Report on an announced inspection of

HMYOI New Hall:

The Rivendell Unit

30 July – 3 August 2007

by HM Chief Inspector of Prisons

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Introduction

The Rivendell Unit is a dedicated 26-bed facility for 17 or 18 year-old young women situated in the grounds of HMP New Hall, near Wakefield. Funded by the Youth Justice Board, the unit opened in December 2005. This was its first full inspection. As with the other four[1] units of its kind, all of which we have inspected recently, we found that Rivendell, although larger and a more awkward design than the others, was an essentially safe and respectful place, with impressive purposeful activity and excellent resettlement arrangements.

After some inevitable teething problems when it first opened, Rivendell was now reasonably safe and well ordered. First night arrangements and induction were caring and thoughtful, marred only by the unnecessary routine strip-searching. Incidents of self-harm were depressingly high, but were managed with care. Good clinical detoxification arrangements were provided in the main prison, although this sometimes allowed the young women to mix unsupervised with adults. Safeguarding and child protection arrangements remained underdeveloped.

Security was tight, perhaps unnecessarily so now that the unit was well controlled and there was little bullying. Although use of force appeared high, this was reducing and de-escalation techniques were well deployed. There was also little use of separation. It was, therefore, time to review approaches to behaviour management in general, including risk assessing whether the restrictions on movement between the spurs were still proportionate and whether more child-friendly and mediation-based alternatives could now be introduced to replace the excessive reliance on adjudications.

Relationships between staff and young women were mutually respectful, supported by an effective personal officer scheme. The unit was clean and tidy, if a little austere. Race issues were well managed, but diversity needed to be better promoted and arrangements for foreign nationals to be improved. Services, such as catering and the shop, were sound, and access to religious services was good. While mental health services were sound, primary healthcare was impoverished.

Young women spent plenty of time out of their cells and were able to engage in a wide range of good quality purposeful activity, with particularly good education and vocational training. However, access to physical education and evening activities was limited, as was the quality of outdoor facilities.

Resettlement was also an area of strength, informed by a comprehensive needs analysis and supported by good management arrangements. A wide range of interventions and reintegration services was available, including effective provision to address substance misuse and good access to release on temporary licence. Public protection was well managed. However, there was scope to develop better and more integrated care planning, and to support further family contact.

It is depressing that we incarcerate significant numbers of young women but, faced with this reality, Rivendell unit, along with the other units of the same type, is to be commended for its safe, decent and purposeful environment. Staff on the unit demonstrated considerable care

[1] Sir Evelyn House situated in the grounds of HMP Cookham Wood has now been re-roled as a boys' unit due to population pressures in the male estate.

and support for the often damaged and challenging young women in their care, and made commendable efforts to address the risks and needs they presented.

Anne Owers October 2007
HM Chief Inspector of Prisons

Fact page

Task of the establishment
Rivendell is a unit for young women aged 17 and 18 years. It is situated within the grounds of HMP New Hall, which is a closed female establishment.

Area organisation
Yorkshire & Humberside

Number held
26

Certified normal accommodation
26

Operational capacity
26

Last inspection
Not applicable

Brief history
Rivendell is funded by the Youth Justice Board and has been operational since December 2005.

Description of residential units
Rivendell is a newly-built unit with three spurs holding eight or nine young women. Upstairs, each spur has its own association area where the young women also have their meals. All rooms have en suite shower facilities. Downstairs are offices, meeting rooms, education classrooms, a nurse's room and the reception area.

Healthy prison summary

Introduction

HP1 All inspection reports carry a summary of the conditions and treatment of prisoners, based on the four tests of a healthy prison that were first introduced in this inspectorate's thematic review *Suicide is everyone's concern*, published in 1999. The criteria 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.

Safety

HP3 Young women were treated well by escort staff, but some inappropriately shared transport with adults and too many arrived late. The otherwise caring experience of reception was marred by routine strip-searching. First night care was good and induction was thorough. Monitoring of safeguarding arrangements and the

management of child protection were weak. Bullying was rare, but self-harm levels were high. Those who self-harmed were well cared for, but care planning and multidisciplinary work were not generally well coordinated. The use of force appeared high, although staff used de-escalation well and there was little use of separation. Security was tight, adjudications were over-used and disciplinary procedures were overly-formal. Young women requiring detoxification received good clinical care, but were not always supervised when mixing with adult prisoners. The unit was performing reasonably well against this healthy prison test.

HP4 Most young women reported good experiences of escort arrangements but some who had shared transport with adult prisoners or young men had suffered harassment. Too many young women arrived too late for the full reception procedures to be carried out. Video conferencing was not used to keep the number of court appearances to a minimum.

HP5 The reception area was pleasant, but lacked written information. Female staff were not always available to deal with new arrivals in reception or through the night. The care with which staff treated new arrivals was undermined by the policy of routine strip-searching. Staff made good use of available background information to inform initial assessments. Nicotine patches were offered to smokers, but late arrivals had to wait until the next day.

HP6 New arrivals were screened and urine-tested. Young women requiring detoxification were immediately transferred to the substance misuse unit (SMU) in the main prison. In the previous six months, 10 young women had required treatment or observation in the SMU. Efforts were made to supervise young women when they mixed with adult prisoners but staff admitted that this was not always possible. Not all staff on the SMU had received child protection training and the regime was very limited.

HP7 Night staff were well informed about new arrivals, and first night monitoring was good. In our survey, 95% of young women said they had felt safe on their first night. Induction was efficient and informative, although there were weaknesses in the written information, which was available only in English.

HP8 The safeguarding committee had been in abeyance for over a year and the re-established meetings were hampered by poor attendance. A good range of data on all aspects of safeguarding, apart from child protection, was available and monitored by the prison-wide safer custody team but data specific to the Rivendell unit was not separately analysed to inform the unit's overall safeguarding strategy.

HP9 Levels of self-harm were high. However, given the lack of analysis, it was not possible to identify the nature of the problem or any patterns or trends. The prison-wide policy on self-harm and suicide prevention did not address the specific issues concerning young women. There were some weaknesses in completion of assessment, care in custody and teamwork documents, but young women who self-harmed had access to a good range of specialist support and their care was reviewed by a multidisciplinary group.

HP10 Bullying was rare and the majority of young women felt safe. Young women who bullied others or displayed particularly aggressive behaviour were targeted for individual interventions. A number of multidisciplinary forums considered various aspects of individual young women's care, including those who bullied others or self-

harmed, but they were not coordinated and young women did not have individual care plans.

HP11 Child protection work was poorly managed. There was no separate child protection committee and the lack of proper safeguarding arrangements meant there had been no external scrutiny of child protection for eight months. Some officers cross-deployed from the main prison did not have child protection training. Referrals were not analysed and, as with other areas of safeguarding, the failure to identify patterns and trends was hindering future planning.

HP12 Physical security was good and supported by effective staff supervision. Some security measures, including routine strip-searching and restrictions and high levels of control on movement between spurs, were excessive and not based on a risk assessment of the population. An intensive supervision room, which was in effect a special cell, was no longer used. Security information reports generated by the unit were not separately analysed and there was little coverage of security issues relating to the unit at the monthly security meetings in the main prison. The rules were clear and applied consistently.

HP13 The system for disciplining young women was overly-formal and more suited to adults. Adjudications were used too often and many issues could have been dealt with under the rewards and sanctions scheme. There was no use of mediation or restorative justice. Use of force appeared high, but was reducing. However, use of force on the unit was not separately monitored or analysed in any depth. The documentation was not always completed properly. Separation as part of good order or discipline was rarely used and the few young women subject to it still received a good level of staff attention, but were not given clear behavioural targets.

HP14 Mandatory drug testing (MDT) was conducted in the main prison and officers from the unit usually but not always accompanied young women. MDT officers had not received child protection training. All tests had been negative.

Respect

HP15 All young women said most staff treated them with respect. Relationships between staff and young women were good and young women found their personal officers helpful. The living areas were a little austere. All aspects of catering were good. Race relations were generally sound, but diversity was little promoted. The needs of foreign national young women were not always met and guidance for staff was lacking. Young women could attend the main religious services, but chaplains were not resourced to carry out a full pastoral role on the unit. Primary healthcare was poor, but mental health provision was good. Most applications were dealt with informally, but formal applications needed to be improved. The rewards and sanctions scheme was well managed, but not sufficiently motivational. The unit was performing reasonably well against this healthy prison test.

HP16 All young women had their own cell with a shower and wash basin. The unit was mostly clean and tidy, if a little austere compounded by restrictions on movement between spurs. Relationships between staff and young women were good and 100% of young women in our survey said staff treated them with respect. Young women

found their personal officers helpful and the personal officer scheme was well managed.

HP17 There had been few racist incident complaints and they had been investigated thoroughly. Ethnic monitoring information was not unit-specific and was not used to identify issues of concern relative to the unit. Diversity was little promoted. Few foreign national young women were held on the unit, but the lack of clear guidance to staff meant that issues were not always identified and addressed.

HP18 The majority of young women said access to religious services was good. All services took place in the main prison and young women closely supervised. There were some evening activities they could not attend due to lack of unit staff to supervise them. The liaison chaplain for the unit saw all new arrivals but did not have adequate facility time to carry out a full pastoral role on the unit.

HP19 Most issues raised by young women were dealt with informally so few applications and complaints were made. Outstanding applications were not automatically followed up. Replies were prompt, but responses to complaints were generally poor. Administrative arrangements for formal applications and complaints did not ensure confidentiality. Advocates visited regularly but their role was not understood by all staff. There were unit meetings to discuss issues of concern, but it was not clear how issues raised were followed up or that the meetings were effectively bringing about change. Young women with legal queries and issues were well supported.

HP20 The rewards and sanctions scheme ensured a good level of staff input and allowed young women to be involved in review meetings. The privileges associated with each level were not sufficiently motivational to encourage young women to behave well.

HP21 Young women always dined together, apart from occasionally at breakfast when there were insufficient staff both to supervise breakfast and prepare young women for court. The food was good and young women had enough choice, including healthy options. The shop offered a wide range of goods, and approved items could be ordered from catalogues. Depending on their day of arrival, young women could wait up to nine days to receive their first shop order.

HP22 There had been no recent health needs assessment and primary care services were poor. There was no longer a dedicated full-time nurse on the unit during the core day but the mental health nurse was based there permanently and made a very good contribution. Young women did not always have a secondary health screen and those who did not attend for daily medication were not always followed up. Record-keeping was poor. Young women were not offered any immunisations or vaccinations apart from hepatitis B and meningitis C. Health promotion was inadequate and there were no unit-based nurse-led clinics. Young women were not identified separately on waiting lists or life-long condition registers and in some cases were not identified at all. By contrast, mental health services were good. There was good access to a mental health practitioner located on the unit and appropriate referrals were made to other mental health specialists.

Purposeful activity

HP23 Young women enjoyed a good amount of time out of their cells and were purposefully occupied during the day. Education and vocational training provision was of good quality, the curriculum was well balanced and young women made good progress and most achieved some accreditations. Access to physical education was inadequate, although an excellent course was being delivered within the constraints of the unit. Association was never cancelled but evening activities were limited. Young women were able to spend time in the fresh air each day, but the outdoor areas were unattractive and poorly equipped. The unit was performing well against this healthy prison test.

HP24 Most young women began education classes within a few days of arrival. Information, advice and guidance were very good. All young women were given an initial assessment and those requiring additional learning support were identified. Attendance at education was good and few young women refused to take part. Behaviour in lessons was good and teaching and learning were satisfactory or better overall. The curriculum achieved a good balance between vocational training, basic skills and personal and social skills development and the standard of work produced was generally good. There was an appropriate emphasis on achievement and young women made good progress in literacy and numeracy, which were well integrated with vocational training courses. Achievement in vocational training courses was also good and most young women achieved some accreditations. The needs of more able young women, particularly those wishing to study at GCSE level, were not so well provided for.

HP25 All activities were well coordinated, management information was well analysed, plans were detailed and realistic, and quality assurance procedures were good. Transition planning was good and teaching staff attended training planning meetings and made a good contribution. There were good links with local colleges and Jobcentre Plus and good communication with youth offending teams, but no careers guidance or input from the Connexions service. The library was based in the main prison. It was a good resource, but young women had poor access to it.

HP26 Physical education (PE) provision was inadequate, with young women having only three hours of compulsory PE a week, no formal outdoor activities and no access to the gym in the main prison. However, the fitness programme on the unit was of high quality, and a locally-devised personal achievement award motivated young women to progress.

HP27 Young women spent plenty of time out of their cells. However, they sometimes had to stay locked up for periods after lunch and education when staffing levels were too low for adequate supervision. Young women on the basic level of the rewards and sanctions scheme had less time unlocked and fared particularly badly at weekends. There was insufficient activity in the evenings and at the weekends and young women complained of boredom. Everyone had regularly scheduled time outdoors and association was never cancelled. The outdoor areas were unattractive and poorly equipped and did not encourage young women to use them.

Resettlement

HP28 Resettlement and reintegration planning were very well managed. A comprehensive needs analysis had been carried out. All young women had access to specialist staff to address their assessed welfare needs and could take part in offending behaviour work if appropriate. Young women with substance use problems were well provided for. Release on temporary licence was well used to help young women prepare for release. Public protection arrangements were very good. Not enough was done to promote family contact. The unit was performing well against this healthy prison test.

HP29 There was no unit-specific resettlement committee, but relevant issues were covered at a monthly unit management meeting. The needs of the young women had been analysed in an innovative approach using aggregated data from ASSET[2] documentation, and the services provided were tailored to meet identified need. Young women were seen regularly by the unit youth offending team (YOT) staff to address their welfare needs and offending behaviour, and those deemed suitable were selected for a locally-developed offending behaviour group work programme. In our survey, only 21% of young women, significantly better than the comparator of 63%, said there were still issues they would like help with before release.

HP30 Members of the newly-formed casework team worked closely with YOT staff and were responsible for the training plan process. They always spent time helping young women to prepare for training planning meetings. All young women whether sentenced or on remand were subject to the same efficient planning process. Reviews were well conducted and well attended and appropriate targets that focused on the needs of the individual were set, particularly for education and training.

HP31 Good use of release on temporary licence helped young women prepare for release, while a joint protocol with the main prison ensured that those remaining in prison beyond the age of 18 received an agreed level of service from the unit YOT so that the training planning process could continue until their release. Most young women were granted early release because they had achieved their targets. We saw one young woman released without accommodation despite efforts by unit staff working with the community YOT. A representative from the unit always attended the first review in the community.

HP32 Information-sharing between different agencies working on the unit was good and enhanced by the introduction of an integrated filing system where all staff kept records in a shared file. There was a strong commitment towards achieving successful multi-agency partnership working. The daily unit briefing also ensured that staff were kept informed.

HP33 Public protection was well managed through a weekly public protection committee meeting. Internal and external information-sharing ensured that each case was properly monitored and reviewed.

HP34 Systems for mail were good and young women had easy access to the telephones. Visits were available every day, but took place in the main prison where young women were subjected to the same procedures as adult prisoners, which was

[2]Youth Justice Board assessment documentation completed by youth offending teams

inappropriate. There were good systems to ensure that young women did not have contact with those who may have posed a risk to them and that child visitors were protected. Only young women on the enhanced level of the rewards and sanctions scheme received entitlement to visits in line with our expectations. Not enough was done to encourage family contact.

HP35 New arrivals were assessed by the young people's substance misuse service (YPSMS) within five days, but this time span was too long for some. The YPSMS was well integrated in the unit and had recently introduced substance misuse intervention team (SMIT) meetings combined with safeguarding to discuss individual care plans. Young women could access a range of age-appropriate interventions. The YPSMS had established good links with YOT workers and community providers, and joint work was evident in care plans and training planning meetings. Preparation for release included information on overdose prevention and a release pack. Joint work with the clinical substance misuse service and the YPSMS was insufficiently developed.

Main recommendations

HP36 Young women should not share transport with adults or young men.

HP37 Young women should be strip-searched only on the basis of a thorough risk assessment that indicates this is necessary to protect them or others from harm.

HP38 There should be a full-time dedicated primary care nurse for the young women. He or she should be readily available to young women during the core day and attend detention and training order and other care planning meetings as appropriate.

HP39 An integrated care planning system should be introduced.

HP40 All security measures within the unit should be risk assessed to ensure that they are proportionate.

HP41 There should be a comprehensive behaviour management policy.

Section 1: Arrival in custody

Courts, escorts and transfers

Expected outcomes:
Children and young people travel in safe, decent conditions to and from court and between different establishments. During movement the individual needs of young people are recognised and given proper attention.

1.1 The majority of young women said they had been treated well by escort staff and had felt safe. However, some had shared transport with adult prisoners or young men and some arrived as late as 9pm, having spent too long in court cells or escort vehicles. These problems were not being addressed through the safeguarding committee. Video conferencing was not used despite its availability on the main site.

1.2 In our survey, 90% of young women, similar to the comparator[3], said they had been treated well or very well by escort staff and 94%, significantly better than the comparator of 57%, said they had felt safe travelling to or from court. Despite these positive results, some young women had shared transport with adult prisoners or young men. Staff had recently started to record these cases, two of which had occurred in the previous month. Two allegations of sexual harassment by male prisoners towards young women had been made in the previous year. The more serious of the two had been investigated but the other, more recent, incident had not.

1.3 Late arrivals were a problem, with seven young people arriving late in the previous month alone. Most of these young women had been admitted at around 9pm, which meant they had spent an unnecessarily long time in court cells or prison vans. Each late arrival was reported to the Youth Justice Board. Staff working in reception described a marked difference in the performance of escort providers, with that of the contractor dealing with secure training centres consistently good and that of the contractor dealing with the courts not good. Video conferencing, which might have reduced the level of late arrivals, was not used even though the facilities were available on the main site.

