

Executive Summary

- Recent scandals at Medway Secure Training Centre have exposed weaknesses in the legal protections available to children in custody in the youth justice system.
- This is despite the fact that since the late 1990s, safeguarding and child protection in places of child custody have been significantly reformed and expanded in scope.
- Under new regimes of safeguarding, policy compliance has sometimes become the priority, with the effectiveness of properly-applied policy not being questioned. In this context, new and developing risks of abuse have gone unrecognised.
- Historical research helps us to see how past safeguards, which had previously been assumed to be effective, had in fact broken down. This usually happened not only as the result of misconduct by 'bad apples'.
- Instead, the actions of 'bad apples' usually occurred within unhealthy institutional cultures in which staff used abusive methods such as bullying and violence to secure legitimate outcomes such as the maintenance of order. Such methods were often resorted to at times of institutional pressure, for example during periods of overcrowding or budgetary constraint.
- Those charged with managing and monitoring conditions in youth custody often gave such methods their tacit endorsement, evaluating them not in terms of individual children's welfare, but in terms of institutional priorities.
- In such morally compromised climates, 'bad apples' were able to pursue wholly illegitimate and indefensible ends – such as the sexual abuse and exploitation of children and young people – with impunity.
- Understanding the cultural contexts of past abuse highlights the dangers of complacency regarding today's safeguarding policies. Despite the more proactive safeguards implemented since 2000, unhealthy occupational cultures – featuring confusion over institutional goals, low staff morale, hierarchical management structures, and institutional isolation – have not been eliminated from the secure estate.
- The implication is that custodial institutions for children are inherently risky environments, particularly where they are not explicitly organised around an ethos of care, or where wider organisational priorities (such as the need for cost efficiencies) clash with that ethos. Youth custody therefore must remain a minimal last resort, used where there is no non-custodial alternative.

Introduction

Public life in Britain has been deeply marked by growing awareness of historical abuses against children. Numerous former staff members have been convicted of abuses perpetrated between the 1960s and 1980s; further allegations are being [pursued by police](#). Yet this trend has been slow to develop in relation to children in custody. Despite many instances of abuse in children's homes, and some criminal convictions for individual custodial staff, the [Independent Inquiry into Child Sexual Abuse](#) (IICSA) became, in July 2018, the first public inquiry to consider whether child sexual abuse (CSA) was a more systematic problem in English and Welsh youth custody.

Current safeguarding practices — that is, the array of preventive and investigative measures to protect children which organisations must implement by law — were developed in the care system in the 1980s. They took some time to spread into penal settings, but children in custody today receive (on paper) a greater degree of legal protection than ever before. Yet secret filming by BBC Panorama in 2016 [exposed physical and emotional abuse](#) by staff at the Medway Secure Training Centre (STC). A subsequent investigation [warned](#) that these breakdowns might be replicated elsewhere, and in 2016/17 the Chief Inspector of Prisons [reported](#) that 'not a single establishment [had been judged] safe to hold children and young people' during the previous year. Even in a transformed regulatory environment, it appears that abuse is still possible, calling into question the gains of the last two decades.

This policy paper uses original archival research to argue that past regulatory regimes failed *not only* because they were badly designed, *but also* because of certain inherent features which make custodial institutions for children particularly risky sites for abuse. It argues that it is impossible simply to 'manage out' the risk of abuse through improved policy alone, and that a renewed focus on staff culture is required to effectively safeguard children's welfare.

Reactive safeguards and their shortcomings, 1960-90

The aims of youth custody

From 1960 until the early 1980s, two main kinds of Prison Service establishment held 'juvenile' (14 to 17 years old) and 'young' (17 to 21 years old) offenders: borstals and Detention Centres (DCs).

The first borstal had opened in the eponymous village near Rochester in 1902, with the system being implemented nationally from 1908. Achieving great rehabilitative prestige between the wars, by mid-century the reputation of borstals was threatened by overcrowding, high recidivism, and declining public confidence in their methods.

