Oakhill Secure Training Centre

Chalgrove Field
Oakhill
Milton Keynes
MK5 6AJ

Full inspection

Inspected under the secure training centres joint inspection framework

Information about this secure training centre

Oakhill Secure Training Centre is operated by G4S Care and Justice Services. The centre provides accommodation for up to 80 children and young people, male and female, aged 12 to 18 years, who are serving a custodial sentence or who are remanded to custody by the courts. There were 43 children and young people resident at the secure training centre at the time of this inspection: 3 girls and 40 boys.

Education is provided on site in dedicated facilities by G4S. Healthcare services are provided by Dr PA. The commissioning of health services at this centre is the statutory responsibility of NHS England under the Health and Social Care Act 2012.

Inspection dates: 15 to 19 June 2026

Overall experiences and progress of children and young people, including judgements on:	**inadequate**
Children's education and learning	requires improvement to be good
Children's health	requires improvement to be good

Taking into account:

How well children and young people are helped and protected	inadequate

The effectiveness of leaders and managers requires improvement to be good

Dates of the last inspection: 21 to 25 July 2025

Judgement at the last inspection: inadequate

Recent inspection history

Inspection date	Inspection type	Inspection judgement
February 2026	Assurance	No judgement
September 2025	Monitoring	No Judgement
July 2025	Full	Inadequate

Summary of findings

Since the previous full inspection in July 2025, there have been some improvements. These were initially led by an interim director and then taken forward by the new director who was appointed on 8 December 2025. A handover period between the interim director and newly appointed director took place until the interim director returned to their substantive post in January 2026. Children's health needs are now better understood and their health improves. Targeted work is creating the foundation to better support their educational achievements, and leaders have stabilised the workforce while setting clearer standards of acceptable practice. A reduction in the number of children living in the centre has reduced staff workloads, impacting positively on the support children receive, particularly in respect of preparation for transitions. Some staff and children told inspectors that the culture is more child centred. Extensive investment continues to improve the environment, meaning that the centre is now cleaner and more welcoming.

While there is a systematic approach to improvement, and most recommendations from the previous full inspection have been progressed, there remain some serious concerns relating to how a small number of children are helped and protected. Given the magnitude of inadequacies identified in 2025 and considering that the new director has had limited time to continue to build on the work of the previous interim director, leaders continue to deal with legacy issues, including some poor staff behaviours that impact on children's safety and wellbeing. Although leaders mostly take authoritative action in dealing with these shortfalls, actions taken are not always sufficiently timely or robust. As a result, although concerns are not widespread, they are serious in how well children are helped and protected, and their overall experiences remain inadequate.

Inspection judgements

Overall experiences and progress of children and young people: inadequate

1. Most children's experiences have improved in several areas since the previous inspection. However, a range of safeguarding factors impact negatively on their experiences. One incident, where multiple staff did not follow a child's safety plan, could have had the most serious consequences. At the time of this inspection, high levels of violence and use of force were impacting on children's experiences and wellbeing. The safeguarding team does not always fully explore all aspects of incidents in detail, which could place children at risk. Some staff working in the centre are not clear about their safeguarding responsibilities, and quality assurance systems do not always identify and result in prompt actions regarding poor practice.

2. Some children's experiences are poor. In one incident, staff physically restrained a child when they were naked. Poor decision-making about which staff should

intervene compromised the child's rights and dignity, and it likely impacted on their emotional wellbeing.

3. The range and accessibility of evening enrichment activities for children are limited. Some children shared that they are bored and insufficiently occupied during the period between mealtimes and bedtime. They do not have an understanding of what activities are available, with staff delivering many activities sporadically and inconsistently. This limits children's ability to look forward to and enjoy enrichment activities.

4. Staff are not consistently aware of or undertaking assessments as to whether mail and telephone monitoring should be implemented for individual children to strengthen public protection arrangements.

5. Staff do not consistently complete key-work packs with children to help them to develop life skills. This is not supporting children to develop important skills in preparation for adult life.

6. Most children speak positively about the residential staff, noting that they usually have someone to talk to when they are worried or sad. Inspectors observed some positive interactions between children and staff, reflecting trusting relationships and caring responses to most children's needs.

7. Staff respect each child's unique faith. Children have individualised care plans that detail how staff will support them to practise their specific beliefs. Children are provided with physical items, meals that meet dietary requirements and community links that they need to help them to follow their faith. This sensitive and tailored approach helps to strengthen their sense of identity and emotional wellbeing.

