Commission for Social Care Inspection

Champions for Social Care Improvement

csci

inspection report

UNANNOUNCED INSPECTION VISIT

Hassockfield Secure Training Centre

August and October 2004

1. Introduction

1.1. This unannounced inspection visit was carried out at the request of the Chief Inspector of the Commission for Social Care Inspection (CSCI) following the death in custody of a child at Hassockfield Secure Training Centre (STC) on the 8 August 2004. Andrew Robinson and Steve Hart from CSCI undertook this inspection. The previous full, announced inspection took place in April 2004.

1.2. The purpose of this inspection visit and our subsequent work was to ensure that other children living in the establishment were safe and that STC staff and managers were following procedures to safeguard children at the centre. Because our visit took place whilst other investigations were being conducted by the Police, Premier Training Services Limited (the company responsible for the STC) and the Youth Justice Board (YJB), we were careful to avoid compromising those processes. We therefore did not directly investigate the circumstances surrounding the death of the young person, but considered issues that the Police and the YJB Regional Manager identified during the course of their investigations that were of direct relevance to the safety of the young people.

1.3. The inspection visit started on 17 August at 11.30 am and was completed by 3 pm on 18 August The visit focused on the management of the young people at the centre, the staffing arrangements, the management of practice and the relationships between the staff and young people. After the visit we requested additional procedural information from the Director of Hassockfield and that revisions be made to the Director's Rules. We subsequently met again with the investigating police officers on the 7 October 2004 in order to update ourselves about the progress of their enquiry and finalise this report.

1.4. We met with managers and staff, spent time with young people in every unit in the centre and talked with them about safety, bullying and how they were feeling about life at the centre. We examined records of three young people and obtained statistical information. We met with the YJB Regional Manager, the YJB's Director of Practice and Performance, with the police investigating the death on behalf of the Coroner and with a representative of National Youth Advisory Service, which provides the advocacy service for young people at the centre.

1.5. The Director of Hassockfield was on leave at the time of our inspection. The Head of Programmes was managing the centre in

his absence. At the end of the inspection we fed back our headline findings to the senior managers of the centre, the YJB Regional Manager and to a senior external manager of Premier Training Services.

2. Management and Staffing

2.1. At the time of the inspection visit the staffing levels were adequate to ensure the care and safety of the young people at the centre. The levels on each shift showed that Premier Training Services complied with the contract requirements for staffing laid down by the YJB.

2.2. We were told that immediately after the death of the young person, senior managers had arrived on the scene to support the duty staff. The staff involved in the incident had been offered counselling through the Independent Counselling and Advice Service. This service had been extended to all staff and was also available to managers. Staff and managers had appreciated it and we were told that the service continued to be well used.

2.3. Staff were obviously and understandably shocked by the death and many looked physically and emotionally tired. Managers recognised this and staff said that they felt supported by them, by the company and by their immediate colleagues.

2.4. However senior managers needed to develop a coherent recovery plan to enable the centre to regain its ability to function fully at the earliest opportunity whilst remaining sensitive to the grieving process and other effects that would continue to be apparent for a considerable time. Such a plan was not in evidence at the time of our visit.

2.5. The centre had been operating from March 2004 until August 2004 with five staff suspended. Following a disciplinary hearing two of the five staff members were dismissed and three re-instated to full duties. Because of the suspensions, overtime working had risen. Managers kept the situation under close scrutiny so that they could take action when there were signs that it was becoming unsustainable and also to ensure that overtime did not fall too heavily upon a small number of individuals.

2.6. Staff turnover and sickness rates were also systematically and routinely monitored and were low for a centre such as this. An active ongoing recruitment campaign ensured that the centre was fully staffed to its complement numbers. However the need

to maintain staffing numbers was crucial if the centre was to avoid having to rely upon overtime working. We saw statistics going back to the previous inspection in April 2004 to show that the centre had been fully staffed throughout that period. At the time of our visit the staffing position was easing following the return to work of three of the suspended staff members, the introduction of some new staff who had completed their basic training and the re-location of a young woman from the health block to a unit in the centre which freed the staff working with her to be re-located to their normal duties. The HR manager told us of the arrangements that the centre was making to ensure that staffing levels and work patterns would not compromise the safety and wellbeing of young people.