1.4 Problems with late arrivals and shared transport had not been raised at safeguarding committee meetings for some considerable time (see safeguarding section). There was no log in reception where young women's comments about their journeys to and from the unit could be recorded.

1.5 Young people could wear their own clothes to court and anyone known to be pregnant was always transported in a people carrier.

Recommendations

1.6 Incidents when young women have shared transport with adult prisoners or young men or arrived late should be routinely discussed at the safeguarding strategy meetings and properly investigated.

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

1.7 A log where young women can record comments about their treatment travelling to and from court should be held in reception.

1.8 Video conferencing facilities should be used whenever possible and appropriate to keep court appearances to a minimum.

First days in custody

Expected outcomes:
Children and young people feel safe on their reception into the establishment and for the first few days. Their individual needs, both during and after custody, are identified and plans developed to provide help. During induction into the establishment young people are made aware of establishment routines, how to access available services and given help to cope with being in custody.

1.9 The reception area was pleasant but lacked sufficiently useful information. Reception procedures were carried out efficiently. Staff treated new arrivals well and with sensitivity, but this was undermined by routine strip-searching. Female staff were not always available to deal with new arrivals in reception or through the night. New arrivals were carefully monitored and most young women said they had felt safe on their first night. Induction was comprehensive and completed reasonably quickly. Some written information was out of date or inappropriate for the age-group and all was available in English only.

Reception

1.10 The unit was notified of a young woman's arrival in advance, allowing the duty manager to identify staff to undertake reception procedures and personal officer work and to allocate a cell. A female member of staff was not always on duty when young women arrived late. During the inspection, one young woman was admitted late by two male staff. She was not strip-searched immediately because there was no female member of staff on duty, but was automatically, and unnecessarily, strip-searched the following morning.

1.11 The unit's reception area was separate from the main prison. Young women were admitted through a side entrance leading directly to the unit and had no contact with adult prisoners on the main site. Reception was small but clean, bright and simply furnished. Little information on display had been produced by young women themselves, as we have seen used to good effect elsewhere, and most posters were formal policy documents of limited interest to young women. All information was available in English only.

1.12 The reception process was thorough and staff treated young women sensitively. In our survey, 100% of young women, against a comparator of 82%, said they had been treated well or very well in reception. The young woman's warrant was checked and the reception officer ensured that she understood the instructions of the court. Initial documentation had normally been faxed through in advance or accompanied the young woman, although it was missing in about 5% of cases. Where it was missing, the Youth Justice Board was informed immediately. Missing documentation was usually obtained within two working days.

1.13 Staff used the available background information, including ASSET forms, pre-sentence and post-court reports, when completing the initial vulnerability assessments. All completed initial paperwork was placed in the integrated filing system and all staff had access to it. Copies of

any essential relevant background information relating to vulnerability were also placed in a file in the unit office on the residential area.

1.14 All new arrivals were observed closely, usually every hour, for the first 24 hours. The unit rules and procedures, including the no smoking policy, were explained. Reception staff said that most young women new to the unit, many of whom were smokers, were unaware of the policy, which often resulted in conflict on arrival. In our survey, only 11% of young women said they had received written information about what would happen to them at the establishment before they arrived. All new arrivals were seen by a nurse in a private medical room to identify any immediate health needs but anyone arriving after 8pm had to wait while a nurse was escorted from the main site. Smokers were offered nicotine patches but for no apparent reason late arrivals had to wait until the next day, which caused unnecessary distress.

1.15 All young women admitted to and discharged from the unit were routinely strip-searched. This was carried out sensitively, but was not risk assessed, intrusive and degrading, particularly given that many young women were likely to be victims of sexual abuse. Strip-searches were carried out in a very brightly-lit shower room with no screen. The dressing gowns provided were not always cleaned after each use.

1.16 New arrivals were given a first night pack of basic toiletries and an option of £2 telephone credit or the equivalent in sweets. They were offered a hot drink and meal in reception and given the opportunity to call a member of their family. Property was checked and logged, but our survey results indicated that property arrived with young women in only 42% of cases, significantly worse than the comparator of 73%. Staff were unclear about the reasons for this.

First night

1.17 Reception staff took young women to the residential area. Young women arriving there before 8pm were shown around and introduced to their personal officer if they were on duty. Those arriving later were simply introduced to staff on night duty before being placed in their cell. New arrivals could choose to mix with other residents if they were unlocked or to remain in their cell. There was no formal peer support system for new arrivals. Night shifts were always covered by established unit staff, which ensured that officers on duty had a good knowledge of the young people in their care. We observed good quality handovers between shifts, with detailed information about new arrivals shared.

1.18 As in reception, a female member of staff was not always on duty at night and it was not unusual for both staff to be men, as was the case during our night visit. While we were impressed by their knowledge of the young women and their understanding of the nature of their task, the lack of a female officer was problematic. In our survey, 95% of young women, significantly better than the comparator of 53%, said they had felt safe on their first night.

Induction

1.19 Induction started the morning after arrival. It was scheduled to last five days but was normally completed well within that time. The timetable included scheduled slots with allocated workers, but in practice the timings were flexible. Staff and visiting specialists saw new arrivals as soon as possible and this worked well. Most information was given to young women individually by a member of the discipline staff. Other staff on the unit, such as the youth offending team and substance misuse workers, introduced themselves and explained their role as soon as they came on duty. Induction was reasonably focused and did not involve long periods when young women were unoccupied. Young women normally started attending classes by the third or

fourth day. In our survey, 75% of young women, against a comparator of 59%, said they had induction within their first week and 60%, against a comparator of 42%, said it had covered everything they needed to know.

1.20 All young women were issued with a rather formal induction booklet laid out in the traditional style of an adult prison. Some of the material was out of date and there was no reference to more recent initiatives such as the no smoking policy. Young women on the unit had not been involved in its development but they had been involved in producing a DVD explaining how the unit was run. The DVD had not been completed.

1.21 Induction information was in English only. Although only very few young women admitted to the unit could not speak English, interpreting and translation services were not always used quickly when required. During the inspection, one Romanian young woman who could not speak English had to wait until her fourth day before an interpreter visited and her induction could be carried out properly (see section on foreign nationals).

Recommendations

1.22 A female member of staff should always be on duty in reception and in the residential unit.

1.23 Young women in need of nicotine replacement patches should be provided with them on the day of their arrival, even if they arrive late.

1.24 Young women should be given essential information at court about what will happen to them on arrival at the unit.

1.25 A peer support scheme, overseen by staff, should be introduced to help new arrivals settle in.

1.26 Translation and interpreting services should be sought without delay for new arrivals who cannot speak or read English well.

1.27 The reasons why young women report difficulties with property on arrival should be investigated.

1.28 Screening should be provided in the strip-search area and young women provided with clean dressing gowns.

Housekeeping points

1.29 The induction booklet should be revised to ensure that it is up to date and fit for purpose. It should be produced in an age-appropriate format with the help of young women on the unit.

1.30 Young people should be involved in the production of age-appropriate and relevant information to display in the reception area. The information should be displayed in a range of languages.

Section 2: Environment and relationships

Residential units

Expected outcomes:
Children and young people live in a safe, clean, decent and stimulating environment within which they are encouraged to take personal responsibility for themselves and their possessions.

2.1 All cells were single occupancy and had integral sanitation. They were well equipped and reasonably pleasant, but the overall appearance was spoilt by traditional cell doors. The communal areas needed some attention to make them more comfortable and suitable for the age-group. The young women were separated into small living groups, which many found restrictive. They shouted to each other through the windows at night. Young women had access to cleaning materials and good laundry facilities and were expected to keep themselves and their environment clean. Staff supervision and their level of interaction with young women were good. All young women could wear their own clothes.

2.2 The unit had 26 cells spread across three residential spurs (see fact page). One of the cells was larger and suitable for a young woman with physical disabilities. All cells were single occupancy with integral sanitation, including a shower and washbasin with drinking water. The shower and toilet areas were not visible through observation panels and panels were not obstructed. Apart from the traditional cell doors, cells could have been described as rooms. All contained a kettle, television and call bell. They were comfortably furnished and had curtains and duvets. There was also a separation cell and a quiet room on the unit used for one-to-one interviews. The offensive displays policy was enforced consistently. There was some minor graffiti in cells but none of it was offensive.

2.3 The servery area and unit office were in the centre of the three residential spurs and staff consistently applied the rules preventing unsupervised access to them. The residential spurs were divided from one another by locked doors and each had its own dining and association area. Staff supervision of communal areas was effective. Young women from different spurs rarely mixed together as a group other than during education. Several young women complained that the residential groups were too small and said they quickly became bored with the limited choice of company. The requirement for staff to repeatedly lock and unlock doors linking the spurs during controlled movement created an environment more comparable with a standard prison wing than other small units holding young women.

2.4 The communal living areas each had dining tables and chairs and all young women ate communally, usually with staff. There were a few easy chairs, a variety of board games, a karaoke machine, game consoles and a television. These areas looked worn, the furnishings were sparse and the decoration was not particularly age-appropriate. Notice boards contained a reasonable amount of information, but none of it was eye-catching and none had been produced by the young women.

2.5 After a short period when young women called to one another through windows and doors, the unit quietened down quickly after evening lockup. In our survey, 47% of young women, significantly worse than the comparator of 9%, said other young women had shouted to them and 39%, significantly worse than the comparator of 9%, said they had shouted to others. No young women said they found this threatening.

Hygiene

2.6 Young women had access to cleaning materials and were expected to clean their cells, usually at weekends to coincide with the weekly judging of 'cell of the week'. Cells were mostly clean, but a few were very untidy. The communal areas were clean and the young women routinely cleared up after meals.

2.7 Cells were equipped with all necessary toiletry and sanitary items, and replacement items were available as required. Razors were not allowed in possession, but were handed out and collected after use on Saturdays. Additional toiletries were available from the canteen.

Clothing and possessions

2.8 All young women could wear their own clothes and there were clear guidelines on the amount and type of clothes they could have in their cells. A good stock of clothes was available for young women with insufficient or inadequate clothing and plentiful supplies of new underwear were kept in reception for new arrivals. All young women were given gym kit for physical education sessions.

2.9 The unit had good laundry facilities and all laundry, including sheets, towels and duvet covers, was done for young women once a week. Young women did their own ironing on their residential spurs.

2.10 Property storage facilities in reception were limited. Property was stored in sealed property bags or boxes and young women were encouraged to hand out unwanted property to family or friends.

Recommendations

2.11 Cells should be assessed daily for cleanliness and tidiness.

2.12 The communal parts of the residential areas should be furnished and decorated in an age-appropriate way.

2.13 Young people should be allowed more association between different residential spurs.

Housekeeping point

2.14 Notices should be improved, with input from young women, to attract attention to the information displayed.

Relationships between staff and young people

Expected outcomes:
Children and young people are treated respectfully by all staff, throughout the duration of their custodial sentence, and are encouraged to take responsibility for their own actions and decisions. Staff listen, give time and are genuine in their approach. Healthy establishments demonstrate a well-ordered environment in which the requirements of security, control and

welfare are balanced and in which all children and young people are treated fairly and kept safe from harm.

2.15 Relationships between staff and young women were respectful and relaxed. Staff retained appropriate levels of control to ensure a safe environment and challenged inappropriate behaviour.

2.16 Relationships between staff and young women were very good and 100% of young women in our survey, against a comparator of 73%, said most staff treated them with respect. Good staff interaction was evident and there were good systems for sharing information, including a daily morning meeting, a wing observation book with detailed, informative entries and good quality entries in personal history sheets.

2.17 Staff knew the young women and their individual circumstances very well. They referred to them by their first names and all uniformed staff wore tracksuit-type uniforms. Staff challenged inappropriate behaviour and language and set clear boundaries. The young women appeared comfortable approaching staff with problems and requests.

2.18 All staff we saw were enthusiastic about their choice to work with adolescent young women. They showed an understanding of their needs and a concern to help them address the factors that had led to their offending. In our survey in response, one young woman wrote: 'Everything is good. I have been here 4 months and have got my early release so I have only got 2 days left but I wouldn't have been bothered if I were here longer'.

Personal officers

Expected outcomes:
Personal officers are the central point of contact for children and young people, providing frequent purposeful contact within the establishment, and proactively establishing and maintaining links with external agencies (especially youth offending teams) and friends, families or carers.

2.19 The personal officer scheme was effective and age-appropriate. Young people knew their personal officers and found them helpful. There was a need to ensure that the role of the personal officer was not diminished following the introduction of a dedicated casework team.

2.20 Young women were allocated a personal officer and back up officer on arrival and usually met them as soon as the officer was on duty. In our survey, 65% of young women, against a comparator of 68%, said they had met their personal officer in their first week and 70%, against a comparator of 63%, found them helpful.

2.21 Personal officers made good quality entries in wing files, with two or three detailed and objective contributions made each week. Management checks were also good quality and encouraged consistently high standards. Personal officers shared the contents of their own files with individual young women but young women were not allowed to read the files themselves.

2.22 A relevant and age-appropriate unit personal officer policy had been published and had recently been amended to modify the personal officer role following the introduction of a

dedicated casework team (see section on resettlement strategy). The modified role was intended to '…provide the kind of care, support and consistent boundaries that any good parent would give to their children'. Personal officers we spoke to were concerned that the new casework team could diminish their role.

Recommendations

2.23 Young people should be allowed supervised access to read the contents of their wing narratives.

2.24 The introduction of the casework team should be carried out in conjunction with the continuing development of the role of the personal officer to ensure that the distinctions between the two roles complement each other.

Section 3: Duty of care

Safeguarding

Expected outcomes:
The safety of children and young people is a paramount consideration in the development of all policies and procedures. There is a clear safeguarding strategy drawing together key policies designed to keep children and young people safe.

3.1 Monitoring of safeguarding arrangements was not sufficiently robust. The safeguarding committee had not met for a year and had only recently been reinstated. There was data on the main safeguarding areas, with the notable exception of child protection, but it was not analysed and used to inform the safeguarding strategy. Comprehensive individual records were kept but young women did not have individual care plans.

3.2 The governor was a member of the Wakefield District Safeguarding Children Board. Previously sound arrangements to monitor and review all aspects of safeguarding had not functioned properly for over a year. The safeguarding committee had not met between July 2006 and March 2007, which had meant no external scrutiny of safeguarding arrangements by the local authority in that period.

3.3 Recent efforts had been made to revise the terms of reference and designated membership of the safeguarding committee. Similar efforts had been made to reinstate quarterly safeguarding committee meetings but attendance by relevant departments and external agencies had not been good. The escort contractors had recently announced that they did not intend to attend all safeguarding meetings despite the safety concerns relating to late arrivals.

3.4 With the exception of child protection, a range of data about the main safeguarding areas was available through the monthly safer custody departmental reports. Self-harm, bullying, the use of force, and fights and assaults involving young women were monitored monthly by the safer custody team as part of the whole prison monitoring arrangements, but there was no ongoing analysis of unit-specific data to identify patterns or trends to inform the unit's safeguarding strategy.

3.5 A daily unit briefing and various operational meetings took place to discuss different aspects of safeguarding and care planning for individual young women. The recently-introduced weekly substance misuse intervention and treatment and safeguarding meetings were intended to become the main forum for such discussions, but there was some duplication of effort and a lack of coordination between the various meetings.

3.6 As part of a new integrated filing system, all relevant records for individual young women, including training plan documents, were held in one central file, which meant that staff had easy access to all information about the young women in their care. There were, however, no individual care plans covering all aspects of the young women's care.

Recommendations

3.7 The unit manager should ensure appropriate attendance at the safeguarding committee meeting.

3.8 All available data relating to safeguarding issues specific to the Rivendell unit, including child protection, should be analysed for patterns and trends and regularly monitored by the safeguarding committee.

Bullying

Expected outcomes:
Children and young people feel safe from bullying and victimisation (which includes verbal and racial abuse, theft, threats of violence and assault). Active and fair systems to prevent and respond to bullying behaviour are known to staff, children and young people and visitors, and inform all aspects of the regime.

3.9 The violence reduction strategy was comprehensive, but significant aspects were not being implemented. Bullying was rare. Most young women felt safe, had confidence to report intimidating behaviour and believed that staff would deal with it. Young women who bullied others or displayed particularly aggressive behaviour were targeted for individual interventions. This was a good initiative, but the work was not coordinated through individual care planning.

3.10 A unit-specific violence reduction strategy document had been produced that outlined what was expected of young women, appropriate and inappropriate behaviour and the broad mechanisms in place to manage problematic areas. It was comprehensive, but aspirational in that much of what was outlined was not in place.

3.11 An analysis of exit interviews from across the whole establishment had been undertaken in March 2007 but this had included only three young women from the unit, which was insufficient to provide information for analysis specifically for this group. Information on bullying was also collated monthly but was not evaluated to identify specific concerns within the unit (see section on safeguarding). A planned 'buddy' scheme to support more vulnerable young women had proved difficult to implement as most young women received relatively short sentences.

3.12 Running in tandem with the violence reduction strategy was the prison-wide anti-bullying policy. In line with national guidance, the policy outlined a model of intervention, although more adjustment was required to meet the needs of young women.

3.13 In the previous six months, seven young women had been placed on stage two of the strategy and another two on stage one. A number of other incidents initially identified through the anti-bullying mechanism, including often minor assaults and other inter-personal conflict, had appropriately been resolved informally. No staff training in anti-bullying had taken place in the previous year.

3.14 The behaviour of young women on stage one and two of the strategy was monitored for seven days, although how staff identified and dealt with continuing problems was unclear and there was evidence that some more subtle bullying was apparently missed. Young women on stage two were also expected to address their behaviour using an adapted form of the anti-bullying book designed for adult prisoners. No one on the unit was undertaking this work during the inspection and cases filed in the safer custody office or backdated files did not have these books with them.