DCs were created in the early 1950s, partly because of perceived shortcomings in the borstal system. Rather than rehabilitation and training, their original aim was to subject 'delinquent' children to 12 weeks or less of deliberately punitive imprisonment: a 'short sharp shock' of military drill and physical training, intended to deter further offending. However, these aims were rapidly (though unevenly) diluted by programmes of rehabilitative training and education, especially where DC staff came in from the borstal system. This dilution was generally resisted by magistrates and many DC officers, who found the 'short sharp shock' a more intelligible rationale for custody.

Thus both principal forms of youth custody during this period were subject to conflict over their aims and methods. Indeed, it is clear from the archival record that this conflict deeply influenced their occupational cultures, and the way children and young people were treated in different establishments.

Formal regulations

All Prison Service establishments were governed by the [Prison Act 1952](#), and by the powers of the Secretary of State to create further statutory and non-statutory regulations. The various Borstal, DC and Prison Rules all forbade the 'unnecessary' use of force by staff, and regulated the use of punishments, including isolation and restraint (corporal punishment, already rare by 1960, was formally abolished in 1967). Unlike today, there was very little substantive difference between the regulations affecting establishments for children and adults.

Borstal governors and DC wardens received Standing Orders and Circular Instructions from the Home Office. Until the 1980s, these documents were classified official secrets, were not published or indexed and were not routinely available to inmates or staff, because further dissemination was at the governors' and wardens' discretion. Researchers Stan Cohen and Laurie Taylor found in the late 1970s that official secrecy made it impossible to establish what formal regulations were

currently in effect; in the 1980s, both the Prison Reform Trust and the Chief Inspector of Prisons suggested that staff were often ignorant of policies affecting their work.

In practice, staff were entrusted with a wide degree of discretion. It is likely that to a greater extent than official rules and policies, their behaviour was influenced by personal beliefs and values, and by the norms of occupational culture. Since cultural norms vary widely between establishments, it is also likely that the treatment of children varied accordingly.

Sources of independent scrutiny

Child abuse inquiries [in the UK](#) and [elsewhere](#) have consistently found that abuse is particularly associated with:

- Wide disparities of power between adult staff and resident children;
- The relegation of children's welfare by institutional priorities, especially at times of institutional pressure and change (such as the need to make budgetary savings);
- Closed-off cultures in which 'normal' standards of interpersonal behaviour are held not to apply.

Each of these conditions can apply in youth custody, and independent scrutiny is therefore important. Contemporary regulations recognised this need in two ways. First, a Prisons Inspectorate was responsible for five-yearly inspections. Second, the Home Secretary appointed local lay volunteers to serve as a Board of Visitors in each establishment. Boards were expected to monitor conditions and report annually. They were also expected to hear complaints, and (very rarely) to conduct formal inquiries. They also had a somewhat contradictory disciplinary function: they heard serious disciplinary charges against inmates, handing down punishments if required.

Both the Inspectorate and the Boards were hampered by significant blind spots and they lacked a systematic monitoring framework with the welfare of children and young people at its heart. They tended to evaluate custodial practices by reference to institutional priorities rather than individual needs. As a consequence, they missed instances of risk.

The Prisons Inspectorate

The Inspectorate's function was to comment on the performance of the penal system as a whole, not investigate specific allegations. Its reports were not published before 1982, but reports appended to files in the archives suggest that administration, efficiency and effective management preoccupied inspectors, more than monitoring adherence to defined standards. There is no evidence of any systematic effort ([as is made today](#)) to gather inmates' views about their conditions and treatment.