2.7. As mentioned in the previous paragraph, during the period from 4 August until 18 August 2004 a young woman was "housed" in the health care block and supervised by female care staff on overtime. This was because there were no vacancies for young women either within Hassockfield or elsewhere in the secure estate. Because of these placement pressures underpinned by legislation, the YJB authorised the STC to exceed their maximum occupancy figure set out in the statement of purpose. The establishment was not bound by the statutory regulations governing registered children's homes. However, had this been the case, it would not have been permitted to exceed maximum occupancy without formal application to, and approval by the independent regulator. It is our judgement that it is no more acceptable for STC's to be requested by their contracting authority to increase their maximum occupancy in order to "house" young people in unsatisfactory short term conditions for whom there are difficulties in finding suitable placements, than it would be in other residential child care settings. Although the YJB paid for one extra member of staff on each shift to look after the young person in the health care unit, a second member of staff was required and the on-call nurse took on this role. This meant that when the nurse was away from the unit undertaking other duties, including attempting to resuscitate the young person on the night of his death, the young woman in question was being cared for by only one member of staff in an isolated health block away from her peers.

3. Assessment, Planning and Review.

3.1. Between 1 April 2004 and 17 August 2004 a total of 87 trainees were admitted to the centre of whom 29, or one third, were on remand. We saw evidence of timely assessment work, which was well documented on case files and acted upon.

3.2. Managers and staff told us that the large number of admissions had created a less stable atmosphere than had historically been the case. Many of these trainees were described as being extremely vulnerable and some had volatile and challenging behaviour. Coupled with the fact that a significant number of young people were being admitted on remand and therefore had a lesser commitment to life in the centre than their sentenced counterparts, managers and staff argued that the task was becoming increasingly complex and more difficult to achieve.

4. Care of Young People

4.1. The last full inspection noted that the relationship between young people and staff at the centre was positive and caring. We continued to observe positive relationship during this visit including many examples of staff ensuring that young people were safe from harm, listened to and treated with respect and dignity.

4.2. The young people we met reported that on the whole they felt safe and were confident that all staff would intervene on their behalves if necessary. We witnessed one example where an incident of bullying was dealt with in accordance with internal procedures and the perpetrator was moved to a different unit in order to safeguard the victim. (see also 4.11 below)

4.3. Young people knew how to complain and trusted staff to treat their complaint seriously, even if ultimately they were not always in agreement or satisfied with the outcome.

4.4. Since the death of the trainee, the YJB Regional Manager had been on site on a daily basis and had focused his attention upon the safety and wellbeing of the young people. He stated that they were being adequately looked after and afforded proper safeguards.

4.5. The National Youth Advisory Service representative (the body which provided confidential advice and advocacy for the young people) also said that staff were doing their best to ensure the safety and wellbeing of each young person. This was a view echoed by the police who had interviewed young people in each house unit at the centre since the death. In the course of the interview an officer asked each young person directly about their sense of security. They received no complaints and many young

people were described as being positive about their experience in the STC.

4.6. However a considerable number of the staff to whom we spoke commented that they felt their job had been made more difficult since the restraint hold called the seated double embrace had been suspended by the YJB pending the outcome of an investigation into its safety. They considered that it was now harder to assist young people to calm down following a restraint. Although they recognised that this method had been suspended for sound reasons, they felt that they had been denied the opportunity to sit and talk with young people and gradually release them from the hold as they settled. They stated that the number of restraints that were followed by periods of single separations had risen because they had to adopt a practice of releasing young people while they were still in a threatening and sometimes aggressive state and therefore unable to be re-integrated into the main group. They also speculated that injuries sustained by staff and young people had risen directly as a result of premature release of holds. These issues should be fully explored in the review of methods of physical intervention currently being undertaken by the YJB. We have subsequently been informed by the YJB that their own analysis showed that there had been no increase in injuries to staff or to young people.

4.7. During interviews with staff and managers it became clear that they were confused about the basis on which physical intervention is permitted with young people. Following the inspection the YJB provided clarification of this.

4.8. During the visit we saw evidence of an incident in which child protection procedures were applied appropriately. This resulted in a referral being made to the local child protection team.

4.9. There were comprehensive, multi-disciplinary procedures for managing the risk of suicide and self-harm (the HRAT procedures) which involved senior qualified staff reviewing each young person who was identified as being at risk. Between April and August 2004 the monthly figures provided by the establishment showed that there were between 12 and 17 HRAT files open in any one month. In the same period there was a total of 93 recorded incidents of self-harm involving 30 young people with the monthly total varying between 11 in August and 29 in May.

