Report on an announced inspection of

HMYOI Stoke Heath

Juveniles only

13 – 17 October 2008

by HM Chief Inspector of Prisons

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Introduction

HMYOI Stoke Heath holds a challenging mix of sentenced young adults and sentenced and remanded juveniles. This full announced inspection looked only at the juvenile side of the establishment, which a year before had suffered a serious disturbance. Stoke Heath was also having to manage the impact of a rolling programme of repairs and refurbishment. It was therefore commendable that, despite this upheaval, we found an essentially safe, respectful and purposeful juvenile facility, focused on work to reduce re-offending.

There had been improvements to the reception area. Late arrivals and unnecessary delays led to young people reporting an unwelcoming experience. First night and induction arrangements were adequate, but could be improved. The roles of the safeguarding and violence reduction committees overlapped and needed clarification. Nevertheless, child protection was well managed, young people at risk of self-harm were well cared for and improvements had been made to anti-bullying procedures. Efforts had also been made to manage vulnerable young people better, but the independent care and support unit remained austere. Use of force was decreasing and the separation and reintegration unit had improved.

The environment was improving as refurbished accommodation came back on stream. However, the significant size of the residential units made them difficult to supervise and placed considerable demands on staff. Despite this, relationships between staff and young people were generally good, supported by well functioning personal officer and rewards and sanctions schemes. Race and diversity were well managed, and good efforts were made to address the needs of the small number of foreign nationals. Healthcare services were reasonable.

The time young people spent out of cell did not match our expectation, but was at least predictable and association was never cancelled. Opportunities for exercise in the open air were limited. Education was generally satisfactory. There was a broad range of courses and teaching and levels of achievement were satisfactory. However, punctuality was poor and behaviour in class variable, although disruptive pupils were well managed. Physical education was developing well, but there were problems with attendance.

Resettlement was improving, but would benefit from a comprehensive needs analysis to guide further developments. Training planning and remand management were good, as were public protection arrangements. Resettlement services were generally sound, but more use could be made of release on temporary licence.

The serious disturbance at Stoke Heath's juvenile facility a year ago had inevitably affected the confidence of staff. The establishment was also undergoing a large-scale and disruptive programme of refurbishment to address fire safety issues. It was, therefore, to the considerable credit of managers and staff that, given this backcloth and the many everyday challenges thrown up by a volatile population of young people, this inspection found an essentially safe and respectful facility, with some good quality purposeful activity and a proper focus on work to reduce re-offending.

Anne Owers — February 2009
HM Chief Inspector of Prisons

Fact page

Role of the establishment
Stoke Heath is a young offender institution holding young adult males aged 18–21 and young people under 18 (male).

Area organisation
West Midlands

Number held
568

Certified normal accommodation
634

Operational capacity
750

Last inspection
19–23 March 2007

Brief history
Stoke Heath was built in 1964 as a category C adult prison. It was converted to a borstal two years later. Stoke Heath doubled in size in 1997 with two new wings. The establishment has managed overcrowding since 2002, with an extra 116 young offenders above normal capacity. A new healthcare centre was opened in 2004, and there is a new resettlement unit. A new wing holding 60 young adults opened in January 2008. Since January 2008, a wing or part of a wing has been out of operation on a rotation basis due to fire safety work throughout the establishment.

Description of residential units

		Operational capacity/CNA
A wing	Induction unit/sentenced juveniles	72/72
B wing	Young adults/healthy living unit	72/72
C wing	Sentenced juveniles/vulnerable juvenile unit	72/72
D wing	Juvenile remands/juvenile personal development unit	58/58
E wing	Young adults/induction unit	116/60
F wing	Young adults	150/120
G wing	Young adults	150/120
I Wing	Young adults	60

Section 1: Healthy prison assessment

Introduction

HP1 All inspection reports include 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 people reported an unwelcoming reception experience, exacerbated for many by arriving late. All young people were strip searched. Improvements had been made to the reception area. Immediate needs were dealt with, but thereafter new arrivals spent too long in holding rooms. First night procedures were good, but cells were poor and vulnerability assessments were inadequate. Induction was comprehensive, but young people spent too much time locked up. The safeguarding committee carried out an effective operational function, but there were some gaps in the strategic management of safeguarding. There had been some improvement in the care of vulnerable young people, although a small number remained isolated in the independent care and support unit. Child protection was well managed and young people at risk of self-harm were generally well cared for. Management of bullying had improved. Disciplinary procedures were carried out effectively, but some punishments were excessive. The separation and reintegration unit had improved in appearance and practice. The use of force was decreasing, with good governance. Overall the establishment was performing reasonably well against this healthy prison test.

HP4 Despite recent improvements, too many young people arrived late after lengthy waits in court and travelling with adults. The previous lack of important documentation accompanying new arrivals had begun to improve. Discharge-to-court arrangements were efficient, but video-link facilities were underutilised.

HP5 Improvements had been made to the reception area and all new arrivals were offered a free telephone call and a shower. We observed relaxed interaction between reception staff and young people, but young people we spoke to described an unwelcoming approach which was repeated in survey findings. They waited for too long in grubby holding rooms with little to occupy them. The support of Insiders was not offered in reception. First night procedures were thorough, but the quality of initial vulnerability assessments was generally inadequate, as were related risk management plans. Cells which were shown to us as ready for new arrivals were in a poor state.

HP6 The induction programme was comprehensive and the majority of young people said that it covered everything they needed to know. Young people started their induction quickly, but spent too much time locked up between sessions. The sessions we observed were age appropriate and well delivered. The absence of a designated induction classroom on the unit was a disadvantage.

HP7 All relevant departments and the head of Shropshire Children's Services regularly attended the safeguarding committee meetings. There was poor coordination between the safeguarding committee and the violence reduction committee, as reported at the previous inspection, and there were gaps in the strategic management of some aspects of safeguarding as a consequence. However, the safeguarding committee carried out some useful operational management functions.

HP8 Some improvements had been made to the management of particularly vulnerable young people. Multidisciplinary care planning had been introduced, but it was limited in scope. More robust gatekeeping of referrals had reduced the number of young people located in the independent care and support unit, but the environment remained austere. Young people located there remained largely isolated from their peers and the restricted regime did not meet their individual needs.

HP9 Governance arrangements for child protection were efficient and referrals were dealt with well. Overall there was a good level of engagement and external scrutiny of child protection by Shropshire Children's Services. Robust internal investigations were carried out when allegations against members of staff did not reach the threshold for investigation by the local authority. There were regular multidisciplinary meetings to oversee the progress of individual cases but monitoring and analysis of child protection referrals were limited. The majority of dedicated juvenile staff had been trained and Criminal Records Bureau (CRB) cleared and had a good level of awareness of child protection, but it could not be guaranteed that staff who were cross deployed from the young adult side were either trained or CRB cleared.

HP10 Bullying remained a significant problem and young people highlighted verbal abuse as a main concern. Overall the management of bullying had improved. Efforts were made to identify bullying from a range of sources, including injury reports and surveys. Staff were alert to bullying, but, although many referrals were made, we came across examples of potential bullying which had been identified through security information reports, wing observation reports and complaints, but had not been referred through the formal bullying systems or investigated properly. There was a range of interventions for identified bullies and support programmes for victims, although take up by victims was low.

HP11 There was a comprehensive suicide and self-harm prevention policy and staff had been trained in and were familiar with assessment, care in custody and teamwork (ACCT) procedures. Residential staff, including night staff, demonstrated good knowledge of young people subject to ACCT monitoring, and day-to-day care and support was good. Individual cases were monitored effectively by the safeguarding committee, but the strategic management of self-harm was inadequate due to limited analysis of available data. Quality assurance systems were thorough and overseen by the safeguarding committee. Although weaknesses in completion of the documentation had been identified, they had not been addressed. Attendance at reviews was not always consistent. Concerns at our previous inspection about the over-frequent use of strip clothing had been addressed.

HP12 Security was managed well and dynamic security was good. There were efficient arrangements for disseminating security information to staff. Strip searching was a routine part of many procedures, including reception and visits, with no regard to individual risk or vulnerability. Otherwise, security arrangements were appropriate and did not adversely affect the regime.

HP13 Young people were seen by advocates prior to adjudication whenever possible. The setting for adjudications was age appropriate and we observed the procedure being carried out satisfactorily. The vast majority of a sample of adjudications that we examined had been completed correctly. Some punishments were excessive and affected young people's contact with their family. There was a comprehensive behaviour management policy which encouraged staff to use less formal disciplinary measures. However, minor reports were rarely used and staff told us they had little confidence in the system. Mediation was used to good effect.

HP14 The use of force was decreasing, and this was to be welcomed. The weekly use of force monitoring meeting provided good governance. There was effective data collection and analysis relating to the use of force. Records were kept of injuries sustained by young people during restraint, but analysis and use of these data were inadequate and neither the violence reduction committee nor the safeguarding

committee routinely monitored the data. The special cell had only been used once in the past 10 months, which was a significant improvement.

HP15 The cleanliness and appearance of the separation and reintegration unit (SRU) was much improved and staff treated young people well. The regime was consistently delivered and included some education provision, but young people were not permitted to attend their normal allocated education or vocational training courses. Reviews were completed well and there were some recent examples of reintegration planning for a few young people. However, a small number of young people who spent up to 30 days in the SRU did not have individual care plans.

HP16 The opiate detoxification regime was not sufficiently flexible to meet the complex needs of the small number of young people requiring it. More young people needed alcohol detoxification and this was delivered appropriately. Mandatory drug testing (MDT) rates were low, but still involved routine strip searching which was inappropriate.

Respect

HP17 There had been noticeable improvements in the condition of the residential units and grounds, but caring for large numbers of challenging young people in such sizeable units was a difficult task. Access to showers and telephones was good. Young people dined out regularly and the food was reasonable. Relationships between staff and young people had improved considerably and the personal officer scheme worked well. The rewards and sanctions scheme was effective. Applications and complaints were dealt with efficiently. Chaplains provided very good support to young people. Race and diversity were well managed and the needs of young people who were foreign nationals were generally met. Healthcare provision was generally reasonable, but young people with no clinical need were occasionally allocated to an inpatient bed. Overall the establishment was performing reasonably well against this healthy prison test.

HP18 Residential units had the capacity to hold over 70 young people and the four-storey layout was not ideal. This made the task of caring for very challenging young people difficult. A programme of repainting and refurbishment was in progress and communal areas were clean and tidy, including the grounds. The condition of cells was more variable, although young people were equipped with duvets and curtains and new furniture stock was gradually replacing old and broken items. There were no offensive displays. Showers had been improved, shower screens had been installed and staff supervision was good. In our survey 89% reported daily access to showers, well above the comparator of 55%. All young people were required to wear prison issue clothing, but it was in good condition and laundered weekly.

HP19 The quality of meals and quantity of food were acceptable. Young people were able to dine out every day for all meals, except breakfast. At weekends breakfast packs were issued the previous evening and few young people saved their breakfast until the following day. A reasonable variety of products were available from the prison shop, but young people complained legitimately that they could not order items available in jars or tins.

HP20 Seventy-six per cent of survey respondents reported that most staff treated them with respect, which was significantly better than the 60% reported in the previous survey. We observed generally respectful or friendly relationships, including common use of

first names. Consultation, for example at monthly trainee meetings, contributed to constructive relationships.

HP21 There was an effective and innovative personal officer scheme, based on a detailed policy with management checks to ensure compliance. All young people we spoke to knew who their personal officer was and spoke well of how the scheme worked. An innovative arrangement had been put in place to enable personal officers to attend training planning meetings, but there were other important meetings, such as assessment, care in custody and teamwork reviews, which they did not attend.

HP22 The rewards and sanctions scheme worked well through a system of merits and demerits, with good input from a range of departments. Young people were motivated to achieve the required standards by differentials between the levels. Reviews were conducted well and young people were encouraged and enabled to participate. They were given appropriate targets and understood how to progress within the scheme. The basic regime was not excessively punitive apart from restriction of telephone calls to three times a week.

HP23 Applications and their progress were not systematically logged. There was some evidence that this stemmed from officers' accessibility and willingness to deal with issues as they arose, sometimes with the assistance of advocates. Complaints were generally dealt with within a few days. Responses were respectful and apologies and offers of compensation were made where appropriate. Monthly representative meetings with staff, advocates and the Independent Monitoring Board offered young people the opportunity to air their grievances before considering a formal complaint.

HP24 There was a strong chaplaincy team, well integrated within the establishment, and contributing to positive work with young people over and above their pastoral role. The programme of work with families, in particular young fathers, was a particularly good example. The chaplaincy accommodation had been improved by enlargement of the multi-faith area.

HP25 An overarching diversity policy had been drafted and there was an effective system to identify and support young people indicating any disability on arrival. With limited resources, the two disability liaison officers were developing an outline for an impact assessment, but needed time to undertake this important task. There had been progress in recognising and addressing the needs of young people from black and minority ethnic backgrounds, including systematic consultation. Race equality action team (REAT) meetings were well attended and included young people who had been trained and were supported in their role. Ethnic monitoring was presented in an accessible format and disparities were investigated appropriately. Race incident report forms (RIRFs) were scrutinised by the full-time race equality officer and the deputy governor, and were linked with security reports. Insults were a recurrent theme. RIRFs were investigated well and a timely response was given to the complainant.

HP26 There were few foreign national young people. A policy had been formulated and there were bimonthly meetings with the foreign national coordinator. Issues raised were discussed at REAT meetings. Some essential information was available in other languages and a professional interpreting service was used, mainly for training planning meetings. The foreign national coordinator had developed a collaborative link with an immigration office in Birmingham, but independent immigration advice was in short supply in the area.

HP27 The healthcare reception process was satisfactory and first night medication was available. There was an appropriate range of clinics and a reasonable staff skills mix. There was a children's nurse in the team and GP cover was adequate. There were no treatment rooms on the residential units, nor suitable rooms for the administration of medicines or healthcare consultations. The record keeping system was unsound. Not all inpatients had clear care plans and they did not all have a clinical need. They often spent too long locked up. Primary care mental health nurses were often allocated to generic nursing duties which affected their ability to carry out their mental health work. Healthcare staff did not routinely attend planning meetings, including pre-release meetings. The waiting list for dental services was poorly managed and there was no triage. Clinical governance arrangements were appropriate.

