Report on an unannounced short follow-up inspection of

HMYOI Ashfield

26 – 29 August 2008

by HM Chief Inspector of Prisons

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Contents

Introduction

Ashfield is a privately-run male juvenile establishment, holding 387 young men at the time of the inspection. It has been open for around nine years, and its first three years were extremely troubled, culminating in a very poor inspection report in 2002 and a temporary takeover by the public sector Prison Service.

Since then, inspection reports have described rapid and sustained improvement, which this report shows has continued. Previous performance in safety, respect and activities had been maintained, and there had been improvements in the establishment's resettlement work.

Ashfield remained a largely safe place, where fewer young people than at comparator prisons said they had felt unsafe. Late arrivals, however, impacted on the establishment's ability to support young people in the early days of custody. Both assaults and the use of force were high, though steps were being taken to address the underlying causes, using some innovative interventions. The role of the 'reorientation' unit was unclear, and the lack of an on-site social worker was affecting safeguarding work and work with looked-after children.

Relationships between staff and young people were appropriate, and the role of personal officers was unusually well developed. Procedures for managing race and diversity had improved, though the perceptions of black and minority ethnic young people remained particularly poor. Both healthcare and the support for young people with substance abuse problems had improved.

As at previous inspections, the quantity and quality of purposeful activity for young people at Ashfield was very good. Education offered a broad curriculum, with specialist support for those with attention deficit and hyperactive disorder (ADHD). Some vocational courses had been introduced, and the Connexions work had improved. Young people were out of their cells for an average of just under 10 hours a day, and physical education activities were good.

At the last inspection, resettlement was rated as not performing sufficiently well. This had improved significantly, with improvements to both strategic management and the delivery of services. Attendance at planning reviews had improved, though, as over a quarter of young people lived more than 100 miles away, few families were able to attend. Support for young people serving long and indeterminate sentences remained inadequate.

This is another positive inspection of Ashfield. Managers and staff had responded to weaknesses highlighted in previous reports, with some innovative approaches. Though relationships between staff and young people remained generally good, the high level of assaults and use of force bore witness to the difficulty of managing this volatile population safely in large establishments and units. Nevertheless, this report shows that Ashfield had been able to sustain and continue the progress it has made over the last six years.

Anne Owers
HM Chief Inspector of Prisons

December 2008

Fact page

Task of the establishment
Ashfield is a young offender institution for sentenced and remanded male juveniles (aged between 15 and 18), serving courts stretching from West Wales to London.

Area organisation
Office for National Commissioning.

Number held
26 August 2008 : 387

Certified normal accommodation
400

Operational capacity
400

Last inspection
September 2006

Brief history
Ashfield opened on 1 November 1999 following the award of a design, construct, manage and finance contract to Premier Prison Services Ltd. It is built on the site of the former Pucklechurch remand centre. The establishment was re-roled in 2005 to accommodate solely juveniles after investment from the Youth Justice Board and has been run solely by Serco since July 2005.

Description of residential units
There are two housing units, each X-shaped and divided into four wings. Each wing can hold between 40 and 64 young people in single and double cells with integral sanitation.

Section 1: Healthy prison assessment

Introduction

HP1 All inspection reports include a summary of an establishment's performance against the model of a healthy prison. The four criteria of a healthy prison are:

Safety	prisoners, even the most vulnerable, are held safely
Respect	prisoners are treated with respect for their human dignity
Purposeful activity	prisoners are able, and expected, to engage in activity that is likely to benefit them
Resettlement	prisoners are prepared for their release into the community and helped to reduce the likelihood of reoffending.

HP2 Under each test, we make an assessment of outcomes for prisoners and therefore of the establishment's overall performance against the test. In some cases, this performance will be affected by matters outside the establishment's direct control, which need to be addressed by the National Offender Management Service.

...performing well against this healthy prison test.
There is no evidence that outcomes for prisoners are being adversely affected in any significant areas.

...performing reasonably well against this healthy prison test.
There is evidence of adverse outcomes for prisoners in only a small number of areas. For the majority, there are no significant concerns.

...not performing sufficiently well against this healthy prison test.
There is evidence that outcomes for prisoners are being adversely affected in many areas or particularly in those areas of greatest importance to the well being of prisoners. Problems/concerns, if left unattended, are likely to become areas of serious concern.

...performing poorly against this healthy prison test.
There is evidence that the outcomes for prisoners are seriously affected by current practice. There is a failure to ensure even adequate treatment of and/or conditions for prisoners. Immediate remedial action is required.

HP3 This Inspectorate conducts unannounced follow-up inspections to assess progress against recommendations made in the previous full inspection. Follow-up inspections are proportionate to risk. Short follow-up inspections are conducted where the previous full inspection and our intelligence systems suggest that there are comparatively fewer concerns. Sufficient inspector time is allocated to enable inspection of progress and, where necessary, to note additional areas of concern

observed by inspectors. Inspectors draw up a brief healthy prison summary setting out the progress of the establishment in the areas inspected. From the evidence available they also concluded whether this progress confirmed or required amendment of the healthy prison assessment held by the Inspectorate on all establishments but only published since early 2004.

Safety

HP4 In September 2006, we found that the establishment was performing reasonably well against this healthy prison test. We made 36 recommendations in this area, 21 of which had been achieved or partially achieved and 15 not achieved. We have made 12 further recommendations.

HP5 Most young people reported feeling safe. Over half of responses to the safety questions in our survey were significantly better than the comparators[1] and also indicated improvement since the previous inspection in a number of areas. There was less shouting out of windows and the atmosphere was mostly calm and well ordered. Reception and first night procedures were generally efficient and supportive and information arriving with young people had improved, but the high number of late arrivals had a chronic impact on the ability of staff to carry out full checks and assessments. First night cells were not properly prepared. Young people were still routinely strip searched for a variety of reasons.

HP6 Most adjudications now took place on the wing in an age-appropriate environment. Minor reports were used well. There was a lack of clarity about the role and function of the reorientation unit, which was in a poor state of repair. The special cell was little used, but several young people had been held there for very long periods, including overnight, without justification. Use of force was high, but most incidents were spontaneous and force was mostly used appropriately. The level of violence between young people was worryingly high, but a great deal of work was under way to address the underlying causes. Interventions such as therapeutic crisis intervention (TCI) and the restorative justice, anger management and behaviour modification programmes were developing well.

HP7 Safeguarding arrangements were fully integrated and continued to be effective. Bullying was a significant problem, but was managed well. Some procedural weaknesses in how young people at risk of self-harm were dealt with had been identified internally and were being addressed. Child protection arrangements were not as thorough as previously, but remained adequate. However, the absence of an on-site social worker was impacting on the quality of both this work and work with looked-after children.

HP8 On the basis of this short follow-up inspection, we considered that the prison was still performing reasonably well against this healthy prison test.

[1] The comparator figure is calculated by aggregating all survey responses together and so is not an average across establishments.

Respect

HP9 In September 2006, we found that the establishment was performing reasonably well against this healthy prison test. We made 42 recommendations in this area, 33 of which had been achieved or partially achieved and nine not achieved. We have made eight further recommendations.

HP10 The residential units provided a reasonable living environment and the living areas were clean and tidy. Relationships between staff and young people were age-appropriate and most young people responded positively to staff. Personal officers continued to provide good day-to-day care and there was some evidence to indicate that they had become more involved in care planning.

HP11 Less than half of young people said it was easy to make a complaint and few said they were sorted out fairly. The rewards and sanctions scheme was better managed, but many thought it was applied unfairly and the criteria for reaching the highest level were too restrictive. Young people on the basic level were inappropriately denied daily access to the telephone.

HP12 Healthy options had been introduced to the menu and young people were significantly more positive about the quality of the food. More healthy food options were also now available from the shop.

HP13 Despite some improvements in race relations work, including a full-time diversity officer post and regular diversity team meetings, black and minority ethnic young people's perceptions of their treatment were poor, particularly relating to their treatment by staff. Foreign national young people continued to receive little support. A small number of staff tried hard to help them when possible and caseworkers tried to get advice for them from specialist immigration agencies, but this was not systematic.

HP14 The chaplaincy team continued to function effectively and the level of outreach work provided had increased with the appointment of a community chaplain. However, young people on the reorientation unit were still inappropriately prohibited from attending services in the chapel regardless of risk.

HP15 Healthcare provision continued to be good and had improved. Services for young people with substance misuse problems were now more structured, with improved joint working.

HP16 On the basis of this short follow-up inspection, we considered that the prison was still performing reasonably well against this healthy prison test.

Purposeful activity

HP17 In September 2006, we found that the establishment was performing well against this healthy prison test. We made 15 recommendations in this area, all of which had been achieved or partially achieved. We have made five further recommendations.

HP18 The curriculum was well balanced and there was better provision for more able young people. Opportunities to gain useful employment-related qualifications had been introduced and Connexions offered good careers advice. More vocational subjects

with good facilities had been introduced, but the facilities in construction and carpentry remained insufficient. Provision for speakers of languages other than English was inadequate.

HP19 Young people displaying difficult behaviour in classrooms were now given individual support and tuition in a dedicated room and an intensive programme had been introduced to provide those with attention deficit and hyperactive disorder with effective strategies to minimise its effect. Vulnerable young people were also catered for.

HP20 Staff from the education department now attended more than two-thirds of training planning meetings, but there was still scope for improvement.

HP21 The range of physical education activities had been expanded and now provided a good balance of indoor and outdoor team and individual sports. More able young people were well catered for through sports academies linked to professional clubs and community groups. Participation by different groups of young people in evening and weekend sports activities was not well monitored.

HP22 On average, young people were out of their cells for 9.5 hours each day. They were encouraged to exercise in the fresh air, but there was no equipment for outdoor activities in the exercise yards.

HP23 On the basis of this short follow-up inspection, we considered that the prison was still performing well against this healthy prison test.

Resettlement

HP24 In September 2006, we found that the establishment was not performing sufficiently well against this healthy prison test. We made 29 recommendations in this area, 21 of which had been achieved or partially achieved and eight not achieved. We have made three further recommendations.

HP25 Significant progress had been made in this area, with improvements to both strategic management and reintegration services. There was now a properly constituted policy committee that was informed by a needs analysis. Links had been made to establish support networks outside the prison. The Connexions service had expanded and the role of information, advice and guidance staff extended so that they now provided additional vocational input. Significant improvements had been made to helping young people find accommodation on release and funding had been secured for a halfway house for those needing extra support.

HP26 Attendance at planning reviews had increased, although few families attended as many lived far away, including over a quarter who lived more than 100 miles from Ashfield. Better use was made of assessment information and target setting was more focused. Caseworkers supported young people well through the training process, but the in-house youth offending team was not sufficiently closely involved.

