A thematic review of

Outcomes for girls in custody

September 2022

Contents

Introduction 3

Section 1 About this report 7

Section 2 Prior to custody 11

Section 3 Experiences in custody 13

Section 4 Health care 18

Section 5 Transition to adult prisons 22

Section 6 Outcomes on release 24

Appendix I Glossary 26

Introduction

As a result of the pandemic and the success of schemes to divert girls away from custody, there were only 14 girls in the youth custodial estate at the time of this thematic inspection.

Without exception these girls had long histories of exposure to traumatic events and came into custody with multiple and complex needs. In many cases opportunities for early intervention in the community had been missed and the failure to provide for these girls had often led to an escalation in poor behaviour and ultimately to a custodial sentence. We found several examples of girls remanded to custody simply because there was no other placement available, either in hospital or in the community.

With so few girls in custody, the challenge is to make sure there are enough of the right type of facilities in the right place when needed. After the closure of Rainsbrook Secure Training Centre in July 2021, the Youth Custody Service (YCS) opened a unit in Wetherby Young Offender Institution to ensure it had at least one establishment that could not refuse to take girls remanded or sentenced to custody by the courts.

We found the national system was frail; while youth custody service (YCS) leaders preferred to place girls in secure children's homes (SCHs), legislation required SCH managers to refuse a placement if they felt they could not meet a girl's needs (see glossary). In principle the legislation is meant to protect children from being placed in an unsuitable secure children's home. In practice this means that all SCH managers can refuse to offer a girl a place, and girls with the highest level of need are concentrated in Wetherby YOI, the institution with fewest resources.

In all settings, we saw frontline staff doing their best to care for some very vulnerable girls and every girl we spoke to commented positively about the staff looking after them. We also found good partnership work between health, education and care staff that aimed to meet the needs of the girls.

The key difference in the experience of girls placed in SCHs and Wetherby YOI was the amount of time they spent out of their room. While girls in SCHs routinely spent long periods of time out of their room engaging with staff and other children, those at Wetherby were limited to around five hours each day. This difference was not driven by the girl's needs but by the culture and resources of the establishment.

There were some very concerning outcomes for girls in the area of safety; they were 12 times more likely than boys to self-harm and more likely to be restrained, often in response to self-harm. While it is sometimes necessary to use restraint to keep a girl safe, too often they were left alone in their cell after the restraint without additional support. One girl we spoke to was restrained six times in one night in response to her self-harm. This was clearly traumatising and could potentially increase the risk of further attempts. The vicious cycle of self-harm and restraint needs to be addressed urgently.

While the children's estate made good preparations for girls transitioning to adult prisons, this often had little impact on their day-to-day experience once they arrived. We spoke to 18-year-olds in adult prisons who felt unsupported and did not know how to get everyday requests resolved.

Preparation for release was undermined by a lack of support in the community. In our case sample, three of the seven girls who had left custody in 2021 were in the community and all faced difficulties accessing their accommodation, education or health care support. In one case, accommodation was only arranged two days before release and was in sheltered housing normally used for the elderly. Of the remaining four girls, three remained in a secure placement under welfare or health care legislation. One girl had reoffended and was back in custody.

We observed many dedicated frontline staff doing their best in extremely difficult circumstances. Despite this the custodial estate did not function effectively and too often girls with the highest level of need were placed in establishments with the least resource. Vulnerable girls could not access the support they needed in the community and were sometimes remanded to custody because there was nowhere else for them to go. Outcomes for girls in key areas were poor and they faced significant challenges when they were released or transferred to the adult estate. We have identified six concerns that require cross-departmental work to ensure some of the most vulnerable girls in the country are given effective care and support.

Charlie Taylor
HM Chief Inspector of Prisons

Justin Russell
HM Chief Inspector of Probation

Amanda Spielman
HM Chief Inspector, Ofsted

Ian Trenholm
Chief Executive, Care Quality Commission

Gillian Baranski
Chief Inspector, Care Inspectorate Wales

September 2022

Concerns

Concern 1: A lack of alternative provision and intervention meant that custody was not always justified or used as a last resort.

We saw examples of girls being remanded to custody because there were no other available options. In other cases, a lack of appropriate early intervention in the community led to girls' behaviour escalating until they received a custodial sentence.

Concern 2: The national system for caring for girls in custody did not function well; often girls with the highest level of need were placed into the institution with the least resources.

There were two different types of institution in England and Wales for fewer than 20 girls. Legislation (see glossary) required secure children's homes to refuse to provide placements for a girl if they could not meet their needs. The consequence of this was that girls with the highest level of need were held in Wetherby Young Offender Institution, which had fewer resources to meet their needs.

Concern 3: Girls were far more likely than boys to harm themselves, experience restraint and to be involved violence during their time in custody.