Purposeful activity

HP28 Although not meeting our expectation of 10 hours a day, time out of cell was predictable. Access to association was good, with appropriate activities managed by staff, but there were too few opportunities for time in the open air. Young people were allocated to education soon after their arrival after a thorough initial assessment. There was a broad range of courses and a sufficient number of activity places. Attendance was satisfactory, but there were serious problems with punctuality. Teaching, achievements and standards were satisfactory. Behaviour in class was variable, but the inclusion room was successful. There was good celebration of achievements. PE provision was developing well, but there were some problems with attendance. Support offered by Connexions was poor. Overall the establishment was performing reasonably well against this healthy prison test.

HP29 The average time spent out of cell was just under nine hours a day, with considerably less at weekends. The regime was predictable and young people had association every day which was rarely cancelled. Staff interacted very well with young people during association, undertaking various activities with them. Association rooms were well equipped and young people on the enhanced regime had particularly good facilities. The youth club and enrichment rooms were a valuable addition. Scheduled time in the open air was as little as one hour at the weekend. Even then, it coincided with other activities.

HP30 The assessment and induction process for learning and skills was thorough and included screening for a range of behavioural difficulties. Young people were given good advice about education and vocational training courses. There were sufficient places to ensure that all young people had an allocated activity for most of the day. The number of vocational places had increased recently, although it remained low. There were well developed plans to increase it further. There was a good range of educational courses and teaching and learning were satisfactory overall. Behaviour was sometimes poor and not adequately challenged. There was a small exclusion/time out room. This was used to good effect so that very few young people were returned to their cells for poor behaviour. Learning support assistants were effective. Nurture groups and outreach support on the units for a small number of young people with learning disabilities sometimes prevented them from attending mainstream classes.

HP31 Attendance was satisfactory and well monitored, but punctuality was poor and late starts and early collections affected the quality of lessons. In the previous year, 87% of young people had left the establishment with a qualification. Although the majority of

accreditations were at level one, this was appropriate and a good achievement for some. The availability of courses for more able young people and those serving longer sentences had improved. The standard of young people's work was satisfactory overall, with some good quality work in vocational and practical subjects. Successes were celebrated, for example through awards events which young people and their parents or carers valued highly.

HP32 Access to PE was good and the programme was well balanced with a range of accredited courses. Poor attendance and refusals were disruptive to the programme. The department had developed good links with departments such as psychology, young people's substance misuse service and healthcare. External links were developing well, for example with a local special school and participation in local basketball and football leagues. The facilities were managed well, but monitoring of attendance needed improvement.

HP33 Access to the library was satisfactory during the week, but there was no weekend provision. The library stock was sufficient and the range of books, including some texts in Welsh, was appropriate for the age group.

HP34 Links with employers and agencies to help young people find employment or training on release were inadequate. Some basic general careers advice was provided through citizenship and personal development courses, but there was insufficient input from Connexions. Young people from Wales, who formed almost a third of the population, did not receive their entitlement to guidance from Careers Wales.

Resettlement

HP35 There was significant and continuing improvement in the management of resettlement and the development of reintegration services. A needs assessment was required to support further development. Arrangements for training planning and remand management were good. A small number of high quality work placements were available through release on temporary licence, although they had not been used very much. Public protection work was thorough. Access to telephones and visits for family contact was good. Young people serving indeterminate sentences were managed efficiently. Substance misuse services were good, but lacked nicotine replacement therapy and voluntary drugs testing. Overall the establishment was performing reasonably well against this healthy prison test.

HP36 A new reducing reoffending policy was being developed, but a resettlement needs analysis had not been carried out. The resettlement committee had met regularly for the last six months, with good attendance following a period of drift. The designated membership of the resettlement committee was appropriate and the committee was beginning to function more effectively. There were no community representatives, but the head of the on-site youth offending team (YOT) attended a regional community forum involving YOT managers and secure accommodation providers.

HP37 Allocation of responsibility for individual resettlement pathways was beginning to improve the development of reintegration services. Contact had been made with a local Citizens' Advice Bureau to obtain some specialist input regarding finance and debt. Release on temporary licence was being used for a small number of high quality placements. Very few young people were released without accommodation thanks to

the in-house YOT team. Relateen offered a useful family conciliation service, which complemented the work being carried out with young fathers by the chaplaincy. A range of short locally accredited generic cognitive skills courses was delivered by a joint team of psychologists and officers. A practical pre-release course was provided for all young people.

HP38 Training planning and remand management were managed well and reviews were conducted within relevant timescales. Young people were well supported through the process, but the venue was too small to accommodate a large number of people. There was not always sufficient input to the reviews from specialist departments and less than half were attended by families. A high proportion of first reviews in the community were attended by prison staff which helped to maintain the continuity which the detention and training order sentence was designed to provide.

HP39 Multi-agency public protection arrangement cases were systematically monitored and reviewed and there were good links with relevant community-based agencies. Young people who were subject to other public protection measures, such as risk to children, harassment or hate crimes, were not subject to the same level of scrutiny.

HP40 Access to telephones was good and there was an effective system in place to facilitate telephone contact with families for young people without telephone credit. Facilities for visits were generally good. The visits booking system worked well, but young people were not always taken to their visit on time. There was a good visitors' centre, and the visits room was bright and comfortable with helpful staff. Provision of refreshments was limited to afternoon visits. Family days were organised and welfare visits were arranged when necessary. Young people were subject to random strip searching after visits which was inappropriate. Although there were few closed visits, the security policy placed an over-reliance on a drug dog indication to support a closed visit.

HP41 The management of young people sentenced to indeterminate sentences was efficient within the constraints of a national system developed for adults.

HP42 There was a comprehensive substance misuse strategy, which included alcohol, and was informed by an annual needs analysis. A wide range of drugs education group work sessions was provided for all young people. Nicotine replacement therapy was not available because the PCT would not provide funding. There was no provision for voluntary drug testing and compliance testing was not an appropriate alternative.

Main recommendations

HP43 Reception procedures should be improved so that new arrivals do not spend a long time waiting in holding rooms.

HP44 There should be a review of the roles of the safeguarding and violence reduction committees to improve the coordination of all aspects of safeguarding.

HP45 Residential units should hold no more than 40 young people so that they can be managed safely.

HP46 Young people should be able to exercise in the open air every day.

HP47 An analysis of the resettlement needs of the young people population should be carried out. The results should be used to inform the resettlement strategy.

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 Young people were sometimes escorted with adults and often arrived at the prison after 7pm following lengthy waits in court. The extent of these problems was difficult to assess as accurate records were not collated and there were no formal systems to address this with the escort providers. The number of young people arriving without information following the introduction of electronic documentation exchange (e-ASSET) had begun to reduce. Court movements were managed efficiently, but the video link was under-utilised.

1.2 A significant number of young people arrived late, often after lengthy journeys and long periods waiting in court cells after completion of their case. Records indicated that young people had been given refreshments, usually sandwiches and a carton of water, during their journey. All the records we examined were for journeys of less than two hours and no young people had been given comfort breaks. Some young people in a focus group confirmed that they had been given a comfort break during a journey of four and a half hours. One young person in a focus group indicated that he had asked for a comfort break, but this was refused and he had been given a bag to urinate in. Reception staff routinely asked young people about their journey and if they had any complaints.

1.3 Details of any young people arriving after 8pm were noted on the daily briefing sheet the next morning, and there was evidence of action having been taken by the operations governor in some extreme cases. However, information about late arrivals was not monitored, making it impossible to establish the extent of the problem. While managers informed us that they did complain to escort contractors about late arrivals at the security meetings, there appeared to be no formal system to investigate the cause and ensure that performance measures were applied to the contractor when appropriate.

1.4 Young people sometimes travelled in vehicles which also held young adults or adults. It was not possible to find out how often this occurred as the establishment did not collect this information. The recent move to exchange documentation electronically (e–ASSET), including pre-court and post-court reports and ASSETs (Youth Justice Board assessment documentation), had resulted in an increase in the number of young people arriving without documentation. In July 2008 26.67%, and in August 47.62%, of new receptions arrived without full information. Managers had been active in tackling this issue, and the situation had improved significantly, with approximately 13% in September arriving without documents.

1.5 Discharge-to-court arrangements worked effectively, and all young people were discharged to court on time, but the video-link facilities for court appearances were under-utilised.

Recommendations

1.6 Young people should arrive by 7pm so that they can be properly assessed and helped to settle in on their first night in custody.

1.7 All relevant information about new arrivals should be sent to the establishment in advance of their arrival.

1.8 Information about late arrivals and the number of young people who have shared transport with adults should be collected and monitored and included in regular meetings with the escort providers to address the issues.

1.9 The establishment should work with courts to promote the use of video link for court appearances where appropriate.

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.

1.10 Despite recent improvements to the reception area, the layout remained poor, and parts of the area were dirty and untidy. The basic needs of new arrivals were met – they were offered food, a shower and a free telephone call – and we observed sensitive treatment by staff. However, they then spent too long waiting in reception locked in dirty and uncomfortable holding rooms. All young people were strip searched on arrival without any assessment of risk or vulnerability. There were no designated first night cells, and cells allocated to new arrivals were dirty and poorly equipped. The quality of vulnerability assessments was generally inadequate, but first night procedures were thorough and enhanced supervision arrangements were good. Insiders were not routinely deployed as part of reception or first night procedures. The induction programme was thorough, but young people were not kept fully occupied during the two-week course and spent too much time locked in their cells.

Reception

1.11 We observed reception staff dealing with young people politely and making efforts to put them at their ease, although some addressed new arrivals by their surname only. Young people were asked if it was their first time in custody and staff noted when the young person appeared quiet or overwhelmed. New arrivals were given a helpful booklet with details of some support services and an explanation about what would happen in reception and on their first night, but this was only available in English. Insiders were not routinely available in reception.

1.12 The reception area had recently been extended, adding two interview rooms, a dining area, a nurses' room and a new shower area with three showers in individual cubicles. However, there were aspects of the layout which were not ideal, for example new arrivals were required to stand

at the front desk for the initial booking-in procedure which could include exchange of sensitive information in the hearing of others. Property was checked in the main reception area within view of the holding rooms, offering little privacy. Juveniles and young adults could not be separated if required unless one group was locked in a holding room. The holding rooms were grubby and covered in graffiti, despite some efforts with anti-graffiti paint. They were equipped with a bench and a television, but the television was positioned on a shelf in the corner, and the screen was not visible from the bench seating area. The holding rooms had Perspex doors and windows which allowed staff to observe young people waiting in the rooms. Staff based at the reception front desk had a good view of the holding rooms. There was a seating area and some notice boards in the corridor outside the dining area. We were told that young people were sometimes allowed to sit in this area rather than in the holding rooms, but only if young adults were not using the area. We did not observe any young people using this area.

1.13 All young people were routinely strip searched upon arrival in reception (see security and rules section). The searching area had been moved to a room away from the main corridor which was cramped and untidy. Young people were made to stand on a slatted wooden platform during the search, which appeared unnecessarily uncomfortable.

1.14 New arrivals were given an adequate reception pack and offered a shower and a free telephone call in reception. The telephone was fitted with a privacy hood, but its location, adjacent to the front desk in sight and hearing of staff and other young people or young adults, afforded little privacy.

1.15 All young people were offered a hot microwave meal on arrival. There was a choice of meals, including vegetarian and halal. The kitchen area was dirty and the microwave was particularly grubby. The freezer for storing meals was in a very poor state, and it was impossible to tell if food was stored at the correct temperature.

1.16 There was a dining area where young people could sit to eat a meal. There were a number of electrical boxes and switches accessible to young people in the room, which presented a potential hazard. We were told that the area was rarely used, and that young people often ate in the holding rooms.

1.17 Young people spent longer than necessary in reception. Only 44% in our survey said they spent less than two hours in reception, which was significantly worse than the comparator of 82%. We observed young people spending long periods in reception sitting in holding rooms. Some delays related to the availability of healthcare staff at busy times of the day when they were required elsewhere to administer medication (see section on primary care). We were told that during patrol periods working practices only allowed one person in each holding room in reception, meaning that any young person in excess of this number might be held on an escort van or placed temporarily in the healthcare centre.

1.18 In the new interview rooms, first night staff conducted initial one-to-one interviews in private and written procedures emphasised the importance of using the initial interview to identify risks and vulnerability. The interviews we observed were conducted in a relaxed, professional and age-appropriate manner. Healthcare staff used the new nurses' room to conduct private interviews.

1.19 Although we observed relaxed interaction between staff and young people in reception, young people we spoke to described a less than welcoming experience and, in our survey, only 54% of young people stated that they had been treated well or very well in reception, which was significantly worse than the comparator of 70%.

First night

1.20 The quality of initial vulnerability assessments that we examined ranged from poor to satisfactory. Many were superficial and showed no evidence that the member of staff completing the form had read the relevant documents, including the ASSET. Risk management plans were inadequate, often simply listing a number of departments. Only a few were of a high standard. This was particularly disappointing since the safeguarding policy contained some very useful guidance for staff about the completion of vulnerability and risk assessments.

1.21 After completing reception procedures, young people were located on A unit which was the induction unit. There was a good first night policy. A second first night interview took place on the induction unit, during which the information gathered in reception was checked for completeness and more detailed information about support services was given. In the interviews we observed, young people were given the opportunity to ask questions. In addition to the free call offered in reception, new arrivals were given £2 pin credit and a second free call to their family to assist them in arranging a reception visit. This was offered to them on their first night, but could be taken the following day at a convenient time.