8. Parents spoken to during the inspection provided positive feedback about their children's progress and shared that they are made to feel welcome when they visit the centre.

9. Visiting arrangements for children have improved since the previous inspection. Children are helped to maintain contact with those who are important to them through face-to-face visiting, telephone calls and virtual arrangements. One child shared how they are looking forward to cooking with their family during their next visit and playing with toys with their young siblings that have been purchased and are accessible in the visitors' hall. Regular family days are thoroughly enjoyed by children and reinforce to them that family visits are important and highly valued. This is also supporting enduring family relationships.

10. Children know how to make a complaint. Investigating officers review complaints in a timely manner and provide children with a detailed response. The investigating officer works with internal departments, such as health and education, when relevant to address concerns children may have. Children receive outcome letters explaining the complaint decision and the process for appealing against this if they are unhappy with the outcome.

11. Children have access to the help and support of independent advocates, who visit the centre regularly. They help children to express their views.

12. There have been improvements to children's living areas since the previous inspection. The environment is now clean and welcoming. With staff support, children have started to invest in their environment. For example, they have been involved in choosing colours for their house units and, together with staff, have built new planting areas, which make the premises more inviting. Leaders have secured investment to continue the environmental improvement journey.

13. Children have meaningful opportunities that support their resettlement and readiness for reintegration back into the community. Since the previous inspection, there has been an increase in children accessing release on temporary licence, with a wider range of opportunities available. For example, one child benefited from attending a first-aid course in the community on this basis, in support of their future career opportunities.

14. Staff prepare most children well for release or transfer to a prison or young offender institution. Resettlement planning for children on remand and for those convicted remains a strength. Children and case managers have well-established relationships, supported by regular face-to-face meetings. As a result, planning is more effective, with children proactively engaging with their resettlement plans.

Children's education and learning: requires improvement to be good

15. Since the previous inspection, improvements to the quality of education children receive have been too slow. More recently, there have been several improvements. More staff have been recruited, more subjects are being taught and leaders have introduced the 'pupil passport', which identifies children's targets and strategies to help support them to stay focused in education. In addition, laptops are now available for children to use to develop their digital skills and to conduct appropriate research. The education leadership team has now started to think evaluatively about the provision it offers. At the time of the inspection, the improvements made were in their infancy, and time is required to demonstrate sustainable impact for children.

16. Most education staff have the necessary knowledge and skills to work effectively and sensitively with children. Most staff hold a teaching qualification. Academic staff hold teaching qualifications at various levels, and vocational tutors hold assessor and basic certificates. However, a few staff do not have an appropriate level of qualification in the subjects they teach. Staff do not benefit sufficiently from a well-thought-out, well-developed professional development programme to ensure that their subject knowledge and pedagogical skills are up to date, limiting the quality of what they teach.

17. Education staff assess children's academic abilities on arrival at Oakhill. They use this information, alongside education, health and care plan targets and the child's voice, to plan learning. Teachers know and implement these plans, including

strategies to help children focus in lessons. Plans are still developing, especially for the most-able children and those aiming for higher study.

18. In lessons, teachers regularly assess children's learning. They mark children's work and provide them with both written and verbal feedback. Written feedback praises children for what they have done well and identifies what they need to do to improve. Children use this to prevent them from repeating the same mistakes. Most children said that they engage with and view education more positively now than when they were in the community, including their attendance, which has improved.

19. Some children were able and well supported by teachers to sit GCSE examinations, with some only arriving at Oakhill a few days before. Staff were tenacious in ensuring access to the appropriate awarding body exam papers. While it is positive for children to take these examinations, there is not a developed curriculum, which would facilitate the teaching of all subjects to GCSE level.

20. Teaching staff provide frequent written feedback to professionals and parents to share the progress children make. The information provided in the written reports is overly generic and does not focus specifically on what children have been working on or what they need to do to achieve their aspirations. The reports do not demonstrate the progress children make towards their targets. However, staff do identify many positive aspects, typically commenting on children's behaviours and attitudes to education.