HP27 Support for young people serving indeterminate and long sentences remained inadequate. Some specialist provision had been introduced for young people convicted of a sexual offence. Public protection cases were identified quickly and

were then subject to detailed discussion and regular review and monitoring at the committee.

HP28 Some improvements had been made to the visiting arrangements, including better arrangements for visitors to book visits and a reinstated parenting group.

HP29 On the basis of this short follow-up inspection, we considered that the prison was now performing reasonably well against this healthy prison test.

Section 2: Progress since the last report

The paragraph reference numbers at the end of each recommendation below refer to its location in the previous inspection report.

Main recommendations — To the Youth Justice Board & NOMS

2.1 Escort arrangements should fall within the establishment's safeguarding and security arrangements and there should be better liaison with escort contractors to improve the safety and efficiency of escorting procedures. (HP44)
Partially achieved. Representatives from the local escort contractor, Reliance, now regularly attended the security committee meetings. Despite this, late arrivals continued to be a serious problem (see also paragraphs 2.9 and 2.10). In our survey, 10% of young people, significantly worse than the comparator of 7%, said they had spent more than four hours in the escort van.

2.2 The National Offender Management Service (NOMS) and Youth Justice Board (YJB) should clarify the accountability arrangements for Ashfield, and in particular ensure that it is a fully supported part of a resettlement planning framework. (HP45)
Partially achieved. The accountability arrangements had not been fully clarified and discussions to agree precisely what these should be were still taking place between NOMS and the YJB. At the time of the inspection, responsibility for commissioning remained with NOMS, but was being transferred to the YJB. However, there had been progress in the strategic support available in relation to resettlement. The director had recently been invited to attend the area resettlement forum as an active member, which would help Ashfield to collaborate with regional colleagues working in this field.

Further recommendation

2.3 The external arrangements for commissioning and monitoring services at Ashfield should be clarified and formalised.

Main recommendations — To the Director

2.4 There should be a comprehensive behaviour management policy incorporating therapeutic crisis intervention, behaviour modification programmes and the use of properly managed 'time out' facilities on residential units. (HP46)
Not achieved. Restorative justice practices had been introduced in May 2006 and were used extensively to deal with conflicts between young people and between young people and staff, but there was no overarching behaviour management policy setting out how the range of problematic behaviour was dealt with and the various interventions available. The introduction of therapeutic crisis intervention (TCI) techniques and the use of behaviour modification programmes were being developed well. There were still no time out facilities on residential units.
We repeat the recommendation.

2.5 Effective race relations management procedures, that reflect the positive duty to promote race relations, should be put in place. (HP47)
Achieved. Racial impact assessments had been completed and the monitoring of access to

facilities and services was being improved with the introduction of SMART monitoring. A full-time diversity manager had also been appointed since the previous inspection.

2.6 The quality of vulnerability assessments should be improved and a quality assurance system should be built into the process. (HP48)
Partially achieved. Vulnerability assessments were of a reasonable quality. In addition to the standard T1V forms, 'stay safe' referral forms were used to pass information quickly to the stay safe coordinator when staff were concerned about a young person's vulnerability. The coordinator checked the quality of some T1V forms, but this was not always done regularly.
We repeat the recommendation.

Recommendations — To NOMS

2.7 As the responsible public authority under the Race Relations (Amendment) Act 2000, NOMS should provide clear guidance, support and monitoring on the promotion of race equality within Ashfield. (3.55)
Partially achieved. The director was invited to diversity groups and events organised by the area manager. However, formal guidance, support and monitoring were still lacking.
We repeat the recommendation.

2.8 There should be a system of minor reports that involves managers with an in-depth knowledge of the circumstances of individual young people and their conditions. (6.34)
Achieved. Minor reports had been introduced and were increasingly used to manage lower-level discipline offences. The records indicated that they were well managed and punishments were appropriate.

Recommendations — To the Youth Justice Board & NOMS

Courts, escorts and transfers

2.9 Young people should be collected from the courts and taken to Ashfield soon after their hearing has been discharged. (1.10)
Not achieved. Young people continued to wait too long in court cells, sometimes up to six hours, before being collected by the escort provider. Members of the Independent Monitoring Board (IMB) were concerned that the escort provider covering London and the South East prioritised adults and young adults because Ashfield accepted new arrivals 24 hours a day while other establishments locked prisoners out at 7pm. This view was supported by our conversations with escort and reception staff.
We repeat the recommendation.

2.10 Young people should be delivered to Ashfield from court by 7pm at the latest. (1.11)
Not achieved. Young people frequently arrived after 7pm and many after 9pm. In the six months to the end of July 2008, 145 young people had arrived after 9pm, with the latest arriving at 1am. We were told that it was not unusual for young people who arrived late to be collected to return to court at 6am the next day. Young people who arrived on the first night unit after 11pm were not given a full first night interview until the following morning so were monitored by staff every 15 minutes overnight. Despite this, the late arrival of young people presented a significant and disturbing risk.
We repeat the recommendation.

2.11 Male juveniles should not travel in the same cellular vehicles as women. (1.12)
Not achieved. Young people still travelled in the same vehicles as women. Some new arrivals

we spoke to had been transported in the same vehicle as an adult male prisoner and reception staff said this was not unusual.

Further recommendation

2.12 Young men should not travel in the same vehicles as adult men or women.

2.13 Young people should be given sufficient meals and toilet stops on journeys to and from the establishment. (1.14)
Partially achieved. In our survey, only 20% of young people said they had been given enough comfort breaks. Although this was better than the comparator and an improvement on 2006, prisoner escort records (PERs) indicated that young people were not offered comfort breaks on journeys lasting more than two hours. Some young people said they had been refused comfort breaks and given bags to urinate in instead. However, PERs showed that young people had been given meals at appropriate times and intervals.

Further recommendation

2.14 Young people should be offered a comfort break at least every two hours.

2.15 The quality of written information on prisoner escort records and of verbal handovers should be improved. (1.15)
Achieved. The information arriving with young people had improved. PERs were normally of a good standard and verbal handovers were provided by escort staff.

Training planning and remand management

2.16 Young people sentenced to life should be transferred to first-stage prisons as soon as possible. (8.47)
Partially achieved. Only one young person was serving a life sentence and nine were serving detention for public protection sentences (DPPs). The transfer coordinator kept records of any issues with transferring young people to other establishments and actions taken to facilitate their transfer. Young people were routinely held at Ashfield until their 18th birthday and transfer to a first-stage prison was sought just before their change in status. Some young people could spend over 12 months at Ashfield before transferring to a more appropriate establishment. This was mainly because HMPs Castington and Warren Hill were the only two juvenile first-stage prisons available and Ashfield rarely transferred young people there as juveniles. The only exception was when a young person was assessed as at risk from other young people at Ashfield and it was deemed unsafe for him to remain. Records showed this had not happened in the previous 12 months. It was rare for there to be delays in transfers due to population pressures, but delays in lifer sentence plans being prepared by the casework team delayed some young people being considered for, or transferred to, other establishments.

2.17 One 19 year-old had been sentenced to an indeterminate sentence as a juvenile, but there had been ongoing difficulties in transferring him, most recently because his parole paperwork had commenced at Ashfield and needed to be completed before any transfer was considered. He had been at Ashfield for over 18 months.
We repeat the recommendation.

2.18 The YJB and the Prison Service should develop a comprehensive strategy for young people held under section 92 of the Powers of the Criminal Courts (Sentencing) Act 2000 and those serving indeterminate sentences to cover their placement and overall management during sentence, including movement into the adult estate. (8.48)
Not achieved. There was no strategy for the overall management of young people sentenced under section 92 of the powers of the criminal courts (sentencing) act 2000 and those serving indeterminate sentences.
We repeat the recommendation.

Substance use

2.19 The adult-oriented practices and procedures of mandatory drug testing (MDT) should cease. (8.68)
Not achieved. Mandatory drug testing (MDT) was conducted according to Prison Service Order 3601, although procedures to manage MDT testing were respectful and carried out sensitively. Staff had received child protection training and managed young people well. There was no evidence of strip searching. Security measures included active and passive dogs and monitoring visitors. MDT levels were low and most finds related to cannabis and alcohol.
We repeat the recommendation.

Recommendations — To the Youth Justice Board

2.20 Young people should always arrive with sufficient pre- and post-court information, including ASSET (YJB assessment document) and vulnerability assessments, to enable staff to complete initial risk and vulnerability assessments. (1.13)
Achieved. Young people usually arrived at reception with ASSETs and other appropriate pre- and post-court information. On the rare occasions when this was not the case, reception staff located the necessary information through the secure email link with the Youth Justice Board and arranged for it to be faxed through.

2.21 Support packages such as the RAP (resettlement and aftercare provision) should be consistently available to all young people who need them. (8.69)
Not achieved. The RAP service was still restricted to a limited amount of areas and not all young people who needed this support were able to benefit from it.
We repeat the recommendation.

Recommendations — To the Director

First days in custody

2.22 All newly arrived young people should be routinely offered a shower in reception or on their first night unit. (1.35)
Partially achieved. Most young people could shower on the first night unit and those arriving when the unit was locked for the night were offered a shower in reception. The reception showers were clean and young people were given toiletries, towels and bathrobes. However, young people who arrived very late (see paragraph 2.10) could not have a shower.
We repeat the recommendation.

2.23 Insiders should be given a formal job description and staff should support them in their role. (1.36)
Achieved. Although they did not have a formal job description, the two Insiders we spoke to

said they had been trained and were clear about their responsibilities. They felt well supported by the manager responsible for them and by reception staff.

2.24 There should be an alternative route to the induction unit for young people who arrive in the evening so that they are not subjected to intimidation from others who are locked up. (1.37)
Not achieved. Every route from reception to the first night unit went past young people locked in their cells. New arrivals were therefore still exposed to shouting and intimidation, but the establishment had taken steps to address this. They were taken to residential units in groups supervised by at least two members of staff and the numbers of the cells overlooking the route were noted on the outside wall to help staff identify and challenge anyone shouting. In our survey, 21% of young people said other young people had shouted at them on arrival, which was significantly better than the comparator of 40% and than the 29% in 2006.

2.25 Rooms for new arrivals should be properly cleaned and prepared in advance and checked by a member of staff before a young person is allocated to them. (1.38)
Not achieved. During the inspection, one young person was allocated a cell with a filthy toilet brush, soiled duvet, grubby floor and dirty bin. He complained during his first night interview and was immediately allocated a different cell. Other young people on the induction unit complained that their cells had not been clean when they arrived. Of the four unoccupied cells on the induction unit marked as ready for occupation, three were adequately clean, but one had not been properly swept and mopped.
We repeat the recommendation.