1.22 Information which arrived with young people such as ASSET and pre- and post-court reports were passed to first night staff so that they were properly informed about new arrivals. Files we examined were well ordered. Young people arriving without necessary information who were identified as vulnerable were placed on enhanced supervision and we were impressed with the quality of the supervision logs which showed a good level of staff interaction. Staff we spoke to showed a good level of understanding of the new arrivals on the unit. A cell sharing risk assessment was completed for all young people before they were located on their first night. Except in exceptional circumstances, all new arrivals were allocated to a single cell. Insiders were not routinely available on the induction unit as part of first night procedures. There were no designated first night cells and new arrivals were located wherever there was a space. This meant that young people experiencing their first night could be scattered over three landings, making monitoring by evening and night staff problematic.

1.23 Cells that we inspected, that were supposedly ready for occupation, were dirty. Some contained rubbish. Most were covered in graffiti. One had a ripped mattress and another had a mattress and pillow covered in graffiti. A number were missing furniture (see section on accommodation and facilities).

1.24 In our survey 79% of young people said that they felt safe on their first night, which was significantly worse than the comparator of 84%.

Induction

1.25 There was a two-week rolling induction programme. Young people started their induction the day after their arrival or on Monday if they arrived over the weekend.

1.26 The induction programme was comprehensive, and in our survey 62% of young people stated that it covered everything they needed to know, which was significantly better than the comparator of 54%. The sessions we observed were age appropriate and used a variety of media. An induction pack was given to all new arrivals which contained useful information about the prison facilities and details of prison rules and complaints procedures, but it was not available in languages other than English.

1.27 Induction was a rolling programme running Monday to Friday. Young people who had been to Stoke Heath before and had left within the previous three months were able to undergo a fast track induction. Induction included individual interviews and assessments by induction staff and other departments, such as education, youth offending team workers and chaplaincy, and group presentations. Often the interviews or group sessions did not occupy the whole session or young people were unoccupied while others had individual assessments. During these periods young people were locked in their cells. There was no designated area for delivery of the induction programme. Staff used the association room or interview rooms, depending on when these areas were free.

Recommendations

1.28 Reception staff should address new arrivals by their preferred name.

1.29 Insiders should be routinely on duty in reception and should meet new arrivals as part of first night procedures.

1.30 Information leaflets given to young people in reception and on induction should be available in a range of different media and languages to meet the needs of the population.

1.31 The electrical boxes and switches in the dining area should be made inaccessible to young people.

1.32 Young people should be able to make a telephone call in reception in private.

1.33 There should be a quality assurance system in place to ensure that vulnerability assessments and risk management plans are of a consistently good standard.

1.34 First night accommodation should be clean and suitably equipped.

1.35 There should be a designated room for delivery of the induction classes.

1.36 Young people should be fully occupied during their induction programme.

Housekeeping points

1.37 All areas of reception and all equipment should be maintained in a safe, clean and hygienic state – particularly holding rooms, the searching area and the kitchen.

1.38 The televisions should be relocated so that they can be viewed from the seating area.

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 Young people were held in units of up to 72 which made the task of caring for them very challenging for staff. There were noticeable improvements to the accommodation and grounds, which were generally clean and tidy. The condition of cells was variable. All had duvets and curtains; new furniture was being issued to replace worn furniture; but graffiti was a persistent problem. The policy prohibiting offensive displays was enforced. All young people wore clothing issued by the establishment which was generally in good condition and laundered weekly. Access to showers and telephones was good. Staff supervised showers well. Some telephones were in cubicles which facilitated private conversation.

Accommodation and facilities

2.2 The three units housing juveniles, A, C and D, were similar, and all housed both convicted and unconvicted young people. A was the first night and induction unit. A and C units had 72 beds each. To mitigate some of the difficulties associated with managing such large numbers of challenging young people, association periods were split so that only half the unit was allowed out at any one time.

2.3 Most were single cells with four double cells on each unit. D unit had 58 beds in single cells. Risk assessment informed decisions about who could share one of the few double cells, but the policy did not prohibit sentenced and remanded young people from sharing. Many young people asked if they could share. All had in-cell sanitation. In the double cells the toilet and sink were in an enclave, separated from the cell by a door which afforded adequate privacy. Grilled cell windows could be opened a few inches for ventilation. The condition of cells was varied. Graffiti was common and often could not be remedied by cleaning. Old and broken furniture was being replaced with new stock, including lockable cupboards. Some young people complained about old and hard mattresses and pillows. We saw few damaged mattresses and some spares were kept on the units. All cells were issued with duvets, curtains and a television.

2.4 A programme of redecoration and refurbishment was in progress to improve the accommodation. The communal areas, including the dining room on each unit, had been repainted and were clean and tidy. It helped that the tutor supervising the accredited cleaning course accompanied her charges on to the wings to put their training into practice buffing the floors. The landings were not cluttered by a plethora of new and old notices. Some signage was hand drawn, colourful and child friendly. Each unit had a pair of association rooms, with one available to those on enhanced status which was equipped with a wider range of recreational facilities and sofas. Both had decent, comfortable seating. In addition to television and table games, there was a range of different pastimes. On A unit, in particular, staff took pride in accumulating a range of board games, books and models in their ‘enrichment room’. Each unit had a similar display of key notices and photographs on glazed notice boards.

2.5 Many cell notice boards were unattractively covered in toothpaste which had been used as adhesive, although new notice boards were included in the fresh stock of furniture. We did not see a single offensive display. Kettles were not issued, but every young person had a flask which could be filled from the boiler on the landing.

2.6 The four-storey layout of the accommodation, with the staff office on the ground floor, had some disadvantages. Some young people said cell call bells were not always answered promptly. These were electronically recorded and, on the sample records seen, delays were not frequent. The layout also made it more difficult for staff to identify and deal promptly with shouting through windows or doors. This was a recurrent problem, although it was not particularly noisy during our night visit.

2.7 Like other communal facilities, telephones were located on the ground floor. Telephone access and privacy was much improved, with four telephones on two units and three on the third. Two were within cubicles and others under privacy hoods. Only 16% of survey respondents indicated any problems getting access to the telephones, which was significantly better than the comparator of 32%.

2.8 Efforts had been made to keep the grounds tidy and pleasant. We saw very little rubbish lying about during the inspection, and the flowerbeds held diverse and interesting plant specimens.

Hygiene

2.9 Young people were encouraged to keep their cells tidy, with bedding neatly rolled up during the day. Personal hygiene stocks were available to young people and all cells were issued with cell-cleaning kits and inspected at the weekend. Levels of tidiness varied midweek and we were not convinced that vacated cells were cleaned promptly to ensure they were in order when a new occupant arrived (see arrival in custody section). The cleaning materials issued were not sufficient to keep the toilets clean, and these were in need of deep cleaning.

2.10 Showers had been improved, with dividing screens for privacy. During association four young people were allowed in the showers at a time, in 10-minute slots, following the order of a list compiled by staff to avoid incidents. They were not locked in but periodically checked by staff. Young people could use the showers at other times, for example if they had just arrived, and we came across examples of fearful youngsters given access singly, under staff supervision, until they became settled. In our survey, 89% of respondents said they could have a daily shower, which was significantly better than the comparator of 55%. Shower areas were generally tidy, with discarded underwear in a laundry bin rather than on the floor.

Clothing and possessions

2.11 All young people, including those on enhanced status, wore standard issue clothing. Entitlement was on a published list, as was other permitted property which varied according to status. The policy was that young people should present as tidy, with shirts tucked in. We did not see young people wearing assorted, ill-fitting clothes, nor did we see personal clothing draped around cells after hand washing. All clothing was sent to the establishment laundry following weekly kit change. Managers were considering installing washing machines in under-utilised rooms beside the showers, which might then be linked with permitting enhanced young people to have their own clothing. In addition to outer clothing provided for working outdoors, each unit had a stock of outerwear for young people taking exercise in inclement weather.

2.12 We did not see stockpiles of toiletries and personal possessions in cells, which often raise questions about bullying. Permitted possessions could be recovered from reception by submitting an application on the unit, to be followed through on the following Saturday.

Recommendations

2.13 Cell toilets should be deep cleaned regularly.

2.14 Sentenced and remanded young people should not share cells.

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 Effective efforts had been made to improve relationships between young people and staff since the previous inspections. Young people were generally referred to by first names and there was constructive interaction, including at monthly meetings between staff and unit representatives.

2.16 In our survey, 76% of young people said most staff treated them with respect. This was close to the comparator of 75% for similar establishments, but much improved on the 60% reported in our 2007 inspection. The majority of A, C and D unit staff were based permanently within these units, had received training to work with young people, and wore softer uniforms – polo shirts, in different colours according to rank, displaying their names. Psychology were delivering a continuing programme of pro-social modelling to all staff. There was some cross-deployment of staff in standard Prison Service uniform from the young adults' site. On one unit, this had happened on six of the previous 14 days, usually with one imported officer and once with two (see safeguarding section). We were told that a permanent member of the juvenile staff team was always allocated to the area at night.

2.17 Young people were usually referred to by their first names, with both names marked up on the office board and outside cell doors. We observed good levels of interaction between staff and young people, particularly on A unit, and staff generally knew and shared relevant information about their charges. During observed association, one or more staff members were actively engaging with young people. The low level of written applications suggested that many issues were resolved by talking to staff, which young people confirmed. Monthly consultation meetings between staff and representatives from young people and young adult units also provided an opportunity for issues to be aired, and sometimes resolved. These were chaired by a principal officer and a governor was usually in attendance. Minutes indicated action points which were reported on at the next meeting.

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.

2.18 There was an effective and innovative personal officer scheme, based on a detailed policy with management checks to ensure compliance. All young people we spoke to knew who their personal officer was and spoke well of how the scheme worked. Records did not fully reflect the extent of engagement that personal officers had with young people and their families. An innovative arrangement had been put in place to enable personal officers to attend training planning meetings, but there were other important meetings relating to the care of young people they were responsible for, such as assessment, care in custody and teamwork (ACCT) reviews, that they did not attend.

2.19 An unusually effective personal officer scheme had been developed, supported by a detailed written policy and senior officer checks. All young people seemed to know their personal officer and substitute, and reported favourably on the scheme, even if they did not always get on well with their allocated officer. Soon after arrival they were told the names of their first and second personal officers, given these in writing, and shown their paired pictures on the unit notice board. The names were also on the card outside each room door. This information was stamped inside their wing history sheet. Recorded meetings were not always within the targeted first 24 hours and weekly thereafter, but in our survey 58% of respondents confirmed that they had met their personal officer within the first week, which was significantly better than the comparator of 45%. Frequency of entries, and monthly senior officer checks, showed that the system was functioning. There were few negative comments. Our conversations with young people suggested that officers did more than they recorded. For example, we noticed a number of telephone calls made to family members, which suggested that concerns had been discussed leading to this outcome, even if the detail was not fully noted. When young people moved unit, they were told in advance who their new personal officers would be and staff exchanged relevant information. In some cases, notably on A unit, officers recommended that a young person stay put if he had particular problems settling in, to ensure continuity of support.

2.20 Although personal officers did not always attend all relevant meetings concerning the care of the young people they were responsible for, such as ACCT reviews, we were impressed by an innovative scheme to instil close collaboration with the caseworking team and encourage attendance at training planning reviews (see training planning section). The chaplaincy team reported that some personal officers had taken the opportunity to meet relatives during special family visits in the chapel.

Recommendations

2.21 Records should reflect important aspects of personal officer work undertaken with young people.

2.22 Personal officers should attend all meetings relating to the care of the young people they are responsible for.

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 The safeguarding committee met regularly, the designated membership was appropriate and included the head of Shropshire Children's Services. Attendance was good. There was a lack of coordination between the work carried out by the safeguarding committee and the violence reduction committee. There were some gaps in the strategic management of some important areas of safeguarding as a consequence. However, the safeguarding committee carried out some useful operational management functions. Some improvements had been made to the management of particularly vulnerable young people, but the individual needs of those placed in the independent support and care regime (ISCR) unit were not being met.

3.2 A draft safeguarding policy had not been ratified by the Local Safeguarding Children Board (LSCB). Discussions were continuing on aspects of the policy which Shropshire Children's Services were not content to agree. The safeguarding policy included child protection procedures, suicide prevention and self-harm management, guidance on the management of vulnerable young people and the violence reduction policy.

3.3 The safeguarding committee met monthly and was chaired by the head of safeguards. The designated membership included all relevant departments and residential staff. External members included escort services, the Samaritans and the assistant head of Shropshire Children's Services. The meetings were generally well attended. The safeguarding committee had a predominantly operational role which it carried out well. The regular operational functions included ongoing case discussions concerning young people who were subject to assessment, care in custody and teamwork (ACCT) procedures and regular oversight of quality assurance of ACCT documentation. However, this was not in line with the responsibilities for strategic management of some areas outlined in the draft safeguarding policy. We were told that the violence reduction committee carried out the strategic management function for all safeguarding areas as well as violence reduction, but there were some omissions. There was a lack of monitoring and analysis of some important safeguarding areas. Although data were collected for submission to the Youth Justice Board on injuries sustained during restraint, there was no ongoing monitoring by either the violence reduction committee or the safeguarding committee. Limited analysis of child protection referrals compounded this omission (see section on child protection). There was a paucity of data relating to self-harm incidents (see section on self-harm and suicide) and, despite a good level of discussion of individual cases, there was no strategic management of self-harm prevention. Following the previous inspection, we reported that there was a lack of clarity and coordination between the work of the violence reduction committee and the safeguarding committee, and little had changed.

3.4 There had been some recent improvements to the management of particularly vulnerable young people. A system of multidisciplinary care planning had been introduced and the vulnerable trainee unit had been renamed the independent support and care regime (ISCR). However, the care plans that we examined were limited in scope and inadequate for addressing the individual

needs of vulnerable young people. More robust gate-keeping of referrals had reduced the number of young people located on the unit. At the time of the inspection, four young people were located in the ISCR. All had been convicted of sex offences. There had been some changes to the previous regime for vulnerable young people placed there, who were now able to attend education and some other activities off the unit as a discrete group. The environment had not changed and was still austere and uncomfortably confined. It remained an inappropriate location for a group of young people who were not permitted to associate with others at any time.