While there are occasions when staff have to use restraint to prevent girls harming themselves, we saw examples of girls being restrained multiple times in a short period with little support offered after the incident to address the underlying cause of self-harm.

Concern 4: Girls who needed tier 4 mental health beds waited too long for transfer to hospital.

During this delay, very unwell girls were held in institutions unable to meet their needs.

Concern 5: Transition plans had little impact on the day-to-day experience of young women when they were transferred to the adult estate.

Cases we examined showed 18-year-olds were often overwhelmed by the transition and did not know how to adjust to life in adult establishments.

Concern 6: Suitable accommodation was not secured early enough before release.

This prevented effective planning for health care and education, training and employment. When accommodation was arranged it was not always suitable.

Section 1 About this report

Aim and methodology

1.1 HM Inspectorate of Prisons carried out this thematic inspection with the Office for Standards in Education Children's Services and Skills (Ofsted), HM Inspectorate of Probation, Care Inspectorate Wales and the Care Quality Commission.

1.2 The aim was to consider whether provision for girls in custody meets their needs, including on their release to the community and when they transition to the adult estate. We spoke with girls and young women with recent or ongoing experience of custody, and with professionals involved in their care. We examined the case files of 15 girls in detention, seven girls and young women who had left custody in the second half of 2021 and three young women who had transitioned from an SCH or STC to an adult prison after their 18th birthdays. We interviewed nine girls in children's custody and three young women who had recently moved to the women's estate.

Changes in custodial provision

1.3 The removal of girls under 18 from the general population of adult female prisons, together with an increasing number of girls being sentenced to detention and training orders, led to the commissioning of five designated girls' units within adult female prisons, which opened between 2004 and 2006. This approach ensured that girls were accommodated separately from adults. The distinct needs of girls were also beginning to be recognised within other forms of secure accommodation. In 2006, expansion at Hassockfield STC (Minerva Unit) increased capacity for young women by 16 and included provision for mothers and babies. An enhanced young women's unit and mother and baby unit was also created at Rainsbrook as part of the same expansion scheme.

1.4 From 2010, as a result of a combination of factors such as the success of diversion schemes, the changes in the types of offending and sentencing guidelines, the numbers of children in custody began to decrease and in 2014 all five designated units in the adult female prisons were decommissioned for use by girls (under 18). Girls could only be placed in STCs and SCHs.

1.5 The continued decline in the number of children held led to the closure of Hassockfield STC in 2014. Medway STC was closed in March 2020 and identified as a site for a new secure school. This left just Rainsbrook STC near Rugby still holding girls. In July 2021, following ongoing concerns about safety and performance, Rainsbrook STC was also closed.

1.6 The closure of Rainsbrook STC highlighted the frailty of the system; the YCS wanted to decant the five girls living there to SCHs which were, at

the time, the only other option for girls in the custodial estate. However, the SCHs refused placements for two of the girls, leaving the YCS with only the Keppel unit (part of Wetherby YOI) as a viable option to accommodate them. In March 2022 a further unit was opened in Oakhill STC but at the time of writing no girl had been placed there and it would only be used if a girl aged under 15 could not be placed into an SCH. In practice during this inspection girls could be placed in SCHs or at Wetherby YOI.

Placement decisions

1.7 The way the system operates is dysfunctional. The YCS is responsible for finding a place for any girl that the court remands or sentences to custody. There are seven SCHs commissioned by the YCS that can look after such girls and leaders from the YCS have expressed a preference for placing girls in these better-resourced homes rather than the YOI.

1.8 SCHs have the highest cost, at £278,000 per place on average, compared with £119,00 in a YOI. Under the Care Standards Act 2000 and the Children's Home's Regulations 2015 (see glossary) SCH managers are required to refuse children if they feel they are unable to meet their needs. The individual decisions may be understandable, but in a system that cannot refuse to accommodate girls sent to custody by the courts, the cumulative impact of all seven SCH managers refusing to offer a placement to the same girl is stark. It leaves the YCS with no other option than to place girls with the highest level of need into an establishment with fewer resources to meet that need. Over time this has led to a concentration of a complex group of girls in one unit at Wetherby YOI which is a challenging situation for local leaders and staff to manage.

1.9 Managers of SCHs told us they had around 30 minutes to decide whether to accept a girl referred by the YCS placement team. They considered factors including the needs of the children already at the SCH; whether a co-defendant was at the SCH; where the child was from; any gang affiliations or other known relationships with the existing population; and whether the SCH could meet the needs of the child being referred. One SCH manager said that the high level of need of many of the girls meant it could be difficult to accept a girl rather a boy with lesser needs.

Provision in YOIs and STCs

1.10 Once the decision was made to place girls at Wetherby YOI, a plan was drawn up to convert one of the living units into suitable accommodation. A manager with experience of working with women in custody was appointed to lead the unit and staff at Wetherby contacted the girls due to move there.