2.26 The content of the YJB welcome pack should be improved. (1.39)
Achieved. New arrivals were given toiletries, stationery and a puzzle book. They were offered a choice of two shop packs containing sweets and snacks.

2.27 All specialist staff (or a representative) should attend their timetabled slots on the induction programme. (1.40)
Achieved. Specialist staff now regularly attended their designated slots on the induction timetable. In our survey, 61% of young people, significantly better than the comparator of 49%, said the induction course covered everything they needed to know about the prison.

2.28 Induction feedback data should be stored centrally, analysed regularly and the results used to review the programme delivery and content. (1.41)
Not achieved. Feedback was still collected and was stored, but it was not used to review the programme delivery and content.
We repeat the recommendation.

Additional information

2.29 In our survey, 90% of young people, significantly better than the comparator of 79%, said they had been in reception for less than two hours. Reception staff interacted well with young people and carried out reception procedures efficiently. Once on the first night unit, other than those who arrived very late, young people were interviewed in private by first night staff and given the opportunity to make a telephone call. The interviews we observed were of a high standard. In our survey, 86% of young people, significantly better than the comparator of 79%, said they had felt safe on their first night.

Residential units

2.30 Residential units should hold no more than 40 young people. (2.12)
Not achieved. The residential units could hold between 40 and 64 young people in single and double cells. Some units were holding over 40 young people during the inspection.
We repeat the recommendation.

2.31 Cell alarm bells should be responded to within five minutes. (2.13)
Achieved. Records of a central monitoring system for the previous 11 months indicated that most cell alarm bells were responded to within five minutes. There were only seven exceptions, five of which came from the same cell on the same day.

2.32 The reasons for the frequent complaints about rashes from sheets should be investigated and appropriate action taken. (2.14)
Achieved. New washing machines had been installed and different detergents were used. There were no longer any complaints about rashes from sheets.

Additional information

2.33 The residential units were mostly bright and tidy. Young people were actively involved in keeping their environment clean and regular painting took place. One young man who took particular pride in his painting work said he had completed three accredited courses and intended to pursue this line of work after release. However, telephone booths were messy, with papers strewn across the floor. There was an informal atmosphere on the units and first names were used regularly between staff and young people. There were some volatile young men and some flash points, but these did not result in a tense atmosphere. Young men ate out of their cells and had free choice over who they sat with.

Personal officers

2.34 The role of personal officers should be extended so that they become more actively involved in the welfare of young people and help prepare them for release. (2.30)
Achieved. Personal officers were more involved with training planning meetings. In July 2008, personal officers had attended 76% of training planning meetings. In our survey, 55% of young people, significantly better than the comparator of 47%, said they found their personal officers helpful. Personal officers offered good day-to-day care and there was some evidence that they had become more involved in day-to-day care and planning.

2.35 Background information on young people should be held on residential units to be easily accessible to residential staff. (2.31)
Partially achieved. E-Asset was being introduced and would give residential unit staff access to background information on the young people in their care. Training in use of the system was under way.

2.36 Links between personal officers and the casework team should be formalised. (2.32)
Achieved. Links between personal officers and caseworkers appeared stronger. The caseworker for each young person was listed alongside the personal officer in wing offices and greater attendance by personal officers at training planning meetings had helped facilitate a more consistent understanding of the needs of individual young people.

2.37 There should be ongoing management oversight and support of personal officer work. (2.33)
Achieved. Entries in wing files were regularly reviewed by senior custody managers and shortfalls were acted on. Unit managers also carried out random quality checks. The role of personal officers in carrying out rewards and sanctions reviews each week further ensured that the quality of their work with young people was scrutinised.

2.38 Personal officers should regularly visit young people located in the reorientation (segregation) unit. (2.34)
Not achieved. There was little evidence that personal officers visited young people in the reorientation unit even though some young people had lengthy stays there.
We repeat the recommendation.

Safeguarding

2.39 The monitoring of injuries arising out of the use of force should be brought within the remit of the safeguarding committee. (3.7)
Achieved. The safer custody coordinator kept a log of every injury sustained during use of force and this information was now a standard agenda item at the safer custody committee.

Additional information

2.40 Safeguarding work continued to be managed well. An overarching policy was implemented through an effective committee overseen by an extremely experienced safeguarding manager. Only 18% of young people reported ever feeling unsafe while at Ashfield, which was significantly better than the comparator of 30% and the 25% in 2006.

Bullying

Additional information

2.41 Anti-bullying procedures were well developed and continued to be managed well. In the previous six months, 452 suspected bullying incidents had been reported using a stay safe referral form. This was a substantial increase on the previous 12 months. The stay safe coordinator, or in her absence a unit manager, investigated every incident and decided on the appropriate action. If necessary, suspected bullies were placed on formal anti-bullying procedures, although the early identification of potential problems and the prompt action of staff and the stay safe coordinator often meant formal procedures were not necessary. Young people who were brought to the attention of the stay safe coordinator were referred to as at risk young people and managed and supported using a care plan. All were interviewed and measures were put in place in discussion with them to ensure their safety. These cases were then reviewed at the stay safe meetings.

2.42 In the 12 months to July 2008, there had been 500 uses of force, 347 assaults and 912 fights, slightly higher levels than in 2006. Managers were aware of the high levels of violent behaviour and were analysing statistics and incidents in an effort to understand the underlying issues involved. The effort and resources devoted to managing the problem, such as training staff in therapeutic crisis intervention (TCI), were commendable.

Self-harm and suicide

2.43 All issues identified in initial assessment, care in custody and teamwork (ACCT) assessments should be dealt with, required action followed through and accurate records kept. (3.24)
Not achieved. An audit of the ACCT procedures was under way and had highlighted various weaknesses that were similar to our findings. Initial assessments were not always comprehensive and reviews were not sufficiently thorough. Reviews did not always take place within the required timescales and targets set in care maps tended to be formulaic and did not address identified needs. An action plan was being developed to address these weaknesses.
We repeat the recommendation.

2.44 ACCT reviews should be inclusive and involve staff who know the young person's circumstances. They should always include social workers and youth offending team (YOT) workers. (3.25)
Not achieved. Most reviews comprised only a member of staff and the young person. Written contributions from staff working outside the residential area were limited.
We repeat the recommendation.

2.45 The attendance of families at ACCT reviews should be encouraged, unless this is not in the young person's interest. (3.26)
Not achieved. Staff said this was difficult to achieve given how far away most families lived. The proportion of young people whose homes were within 50 miles of Ashford had fallen from 22% in 2006 to 14%.
We repeat the recommendation.

Child protection

2.46 The child protection policy should be published as soon as possible and the contents disseminated to staff. (3.38)
Partially achieved. The previous policy had been published, but the most recent version had not yet been signed off by senior staff from NOMS and the local authority.
We repeat the recommendation.

2.47 All allegations relating to child protection should be passed immediately to the child protection coordinator. (3.39)
Achieved. All allegations were passed to the stay safe coordinator who acted as the child protection coordinator.

2.48 The child protection log should be monitored regularly by a senior manager in the local authority social services department. (3.40)
Not achieved. The child protection log was taken to the local safeguarding children board when a representative from Ashfield attended, but it was not formally or regularly scrutinised by an independent source.
We repeat the recommendation.

Additional information

2.49 The absence of an on-site social worker was a significant weakness. The establishment-based social workers had previously carried out an extremely useful role helping to ensure that child protection referrals were dealt with quickly and efficiently. The lack of specialist input meant

prison staff had to carry out these tasks. Inevitably, they were less skilled and expert in this work, which sometimes resulted in delays (see recommendation at paragraph 2.152).

Race equality

2.50 Staff diversity training should include awareness of religious difference. (3.49)
Achieved. Awareness of religious difference was included in initial staff training and the chaplains were preparing awareness packages focusing on Christians and Muslims.

2.51 The role of the assistant race relations officers and prisoner representatives should be widely advertised. (3.50)
Achieved. There were fewer assistant race relations officers, but their role and that of young people acting as representatives had been publicised through the prison radio station. Young people who acted as representatives wore identifying T-shirts and we saw many young people approach and talk to them.

2.52 Diversity management team (DMT) meeting minutes should clearly show that issues raised have been followed up. (3.51)
Achieved. The minutes identified action points that had been followed up.

2.53 Ethnic monitoring data should be checked for accuracy, analysed using range setting, discussed by the DMT and acted upon whenever appropriate. (3.52)
Partially achieved. Ashfield had just introduced the SMART tool used across the public Prison Service and was shortly due to submit its first set of data to the race equality action group. This offered the potential for the diversity management team to undertake more effective range setting and meaningful monitoring.
We repeat the recommendation.

2.54 Racist incident report forms should be freely available on the units. (3.53)
Partially achieved. Racist incident report forms were still not available on the wings and could only be requested with an envelope from wing offices. However, young people could also use a free telephone number to request a form from the diversity manager, who would deliver and, if preferred, collect it in person.
We repeat the recommendation.

2.55 Relevant staff should always be interviewed when a racist incident complaint is made. (3.54)
Achieved. All 23 racist incident complaints made in the previous six months had been investigated properly and this was quality assured by a member of the local Race Equality Council and the Independent Monitoring Board. Copies of responses to young people were filed with the complaint.

2.56 There should be interventions to challenge racism. (3.56)
Achieved. The race and diversity manager provided individual awareness sessions for anyone involved in a racist complaint and was confident that staff were challenging inappropriate behaviour or language.

2.57 Racial impact assessments should be conducted. (3.57)
Achieved. Ashfield had obtained advice and support on how to complete its racial impact assessments. Ten had been completed, as required by the race equality action group.

2.58 Specialist black and minority ethnic groups already involved with the establishment should be invited to attend the DMT meetings. (3.58)

Partially achieved. A representative from the local Race Equality Council was invited to attend diversity management team meetings, but this had not been possible recently due to some internal issues and their attendance had been irregular.

Further recommendation

2.59 Specialist black and minority ethnic groups already involved with the establishment should be encouraged and supported to attend the diversity management team meetings.

Additional information

2.60 At around 30%, the percentage of young people from a black and minority ethnic background was broadly the same as it had been at the last inspection. Since then, the role of part-time race relations liaison officer had been replaced by a full-time diversity officer post. Diversity management team meetings took place regularly, chaired by senior managers and attended by representatives of the young people. There was a regular forum for black and minority young people and weekly meetings for the young people's representatives.