3.5 The Governor was a member of the LSCB and the head of safeguards represented the establishment at LSCB meetings.

Recommendations

3.6 The terms of reference of the safeguarding committee should be clarified so that all aspects of safeguarding are properly managed and coordinated.

3.7 The safeguarding policy should be agreed with the Local Safeguarding Children Board without delay.

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

3.9 Alternative arrangements should be made in discussion with the Youth Justice Board for the placement of particularly vulnerable young people if they cannot be managed safely on normal location.

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.

3.10 Bullying remained a significant problem and verbal abuse seemed to be the greatest concern for young people, but overall the management of bullying had improved. Good efforts were made to identify bullying from a range of sources, including injury reports and surveys. Information provided to the violence reduction committee was good quality and was used very effectively. Staff were alert to bullying, but not all incidents were referred through the correct system or investigated properly and recording of bullying was inconsistent. Consequently the extent of bullying was not accurately identified. There was a good range of interventions available for identified bullies from individual support and development services (ISDS), and a similar range of support for victims, although take up was low. Staff entries in monitoring documents lacked evidence of engagement between staff and young people. Local posters about bullying were eye-catching and age appropriate.

3.11 Guidance on anti-bullying procedures was explained in the violence reduction strategy which had been updated in April 2008. The violence reduction committee met monthly and was chaired by the deputy governor. These meetings were well attended with representatives from all key areas within the establishment.

3.12 The quality of monitoring data provided to these meetings was good and included a breakdown of all violent incidents involving both populations. Hot spots for incidents and emerging trends were also identified. The committee interrogated and used this information in an impressive way. One example was targeted forums with young people based on this information. One such forum had been held on C unit after it emerged that a disproportionate number of incidents had occurred there.

3.13 Anti-bullying procedures were the responsibility of the head of safeguards. A full-time clerk, who had been in post since August 2008, collated reported incidents and maintained a log. The log listed outstanding investigations and young people on the various stages of monitoring. There were also two safeguarding officers available during the main part of each week day. Their role was to work with identified bullies, open monitoring documents and arrange reviews.

3.14 A bullying exit survey had taken place and analysis of the findings was published in April 2008. Results were based on 155 exit forms submitted by those being released over a 12-month period. This represented a return of only 9.6%. The analysis confirmed that 17% of respondents reported that they had been bullied at Stoke Heath. Respondents felt unsafe in the gymnasium, showers, wings and manufacturing department. The analysis did not differentiate between young adults and juveniles. In our own survey, 29% of young people said that they had been victimised by another young person while at Stoke Heath against a comparator of 22%. Twenty-one per cent of those who felt they had been victimised reported that the incident involved insulting remarks, which was significantly worse than the comparator of 12%. In addition, responses to all four questions about the extent of shouting out of windows and how threatening this felt were significantly worse than the comparators. However, this was not apparent during the inspection and the establishment was quiet and well ordered during our night visit.

3.15 Arrangements were good for identifying potential bullying incidents reported in injury to prisoner forms (F213s). Local guidance required staff to report suspected bullying incidents on bullying alert forms (BAFs) and submit them to the safeguarding team. In a seven-week period since 23 August 2008, 162 BAFs had been submitted which indicated that staff were alert to bullying concerns. However, this figure could not be relied on as an indicator of bullying, as the clerk raised additional BAFs for each young person named in the original, potentially resulting in multiple BAFs for a single incident. In addition, we found many examples of potential bullying behaviour that had been missed in security information reports, wing observation books and complaint forms. These inadequacies suggested that the extent of bullying was not accurately identified. Bullying incidents were passed to the unit manager to investigate, but the quality of investigation was, at best, variable. We saw many examples where investigations had not been conducted.

3.16 Information about the local anti-bullying strategy was explained on induction and well publicised in all residential units through standardised notices. Anti-bullying posters had been designed locally. These were eye catching and age appropriate.

3.17 There were three stages to the anti-bullying strategy. Perpetrators were advised whenever a BAF was received. After three BAFs were submitted naming a young person as a bully, a stage 1 monitoring booklet was raised. Reviews were completed each week and, if further BAFs were received in that time, the bully was placed on stage 2. Those on stage 2 were assessed by staff from the individual support and development services (ISDS) based on D unit, although young people were no longer automatically removed from normal location. Staff from the ISDS spent time with young people to map their needs against a range of available interventions which were delivered on a one-to-one basis. These usually took place over a two-week period and were built in to individual timetables to minimise disruption. There was an extensive list of interventions for bullies and victims. Feedback was collected, but no analysis had been completed. It was not

possible for us to evaluate the courses available, but we spoke to young people who had completed stage 2 and they were very positive about their experience.

3.18 After completion of stage 2, young people were placed on stage 3 which involved further monitoring for a period of six to eight weeks. Monitoring entries during this and the earlier stages were mainly observational and provided little evidence of engagement between staff and young people.

3.19 Similar arrangements were in place for victims of bullying, with monitoring arrangements based on a three-stage system and a range of interventions available at stage 2. We were told that, while support was provided, victims routinely declined the interventions offered.

3.20 Valuable electrical items such as CD players were sealed with tamper-proof seals in reception.

Recommendations

3.21 Reporting procedures for bullying incidents should be properly adhered to. There should be a quality assurance system to monitor the procedures and this should include checks on all potential sources of information such as observation books, complaints and security information reports.

3.22 Monitoring records at all stages of the anti-bullying procedure should provide evidence of engagement between staff and young people.

3.23 Efforts should be made to improve the take up of support for victims of bullying.

Housekeeping points

3.24 Analysis of bullying surveys should distinguish between the two populations held.

3.25 The quality and effectiveness of stage 2 interventions for identified bullies should be subject to evaluation.

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.

3.26 Staff had been trained in suicide and self-harm prevention and the comprehensive suicide and self-harm prevention policy provided useful staff guidance. Day-to-day care for young people subject to ACCT procedures was good. The safeguarding committee carried out an effective role in routinely monitoring individual cases, but the strategic management of suicide and self-harm was hindered by limited analysis of the available data. Quality assurance was thorough and a number of weaknesses in the documentation had been identified, but not addressed. Attendance

at reviews was not always consistent. Focus groups were held with young people to discuss issues concerning bullying and self-harm. There was no peer support scheme.

3.27 An up-to-date and comprehensive suicide and self-harm policy had been produced. A useful guide for staff entitled 'Caring for those in crisis' was also available which provided a brief summary of all the key elements of the ACCT process. All discipline staff had been trained in ACCT procedures. Residential staff demonstrated a good knowledge of young people on the unit who were being monitored and there was evidence of a good level of support and care on a day-to-day basis. During our night visit we found that staff were well acquainted with the main contents of the summary document. Night staff were aware of all young people subject to ACCT, and they appeared to have been well briefed about these young people by day staff. In addition to the handover briefings which took place between staff on the units, there was also a daily written handover covering issues relating to the ACCT procedures which was completed by the duty governor. All the night staff to whom we spoke carried ligature shears, although none of them had completed up-to-date first aid training.

3.28 Managerial oversight of suicide and self-harm was the responsibility of the head of safeguards. The statistical information which was produced for the safeguarding meeting was largely monthly snapshots without detailed analysis, and there was no ongoing monitoring of patterns or trends. Although there was no formal analysis, from our own sampling it was evident that the majority of the incidents of actual self-harm were fairly superficial cuts and scratches. However, the safeguarding committee did efficiently monitor outstanding ACCT cases and minutes of the meetings demonstrated a good level of discussion with action points followed up. There were usually around 10 open ACCT cases at any one time.

3.29 The quality assurance arrangements covering ACCT documentation were thorough. The safeguarding principal officer and unit senior officers carried out regular checks. The quality of ACCT documentation was discussed regularly at the safeguarding committee. Weaknesses were highlighted on a regular basis, relating mainly to poorly written observation entries and late reviews. While it was commendable that such close attention was being paid to these weaknesses, it was concerning that there appeared to have been little discernible improvement over the previous six months.

3.30 A full-time principal officer acted as the suicide and self-harm prevention coordinator. There were a further two safeguarding officers, and ACCT assessors were based on each of the residential units. A duty ACCT assessor was also available. This meant that there was always sufficient cover. The ACCT log was updated daily and was held in the communications room. In each unit office a central list of all individuals currently subject to an open ACCT document was discreetly displayed.

3.31 Focus groups of around 10 young people were convened regularly by safeguarding officers on the units to raise awareness about bullying and self-harm.

3.32 Most ACCT reviews were chaired by a unit senior officer. They usually included a member of unit staff, a representative from healthcare and sometimes a member of the chaplaincy team. The attendance of other specialist staff and personal officers was inconsistent.

3.33 Community-based YOT workers were routinely notified of any young people who were subject to ACCT procedures and the establishment expected them to pass the information to parents or carers, although there was no formal agreement to do so.

3.34 We observed an ACCT review. This took place in the healthcare unit and was chaired by a unit principal officer. A nurse, the duty ACCT assessor who was the imam, and the young person

were present. The meeting was well chaired and it was clear that staff made considerable effort to engage the young person, who had difficulty expressing himself. By the end of the review, he was sufficiently reassured to agree to return to normal location. Young people subject to ACCT procedures who gave particular cause for concern tended to be located initially in the healthcare unit. We found no evidence that healthcare beds were used routinely for young people at risk of self-harm and no evidence of lengthy stays. Concerns highlighted following the previous inspection about the over-frequent use of strip clothing had been heeded and this no longer took place without the express approval of the governing governor. There had been no use of strip clothing in the previous 12 months.

3.35 There were a number of young people who had received training as Insiders, but they had no responsibilities to support young people at risk of self-harm. There were cordless Samaritan telephones on each of the residential units. It was not possible to determine how frequently these were used, as logs had just been introduced and there were no entries. Young people could also contact the Samaritans from the PIN phone system. The contact details for the Samaritans were fully explained on induction and well publicised on all units.

Recommendations

3.36 Managers should ensure that weaknesses in work practices relating to ACCT, which are identified through quality assurance checks, are remedied.

3.37 All incidents of self-harm or attempted self-harm should be recorded, and aggregated data should be routinely analysed to establish patterns or trends. This management information should be monitored by the appropriate strategic management committee.

3.38 ACCT reviews should be multidisciplinary and staff who have regular contact with the young person should attend. This should always include the personal officer.

3.39 There should always be staff on duty who are first aid trained.

3.40 The establishment should ensure that parents or carers are notified when a young person is being formally monitored for self-harm, unless a decision has been made not to do so in the best interests of the young person and in accordance with Frasier competency guidelines.

3.41 A peer support scheme should be introduced for young people at risk of self-harm.

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.

3.42 Governance arrangements for child protection were efficient and referrals were dealt with well. Overall there was a good level of engagement and external scrutiny of child protection by Shropshire Children's Services. Robust internal investigations were carried out when allegations against members of staff did not reach the threshold for investigation by the local authority.

There were regular multidisciplinary meetings to oversee the progress of individual cases, but monitoring and analysis of child protection referrals were limited. Good efforts were made to advise young people of support services. The majority of staff were trained and Criminal Records Bureau (CRB) cleared and had good knowledge of child protection issues. Not all staff who were cross deployed from the adult side when there were staff shortages were trained to work with children or CRB cleared.

3.43 The majority of staff working with children and young people under the age of 18 had undergone some child protection training through the Juvenile Awareness Staff Programme. Exceptions were eight newly appointed officers who were due to be trained. Some duty governors, who were the first point of contact for child protection referrals in the absence of the child protection coordinator, had not been trained.

3.44 There had been no joint training for some time with the local authority, Shropshire Children's Services but, following criticisms in the most recent joint area review, a programme of joint multidisciplinary training was due for imminent delivery by the local authority. Child protection referrals which we examined demonstrated a good level of staff understanding of child protection concerns, and staff we spoke to were able to describe how they would use the child protection procedures when concerns were highlighted.

3.45 All but two members of staff (who were awaiting clearance) working with children and young people under 18 had undergone Criminal Records Bureau (CRB) checks to enhanced level. However, staff who usually worked with the young adult population had not been trained in child protection and two thirds had not been CRB checked. This was unsatisfactory since staff from the young adult side were regularly cross deployed to manage the under 18 population when there were staff shortages.

3.46 The child protection policy was due to be reviewed. It followed a standard format as set out in Prison Service Order 4950, but did not cover child protection issues specific to the population. For example, the explanations of abuse and neglect had far more relevance to children in community settings and did not provide useful illustrative examples for staff working with adolescents in custody.

3.47 The safeguarding policy which was in draft (see safeguarding section) included a reference to whistle-blowing procedures to ensure that staff raised legitimate concerns about the conduct of other staff. It referred to the need to have clear procedures and support systems in place, but they were yet to be developed.

3.48 The safeguarding manager acted as the child protection coordinator and was the first point of contact for all referrals, working closely with the establishment social worker. Referral systems were clear and referrals were managed efficiently. The criteria for referrals clearly set out that all allegations concerning treatment by members of staff should be referred to the local authority for initial investigation. These criteria were followed. Referrals were also made when young people bullied or assaulted each other. Many of these were deemed by the local authority not to reach the threshold for a child protection (section 47) investigation. Appropriate decisions concerning thresholds had been made in the examples we examined in this category. As part of the planned programme of joint multidisciplinary training, the local authority had indicated an intention to work with the establishment to improve their understanding of the thresholds for an investigation so that referrals were made appropriately and not simply as a precautionary measure. Strategy meetings and case conferences were convened appropriately. The in-house social worker dealt with disclosures of historic abuse appropriately. All were directed to the home authority through Shropshire Children's Services.