21. Education leaders have introduced some additional subjects since the last inspection. These include the reintroduction of construction, business studies and foundation topics that underpin children's learning, such as reading and handwriting. A barbering teacher has been recruited, and the centre hopes that this subject will be delivered very soon. Children can select a vocational pathway they are interested in studying. A few children engage in work experience around the centre, such as in the kitchens, which they thoroughly enjoy. A few children who spend lengthy periods of time at Oakhill end up repeating subjects due to the limited range of taught subjects on offer.

Children's health: requires improvement to be good

22. Overall, the healthcare provider has made significant progress since the previous inspection, with healthcare services being increasingly effective in meeting children's needs. However, children's health and wellbeing are not fully supported because aspects of the centre-wide approach and day-to-day care do not consistently complement the positive healthcare input being provided. This has the potential to reduce the overall impact of healthcare interventions and could limit the progress made in improving children's health and wellbeing.

23. Children typically receive timely and comprehensive health assessments on admission. These include a comprehensive health assessment tool screening and 'My Story' work, which help staff to understand children's physical health, emotional wellbeing and neurodevelopmental needs at an early stage. This enables

healthcare staff to identify needs quickly and support children to access appropriate interventions without delay.

24. Children have good access to a suitable range of healthcare services. Regular GP clinics, dental and optician provision, vaccinations and specialist services, including psychology and substance misuse support, are available and used. Healthcare staff contribute to multi-disciplinary meetings and wider strategy discussions. This supports a shared understanding of children's needs and promotes more consistent responses to their presentation and risks.

25. Children are supported by health staff through regular wellbeing check-ins and access to targeted interventions. Healthcare staff build positive relationships with children and are responsive to children's changing needs. Following incidents, including self-harm, children are seen by healthcare staff and receive the necessary follow-up care. This helps to ensure that children's immediate health and emotional needs are recognised and addressed. Discharge summaries are routinely completed, supporting continuity of care as children move on from the centre.

26. Healthcare provision has improved notably since the last inspection. Governance, audit and oversight arrangements are more established and provide leaders with improved grip and visibility of practice. Leaders understand the strengths and areas for development within the service and have taken appropriate action to address shortfalls. As a result, healthcare and wellbeing staff are better supported to carry out their roles, and children typically receive safe and timely healthcare that meets their immediate needs.

27. Despite progress, there still remain some areas for improvement that the healthcare provider continues to work on. For example, the embedding of medicines administration processes to minimise all risks to children. Also, not all children who had a specific or underlying healthcare need had an appropriate care plan in place to ensure that this informed targeted interventions to meet these needs.

How well children and young people are helped and protected: inadequate

28. When safeguarding concerns arise, the safeguarding team does not always fully explore all aspects of the incident. On a small number of occasions, the safeguarding team was too narrow in its focus to the detriment of fully understanding broader concerns in respect of staff practice and behaviours. For example, on one occasion, the team did not explore whether other staff members reported a safeguarding concern in a timely manner or whether there were delays in reporting. This narrow focus could mean that staff members continue working with children when there may be concerns about their knowledge and understanding of expectations and practice that have not been addressed.

29. In one significant incident, multiple staff did not follow a child's explicit safety plan. An item was placed in a young person's room contrary to the plan. This had the potential for the young person to seriously harm themselves. While an initial fact-

finding investigation identified key factors and leaders took some actions, they did not share all of those factors with the local authority designated officer (LADO). The LADO's guidance to the centre was therefore limited, and this restricted the LADO's overview and potential safeguarding advice and action. There is an overreliance by leaders on an ongoing commissioned investigation to inform next steps, despite already identifying significant shortfalls. The investigation is delayed and has not been expedited, and so all necessary actions to safeguard children and avoid a similar incident occurring have not been taken. Consequently, it remains unclear whether all staff at the centre understand the potential risks and actions that must be taken to help, protect and safeguard all children and young people.

30. Most allegations about staff are explored and referred appropriately to the LADO in a timely manner. Leaders attend regular meetings with the LADO to discuss safeguarding concerns and to ensure that there is external scrutiny of safeguarding matters. This is an improvement from the previous inspection. However, some safeguarding concerns remain open for long periods of time. This is usually due to waiting for external professionals to speak with children. While leaders provide some challenge in respect of this, it is limited. As a result, some safeguarding concerns are not always fully explored and concluded in a timely manner.

31. The newly appointed head of safeguarding has begun to identify areas for further development. Some shortfalls remain in the same areas identified at the previous inspection. Recording systems are overly complicated, making it difficult to follow, understand and review all areas of potential concern relating to each incident. The head of safeguarding has put forward a business plan to introduce a safeguarding recording system to support effective actions and tracking of cases.