2.61 Despite some improvements to work practices, responses from black and minority ethnic young people to a number of questions in our survey were poor. Notably, responses to almost all questions about treatment by staff were significantly worse than those from white young people. Thirty-one per cent of black and minority ethnic young people, significantly worse than the comparator of 15%, said they had been victimised by staff and 7% said this had involved racial abuse.

Further recommendation

2.62 Work should be undertaken with young people from black and minority ethnic backgrounds, using the expertise of young people who act as race relations representatives, to ascertain the reasons for negative perceptions of their treatment, particularly by staff.

Foreign national young people

2.63 There should be a foreign national coordinator with day-to-day contact with the young people to develop provision for foreign nationals. (3.67)
Partially achieved. A coordinator had been appointed, but had limited dedicated time to support foreign national young people. A new coordinator had recently been identified who would need sufficient time to offer meaningful regular contact with young people and build on the work and commitment of the previous coordinator.

2.64 The foreign national policy should reflect the specific circumstances and needs of young people, and the diversity management committee should actively oversee its development and implementation. (3.68)
Not achieved. There were 29 foreign national young people. It was unclear how they found out their entitlements with regard to maintaining family contact. Staff we spoke to knew foreign national young people were entitled to a free telephone call, but gave different answers as to the length and frequency of such calls. Efforts were made to support individual young people, including a recently established fortnightly forum for them. A small number of staff expended a lot of energy in this area and there was evidence that face-to-face and telephone interpreters

were used, but more dedicated resources were required to embed this work.
We repeat the recommendation.

2.65 Links with a specialist independent immigration advice agency should be developed. (3.69)
Not achieved. There were no established links with specialist agencies and there were young people who needed such advice. Caseworkers did their best to get advice and support for young people, but these efforts were ad hoc and time consuming rather than systematic.
We repeat the recommendation.

Contact with the outside world

2.66 The delays faced by visitors trying to book a visit by telephone should be addressed, and there should be a system to enable visitors to book their next visit during a visit to the establishment. (3.87)
Achieved. Visitors could book their next visit at the visitors' centre. The telephone booking line was available from 9.30am to noon and from 1.30pm to 4pm. There were plans for a second line in mid-September.

2.67 The face of the young person in photographs taken on family days should not be cut out routinely. (3.88)
Achieved. This no longer happened.

2.68 The 'lads and dads' parenting group should be reinstated. (3.89)
Achieved. Meetings of the group now took place regularly.

2.69 Personal officers should accompany young people more regularly on home and community visits. (3.90)
Not achieved. Personal officers had limited opportunities to become involved in this kind of activity, but this support was offered by an excellent family liaison team.

Applications and complaints

2.70 The outcomes of applications and the time it takes to process them should be recorded and monitored. (3.103)
Achieved. All applications were logged and the dates of replies noted. The system was monitored by the head of residence.

2.71 The establishment should carry out its own survey about complaints to ascertain why young people feel they are sometimes made or encouraged to withdraw complaints. (3.104)
Not achieved. A survey of complaints had taken place in October 2007, but did not include specific questions on why young people felt they had been made or encouraged to withdraw complaints. The results had not yet been analysed, but the response rate had been only 37%, which could make it difficult to draw definite conclusions. In our survey, 11% of young people, not significantly different to the 16% in 2006, said they had been encouraged to withdraw a complaint. There were other indicators in our survey that young people were not satisfied with how complaints were managed. Only 13%, significantly worse than the comparator of 17%, said complaints were sorted out fairly and 41%, significantly worse than the 51% in 2006, said it was easy to make a complaint.

Further recommendation

2.72 Managers should engage with young people in focus groups or consultation groups to ascertain why confidence in the complaints system is low. This arrangement should be supported by regular surveys.

Health services

There should be day care facilities in the healthcare department to offer individual support to young people who find it difficult to cope on the units. (4.51)
Partially achieved. Day care services were still limited and delivered mainly in the small in-patient area by learning support assistants and supporting healthcare officers. A room in healthcare had been adapted to support day care services and occupational therapists had been recruited, but were not yet in post. A structured day care service was planned and would be delivered when staff had started work, but it would not be sufficient to meet the needs of young people who needed extra support. There was scope to adapt some in-patient cells, which were rarely fully occupied, to enable additional day care facilities to be brought into use.

Further recommendations

2.73 Serco Health should analyse the reasons for admission to the in-patient unit with a view to reducing the number of in-patient beds.

2.74 Additional funding should be sought to enhance and expand the existing day care facilities.

2.75 An occupational therapist should be employed to support in-patients and offer additional support to young people on the units. (4.52)
Achieved. A full-time occupational therapist had been recruited and was to take up the post imminently. A part-time therapist had also been recruited, but had not yet been given a date to start.

2.76 The unnecessary transcription of prescriptions should cease and original prescriptions should be faxed to the pharmacy. (4.53)
Partially achieved. Prescribed medicines were written directly onto computerised prescription sheets and sent to the pharmacy. However, the medication was dispensed from prison stock by nurses with the patient's name written on the medicines box. This was in effect secondary dispensing and not in accordance with current Nursing & Midwifery Council standards for medicines management.

Further recommendation

2.77 Stock medicines should be properly labelled by the pharmacy with the facility for the nurse to write the patient's name on the label.

2.78 Stock levels should be agreed in consultation with the supplying pharmacist, the pharmacist from HMP Bristol and the GP. (4.54)
Achieved. A new pharmacy supplier had been in place for four weeks and the process of agreeing stock levels with health staff, including the GP, was under way.

2.79 All medicines supplied by the pharmacy should be appropriately labelled. (4.55)
Not achieved. Some medicines were labelled, but the new pharmacy system was not

sufficiently embedded for this to have extended to all stock.
We repeat the recommendation.

2.80 All pre-packs should be dual-labelled when the pre-pack is dispensed against a prescription; one label should be removed and attached to the prescription form. (4.56)
Not achieved. There was no dual-labelling system as all medicines were dispensed from stock.
We repeat the recommendation.

2.81 Patient information leaflets should be supplied with medication wherever possible, and notices should be prominently displayed to advise young people of their availability on request. (4.57)
Achieved. Notices advertising the availability of patient information leaflets were prominently displayed on wing treatment room doors. Leaflets were issued with medicines when possible.

2.82 The pharmacist should visit Ashfield once a month, and provide clinical input into the pharmaceutical service. (4.58)
Achieved. The contract with the new pharmacy supplier included pharmacy support in Ashfield at least monthly. A drugs and therapeutics committee had recently been established, attended by the pharmacist, senior doctor and primary care lead nurse, and was due to meet monthly to coincide with the pharmacy visits. However, the pharmacist was new to prison work and would have benefited from advice from a senior prison pharmacist.

2.83 The in-possession policy document should include a risk assessment tool for medication and the young person, and the appropriate use of in-possession medication should be encouraged. (4.59)
Achieved. The doctor completed an in-possession medication risk assessment on young people. Young people deemed suitable to have medication in-possession were asked to sign a medication compact. In-possession medication was encouraged where appropriate and only when the young person met the criteria.

2.84 Patient group directions should be introduced. (4.60)
Achieved. Patient group directions (PGDs) had been introduced and were used by nurses. A programme of updating the PGDs was under way and would be discussed at the drugs and therapeutics committee.

2.85 There should be a written record of date checks of pharmacy stock. (4.61)
Partially achieved. The new pharmacy stock levels were nearing completion and would be signed off by the pharmacist when total stock levels were agreed.
We repeat the recommendation.

Further recommendation

2.86 The healthcare manager should seek the assistance of the senior pharmacist at HMP Bristol and the primary care trust in setting up the new pharmacy system to ensure that future clinical practices meet the criteria for prison pharmacies as laid down by the Royal Pharmaceutical Society.

2.87 A counsellor with specialist experience in managing young people who have been subject to sexual abuse should be employed. (4.62)
Achieved. An external specialist sexual abuse counselling service had been introduced and two trained counsellors provided support to young people. Young people attended 12-week

one-to-one courses. Other organisations were providing additional support to young people, including bereavement counselling. All support services linked in with the mental health in-reach team (MHIRT) and all attended relevant meetings, including the multidisciplinary referral meetings.

Additional information

2.88 Young people continued to get a high level of good quality psychiatric support from a dedicated and progressive group of health professionals. The MHIRT now included a clinical forensic psychologist and a community psychiatric nurse trained in the management of patients with dialectical behaviour issues. The nursing team also included nurses specialising in the care of young people with learning disabilities. Occupational therapists were being recruited to improve day care services across the prison and the whole team was supported by three consultant psychiatrists. The team was concerned about the lack of mental health information accompanying young people transferred from other juvenile establishments. Staff said young people were often transferred without completed supporting medical documentation, including medication charts. This made initial psychiatric assessments extremely difficult and often delayed the continuing clinical management of young people arriving at Ashfield.

2.89 The good standard of primary care services had been maintained, with a broad range of visiting health professionals.

Further recommendation

2.90 Juvenile units transferring young people to another establishment should provide all supporting clinical documentation, including clinical records and medication charts, at the time of transfer.

Education provision

2.91 There should be steps to meet the education needs of the more able young people. (5.19)
Partially achieved. There were programmes of differing lengths and levels that took young people's abilities, previous experience, interests and length of stay into account, but courses in English for speakers of other languages (ESOL) were underdeveloped. Young people were placed on courses that largely met their educational needs. Accreditation at level 2 was good as young people progressed onto these more challenging courses. Some qualifications in vocational subjects had been discontinued and replaced by more challenging employment-related courses. However, the prison acknowledged that there was scope for developing more courses at level 3. Connexions provided young people with helpful careers advice. The prison recognised the need to supplement this work with advice and guidance throughout a young person's stay.

Further recommendation

2.92 Provision for young people who speak languages other than English should be increased.

2.93 There should be better use of young people's literacy and numeracy targets when planning their work. (5.20)
Partially achieved. Much good work had been done in the development of thorough and

robust systems to identify young people's abilities in literacy and numeracy. As a result, young people were placed on literacy and numeracy courses that were at the appropriate level for them. Their progress and achievement in literacy and numeracy was good and levels of accreditation were high. However, the setting of targets and the monitoring of progress towards them through individual learning plans were inconsistent and sometimes poor. In many cases, learning plans were used solely to record work completed.

Further recommendation

2.94 Better use should be made of individual learning plans in the application of targets and the way work is monitored.

2.95 There should be a proper 'time out' facility in the education block. (5.21)
Achieved. A dedicated room had been established where learning support assistants provided individual support and tuition to those finding it difficult to work in groups. The number of young people returned to the residential units for poor behaviour was now very low. Ashfield had introduced an intensive programme to help young people with attention deficit and hyperactive disorder (ADHD) to work with their condition and give them a range of effective strategies to minimise its effect. These included yoga sessions to reduce stress and activity levels. Each participant was given a short document setting out how he should treat others and how best others should approach him to minimise the possibility of an inappropriate reaction. The access group provided effective support for vulnerable young people.