3.15 Particularly difficult young women and those whose aggression was not necessarily manifested in bullying followed behaviour management programmes. These consisted of an individual

timetable with activity planned for each session throughout the day/week, usually involving structured sessions with the unit's dedicated mental health in-reach worker, the youth offending team key worker and others as appropriate. The programmes were monitored through weekly multidisciplinary meetings, but no care plans were developed outlining who or what department would address what aspect of the identified problematic behaviour. Similarly, no such care plans were developed for those managed through the anti-bullying programme. This risked duplication and could leave some staff unaware of work being undertaken with a young woman.

3.16 Young women we spoke to were aware of the anti-bullying strategy and said it was implemented effectively. In our survey, only 5% of young women said they had ever felt unsafe, 5% said they had been victimised by other young women and 68% said they believed they would be taken seriously if they told staff they felt victimised. These results were significantly better than the respective comparators of 34%, 31% and 39%.

Recommendations

3.17 The unit's violence reduction strategy should be adjusted to the needs of the young women on the Rivendell unit and fully implemented.

3.18 All staff on Rivendell unit should undertake anti-bullying/violence reduction training.

3.19 All young women leaving the unit should be offered an exit interview and the results analysed to inform the unit violence reduction strategy.

Self-harm and suicide

Expected outcomes:
Children and young people at risk of self-harm or suicide are identified at an early stage, and a care and support plan is drawn up, implemented and monitored. Assessment of risk/vulnerability is an ongoing process. Children and young people who have been identified as vulnerable should be encouraged to participate in appropriate purposeful activity. All staff are aware of and alert to vulnerability issues, are appropriately trained and have access to proper equipment and support.

3.20 The number of self-harm incidents was high. We were told the majority of incidents were minor but there was an absence of analysis to verify this. Assessment, care in custody and teamwork documentation, including assessments and observation records, was not always completed to a good standard and this had been identified by unit managers through quality checks. Reviews were usually multidisciplinary and young women had access to a good range of specialist support, but unit staff were not always sufficiently conversant to add support to the care plan. One third of staff had not undertaken the foundation suicide and self-harm course.

3.21 The unit did not have its own self-harm and suicide policy, but instead worked to the wider prison's document. In the previous six months, there had been 127 incidents of self-harm with 39 assessment, care in custody and teamwork (ACCT) forms open. Information on such cases was compiled by the prison's safer custody group, but was not evaluated and analysed separately (see section on safeguarding). Therefore, while staff said that nearly all opened ACCTs related to relatively minor cases of self-harm, there was no evidence to support this assumption.

3.22 The quality of initial assessments was quite poor in the cases we reviewed. Most were simply an account from the young woman of what she had done and why. There was little or no reference to information from other documents, historical or contemporary, and often little indication of the underlying causes. In a number of cases, the care maps were very general and targets/objectives were not SMART and were orientated to managing the immediate concern rather than addressing the underlying causes. Managers had also identified these shortfalls through quality checks. Only 18 of the 26 staff had undertaken foundation training in suicide and self-harm. Initial assessments and reviews were always undertaken within the appropriate timescale, usually by a multidisciplinary group. Subsequent reviews included wider representation and were sometimes rearranged specifically so that appropriate staff could attend.

3.23 The mental health in-reach worker on the unit could arrange access to a consultant psychiatrist, who attended the unit for half a day a week, a clinical nurse specialist, who offered anger management interventions across the prison, and a clinical psychologist from a local secure forensic unit. However, many young women had relatively short sentences and did not have enough time to access this specialist support. There was no dedicated provision from the wider prison's psychology department, but we were assured that young women who needed to be seen received an appropriate level of service (see section on healthcare). Where specific work was orientated to underlying issues, such as through the young people substance misuse service or youth offending team, there appeared to be little wider staff understanding of this to reinforce any change in behaviour.

3.24 At the time of the inspection, just one young woman was subject to ACCT. She said all staff on the unit had been supportive and that she felt able to talk to some of them if she felt particularly anxious. The records indicated that appropriate checks were made consistently but most merely indicated that there were 'no indications of self-harm behaviour' with little wider description. This was reflected in other cases we reviewed.

Recommendations

3.25 A suicide and self-harm policy should be developed specifically for the unit.

3.26 All staff should undertake at least the foundation training course in suicide and self-harm.

3.27 Initial and subsequent assessments in ACCTs should include evaluations of behaviour drawing on historical and contemporary documentation along with an account of the actual incident triggering the process.

3.28 Targets identified in care maps should be specific, measurable, achievable, realistic and timebound.

3.29 Where specific interventions are used to address a young woman's underlying problems, this information should be included in ACCT documentation so that other staff can reinforce such work.

Child protection

Expected outcomes:
The establishment provides a safe and secure environment, which promotes the welfare of the children and young people in its care, protects them from all kinds of harm, and treats them with dignity and respect. There is an openness on the part of the establishment to external agencies and independent scrutiny, including openness with families and the wider community

3.30 Child protection procedures were not managed well. During the lengthy period that the safeguarding committee had not functioned, there had been no external scrutiny or proper management oversight of child protection procedures. Record-keeping, data collection and monitoring of child protection were inadequate.

3.31 A comprehensive and unusually straightforward child protection policy had been presented to Wakefield District Safeguarding Children Board, but had not yet been agreed. The policy was not being implemented fully, particularly with regard to the monitoring and review arrangements.

3.32 Most unit staff had been trained in child protection awareness, but staff cross-deployed from the main prison when there were staff shortages had not. Everyone in the prison had received enhanced Criminal Records Bureau clearance.

3.33 A significant number of child protection referrals had been made, over 160 in the previous 12 months. Staff said they erred on the side of caution and tended to make child protection referrals when they were concerned about young women for a variety of reasons that did not fulfil the criteria. However, child protection referrals were not analysed so we were unable to verify this or identify any relevant patterns or trends.

3.34 There were some serious deficiencies in the child protection documentation. A log of child protection referrals was not maintained. The social worker, who had recently taken up employment elsewhere, had developed her own recording systems and did not use the standard Prison Service child protection logs. Individual records of referrals were incomplete and lacked sufficient detail to give assurance that child protection referrals had been investigated properly. The safeguarding committee had not met for a year (see section on safeguarding) and there was no separate child protection committee. During this period, the social worker and the unit governor had monitored the progress of individual cases and there had therefore been no proper external scrutiny or management oversight of child protection.

3.35 There was no social worker in post, but a replacement had been recruited and was due to join the unit shortly.

Recommendations

3.36 Unit managers should seek to ensure that the child protection policy is ratified by Wakefield Safeguarding Children Board without further delay.

3.37 Staff cross-deployed from the main prison to work in the unit should have child protection training.

3.38 A log of all child protection referrals should be maintained and kept confidentially by the governor. The log should be routinely monitored by a representative from the local safeguarding children board, the governor, the Youth Justice Board and the area manager.

3.39 Child protection referrals should be analysed so that patterns and trends can be identified.

Race equality

Expected outcomes:
All children and young people experience equality of opportunity during every aspect of their time in custody, are treated equally and are safe. Diversity is embraced, valued, promoted and respected. The idea that different people have different backgrounds and values is introduced to young people as an integral part of communal living.

3.40 The race equality action group dealt with the whole prison. Race and diversity issues specific to Rivendell unit were not explicitly covered and there was no forum for this within the unit. There had been very few formal racist incident complaints and all had been dealt with very well. Complaint forms were not widely available. Race relations on the unit appeared to be good. There was little promotion of diversity.

3.41 A race equality action team (REAT) for the main prison also had responsibility for the unit. It met bi-monthly chaired by the governor and was well attended. The minutes were comprehensive and covered all aspects of diversity. There was a clear action plan for the whole prison. There was a specific race and equality policy for the unit, but issues relating to it were not specifically covered either in the REAT meetings or the establishment's action plan and there was no unit forum to discuss diversity issues. The recently-reformed safeguarding committee was the most appropriate forum for this. Young women had not been asked to provide a diversity representative to ensure that their views were taken into account and diversity was not covered in the unit participation meetings.

3.42 There was a designated race equality officer (REO) on the unit. He was trained in diversity, but had not been trained to carry out investigations. He had 16 hours of flexible time a week for the work, but this was not guaranteed. He was not a member of other committees, such as the safer custody meetings, security meetings and foreign national meetings, but did provide reports. A diversity manager was about to be appointed to cover the whole prison, including the unit. The unit REO had recently resigned and it was not clear whether there would be a unit diversity liaison officer.

3.43 Eighty-four per cent of staff were trained in diversity and there was a rolling programme of such training. Young women using inappropriate or offensive language were challenged and staff we spoke to were aware of their responsibilities in this area. We received no complaints from young women of any racial tensions in the unit. In our survey, no young women said they had been victimised because or their race or ethnic origin.

Managing racist incidents

3.44 The racist complaints box was clearly displayed in a communal area but general complaint boxes on the residential corridors were also used. Racist incident report forms (RIRFs) were

available only by the box in the communal area and no supplies were freely available on the residential spurs. To date in 2007, there had been five RIRFs and all but one had been answered in time. The reports were to a high standard with clear outcomes and cross-referenced to all appropriate departments. The one report completed out of time began with an apology followed by a thorough answer. There was verbal and written feedback on all reports. A local area committee met the hate incidents security panel, which included the three local prisons, the Bradford hate crime alliance and Kirklees racial equality council. This reviewed many of the racist incident reports and was a good initiative.

3.45 Ethnic monitoring data collected for New Hall incorporated the unit and was used to monitor trends and patterns, but this had little relevance to the unit as the vast majority of data related to the main prison.

Race equality duty

3.46 There was little promotion of diversity within the unit. The disability liaison officer worked from the main prison and acknowledged some weaknesses in awareness and promotion. One cell was adapted for a young woman with disabilities and a lift in the unit made it accessible. There was disabled access in visits. The race equality meeting had recently agreed to have separate parts of each meeting to discuss race equality and disability.

Recommendations

3.47 The diversity manager should be trained to carry out investigations.

3.48 There should be a unit diversity liaison officer to ensure that diversity issues specific to the unit are addressed.

3.49 Racist incident report forms should be freely available on all residential spurs.

3.50 All staff on the unit should be trained in diversity.

3.51 There should be oversight of diversity matters relating to the unit through the safeguarding committee.

3.52 Young women should be regularly consulted about diversity issues through the participation meetings and represented at the safeguarding committee meetings to present concerns.

3.53 Race relations and diversity should be promoted positively in the unit and should involve young women and multidisciplinary staff.

Good practice

3.54 *A local area committee met the hate incidents security panel, which included the three local prisons, the Bradford hate crime alliance and Kirklees racial equality council. This reviewed many of the racist incident reports and was a good initiative.*

Foreign nationals

Expected outcomes:
Children and young people who are foreign nationals should have the same access to all facilities as other children and young people. All establishments should be aware of the specific needs that children and young people who are foreign nationals have and implement a distinct strategy, which aims to represent their views and offer peer support.

3.55 The foreign national policy was not unit-specific and guidance for staff and formal support for young women was lacking. Translation and interpreting services were little used.

3.56 The main prison foreign national committee had met three times in 2007, but with no representatives from the unit. There was no unit foreign nationals coordinator or anyone designated to develop services and support for young women. The foreign national policy for the prison did not refer to the different and specific needs of young women on the unit as children. There were no foreign national support groups in the main prison that the young women could make use of and appropriate adult women prisoners were not used to support young women, as we have seen work to good effect elsewhere.

3.57 Only three foreign national young women had been held in the unit in the previous year. The most recent was a Romanian young woman who had arrived at the weekend and had waited four days before she had access to an interpreter. Although staff and other young women on the unit did their best to communicate with her, no formal support was readily available. Little information had been translated into other languages and The Big Word translation service had not been used. The Romanian young woman had signed all the relevant induction paperwork, but clearly had not been able to understand it.

3.58 There was no written guidance for staff or young women about the entitlements of foreign national young women. Staff said foreign national young women could have a free monthly five-minute telephone call in lieu of a visit, which was insufficient for this the age-group. International telephone cards were available and foreign national young women had an additional £6 credit each month. There was no additional entitlement to letters.

3.59 Although the need to contact the Border and Immigration Agency was not great, staff were not familiar with contact details or procedures to assist young women with immigration issues.

Recommendations

3.60 The specific needs of children who are foreign nationals should be formally acknowledged within a unit policy.

3.61 There should be a designated foreign national coordinator for the unit.

3.62 Computer software that allows material to be translated into different languages should be obtained.

3.63 Young women who require the services of an interpreter should wait no longer than 24 hours and should not be asked to sign anything in the absence of an interpreter.

3.64 There should be clear guidance for staff and young women setting out the entitlements of foreign national young women and how they should be supported.

3.65 Free weekly telephone calls should be offered in lieu of a visit.

3.66 Young women should be allowed to exchange two ordinary letters for one airmail letter.

Contact with the outside world

Expected outcomes:
Children and young people are encouraged to maintain contact with family and friends through regular access to mail, telephones and visits.

3.67 Letters were sent and received without delay. Access to telephones was good. Visits took place in the main prison and young women were subjected to the same procedures as adult prisoners, which was inappropriate. There were good systems to ensure that young women did not have contact with those who may have posed a risk to them and that child visitors were protected. Only young women on the enhanced level of the rewards and sanctions scheme received an adequate entitlement to visits. Little was done to encourage family contact.

Mail

3.68 Young women were given a free letter on arrival and then three free letters a week. All incoming and outgoing mail, apart from legal in confidence, was read and any that presented child protection issues was withheld. Unsuitable outgoing mail was returned to the writer with an explanation, while unsuitable incoming mail was placed in stored property and the intended recipient informed. This level of censorship was appropriate given the need to protect a vulnerable group of young women and young women did not raise it as an issue. Parcels were delivered direct to the unit and opened in front of staff in reception. Delivery and collection of mail was timely. In our survey, 30% of young women, significantly better than the comparator of 58%, said they had had problems sending or receiving mail.

Telephones

3.69 There were two fixed telephones in separate booths and each residential corridor had a trolley telephone that young women could take to their rooms. In our survey, all young women, against a comparator of 64%, said they could use the telephone to talk to someone in their family every day. Notices by the telephones warned that calls could be monitored. Young women without telephone credit who needed to make a welfare or legal telephone call could do so, and staff helped them when necessary.

Visits

3.70 Next of kin or anyone acting in that capacity received written information about visiting hours, booking and visits arrangements as soon as the young woman arrived at the unit. Domestic visits were booked through the main prison visits line and were available every weekday afternoon and at weekends. Young women on remand were entitled to visits every day, but entitlements for sentenced young women were inappropriately differentiated according to their level on the rewards and sanctions scheme. At enhanced level, the entitlement was four visits

a month, those on standard level could have three, but those on basic level were entitled to only two. Legal visits were available every weekday.

3.71 The unit did not operate an approved visits scheme, but there were good systems to ensure that the public protection register was updated daily to protect child visitors. Visitors under 18 were allowed to visit if they were accompanied by an adult. Up to six visitors per prisoner (only three aged 18 or over) could visit at one time. Staff said some young women received far more visits and support than others, which was not surprising as half were over 50 miles from their home area and four were over 100 miles away. Families had not been surveyed or consulted to ascertain why the take-up of visits for some was very low. The unit had not arranged any family days. There were no instances of accumulated visits being used, but one young woman had been able to have visits with a family member who was in the main prison. There was no dedicated family liaison officer and, although unit staff had some telephone contact with families, there was nothing in place specifically to encourage and facilitate family contact.

3.72 Young women were escorted to the main prison for visits and the escort remained there with them throughout. The visits hall had a snack bar and a well-resourced staffed crèche, although toilet and baby-changing facilities were dirty. No domestic visits took place during the inspection.

3.73 No transport was provided to the unit, although a bus service from Wakefield and Huddersfield stopped at the top of the road leading to New Hall. Visitors to the unit could use the main prison visitors' centre that was open in the afternoons. They were given a rub-down search, as were young women on the unit before visits. Random strip-searches took place at the end of every visits session and young women were not exempt from this. All prisoners, including young women, who used the toilet in the visits hall were strip-searched. One young woman had been placed on closed visits with one specific visitor because of information received about that visitor. This was appropriate.

Recommendations

3.74 There should be a comprehensive strategy to encourage and enable more family contact.

3.75 All young women who are sentenced should be entitled to a visit each week.

3.76 Toilets and baby-changing areas in the visits hall should be checked and cleaned regularly.

Applications and complaints

Expected outcomes:
Effective application and complaint procedures are in place, are easy to access, easy to use and provide timely responses. Children and young people feel safe from repercussions when using these procedures and are aware of an appeal procedure. Independent advocates are easily accessible and assist young people to make applications and complaints.

3.77 Most queries and issues raised were dealt with informally and the number of formal applications and complaints tended to be low. Administrative arrangements did not ensure

confidentiality, and the role of advocates and the participation meetings was unclear. Replies were prompt, but responses to complaints were generally poor.

3.78 Most queries and issues were dealt with informally by staff on the unit. The induction booklet briefly mentioned the existence of applications and complaints procedures, but did not describe how they worked, although this information was on display on unit notice boards.

3.79 There were between 10 and 20 written applications a month, most related to property, wages and changes to the personal telephone lists young women were able to have. There were application boxes with supplies of application forms on each residential area. Boxes were emptied daily. Applications were recorded on a central log, given a serial number and passed by the unit senior officer to an appropriate member of staff, with the date and name of the recipient recorded. Replies were usually received within a week, but there was no routine system to follow up outstanding replies. Young women did not sign to indicate they had received a reply.