1.11 Leaders and managers were clear that if girls were to be placed at Wetherby YOI long-term, extensive work would need to be done to ensure staff could meet their needs. Some of this work is now

underway, including a new reception facility specifically for girls and refurbishment of the living accommodation.

1.12 There is a risk that the new units at Wetherby YOI becomes the default provision for girls who are not accepted by SCHs. Most of the girls in custody have already experienced some form of exclusion or rejection. It is important that placement at Wetherby or Oakhill does not reinforce feelings of low self-esteem or of not being wanted, or that Wetherby YOI is seen as the last resort.

1.13 The girls we spoke to had some understanding of why they had been placed in a SCH or YOI. One girl was clear that she was going to Wetherby because nowhere else would take her, while another described being too high risk to be placed in an SCH.

1.14 Despite the best efforts of committed staff at Wetherby YOI no one could give a positive reason (other than the lack of any alternative) for any girl being placed there. It will be important for the new unit at Wetherby, and any future unit at Oakhill STC, to build a clear sense of identity and purpose.

Transferring to the adult estate

1.15 If a girl turns 18 during her sentence she is usually transferred to an adult prison unless she has a short time remaining in custody, is participating in a specific programme or intervention, is within the 'parole window', or has a high level of vulnerability or complex needs. During the transfer, responsibility for a girl's sentence planning may pass from youth offending teams (YOTs) to the probation service, disrupting existing relationships between girls and their youth offending workers.

1.16 The transition to a women's prison can also lead to a change in available services. For instance, transitioning from children's mental health services to services in adult establishments can be difficult as there are often different criteria that must be met before a girl can receive support.

Care for girls in custody

1.17 In 2021 the YCS and NHS England jointly developed a draft strategy for the care of girls in custody, based on work undertaken by the Centre for Mental Health and Leaders Unlocked. It involved peer-led interviews with girls in custody and a review of relevant literature, data and interviews with professionals with experience of the children's custodial estate.

1.18 The strategy outlined five priority areas to guide planning and activity to address the needs of girls. It recognised the inherent dangers of inadvertent 'gender-blindness' and the difference between the needs of girls and boys entering the custodial system, for example, in the areas of self-harm and risk of sexual exploitation. Broad differences in risk factors and in the way that boys and girls respond to a custodial

environment were also addressed, and a linked plan set out time-bound actions.

Section 2 Prior to custody

2.1 Relatively few girls enter custody and many of the girls we encountered during this inspection were already known to YOTs, children's social care teams and other community teams (see paragraph 4.8). Trauma, neurodivergent conditions, self-harm, substance misuse, mental ill-health and disrupted education featured in many of their histories, with some having committed several previous offences. Staff working with the girls and managers of community and custodial services identified a lack of suitable placement options in the community as a common concern and spoke of the need for bespoke placements at an earlier age. One girl was described by community-based professionals as not ticking the right boxes for what was available and falling through the cracks. This lack of early intervention in the community was cited by professionals as a key factor in the escalation of girls' behaviour, leading to their being remanded or sentenced to custody.

2.2 Despite significant senior management oversight in trying to manage the risk the girls presented and meet their complex needs, many local authorities did not provide and could not commission appropriate provision. One head of corporate parenting told inspectors they had done their best to address the current need, but 'we just don't have secure beds'. Many senior professionals mentioned a lack of tier four mental health beds (see glossary) as a significant problem, and we saw girls coming into custody because there were no available hospital beds.

2.3 Typically, girls who ended up in justice settings required a therapeutic environment where past trauma and adverse childhood experiences, including sexual and physical abuse, could be addressed. In many of the cases we reviewed, the girl's needs were not met because these placements were not available; their behaviour then escalated and they entered the criminal justice system. Staff and managers in custody and the community shared the frustration that while meaningful interventions could not occur because the girls were not living in stable enough environments, until they completed this work they were unlikely to settle. At the end of custodial periods, staff were similarly frustrated that there was a lack of step-down accommodation to support transition from a secure environment to life in the community.

Case study

A 15-year-old girl had a history of poor education attendance and had spent time in a child and adolescent mental health (CAMHS) inpatient unit. As her behaviour escalated, including being arrested by police, the local authority tried without success to obtain a secure welfare bed as an alternative to residential care. Eventually she was charged with having assaulted an emergency worker and remanded into custody in an SCH. A subsequent psychiatric assessment determined that she was not fit to plead and

charges were withdrawn. She remained as a welfare placement in the care of the SCH.

2.4 Records provided other examples of unsuccessful attempts to find suitable placements. YOT records for one girl included:

> 'On the [date] (pre-sentence) – 26 active referrals for secure placements and only 2 beds available. The [local authority] were advised that [girl's] profile did not match the criteria for the available beds and she would remain on a waiting list. Also, 61 [non secure] residential placements were contacted, all of which declined to offer her a place.'