The 1977 Inspectorate report on HMDC Medomsley is of particular interest. Inspectors were aware of Medomsley's past reputation as a particularly 'tough' place, and they describe the 'venom and acrimony' which existed between a liberal Warden and a more punitively-oriented staff union. In the inspectors' opinion, 'neither [the staff nor the inmates] seem to know what the purpose of the centre really is.' They summarised Medomsley as 'a place where nothing of any import ever occurs and one which is unlikely to cause any problems'. Inspectors noted that 13 trainees worked in the kitchen for over 12 hours a day, and were hand-picked from the general population by [one single officer](#), who was [subsequently convicted](#) of systematic sexual abuse committed over a period of fifteen years or more. They do not appear to have perceived risk in these working arrangements.

Boards of Visitors

Boards lacked clarity and consistency as to their aims and methods. While archival records show evidence of challenges to custodial practice, more often than not these related to material matters such as quality of food, uniforms, or facilities. Criticisms of the style or nature of staff-inmate relationships were conspicuously rare, and tended to take the side of staff. Some Boards devoted considerable effort to defending their establishment against outside criticism. For example, the Board of Risley Remand Centre (which held children) wrote many letters in the late 1960s and early 1970s to local newspapers, MPs and the Home Office, censuring them for having traduced the reputation of Risley and its staff by drawing attention to a spate of suicides.

Boards may not have understood their role to include holding staff to stated policies. For example, at HMDC New Hall in 1971, the Board's annual report endorsed the Warden's decision to bypass official disciplinary procedures, thereby avoiding administrative logjams. In the same year, the Board's Inquiry concerning allegations of staff brutality had cleared the officers concerned; its annual report noted its concern 'that officers should be liable to such ill-founded accusations with the consequent distress'.

Some DC Boards saw themselves as the guardians of the original 'short sharp shock', and made common cause with officers to defend this punitive vision of custody. In 1975 at Medomsley, the Board disagreed so strongly with the Warden's rehabilitative innovations that all but two of its members resigned. This suggests again that Boards and staff differed in their interpretation of what custody was *for*. Their interpretation of staff and inmate behaviour probably varied accordingly.

Board membership also lacked diversity. Until the 1980s, Board members were recommended to the Secretary of State by governors, wardens or existing Board chairmen. Most were white, many were retired, and a significant proportion were

drawn from the magistracy, noted for its punitive understanding of the aims of custody during this period. Boards often interpreted emotional distress, self-harm and the like not as evidence of vulnerability, but as 'manipulation'. Sometimes they treated it as a punishable disciplinary offence. The implication was that children and young people should adapt to the (implicitly legitimate) strictures of the custodial setting, rather than the other way around.

Complaints and disclosures

Because of these blind spots, official responses to abuse relied largely on complaints and disclosures to bring problems to light. Yet the formal redress available to prisoners during this period was minimal; indeed, shortcomings in the complaints system were a major topic for penal reformers and the Inspectorate by the 1980s. [Compared to today](#), complaints were difficult to make and subject to less thorough investigation. Children and young people were also far less likely to complain, according to Home Office research in the early 1980s.

Complaints could be raised with staff, the governor, or the Board of Visitors, but were subject to particular rules if they concerned staff conduct. A 1961 Circular Instruction (in force until at least 1978) specified that complainants must be warned that 'false and malicious allegations' against officers constituted a punishable offence. If they wished to continue, the complaint was to be lodged in writing, and would be heard within the prison by a governor or a member of the Board of Visitors. Complainants who felt they had not had a fair hearing could, in theory, write to their MP, to the Secretary of State, or to the European Court of Human Rights. However, *all* prisoner correspondence was subject to censorship, and trying to send letters risked reprisals.

No central complaints records were kept until the 1990s, making it impossible to estimate their numbers or the prevalence of different forms of investigation. 'Superior investigations' (by a more senior governor from outside the establishment) were rare. Rarer still were full external inquiries: in the eighteen years from 1956 to 1974, eight complaints were investigated in this way. All but one were raised by ex-inmates who contacted their MP or the media following release, underlining the difficulty of raising complaints while imprisoned, and suggesting that adverse publicity was the key factor in generating an external inquiry.