3.80 About five written complaints were made each month, most relating to health services. Responses were prompt, but replies mostly lacked detail and courtesy. Some replies were irrelevant and unhelpful, for example referring to staff being on training rather than addressing the complaint. The complaint box was emptied daily by a member of night care staff and the complaints left for the senior officer to deal with the following morning. All complaints were therefore contained and managed within the unit, which undermined the integrity of the system. In our survey, 40% of young women, against a comparator of 65%, said it was easy to make a complaint and 19%, against a comparator of 27%, said complaints were sorted out fairly. Complaints across the whole prison were analysed for patterns and trends, but there was no separate analysis of those emanating from the unit.

3.81 The advocates visited the unit two or three times a week, usually in the evening. Young women tended to raise general issues with them and there were no discernable trends. Advocates and staff from the YMCA held monthly 'participation meetings' where young women could raise issues of concern or interest. Unit staff were present, but their attendance was inconsistent and they often had little time to prepare. Senior staff rarely attended. The meetings were minuted, but it was not clear how action points were followed up and there was no evidence to confirm that points raised by young women were acted on. The meetings appeared to have had little impact.

Recommendations

3.82 Replies to complaints should be courteous and address the issue raised.

3.83 The complaints box should be emptied by administrative staff from the main prison to ensure confidentiality and preserve the integrity of the complaints system.

3.84 Complaints generated from the unit should be analysed to determine patterns and trends.

3.85 Senior unit staff should be actively involved in the participation meetings.

3.86 The role and function of the advocates and the participation meetings should be clarified and communicated to all staff and young people.

Housekeeping points

3.87 The induction booklet should describe how the applications and complaints systems work.

3.88 A tracking system should be introduced to allow follow-up of late replies to applications. Young people should be asked to provide a signature on receipt of the reply.

Legal rights

Expected outcomes:
Children and young people are told about their legal rights during induction and can freely exercise these rights while in the establishment.

3.89 A full range of advice and guidance was available to young women through the in-house youth offending team workers and the designated legal rights officer.

3.90 All young people were interviewed by a unit youth offending team (YOT) worker the first working day after their arrival. The YOT workers were experienced in dealing with bail applications and appeals and routinely provided guidance and assistance on these matters. They were also in regular contact with colleagues in home-based YOTs. Where necessary, they collaborated with solicitors on legal matters.

3.91 A trained legal rights officer also worked on the unit and an explanation of the service he provided was displayed on the notice board. On average, he saw two young women a week and most of the help he provided involved providing additional letters and telephone calls to solicitors.

Section 4: Health services

Expected outcomes:
Children and young people are cared for by a health service that assesses and meets their needs for healthcare while in custody and which promotes continuity of health and social care on release. The standard of healthcare provided is equivalent to that which children and young people could expect to receive in the community.

4.1 No complete health needs assessment was available. Primary care services were not specific to young women and there was no dedicated nurse for the unit during the core day. Primary care nurses did not attend detention and training order or other care planning meetings. There was no formal information-sharing policy and there was a lack of integration of primary care staff into the unit. Some young women were not given a secondary health screen and some referrals to other health professionals were not actioned. Clinical record-keeping was poor. There were serious issues around medicines management and no evidence that young women who failed to attend for their medications were followed up. Only hepatitis B and meningitis C vaccinations were available. Health promotion was inadequate. Young women were not identified separately on waiting lists or life-long condition registers and were sometimes not identified at all. Mental health services were good, but not child and adolescent mental health services-led, although the Department of Health had allocated funding for a tier 3 service at the establishment.

Joint working with the NHS

4.2 Wakefield District Primary Care Trust (PCT) commissioned services for all health services at New Hall, including the Rivendell unit. The Youth Justice Board allocated additional ring-fenced funding for health services on the unit, although how this was used was unclear. Primary care and substance use services were provided by the PCT and mental health services by South West Yorkshire Mental Health Trust. The PCT had started work on a health needs assessment in January 2007, but this was not complete and was not available to us or to those commissioning and providing services. There was no specific service level agreement for health services on the unit. Responsibility for providing primary care to young women lay with the primary care team but there were problems. During the inspection, the service improvement strategic forum proposed and agreed that the substance misuse service would take on the complete management of primary healthcare and the clinical management of substance-dependent young women on the unit subject to recruiting adequate numbers of nursing staff to provide 24-hour cover.

Environment

4.3 A health services room on one spur of the unit was isolated and young women had to be escorted to it. It was similar to a clinic room in a GP surgery and had a separate area with lockable metal cupboards for the storage of medications. There was a fridge for thermolabile medications and minimum and maximum temperatures were recorded daily, but no action appeared to have been taken when the temperature had consistently been above the optimum. Medications were given out through a small hatch in a glass screen. Action had been taken to address some inadequacies highlighted by a recent infection control audit undertaken by the PCT. Emergency equipment, including a defibrillator, was kept in the main office on the unit and checked daily. Despite recent written instructions that all emergency bags should

contain a 'spacer' for use when administering inhalers to asthmatics, the bag on the unit did not have one.

4.4 Nurses and the GP saw young women in the clinical room, but young women had to be escorted to the main prison health centre for some services. A range of health promotion materials was kept in a rack outside the clinical room, but there was no other health promotion information elsewhere in the unit where it would have been more accessible.

4.5 The dental surgery was in the main healthcare block and had been refurbished about 18 months previously. The standard of equipment was good and cross-infection controls were satisfactory, although the PCT had not carried out a recent official inspection.

Staffing

4.6 A non-operational prison head of health care at New Hall was responsible for monitoring the primary care, substance misuse and mental health contracts, each of which had a service lead but not all were based at the prison.

4.7 There was no full-time dedicated primary care nurse for the unit. The primary care team for New Hall consisted of a modern matron, two band 6 nurses, one of whom had responsibility for the unit, seven band 5 nurses and four band 3 health support workers. One of the band 5 nurses, who worked three days a week, was the named nurse for the unit. On the days she was not on duty, any of the other nurses could be allocated to the unit. On one day of the inspection, the named nurse was on duty but was allocated to duties elsewhere and was not available to young women. We were told she was increasing her hours, but we remained concerned that primary care nursing for the unit was sub-optimal. A female GP provided one session a week to the unit, although two of the previous eight sessions had been cancelled. Out-of-hours cover was provided by the local on-call GP service.

4.8 The named nurse had not received child protection training and, while we were assured that all primary care nurses had enhanced Criminal Records Bureau checks, documentary evidence was not available in all cases. Some primary care staff required resuscitation training, but there were plans to address this within the next month.

4.9 A full-time mental health practitioner (registered mental health nurse) was based on the unit and well integrated into the team. She made a point of being available to young women when they had breaks from education and association. A consultant forensic psychiatrist provided one session a week to the unit, accompanied by a specialist registrar. Other health professionals were available as required. All mental health professionals were employed by the South West Yorkshire Mental Health Trust adult services; none were from child and adolescent mental health services (CAMHS).

4.10 Dental services were provided by the PCT dental service. Three female dentists divided the work between themselves.

4.11 There were clinical governance arrangements and monthly meetings. Serious untoward incidents and complaints were standard items on the agenda, but issues raised about and by young women did not appear to have been discussed.

Records

4.12 Clinical records were paper-based and held in a filing cabinet in the clinical room on the unit. The whole prison was transferring to an electronic clinical records system within a month of the inspection. There were plans for health staff to be trained on the new system and clinical records were being summarised for it.

4.13 Record-keeping was generally poor and sometimes non-existent. Some young women had not received a secondary (physical) health screen despite being on the unit for several weeks. A further concern was that the instructions for the pilot four-part comprehensive health screening tool were not always followed. The records of adult prisoners were reviewed by administrative staff and clinical details were entered on the 'medical' part of the local inmate database system so that comprehensive information, such as the number of asthmatics at New Hall, was available. However, clinical records of young women were held separately so this information was not always recorded and there were discrepancies in the information held.

4.14 Standard prescription charts were used. Entries on these were also poor or non-existent. Some young women who failed to attend for daily medications had not been followed up.

4.15 Dental records were appropriately annotated and stored in the dental surgery. The clinical records were not annotated.

4.16 There were no polices or procedures specific to young people. A generic communicable diseases policy covered such issues as an outbreak of food poisoning, but there were no policies for an outbreak of a childhood disease such as chicken pox or measles on the unit.

Primary care

4.17 New arrivals were given an initial health screen by one of the substance misuse nurses and anyone with a clinical need was admitted to the main prison substance misuse unit (see section on substance use). Smokers were given nicotine patches but late arrivals sometimes had to wait until the next day (see section on arrival in custody). There were no information leaflets about health services on the unit and the information included in the induction booklet was out of date and inaccurate.

4.18 Young women were usually, but not always, seen by a primary care nurse on the unit the day after arrival. Young women wanting to see a member of the health services team were encouraged to speak to the nurse during the three treatment times at 7.45am, 1.30pm and 6pm. Nurses did not have triage algorithms (except for dental pain) and relied on experience. One nurse had documented that she felt unable to give even simple dietary advice. The nurse could refer the patient to the nurse practitioner in the main prison or the GP.

4.19 Primary care nurses did not routinely attend detention and training order or other care planning meetings and therefore had little or no opportunity to speak to community youth offending team workers or parents or carers about the young women. Young women's consent was obtained to gather information from their GPs, but this did not appear to be followed up if it was not immediately forthcoming. There was no information-sharing protocol and nurses did not appear to be aware of the integrated records system used by other members of the multidisciplinary staff on the unit.

4.20 The nurse allocated to the unit was also expected to issue medications to prisoners in the main prison's care and separation unit and was therefore unavailable to young women when they were on a break from education. When nurses were not on the unit, staff had to call them to attend from the main prison. Complaints from young women and reports from unit staff detailed unacceptable delays before a nurse attended the unit. There had been a recent meeting to try to resolve some of the issues. The senior managers of primary care were aware of the issues and assured us that action was being taken to improve the care for young women.

4.21 Young women could have some medications as daily in possession and others, such as antibiotics, weekly, although most medications appeared to be administered directly by the nurses. They could have a maximum of three days-worth of ibuprofen and six paracetamol tablets in possession each week. There were no documented risk assessments for in possession medications and young women could not see a pharmacist.

4.22 The primary care nurses provided only hepatitis B and meningitis C vaccinations, so young women were not able to receive any childhood vaccinations or immunisations they had missed.

4.23 Any young woman needing to see a GP was put on the list to see the doctor when she attended the unit on Thursday afternoons or on the waiting list for a GP in the main prison. We were assured that young women could be seen urgently, but the waiting time for a routine appointment with a GP in the main prison was at least a week.

4.24 No specific nurse-led clinics were held on the unit. The lists of those with life-long conditions were prison-wide and did not identify young women from the unit. The nurse who ran the asthma clinic was not aware of all young women with asthma, so they did not receive care in line with national guidance.

4.25 There were three dental sessions a week for the whole prison and one oral health promotion session a month. The dental waiting list was produced by prison staff and managed by the dental team, with priority given to urgent cases. The failure to attend rate was low at approximately 15%, which was helped by filling missed appointments at short notice. The dentists provided the full range of treatments available under the NHS. A protocol for triaging patients with toothache when the dentist was not available had been developed for healthcare staff but there was no provision for treatment when the dentist was not present.

4.26 The list for an initial assessment for dental treatment contained 62 names, the longest wait being just under three months. Approximately two-thirds of the list had been waiting less than one month. The PCT commissioners told us that the service was under review with a view to reducing waiting lists further. It was not easy to identify how many of those on the list were from the unit but our own enquiries indicated there were five. One young woman had been noted on her arrival to require dental treatment, but had been added to the list only six weeks later when she was in acute pain. There were similar issues with waiting lists for other health professionals.

4.27 Young women leaving the unit were seen by a primary care nurse in the unit a few days beforehand to be weighed and to allow arrangements to be made for any medications they needed to take home. They were given a letter for their GP, which clearly stated that they had been in prison, and a range of leaflets on substance use harm reduction and other health promotion subjects. There appeared to be little liaison with youth offending team health workers.

In-patients

4.28 No young woman from the unit had been admitted to the in-patient unit. However, there were no protocols to ensure that anyone who was admitted was suitably protected while there.

Mental health

4.29 The mental health practitioner saw all young women on their first full day on the unit. She undertook a comprehensive assessment and discussed any issues of concern. She also took referrals direct from unit staff and the primary care nurse. She attended certain detention and training order and other care planning meetings, including assessment, care in custody and teamwork reviews. She could refer young women to various mental health nurse specialists and a clinical psychologist at New Hall who could provide anger management, trauma and abuse counselling and support for young women who self-harmed. Each had a small waiting list but the unit mental health practitioner was confident that all young women received adequate support. She discussed all new cases with the consultant psychiatrist or his specialist registrar. If a young woman had previously been known to CAMHS in the community or had complex issues, the mental health practitioner commenced enhanced care programme approach. Six of the 22 young women on the unit were being seen regularly by the consultant or his colleague. They provided comprehensive information to the young woman's GP or other health professionals.

4.30 The Department of Health had recently allocated £60,000 through the PCT to support the implementation of tier 3 CAMHS. This would provide multidisciplinary specialist assessment, treatment and ongoing care for children with severe and complex mental health problems and disorders. The PCT did not have any firm plans for how the service was to be developed.

Recommendations

4.31 A health needs assessment should be finalised and used to plan, commission and implement child-specific services. The services should be easily identifiable within any service level agreements.

4.32 All mental health services should be commissioned from and provided by CAMHS.

4.33 All health professionals in contact with the young women should have enhanced Criminal Records Bureau checks and child protection training.

4.34 All medicine refrigerators should be kept between 2 and 8 Celsius and should be adjusted accordingly when necessary.

4.35 Health promotion materials should be readily available throughout the unit.

4.36 A full dental surgery inspection should be carried out by or on behalf of the primary care trust.

4.37 All clinical records should be contemporaneous and conform to professional guidance on record-keeping from the relevant regulatory bodies. All health interventions should be recorded.

4.38 There should be an auditable system to ensure that young women who fail to attend for medications are seen and the reasons for non-attendance discussed and documented.

4.39 Life-long condition registers and waiting lists should include and clearly identify young women so that their use of health services can be monitored.

4.40 There should be child-specific policies and protocols, particularly for the outbreak of communicable diseases.

4.41 Triage protocols should be developed to ensure consistency of advice and treatment to all young women.

4.42 A formal system of documented risk assessment for all patients should be introduced to ensure consistency when determining suitability for in possession medication and whether daily, weekly or monthly supply is appropriate.

4.43 Young women should be able to receive the full range of childhood and adolescent immunisations and vaccinations.

4.44 Young women should be able to access out-of-hours emergency dental care.

4.45 The number of oral health promotion sessions should be increased to one session a week and prison health promotion staff should be trained in oral health issues.

4.46 Healthcare staff should see young women at least a week before they are due to be discharged. The discharge clinic should include a well woman assessment and assistance in registering with a GP and other healthcare professionals as required in liaison with youth offending team health workers.

4.47 There should be clear protocols to ensure a young woman's safety if she is admitted to the main prison in-patient or mother and baby unit.

4.48 Information-sharing protocols should exist with appropriate agencies to ensure efficient sharing of relevant health and social care information.

4.49 Following reception screening, a further health assessment should be carried out and recorded by trained staff, no later than 72 hours after the young woman's arrival in custody.

4.50 All young women should receive a pharmacy service equivalent to that in the community, which includes direct access to advice by appropriately trained pharmacy staff, information about the benefits and risks of medications, and the self-administration of medication.

Housekeeping point

4.51 The emergency bag on the unit should contain a 'spacer' for the administration of inhalers to asthmatics in line with local policy.

Section 5: Activities

Education, training and library provision

Expected outcomes:
Inspection of the provision of education and educational standards as well as vocational training in YOIs for juveniles is undertaken by the Office for standards in education (Ofsted) working under the general direction of HM Inspectorate of Prisons. Education and training are expected to be at the heart of the provision in a YOI and all children and young people should be engaged in good quality education and training which meets their individual needs. For information on how Ofsted inspect education and training see the Ofsted framework and handbook for inspection. Children and young people below the school-leaving age should be following the national curriculum.

5.1 Young women were quickly assessed and allocated to a programme of education. Attendance and behaviour at classes was good and few young women refused to take part. The curriculum maintained a good balance between vocational training and basic and personal and social skills. The timetable was well coordinated and staff absences were covered by experienced teachers so that classes were rarely cancelled. Standards of work were good in most subjects with good learning support and appropriate emphasis on the accreditation of achievements but more able students were not sufficiently well catered for. Literacy and numeracy were well integrated with vocational training and young women made good progress and gained accreditations in these areas. Transition planning was generally good but there was a lack of careers education or information. Information, advice and guidance were very good. The library was a good resource but access was inadequate.

5.2 Most young women were allocated to education soon after their arrival. At 86%, attendance was good. Unauthorised absence was low with few refusing education. There were good arrangements to ensure continuity of education through outreach tutors for the small number of young women returned to their rooms for any reason. The learning support unit was also used well to provide more individual support when required and as a 'time out' facility when necessary.

5.3 Behaviour management was effective. Education staff worked well with discipline staff to maintain discipline in classrooms in line with a clear departmental behaviour management policy that had good links to the rewards and sanctions scheme. Young women showed respect for teaching staff, discipline staff and their peers and were motivated and participated well in lessons. Their behaviour was generally good and relationships between young people, teachers and learning support assistants (LSAs) were also good. Young women were quick to refer to ground rule infringements as they occurred and were supported well by staff to challenge inappropriate behaviour or discussion within their own peer group.

5.4 The curriculum was well constructed to ensure a good balance between vocational training, basic skills and the development of personal and social skills. Young women all followed compulsory literacy, numeracy, ICT and art classes as well as personal, health and social education modules, which included focus on drug awareness and education, offending behaviour, sexual health and relationships and citizenship. They also followed one vocational pathway from a choice of hairdressing, catering, business administration and creative life skills. Timetabled arrangements to ensure that young women were not removed from education

classes for meetings and other appointments were working well. Young women attended education for 35 hours a week throughout the year, which was intensive and did not always provide enough variation of activity.