4.10. Systems were in place to ensure that any concerns about the mood or behaviour of young people subject to the HRAT procedure were recorded by staff, shared appropriately and acted upon without delay. However in light of the death of the young person, the centre should review its procedures for instigating or re-instigating HRAT status to ensure that any lessons that can be learned are understood and acted upon.

4.11. Incidents of bullying were taken seriously and acted upon in accordance with the internal procedure. Young people told us that bullying was not a particular issue. Those who had experienced it said staff had dealt with it adequately. In July there were 23 incidents of bullying recorded; 8 involving verbal abuse, 5 physical abuse, 1 of racial abuse and 9 of threats/intimidation. This compares with a total of 21 incidents in June and 13 in May. There was no obvious reason for this upward trend except that there may be some increased sensitivity to the situation following the trauma of recent events. It will be considered in detail at the time of the next full inspection.

4.12. We learned during the course of this visit that neither the video recording system nor the morse watchman monitoring system were operational on the unit in which the young person died. The morse watchman electronically records each occasion when a member of staff “pegs” a receptor on each young persons door in order to demonstrate that a room observation had taken place. The video recording would have provided visual evidence of the check having been made. The reasons for and the precise timing of the failures were both subject to separate investigation by the police. However the consequence of the failure was that there were neither morse watchman records nor video recordings to show that a young person had been observed to be safe during the periods when they were locked in their room. Following our inspection visit, procedures were put in place on the instruction of the Director to ensure a comprehensive system for recording and monitoring observations of young people and to provide management information to demonstrate compliance with the policy. A contingency plan was also put in place to ensure that all systems failures were reported immediately and replaced by an effective paper system until they again became fully operational.

5. Conclusion.

5.1. Our overall impression of the centre was that relationships between staff and trainees continued to be warm, caring and positive. The young people we spoke to on the whole felt safe

and we saw appropriate action being taken when another trainee was bullying a young person.

5.2. Staff were understandably tired and shocked by the events surrounding the death of the young person. They were, however, feeling supported by management and a counselling service was available to them. However we concluded that a formal recovery plan was required to manage the next period during which feelings about the recent trauma would periodically be aroused and need to be dealt with appropriately.

5.3. During this inspection we saw and were told about ways in which systems, processes and practices fell short of what was required to ensure the safety and well being of young people. These included staff being away from their workstations for excessive periods of time and the absence of contingency arrangements in the event of systems failure. During and after the inspection visit we received assurances that action was being taken to ensure that adequate safeguarding arrangements were in place. We were therefore satisfied for the establishment to continue to operate.

5.4. The last full inspection report (April 2004) identified that management, risk assessment and quality assurance systems and processes need to be developed to underpin safe practice. We also commended in Chapter 7 of that report that the management team would benefit from the appointment of an experienced child care manager who could help raise standards of practice and ensure that systems are developed that provide appropriate safeguards. The evidence of this inspection reinforces the importance of these recommendations.

6. Recommendations.

1. **An establishment recovery plan should be developed for the centre and implemented. (2.4)**

2. **The YJB should stop placing young people in establishments in excess of the maximum stated capacity without any arrangement being in place for independent judgements about the impact on the establishment to be made in advance of placement. (2.7)**

3. **The YJB review of physical control methods should consider the impact on young people and staff of the**

recent suspension of a particular method of physical restraint. (4.6)

4. **The Director must ensure that all staff are aware of the latest guidance governing the use of physical control and that training is always given when changes to policy and practice is made. (4.7)**

5. **The YJB, in conjunction with Directors of STCs, should develop a consistent format for recording critical incidents in which physical control is used that clearly identify the grounds for doing so. (4.7)**

6. **The YJB and the Director should ensure that the arrangements for scrutinising critical incident records are effective. (4.7)**

7. **The Director should monitor the level of recorded incidents of bullying and take action if it continues to increase. (4.11)**

8. **The Director should ensure that all Director's Rules and associated policies, procedure and operational guidance are fully understood and implemented by staff (4.12)**

9. **The Director should "risk assess" all operational systems and contingency plans should be developed to provide alternative arrangements to be used in the event of system failure. (4.12)**

10. **Premier Training Services should again consider the appointment of an experienced, qualified and senior child care professional to complete the management team. (5.4)**