None of these complaints alleged sexual misconduct by staff, but five alleged staff brutality in establishments which routinely held under-18s. Some of these five were wholly or partly upheld. No inmate received legal representation, while staff were represented in seven of the eight cases. Only the first two inquiries published full reports; the archived papers of [one inquiry](#) are unavailable to public view, to protect the identities and reputations of the officers involved (who were cleared of wrongdoing). It is therefore difficult to evaluate the quality or independence of

external investigation, despite evidence that, procedurally at least, it tended to favour staff.

Given how difficult it was to raise complaints, it is highly unlikely that the handful upheld by external inquiries represent the true extent of abuse perpetrated by staff.

Staff disciplinary proceedings

Arrangements for dealing with staff disciplinary matters in this period suggest a limited but definite official tolerance towards certain forms of offending by staff, provided they took place off duty. For example, a 1980 file indicates that 'minor' off-duty violence (e.g. a 'first offence of common assault or ABH') would not have resulted in an officer's dismissal. Even 'minor' (though unspecified) off-duty sexual offences did not result in automatic suspension/dismissal, but were reviewed case-by-case. By today's standards, there was a stronger presumption of innocence, a high burden of proof, and a lack of preoccupation with the potential risk generated by such allegations.

Developments in institutional safeguarding, c. 1990 to 2016

The regulation of staff behaviour was to change following a steady stream of scandals and inquiry findings in the 1980s and 1990s. Child abuse in the care system, especially children's homes, led to the perception that children 'living away from home' were subject to distinctive kinds of risk, and required specialist forms of 'child protection'. The [Children Act 1989](#) consolidated policies which had developed during the decade or so previously, formalising three significant shifts in official thinking:

- The general principle that courts and government agencies must treat children's welfare as the *paramount consideration* in any decision affecting them;
- A presumption against institutional care if children could not be left with their natural parents — foster care was preferred;
- A requirement that local authorities (LAs) investigate cases of abuse, and decide child protection measures in response.

Since it was impossible for LAs to discharge this function alone, a very strong emphasis on [multi-agency coordination](#) has also emerged, with LAs in the lead.

New critiques of youth custody

The 1989 Act had profound but delayed implications for the regulation of youth custody. LAs' general duty to protect the welfare of *all* children in their area presumably included those who 'lived away from home' in Young Offender Institutions (YOIs); yet YOIs were not listed within the scope of the 1989 Act. Advice taken by the Prison Service on this legal ambiguity suggested that YOIs were *not* subject to regulation by LA child protection teams, but this position was not to be tested in court until later.

Penal reformers soon employed the conceptual and legal resources of the 1989 Act in their campaigning on youth custody. In particular, the paramountcy of the child's welfare rendered certain custodial practices (such as pain-inducing restraint) deeply problematic. These forceful critiques were rapidly adopted by official bodies such as the Inspectorate. Already re-established on a more independent footing in the early 1980s, it now published its reports; such publicity placed new pressure on a Prison Service previously accustomed to official secrecy. From the mid-1990s, the Inspectorate recruited child protection experts to develop its methodology. Reports began to describe children in custody as '[living away from home](#)', and previously peripheral issues like self-harm, [suicide](#), and strip-searching moved to the core of [a new focus on safety](#).

A new orthodoxy in safeguarding

One consequence of these changes, in 1998, was Prison Service Order 4950, which required YOIs to implement child protection and safeguarding policies, though without settling the legal question of whether they came under the 1989 Act. In 2002 Lord Munby's [High Court ruling](#) determined that they did. This new regulatory framework was strengthened after the [Victoria Climbié Inquiry](#) exposed severe failures in multi-agency coordination. Under the [Children Act 2004](#), all government agencies acquired a statutory duty to work together to safeguard children's welfare.

