruling
Children in custody have legal right to same services and protections as anywhere else
Children Act 1989 applies to prisons
UN Committee for Rights of the Child report on UK
Again voices 'deep concern' re custodial conditions for children
First Joint Chief Inspectors report on safeguarding
Children in YOIs 'face the gravest risks to their welfare'
Safeguarding in YOIs is 'a major concern'
ACPCs not engaging with YOIs
STCs are described as better owing to better staff ratios and smaller overall size
LASCH safeguarding best of all
Last YTC closed
2003
Criminal Justice Act
Further punitive sentences
IPP created
Other sentences increased
All previous convictions to be treated as aggravating
Laming Report published into failures of child protection in the Climbié case
Finds council child protection arrangements underfunded and understaffed
Multiple defects in multi-agency work
Serious mistakes and failures by multiple agencies
'Every Child Matters' launched by HM Government
Reframes child protection within a broader agenda of 'safeguarding'
All children to be guaranteed support for five aims
Stay safe
Be healthy
Enjoy and achieve
Make a positive contribution
Achieve economic well-being
2004
Children Act
Extends full safeguarding duties to CJ agencies
Extension of multi-agency work to coordinate children's services
Further coordination of universal preventive services and structures
Local Safeguarding Children Boards to replace ACPCs
Bichard Inquiry into the Soham murders
Recommended a registration scheme for adults working with minors and vulnerable adults
Resulted in the Independent Safeguarding Authority (subsequently merged with the Criminal Records Bureau to form the Disclosure and Barring Service)
2005
Church of England review concludes prison service is failing in duty of care to children
Second Joint Chief Inspectors report on safeguarding
Finds that the coordination and priority given to safeguarding has improved
Level varies between agencies
Problems of implementation in YOIs
STCs and LASCHs still seen as better
2006
Independent Carlile Report into practices in the secure estate
Prompted by two deaths of young people in STCs following restraint
New emphasis on routine custodial practices
Argues that much treatment routine in secure estate would trigger child protection investigation in any other setting
Restraint
Strip-searching
Solitary confinement
Argues for reframing of these practices and greater regulation
2007
MoJ created - oversight of prison and probation taken over from Home Office
Death of Baby P (Peter Connelly)
Renewed focus on failings in multi-agency child protection
2008
Criminal Justice and Immigration Act
Consolidates community orders into single Youth Rehabilitation Order
(Unimplemented) Requires courts to balance prevention of offending with child welfare
New statutory alternatives to custody
Third Joint Chief Inspectors report into safeguarding
Progress has been significant esp. in YOIs
2009


Significant concerns remain
Overuse of strip-searching, restraint and solitary confinement a major concern
2010
Cameron government begins to move away from some rhetoric of Every Child Matters and reduces funding for achieving its outcomes
Statutory guidance: Working Together to Safeguard Children
2011
Munro Review of child protection arrangements
Seeks to reduce 'box ticking' and central government prescription
In favour of increased focus on needs of the child
Claimed to move child protection from a focus on compliance to a 'learning culture'
2012
Legal Aid, Sentencing and Punishment of Offenders Act
Remand to be paid for by LAs
New powers of conditional discharge for children
Some constraints on child custody
Murder of Daniel Pelka by his mother and her partner
New Ways of Working/Fair and Sustainable
30% staff and budget cuts implemented in HMPS establishments
2013
Transforming Youth Custody (white paper)
Proposes Secure College to consolidate youth custody for 12-17 year olds
2014
Anti-Social Behaviour, Crime and Policing Act
Replaces ASBOs
Creates further diversionary/alternative to custody measures for children
Establishment of IICSA
2015
Rainsbrook STC found inadequate in all areas of provision by Ofsted
Updated version of Working Together guidance
2016
Abuse scandal at Medway STC following BBC Panorama footage