2.96 The education department should always be represented at training planning meetings and make an input into resettlement, transition and pre-release planning. (5.22)
Partially achieved. The education department had improved its representation at training planning meetings and had increased its input into sentence planning, resettlement and pre-release activity. It now routinely allocated staff to attend meetings and identified and recorded attendance. Reasons for non-attendance were investigated. The proportion of meetings attended by an education representative had increased from less than half to more than two-thirds. The department routinely provided written reports on young people's progress towards their targets for training planning meetings.

Further recommendation

2.97 Education staff should be present at all training planning meetings.

2.98 There should be sufficient space for activities in the vocational areas. (5.23)
Partially achieved. Facilities for newly introduced vocational subjects such as horticulture and plumbing were spacious and well designed. A new light and airy 'art village' had been provided, but the space available for some longer established activities, particularly construction and carpentry, remained insufficient.
We repeat the recommendation.

2.99 Ventilation in classrooms should be improved. (5.24)
Partially achieved. Appropriate air conditioning had been installed in 13 classrooms and was planned for a further nine.

2.100 Data should be used systematically to inform decision-making or to identify problems or potential problems. This should include routine analysis of the performance of individual courses, the reasons why young people are returned to the units from

education, and absences. (5.25)
Achieved. Information on key aspects of the performance of the education department was now collected systematically. New procedures for the analysis of this data had been introduced and were effective in highlighting areas where performance was good and important issues that required attention. Attendance was monitored rigorously and absences were followed up quickly. A detailed analysis was carried out of the reasons behind young people being returned to the residential units and appropriate action had been taken to reduce the number significantly.

Physical education and health promotion

2.101 Young people's choice of activities should be monitored to ensure that they have a balanced experience of the range available. (5.39)
Achieved. Many new sports had been introduced and there was now a good range of activities as part of the core physical education (PE) curriculum. This had been well planned and ensured that young people were able to gain experience in team and individual sports. There was also a good balance of indoor and outdoor activities and the department successfully encouraged young people to exercise in the fresh air. More able young people were provided for very well by the sports academies, many of which were linked to professional clubs and community groups. The department was equally successful in ensuring that the needs of less able young people were also met through the promotion of an inclusive culture and the introduction of minor games.

2.102 The number of free weights sessions should be reduced and replaced with activities that are more appropriate for young people. (5.40)
Achieved. The department had significantly and appropriately reduced the availability of free weights and the process had been well managed. Weights were still available in the evenings and their use was closely monitored. Only young people on the gold level of the rewards and sanctions scheme could access weights as part of core PE. There was now a good range of activities more appropriate to young people and more were planned.

2.103 The departmental survey of young people's views of PE should be more frequent and used to review and improve PE provision. (5.41)
Achieved. Young people's views were sought systematically at the end of every 12-week PE 'module'. There was a high response rate and the results were published in a clear and age-appropriate way on the main notice board in the sports hall. PE was also included in the quarterly focus group meetings held by education staff, which had resulted in the introduction of new activities such as golf and table tennis.

2.104 The use of PE facilities should be monitored to ensure equitable use by different groups of young people. (5.42)
Partially achieved. Participation in the sports academies by different groups of young people was monitored closely. Participation in evening and weekend recreational PE was monitored less rigorously, so it was difficult to identify any under- or over-usage by different groups.

Further recommendation

2.105 The use of recreational physical education should be monitored to ensure equitable use by different groups of young people.

2.106 All young people should be able to shower after PE sessions. (5.43)
Achieved. Start and finish times of sessions had been amended so that all young people could shower after activities. The showers were well supervised and a recent survey indicated that young people felt safe in the gym. All young people were issued with clean kit and shower gel, but some of the kit was old and worn.

Faith and religious activity

2.107 Young people held in the reorientation unit should be permitted to attend religious services unless a risk assessment indicates that this would be unsafe. (5.52)
Not achieved. Staff reported that including young people from the reorientation unit in corporate worship was disruptive for other worshippers. The chaplaincy therefore provided individual support and worship to young people in the unit. This effectively meant that a blanket decision had been taken to bar all young people held in the reorientation unit from attending the chapel, which was inappropriate (see recommendation at paragraph 2.135).

Additional information

2.108 The chaplaincy remained an integral part of Ashfield. In addition to the established staff and a team of 80 volunteers who offered mentoring and community support, there was now a paid community chaplain who visited on one day each week and maintained contact with young people in South Wales after their release. One team member was developing an awareness package about the travelling community for staff and young people and there were plans to introduce a support group for travellers. The Christian and Muslim chaplains were involved in designing a one-day package about their faiths that they could deliver jointly.

Time out of cell

2.109 Exercise yards should be converted into suitable outdoor recreational areas for young people and include seating and equipment for outdoor activities. (5.59)
Partially achieved. Young people benefited from an average of 9.5 hours unlocked each day and exercise in the fresh air was a regular feature. Outdoor recreational areas were clean, tidy and in a good state of repair. There was little evidence of graffiti. Benches had been installed, but no equipment for outdoor activities had been provided.

Further recommendation

2.110 Equipment for outdoor activities should be provided in the exercise yards.

Security and rules

2.111 Routine strip searching of juveniles should cease. (6.11)
Not achieved. All new arrivals were routinely strip searched. All young people were also routinely strip searched as part of a full cell search. Given that half of all cells were searched each month, most young people could therefore expect to be strip searched every second month. This was unacceptable.
We repeat the recommendation.

Further recommendation

2.112 Strip searching should take place only following a comprehensive risk assessment and on the authorisation of a governor when a risk of harm to the young person or others has been identified.

Additional information

2.113 Security procedures were well developed. Staff were encouraged to provide information to the security department on security information reports (SIRs). Approximately 4,000 SIRs had been submitted to date in 2008, indicating that staff had confidence in the security systems.

Discipline

2.114 Adjudications should not take place in the reorientation unit. They should be conducted on the residential units or in an age-appropriate, non-intimidating environment. (6.35)
Achieved. Adjudication hearings for all young people except those on the reorientation unit took place on their residential unit. Hearings were relaxed and age appropriate.

2.115 Exclusion from education should not be used as an adjudication punishment. (6.36)
Achieved. Exclusion from education was no longer given as a punishment for a proven adjudication.

2.116 Adjudication punishments should take full account of the young person's age, level of maturity and vulnerability. (6.37)
Achieved. Adjudication records showed that punishments awarded were proportionate and age appropriate. There were also examples where adjudicators had taken the young person's individual circumstances, vulnerability and level of maturity into consideration when deciding the punishment.

2.117 There should be a formal system of oversight and quality assurance of records of adjudication hearings. (6.38)
Achieved. Quarterly adjudication audits were conducted by the deputy director and any concerns were fed back to adjudicators.

2.118 Young people should never be held in the special cell overnight. (6.39)
Not achieved. The special cell had been used seven times in 2007 and twice in the previous six months. In November and December 2007, it had been used four times and on each occasion the young person had been held overnight. The longest stay was 28 hours and 10 minutes. Records of two of these incidents showed that the young people had been held in the

special cell long after their behaviour had settled and they had regained self control. In both cases, the young people had slept for a number of hours. This was unjustified and unacceptable.
We repeat the recommendation.

Further recommendation

2.119 The use of the special cell should be authorised in advance by the duty governor and there should be continued authorisation every 30 minutes.

2.120 All staff should be trained in the model of therapeutic crisis intervention and there should be a policy on its implementation to reduce the incidence of spontaneous use of force. (6.40)
Achieved. Eighty-eight per cent of staff had been trained in therapeutic crisis intervention (TCI) techniques and there was a policy detailing implementation.

2.121 Specific data on injuries that young people have sustained from the use of force should be compiled and analysed and submitted to the stay safe committee to be monitored. (6.41)
Achieved. Information detailing injuries sustained by young people as a result of use of force was collated and presented to the stay safe committee. This revealed that a number of young people had sustained friction injuries after being restrained on the carpeted flooring of the reorientation (care and separation) unit.

2.122 All staff authorised to carry out control and restraint (C&R) should be trained in de-escalation techniques. (6.42)
Achieved. TCI techniques had been introduced with the aim of reducing the number of incidents where use of force was necessary to restrain young people. All new officers were trained in these techniques as part of their initial training and existing officers were receiving the training (see paragraph 2.42).

2.123 All cells and communal areas in the reorientation unit should be clean and well maintained. (6.43)
Not achieved. The reorientation unit had recently been used as a resettlement unit before reverting to a separation unit in July 2008. While used for resettlement, the communal areas and all cells except the special cell had been carpeted, but several flooding incidents had left the carpets stained and smelling musty. Young people and staff involved in C&R on the unit had sustained carpet burns. In some cells, the carpets had been ripped up, leaving a bare concrete floor. The special cell was in a particularly poor state and was not fit for purpose. The walls and floor were painted grey and the non-slip paint on the plinth had chipped away leaving bare concrete. The small exercise yard was surrounded by screened fencing and contained no seating. Young people were always given exercise individually.
We repeat the recommendation.

Further recommendations

2.124 Carpet should be removed from the communal areas and cells in the reorientation unit and the floors re-laid with a suitable surface.

2.125 The special cell should not be used until it has been completely refurbished.

2.126 Seating should be provided in the reorientation unit exercise yard.

2.127 Young people on the reorientation unit should be allowed to exercise in association subject to an appropriate risk assessment.

2.128 There should be regular management checks of the quality of entries in personal files in the reorientation unit. (6.44)
Achieved. The files of all young people on the reorientation unit contained detailed entries demonstrating good knowledge of the young person and good insight into their behaviour. The files were regularly checked by managers, whose comments also showed a good understanding of the young people and their difficulties.

Additional information

2.129 Despite the introduction of TCI and other initiatives such as restorative justice and behaviour modification programmes, the incidence of spontaneous use of force remained high. Records showed that most incidents arose in response to assaults on other young people and staff or fights between young people. The use of force forms indicated that force had been used appropriately and that incidents had been de-escalated at the earliest opportunity. However, some statements lacked detail and the orderly officer's check had not been signed on a significant number of forms. Despite this, most records were complete and included forms recording that the young person had been seen by healthcare staff after the incident.

2.130 The reorientation unit had until recently been used as a resettlement unit (see paragraph 2.123), but had reverted to its original use due to difficulties in managing young people on good order and discipline on the residential units. Staff working in the reorientation unit seemed uncertain about the unit's developing function. A unit manager had only recently been appointed and many of the systems and procedures were underdeveloped. A number of staff had not previously worked in a separation unit and some appeared to lack confidence in dealing with challenging young people. Not all had received mental health awareness training. The director had a clear view of how the reorientation unit should be used and intended reviewing its performance in six months time.