Implicitly, YOIs were no longer simply penal institutions, but one of a range of agencies which possessed a duty of care. This represented a shift in official thinking, in which problematic behaviour by children was not straightforwardly a disciplinary problem, but potentially also evidence that YOIs were failing to safeguard their welfare. By extension, abuse could now be the result not only of the illegitimate *overuse* of power, but also its irresponsible *underuse*. One consequence has been the creation of ever more detailed regulations concerning custodial practice. Staff, rather than being entrusted with professional discretion, are now held responsible for delivering these policies.

This process has been widespread but can be charted through the case study of strip-searching. Near-invisible in official records before the early 1990s, it was presumably routine but unremarkable. As late as 1995, inspectors at HMYOI Deerbolt quoted without comment officers' belief that *more* routine strip-searches were needed to guarantee security.

By 2002, this presumption was inverted: routine strip-searching at HMYOI Warren Hill was 'incompatible with best practice in child protection', and by 2005 the routine, non-targeted strip-searching of children at HMYOI Feltham was described by inspectors as 'degrading', suggesting a *fundamentally illegitimate* application of power. A 2006 [independent review](#) by Lord Carlile went further, placing strip-searching among 'a range of practices' which 'would, in any other circumstance, trigger a child protection investigation and could even result in criminal charges'. The use of pain-inducing restraint on children has also become the [subject of activism](#) and [fierce debate](#) following the deaths of two children in STCs in 2004.

Yet the result has not been the elimination of either restraint or strip-searching. Rather, both have [been retained](#), albeit with new and more detailed regulations. The 'revolution in official attitudes' to children described by the Munby ruling has not generated a revolution in custodial practice. Instead, practices previously perceived as normal have been problematised, reevaluated, deemed to possess enduring necessity, and relegitimated. Once regulated by trust in the professional discretion of staff (and by weak complaints procedures), they are now subject to multiple layers of regulation, record-keeping, investigation and monitoring, as well as [systematic](#)

[attempts](#) to take account of the 'voice' of children, who themselves have been recast as the 'users' of custodial 'services'.

These changes ostensibly hold staff to higher standards and promote child safeguarding. However, they also posit *compliance with policy as the primary safeguard against abuse*. This overplays the potential for policy to be effective, because it underplays the importance of individual staff beliefs, and of occupational culture as the moral context for abusive behaviour.

Conclusion: a safeguarding culture?

The [Medway Improvement Board](#) concluded in 2016 that abuse at Medway STC developed despite safeguards *apparently functioning as intended*. Indeed, a recent inspection had [found safety there to be 'good'](#). The troubling implication was that policies which had inspired confidence now offered no guarantees, and that further abuses might be discovered.

Abuse is possible *not only* where staff deliberately abuse legitimate power to pursue illegitimate ends, thus acting as 'bad apples'. It can *also* occur in 'bad barrels', where the methods staff use to pursue legitimate ends become detached from the behavioural norms which would usually constrain them.

The history of DCs in the 1960s and 1970s suggests that this risk is particularly pronounced at times of organisational pressure, when standards can slip because it is easy for power-holders to prioritise their own (or the institution's) priorities over children's welfare. Already subject by the late 1960s to significant uncertainty and conflict over their aims and methods, DCs in the early and mid-1970s were also becoming more overcrowded, at a time of economic recession and budgetary constraint. Officers possessing broad professional discretion could invoke the legitimating rhetoric of the 'short, sharp shock', especially where Boards of Visitors were sympathetic. There is evidence that some maintained order through violence, or by tacitly endorsing the violence of 'daddies' (high-status inmates who practised 'knuckle therapy' on their behalf). Boys and young men in such settings were expected to 'toughen up' by conforming to a stoical, self-sufficient ideal of masculinity. One consequence was to make complaints and disclosures unlikely; another was to exacerbate the disadvantages conferred by intersecting inequalities such as race, ethnicity, sexuality and disability.