32. Despite a reduction in the number of children living in the centre, rates of violence remain exceptionally high and are similar to those found at the time of the previous inspection. Strategies to reduce violence and the use of weapons are now in place, but they have not been fully implemented and so they have not reduced incidents to help keep children safer.

33. While pain-inducing techniques have not been used since the assurance inspection in February 2026, the use of physical restraint since the last full inspection has increased and remains high. Inspectors identified inconsistencies in staff de-escalation practices, failures to maintain dignity in a small number of incidents (as set out in the 'overall experiences and progress' section of the report) and weak management oversight. This limits leaders' ability to provide effective quality assurance with the aim of reducing the use of force. The centre has stopped using metal handcuffs on the children and has replaced these with soft wrist restraints.

34. Inspectors identified a number of concerns about staff antagonising children. In some cases, leaders took prompt and appropriate action to prevent this from happening. However, quality assurance mechanisms are not consistent in identifying poor practices to ensure that action is taken without delay to prevent future incidents. For example, after a child had been antagonised by a member of staff, resulting in the child being physically restrained, it was 11 days before the

safeguarding team carried out further exploration and decided a referral to the LADO was required due to concerns about staff practice with children.

35. On another occasion when physical restraint was used with a child, a concern was raised with the safeguarding team about an inappropriate comment made by a staff member. As this was a conduct matter rather than a safeguarding concern, the safeguarding team referred this to the residential team for action. However, there is no record as to whether any follow-up actions were taken by the residential team to address this issue. A lack of collaboration between teams means that concerns about staff practice with children could go unaddressed.

36. Consequences given to children are not consistently restorative. Children can lose privileges for up to 3 days depending on the incident, which inspectors found in some cases to be overly punitive. Staff responses to consequences lack creative alternatives more closely linked to the child's behaviour. Records of consequences lack details of children's views, which are essential to accurately gauge effectiveness. Leaders are aware and plans are in place to address this.

37. If children are separated from their peers due to risk, this measure of control is now used appropriately, with most periods of separation being brief, averaging around 5 minutes, with the rationale clearly recorded.

38. Staff use security procedures and intelligence well. Increased weapon finds reflect more effective, intelligence-led searching. The introduction of new technology is supporting children's safety while reducing the need for physical searches. This is helping to preserve children's dignity.

The effectiveness of leaders and managers: requires improvement to be good

39. The leadership team has been refreshed, bringing a renewed drive and focus on improving children's experiences at Oakhill. The director is building the foundations to support sustainable change and has appropriately prioritised stabilising the workforce. Recruitment of new staff is now more robust, and turnover has improved. A more stable workforce is helping children to form more enduring and trusting relationships with staff. The director took immediate action following the assurance inspection in February 2026 to eliminate the use of metal handcuffs and inverted wrist holds in managing children's behaviour.

40. Leaders understand the strengths of the service and that there remains significant work to do, albeit from a seriously low starting point, to ensure that children have consistently good care, help and support. All staff have now received safeguarding training, which was a significant shortfall at the previous inspection. There is now a shared ownership and collaboration across the centre to provide a more structured approach to support staff development. Planning has released staff from their usual duties to complete the new minimising and managing physical restraint (MMPR) training. This has taken time, with half of the operational staff having completed this and the remainder due to complete this imminently.

41. A reduction in the number of children living in the centre has had a positive impact on some aspects of the quality of care children receive. Staff workloads have reduced and are currently more manageable. This is enabling staff to have more time to build and sustain relationships with children and more time to deliver the care and support children need. This is contributing to improvements seen in the delivery of interventions, particularly in respect of transitions, and more robust escalation action with appropriate local authorities in identifying accommodation for children moving into the community.

42. As set out in the 'how children are helped and protected' section of this report, a serious incident occurred relating to a highly vulnerable young person. While leaders took some immediate action, this was not sufficiently robust or timely for them to be assured that similar practice will not be repeated. The Youth Custody Service stated that it reviews all safeguarding incidents, and it has provided some challenge to the centre, but it was not fully aware of all the shortfalls in protecting the young person that have been identified by inspectors.