2.131 Young people on the unit received a basic regime, but could not leave the unit to attend education, gym or religious services (see also paragraph 2.107). Education was facilitated on the unit by learning assistants, although the unit was almost full and learning assistants did not have enough time to provide education for all the young people located there.

Further recommendations

2.132 A duty manager should check and sign all use of force paperwork.

2.133 The role and function of the reorientation unit should be clarified and a clear policy and unit procedures should be published.

2.134 All staff working on the reorientation unit should be selected for their suitability for the role and have mental health awareness training.

2.135 Young people on the reorientation unit should be able to attend education, the gym and religious services subject to a risk assessment.

Rewards and sanctions

2.136 Personal officers should be responsible for the weekly review of young people's behaviour and ensure that scores are allocated consistently and fairly. (6.56)
Achieved. The large number of wing files examined all contained regular entries from personal officers and other residential staff. Personal officers or, in their absence, wing officers completed regular reviews of behaviour and allocated scores under the rewards and sanctions scheme. Senior care managers carried out weekly checks and unit managers completed a 10% quality check every month to ensure consistency.

2.137 Young people on the basic level should have daily access to the telephone. (6.57)
Not achieved. Convicted young people on the basic (bronze) level of the rewards and sanctions scheme could still associate only twice a week and remanded young people on basic only three times. As they could make calls only when on association, their access to telephones and ability to maintain contact with family and friends were similarly restricted. Managers said this restriction on association had been discussed and approved by young people's consultation groups. Residential staff said young people could use the telephone in an emergency.
We repeat the recommendation.

2.138 Young people's progress on training plan targets should be taken into account as part of the rewards and sanctions assessment process. (6.58)
Achieved. Every week, education and other activities staff prepared a brief report detailing each young person's participation in their training plan activities and scoring effort and behaviour. These reports were entered in each wing file so that wing staff could take the young person's progress on their training plan into account when assessing their rewards and sanctions level. The young person's progress under the rewards and sanctions scheme was also noted in the training plan. This integrated approach reinforced the scheme.

Additional information

2.139 The rewards and sanctions scheme had been reviewed in October 2007. There were four levels: bronze (basic), silver (standard), gold (enhanced) and platinum (enhanced plus). Fourteen per cent of young people were on bronze, 62% on silver, 20% gold and 0.5% on platinum. The remaining 3.5% were on the reorientation unit and dealt with separately.

2.140 The scheme was well understood by staff and young people. In our survey, 61% of young people said the different levels made them change their behaviour. The platinum level was used to encourage young people to work towards excellent behaviour, but only two young people were on this level. The criteria for reaching platinum included that the young person should have had no findings of guilt on adjudication at Ashfield, which automatically excluded some young people regardless of any improvements and progress made. In our survey, 44% of young people, significantly worse than the comparator of 53% and than the 55% in 2006, said they had been treated fairly under the rewards scheme. The findings were significantly worse for black and minority ethnic young people.

Further recommendation

2.141 The criteria for the platinum level of the rewards and sanctions scheme should be reviewed to ensure that all young people are encouraged to aspire to the highest levels of behaviour.

Canteen/shop

2.142 More healthy food items should be available from the shop to compensate for the removal of less healthy options. (7.13)
Achieved. Less healthy options such as large bags of crisps and some fizzy drinks had been removed from the canteen list and replaced by more healthy options. During the inspection, the option of providing a bag of five pieces of fruit was discussed and agreed by young people's representatives at the food and shop consultation meeting, with a recommendation that the price should be the same as for a multi-bag of crisps. In our survey, 38% of young people, significantly better than the comparator of 21% and than the 25% in 2006, said the food was good or very good.

2.143 Suitable products in tins and glass jars should be available from the shop, unless a risk assessment indicates that this is inappropriate. (7.14)
Achieved. Rather than provide products in tins or glass jars, the shop offered products such as tuna, honey, chocolate spread and sauces in foil pouches and plastic bottles or pouches.

2.144 Young people should be formally notified of the outcome of any shop survey and any changes to the product list, including reasons why suggested items are not included or added. (7.15)
Achieved. Survey results and other useful information were printed on the back of menu sheets issued to each young person.

2.145 The deficit from the general purposes fund should be written off with immediate effect, and profits from the telephones and shop reinvested in regime facilities for young people, rather than used to clear previous debts. (7.16)
Achieved. The deficit had been written off at the end of financial year 2006/07. Profits from the shop and telephones were used for facilities for young people, including replacing damaged cordless telephones that young people could use in their cells.

Resettlement strategy and reintegration planning

2.146 Membership of the resettlement policy committee (RPC) should be extended to include representatives from the community, and its agenda should focus on the strategic management of the resettlement policy rather than operational issues. (8.16)
Achieved. The overall strategic management of resettlement was the responsibility of the head of learning and skills (HoLS), who also chaired the quarterly resettlement committee meetings. There were terms of reference for the meeting and membership comprised relevant departmental heads and staff directly involved in resettlement work, such as the release on temporary licence (ROTL) coordinator. Representatives from the Independent Monitoring Board, a community youth offending team and PEOPLE charity (which delivered group work to young people and was a housing provider) were also members. The focus of the meeting was driven by the resettlement action plan, which was based on the findings of a needs analysis undertaken in 2007 (see paragraph 2.148). This provided the strategic framework for the meeting and covered the resettlement pathways relevant to young people. The action plan was monitored at the meeting, but was out of date as some deadlines had passed with no indication of progress made or whether the objective had been achieved.

Further recommendation

2.147 The resettlement action plan should be implemented rigorously.

2.148 There should be a resettlement needs analysis of the population and its results used to inform all new service developments, including a set of targeted offending behaviour programmes. (8.17)
Achieved. A needs analysis had been undertaken in 2007 and had generated a 41% response rate. The results had been published. Issues raised by young people included access to more offending behaviour programmes, increased contact with Connexions, more ROTL work experience opportunities and more help with finding accommodation on release. The findings had been incorporated into the resettlement action plan and the resettlement policy and some of the objectives had been achieved. A money management course had been introduced and funding had been secured for a halfway house for young people needing extra support on release. The information, advice and guidance (IAG) provision had been increased and a resource room established where young people could find information about resettlement issues in their locality. IAG staff now had contact with young people every six weeks as well as on induction and before release. The offending behaviour provision remained largely the same and continued to be delivered by the psychology department. Programmes were well subscribed and young people serving long sentences were prioritised. Eight young people had been convicted of sexual offences and the Lucy Faithfull Foundation provided one day a week individual work with young people referred to them by caseworkers.

Good practice

2.149 *Funding had been secured for a halfway house for young people needing extra support on release.*

2.150 There should be a detailed resettlement policy based on a needs analysis that specifies local targets and how they are to be achieved. (8.18)
Achieved. The resettlement policy outlined how the six resettlement pathways would be delivered and by whom. It had been informed by a needs analysis and the resettlement action plan detailed the objectives set for improving resettlement provision (see paragraph 2.148).

2.151 All young people should have access to a Connexions adviser and be able to speak to someone about getting a job and New Deal in preparation for their release. This should be monitored through the training planning process. (8.19)
Achieved. Only a third of respondents to the resettlement survey (see paragraph 2.148) said they had had contact with a Connexions worker. As a result, a Connexions worker was available daily and saw young people six weeks before their release and anyone referred to them. This advice and support was supplemented by the IAG work. Connexions had its own target of meeting 70% of young people before release. An offender learning journey coordinator (OLJC) had also been introduced who monitored the learning journey of each young person through to their release in the community. The OLJC worked closely with the IAG coordinator and the Connexions worker and met the Connexions worker every month to monitor referrals and overall engagement with young people. These staff addressed young people's resettlement needs and signposted them to services. They also helped young people to think about education, training and employment plans on release and supported them in

trying to achieve them. The HoLS had secured a further Connexions worker to develop employer engagement and improve partnership working with local employers.

2.152 There should be effective links between the social worker responsible for looked-after children and the training planning process to ensure that the reintegration needs of previously looked-after children are met, particularly with regard to accommodation. (8.20)
Not achieved. Funding for the senior social workers previously employed by South Gloucestershire Children's Services and responsible for looked-after children remained insecure and the posts had been vacant since November 2007 (see also paragraph 2.49). Caseworkers now took the lead in consultation with local authorities to address the needs of looked-after young people in their care. An estimated 30% of young people had been in the care system, but their reviews did not take place regularly. Caseworkers were not equipped to manage some of the complex needs and looked-after children were not receiving a comprehensive service. Caseworkers relied on the relevant local authority children's services to address reintegration needs, but the head of young people's services said responses were variable and sometimes inadequate.
We repeat the recommendation.

Further recommendation

2.153 There should be permanent funding for dedicated social work support to augment child protection and ensure that the needs of looked-after children are catered for.

2.154 Dossiers containing all available information should be sent to the Parole Board within the specified timescale. (8.21)
Not achieved. A custody clerk was responsible for coordinating parole dossiers. The clerk issued notices of when these were due and chased up late submissions. Of the nine dossiers requested in 2008 (originally 15, but some young people had been transferred), two, due on 30 June and 26 July, were still being completed and had not yet been sent to the Parole Board. The remaining seven had been sent to the Parole Board between two and three weeks after the due date. Workload pressures and tight deadlines continued to impact on meeting the timescales, but the establishment was aware that late dossiers were not acceptable.
We repeat the recommendation.

Additional information

2.155 Ashfield was developing more links with the community, particularly with education and training providers, with a view to including them as members of the resettlement committee. An education and training fair planned for September 2008 included housing providers, employers, banks and training organisations.

2.156 Managers and staff said there were still issues with youth offending teams securing suitable accommodation before a young person's release. Records showed that 90% of young people had been released to accommodation between May and June 2008, but there was no indication of whether the accommodation was suitable. The resettlement policy clearly placed the responsibility for securing accommodation on release with the home youth offending team.

Training planning and remand management

2.157 ASSET and other background information should be used to inform training planning reviews. (8.37)
Achieved. Caseworkers used all assessments available during training planning reviews and this was reflected in the sentence planning targets set. The case files examined contained realistic targets that were relevant to the assessed risk posed by the young person and to their needs. Assessments from children's services, the psychology department and ASSET, and information gathered from key staff across the establishment, were largely reflected in the contents of the reviews. Casework staff we spoke to had a good understanding of the young people in their charge and were able to discuss their sentence plans.