2.5 In another case, two psychiatric reports stated a girl needed a hospital bed. Instead, she was remanded into custody as a suitable hospital bed could not be found. None of the SCHs were able to meet her needs and she was placed in the girls' unit at Wetherby YOI.

Section 3 Experiences in custody

Daily life

3.1 YCS information showed that 65 individual girls were held by the YCS in the 18 months from April 2020 to September 2021. Fourteen of them had more than one period in custody during this time.

3.2 Thirteen of the girls in custody whose experiences we reviewed were living in SCHs in England or Wales. The other two were living in the girls' unit at Wetherby YOI.

3.3 All of the locations accommodated boys, though the degree of interaction between boys and girls varied. Most of the SCHs had living units with mixed genders. One SCH and Wetherby YOI had a residential unit specifically for girls, although at Wetherby girls were temporarily living on a small unit with boys while refurbishment work took place on the girls' unit. It was more common for girls and boys to mix for education or recreational activities in the SCHs than in the YOI, where it was subject to a risk assessment.

3.4 Staff opinion was mixed about whether single sex or mixed units were most appropriate. Most staff, including health care staff, expressed a belief that mixed units benefited girls by providing an environment that mirrored the community. However, psychologists viewed mixed units less favourably, and voiced concern about the potential for girls to be re-traumatised.

3.5 Girls themselves mostly said they were not concerned about living alongside or attending activities with boys. One described education with boys as like being back in a pupil referral unit, and that it was nice to speak to people her own age in a similar situation. This suggested shared experiences were as important as gender. However, one girl said boys could be disruptive and another suggested boys got bored, created their own entertainment and caused problems.

3.6 The SCHs offered a better environment for children but there were some differences in experience for girls and boys in all of the settings. Most girls reported having some control over their appearance. They could all wear their own clothes (within the guidelines set by their SCH or YOI) but some girls, including two held in the YOI, did not know how to get their hair cut. One of the girls said that boys had access to a barber but there was nothing for girls. Staff reported that there was good access and funds available to purchase specific items for girls on an individual basis.

3.7 Strong relationships between staff and girls are critical to building trust and in starting to address the trauma experienced by many girls in custody. Relationships between staff and girls were good at all sites. Every girl we interviewed reported having someone to turn to if they had a problem and we found that most members of staff, particularly

those at SCHs, were very knowledgeable about the needs and risks of the children in their care.

3.8 Relationships between the girls themselves were complex and staff members described some challenging dynamics between the children. One said that girls sometimes found it hard to build or understand friendships. Girls being released or new girls arriving could be unsettling for the existing group and staff talked about shifting allegiances and rivalries.

3.9 No specific training course was provided for staff in the secure estate accommodating girls. However, in SCHs trauma-informed training and ACE (adverse childhood experiences) training provided elements that focused on supporting staff to understand the specific needs of girls. Staff said the training they received was useful but expressed a desire for some more specific training about working with girls. At Wetherby YOI, F-CAMHS (Forensic child and adolescent mental health services) had completed some initial training with health care staff on harmful sexual behaviour, outlining the different presentations that could arise between genders. Nevertheless, some health staff felt it would be useful to undertake further training programmes or modules to enable a greater focus on gender-specific aspects that would support their work with girls.

Safety

3.10 Staff highlighted self-harm as a key issue in the care of girls, describing it as challenging and upsetting. Data published by the YCS showed that in the 12 months to December 2021, girls had self-harmed at a rate of 2,395 incidents per 100 girls, more than 12 times the rate of boys (190 per 100). Fourteen of the 17 girls in our review had harmed themselves either in custody or prior to custody. On many occasions restraint had been used in response to self-harm in custody. For example, in one girl's records we found 32 self-harm incidents and the recorded use of restraint to remove ligatures. Another record showed that staff used restraint on one girl six times in one night to prevent self-harm. While it is often necessary for staff to restrain girls to remove the implement they were using to harm themselves, too often staff withdrew once the restraint was over, leaving the girl alone in her room. This was particularly likely overnight where we saw too little evidence of staff leaving room doors open or sitting with girls while they were feeling distressed.

3.11 YCS data for SCHs, STCs and YOIs from April 2020 to March 2021 showed that girls were almost six times more likely to be physically restrained than boys (a rate of 287 restraints per 100 girls per month compared with 48 restraints per 100 boys per month). Physical restraint was used much more often to prevent girls deliberately harming themselves than for boys. This cycle of self-harm followed by restraint was traumatising for girls and failed to address the underlying causes of self-harm.

3.12 Data for the 12 months to December 2021 show that girls were 83% more likely than boys to be assailants (girls were identified as assailants at a rate of 1,174 per 100 girls, compared with a rate of 641 per 100 boys. Girls were less likely to be identified as a victim of violence (a rate of 63 per 100 compared with 97 per 100 boys). Evidence from our inspections of YOIs and STCs shows that girls were more likely to assault staff rather than other children. In our case sample we found examples of girls who had assaulted emergency workers in the community during times of crisis. In custody these girls continued to be involved in acts of violence against staff.