Such staff cultures appear not to have been ubiquitous, though this is not to imply that all borstals and DCs were healthy or safe by today's standards. Even so, historical allegations of *sexual* abuse by staff have not yet surfaced for all establishments, despite their common (and relatively lax) framework of formal regulation. This suggests that weak safeguards were a necessary but not a sufficient cause of this most egregious kind of abuse. Even in the absence of such indefensible conduct, however, an unhealthy staff culture still reflected the irresponsible underuse of power, raising the risk of victimisation *among* inmates whose interactions were minimally regulated.

Reformed safeguards from the 1990s onwards have hindered certain kinds of abuse which were widespread before, as well as regulating practices (such as strip-searching) in which risk was not recognised. Despite this, new critiques and challenges of youth custody have meant that the potential range of actions which can

now be defined as 'abusive' is far wider than before. Staff discretion has been constrained, and more effective power to define what is acceptable lies with officials in the Ministry of Justice, the Youth Justice Board and HM Prison & Probation Service.

Staff within establishments are responsible, as before, for the delivery of policy. But the extent to which they are held accountable has grown, for example through the expansion of published policy, an expanded complaints procedures and other regulatory mechanisms such as audits and inspections. Yet the underlying power relations remain unchanged, because custody is still treated as an ethically distinct environment, in which normal (i.e. outside) standards of adult behaviour towards children do not always apply. Moreover, the emphasis on policy compliance has shifted attention away from the risk that even the best policies can be circumvented, or rendered ineffective by problems they did not foresee.

Safeguarding therefore remains an iterative, contested process, rather than the attainment of a definable standard of professional practice. Historical research demonstrates that institutional child abuse is partly a consequence of power relations and institutional culture, *regardless of prevailing standards of formal regulation*. The risk of abuse can be reduced by correct policies, but some level of risk will remain for as long as youth custody exists, and it is particularly likely to be high at times of institutional pressure, such as when establishments are required to make cost savings or accommodate expanding populations.

Preventive safeguards are therefore important, but so are healthy staff cultures, and critical external scrutiny also plays an essential role. Even so, the potential for abuse to slip under the radar underlines a key principle: that custody should be used for children only as a last resort, where there is no non-custodial alternative.

Further reading

- Independent Inquiry into Child Sexual Abuse. 2018. "Truth Project Experiences Shared: Victims and Survivors Speak Out." London.
<https://www.iicsa.org.uk/victims-and-survivors/experiences-shared>.
- Jarman, B., Delap, L., Jackson, L., Lanskey, C., Marshall, H., & Gelsthorpe, L. (2018). Safeguarding children in the secure estate: 1960 - 2016. Cambridge.
[\[add link when report has been published\]](#)
- Jay, A., Evans, M., Frank, I., & Sharpling, D. (2018). Interim Report of the Independent Inquiry into Child Sexual Abuse. London: HMSO.
- Sayer, Ellie Mendez, Holly Rodger, Claire Soares, and Rachel Hurcombe. 2018. "Child Sexual Abuse in Custodial Institutions: A Rapid Evidence Assessment." London: Independent Inquiry into Child Sexual Abuse.
[https://www.iicsa.org.uk/key-documents/5197/view/Child sexual abuse in custodial institutions REA - Full report.pdf](https://www.iicsa.org.uk/key-documents/5197/view/Child%20sexual%20abuse%20in%20custodial%20institutions%20REA%20-%20Full%20report.pdf).
- User Voice. 2011. Young People's Views on Safeguarding in the Secure Estate: A User Voice Report for the Youth Justice Board and the Office of the Children's Commissioner. London: Youth Justice Board.
https://www.childrenscommissioner.gov.uk/wp-content/uploads/2017/07/Young_peoples_views_on_safeguarding_in_the_secure_estate_2011.pdf.
- Willow, Carolyne. 2015. Children behind Bars: Why the Abuse of Child Imprisonment Must End. Bristol: Policy Press.