5.5 The quality of teaching and learning was satisfactory or better. In the least successful lessons, teaching lacked creativity with little variety of teaching methods. The long education day, cover for absent staff and attendance at break duty limited opportunities for teaching staff to plan work, share good practice and reflect on their performance with colleagues. However, teachers, the special educational needs coordinator and LSAs consistently worked hard and were committed to the unit and their students. Teaching in hairdressing was particularly good, with a strong emphasis on developing practical skills. High expectations were placed on young women. Literacy and numeracy were well linked to the vocational areas of work and tutors were skilled at integrating both into the subject areas. Most young women left the unit with higher levels of attainment than when they entered, particularly in literacy and numeracy.

5.6 Achievement on vocational courses was mostly good. Between 2006 and 2007, for example, 10 young women on hairdressing programmes had achieved a full level 1 national vocational qualification, five in catering had achieved entry level 3, seven in business administration had achieved qualifications at level 1 and 20 had achieved level 1 life skills qualifications. In some instances, young women could progress to higher level qualifications if transferred to the adult prison. Programmes for more academic young women, particularly those wishing to undertake or continue GCSE study, were not sufficiently embedded.

5.7 Transition planning was good. A member of education staff attended all training planning meetings and made useful contributions. There were good links with local colleges and Jobcentre Plus and education staff liaised well with youth offending teams. Young women had good opportunities to develop skills and sufficient practical knowledge to increase their employability on release. They developed good interpersonal skills, self-esteem and self-confidence and were articulate, particularly in summarising information and techniques learned in vocational settings. Insufficient attention was given to harnessing skills development into more formal independent living skills or preparation for work programmes and there was no careers education or access to careers information on the unit. There was no Connexions input. The overall standard of written work was satisfactory, with good use of photographic evidence in catering.

5.8 Teaching resources were generally satisfactory but classrooms and workshops were small and access to storage, good work areas and desk space restricted physical movement and the range of curriculum options available. Insufficient use was made of ICT resources to enhance teaching. Materials to support learning were generally well produced and appropriate for each subject area, although only limited general reference information was available. Topical information and well-designed course-related materials were displayed alongside young women's work in most classrooms. There was good coverage of diversity within the curriculum, but the education unit lacked visual displays to promote diversity.

5.9 Information, advice and guidance were very good. All young women received an effective induction programme that included an initial assessment of their literacy and numeracy levels and identified those who required additional learning support and basic dyslexia screening. The assessments informed effectively the quality of individual learning plans and access to courses. Young people experienced little delay in being allocated to their preferred courses and good arrangements were made to tailor work appropriately if they did. Some outreach provision was available for young women who were unable or unwilling to attend formal classes. Job search and interview techniques were addressed within the skills for life programme. Assessment and monitoring of learning was satisfactory. Target-setting was very

good in literacy and numeracy, clearly identifying the steps young women needed to improve their work, but less well developed in some of the vocational courses. There was no formal system for young women to review personal learning targets and objectives regularly.

5.10 The coordination of education, training, physical education and other activities was good. An integrated approach had resulted in close and effective working relationships. The quality of management information and data analysis was high, with effective support from the education provider (City College Manchester). This information and robust needs assessment were well used to inform planning and development. Strategic planning and self-review was well embedded and informed by input from curriculum leaders. Plans were realistic, identifying clear objectives and milestones. Quality assurance procedures were good, with systematic lesson observations and a well-developed mentoring programme, all clearly synchronised to the provider's performance management arrangements. The education manager, who worked well in partnership with the head of learning and skills, had responsibility for provision across the whole regime and gave strong strategic direction and leadership. Day-to-day operational management and support for teachers on the unit were satisfactory, although not clearly discernible. Positive action had been taken to improve the situation, but not all staff on the unit, including discipline and multi-agency professionals, fully understood or acknowledged where lines of responsibility were drawn.

5.11 The recruitment and retention of suitably-qualified and experienced staff were generally good. Collaborative working with local further and higher education provision had enhanced recruitment procedures and enabled opportunities for student placements within the unit. All permanent staff had or were studying for appropriate teaching qualifications. Experienced and motivated sessional staff were used frequently to cover for absence and holiday leave so that classes were rarely cancelled. Staff development opportunities were adequate and participation on relevant courses and programmes were encouraged if time and resources permitted.

Library

5.12 The library, located on the main site, was small with limited space for private study. However, it was well organised and offered a welcoming relaxed and well-lit environment. Unfortunately, young women had poor access. Literacy sessions were held there as part of education, but little use was made of the library to support the broader curriculum. Young women had further access for an hour during the week and an hour on Saturday mornings. Around 75% typically used the library.

5.13 The library provided a satisfactory range of recreational reading and responded to requests for specific books. A range of easy-read books and large print texts was available. A few books and periodicals were available in different languages, as were dictionaries and language books. Some career texts to support vocational areas were available for reference. All Prison Service Order texts were available and the current legal practitioner texts were up to date. Only one computer was available to users. No specific library provision was available on the unit and there was limited access to reference literature.

Recommendations

5.14 More attention should be given to harnessing skills development into more formal independent living skills or preparation for work programmes.

5.15 The education programme should be revised to introduce more variation of activity.

5.16 Programmes for more academic young women, particularly those wishing to undertake or continue GCSE study, should be improved.

5.17 A more assertive and discernible day-to-day management presence on the unit should be established.

5.18 The quality of target-setting for vocational courses should be improved.

5.19 A more effective system of individual tutorials for young women to review personal learning targets and objectives should be developed.

5.20 The quality of teaching and learning of some staff should be improved by developing the range of teaching methods used and dissemination of good practice.

5.21 A programme of careers education and appropriate resources should be developed and there should be regular input from Connexions.

5.22 Access to library provision as a curriculum resource should be improved.

Housekeeping point

5.23 Better use should be made of ICT resources to enhance teaching.

Physical education and health promotion

Expected outcomes:
Physical education and facilities meet the requirements of the Ofsted common inspection framework (separately inspected by Ofsted). Children and young people are also encouraged and enabled to take part in recreational physical education, in safe and decent surroundings.

5.24 The unit physical education instructor delivered a high quality fitness programme on the unit, but there was no access to the gym on the main site and physical education provision was therefore inadequate. Young women were encouraged to take part in physical education during the school day but outdoor facilities were poor.

5.25 Physical education (PE) provision was inadequate. Young women received three hours of compulsory physical education a week in the small fitness suite on the unit and there were no formal outdoor activities or access to the main gym in the adult prison. Outdoor facilities were inadequate and the Astroturf area had been condemned by specialist advisers as not fit for purpose. A full-time PE instructor had been away training since March 2007, reducing staffing to the equivalent of one full-time post. The absent instructor was due to return shortly, which would allow access to the gym. Limited use of the Astroturf area was also due to be introduced subject to health and safety requirements.

5.26 The teaching and management of the fitness programme on the unit were high quality. Relationships between the female PE instructor and young women were very good and behaviour was also consistently good. A personal achievement award developed by the instructors had been well received by young women and good progress was regularly recorded and tracked. Good attention was paid to health and safety and a satisfactory record of safety was maintained. The instructor used every opportunity to discuss healthy lifestyles and fitness

options. Individual learning goals taking account of young women's needs were negotiated and risk-assessed by the instructor, and suitably differentiated programmes planned for them.

5.27 All young women attended PE in appropriate gym wear and took showers after each session. Voluntary access to the fitness centre was timetabled during a recreational period in the education day and take-up was generally good. Fitness programmes were also available to young women on the detoxification unit. Non-contact team games equipment had been purchased recently but was not yet used.

Recommendations

5.28 Regular access to the main gym should be provided.

5.29 Arrangements for outdoor activities should be improved.

5.30 The necessary improvements should be made to the Astroturf area to ensure that full use can be maintained.

Faith and religious activity

Expected outcomes:
All children and young people are able to practise their religion fully and in safety. The chaplaincy plays a full part in the establishment's life and contributes to the overall care, support and resettlement of children and young people.

5.31 Young women attended main religious services in the prison chapel on the adult site under close staff supervision and the majority of young women said that access to services was good. There were some evening activities they could not attend due to lack of unit staff to supervise them. The liaison chaplain for the unit saw all new arrivals but did not have adequate facility time to carry out a full pastoral role on the unit.

5.32 All religions were catered for apart from Hinduism and Buddhism. All religious services took place in the main prison chapel and young women who wished to take part were always accompanied by unit staff and seated apart from the adult congregation. A liaison chaplain was given only five hours a week to attend the unit, which was not adequate to enable her to attend the full range of unit meetings, attend key individual meetings such as training planning reviews or assessment, care in custody and teamwork (ACCT) reviews and carry out a full pastoral role. She did, however, see all new arrivals as part of their induction and attended ACCT reviews when she could. Young women could attend services in the chapel at weekends with staff supervision and the Thursday morning Roman Catholic mass. Anyone wanting to attend services simply asked to do so and did not have to make a formal application. In our survey, 90% of young women, against a comparator of 73%, said they could attend religious services. However, staffing profiles and the requirement for supervision throughout services meant that young women could not attend Monday evening communion or evening activities on Tuesdays or Wednesdays due to lack of staff.

Recommendations

5.33 All young women should have access to a chaplain of their faith.

5.34 The liaison chaplain for the unit should have adequate facility time to carry out a full pastoral role.

5.35 Young women who wish to attend activities and additional evening services provided by the chaplaincy should be enabled to do so.

Time out of cell

Expected outcomes:
All children and young people are actively encouraged to engage in out of cell activities, and the establishment offers a timetable of regular and varied extra-mural activities.

5.36 Young women had plenty of time out of their cells, but were sometimes locked up when there were staff shortages. Most were usually purposefully occupied in education during the week, but were often bored in the evenings and at weekends. Young women on the basic level of the rewards and sanctions scheme spent too long locked up at weekends. Association was never cancelled. The range of enrichment activities during the evenings and at weekends was not sufficiently structured. All young women had regular times in the fresh air but the outdoor areas were unattractive and did not encourage young women to use them.

5.37 Morning unlock was at 7.30am and the end-of-day lock-up at 8.45pm during the week, changing to 8.30am and 8.30pm at weekends. Young women on the standard and enhanced levels of the rewards and sanctions scheme were usually unlocked all day, although there were sometimes too few staff to supervise communal breakfast and young women had to eat it in their cells (see section on catering). Lunch was eaten communally, although young women were sometimes locked up afterwards if there were not enough staff to supervise them over the staff lunch period. Young women on the lowest level of the rewards and sanctions scheme were locked up for an hour in the afternoon after education, before tea and for evening association. They were unlocked for 9.75 hours during the week and only six hours at weekends and, apart from an hour of exercise and the tea meal, were in their cells after lunch from 12.30pm onwards. Those on the standard and enhanced levels were unlocked for an average of 13.25 hours during the week and 10.5 hours at weekends.

5.38 There was a timetable of seven hours of education and training a day, including physical education sessions. All young women were required to go outside for 20-minute breaks morning and afternoon, with another 30 minutes of optional outdoor exercise after lunch. The outdoor areas were unattractive and poorly equipped and did not encourage young women to use them.

5.39 Two hours of enrichment/association took place in the evenings for all young women apart from those on basic level. This included some voluntary vocational education twice a week and activities arranged by the YMCA three nights a week but the activities were not sufficiently structured to encourage young women to use their time constructively. Evening association took place regularly on separate residential corridors and staff interacted well with the young women. Young women said association was never cancelled. All young women ate in the dining room on their residential corridor and could eat in the cells only in exceptional circumstances.

5.40 There was little structured activity at weekends. The evening meal was an hour earlier and there were no timetabled enrichment activities until the evening. Staff tried to organise events

for all young women, but were hampered by the lack of suitable facilities for outside sports and the lack of anywhere large enough to accommodate all young women together safely and comfortably. Young women said they were particularly bored at weekends.

Recommendations

5.41 Young women on the basic level of the rewards and sanctions scheme should be allowed to spend some time out of their cells on weekend afternoons.

5.42 The outdoor areas should be developed to provide better recreational opportunities and encourage young women to go outside.

5.43 The programme of evening and weekend recreational activities should be improved to include more structured activities for all young women.

Section 6: Good order

Security and rules

Expected outcomes:
Security and good order are maintained through positive relationships between staff and young people based on mutual respect as well as attention to physical and procedural matters. Rules and routines are well publicised in a format that children and young people are able to understand, proportionate, fair and encourage responsible behaviour.

6.1 Physical security was good but some security measures were too extreme and there was over-use of routine strip searching. Unit-specific security information reports were not collated or analysed separately. An intensive supervision room was used inappropriately as a special cell and as a first night cell when two new arrivals came at the same time. Rules were clearly explained, fair and understood.

6.2 Physical security was good. There was closed-circuit television coverage in general areas and the secure environment was supported by effective staff supervision. Rivendell had experienced the same initial difficulties in maintaining good order and discipline as other dedicated units holding young women and as a consequence tight security measures and restrictions on movement between residential spurs had been introduced. For example, two members of staff were permanently positioned in the link corridors to control movement, in addition to escorting staff, and the separate residential spurs were locked off at all times (see also section on residential units). All young women were subject to a rub-down search before they went to any activity (including to education in downstairs classrooms and to the exercise area) and again on their return to the unit. Given the good relationships between staff and the young women and a more settled environment that had improved dynamic security, this level of control was disproportionate to the risk.

6.3 The local security strategy had not been modified to reflect the need to balance security with the welfare of the vulnerable young women in Rivendell. Young women were still strip-searched without risk assessments on reception and discharge, during cell searches, in visits and for mandatory drug testing. The unit was on the agenda of the monthly security meeting, but it was not discussed in any depth and management data specific to the unit were not separately examined.

6.4 Security information reports (SIRs) were collated in the main security department, but those from the unit were not collated or analysed separately. A number of SIRs were not completed within acceptable time limits and were sometimes not signed off where required. Outcomes were satisfactory and could be cross-referenced to safer custody work. The number of SIRs for the unit had fallen in the previous two months, reflecting the lower number of adjudications, incidents and use of force.

6.5 The rules and routines were clearly displayed and young women were aware of them. Rules were applied consistently and fairly. The intensive supervision room log showed that this special cell had been used twice in 2006 for less than two hours and not at all to date in 2007. Staff and management said they now had no intention of using the cell to separate a young woman, but it was used to hold a new arrival if two arrived at the same time. The cell was not appropriate to use either for new arrivals or to separate young women even for short periods.

6.6 The compacts signed were descriptive and young women were encouraged to behave appropriately, think of others, participate in the regime and respect each other. All relevant paperwork was signed and stored properly.

Recommendations

6.7 Security information reports relating to the unit should be collated and analysed separately. They should be signed off correctly and in a reasonable timescale.

6.8 The use of the intensive supervision room or special cell should cease.

Discipline

Expected outcomes:
Disciplinary procedures, the use of force and care and separation are minimised through preventative strategies and alternative approaches: they are not seen in isolation but form part of an overall behaviour management strategy in the establishment. Disciplinary procedures are applied fairly and for good reason. Children and young people understand why they are being disciplined and can appeal against any sanctions imposed on them. Children and young people are physically restrained only as a last resort and when no other alternative is available to prevent risk of harm to the young person or others. Children and young people are held in the care and separation unit for the shortest possible period.

6.9 Adjudications were used excessively. Minor reports had recently been introduced, but some minor breaches were dealt with through the most formal processes rather than the rewards and sanctions scheme. The use of force appeared high, but staff used de-escalation appropriately and the instances of the use of force were reducing. The monitoring and analysis of use of force were not sufficiently robust and there were some shortcomings in the documentation. Injuries sustained during the use of force were not monitored. Separation was rarely used as part of good order or discipline procedures. Young women who were separated continued to receive attention from staff but behaviour targets set were weak and reviews poorly attended.

6.10 Discipline was enforced mainly through adjudications and recently-introduced minor reports rather than the rewards and sanctions scheme. The formal processes were over used, with 93 adjudications in the previous six months alone. In our survey, 45% of young women, against a comparator of 27%, said they had been subject to a formal disciplinary hearing. There was evidence that the number of adjudications was decreasing since the introduction of minor reports.

6.11 Adjudications and minor reports were completed on the unit, adjudications by a duty governor and minor reports by senior officers. Hearings were very formal and often held the day after the alleged incident. In only 30% of cases were young women asked if they wanted the support of an advocate.

6.12 A number of adjudications had not been completed appropriately and some investigations were inadequate. Charges were deemed proved without further enquiry if a young woman pleaded guilty. The adjudication process was used inappropriately for behaviour that should have been dealt with by other means. One young woman found guilty of kissing another young woman was punished by 50% loss of earnings, no canteen and no television for seven days.

Another young woman had been charged with being in possession of felt pens, stationery items and a craft needle. There was no use of mediation or restorative justice.

Use of force and separation

6.13 The use of force appeared high, although the number of incidents was decreasing. There had been 83 instances of the use of force in the previous 12 months and 21% of young women, against a comparator of just 11%, said they had been physically restrained. In most cases we examined, force had been used when a young woman behaving poorly had refused to move from an area such as a classroom or association area. Staff made good efforts to persuade the young woman to move voluntarily before resorting to forcible removal. De-escalation was used well and most young women involved had walked back to their cell with staff of their own accord. Cuffs were often used and staff said this was a safer and more comfortable way of escorting a young woman back to her cell.

6.14 Use of force was not properly monitored to ensure that it was appropriate and conducted with proper authority. Injuries arising out of the use of force were not monitored at all. The use of force in the whole prison was monitored through the safer custody meetings, but unit-specific incidents were not separately analysed. Advocates were informed of every incident but young women were not debriefed and it was not clear what role the advocates were expected to play in the process.