3.13 Some staff felt that girls were viewed as lower risk than boys and were able to have greater access to in-room equipment such as storage boxes and dressing tables.

3.14 Girls we spoke to did not think everyone was treated fairly in the rewards and incentives scheme in their setting, and some reported that the scheme did not encourage them to behave well. One girl told us that standards were different for boys, as girls were expected to demonstrate good behaviour and when boys behaved well they received more praise. Some said that boys were not punished as much as girls, and that outcomes were worse for girls if they behaved as poorly as boys. However, when describing their relationships with staff, some girls thought staff showed them more respect and spent more time with them than boys.

3.15 Two therapeutic staff at different locations said they believed staff were less likely to identify the level of risk when girls were perpetrators of domestic abuse. They believed staff were more lenient and worked harder to understand the behaviours rather than address the immediate presenting risks.

Activity

3.16 The amount of time girls spent out of their room engaged in activity differed sharply in the SCHs and the YOI. In SCHs, girls typically spent most of the day in education or engaged in activities with staff or other children. In the YOI, education was limited to half a day and girls spent an average of five hours out of their cell during the week and less at weekends.

3.17 Girls had a separate space to engage in activities together in the YOI and some of the SCHs we visited. Despite this we were concerned that we did not find any activity groups that were specific to girls and plans to develop provision were at an early stage.

3.18 In most places girls and boys attended education together. Classes included mandatory subjects such as English and mathematics as well as other subjects that children could choose to study. All subjects at the SCHs were open to boys and girls; one girl described participating in a car maintenance course while also completing her driving theory test preparation. Most of the girls could identify something they had learnt which would be of benefit to them after their release.

3.19 A high percentage of the girls had been assessed as having speech and language needs. Staff highlighted that speech and language therapy (SALT) needs may not always have been recognised during the girls' education and that poor behaviour and school attendance could have resulted from their inability to understand what was being asked of them. Poor school attendance often meant communication and other health needs had remained undetected.

3.20 Recreational and sporting activities were open to boys and girls. Some girls were happy to play sports with boys and others preferred to use exercise facilities in single gender groups. The relatively small number of girls accommodated in each SCH meant that some lived on residential units with only boys for company when not in education. One girl in this situation described how staff had responded quickly when she asked to have an activity with another girl, although it was not clear if this would become a regular event. She said of the boys she shared a residential unit with, 'They are so loud' and that she would like to have more contact with other girls.

Contact with the community

3.21 Girls were often held long distances from home. One had a six-hour journey from the court in her home area to the SCH. One girl told inspectors that she was not able to have visits from her family as she was placed in Leeds rather than in London where she was from:

'Everyone I know, all my family are in London. No one can come… you lot should have put me in Feltham'.

Another told us:

'I'm stuck in here. So you don't realise how far away from home you are'.

3.22 A minority of girls said they had frequent visits from family or friends. There was easy access to telephones and they could have secure video calls. Support for girls to maintain contact with family and friends was the same as for boys and did not take account of how far girls were held from home.

3.23 This distance from home also impacted on girls' relationships with community professionals. During the COVID-19 pandemic, more contact had been online or by telephone and virtual attendance was now a time-efficient way of holding planning and review meetings. However, it was less effective for one-to-one work and in building trust in preparation for release. Being held a long way from home also reduced the possibility of girls having escorted visits to view accommodation or education placements before they were released.

3.24 There were many positive examples of YOT workers, social workers and other professionals attending initial planning meetings and records showed regular remand or sentence review meetings were taking place. We found that analysis and review of serious risk of harm had

been carried out in most, but not all, cases. A trauma-informed approach was used and interventions to support girls with education and lifestyle skills were delivered effectively, but work to reduce risk of harm was less evident. MAPPA arrangements for one girl had started early and had supported changes in her level of risk during her sentence, including delivering interventions to minimise the risk of harm.

Section 4 Health care

Governance and leadership

4.1 Other than those who needed a tier four mental health bed (see glossary), we found girls' health care needs were being met in all settings. They were treated as individuals and received personalised care, as well as timely access to mental health and primary care services.

4.2 Health leaders in each secure establishment outlined how gender made a difference; girls had distinct requirements and a tailored response was required to meet their needs. They described how health care teams supported staff in delivering trauma-informed care to girls in often challenging situations. However, not all secure settings had a clearly defined girls' management strategy and we found variable progress in the formulation of plans to consider recommendations from the Centre for Mental Health report (see paragraphs 1.17 and 1.18).