3.49 A monthly meeting took place to review all outstanding child protection referrals. There were no terms of reference or designated membership for this meeting. There were clear records of individual case discussion, but the meetings were not properly minuted. Consequently, accountability for action points was not always clear and there was no audit trail. The meetings routinely involved the child protection coordinator, a representative from the police child protection team, the in-house social worker and the assistant head of service for Shropshire Children's Services. The child protection log was held securely and access to it appropriately restricted. It was maintained in good order and updated regularly following the monthly meetings. The governor checked all child protection investigations before signing them off. Comments and action taken indicated that this was more than a formality. Robust internal investigations were carried out in cases of allegations against members of staff which had been considered and closed because they did not reach the threshold for a section 47 investigation.

3.50 There was some analysis of child protection referrals, but it was limited to monthly snapshots. There was no ongoing analysis of patterns or trends, for example by number or type of referral, which would have identified areas requiring further interrogation.

3.51 There were posters on display on the residential units informing children and young people about freephone access to Childline and the National Youth Advocacy Service. These numbers were put on to every young person's individual PIN system on arrival. Barnardo's provided a counselling service for young people who had suffered historic abuse, and there was additional support available through the in-house social worker and mental health in-reach services.

Recommendations

3.52 All staff working with young people should be trained in child protection and have enhanced CRB clearance.

3.53 The child protection policy should be revised in conjunction with the Local Safeguarding Children Board to ensure that it is helpful and relevant to staff working with the population at Stoke Heath.

3.54 There should be clear procedures and support systems in place to ensure that staff report legitimate concerns about the treatment of children and young people by staff, and to give assurance that the position and prospects of the reporting member of staff are not prejudiced.

3.55 Analysis of child protection referrals should be improved to include identification of patterns and trends.

Housekeeping point

3.56 The monthly meetings to monitor outstanding child protection cases should be properly minuted to ensure accountability.

Good practice

3.57 *The telephone numbers of Childline and the National Youth Advocacy Service were added to every young person's individual PIN system on arrival.*

Diversity

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.

3.58 The race equality action team (REAT) managed sound structures, and the wider diversity agenda was being developed. There were good consultation arrangements and focus groups had been held as part of impact assessments. Young people who acted as race equality representatives from each unit met regularly with the full-time race equality officer (REO) and attended the bi-monthly REAT meetings. They received training and resource packs to help them work effectively in this role. Race equality information boxes were located on all units and in the visits hall. Racist incident report forms were readily available, well managed by the full-time REO, and were all checked by the deputy governor. There had been some recent success in obtaining external input to the REAT, including quality assurance of racist incident reports. There had been successful efforts to promote cultural diversity. An overarching equality and diversity policy was being drafted. There was currently no diversity manager, but two part-time disability liaison officers had set up a sound system to identify and address presented disabilities at an early stage.

Diversity

3.59 A quarter of the juvenile population were of black or minority ethnic background, largely from the West Midlands conurbation. They had been involved in focus groups for the purpose of impact assessment of establishment policies, and had the opportunity to air their views regularly at general meetings or at race equality meetings. Units each had a juvenile race equality representative, who was sometimes nominated as a result of showing a constructive interest in the race equality package delivered on induction. They had their own monthly meetings with the race equality officer (REO) which fed into the bi-monthly race equality action team (REAT) meetings, dealing with establishment-wide issues. The REAT meetings were managed very effectively. They were chaired by the deputy governor and well attended by functional heads. In recent months attendance had numbered over 20. This included juvenile representatives from all units.

3.60 Functional heads, other staff and young people's representatives had attended training in 2007 on managing and promoting race equality. Information provided to us indicated that just over 40% of staff had received diversity training, although this figure may not have included all relevant training, and the proportion relating to staff working on A, C and D units could not easily be identified. The REO, a senior officer, had been trained for the role. His post was full time, for the whole of the establishment, with 20 hours a week support from an assistant. Units had race equality liaison officers. They did not have allocated time, but they, and representatives, were equipped with useful resource packs. Information about this structure was included on diversity notice boards on all units.

3.61 There had been successful efforts recently to promote cultural awareness. During black history month, the chaplaincy hosted an all-day event with displays, talks by invited speakers, music and hot food from different cultures. Staff and groups of young people and young adults visited in turn during the day. The special menu was shared on the units. The event was very popular. A

recent health fair had included information about health problems associated with different ethnic groups.

3.62 The REAT monitored and added to targets in the establishment race equality action plan. Fixed items on the REAT agenda included development of impact assessments, ethnic monitoring, a summary of racist incident report forms (RIRFs), security information reports and community engagement. There had been a number of visits to agencies in the community, but difficulty in persuading them to visit the establishment. The primary care trust had made some contribution to the race equality agenda. Their review and comments were logged on the RIRFs file. More recently, a representative of a voluntary agency dealing with young people, Pioneers Leading the Way, had attended a meeting and commented on racist incident reports, with a commitment to continuing support.

3.63 Some of the data for ethnic monitoring identified young people and young adults separately, and could be scrutinised for any disproportion. Diagrams summarising the data showed combined information for the whole establishment. If ethnic monitoring indicated a disproportion for two consecutive months, a pro forma investigation and report form was issued to the functional head. We were shown a large folder of such investigations, including consultation with young people. For example, relatively few black or minority ethnic young people had applied for release on temporary licence, and this was under investigation. Although representatives had been given some training to understand these processes, the REAT meeting tried to present the information in an accessible way for the benefit of all present. The technical expertise of the Imam had been used to compile summary charts which were presented on a large-screen television. Reports on impact assessments, ethnic monitoring and REAT minutes were distributed to attendees and the library, and placed in race equality boxes on all units. The visits centre had its own race equality information box and RIRFs beside a complaints box.

Managing racist incidents

3.64 Fifty RIRFs had been received from young people between April and September 2008. Evidence through consultation with young people and analysis of the RIRFs suggested that this was a positive indicator of confidence in the system, rather than an indicator of a high level of racial tension in the establishment. Following consultation with young people, the boxes and forms had been relocated to staircase landings, out of sight of the unit office, to be emptied by the REO or his part-time assistant (see section on applications and complaints). RIRFs were also being taken from other sources. Security produced a monthly spreadsheet which facilitated identification of all security information reports with a racial element. We examined some completed RIRFs. The majority were about insults called out and none related to staff conduct. A number were completed by staff, often on behalf of a young person. In some cases extensive explanation was provided of what constituted a racist incident. The REO had his own two-part acknowledgement slip, keeping one part with the RIRF to show when the numbered acknowledgement was issued. This was usually dated the same or next day. Investigation reports were all typed, with information under headings to show clearly what steps had been taken and what the findings were. On all forms seen, parties and witnesses were interviewed. In proven cases the young person who had demonstrated racist behaviour was spoken to by the REO. The typed response to the complainant was generally within the four-week target timescale and explained clearly. The deputy governor checked all RIRFs, and we saw suggestions made on a number of those checked.

Diversity duty

3.65 The establishment had a race equality policy, and an annual report, but no general diversity policy and no diversity manager. An overarching equality and diversity policy was in draft form. There was a disability policy covering most areas of prison life which was currently being rewritten. Two staff members had been allocated half a day a week each to act as disability liaison officers for the whole establishment, including staff. Despite the meagre time allowance, they had set up some good documentation and liaison systems. All new arrivals were asked about disability, including learning disability and dyslexia. The staff took this information each day and made the appropriate entry on the local inmate database system (LIDS) to enable all staff to be informed. They did not take for granted that some would be picked up by healthcare or education within the initial assessment process, but interviewed all reported cases and liaised with other staff to identify and meet needs. They opened their own case file to record the information and appropriate referrals to other staff, for example for remedial gym. Among the 22 young people on file, in two-thirds of cases learning disability or dyslexia was indicated. We spoke to one of the young people. He told us of a series of measures that had been taken by various staff to accommodate his needs.

3.66 The accommodation was not designed with physical disabilities in mind. Even healthcare was poorly equipped: there was no hoist for the bath and the shower had a step (see healthcare section). Staff said they did not receive physically disabled people, although a young person's mobility might occasionally be limited by a temporary injury.

3.67 Training for disability liaison officers was limited, but they had had a recent meeting with the West Midlands area diversity manager, attended meetings with their counterparts, consulted other bodies, and built up a resource pack to improve their own performance. They were keen to undertake an impact assessment, and had a draft plan for this, but so far had not had the time to take on such a large task. They had taken the initiative to push a wheelchair around some areas to highlight deficiencies. Some provision had been made for disabled visitors, although there was scope for improvement following an informed impact assessment. For example, there was a ramp leading up to the visits centre, but no convenient pathway from the disabled parking lot to the ramp. A toilet for disabled people in the visits hall appeared to be rarely used and not cleaned as regularly as the hall itself.

3.68 The librarian recognised that a lot of young people had difficulty reading or avoided it, and sought to guide them towards realising their potential. Over some years he had developed his own reading assessment card, with simple phrases incorporating a scale of challenges, which he used to show people what they could do rather than highlight what they could not yet do. He then guided them to his stock of graded easy readers, many of them short stories of suspense to hold the attention of this age group.

Recommendations

3.69 The establishment should have an overarching equality and diversity policy to meet identified needs of the young population, to be taken forward by a diversity manager.

3.70 All staff should be up to date with diversity training.

3.71 The disability liaison officer(s) should be enabled to conduct an impact assessment of provision for people with a range of disabilities.

Housekeeping point

3.72 The toilet for disabled people in the visits hall should be cleaned and checked daily.

Good practice

3.73 *The two part-time disability liaison officers had set up a good system as a basis for care planning and, as an early step towards impact assessment, had tried to push a wheelchair around parts of the establishment.*

3.74 *The librarian had developed his own simple reading assessment document, with the aim of guiding people to manageable and interesting reading material, rather than reaffirming reading difficulty.*

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.

3.75 Only a few of the young people were foreign nationals and, in accordance with a written foreign national policy, they joined with foreign national young adults in regular meetings organised by the race equality officer who was also the foreign nationals coordinator. Response from the Criminal Casework Directorate of the UK Border Agency (UKBA) was not always satisfactory, but recently developed links with a helpful UKBA office in Birmingham were effective. Independent immigration advice was in short supply in the area.

3.76 Five young people had been referred to the UK Border Agency (UKBA) as foreign nationals. In some such cases, UKBA confirmed that referrals were in fact British. The clerk who liaised with UKBA told us that people under the age of 18 were not detained under the Immigration Act at the end of their sentence, but were released. Once they were over 18, and moved to the young adults site, the outcome might be different. Contact with UKBA Criminal Casework Directorate (CCD) was less than satisfactory. When young people appearing to be foreign nationals arrived, the clerk completed a questionnaire with them and sent the information to CCD, but often did not receive a reply, or the response did not identify the author, or caseworkers kept changing. Trying to find out who was responsible wasted a lot of his time. By contrast, staff at the Birmingham immigration office, with whom a link had recently been developed, were accessible and willing to assist with queries.

3.77 The REO also took on the role of foreign nationals coordinator. He had been in touch with coordinators in establishments with larger foreign national populations to develop his own expertise. Foreign nationals were a fixed item on the agenda of REAT meetings. A written policy outlined what foreign nationals could expect at the establishment, including a monthly free international telephone call if they had no social visitors and up to two free letters a week. Those who were eligible were receiving their entitlements. Bi-monthly meetings were held to give the small group of foreign national young people and young adults the chance to meet each other and raise their particular queries with staff. Different staff were invited to deal with issues raised.

An immigration officer from the Birmingham enforcement office also attended to address the group and interview individuals. Few specialist solicitors had been identified within a reasonable area: one was in Stoke-on-Trent and another in Manchester. A member of the chaplaincy team held separate meetings for Irish travellers.

3.78 The librarian identified which nationalities were in the establishment and had a reasonable stock of foreign language material, including some easy readers and some with bilingual text, to supplement English for speakers of other languages (ESOL) classes run by the education department. He could draw on the stocks of Shropshire libraries.

3.79 Staff speaking different languages were listed, and there was some use of professional interpreters to interview those with no or little English. They were principally arranged for training planning meetings, although if an interpreter was coming to a meeting, other staff sometimes took the opportunity to use the service. Apart from general prisoner information booklets and complaints information, there was no stock of information in different languages. Staff said they were aware that further material could be downloaded from the Prison Service intranet and they used it as need arose. The imam downloaded news and other information in different languages from reputable websites. A small stock was maintained of popular items from a minority order sheet, additional to the Aramark shop list, to avoid delay when people who had just arrived wanted to place an order.

Recommendations

3.80 The establishment should liaise with UKBA to ensure that caseworkers within the Criminal Casework Directorate identify themselves and provide contact details on their communications.

3.81 A link with an independent, specialist source of immigration advice should be developed.

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.

3.82 Access to telephones was good and there was an effective system in place to facilitate telephone contact with families for young people without telephone credit. There were opportunities to have a reception visit and thereafter to book visits during the week and at the weekend to accommodate visitors' requirements. Family days were organised and welfare visits were arranged when necessary. The booking system worked well, but young people were not always taken to their visit on time. Facilities for visits were generally good. There was a spacious visitors' centre, and the visits room was bright and comfortable and staff were helpful. Provision of refreshments was limited to afternoon visits. Young people were subject to random searching after visits which was inappropriate and, although there were few closed visits, the security policy placed an over-reliance on a drug dog indication to support a closed visit.

Mail

3.83 Young people we spoke to in groups indicated that they had experienced some delays in receiving their mail, and 33% indicated in our survey that they had problems sending or receiving mail. The systems for collection and delivery of mail appeared robust, and we could find no evidence of or explanation for delays.

Telephones

3.84 Young people did not report any problems obtaining access to telephones. In our survey, 84% stated that they could speak to someone in their family every day, which was significantly better than the comparator of 54%.

3.85 Blue card phone cards were available to foreign nationals or young people with family abroad, enabling them to make calls at a reduced rate.

3.86 Residential senior officers had access to a PIN account and credit which they could use to allow young people with no credit to contact family or friends if they had a justifiable need. A PIN phone call register recorded the use of this account and showed that young people were regularly allowed free calls to family. We also noted that care maps in ACCT documents sometimes referred to young people being given free calls. There was evidence that personal officers, advocates and the chaplaincy team assisted young people with family contact at times.