6.15 The documentation we examined was generally of a good standard and incidents were clearly explained. The orderly officer had not always signed to confirm that force was authorised and only one side of the report of injury form was photocopied so it was difficult to determine the level of medical assessment or outcome.

6.16 Separation had been used as part of good order or discipline (GOOD) procedures only three times to date in 2007, with a maximum time of six days. It had taken place on the unit with young women located in their own cells. The correct documentation had been completed, although there were some administrative errors. Young women who were separated were not allowed to attend education, but were given work to do in their cells by teaching staff. Staff checked on them and encouraged them to do their set work. They were also given access to the unit gym and time outside in the fresh air. The three-day reviews were poorly attended, the young woman involved was not always present and behaviour targets set did not adequately address the problem behaviour.

Recommendations

6.17 Adjudications should involve thorough investigation and young women should be routinely informed that they are entitled to seek the advice or help of advocates.

6.18 Young women who have been restrained should be properly debriefed after the incident. The role of the advocates in the process should be made clear.

6.19 There should be separate monitoring and analysis of the use of force on the unit to identify patterns or trends and this should be overseen by the safeguarding committee.

6.20 There should be a formal quality assurance system to check that the use of force documentation has been completed correctly.

6.21 Full records of medical examinations and any reported injuries (F213s) should always be attached to the use of force forms.

6.22 Injuries sustained during restraint should be monitored by the safeguarding committee.

6.23 All separation paperwork should be completed correctly and reviews should be multidisciplinary and involve young women.

6.24 Young women who are separated should have detailed behaviour targets so that progress can be measured and to help them avoid further incidents.

6.25 Young women who are separated should be able to take part in education unless a risk assessment deems this inappropriate.

Rewards and sanctions

Expected outcomes:
The primary method of maintaining a safe, well-ordered and constructive environment is the promotion and reward of good behaviour. Unacceptable behaviour is dealt with in an objective and consistent manner as part of an establishment-wide behaviour management strategy. Children and young people play an active part in developing standards of conduct.

6.26 The rewards and sanctions scheme was managed efficiently, with wide-ranging staff involvement. Unusually, it allowed young women to be actively involved in review decision-making. However, the scheme was not yet having enough impact on behaviour primarily because the privileges available at different levels were not sufficiently motivational.

6.27 The rewards and sanctions scheme had been introduced at the beginning of 2007 and the transparency of the review process was pivotal in its effective operation. Each week, around six cases were examined in detail. Boards were chaired by the unit principal officer and included representatives from education, the youth offending team and the mental health worker. Other members of staff were invited to submit reports on behaviour. Once staff had considered all reports and completed their own discussions, the young woman involved was invited to join the meeting and her views were taken into account. Young women were informed of the result, but anyone wanting to challenge a decision was advised to use the complaints system, which was not satisfactory (see section on applications and complaints). In our survey, 63% of young women, against a comparator of 72%, said they had been treated fairly in their experience of the rewards and sanctions scheme.

6.28 Information on the rewards and sanctions scheme was on display in the main living area and the young women we spoke to understood how it worked. One young woman was on the lowest level of the scheme and her circumstances were reviewed every week. Sixteen young women were on standard and five were on the enhanced level. New arrivals who had been on enhanced level at a previous unit could remain on that level until their first review.

6.29 The privileges associated with the different levels were not sufficiently motivational and the scheme was not yet having a significant impact on behaviour. In our survey, only 35% of young women, against a comparator of 52%, said the different levels made them change their behaviour.

Recommendation

6.30 There should be greater differentiation between privileges associated with the different levels of the rewards and sanctions scheme.

Section 7: Services

Catering

Expected outcomes:
Children and young people are offered varied meals to meet their individual requirements, in particular as growing adolescents, and food is prepared and served according to religious, cultural and prevailing food safety and hygiene regulations.

7.1 All meals, apart from some breakfasts, were eaten communally, usually with staff. Daily menus offered sufficient quantity and choice, and healthy options and dietary needs were properly catered for. A good range of fresh fruit was available. The servery was clean and tidy. The catering manager visited the unit for feedback every month and no comments had been made in the complaints book for some time.

7.2 Food was prepared in the main prison kitchen and brought over to the unit on an insulated trolley. The food we sampled was good. The menu was on a three-week cycle and included a suitable range of food for different diets, enough choice and healthy options. Portion sizes were generous and consistent. Breakfast was cereal and milk and officers made toast for the young women. Lunch was a sandwich or a hot meal depending on the season. Tea was a hot meal unless the young woman chose a sandwich or salad option. A good range of fruit was available. Young women were given biscuits for the week ahead with their Monday tea and some ate these within 24 hours.

7.3 Forms to order food were handed out on Wednesdays and collected on Fridays. Five additional meals were provided each day so that staff could eat with young women and to ensure sufficient choice for new arrivals. There was a communal dining area and young women usually ate with staff. However, there were times when there were insufficient staff to cope with preparing for court appearances and serving breakfast in the dining room, and young women therefore ate in their cells. The servery was clean and tidy and food was stored in a large refrigerator when necessary. Access to the servery was prohibited to young women unless an officer was present. All health and safety requirements were complied with. Young women working in the servery were properly trained for this paid work and were on the enhanced level of the rewards and sanctions scheme.

7.4 The catering manager visited the unit for feedback every month and no comments had been made in the complaints book for some time.

Canteen/shop

Expected outcomes:
Children and young people can purchase a suitable range of goods at reasonable prices to meet their ethnic, cultural and gender needs, and can do so safely, from an effectively managed shop or canteen system.

7.5 The shop offered a wide range of goods and there were arrangements for the safe distribution of orders to prevent bullying. Although they were provided with a basic reception pack, new arrivals could wait up to nine days before receiving their first order.

7.6 Aramark held the shop contract. The shop list had over 350 items, including a range of toiletries for black and minority ethnic young women and a choice of fresh fruit but the only hobby items were drawing materials. Young women could comment on the shop service through a prison-wide review that took place three times a year. In our survey, 70% of young women, against a comparator of 54%, said the shop provided a wide enough range of goods.

7.7 Young women could readily get up-to-date information about their finances from unit staff. They made their orders on Thursdays and the goods were delivered in sealed plastic bags on Saturday mornings. There were arrangements to ensure that distribution discouraged bullying. Young women could also order approved items from the Avon and Argos catalogues without any additional administration charge. Family and friends could order from Argos on their behalf. These goods were delivered directly to the unit and passed to the young woman after appropriate testing by the works department. Young women could order from a list of approved magazines. There were no arrangements for newspapers to be available.

7.8 New arrivals were given a reception pack of essential items but had to wait until their first Thursday to make an order from the shop. Depending on what day they arrived, some could therefore wait up to nine days before receiving their first delivery of goods.

Recommendations

7.9 The shop list should include a range of hobby materials.

7.10 New arrivals should be able to place a shop order within their first 24 hours.

Housekeeping point

7.11 Newspapers should be available to young women.

Section 8: Resettlement

Resettlement strategy

Expected outcomes:
Resettlement underpins the work of the whole establishment. The resettlement strategy is informed by assessment of the needs of children and young people. Resettlement is supported by strategic partnerships in the community, and in particular youth offending teams, to assist the reintegration of children and young people into the community and to prevent them reoffending on release.

8.1 There was a clear resettlement policy and all aspects of resettlement were well managed. Services were delivered based on identified need through an innovative approach using ASSET information. Improvements had been made to the training planning process following the recent introduction of a small dedicated casework team. Good use was made of release on temporary licence.

8.2 The unit resettlement policy clearly set out aims and how these would be achieved. The unit manager was a member of various relevant external committees, including the juvenile unit managers meetings, the Youth Justice Board secure estate meetings and the regional youth offending team (YOT) managers meeting. The unit manager also had regular monthly contact with the local YOT manager. There was no unit-specific resettlement committee, but various aspects of resettlement were covered adequately at the monthly unit management meeting.

8.3 Good use was made of individual assessments contained within the ASSET documentation. Data had been aggregated and provided a useful needs analysis of the young women. The results, which showed that 86% had behaviour difficulties and 19% some form of learning difficulty, were used to make informed decisions about how young women should be managed. They were not, however, widely circulated to unit staff.

8.4 YOT staff on the unit had developed an offending behaviour group work programme designed specifically to meet the needs of the young women identified through the needs analysis. Young women were selected for this based on their risk of reoffending, determined through ASSET scores. The programme was delivered by one of the YOT workers and a member of the discipline staff. In the session we observed, staff successfully engaged young people in discussion about the seriousness of their offences. The YOT workers had established links with university researchers who were helping to evaluate the programme. They had also compiled a database of young women who had completed the course, containing the risk of reoffending ASSET scores pre-custody along with the scores at the end of the young women's licence. The programme was a promising initiative, but was not accredited.

8.5 All young women were allocated a YOT worker and each of the three YOT workers held a small caseload. Those not involved in the group work programme were seen individually weekly to address their welfare needs and their offending behaviour. In our survey, only 21% of young women, significantly better than the comparator of 63%, said there were still issues they would like help with before release.

8.6 A casework team of four officers had been set up shortly before the inspection to improve the quality of work carried out within the training plan process. Caseworkers had been selected

through open competition and had a clear job description. The aim was for them to work closely with YOT workers and be responsible for the training plan process, in which they had already been trained. Early indications were that there had already been some improvements to the training planning process. Caseworkers had more time than personal officers to dedicate to this work so young women were better prepared for their reviews (see recommendation at paragraph 2.24).

8.7 After reviewing best practice elsewhere and seeking advice from the Youth Justice Board, the YOT manager had led a good initiative to improve communication between the different agencies working in the unit. An integrated filing system had subsequently been introduced allowing all staff working with young women to record and share information in the same file. This was evidence of the strong commitment towards achieving successful multi-agency partnership working.

8.8 Release on temporary licence (ROTL) was used to good effect and actively promoted. On average, two or three young women each month were given this opportunity, usually for town visits to meet family members and help prepare for release or for interviews. Some young women had managed to secure good quality college placements as a result.

8.9 Young women who reached the age of 18 were transferred to E wing in the main prison and a joint protocol had been developed in conjunction with staff working there. This ensured that young women continued to receive an agreed level of service.

Recommendation

8.10 The offending behaviour group work programme should be processed for accreditation.

Housekeeping point

8.11 Results of the needs analysis should be disseminated to all unit staff.

Good practice

8.12 *Good use was made of individual assessments contained within the ASSET documentation and data had been aggregated to provide a useful needs analysis of the young women.*

8.13 *The integrated filing system ensured that all staff working with young women recorded and shared information in the same file.*

8.14 *The production of a protocol to ensure that young people transferred to E wing continued to receive an agreed level of service was an example of good collaborative work across the prison.*

Training planning and remand management

Expected outcomes:
All children and young people have a training plan based on an individual assessment of risks and needs, which is regularly reviewed and implemented throughout and after their time in custody.

8.15 All young women, whether sentenced or on remand, were subject to the same efficient planning and review process. Reviews were well attended and appropriately focused. Young women were central to the discussions and helped to prepare for their reviews and made a valuable contribution. Early release was managed well. The unit-based YOT workers worked well with community-based colleagues to prepare young women for release but not all young women had their accommodation needs met before discharge. There were efficient arrangements to manage young women subject to public protection measures, both during their sentence and to prepare for their release.

8.16 All young women, whether convicted or on remand, were subject to the same planning arrangements. These were based on the detention and training order (DTO) planning process that was linked to the Youth Justice Board National Standards. The work was led by the three YOT officers seconded from Wakefield YOT. The YOT workers chaired all reviews and worked closely with the casework team (see section on resettlement strategy). The casework officers carried out most of the preparatory work for reviews with young people, as well as completing the necessary documentation.

8.17 Planning meetings were always attended by the community YOT worker and representatives from the young people's substance misuse service and the education department. Family members were encouraged to attend and were present at around half of the reviews. The young woman's personal officer had previously attended all training planning meetings, but information was now delivered by the caseworkers, who attended all reviews and helped young women to prepare for them.

8.18 The two reviews we observed were well conducted by the appropriately-skilled YOT workers who chaired them. The level of attendance by community YOT officers for young women on remand matched that for those who were sentenced, which was largely attributable to the unit's specialist remand YOT worker's persistence in ensuring that community-based colleagues attended all scheduled reviews. Discussions covered all aspects of the young woman's welfare and issues relating to offending behaviour were also dealt with appropriately. Important subjects such as physical and mental health, performance on the rewards and sanctions scheme and eligibility for release on temporary licence were all covered as a matter of course. The targets relating to education and training were particularly focused and the more general targets were reasonably specific. There was particular emphasis on ensuring that the young woman was at the centre of the discussion. The supporting documentation indicated that discussions of the quality we observed were typical.

8.19 Virtually all young people were granted early release, although this was decided through discussions at training planning meetings and was not automatic. One young woman had been appropriately refused early release because she had failed to cooperate with the targets in her plan.

8.20 One young woman was discharged during the inspection without specified accommodation. The unit-based YOT workers had begun to advocate on her behalf as soon as she had arrived in custody to ensure that she had an allocated supervising officer and had raised the accommodation problem with community-based colleagues at the earliest opportunity. Unit staff had supported the young woman well throughout her time on the unit, but this good work was likely to be jeopardised by the lack of any secured accommodation on release. On the day of her discharge, the young woman was due to be picked up by her YOT worker and had been told that she would be provided with accommodation of some sort, but she did not know where she was going to live and was extremely anxious.

8.21 A representative from the unit always attended the first review in the community.

8.22 Public protection issues were usually dealt with by the unit-based YOT manager. A unit-based public protection committee met weekly. It was chaired by the YOT manager and attended by the unit principal officer, one of the YOT workers, the mental health worker, a member of education staff and a representative from the main security department. The discussions were very detailed. All new cases were considered initially to determine if the young woman could be permitted to use tools and an appropriately cautious approach was taken when insufficient information was available. All active or potential multi-agency public protection arrangement (MAPPA) cases were monitored and reviewed. The level of restrictions imposed was altered as new information came to light. There was a helpful flow of information between unit staff and colleagues on the main site. Links with YOT workers and the police in the community were very good and the YOT workers were assiduous in their attempts to obtain 'missing information'. Representatives from the unit always attended when they were invited to MAPPA reviews in the community.

Recommendation

8.23 Agreement regarding a discharge address should be finalised at pre-release training planning meetings.

Substance use

Expected outcomes:
Children and young people with substance-related needs are identified at reception and receive effective support and treatment throughout their stay in custody, including pre-release planning. All children and young people are safe from exposure to and the effects of substance use while in the establishment.

8.24 Young women requiring clinical management and supervision were treated at the adult substance misuse unit. Prescribing regimes were needs-based, with care provided by a specialist team. There were risk management protocols, but girls mixed with adults during exercise and association, and the regime was poor. Not all staff had child protection training. Joint work between the clinical substance misuse service and the young people's substance misuse service (YPSMS) was insufficiently developed. The YPSMS was well integrated in the unit and young women could access a range of age-appropriate interventions. All voluntary and mandatory tests had been negative.

8.25 There was a comprehensive substance misuse strategy for the unit and the YPSMS had conducted a needs analysis for the last quarter. Regular population needs assessments, standardised across the young people's estate, were due to be introduced. The YPSMS annual delivery plan had been finalised and agreed.

8.26 The YPSMS was represented at the main prison monthly drug strategy meetings and provided service updates. The manager attended local community rehabilitation and aftercare provision meetings but had not yet formed strategic links with local drug and alcohol action teams. There were joint working protocols with other service providers but the new healthcare/YPSMS protocol had not been finally agreed. YPSMS staff attended a range of multidisciplinary unit meetings and had recently introduced substance misuse intervention team (SMIT) meetings combined with safeguarding to discuss individual care plans. Joint care coordination between

the YPSMS, primary healthcare, mental health in-reach and the substance misuse unit (SMU) had not been formalised.

8.27 New arrivals were screened and urine-tested at reception. Those requiring clinical management and supervision were immediately transferred to the SMU in the main prison where they were interviewed by the GP and treatment was started on the first night. Clinical staff had specialised in substance misuse treatment. The unit's three GPs also worked at the community drug service and could access the support of the primary care trust's clinical lead who offered weekly clinics at the SMU.

8.28 There were comprehensive clinical management protocols and flexible prescribing regimes. In the previous six months, eight young women had been treated for alcohol, eight for heroin and one for benzodiazepine dependency. Two amphetamine users were admitted for observation. Methadone treatment included maintenance for pregnant young women and those on short sentences.

8.29 A protocol for managing young women located on the SMU stipulated single cell accommodation, separate shower arrangements and observation during association and exercise when they mixed with adults. However, staffing levels were limited, the 48-bed unit was often very busy and not all staff had received child protection training. The regime for young women was very limited and they did not have access to education.

8.30 Young women stayed on the SMU until they completed their alcohol detoxification programme or had stabilised on methadone. Individual care plans were drawn up but were not shared with the YPSMS who visited the young women. Discharge plans were sent to Rivendell's primary care nurse but not communicated to the YPSMS. This lack of information-sharing was undermining good joint care coordination.

8.31 There were welcome plans for the substance misuse service to take over the complete management of primary healthcare on Rivendell unit, including the clinical care of substance-dependent young women, subject to recruiting additional nursing staff to provide 24-hour cover (see also section on health services).

8.32 All young women received a mental health screen within their first three days. A full-time RMN offered a range of primary mental health care services on the unit and could refer substance-users who had experienced trauma and abuse to specialist services shared with the adult site. She liaised well with the SMU and the YPSMS but joint care coordination had not been formalised.

8.33 The YPSMS consisted of a manager, who was also responsible for two other young women's units, and two experienced full-time workers. There were appropriate supervision arrangements and access to relevant training. Administrative support had been lacking for some time, which affected data collection. Workers shared an office with YOT staff.