4.3 Lincolnshire SCH had adopted a centre-wide approach to reviewing the recommendations in the report for the care of girls in custody and a monthly meeting was convened to review each outcome. Plans included the analysis of self-harm and use of force and restraint data, a review of resettlement plans, a review of the training pathway, and the promotion of healthy relationships. The aim was to make sure that the needs of the girls underpinned future developments.

4.4 At other centres, although health professionals could explain how they provided a bespoke service and had set out their intentions for developing and embedding a girl's strategy within the Framework for Integrated Care (also known as Secure Stairs), plans had not progressed far enough.

4.5 Wetherby YOI had devised an initial girls' strategy when the decision was made to accommodate girls following the closure of Rainsbrook STC. It acknowledged that staff would need training in working with girls and there were plans for a health needs analysis, staff training needs analysis, and workforce delivery assessment. The strategy included monitoring progress against standard operating procedures, providing templates for staff, and sharing educational guides for staff reference.

4.6 Without exception, multidisciplinary teams included professionals with a diverse range of expertise and skills to support with the coordination of care for girls with complex health needs. Staff at each setting had good access to core mandatory modules and additional health care training. One centre had delivered bespoke training in response to incidents involving young girls, but in most settings existing training programmes were modified to support staff in understanding and meeting the specific vulnerabilities and needs of girls in the secure estate. Some care staff said they would welcome more training to support their work

with girls, and the consistent delivery of gender-specific modules would help to reinforce and build on knowledge and expertise.

4.7 Health care staff received regular supervision, including in safeguarding, and care staff were offered support to help manage complex and challenging situations. Care staff inductions, however, did not include a bespoke module for working with girls and gender was not discussed as an independent topic in internal meetings, which may have meant that opportunities to establish and progress an approach to working effectively and successfully with girls were missed.

4.8 When a girl's entry into custody was planned, information sharing was mostly good and was completed in good time. Staff in many establishments received sufficient information about the health needs of girls from community professionals, but some placements were made at very short notice following a remand to custody. In some instances, girls had only recently become known to services and little information was available about them. Staff made good efforts to obtain health information. This included therapists liaising with community teams to identify early neurodiversity diagnoses to support with formulation (see glossary) and the development of effective management plans. When limited information was available, health professionals engaged with parents and carers to understand a girl's developmental and social history.

4.9 We found examples of secure custody leaders working with local partners to meet children's needs. Staff at Lincolnshire SCH were working with a local trust to implement sexual safety as part of the CAMHS service, and there was much that would be relevant to working with girls. At the time of our visit progress had been affected by COVID-19, but collaborative work was planned with children to design tools, risk assessments and information leaflets to help children feel safe.

4.10 Some therapists at Vinney Green SCH had forged links with a health provider at a local women's prison. This had helped with transitional planning and achieving continuity of care across pathways. We found examples of patient feedback which outlined how this planning and therapeutic support had been invaluable to girls' well-being and care.

Assessment, planning and intervention

4.11 Health staff told us that girls entered custody with increasingly complex needs. Many had experienced multiple traumas and most of the girls had poor mental health and were deemed a significant risk of harm to themselves or others. A majority displayed considerable and often repeated self-harming behaviour.

4.12 Across all centres we found integration of work between health, education and residential staff to ensure the health needs of girls were met. Health staff consistently offered support to staff across the centre to help them understand a child's experiences and how best to work with them.

4.13 All girls were allocated a health care coordinator or named nurse and there was flexibility in identifying an appropriate lead. Therapists explored a girl's interests and joined in with card games, art, education, sport and cooking sessions on a regular basis to forge trusting relationships. Staff told us that, in general, more time was needed to build therapeutic relationships with girls and develop their self-esteem before it was possible to deliver meaningful therapeutic interventions.

4.14 Allocations were often led by the strength of the relationship a girl formed with a practitioner. In one case, a substance misuse worker was allocated as care coordinator to a girl because they had built a trusting relationship and, over time, the girl was encouraged to allow a clinical psychologist to join their sessions. This approach enabled a second trusting relationship to develop and therapeutic treatment to commence.

4.15 At Wetherby YOI, all girls were initially placed on a 'virtual' ward, where their needs were discussed daily by a multidisciplinary team and any common themes were addressed. At other centres, all children were discussed in a multidisciplinary health forum and more in-depth case discussions were regularly held to share experiences across each discipline to progress their treatment and care.

4.16 We found that girls mostly had the same access to services as boys and that this was based on an individual's assessed need. At Wetherby at the time of our visit, all girls could be seen by the occupational therapist. This initiative had been introduced following the change in the model of care and staff anxiety about the centre accommodating girls. The occupational therapist assessments aimed to provide a holistic, multidisciplinary approach for each girl.

4.17 Staff carefully considered in formulation whether it was appropriate to begin psychosocial interventions in custody. This could depend on the length of a girl's sentence and if it was appropriate to transfer a therapeutic intervention to a new provider when a girl left custody. Staff highlighted how the transfer of an intervention to the community could be complex, as a therapeutic relationship would need to be built with a new professional; there was a risk that a child could be retraumatised if the work was not consistently delivered.