43. There have been delays in some areas of important mandatory training, such as self-harm training, being completed by all staff. As a result, leaders cannot be assured that all staff are competent in this aspect of safeguarding practice. This was reflected in the serious incident previously mentioned above. Leaders are fully aware that staff skills need to be strengthened. They also have plans to strengthen staff skills through other specialist training, including on trauma-informed practice, autism and attention deficit hyperactivity disorder, to enhance the quality of care and support provided to children.

44. Quality assurance mechanisms, while improved, remain inconsistent. The appointment of a dedicated head of safeguarding is bringing greater prominence to and oversight of safeguarding practices. Despite this, there are missed opportunities to inform wider learning, particularly where staff practice may have contributed to children's behaviours escalating. Through the implementation of weekly director-chaired restraint minimisation meetings, leaders have greater oversight through the limited sampling of occasions when physical restraint is used on children. Routine quality assurance of the use of MMPR remains inconsistent in identifying practice shortfalls and learning to improve children's care and experiences. This includes weaknesses in seeking purposeful feedback from children to inform staff on what helps the children and inform planning to help reduce the use of force.

45. The director is rightly focused on strengthening performance and quality assurance. The centre has appointed an education specialist to provide independent scrutiny of how well children are helped to achieve their educational potential. An independent audit has also been undertaken to help leaders better understand children's experiences. Senior leaders undertake daily walkarounds of the centre, and they have reintroduced a compliance matrix across each department, which is reviewed on a weekly basis. These performance activities are providing leaders with a better understanding and oversight of children's living environments and the care they

receive. Leaders are fully aware that there is still a significant amount of work to do to embed a robust safeguarding culture via a comprehensive quality assurance framework with a greater focus on the quality and impact of practice.

46. Most operational staff receive regular formal supervision from their line managers. The quality and impact of this are variable, with poorer examples lacking reflection, focus on children's needs and care, and time-bound actions to help improve the support children receive. Not all senior leaders have supervision records to support accountability.

47. Most staff spoken with during the inspection told inspectors that they feel better supported and feel positive about the changes the new permanent leadership team has made and is still making. Despite this, there remains a significant minority of staff who report less favourably about the conditions they work in and the support they receive from leaders and managers.

What needs to improve:

Recommendations

- Ensure that all staff are fully cognisant of children's safety plans and implement them fully.
- Ensure that in the safeguarding of children:
  - referrals to the local authority and/or LADO contain all relevant details from appropriate fact-finding
  - the safeguarding team is sufficiently curious about concerns raised and that it looks more broadly into any incident to explore concerns fully
  - concerns are fully followed through even if they are passed to other departments
  - escalation processes are followed to remind external professionals of their safeguarding responsibilities to visit or speak with children in a timely manner
- Implement a policy or strategy that is then known, and delivered, by all staff across the centre, which is focused on reducing the rates of violence, use of physical restraint and weapons and which models child-focused practice, including through the use of de-escalation.
- Strengthen the quality of recording of the child's voice following any incident where physical restraint has been used.
- Strengthen public protection arrangements to ensure that children are appropriately considered for telephone and mail monitoring. Ensure that all staff understand this process and implement it.
- Widen the range of enrichment activities so that they are accessible to more children, supported by a predictable timetable that staff and children can follow easily and consistently.

- Ensure staff support children, including helping them prepare for the future, by ensuring that key-work sessions are completed promptly and fully.
- Continue to improve the quality of education children receive to ensure that they can make rapid and sustained improvements from their starting points.
- Provide explicit health management strategies within care plans for children with underlying or specific health conditions.
- Further develop and embed robust performance and quality assurance systems across the centre to ensure that there is detailed and thorough oversight of the quality of practice that then improves.
- Strengthen the quality, consistency and impact of formal supervision for staff at all levels to help them to provide good-quality safe care to children and to promote continual development of staff.
- Ensure that all outstanding mandatory training is completed by staff, including self-harm training, and continue to develop the training programme at pace to better equip staff to meet the range of needs of the children living at the centre.

Information about this inspection

Inspectors have looked closely at the experiences and progress of children and young people under the secure training centres inspection framework.

This inspection was carried out in accordance with Rule 43 of the Secure Training Centre Rules (produced in compliance with Section 47 of the Prison Act 1952, as amended by Section 6(2) of the Criminal Justice and Public Order Act 1994), and Section 80 of the Children Act 1989. His Majesty's Chief Inspector's power to inspect secure training centres is provided by Section 146 of the Education and Inspections Act 2006.

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Secure training centre details

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