8.34 The YPSMS team was well integrated in the unit and attended a range of multidisciplinary meetings. The recently-established SMIT meetings were to become the forum for young women's care coordination. Workers contributed to training planning meetings and provided progress reports.

8.35 New arrivals were assessed within five days, but this time span was too long for some. In June 2007, three young women had been released from court and two transferred before they could be assessed. A total of 110 young women had received initial assessments in the previous

year against a key performance target of 60. The unit was piloting a multidisciplinary assessment tool covering physical and mental health as well as substance use.

8.36 The previous quarter's needs analysis showed that only 6% (three girls) had not used substances, excluding tobacco. Over two-thirds required tier 3 or 4 interventions for problematic use, which mainly involved alcohol, cannabis, ecstasy and then amphetamines.

8.37 All young women undertook substance misuse awareness and education sessions. The YPSMS delivered its own module, as well as co-facilitating a five-week rolling open college network-accredited programme together with education. Care plans relating to substance use were in place for all young women and the service utilised the 'better choices' intervention pack to engage problem users. Modules covered specific substances including smoking cessation and sexual health, and were used flexibly according to individual need. The service used art and poster sessions to engage young women and their magnetic ear bead therapy (rather than auricular acupuncture) was proving popular. Dedicated physical education input was planned.

8.38 The YPSMS had established good links with YOT workers and community providers, and joint work was evident in care plans and training planning meetings. Preparation for release included information on overdose prevention and a release pack. Rehabilitation and aftercare provision in the community varied greatly across the wide catchment area and was unavailable to many young women on release.

8.39 Young women could access voluntary drug testing and seven young women had signed compacts. Testing was infrequent. The scheme was mainly promoted to those on enhanced privileges, who would otherwise be required to sign compliance testing compacts. The link to rewards and sanctions was inappropriate. Testing took place in the reception area and no one had yet tested positive.

8.40 Mandatory drug testing (MDT) was conducted in the main prison and officers from the unit usually, but not always, accompanied young women. MDT officers had not received child protection training. Girls did not mix with adults, but adult protocols and procedures were applied, including strip-searching and holding girls for up to five hours if they could not provide a sample. The appropriateness of MDT for this age-group was inappropriate, particularly since all tests had been negative.

Recommendations

8.41 The YPSMS should develop its links with strategic planning groups in the community.

8.42 The draft joint working protocol between health services and the YPSMS should be agreed and implemented.

8.43 The regime for young women on the substance misuse unit should be improved, including access to education appropriate to meet their individual needs.

8.44 Young women on the substance misuse unit should be supervised at all times when mixing with adult prisoners.

8.45 Nursing and discipline staff on the substance misuse unit should undertake child protection training.

8.46 Multidisciplinary joint care coordination should take place between the substance misuse service, the mental health in-reach service and the YPSMS.

8.47 Young women should receive initial substance misuse assessments within two to three days of arrival.

8.48 Voluntary drug testing should be promoted and take place regularly. It should not be linked to rewards and sanctions.

8.49 The adult-oriented procedures of mandatory drug testing are not appropriate for young people and should not be applied.

Housekeeping point

8.50 Administrative support should be available to the YPSMS to facilitate essential data collection.

Section 9: Recommendations, housekeeping points and good practice

The following is a listing of recommendations and examples of good practice included in this report. The reference numbers at the end of each refer to the paragraph location in the main report.

Main recommendation

To the Youth Justice Board & NOMS

Courts, escorts and transfers

9.1 Young women should not share transport with adults or young men. (HP36)

Main recommendations

To the Governor

9.2 Young women should be strip-searched only on the basis of a thorough risk assessment that indicates this is necessary to protect them or others from harm. (HP37)

9.3 There should be a full-time dedicated primary care nurse for the young women. He or she should be readily available to young women during the core day and attend detention and training order and other care planning meetings as appropriate. (HP38)

9.4 An integrated care planning system should be introduced. (HP39)

9.5 All security measures within the unit should be risk assessed to ensure that they are proportionate. (HP40)

9.6 There should be a comprehensive behaviour management policy. (HP41)

Recommendation

to the Youth Justice Board & the Governor

First days in custody

9.7 Young women should be given essential information at court about what will happen to them on arrival at the unit. (1.24)

Recommendation

to the Youth Justice Board

Training planning and remand management

9.8 Agreement regarding a discharge address should be finalised at pre-release training planning meetings. (8.23)

Courts, escorts and transfers

9.9 Incidents when young women have shared transport with adult prisoners or young men or arrived late should be routinely discussed at the safeguarding strategy meetings and properly investigated. (1.6)

9.10 A log where young women can record comments about their treatment travelling to and from court should be held in reception. (1.7)

9.11 Video conferencing facilities should be used whenever possible and appropriate to keep court appearances to a minimum. (1.8)

First days in custody

9.12 A female member of staff should always be on duty in reception and in the residential unit. (1.22)

9.13 Young women in need of nicotine replacement patches should be provided with them on the day of their arrival, even if they arrive late. (1.23)

9.14 A peer support scheme, overseen by staff, should be introduced to help new arrivals settle in. (1.25)

9.15 Translation and interpreting services should be sought without delay for new arrivals who cannot speak or read English well. (1.26)

9.16 The reasons why young women report difficulties with property on arrival should be investigated. (1.27)

9.17 Screening should be provided in the strip-search area and young women provided with clean dressing gowns. (1.28)

Residential units

9.18 Cells should be assessed daily for cleanliness and tidiness. (2.11)

9.19 The communal parts of the residential areas should be furnished and decorated in an age-appropriate way. (2.12)

9.20 Young people should be allowed more association between different residential spurs. (2.13)

Personal officers

9.21 Young people should be allowed supervised access to read the contents of their wing narratives. (2.23)

9.22 The introduction of the casework team should be carried out in conjunction with the continuing development of the role of the personal officer to ensure that the distinctions between the two roles complement each other. (2.24)

Safeguarding

9.23 The unit manager should ensure appropriate attendance at the safeguarding committee meeting. (3.7)

9.24 All available data relating to safeguarding issues specific to the Rivendell unit, including child protection, should be analysed for patterns and trends and regularly monitored by the safeguarding committee. (3.8)

Bullying

9.25 The unit's violence reduction strategy should be adjusted to the needs of the young women on the Rivendell unit and fully implemented. (3.17)

9.26 All staff on Rivendell unit should undertake anti-bullying/violence reduction training. (3.18)

9.27 All young women leaving the unit should be offered an exit interview and the results analysed to inform the unit violence reduction strategy. (3.19)

Self-harm and suicide

9.28 A suicide and self-harm policy should be developed specifically for the unit. (3.25)

9.29 All staff should undertake at least the foundation training course in suicide and self-harm. (3.26)

9.30 Initial and subsequent assessments in ACCTs should include evaluations of behaviour drawing on historical and contemporary documentation along with an account of the actual incident triggering the process. (3.27)

9.31 Targets identified in care maps should be specific, measurable, achievable, realistic and timebound. (3.28)

9.32 Where specific interventions are used to address a young woman's underlying problems, this information should be included in ACCT documentation so that other staff can reinforce such work. (3.29)

Child protection

9.33 Unit managers should seek to ensure that the child protection policy is ratified by Wakefield Safeguarding Children Board without further delay. (3.36)

9.34 Staff cross-deployed from the main prison to work in the unit should have child protection training. (3.37)

9.35 A log of all child protection referrals should be maintained and kept confidentially by the governor. The log should be routinely monitored by a representative from the local

safeguarding children board, the governor, the Youth Justice Board and the area manager. (3.38)

9.36 Child protection referrals should be analysed so that patterns and trends can be identified. (3.39)

Race equality

9.37 The diversity manager should be trained to carry out investigations. (3.47)

9.38 There should be a unit diversity liaison officer to ensure that diversity issues specific to the unit are addressed. (3.48)

9.39 Racist incident report forms should be freely available on all residential spurs. (3.49)

9.40 All staff on the unit should be trained in diversity. (3.50)

9.41 There should be oversight of diversity matters relating to the unit through the safeguarding committee. (3.51)

9.42 Young women should be regularly consulted about diversity issues through the participation meetings and represented at the safeguarding committee meetings to present concerns. (3.52)

9.43 Race relations and diversity should be promoted positively in the unit and should involve young women and multidisciplinary staff. (3.53)

Foreign nationals

9.44 The specific needs of children who are foreign nationals should be formally acknowledged within a unit policy. (3.60)

9.45 There should be a designated foreign national coordinator for the unit. (3.61)

9.46 Computer software that allows material to be translated into different languages should be obtained. (3.62)

9.47 Young women who require the services of an interpreter should wait no longer than 24 hours and should not be asked to sign anything in the absence of an interpreter. (3.63)

9.48 There should be clear guidance for staff and young women setting out the entitlements of foreign national young women and how they should be supported. (3.64)

9.49 Free weekly telephone calls should be offered in lieu of a visit. (3.65)

9.50 Young women should be allowed to exchange two ordinary letters for one airmail letter. (3.66)

Contact with the outside world

9.51 There should be a comprehensive strategy to encourage and enable more family contact. (3.74)

9.52 All young women who are sentenced should be entitled to a visit each week. (3.75)

9.53 Toilets and baby-changing areas in the visits hall should be checked and cleaned regularly. (3.76)

Applications and complaints

9.54 Replies to complaints should be courteous and address the issue raised. (3.82)

9.55 The complaints box should be emptied by administrative staff from the main prison to ensure confidentiality and preserve the integrity of the complaints system. (3.83)

9.56 Complaints generated from the unit should be analysed to determine patterns and trends. (3.84)

9.57 Senior unit staff should be actively involved in the participation meetings. (3.85)

9.58 The role and function of the advocates and the participation meetings should be clarified and communicated to all staff and young people. (3.86)

Health services

9.59 A health needs assessment should be finalised and used to plan, commission and implement child-specific services. The services should be easily identifiable within any service level agreements. (4.31)

9.60 All mental health services should be commissioned from and provided by CAMHS. (4.32)

9.61 All health professionals in contact with the young women should have enhanced Criminal Records Bureau checks and child protection training. (4.33)

9.62 All medicine refrigerators should be kept between 2 and 8 Celsius and should be adjusted accordingly when necessary. (4.34)

9.63 Health promotion materials should be readily available throughout the unit. (4.35)

9.64 A full dental surgery inspection should be carried out by or on behalf of the primary care trust. (4.36)

9.65 All clinical records should be contemporaneous and conform to professional guidance on record-keeping from the relevant regulatory bodies. All health interventions should be recorded. (4.37)

9.66 There should be an auditable system to ensure that young women who fail to attend for medications are seen and the reasons for non-attendance discussed and documented. (4.38)

9.67 Life-long condition registers and waiting lists should include and clearly identify young women so that their use of health services can be monitored. (4.39)

9.68 There should be child-specific policies and protocols, particularly for the outbreak of communicable diseases. (4.40)

9.69 Triage protocols should be developed to ensure consistency of advice and treatment to all young women. (4.41)

9.70 A formal system of documented risk assessment for all patients should be introduced to ensure consistency when determining suitability for in possession medication and whether daily, weekly or monthly supply is appropriate. (4.42)

9.71 Young women should be able to receive the full range of childhood and adolescent immunisations and vaccinations. (4.43)

9.72 Young women should be able to access out-of-hours emergency dental care. (4.44)

9.73 The number of oral health promotion sessions should be increased to one session a week and prison health promotion staff should be trained in oral health issues. (4.45)

9.74 Healthcare staff should see young women at least a week before they are due to be discharged. The discharge clinic should include a well woman assessment and assistance in registering with a GP and other healthcare professionals as required in liaison with youth offending team health workers. (4.46)

9.75 There should be clear protocols to ensure a young woman's safety if she is admitted to the main prison in-patient or mother and baby unit. (4.47)

9.76 Information-sharing protocols should exist with appropriate agencies to ensure efficient sharing of relevant health and social care information. (4.48)

9.77 Following reception screening, a further health assessment should be carried out and recorded by trained staff, no later than 72 hours after the young woman's arrival in custody. (4.49)

9.78 All young women should receive a pharmacy service equivalent to that in the community, which includes direct access to advice by appropriately trained pharmacy staff, information about the benefits and risks of medications, and the self-administration of medication. (4.50)

Education, training and library provision

9.79 More attention should be given to harnessing skills development into more formal independent living skills or preparation for work programmes. (5.14)

9.80 The education programme should be revised to introduce more variation of activity. (5.15)

9.81 Programmes for more academic young women, particularly those wishing to undertake or continue GCSE study, should be improved. (5.16)

9.82 A more assertive and discernible day-to-day management presence on the unit should be established. (5.17)

9.83 The quality of target-setting for vocational courses should be improved. (5.18)

9.84 A more effective system of individual tutorials for young women to review personal learning targets and objectives should be developed. (5.19)

9.85 The quality of teaching and learning of some staff should be improved by developing the range of teaching methods used and dissemination of good practice. (5.20)

9.86 A programme of careers education and appropriate resources should be developed and there should be regular input from Connexions. (5.21)

9.87 Access to library provision as a curriculum resource should be improved. (5.22)

Physical education and health promotion

9.88 Regular access to the main gym should be provided. (5.28)

9.89 Arrangements for outdoor activities should be improved. (5.29)

9.90 The necessary improvements should be made to the Astroturf area to ensure that full use can be maintained. (5.30)

Faith and religious activity

9.91 All young women should have access to a chaplain of their faith. (5.33)

9.92 The liaison chaplain for the unit should have adequate facility time to carry out a full pastoral role. (5.34)

9.93 Young women who wish to attend activities and additional evening services provided by the chaplaincy should be enabled to do so. (5.35)

Time out of cell

9.94 Young women on the basic level of the rewards and sanctions scheme should be allowed to spend some time out of their cells on weekend afternoons. (5.41)

9.95 The outdoor areas should be developed to provide better recreational opportunities and encourage young women to go outside. (5.42)

9.96 The programme of evening and weekend recreational activities should be improved to include more structured activities for all young women. (5.43)

Security and rules

9.97 Security information reports relating to the unit should be collated and analysed separately. They should be signed off correctly and in a reasonable timescale. (6.7)

9.98 The use of the intensive supervision room or special cell should cease. (6.8)

Discipline

9.99 Adjudications should involve thorough investigation and young women should be routinely informed that they are entitled to seek the advice or help of advocates. (6.17)

9.100 Young women who have been restrained should be properly debriefed after the incident. The role of the advocates in the process should be made clear. (6.18)

9.101 There should be separate monitoring and analysis of the use of force on the unit to identify patterns or trends and this should be overseen by the safeguarding committee. (6.19)

9.102 There should be a formal quality assurance system to check that the use of force documentation has been completed correctly. (6.20)

9.103 Full records of medical examinations and any reported injuries (F213s) should always be attached to the use of force forms. (6.21)

9.104 Injuries sustained during restraint should be monitored by the safeguarding committee. (6.22)

9.105 All separation paperwork should be completed correctly and reviews should be multidisciplinary and involve young women. (6.23)

9.106 Young women who are separated should have detailed behaviour targets so that progress can be measured and to help them avoid further incidents. (6.24)

9.107 Young women who are separated should be able to take part in education unless a risk assessment deems this inappropriate. (6.25)

Rewards and sanctions

9.108 There should be greater differentiation between privileges associated with the different levels of the rewards and sanctions scheme. (6.30)

Canteen/shop

9.109 The shop list should include a range of hobby materials. (7.9)

9.110 New arrivals should be able to place a shop order within their first 24 hours. (7.10)

Resettlement strategy

9.111 The offending behaviour group work programme should be processed for accreditation. (8.10)

Substance use

9.112 The YPSMS should develop its links with strategic planning groups in the community. (8.41)

9.113 The draft joint working protocol between health services and the YPSMS should be agreed and implemented. (8.42)

9.114 The regime for young women on the substance misuse unit should be improved, including access to education appropriate to meet their individual needs. (8.43)

9.115 Young women on the substance misuse unit should be supervised at all times when mixing with adult prisoners. (8.44)

9.116 Nursing and discipline staff on the substance misuse unit should undertake child protection training. (8.45)

9.117 Multidisciplinary joint care coordination should take place between the substance misuse service, the mental health in-reach service and the YPSMS. (8.46)

9.118 Young women should receive initial substance misuse assessments within two to three days of arrival. (8.47)

9.119 Voluntary drug testing should be promoted and take place regularly. It should not be linked to rewards and sanctions. (8.48)

9.120 The adult-oriented procedures of mandatory drug testing are not appropriate for young people and should not be applied. (8.49)

Housekeeping points

First days in custody

9.121 The induction booklet should be revised to ensure that it is up to date and fit for purpose. It should be produced in an age-appropriate format with the help of young women on the unit. (1.29)

9.122 Young people should be involved in the production of age-appropriate and relevant information to display in the reception area. The information should be displayed in a range of languages. (1.30)

Residential units

9.123 Notices should be improved, with input from young women, to attract attention to the information displayed. (2.14)

Applications and complaints

9.124 The induction booklet should describe how the applications and complaints systems work. (3.87)

9.125 A tracking system should be introduced to allow follow-up of late replies to applications. Young people should be asked to provide a signature on receipt of the reply. (3.88)

Health services

9.126 The emergency bag on the unit should contain a 'spacer' for the administration of inhalers to asthmatics in line with local policy. (4.51)

Education, training and library provision

9.127 Better use should be made of ICT resources to enhance teaching. (5.23)

Canteen/shop

9.128 Newspapers should be available to young women. (7.11)

Resettlement strategy

9.129 Results of the needs analysis should be disseminated to all unit staff. (8.11)

Substance use

9.130 Administrative support should be available to the YPSMS to facilitate essential data collection. (8.50)

Good practice

Race equality

9.131 A local area committee met the hate incidents security panel, which included the three local prisons, the Bradford hate crime alliance and Kirklees racial equality council. This reviewed many of the racist incident reports and was a good initiative. (3.54)