4.18 Where girls were subject to long periods of time on remand, health staff worked with interventions staff to manage a girl's anxiety around the court process. Interventions also focused on retaining and building a girl's independent living skills to support her future return to the community.

4.19 Girls were given a choice about the gender of health practitioners when possible and arrangements could be made to access a female practitioner through community services. In one SCH there was evidence that engagement of girls with physical health services had increased after a female nurse had been recruited; previously there had only been a male nurse in place.

4.20 We found examples of girls being placed in the secure estate because there were no available mental health placements that could meet their needs. In one example, a girl was remanded to custody as no suitable community-based proposal could be suggested to the court. Placing girls in the criminal justice system due to a lack of appropriate health care not only fails to meet their needs but may further traumatise them.

4.21 We also discovered a delay in moving a girl to tier four mental health inpatient provision. Staff told us this was challenging and often upsetting, as they were unable to provide the care these very unwell girls needed.

4.22 Many of the girls had a limited understanding of safe or positive relationships and interventions often included building on their knowledge of risky situations and how to stay safe. We saw many examples of staff working creatively with girls to engage them in sessions and to further support them following their transition to the community. For example, on transfer to the community one professional had raised an alert on a girl's case record with the local sexual health service to enable her to be seen as priority if she requested support. This aimed to minimise the risk of her withdrawing from the service and to ensure she was safe.

4.23 Health staff factored in a girl's menstrual cycle to assessments and interventions to identify if hormonal changes impacted on their physical, mental health, and sensory needs.

4.24 We found girls were involved in their individual care planning and that therapeutic staff continuously reviewed how best to engage them in their care. However, there was not always a systematic approach to ensure girls were able to influence other key aspects of service delivery. For example, health care staff often contributed to the delivery of enrichment sessions in school holidays and at weekends. Health and well-being sessions in one secure setting had included sex education and nutritional advice, but we did not find routine evaluations of the sessions by health care staff. This meant opportunities to explore preferred topics or to understand if girls would prefer mixed or gender-specific sessions to be held were missed.

4.25 Staff promoted consistency in the care of girls as they moved to a community environment. For example, health care staff at Clayfields SCH held ongoing meetings with a professional from a forensic CAMHS service and a network of other professionals including the YOT and social worker. When a girl returned to the community, staff also delivered trauma-informed training to residential staff at the girl's accommodation to enable care to be delivered in line with the therapeutic recommendations.

Section 5 Transition to adult prisons

5.1 The transition experience is often jarring for girls and can mean going from a small SCH with fewer than 30 children to a prison holding up to 500 prisoners. For girls in the one Welsh SCH, there was an additional concern about moving to a prison in England, as Wales does not have any prisons for women.

5.2 Oversight of each transition plan is provided by the Women's Estate Case Advice and Support Panel, and starts six months before a girl's 18th birthday. The panel kept each transition under review for a few months after transfer and had a formal review meeting for each. This included some input from the young woman who had transitioned, although they did not attend the meeting in person. The meeting was a good forum to identify what had worked well and what needed to be addressed for future transitions.

5.3 Health care staff working with children voiced concerns about the vulnerability of young women with complex needs transferring to the adult estate, where the high level of support they had become used to would no longer be available. In all cases, young women were moved to adult environments where the delivery of interventions was much reduced, further adding to their vulnerability.

5.4 We interviewed three young women who had transitioned from an STC or SCH to an adult prison after their 18th birthday. One had since transferred to another prison to access courses she was interested in. Information sharing between the two adult prisons had been poor and we found little awareness of the vulnerability of young women at the new prison, including whether they had originally come from the youth custody estate. As a manager told us four weeks after the girl's transfer:

'We only became aware last week that [girl's name] had come from the youth custody estate – this is not something we usually check for.'

5.5 All three young women had known a move would happen when they reached 18. They described the experience of going from being the oldest, and in some cases a role model for younger children, to being the youngest in a much bigger establishment and having other prisoners call them, for example, 'baby'.

5.6 For one of the three girls, the move happened the day after her 18th birthday with no prior warning. She described having little useful preparation for her move to an adult prison. In another case the girl had meetings with a manager from her new prison before her move, but said most of what she was told would happen did not materialise. Another young woman said she would have liked more information about basics such as canteen sheets.

5.7 All three young women said they had found out about processes and how to get things done at their new prisons from other prisoners, rather than from staff who had been tasked with helping them to settle in. One young woman told us she did not know who to ask when she had a problem and resorted to 'kicking off' to get things done. All three had experienced pandemic restrictions following their arrival at adult prisons and these compounded the issues they faced.