2.158 Young people should be prepared in advance of training planning reviews so that they can participate effectively. (8.38)
Achieved. Young people were given seven days' notice of training planning meetings. Those we spoke to knew what the meeting was about and who would be attending and said they were able to participate. Young people under school-leaving age had a dedicated caseworker on their unit so communication was good. At the beginning of 2008, Ashfield had piloted a scheme where young people on the resettlement unit had chaired their own meetings. Staff said young people had appreciated having more control of the meeting and had felt able to hold staff accountable when tasks assigned to them had not been completed. The resettlement unit had since closed, but the head of young people's services said this would be explored when a new resettlement unit had been established.

Good practice

2.159 *Ashfield had piloted a scheme where young people on the resettlement unit had chaired their own training planning meetings. Staff said young people had appreciated having more control of the meeting and had felt able to hold staff accountable when tasks assigned to them had not been completed.*

2.160 Training planning reviews should be consistently chaired by skilled staff. (8.39)
Partially achieved. Caseworkers had received ongoing training as part of their appraisal process and managers said they routinely attended planning reviews to ensure the quality of meetings. However, we attended one training planning review meeting that was not adequately chaired by the caseworker. The discussion was relevant, but salient points were lost as the meeting was allowed to drift. Those attending were not introduced at the start and the main outcomes were not summarised at the end.
We repeat the recommendation.

2.161 Training planning targets should take into account previous assessments and address individual need. (8.40)
Achieved. See paragraph 2.157.

2.162 Key staff should always attend training planning reviews and family members should be actively supported to attend. (8.41)
Partially achieved. Attendance by key staff, external youth offending teams (YOTs) and family members was monitored and the information fed back to the head of young people's services. In July 2008, 162 planning meetings had been convened and a representative from the education department attended 60%, personal officers 76% and family members only 6%.

Departments such as psychology provided update reports. There were no figures for YOT attendance in July, but YOT workers had attended 82% of the 83 meetings in August. Ashfield placed the onus on home YOTs to support families to attend the meetings. However, less than 15% of young people lived within 50 miles of the prison and over a quarter lived over 100 miles away. As many young people were from in and around London, Ashfield had provided a free fortnightly bus service from Paddington station, but, despite subsequently imposing a nominal charge for the service, the costs had become too great and the service had been withdrawn.
We repeat the recommendation.

2.163 A representative from the establishment should attend first reviews in the community whenever possible and appropriate. (8.42)
Achieved. On average, caseworkers were attending between eight and 10 community reviews each month and these were largely prioritised according to risk. Attendance was monitored and the reviews were not restricted by location.

2.164 There should be better integration of the work of the in-house YOT with that of the casework team. (8.43)
Not achieved. As in 2006, there was no formal handover of cases that had been managed by the YOT and transferred to the casework team once sentenced. We saw an example of one young person who had been well known to the YOT while on remand. When he had subsequently received a long sentence, there had been no liaison between the YOT and the casework team and his initial planning meeting had taken place with no input from the YOT, even though the caseworker had only recently met the young person. This was described as standard procedure, although the YOT team manager said staff would attend initial planning meetings if there were risk issues. We did not see any examples of this.
We repeat the recommendation.

2.165 There should be more lifer-trained staff and there should be adequate administrative support to complete lifer work. (8.44)
Not achieved. Two Section 91 caseworkers managed young people sentenced to indeterminate sentences, including those sentenced to detention for public protection (DPP). Only one had received lifer training and the other was on a waiting list for the course. They had no administrative support and there was no longer a lifer manager.
We repeat the recommendation.

2.166 Young people who face a life sentence should be identified on remand, given support and have the elements and implications of a life sentence explained to them and, where appropriate, their families. (8.45)
Not achieved. Young people who potentially faced long sentences were not targeted for support and there was no liaison with the casework team that would ultimately be responsible for them.
We repeat the recommendation.

2.167 Young people sentenced to life should have access to formal systems to support them while they wait to be transferred. (8.46)
Partially achieved. There were no formal systems to support young people waiting to be transferred or procedure for ensuring that their time at Ashfield was not reduced to waiting for a transfer to a more appropriate establishment. However, all young people sentenced to indeterminate sentences were prioritised for offending behaviour programmes and had access to the full range of resources available, including education. Although the offending behaviour groups were not accredited, if part of their sentence planning targets, the work could commence at Ashfield.
We repeat the recommendation.

Additional information

2.168 The casework team comprised 10 staff, two of whom were Section 91 caseworkers. Each caseworker had about 25 cases and between eight and 12 training planning meetings were convened each day. The head of young people's services said this had decreased since 2006, allowing staff to improve the quality of their work. A coordinator managed the organisation of all the meetings and each young person's review dates were set at the beginning of their sentence. The case files we looked at were well ordered and allowed easy navigation to relevant information. Assessments prepared by the outside YOT were available and training plans were easy to understand and relevant to the young person.

2.169 YOT workers continued to manage bail and remand services. The team comprised two youth justice support workers and two YOT social workers. The YOT senior practitioner attended key meetings so was able to brief staff of service developments in the prison. YOT team members were allocated prison meetings that they were required to attend and kept the rest of the team briefed. The team had approximately 30 cases each and prepared parole and home detention curfew reports that required liaison with the casework department. Remand reviews were mainly conducted without contributions from other departments, although they were invited if necessary. Young people on remand had access to the same education provision as those who were sentenced apart from some of the long-term courses, and YOT staff liaised with home YOTs over any resettlement issues.

2.170 The number of young people serving long sentences had increased and the two Section 91 caseworkers now held 45 cases each. They could not adequately manage this many and some work was therefore delayed or not completed. Staff said the multi-agency risk assessment plans were not completed due to the lack of time to prioritise them. Planning meetings were prioritised and staff said these took place within national standards guidance. There were nine young people serving indeterminate sentences, including eight serving a DPP sentence. In addition, 58 young people were serving long sentences (over two years) and 24 were serving extended sentences. Managers were clearly aware that further resources were required for this area of work and we were told that another Section 91 caseworker was going to be recruited.

Substance use

2.171 Healthcare and the young persons substance misuse service (YPSMS) should formalise joint working arrangements to include joint care planning and care coordination. (8.70)
Achieved. There was evidence of good joint working between healthcare and the YPSMS and a clinical management and detoxification policy had been compiled by the two services. Both were represented at regular meetings, including the substance misuse strategy and the mental health referral meetings.

2.172 A healthcare admissions policy for young people undergoing detoxification should form part of the clinical management policy. (8.71)
Achieved. A comprehensive detoxification and clinical management policy (April 2008) formed the basis for the overall management of young people with a drug or alcohol dependence. This included policies and procedures for screening young people during their first night in prison.

2.173 Prescribing regimes should be flexible and based on individual need, and a clear care pathway should be developed for young people dependent on opiates. (8.72)

Achieved. The detoxification and clinical management policy contained clear protocols on the pharmacological management of young people.

Additional information

2.174 Young people disclosing substance use in the community underwent a comprehensive physical assessment. Those involved with community drug teams and on prescription drugs were contacted by the team and the relevant community pharmacist as soon as possible to establish treatment programmes and prescribing regimes.

2.175 Prescribing was evidence based and followed a full multidisciplinary assessment of individual young people. Detoxification prescribing regimes for alcohol, benzodiazepine and opiate withdrawals were flexible and individually based. There were also policies for the dose reduction or maintenance of methadone.

Public protection

2.176 Initial checks on public protection cases should be carried out immediately on new arrivals. This should include examination of all relevant previous convictions. (8.84)
Achieved. Public protection arrangements had improved and comprehensive checks were undertaken by staff on new arrivals. The police liaison officer had access to the police national computer and all information was gathered to inform cell-sharing risk assessments and to confirm or identify public protection arrangements.

2.177 The public protection committee should not deal with young foreign nationals unless they are subject to public protection measures. (8.85)
Achieved. Foreign national young people were not discussed as part of the overall public protection committee meeting. Attendance at the meetings was good and in-depth discussions focused on complex cases.

Section 3: Summary of recommendations

The following is a list of both repeated and further recommendations included in this report. The reference numbers in brackets refer to the paragraph location in the main report.

Main recommendation — to the Youth Justice Board & NOMS

3.1 The external arrangements for commissioning and monitoring services at Ashfield should be clarified and formalised. (2.3)

Main recommendations — to the Director

3.2 There should be a comprehensive behaviour management policy incorporating therapeutic crisis intervention, behaviour modification programmes and the use of properly managed 'time out' facilities on residential units. (2.4)

3.3 The quality of vulnerability assessments should be improved and a quality assurance system should be built into the process. (2.6)

Recommendation — to the Youth Justice Board

Resettlement strategy and reintegration planning

3.4 Support packages such as the RAP (resettlement and aftercare provision) should be consistently available to all young people who need them. (2.21)

3.5 There should be permanent funding for dedicated social work support to augment child protection and ensure that the needs of looked-after children are catered for. (2.153)

Recommendation — to NOMS

Race equality

3.6 As the responsible public authority under the Race Relations (Amendment) Act 2000, NOMS should provide clear guidance, support and monitoring on the promotion of race equality within Ashfield. (2.7)

Recommendations — to the Youth Justice Board & NOMS

Courts, escorts and transfers

3.7 Young people should be collected from the courts and taken to Ashfield soon after their hearing has been discharged. (2.9)

3.8 Young people should be delivered to Ashfield from court by 7pm at the latest. (2.10)

3.9 Young men should not travel in the same vehicles as adult men or women. (2.12)

3.10 Young people should be offered a comfort break at least every two hours. (2.14)

Health services

3.11 Juvenile units transferring young people to another establishment should provide all supporting clinical documentation, including clinical records and medication charts, at the time of transfer. (2.90)

Training planning and remand management

3.12 Young people sentenced to life should be transferred to first-stage prisons as soon as possible. (2.16)

3.13 The YJB and NOMS should develop a comprehensive strategy for young people held under section 92 of the Powers of the Criminal Courts (Sentencing) Act 2000 and those serving indeterminate sentences to cover their placement and overall management during sentence, including movement into the adult estate. (2.18)

Substance use

3.14 The adult-oriented practices and procedures of mandatory drug testing (MDT) should cease. (2.19)

Recommendations — To the Director

First days in custody

3.15 All newly arrived young people should be routinely offered a shower in reception or on their first night unit. (2.22)

3.16 Rooms for new arrivals should be properly cleaned and prepared in advance and checked by a member of staff before a young person is allocated to them. (2.25)

3.17 Induction feedback data should be stored centrally, analysed regularly and the results used to review the programme delivery and content. (2.28)