Visits

3.87 Young people were given assistance on their first night to arrange a reception visit and full information on induction on how to arrange subsequent visits. Parents and carers were sent an information pack within 48 hours of the young person's arrival giving information about visits, including information on the assisted visits scheme for those on low incomes. This pack also contained the direct number for the induction wing so that families and carers could telephone the wing if they had any concerns. A bus service was provided from a number of cities and towns in the area.

3.88 Both visitors and young people reported that the booking system worked well. Opening times for booking visits had been extended in September to enable visitors to call in the evenings to book a visit. Visitors also appreciated the facility to book their next visit while they were at the visitors' centre.

3.89 Domestic visits were held on Tuesday, Wednesday and Thursday afternoons and in the morning and afternoon at weekends. The sessions had only recently been extended to include morning visits on Saturdays and Sundays. Prior to this extension, visits staff informed us that they were sometimes unable to accommodate all requests for visits at weekends. Morning visits were popular and the only time that demand exceeded the capacity for visits was Sunday mornings. However, an alternative time at the weekend was always available. Young people and their families did not report any difficulty in booking all the visits they required. In our survey, 51% of young people said they were able to get two or more visits a month against the comparator of 46%. More than 45% of young people were over 50 miles from home. There was a procedure for young people whose families lived some distance from the prison to have accumulated visits. We were told that this was little used. Young people could apply for additional visits for welfare reasons and the chaplaincy team arranged additional visits for young people with family

problems. We were given an example of a young person who had been given additional visits at short notice due to a family bereavement.

3.90 Family days were being arranged more frequently, most recently three months before the inspection. A further day was planned shortly after our inspection. Family visits took place in the chapel area and gave young people an opportunity to play with their children or younger siblings. Additional family days had been arranged for young people undertaking a parenting course.

3.91 Legal visits were available three mornings a week with a maximum of 15 spaces on each session. There was only one private visits room and most legal visits took place in the main visits hall. This lack of privacy was not ideal, and staff attempted to give legal visits as much privacy as possible by limiting numbers and spreading them around the large hall. Demand exceeded availability and extra legal visits had been accommodated during domestic visits sessions. On these occasions, professional and legal visitors were informed that privacy was limited.

3.92 The visitors' centre was bright and comfortable with soft seating and toys and books for young children. Staff were helpful and useful information was displayed on notice boards around the room. There were no refreshments available in the centre.

3.93 All visitors were given a rub down search. The searches were conducted sensitively and the procedure was explained. There was a ramp to allow access for visitors in wheelchairs. However, the route from the visitors' centre to the gate was across a grassed area which had become muddy and was unsuitable for wheelchairs or pushchairs (see section on race equality duty).

3.94 In our survey, 52% of young people said that they arrived on time for a visit which was significantly worse than the comparator of 67%. Young people complained in focus groups that either they or their visitors arrived late for visits. The visits sessions we observed started on time, but staff told us that, due to staff shortages, it sometimes took a long time to collect young people from the residential areas and walk them across to visits. The visits hall was spacious and bright and there was some useful information on display. Visits staff were friendly and a tea bar run by volunteers provided drinks and snacks. Visits provision had recently been extended to include morning visits at weekends, but the tea bar was not open in the mornings as there were insufficient volunteers. The only alternative provision was a water dispenser. There were no vending machines. There was a play area for children, and the Pre-school Learning Alliance provided play leaders in the crèche area for some sessions. Staff were positioned around the visits hall where they had a good view, but were unobtrusive. There was a separate area for closed visits, but this was rarely used. At the time of our inspection, no young people were subject to closed visits and there had been no closed visits in the previous six months.

3.95 We observed the passive drug dogs working in the visits area. We were advised that the dogs were trained to stand on their back legs during a search to ensure that they could detect drugs hidden on the upper part of the body. We noted that one of the dogs, which had recently completed training, placed its paws on some visitors in the course of the search. A number of visitors were visibly upset by this and some expressed concern that this was inappropriate. In the event of an indication from a drug dog, the security policy stated that the visitor would be offered a visit in closed conditions with a clear statement that a non-contact or supervised visit was not an option. In the absence of supporting intelligence, it was unacceptable to rely solely on a drug dog indication for the imposition of a closed visit.

3.96 Young people were subject to random strip searches following a visit which was inappropriate.

Recommendations

3.97 Managers should investigate whether there are delays in the delivery of mail as reported by young people.

3.98 Young people should be escorted to the visits hall in good time so that their visit is not delayed or curtailed.

3.99 The path from the visitors' centre to the gate should be paved to allow ease of access for pushchairs and wheelchairs.

3.100 Refreshments should be provided in the visitors' centre.

3.101 Refreshments should be available in the visits hall during the morning sessions at weekends.

3.102 Dog handlers should ensure that dogs do not make contact with the person they are searching.

3.103 Closed visits should not be imposed purely on the basis of a drug dog, but only if there is additional supporting evidence.

3.104 Young people should not be strip searched following a visit unless there is intelligence indicating that it is necessary, supported by a risk assessment.

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.

3.105 The applications and complaints systems worked well. Many queries were resolved informally with staff, rather than through a formal applications system. In response to young people's suggestions, complaints boxes had been moved out of sight of the wing office. They were emptied by the complaints clerk or her supervisor and responses checked were timely and respectful. Barnardo's independent advocates helped young people to resolve some issues, including via the formal complaints process. Monthly consultation meetings with staff gave young people opportunities to air grievances and resolve concerns without resorting to a formal complaint.

3.106 Young people said they usually asked someone if they had a request. For some specific requests, such as recovery of property from reception, pro forma applications were stocked outside the office. The applications book in the unit office did not appear to be used much, with a low number of applications or outcomes recorded. Following consultation with young people, a number of changes had been made to the formal complaints system to improve confidence. The boxes had been relocated out of sight of the office on the first landing of the staircase. All boxes seen had a stock of complaint forms with envelopes for confidential access. They were emptied and restocked daily by the complaints clerk or her supervisor rather than by wing staff. The clerk

logged and distributed them; her supervisor sometimes returned responses if she did not think they were good enough. We looked at some responses, which were usually issued within a few days. Replies were legible, respectful and signed. Some included apologies, and one suggested compensation for some lost property.

3.107 In the last six months, 132 young persons' complaints had been logged. Property and cash, including loss on transfer from one establishment to another, predominated. Complaints were monitored for any trends. There was evidence that the complaints clerk screened complaints of racist incidents and bullying, although we found a few examples of complaints about bullying which had been missed.

3.108 The formal complaints system was explained to people during induction. The written information we saw was not particularly user friendly for this age group, and the information booklet alongside one of the complaint boxes was out of date. In our survey, 45% of young people said they knew how to make a complaint which was significantly worse than the comparator of 81%.There was an alternative source of assistance for young people. Three part-time advocates, employed by Barnardo's, worked with the young people. They participated in the induction process, talking to young people in groups and individually. There were 92 cases during the previous month, of which 32 concerned adjudications, 16 required contact with other agencies, and seven were complaints, including an appeal against an adjudication. Young people needed help with reading and writing as well as grasping the process. Monthly representative meetings with staff also provided an outlet for general grievances.

Recommendations

3.109 The applications log should be kept up to date, recording date of application and outcome.

3.110 Up-to-date information about all complaints procedures, in a format suitable for the young population, should be publicised.

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.

3.111 Young people had solicitors or were able to engage the help of youth offending team workers or independent advocates to find legal advice if required. The library had a reasonable stock of legal reference materials, conspicuously displayed. Legal visits capacity was stretched to meet the current demand for official visits.

3.112 Young people told us they did not have a problem getting legal advice, since they had solicitors allocated within the criminal justice process, and youth offending team (YOT) workers or independent advocates working on site directed them to sources of advice if needed. The library had a stock of reference materials. These were all displayed conspicuously and the librarian had taken some trouble to carry a varied stock of easy-to-read materials, to help people understand the operation of the legal system in England and Wales. His stock included copies of some prison service orders (PSOs), but he had no ready internet access to trace up-to-date PSOs and instructions (see section on library).

3.113 Official visits for solicitors, YOT workers and others were available three mornings a week. There was only one interview room. Typically, one day during the inspection, 15 official visitors were present, spaced around the large visits hall. The notional capacity was 15 to ensure spacing for privacy between occupied tables. Those we spoke to said it could take a couple of weeks to get an appointment, which did not always correspond to the short notice of hearings given by the courts. Visitors said that staff did their best to meet their needs.

Recommendations

3.114 The library should have access to the internet and a printer to trace up-to-date legal reference materials.

3.115 Legal visitors should be surveyed to see if current needs are being met.

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 Clinical governance arrangements were appropriate. The reception process was satisfactory and first night medication was available. There was an appropriate range of clinics and a reasonable staff skills mix. There was a children's nurse in the team and GP cover was adequate. There were no treatment rooms on the residential units or suitable rooms for the administration of medicines or healthcare consultations. Applications for appointments could not be made confidentially. The record keeping system was unsound. Not all inpatients had clear care plans and not all had a clinical need. They often spent too long locked up. Primary care mental health nurses were often allocated to generic nursing duties which affected their ability to carry out their mental health work. The secondary mental health services reconfiguration would improve with the addition of a community adolescent mental health team and was intended to provide additional clinical time. Healthcare staff did not routinely attend planning meetings, including pre-release meetings. The waiting list for dental services was poorly managed and there was no triage for dental services.

Joint working with the NHS

4.2 Health services for young people were commissioned by Shropshire County Primary Care Trust (PCT). The health needs assessment was not up to date, although we were told that it was being revised, with an expected publication date of December 2008. A review of services had been undertaken by Care Services Improvement Partnership (CSIP) which identified areas for improvement.

4.3 Health services did not appear to manage the needs of young people and young adults separately. Most policies were generic to both groups (with a few exceptions such as the immunisation policy, which was age specific). Waiting lists were not age specific. Mental health in-reach services were age specific and, with the planned introduction of the Children and Adolescent Mental Health Service (CAMHS) team, were likely to become more so. However, the primary mental health team held a waiting list for assessment that did not differentiate between the two age groups. The partnership board, which included another prison, met four times a year and was attended by senior staff from the establishment and the PCT. A clinical governance committee, including both establishment and healthcare staff, met quarterly. The establishment's provider manager was a member of the committee and also sat on the clinical governance committee of the PCT. A medicines and therapeutics committee met quarterly and was attended by the pharmacist, a doctor, a nurse and a representative from the PCT.

4.4 Healthcare staff did not routinely attend training planning meetings and reviews, and they did not attend pre-release planning meetings.

4.5 Healthcare staff had received training from both the establishment and the PCT. The establishment had provided training in assessment, care in custody and teamwork (ACCT) procedures and personal protection, and the PCT had provided clinical training. All nursing staff had received child protection training and basic life support and anaphylaxis training.

4.6 Policies were jointly owned by the establishment and PCT. They had originated from the PCT and included establishment-specific information where appropriate.

Environment

4.7 The primary care department was located on the first floor of the healthcare centre and was accessible by a lift as well as the stairs. Treatment and consultation rooms were clean, tidy and appropriately equipped. The waiting room used by young people was unwelcoming. There was fixed seating around the edge of the room and nothing on the walls. The dental surgery, which was located in the healthcare centre, was appropriately equipped, and infection control procedures were satisfactory.

4.8 All medicines were stored in one room in the healthcare centre which was fairly small and lacking ventilation, with only a small extractor fan. The room had no sink. There was a refrigerator for the storage of medicines, but, although daily temperatures were recorded, staff did not appear to understand how to undertake this task. Occasionally the air temperature, rather than the refrigerator temperature, had been recorded.

4.9 There were no treatment rooms on the young people's units and medication was administered from general offices. There were no hand-washing facilities in any of the offices used and no drinking water was available, although one unit did provide a water jug.

4.10 The healthcare room in reception was clean and appropriately equipped, but unwelcoming. The only information displayed was addressed to staff. There was a telephone, but no computer, in the room. All information was recorded manually.

4.11 The inpatient unit was located on the ground floor of the healthcare centre. There were eight cells, two of which were designated as accommodation for disabled people. However, there was no bath hoist and both showers had a step, making them inaccessible to anyone with impaired mobility. There were two association rooms, which were also used for education, with some games and books available. There was also a small meeting room.

4.12 Emergency equipment, including two automated defibrillators, was located in the healthcare centre. Equipment was contained in colour coded bags, enabling nursing staff to identify appropriate equipment. The equipment was checked regularly by nursing staff and records of checks maintained.

Staffing

4.13 There was an establishment provider manager for Stoke Heath and another local prison. Day-to-day management of the unit was undertaken by the head of healthcare who was a registered general nurse (RGN), supported by a clinical nurse manager who was a registered mental nurse (RMN). There were two charge nurses (one RGN and one RMN) and 15 staff nurses comprising eight RGNs, six RMNs and one nurse who was dual qualified as an RGN and a children's nurse (RSCN). There were five health care assistants (HCAs) who were supervised by the qualified staff. At the time of our inspection, there were two nursing vacancies and both appointments, one RMN and one RGN/RSCN, had been offered and accepted. There was also one HCA vacancy which had been offered and accepted. There were two administration staff.

4.14 All nursing staff and HCAs had job descriptions, although the staff nurses had generic job descriptions which were not specific to their roles as RGN or RMN, nor to their skills and

competencies. There were no clinical supervision arrangements, although plans were being developed. Some structured group meetings took place to discuss practice.

4.15 There was a rota of three GPs who visited the establishment each morning and three afternoons each week. Out-of-hours medical cover was provided by the local service provider. A dentist and two dental surgery assistants provided two dental sessions each week. The service level agreement between the establishment and a local pharmacy provided for a pharmacist to visit the prison for 10 half-day sessions each quarter. In practice, the pharmacist did not usually visit the prison except to attend medicines and therapeutics committee meetings. There was also a mental health in-reach team. Other health professionals, including an optician and podiatrist, also attended the establishment.