5.8 The impact on the three girls of moving from a place where they knew everyone and how to get things done, to a place where everything and everyone was new and they had no idea how to resolve problems, cannot be underestimated. One of the three had not attended education since her move, had no daily activity to occupy her time. She was struggling to get a health concern resolved. In essence the girls went from a routine that kept them unlocked and occupied every day to having minimal time out of their rooms and no education, work or other meaningful activity or engagement with peers or staff. Another notable change was living in a predominantly single sex environment after mixing with boys and girls. There did not seem to be much preparation for how this could feel.

5.9 Two sentenced girls in our case sample who were approaching their 18th birthdays and knew what was being arranged for them told us about their anxiety about the likely moves. They thought of adult prison as being somewhere that would offer them less help and support than they were used to, which was realistic given the lower staffing levels there. One of the two girls described good preparation from community professionals for her handover from YOT to probation case management, including joint meetings with her YOT worker and a transitions probation officer. When asked what they would like to change about their SCH experience, one girl said she would like an 18-plus unit for girls. The options for a more phased transition for girls are worthy of exploration.

Section 6 Outcomes on release

6.1 We followed the experience of seven girls who were due to be released from custody into the community in the second half of 2021. One had been returned to custody days after her release and was subsequently sentenced for new offences, two were in tier four mental health units, and another girl was assessed as unfit to plead and the charges against her at court were dropped. She remained in an SCH on a welfare placement. These outcomes reflect the lives of many girls in custody who move between health care, welfare and criminal justice placements as their behaviour escalates or stabilises. Of the remaining three, two girls and one 18-year-old young woman had returned to the community. One had gone back to the family home and the other two were living in accommodation with onsite support and care.

6.2 Planning for release was being managed by community professionals and the secure placement. However, the risks posed by each girl and the risks to her were not always considered in sufficient depth.

6.3 Difficulties in finding suitable accommodation in the community, was a recurring theme during this inspection, with agencies experiencing varying degrees of success in sourcing suitable placements. The inability to identify suitable accommodation on release made planning education and health care impossible.

Case study 1

An 18-year-old was released to sheltered accommodation more usually used for elderly people as an interim measure while more suitable accommodation was found. Despite extensive searches for dedicated provision to meet her needs, none had been identified. The sheltered accommodation was only secured two days before her release from custody, which made release planning in other areas impossible. The additional support provided for her included two carers who were available at all times, but even this had been problematic as the young woman reported that sometimes her carers spoke in a language she could not understand. She completed her time on licence in this accommodation despite it initially being an interim solution to her housing needs. Prior to entering custody, she had a significant offending history, nearly all of which involved offences against care staff or emergency workers. A multi-agency forum had been established prior to her custodial sentence and this had contributed to a comprehensive assessment of her resettlement needs. However, the lack of appropriate accommodation in good time for release prevented other support being put in place and ultimately increased the risk of reoffending.

Case study 2

A 17-year-old was released from custody to a different geographical area than where she was living when she committed her offence.

The search for a suitable community placement began two months prior to her release and once it was found the local authority paid a retainer to ensure the placement would be available when she needed it. The manager of the community placement went to meet the girl at her custodial unit before agreeing to accept her and she was able to visit the placement with custodial staff before her release. One-to-one care was provided by the local authority for the first six weeks of her placement to support the transition from a secure setting to the community.

While case study 2 provides a more positive example of transition arrangements, there remained some gaps in the preparation for the girl's release. CAMHS support was not in place for the day of release and education plans were unclear. Some education packs had been provided for the girl to work through with staff at her placement, but there was no support to help her reintegrate into the wider community.

Appendix I Glossary

CAMHS
Child and adolescent mental health services.

Initial formulation
A formulation (or 'my story') is a collaboratively developed and shared understanding of a child's needs that summarises the core difficulties, explains why they may be happening and, drawing on psychological theory, is an attempt to make sense of them.

A formulation draws together all the relevant information about a child and their experiences into a shared and coherent 'story' (or hypothesis), as an attempt to explain their current presentation. This hypothesis draws on psychological theory and may incorporate, but is not tied to, any particular label or diagnosis. A formulation is a 'plausible account' of a child's situation that has personal and/or collective meaning. It suggests that all behaviour is understandable in context and is developed from a shared understanding of the young person's unique context and life experience ('what's happened to them') in contrast to labelling the child as a problem (what's wrong with them'.

Tier four mental health services
Specialised services that provide assessment and treatment for children and young people with emotional, behavioural or mental health difficulties. There are four tiers of care. Tiers one to three are community or outpatient-based and commissioned by clinical commissioning groups and local authorities. Tier four services treat patients with more complex needs usually requiring inpatient treatment.

The Care Standards Act 2000 and the Children's Home's Regulations 2015
The legislation that governs children's homes. This legislation imposes a duty on managers of secure children's homes to assess whether they can meet the needs of a child. They must also consider the needs of children already living in the home before they make a decision about admission, which may mean that they decline a placement.