Resettlement strategy

9.132 Good use was made of individual assessments contained within the ASSET documentation and data had been aggregated to provide a useful needs analysis of the young women. (8.12)

9.133 The integrated filing system ensured that all staff working with young women recorded and shared information in the same file. (8.13)

9.134 The production of a protocol to ensure that young people transferred to E wing continued to receive an agreed level of service was an example of good collaborative work across the prison. (8.14)

Appendix 1: Inspection team

Nigel Newcomen	Deputy chief inspector of prisons
Fay Deadman	Team leader
Ian Macfadyen	Inspector
Angela Johnson	Inspector
Gerry O'Donoghue	Inspector
Keith McInnis	Inspector

Specialist inspectors

Elizabeth Tysoe	Health services inspector
Sigrid Engelen	Substance use inspector
Stella Butler	Ofsted team leader
Steve Miller	Ofsted inspector
Jane Attwood	HMI Probation
Julia Fossi	Researcher

Appendix 2: Prison population profile

Population breakdown New Hall 30 July 2007

(i) Status	Number of juveniles	%
Sentenced	21	91
Convicted but unsentenced	2	9
Remand		
Detainees (single power status)		
Detainees (dual power status)		
Total	23	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								
16 years								
17 years	8	2	1		3		2	16
18 years					1			1
Total	8	2	1	0	4	0	2	17

(iii) Number of determinate sentences under section 53(2) or section 91 (by age & sentence length)

Sentence	Under 2 yrs	2-3 yrs	3-4 yrs	4-5 yrs	5 yrs +	Total
Age						
15 years						
16 years						
17 years		1	1	1	1	4
18 years						
Total		1	1	1	1	4

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						
16 years						
17 years						
18 years						
Total						

Number of indeterminate sentences by age

Sentence	Section 90 (HMP)	Detention for life under section 91	Section 53 (1)	Section 226 (DPP)	Total
Age					
15 years					
16 years					
17 years					
18 years					
Total					

(iv) 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							
16 years							
17 years	2						2
18 years							
Total	2						2

(v) Main offence	Number of juveniles	%
Violence against the person	6	26
Sexual offences		
Burglary	2	9

Robbery	6	26
Theft & handling		
Fraud and forgery		
Drugs offences		
Driving offences		
Other offences	1	4
Breach of community part of DTO	8	35
Civil offences		
Offence not recorded/ Holding warrant		
Total	23	100

(vi) Age	Number of juveniles	%
15 years		
16 years		
17 years	22	96
18 years	1	4
Total	23	100

(vii) Home address	Number of juveniles	%
Within 50 miles of the prison	12	52
Between 50 and 100 miles of the prison	7	30
Over 100 miles from the prison	4	18
Overseas		
NFA		
Total	23	100

(viii) Nationality	Number of juveniles	%
British	22	96
Black or Black British		
Caribbean		
African		

Other Black		
Chinese or other ethnic group		
Chinese		
Other ethnic group	1	4
Total	23	100

(x) Religion	Number of juveniles	%
Baptist		
Church of England		
Roman Catholic	7	30.4
Other Christian denominations		
Muslim		
Sikh		
Hindu		
Buddhist		
Jewish		
Other	1	4.4
No religion	15	65.2
Total	23	100

Appendix 3: Summary of young people questionnaires and interviews

Juvenile survey methodology

A voluntary, confidential and anonymous survey of a representative proportion of the juvenile population was carried out for this inspection. The results of this survey formed part of the evidence-base for the inspection.

Choosing the sample size

The baseline for the sample size was calculated using a robust statistical formula provided by a government department statistician. Essentially, the formula indicates the sample size that is required and the extent to which the findings from a sample of that size reflect the experiences of the whole population.

At the time of the survey on 4 July 2007, the juvenile population at HMYOI New Hall was 20. All juveniles were selected.

Selecting the sample

Respondents were randomly selected from a LIDS prisoner population printout using a stratified systematic sampling method. This basically means every second person is selected from a LIDS list, which is printed in location order, if 50% of the population is to be sampled.

Completion of the questionnaire was voluntary. Refusals were noted and no attempts were made to replace them. Three respondents returned a blank survey.

Interviews are carried out with any respondents with literacy difficulties. No interviews were conducted.

Methodology

Every attempt was made to distribute the questionnaires to each respondent on an individual basis. This gave the researcher an opportunity to explain the independence of the Inspectorate and the purpose of the questionnaire, as well as to answer questions.

All completed questionnaires were confidential – only members of the Inspectorate saw them. In order to ensure confidentiality, respondents were asked to do one of the following:

- have their questionnaire ready to hand back to a member of the research team at a specified time
- seal the questionnaire in the envelope provided and hand it to a member of staff, if they were agreeable
- seal the questionnaire in the envelope provided and leave it in their room for collection.

Respondents were not asked to put their names on their questionnaire, although their responses could be identified back to them in line with child protection requirements.

Response rates

In total, 17 respondents completed and returned their questionnaires. This represented 85% of the juvenile population. The response rate was 85%.

Comparisons

The following document details the results from the survey. All missing responses are excluded from the analysis. All data from each establishment has been weighted, in order to mimic a consistent percentage sampled in each establishment.

Presented alongside the results from this survey are the comparator figures for all juveniles surveyed in young offender institutions. This comparator is based on all responses from juvenile surveys carried out in four units since 2005.

In all the above documents, statistically significant differences are highlighted. Statistical significance merely indicates whether there is a real difference between the figures, i.e. the difference is not due to chance alone. Results that are significantly better are indicated by green shading, results that are significantly worse are indicated by blue shading and where there is no significant difference, there is no shading.

Juvenile Survey Responses HMYOI New Hall 2007

Juvenile Survey Responses (Missing data has been excluded for each question) Please note: Where there are apparently large differences, which are not indicated as statistically significant, this is likely to be due to chance. NB: This document shows A comparison between the responses from all juveniles surveyed in this establishment with all those surveyed for the juvenile comparator

Key to tables

	Any percent highlighted in green is significantly better than the juvenile comparator	HMYOI New Hall	Juvenile Comparator	
	Any percent highlighted in blue is significantly worse than the juvenile comparator			
	Percentages which are not highlighted show there is no significant difference between the 2007 survey and the juvenile comparator			
	Number of completed questionnaires returned	17	65	
	SECTION 1: GENERAL INFORMATION (Not tested for significance)			
2	Are you 18 years of age?	**5**	**3**	
3	Are you sentenced?	**95**	**69**	
4	Is your sentence 12 months or less?	**75**	**26**	
5	Do you have less than six months to serve?	**81**	**48**	
6	Have you been in this prison less than a month?	**25**	**27**	
7	Have you been to any other YOI during this sentence?	**10**	**26**	
8	Do you usually live in this country?	**95**	**98**	
9	Is English your first language?	**100**	**83**	
10	Are you from a minority ethnic group? (including all those who did not tick White British, White Irish or White Other category)	**5**	**43**	
11	Is this the first time that you have been in a YOI, secure children's home or secure training centre before either sentenced or on remand?	**30**	**58**	
12	Do you have any children?	**10**	**8**	
13	Have you ever been in care? (either foster care or children's home)	**25**	**37**	
14	Are you on a care order now?	**10**	**11**	
	SECTION 2: COURTS, TRANSFERS AND ESCORTS			
15a	We want to know about the most recent journey you have made either to or from court or between establishments? Was the van clean?	**58**	**65**	
15b	We want to know about the most recent journey you have made either to or from court or between establishments? Was the van comfortable?	**13**	**22**	
15c	We want to know about the most recent journey you have made either to or from court or between establishments? Did you feel safe?	**94**	**57**	
15d	We want to know about the most recent journey you have made either to or from court or between establishments? Did you have enough comfort breaks?	**12**	**17**	
15e	We want to know about the most recent journey you have made either to or from court or between establishments? Were your health needs looked after?	**72**	**68**	
16	Did you spend more than four hours in the van?	**37**	**21**	
17	Were you treated well/very well by the escort staff?	**90**	**90**	
18a	Did you know where you were going when you left court or when transferred from another establishment?	**90**	**60**	
18b	Did you receive written information about what would happen to you before you arrived?	**11**	**15**	
18c	When you first arrived here did your property arrive at the same time as you?	**42**	**73**	

	Number of completed questionnaires returned	17	65	
	SECTION 3: YOUR FIRST FEW DAYS HERE			
20	Did you have any problems when you first arrived?	**74**	**69**	
21a	Please answer the following question about your first few days here: Were you seen by a member of healthcare staff in reception?	**94**	**87**	
21b	Please answer the following question about your first few days here: When you were searched was this carried out in an understanding way?	**88**	**85**	
21c	Please answer the following question about your first few days here: were you told what you needed to know by the staff when you first arrived?	**72**	**81**	
21d	Please answer the following question about your first few days here: were you able to make a telephone call to your family/friends on your first day here?	**88**	**88**	
22	Were you in reception for less than 2 hours?	**70**	**87**	
23	Were you treated well/very well in reception?	**100**	**82**	
24a	Did you have access to a chaplain within the first 24 hours of you arriving at this prison?	**55**	**43**	
24b	Did you have access to someone from healthcare within the first 24 hours of you arriving at this prison?	**81**	**80**	
24c	Did you have access to a Listener/Samaritans within the first 24 hours of you arriving at this prison?	**35**	**27**	
24d	Did you have access to the prison shop/canteen within the first 24 hours of you arriving at this prison?	**25**	**11**	
25	Did you feel safe on your first night here?	**95**	**53**	
26	Did you go on an induction course within your first week?	**75**	**59**	
27	Did the induction course cover everything you needed to know about the prison?	**60**	**42**	
	SECTION 4: LIFE HERE			
29	Is it easy/very easy for you to attend religious services?	**90**	**73**	
30	Does the shop/canteen sell a wide enough range of goods to meet your needs?	**70**	**54**	
31	Do you find the food here good/very good?	**25**	**18**	
32	Do you think the overall quality of the healthcare is good/very good?	**81**	**64**	
33a	Is it easy for you to see the Doctor?	**55**	**74**	
33b	Is it easy for you to see the Nurse?	**75**	**87**	
33c	Is it easy for you to see the Dentist?	**10**	**8**	
33d	Is it easy for you to see the Optician?	**5**	**23**	
34	Have you had any problems getting your medication?	**5**	**22**	
35	Have you received any help with any alcohol problems?	**25**	**53**	
36	Have you received any help with any drugs problems?	**10**	**60**	
37	Have you had a 'nicking' (adjudication or minor report) since you have been here?	**45**	**27**	
38	Have you been physically restrained (Cand R) since you have been here?	**21**	**11**	
39	If you have spent a night in the segregation/care and separation unit, did the staff treat you well/very well?	**5**	**3**	
40	Have you talked to an advocate since you have been here (an outside person to help you with the authorities)?	**65**	**60**	
41	Are you on the enhanced (Top) level of the reward scheme?	**30**	**44**	
42a	Please answer the following question about the reward scheme: Do the different levels make you change your behaviour?	**35**	**52**	
42b	Please answer the following question about the reward scheme: Do you feel you have been treated fairly in your experience of the reward scheme?	**63**	**72**	
43	Do you know how to make a complaint?	**81**	**93**	
44a	Please answer the following questions about complaints: Is it easy to make a complaint?	**40**	**65**	
44b	Please answer the following questions about complaints: Do you feel complaints are sorted out fairly?	**19**	**27**	

	Number of completed questionnaires returned	17	65	
	SECTION 4: LIFE HERE continued			
44c	Please answer the following questions about complaints: Have you ever been made to or encouraged to withdraw a complaint?	10	10	
45	Are you normally able to shower everyday if you want to?	100	98	
46	Is your cell call bell normally answered within five minutes?	55	71	
47	Do most staff treat you with respect?	100	73	
	SECTION 5: SAFETY			
49	Have you ever felt unsafe in this prison?	5	34	
51	Has another young person or group of young people victimised (insulted or assaulted) you here?	5	31	
52a	If you have felt victimised by a prisoner/group of prisoners, what did the incident(s) involve: Insulting remarks?	0	23	
52b	If you have felt victimised by a prisoner/group of prisoners, what did the incident(s) involve: Physical abuse?	5	3	
52c	If you have felt victimised by a prisoner/group of prisoners, what did the incident(s) involve: Sexual abuse?	0	0	
52d	If you have felt victimised by a prisoner/group of prisoners, what did the incident(s) involve: Racial or Ethnic abuse?	0	3	
52e	If you have felt victimised by a prisoner/group of prisoners, what did the incident(s) involve: Drugs?	0	0	
52f	If you have felt victimised by a prisoner/group of prisoners, what did the incident(s) involve: Having your canteen/property taken?	0	4	
52g	If you have felt victimised by a prisoner/group of prisoners, what did the incident(s) involve: Because you were new here?	0	1	
52h	If you have felt victimised by a prisoner/group of prisoners, what did the incident(s) involve: Being from a different part of the country than others?	0	0	
54	Has a member of staff or group of staff victimised (insulted or assaulted) you here?	5	12	
55a	If you have felt victimised by a staff/group of staff, what did the incident(s) involve: Insulting remarks?	0	4	
55b	If you have felt victimised by a staff/group of staff, what did the incident(s) involve: Physical abuse?	0	2	
55c	If you have felt victimised by a staff/group of staff, what did the incident(s) involve: Sexual abuse?	0	1	
55d	If you have felt victimised by a staff/group of staff, what did the incident(s) involve: Racial or Ethnic abuse?	0	0	
55e	If you have felt victimised by a staff/group of staff, what did the incident(s) involve: Drugs?	0	1	
55f	If you have felt victimised by a staff/group of staff, what did the incident(s) involve: Having your canteen/property taken?	0	0	
55g	If you have felt victimised by a staff/group of staff, what did the incident(s) involve: Because you were new here?	0	1	
55h	If you have felt victimised by a staff/group of staff, what did the incident(s) involve: Being from a different part of the country than others?	0	3	
57	If you were being victimised by another young person or a member of staff would you be able to tell anyone about it?	88	72	
58	If you did tell a member of staff that you were being victimised do you think it would be taken seriously?	68	39	
59a	When you first arrived here did other young people shout through the windows at you?	40	11	
59b	Did you find this shouting threatening?	0	4	
59c	Do other young people shout through the windows at you now?	47	9	
59d	Do you find this threatening now?	0	2	
59e	Do you shout through the windows at others?	39	9	
59f	Have staff checked on you personally in the last week to see how you are getting on?	42	48	

Comparison with Juvenile Prison benchmark and previous survey results.

	Number of completed questionnaires returned	17	65	
	SECTION 6: USING YOUR TIME HERE USEFULLY			
61	Were you under the age of 14 when you were last at school?	**37**	**28**	
62a	Have you ever been excluded from school?	**90**	**68**	
62b	Have you ever truanted from school?	**88**	**89**	
62c	Do you feel you need help with reading, writing or maths?	**42**	**32**	
62d	Are you doing any education here?	**100**	**90**	
62e	Is education helping you?	**81**	**54**	
62f	Were the teachers understanding with any school problems when you first arrived?	**72**	**51**	
62g	Are you learning a skill or trade?	**70**	**47**	
62h	Are you in a job here?	**12**	**28**	
63	Do you go to the gym more than 5 times each week?	**0**	**27**	
64	Do you go on association more than 5 times each week?	**65**	**66**	
65	Can you go outside for exercise everyday?	**81**	**75**	
	SECTION 7: KEEPING IN TOUCH WITH FAMILY AND FRIENDS			
67	Are you able to use the telephone to speak to someone in your family every day?	**100**	**64**	
68	Have you had any problems getting access to the telephones?	**10**	**25**	
69	Have you had any problems with sending or receiving mail?	**30**	**58**	
70	Is it easy/very easy for you family and friends to get here to visit you?	**35**	**33**	
71	Do you get 2 or more visits each month?	**45**	**50**	
72	Do you arrive on time for a visit?	**40**	**53**	
73	Are you and your family/friends treated well/very well by visits staff?	**74**	**50**	
	SECTION 8: RESETTLEMENT			
75	Did you meet your personal officer within your first week here?	**65**	**68**	
76	Do you feel helped by your personal officer?	**70**	**63**	
77a	Do you know what targets you have been set in your training/sentence plan?	**65**	**65**	
77b	If you want, can you see your training/sentence plan?	**60**	**54**	
78	Has your YOT/social worker/probation officer been in touch since you arrived here?	**90**	**73**	
79	Do you know how to get in touch with your YOT/social worker/probation officer?	**75**	**84**	
80	Do you want to stop offending?	**90**	**62**	
82a	Please answer the following questions on preparation for release: Have you had a say in what will happen to you when you are released?	**37**	**33**	
82b	Please answer the following questions on preparation for release: When you are released will you be living with a family member?	**60**	**29**	
82c	Please answer the following questions on preparation for release: Have you had help with finding accommodation?	**30**	**30**	
82d	Please answer the following questions on preparation for release: Are you going to school or college on release?	**60**	**37**	
82e	Please answer the following questions on preparation for release: Has anyone spoken to you about going to college on release?	**60**	**38**	
82f	Please answer the following questions on preparation for release: Do you have a job to go to on release?	**5**	**7**	
82g	Please answer the following questions on preparation for release: Have you done anything during your time here that you think will help you to get a job on release?	**45**	**57**	
82h	Please answer the following questions on preparation for release: Has anyone from here spoken to you about getting a job on release or about New Deal?	**30**	**21**	
82i	Please answer the following questions on preparation for release: Do you have a Connexions personal adviser?	**55**	**46**	
82j	Please answer the following questions on preparation for release: Is there anything you would still like help with before you are released?	**21**	**63**	
83	Have you done anything or has anything happened to you here that you think will make you less likely to offend in the future?	**35**	**27**	