Records

4.16 Manual and electronic records were maintained for all young people. Some information was routinely entered manually in the hard copy of the notes, while other information was entered electronically. Letters and results were filed in the hard copy of the clinical record, while the GPs used the electronic record. GPs did not routinely have hard copies of the record during consultations unless they specifically requested it. One member of the mental health in-reach team made a cross reference in the electronic record to alert staff to read the information in the hard copy, while other members of the in-reach team did not use the electronic record at all. In-patient care plans were maintained manually in the hard copy of the clinical record. This system of record keeping meant that those caring for patients and making decisions relating to patient care did not have all information readily available to them.

4.17 When young people were released, the hard copy was sealed and stored with their personal record. If they returned to the establishment, the old record was retrieved and attached to the new record.

Primary care

4.18 All new and returning young people were seen by a nurse in reception. We were told by reception staff that waiting for healthcare staff to attend reception sometimes delayed the reception process. This appeared to be more common when the arrival of young people coincided with nurses administering medication on the wings (see section on reception).

4.19 We observed nurses carrying out reception screening who appeared sensitive to the needs of the young people and explained the process to them carefully. All information was recorded manually in the clinical record, and we were told that it would be summarised on the electronic system later. HCAs assisted the nurses with filling out documentation. New arrivals were risk assessed for in-possession medication and first night prescribing was available, including symptomatic relief for young people experiencing withdrawal. There was no provision of nicotine replacement therapy for smokers who would be entering a non-smoking environment (see also substance use section).Young people were given the opportunity to request a dental appointment, and advised that they could apply for one at any time. They were invited to disclose any disability, and this information was recorded to pass on to the disability liaison officers.

4.20 Any young person who had a life-long condition was referred to nurse-led clinics or the GP. If a young person had an outstanding hospital appointment, the probability that this would need to be re-booked was discussed with him and an appointment to see the GP was made. Nursing staff explained how to access healthcare appointments and collect medication. They also gave young

people a leaflet outlining health services at the establishment. The leaflet was poorly printed in text only which we did not feel was age appropriate. Young people received secondary health screening, usually within a week of their arrival at the prison.

4.21 Young people made healthcare appointments either by attending 'sick parade' in the morning on their unit or by completing a general application slip, which was not confidential. Although triage algorithms had been developed, these were not available in the rooms used to see young people on the units and were not routinely used by nursing staff. Clinic lists were taken to the units the evening before appointments were due. We were told that in the past slips had been sent to the units to be given to young people, but that they had frequently not been given out, so this practice had been discontinued. Young people were not told of their appointments in advance, which meant they were not aware that they needed to remain on the unit to be escorted to healthcare, and did not always know why they had an appointment.

4.22 A range of nurse-led clinics included immunisation, sexual health and asthma. Clinics did not differentiate between young people and young adults, and only one waiting list was kept for each clinic. The specific needs of young people requiring immunisation were managed by the RSCN, who also obtained consent for treatment for young people under 16 years of age. The RSCN carried out annual health checks for any looked after children.

4.23 The dentist attended the establishment twice a week. There were about 40 patients on the waiting list, of whom 11 were young people. As the same list was used for young people and young adults, it was not possible to identify the waiting time for young people to receive routine dental appointments, although this was thought to be around three months. Nursing staff received the dental applications and prioritised those considered to be urgent or emergencies. This process did not appear to work well as the nursing staff had not received training in dental triage and did not use dental triage algorithms. A number of young people allocated priority appointments did not require them. Patients attending for 'urgent' treatment were not all offered check-up appointments with encouragement to attend. The failure-to-attend rate was quite high, usually because the patient declined to attend on the day.

4.24 A full range of NHS treatments was offered. Any treatment necessitating a laboratory element had to be authorised by the establishment, which was responsible for paying the laboratory fees. This resulted in three to four weeks' delay in treatment provision.

4.25 There was no oral health education other than that delivered individually in the surgery. There were no oral health education displays or literature. There had been some input at a recent open day. Out-of-hours cover was provided by a local dental centre or accident and emergency. Necessary referrals were made to a local hospital dental department or orthodontist.

4.26 Medicines were administered at 8.30am and 4.30pm. Only one nurse was usually present. Arrangements were made to supply medicines at other times when necessary. Most medicines were administered from stock as deliveries were only received from the local pharmacy three times a week. Using patient named medication would have led to delays in patients receiving their medication.

4.27 Pre-packs were checked by the doctor, who then handwrote patient name and dosage instructions on the label, satisfying legal requirements, but placing extra demands on the doctor's time and losing the opportunity for professional input by the pharmacist. There was no opportunity for young people to consult a pharmacist.

4.28 There was no special sick policy and no list of approved treatments. In practice, special sick medication supplies were generally limited to paracetamol and ibuprofen tablets. Several patient

group directives were in place for vaccination. Patient information leaflets were provided with most in-possession medicines, but this was not always possible with administered medicines.

4.29 There were no specific arrangements for medication for young people attending court. A morning dose would usually be given, and no other medicine was supplied unless the patient held in-possession medication. No clinical audit or prescribing review was carried out.

4.30 If young people needed healthcare outside the establishment, this was arranged. There appeared to be a good relationship between the establishment and local hospitals, with most appointments being made to accommodate the establishment regime. Two routine appointments were available each weekday.

4.31 When young people were released, they were given a letter for their community GP, five days' prescribed medication if appropriate, a general health information leaflet and contact details for NHS Direct which could advise them on registering with a GP if they did not have one. There were no discharge clinics, and healthcare staff did not routinely attend any multidisciplinary discharge planning meetings.

4.32 There were some age-appropriate health promotion displays on the residential units, and healthcare staff had recently organised a health promotion event which included contributions from other departments within the establishment and the community.

Inpatients

4.33 All eight inpatient beds were included in the certified normal accommodation of the establishment. We found examples of young people located in the unit who did not require clinical care. A three-month sample taken from the inpatient register showed that over a third of admissions to the unit had not been located there for clinical treatment or observation.

4.34 All patients in the unit had been assessed on arrival and had care plans, although in some instances these were more a record of care delivered than a clear plan.

4.35 Young people in the unit spent long periods locked in their cells. Although two healthcare staff were allocated to the unit, we observed that one member of staff was often called away to carry out other tasks or attend meetings, requiring young people to remain locked up at these times. Education staff attended the unit on weekdays to work with young people and provide them with in-cell education materials.

4.36 During our visit one young person from the inpatient unit was admitted to hospital for diagnostic tests. Nursing staff maintained close contact with the hospital to monitor his condition. If a young person was admitted to the inpatient unit or sent to an outside hospital, their parents or carers were advised.

Mental health

4.37 Primary care RMNs did not have job descriptions specific to their role as mental health nurses and spent much of their time carrying out generic nursing duties alongside the RGNs. The primary care timetable identified seven mental health triage clinics each week. Statistics collected by the department for one month showed that there had only been 18 instead of 31 mental health triage clinics.

4.38 The primary RMNs undertook mental health screening for young people who had had contact with mental health services in the community. They also received referrals from other nursing staff and the GPs. It was difficult to identify the waiting time for young people to receive primary mental health screening as the waiting list was combined with that of the young adult population. The wait was estimated at six to eight weeks. The primary care RMNs also provided ongoing support for some young people.

4.39 The mental health in-reach team had previously cared for juveniles and young adults at the establishment. A CAMHS team was being introduced which would focus exclusively on the needs of juveniles. The new arrangements increased the nursing time from one and a half days a week to a full-time nursing post, and retained the services of an occupational therapist (two days a week), a psychologist (two days a week) and a psychiatrist (one day a week).

4.40 Although primary mental health assessments provided access to the team, we were told that if nursing staff or a GP were concerned about a young person, they could be fast tracked directly to the team. There were other triggers which would fast track a young person, such as a patient on certain prescribed medication prior to arrival at the establishment.

4.41 The team told us that their work with young people on the units was constrained by a lack of appropriate and available space.

Recommendations

4.42 Healthcare staff should attend multidisciplinary meetings such as training planning reviews and pre-release meetings.

4.43 The unsuitable conditions in the pharmacy should be addressed.

4.44 The need for more appropriate facilities for the administration of medication and appropriate space for healthcare consultations on the units should be addressed.

4.45 There should be a computer available in the reception healthcare room.

4.46 Bathing facilities should be available for inpatients with impaired mobility.

4.47 RMNs and RGNs should have separate job descriptions based on their specific skills and competencies.

4.48 A pharmacist should make regular visits to the prison and should be available for consultations with young people.

4.49 All clinical information (both hard copy and electronic) should be available to healthcare staff during consultations and treatment.

4.50 Healthcare staff should be available to attend reception promptly when young people arrive.

4.51 Young people should be given an age-appropriate leaflet outlining health services available in the establishment.

4.52 Young people should be able to make confidential written applications for healthcare appointments.

4.53 Accurate dental triaging should be carried out by an appropriately trained person.

4.54 Triage algorithms should be available to and routinely used by staff when they are assessing patients.

4.55 Patients attending for emergency treatments should be offered check-up appointments.

4.56 Treatments involving laboratory fees should not be delayed.

4.57 The use of stock medication should be minimised, with named patient medicine issued wherever possible.

4.58 The medicines and therapeutics committee should develop a special sick policy, with a list of approved medicines, which should be reviewed by them on a regular basis to ensure that all appropriate medicines can be supplied. Patient group directives should be produced to allow the supply of more potent medicines by the nursing staff where appropriate.

4.59 The medicines and therapeutics committee should introduce a policy for provision of medicines for discharge and for court appearances.

4.60 Young people should be invited to a discharge clinic prior to release.

4.61 The beds in healthcare should not form part of the establishment's certified normal accommodation.

4.62 Admissions to the inpatient unit should be based on clinical need and subject to audit.

4.63 All inpatients should have a care plan which is regularly evaluated and updated.

4.64 Young people in the inpatient unit should have access to a therapeutic regime and not spend long periods of time locked up.

4.65 Mental health nurses should have protected time to conduct mental health clinics.

Housekeeping points

4.66 Staff should be told how to use the refrigerator thermometer correctly and temperatures should be monitored.

4.67 The healthcare room in reception and the healthcare waiting room should have age-appropriate displays and information available to make them more welcoming to young people.

4.68 Young people should receive advance notice of internal healthcare appointments.

4.69 Separate waiting lists should be maintained for young people and young adults.

4.70 Oral health promotion should be available.

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 people were allocated to education soon after their arrival and after a thorough initial assessment process. There was a broad range of courses and sufficient activity places. Teaching was satisfactory, although some lessons were disrupted by young people behaving inappropriately. However, very few young people were sent back to their cells. Learning support assistants, nurture groups and outreach workers provided good support. Attendance was satisfactory and well monitored and classes were rarely cancelled. There were serious problems with punctuality. Achievements and standards were satisfactory overall. A series of events throughout the year to celebrate achievement were popular with young people and their families. There was insufficient input from Connexions. Welsh young people did not receive their entitlement to careers guidance from Careers Wales. Access to the library was satisfactory during the week, but there was no weekend provision. The library stock was sufficient and the range of books, including some texts in Welsh, was appropriate for the age group.

5.2 Young people received a good quality assessment of their levels of literacy and numeracy and other specific needs soon after their arrival. Initial information provided was used well by the special educational needs coordinator to identify the needs of individual young people. This included dyslexia and behavioural and social difficulties. Young people received good information, advice and guidance during their induction about what educational courses were available. Most young people were allocated to appropriate courses relatively quickly, although there were sometimes delays for vocational courses due to a combination of the time taken to gain security clearance and waiting for the course to begin again. The Welsh coordinator met every young person with a Welsh address during their induction to establish any Welsh language needs.

5.3 The curriculum was sufficiently broad and offered enough activity places for the population, and access to it was satisfactory. In our survey, 67% of young people said that education was helping them, which was significantly better than the comparator of 58%. The recent development of vocational opportunities for young people had been successful, although the number of places available remained relatively low. Following risk assessments, young people and young adults worked together in vocational workshops. There were well developed plans to increase the range of vocational courses in the very near future. The range of educational courses was broad, with an appropriate focus on improving young people's social skills and personal development, as well as their levels of literacy and numeracy. A recent review of the timetable had taken place to cater more for individual needs. It was too early to judge the effectiveness of this development. It was unclear why a two-hour timetabled lunch break was necessary each day.

5.4 Teaching and learning were generally satisfactory, particularly in vocational and practical subjects where young people made good progress. Most lessons were planned well and included learning aims and objectives, but these were not always explained to young people. In the better lessons, young people were clear about what and how they were going to learn. In some lessons, tasks were not sufficiently challenging and failed to engage young people who lost concentration. Their behaviour deteriorated, sometimes to levels that were clearly unacceptable, and they made insufficient progress. The use of bad language in these lessons was prolific. In other lessons, young people behaved exceptionally well and were polite and respectful. They concentrated well on their work and made good progress. There was a small inclusion room which was used to good effect for young people who needed some time out of the classroom as a result of their poor behaviour and very few young people were sent back to their cells. Young people were effectively supported by learning support assistants (LSAs), who helped them to concentrate and remain focused. Some lessons which did not have LSAs would clearly have benefited from this extra support. Learning support, 'nurture' groups and outreach provision on the residential units provided good support for young people with a range of learning disabilities, including emotional, social and behavioural problems. At the time of the inspection there were seven young people receiving this support and all for justifiable reasons.

5.5 Attendance was satisfactory and usually averaged 80%. Teaching staff were aware of reasons for absence and attendance was monitored reasonably well. Classes were rarely cancelled. However, there were serious problems with punctuality. Uncertainty over what time young people would arrive often prevented a crisp and purposeful start to lessons, and the enormous variability in the times they were collected meant that lesson summaries could not be delivered. Young people were sometimes collected long after the lesson had finished, and this created significant problems with their behaviour.