Residential units

3.18 Residential units should hold no more than 40 young people. (2.30)

Personal officers

3.19 Personal officers should regularly visit young people located in the reorientation (segregation) unit. (2.38)

Self-harm and suicide

3.20 All issues identified in initial assessment, care in custody and teamwork (ACCT) assessments should be dealt with, required action followed through and accurate records kept. (2.43)

3.21 ACCT reviews should be inclusive and involve staff who know the young person's circumstances. They should always include social workers and youth offending team (YOT) workers. (2.44)

3.22 The attendance of families at ACCT reviews should be encouraged, unless this is not in the young person's interest. (2.45)

Child protection

3.23 The child protection policy should be published as soon as possible and the contents disseminated to staff. (2.46)

3.24 The child protection log should be monitored regularly by a senior manager in the local authority social services department. (2.48)

Race equality

3.25 Ethnic monitoring data should be checked for accuracy, analysed using range setting, discussed by the diversity management team and acted upon whenever appropriate. (2.53)

3.26 Racist incident report forms should be freely available on the units. (2.54)

3.27 Specialist black and minority ethnic groups already involved with the establishment should be encouraged and supported to attend the diversity management team meetings. (2.59)

3.28 Work should be undertaken with young people from black and minority ethnic backgrounds, using the expertise of young people who act as race relations representatives, to ascertain the reasons for negative perceptions of their treatment, particularly by staff. (2.62)

Foreign national young people

3.29 The foreign national policy should reflect the specific circumstances and needs of young people, and the diversity management committee should actively oversee its development and implementation. (2.64)

3.30 Links with a specialist independent immigration advice agency should be developed. (2.65)

Applications and complaints

3.31 Managers should engage with young people in focus groups or consultation groups to ascertain why confidence in the complaints system is low. This arrangement should be supported by regular surveys. (2.72)

Health services

3.32 Serco Health should analyse the reasons for admission to the in-patient unit with a view to reducing the number of in-patient beds. (2.73)

3.33 Additional funding should be sought to enhance and expand the existing day care facilities. (2.74)

3.34 Stock medicines should be properly labelled by the pharmacy with the facility for the nurse to write the patient's name on the label. (2.77)

3.35 All medicines supplied by the pharmacy should be appropriately labelled. (2.79)

3.36 All pre-packs should be dual-labelled when the pre-pack is dispensed against a prescription; one label should be removed and attached to the prescription form. (2.80)

3.37 There should be a written record of date checks of pharmacy stock. (2.85)

3.38 The healthcare manager should seek the assistance of the senior pharmacist at HMP Bristol and the primary care trust in setting up the new pharmacy system to ensure that future clinical practices meet the criteria for prison pharmacies as laid down by the Royal Pharmaceutical Society. (2.86)

Education provision

3.39 Provision for young people who speak languages other than English should be increased. (2.92)

3.40 Better use should be made of individual learning plans in the application of targets and the way work is monitored. (2.94)

3.41 Education staff should be present at all training planning meetings. (2.97)

3.42 There should be sufficient space for activities in the vocational areas. (2.98)

Physical education and health promotion

3.43 The use of recreational physical education should be monitored to ensure equitable use by different groups of young people. (2.105)

Time out of cell

3.44 Equipment for outdoor activities should be provided in the exercise yards. (2.110)

Security and rules

3.45 Routine strip searching of juveniles should cease. (2.111)

3.46 Strip searching should take place only following a comprehensive risk assessment and on the authorisation of a governor when a risk of harm to the young person or others has been identified. (2.112)

Discipline

3.47 Young people should never be held in the special cell overnight. (2.118)

3.48 The use of the special cell should be authorised in advance by the duty governor and there should be continued authorisation every 30 minutes. (2.119)

3.49 All cells and communal areas in the reorientation unit should be clean and well maintained. (2.123)

3.50 Carpet should be removed from the communal areas and cells in the reorientation unit and the floors re-laid with a suitable surface. (2.124)

3.51 The special cell should not be used until it has been completely refurbished. (2.125)

3.52 Seating should be provided in the reorientation unit exercise yard. (2.126)

3.53 Young people on the reorientation unit should be allowed to exercise in association subject to an appropriate risk assessment. (2.127)

3.54 A duty manager should check and sign all use of force paperwork. (2.132)

3.55 The role and function of the reorientation unit should be clarified and a clear policy and unit procedures should be published. (2.133)

3.56 All staff working on the reorientation unit should be selected for their suitability for the role and have mental health awareness training. (2.134)

3.57 Young people on the reorientation unit should be able to attend education, the gym and religious services subject to a risk assessment. (2.135)

Rewards and sanctions

3.58 Young people on the basic level should have daily access to the telephone. (2.137)

3.59 The criteria for the platinum level of the rewards and sanctions scheme should be reviewed to ensure that all young people are encouraged to aspire to the highest levels of behaviour. (2.141)

Resettlement strategy and reintegration planning

3.60 The resettlement action plan should be implemented rigorously. (2.147)

3.61 There should be effective links between the social worker responsible for looked-after children and the training planning process to ensure that the reintegration needs of previously looked-after children are met, particularly with regard to accommodation. (2.152)

3.62 Dossiers containing all available information should be sent to the Parole Board within the specified timescale. (2.154)

Training planning and remand management

3.63 Training planning reviews should be consistently chaired by skilled staff. (2.160)

3.64 Key staff should always attend training planning reviews and family members should be actively supported to attend. (2.162)

3.65 There should be better integration of the work of the in-house youth offending team with that of the casework team. (2.164)

3.66 There should be more lifer-trained staff and there should be adequate administrative support to complete lifer work. (2.165)

3.67 Young people who face a life sentence should be identified on remand, given support and have the elements and implications of a life sentence explained to them and, where appropriate, their families. (2.166)

3.68 Young people sentenced to life should have access to formal systems to support them while they wait to be transferred. (2.167)

Good practice

Resettlement strategy and reintegration planning

3.69 Funding had been secured for a halfway house for young people needing extra support on release. (2.149)

Training planning and remand management

3.70 Ashfield had piloted a scheme where young people on the resettlement unit had chaired their own training planning meetings. Staff said young people had appreciated having more control of the meeting and had felt able to hold staff accountable when tasks assigned to them had not been completed. (2.159)

Appendix I - Inspection team

Ian Macfadyen	Inspector
Angela Johnson	Inspector
Lucy Young	Inspector
Vinnett Pearcy	Inspector
Bridget McEvilly	Healthcare inspector
Martyn Rhowbotham	Ofsted

Appendix II - Prison population profile

Population breakdown by:

(i) Status	Number of juveniles	%
Sentenced	302	78
Convicted but unsentenced	27	7
Remand	57	14.7
Detainees (single power status)	1	0.3
Detainees (dual power status)	0	0
Total	387	100

(ii) Number of DTOs by age & sentence (full sentence length inc. the time in the community)

Sentence	4 mths	6 mths	8 mths	10 mths	12 mths	18 mths	24 mths	Total
Age								
15 years	7	5	2	3	6	2	1	26
16 years	14	10	4	1	19	9	7	64
17 years	21	9	16	3	27	12	14	102
18 years	0	4	1	1	3	5	5	19
Total	42	28	23	8	55	28	27	211

(iii) Number of SECTION 53 (2)//91s (determinate sentences only) by age & sentence

Sentence	Under 2 yrs	2-3 yrs	3-4 yrs	4-5 yrs	5 yrs +	Total
Age						
15 years	0	3	1	0	3	7
16 years	0	5	9	2	2	18
17 years	1	4	12	7	3	27
18 years	0	1	2	2	1	6
Total	1	13	24	11	9	58

(iv)Number of EXTENDED SENTENCES UNDER SECTION 228 (extended sentence for public protection)

Sentence	Under 2 yrs	2-3 yrs	3-4 yrs	4-5 yrs	5 yrs +	Total
Age						
15 years	0	0	0	0	0	0

16 years	1	3	3	0	2	9
17 years	0	3	5	2	2	12
18 years	1	0	1	1	0	3
Total	2	6	9	3	4	24

(v) Number OF INDETERMINATE SENTENCES by age

Sentence	Section 90 (HMP)	Life sentence under section 91	Section 53 (1)	Section 226 (DPP)	Total
Age					
15 years	0	0	0	0	0
16 years	0	0	0	2	2
17 years	0	0	0	3	3
18 years	1	0	0	3	4
Total	1	0	0	8	9

(vi) LENGTH OF STAY for UNSENTENCED by age

Length of stay	<1 mth	1-3 mths	3-6 mths	6-12 mths	1-2 yrs	2 yrs +	Total
Age							
15 years	7	2	0	0	0	0	9
16 years	12	9	2	2	0	0	25
17 years	25	11	8	1	0	0	45
18 years	2	0	3	0	0	0	5
Total	46	22	13	3	0	0	84

(vii) Main offence	Number of juveniles	%
Violence against the person	94	24.3
Sexual offences	11	2.8
Burglary	55	14.2
Robbery	99	25.6
Theft & handling	19	4.9
Fraud and forgery	0	0
Drugs offences	21	5.4
Driving offences	18	4.7

Other offences	56	14.5
Breach of community part of DTO	4	1
Civil offences	10	2.6
Offence not recorded/ Holding warrant	0	0
Total	387	100

(viii) Age	Number of juveniles	%
15 years	42	10.9
16 years	118	30.5
17 years	189	48.8
18 years	38	9.8
Total	387	100

(ix) Home address	Number of juveniles	%
Within 50 miles of the prison	56	14.5
Between 50 and 100 miles of the prison	125	32.3
Over 100 miles from the prison	101	26.1
Overseas	0	0
NFA	105	27.1
Total	387	100

(x) Nationality	Number of juveniles	%
British	358	92.5
Foreign nationals	29	7.5
Total	387	100

(xi) Ethnicity	Number of juveniles	%
White		
British	253	65.4
Irish	5	1.3
Other White	17	4.4
Mixed		

White and Black Caribbean	22	5.7
White and Black African	2	0.5
White and Asian	1	0.2
Other Mixed	8	2.1
Asian or Asian British		
Indian	3	0.8
Pakistani	6	1.5
Bangladeshi	0	0
Other Asian	8	2.1
Black or Black British		
Caribbean	28	7.2
African	16	4.1
Other Black	18	4.7
Chinese or other ethnic group		
Chinese	0	0
Other ethnic group	0	0
Total	387	100

(xii) Religion	Number of juveniles	%
Baptist	0	0
Church of England	89	23
Roman Catholic	35	9
Other Christian denominations	0	0
Muslim	42	10.9
Sikh	1	0.3
Hindu	0	0
Buddhist	1	0.3
Jewish	0	0
Other	6	1.5
No religion	213	55
Total	387	100