5.6 Almost all the courses offered to young people carried some form of accreditation. Over the previous year, 87% of young people left the establishment with some form of accreditation and for many, given their school history, this was their first experience of educational success. While most accreditation was achieved at entry level and level 1, the availability of courses at level 2 for more able learners and those serving longer sentences had improved. There was still a need to develop more courses at level 3. Young people could gain appropriate qualifications in Welsh language and culture from entry level to level two. One young person had recently taken his GCSE in physics through the medium of Welsh. The establishment had been successful in supporting young people who were taking GCSE courses at the time of their arrival in custody, with many completing their courses and passing their examinations. The standard of young people's work was satisfactory overall with some good quality work in vocational and practical subjects such as cookery and painting and decorating. Successes were celebrated well, for example through awards events which young people and their parents or carers valued highly.

5.7 Leadership and operational management were satisfactory, and educational and vocational training ran smoothly on a day-to-day basis. The offender learning and skills service contractors and the establishment worked well together to improve the provision.

5.8 The provision for entry to employment, education or training upon release had been slow to develop. Links with employers and agencies to help young people find employment or training on release were inadequate. Some basic general careers advice was provided through citizenship courses and a personal development course but there was insufficient input from Connexions. Young people from Wales did not receive their entitlement to careers guidance from Careers Wales.

5.9 Quality assurance arrangements were satisfactory overall. The process for lesson observation had recently improved. Teachers who needed support to improve their teaching could be paired

with more experienced teachers to help share good practice. They could also attend external courses. It was too early to judge the impact of these opportunities.

5.10 The self assessment process was well understood by staff, and the resulting report appropriately identified strengths and areas for development. Attendance by education staff at training planning meetings was inconsistent.

Library

5.11 Library provision was satisfactory. Young people had timetabled access to the library three times a week, one of which was in the evening, but no weekend provision was available. Relevant Prison Service Orders and a good range of up-to-date legal texts were in place (see section on legal rights). The library stock was sufficient, the range of books was appropriate for the age group and some books were available in foreign languages. The range of audio books was limited. A small number of appropriate periodicals was available, but there were no daily newspapers. There were also texts available to support vocational training. Approximately 150 books were loaned weekly and an inter-library loan service was available. Book losses tended to be high. Displays to promote literacy were good. The library accommodation was welcoming. Access to computers in the library was limited, with only one computer available.

5.12 The library had made very good use of European Social Fund funding from the Welsh Assembly to provide a wide range of Welsh language books, games, CDs and books about Welsh culture and heritage. Three young people from Wales had taken part in a project to improve resources in the library. They audited resources, identified gaps and chose and costed a wide range of books and resources.

Recommendations

5.13 Behaviour management should be improved to enable young people to learn more effectively.

5.14 Young people should be brought to and collected from lessons punctually.

5.15 Input by Connexions and Careers Wales should be increased.

5.16 Learning support assistants should be allocated effectively.

5.17 The availability of higher level qualifications should be increased.

5.18 Daily newspapers should be available in the library.

5.19 Young people should have access to the library at weekends.

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.

5.20 Access to physical education was good. The programme was well balanced and included a wide range of accredited courses. Poor attendance and refusals were disruptive to the programme. The department had developed good links with other aspects of the regime such as the psychology service, young people's substance misuse service and healthcare. External links were developing well, for example with a local special school and the primary care trust, and there was participation in a local basketball league and a football league. The facilities were managed well but monitoring of attendance needed improvement.

5.21 The physical education (PE) profile had been recently re-evaluated, and young people could now receive up to five hours of core PE each week. The new profile included a planned programme which incorporated an appropriate balance of skills acquisition and development, indoor and outdoor activities, recreational PE, minor games and accredited courses. The programme was sometimes disrupted by poor attendance and refusals.

5.22 The inter-wing competitions in football, cricket and softball were very popular with young people. Another recent innovation had been the inclusion of prison teams in the West Midlands basketball league and the Telford football league. This gave young people excellent opportunities to develop their interpersonal skills and to maintain contact with people outside the establishment. There were three young people on the Duke of Edinburgh mountain leader course, making very good use of the opportunities presented by release on temporary licence.

5.23 The recent development of the Sports Academy enabled young people to acquire a good range of challenging qualifications recognised by the sports and fitness industries. The classroom mainly used for this purpose was inadequate. There was no restriction on the use of free weights, although a review of this was in progress.

5.24 The department had developed good links with other parts of the regime such as psychology, young people's substance misuse service and healthcare. External links were now developing well, for example with a local special school and the primary care trust.

5.25 Procedures for consultation with young people on how PE could be improved were in place through focus groups and wing representatives. As these arrangements were very recent, it was too early to judge their impact. Use of PE was generally monitored but needed to be analysed in more depth to show, for example, participation by different groups.

5.26 Facilities were managed well. They were clean and tidy and generally of good quality. There were sufficient showers but no modesty screens in place.

Recommendations

5.27 Attendance at core PE lessons should be improved.

5.28 The establishment should make efforts to ascertain why young people refuse to attend PE and address the problems.

5.29 Monitoring the use of the gymnasium should be improved.

5.30 The classroom used for Sports Academy work should be suitable for the purpose.

5.31 Modesty screens should be installed in the gymnasium showers.

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.

5.32 The chaplaincy team was well integrated into the establishment, contributing to purposeful activity and resettlement work, in addition to providing religious services. They offered considerable pastoral support to young people and worked with individuals and groups. Extensive family liaison work included an accredited Being Dad programme.

5.33 The chaplaincy played a central role in the community of Stoke Heath. The chaplaincy block was conveniently located close to but separate from the accommodation units. In addition to a spacious, light, comfortable main chapel, the multi-faith room had been extended to accommodate large groups and could be separated off by a partition. It had a small ablutions area, kitchen and interview or group rooms. Chaplaincy members, equipped with keys, could escort individuals or small groups across to the chapel for individual or group work. The chapel was regularly used for establishment meetings. On one day during the inspection, it hosted a multicultural event for staff and young people during the day, and a family get together for presentation of achievement certificates to young people during the evening.

5.34 The team consisted of a coordinating chaplain, who was on the senior management team, a full-time imam, a full-time ecumenical chaplain and various part-time and voluntary ministers or helpers of other religions. Twenty-nine per cent of young people of Christian denomination were Roman Catholic. Seven per cent were Muslim. More than half declared no religion. However, the chaplaincy team confirmed high levels of pastoral need. They played a significant role in family liaison. In addition to facilitating family contact to meet occasional pressing needs, they ran a structured, accredited programme called Being Dad, which aimed to help young people recognise negative histories and adopt a positive attitude towards partnership and parenthood. This nine-week course, three times a year, involved family visits in the chapel in collaboration with the Pre-school Learning Alliance. Two young people were currently on the course, one having just become a father and the other about to become a father. Families were also invited to join an Eid event and Christmas carol service. They were raising funds to restart the Sycamore Tree community-linked programme. A member of the team who had undertaken a Cruse counselling course devoted much time to families suffering bereavement.

5.35 Two-thirds of survey respondents said it was easy to attend religious services, well above the comparator of just over a half. In addition to regular religious services, the team ran groups, including two evening recreational sessions. Members of the team attended induction and visited healthcare and the separation unit daily.

5.36 There were other regular communal events in the chapel, including recreational activities two evenings a week. Chaplaincy members attended training reviews if they had been closely involved with the young person. The imam had been involved in cultural awareness training and the production of information sheets for staff.

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.

5.37 The core day did not provide enough hours to meet our expectation of 10 hours out of cell. The average time spent out of cell was just under nine hours a day. There was less access to time out of cell at the weekends. Young people had access to association every day and staff interacted with them well during these periods. Recreation facilities on association were adequate and the enhanced association areas for those on the highest level of the rewards and sanctions scheme were well equipped. The youth club and enrichment rooms both provided additional recreational facilities. Young people were not able to exercise in the open air every day.

5.38 At the time of our inspection, the maximum available time out of cell was nine hours and 25 minutes on weekdays and six hours and five minutes at weekends, averaging eight and a half hours a day. The establishment's own figures for September 2008 indicated an average of 8.79 hours per day, which was an improvement on the previous months.

5.39 A youth club was available during the core day on five mornings and two afternoons a week, with a maximum capacity of 14 per session. Young people were timetabled to use the youth club as an alternative to being locked in their rooms when they had no other activities. The youth club room had television screens, games, computer games, music equipment and a comfortable seating area where young people could associate in a relaxed atmosphere. The club was a valuable addition to the regime.

5.40 Each unit had an enrichment/library room which was a quiet area equipped with soft seating and tables, books, games and craft activities. The rooms provided an alternative to the large association rooms. These rooms were often used for assessment, care in custody and teamwork (ACCT) reviews and for other meetings with young people where a private, quiet, relaxed environment might be beneficial.

5.41 Young people were able to attend association every weekday. There were two sessions, with half the young people on each unit associating at a time. There was no evening association at weekends. Association appeared to run to schedule and was never cancelled.

5.42 Each unit had an association room equipped with television, table football and games. There was a separate enhanced association area on every unit with a pool table, television, computer games and sofas. The enrichment rooms could be used during association times if there were sufficient staff available. During association periods, staff interacted well with young people, engaging them in activities and conversations.

5.43 Young people were only offered exercise in the open air for an hour at weekends, and timings clashed with other activities such as visits, enhanced association and chapel. All young people had access to suitable outdoor clothing.

Recommendations

5.44 Young people should have at least 10 hours' time out of cell per day.

5.45 Activities at the weekend should be timetabled so that they do not clash with opportunities to exercise in the open air.

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 Rules of the establishment were clear and applied fairly. Security information reports were submitted by staff from a range of disciplines and were not solely observational, demonstrating a good level of dynamic security. Search targets were being met, and there were good arrangements for disseminating security information to staff. Young people were being routinely strip searched during certain procedures which was inappropriate. All other security arrangements were proportionate and did not have a negative impact on regime delivery.

6.2 The security committee was chaired by the head of security and operations and met monthly. Meetings were generally well attended and regularly included a representative from the escort contractor and the establishment's police liaison officer.

6.3 Normal staffing for the security department during the core day included a principal officer, a senior officer and two collators. A small number of prison officers were provided from within the group's staffing profile each day to cover mandatory drug testing (MDT), escorts and visits. These officers also had individual responsibilities in the security department which took up any spare time they had. Searching staff were provided from the residential units and deployed by the security senior officer.

6.4 There had been two serious disturbances on two of the juvenile units over the past two years, the most recent being a year ago. Both incidents were spontaneous and escalated quickly, resulting in the units being taken out of action for extensive repair and refurbishment. These disturbances underlined the unpredictability of this age group. More recent incidents included roof climbs on the manufacturing department. Work was under way to erect a fence around the vulnerable areas to prevent this occurring in future.

6.5 Since the beginning of 2008, a total of 2,750 security information reports (SIRs) had been submitted for the establishment, an average of 67 a week. SIRs for young adults and juveniles were not usually monitored separately, but we calculated that, over a two-month period from August to September 2008, approximately 44% of the SIRs related to juveniles. Staff from a range of disciplines had submitted SIRs which we found to be relevant. We saw many examples of SIRs that were not purely observational but included information that staff had apparently gleaned through positive relationships with young people.

6.6 New arrivals were asked whether they had any affiliation to a gang and relevant information was stored on a 'gang' database. Related information was monitored each month, and young people were spread around the residential units to disperse the problem as much as possible.

6.7 The establishment had a quarterly target for the completion of routine cell searches which it was achieving. Arrangements were in place for managers to observe some searches to ensure

compliance with procedures. Target searches and reasonable suspicion MDTs were also completed.

6.8 Young people were routinely strip searched in reception, as part of an MDT, prior to a cell search, and as part of a random 10% after visits. Routine searches were inappropriate for this age group. If it was determined that a strip search was required other than in the circumstances listed, a risk assessment was completed and submitted to a governor for approval. This had only occurred on three occasions since the beginning of 2008. We reviewed the risk assessments and found them to be in order. We found no evidence that a young person had been forcibly strip searched.

6.9 The establishment operated a free-flow system to education, and young people were escorted to PE. These and other security arrangements worked well and did not have an adverse impact on the delivery of the regime.

6.10 A monthly security intelligence assessment, including security objectives, was emailed to each member of staff. Other information was disseminated efficiently through the weekly bulletin or briefings by managers.

6.11 Rules of the establishment were fully explained on induction and reinforced in local compacts. Generally rules were applied fairly, although we had concerns that demerits were often meted out for minor reasons (see section on rewards and sanctions).

Recommendation

6.12 The searching policy should be reviewed. Young people should not be routinely strip searched and all strip searches should be carried out only on the authorisation of the duty governor following a rigorous risk assessment.

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 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.

6.13 The majority of adjudications were completed well with good use of advocates. Punishments sometimes involved 100% stoppage of earnings for long periods, which was excessive. There was a comprehensive behaviour management policy which encouraged the use of less formal disciplinary procedures. Mediation work was carried out effectively, but there was little use of minor reports. Levels of use of force had reduced significantly over the past year, but further improvement was needed. The use of force was monitored well. Generally documentation was completed to a good standard and there was good governance in place. There were no cooling off/time out facilities but young people were debriefed following restraint. Special accommodation had only been used once in the previous 10 months which was a significant improvement. Overall, standards of cleanliness in the separation and reintegration unit (SRU)

had improved, and efforts had been made to tackle graffiti. Staff treated young people well. The regime was consistently delivered, although young people could not attend their allocated education or training courses. Reviews were completed well and there had been some positive steps taken towards reintegration in certain cases. A few young people spent lengthy periods of up to 30 days in the SCU, but did not have individual care plans.

Disciplinary procedures

6.14 Adjudication standardisation meetings took place quarterly and were chaired by the governor or the deputy governor. Punishment tariffs were available for young people on request from the library office. Their availability was not well publicised and the librarian confirmed that they had never been requested. In the six-month period between March and August 2008, there had been 697 adjudications involving young people at an average of approximately 28 a week.

6.15 Prior to adjudication, young people were seen by staff from the Barnardo's advocacy service. The advocates made themselves available to assist the young person with making a written statement or to attend the hearing. They were not available during one day of the inspection and did not attend on Saturdays when adjudications were held. At the hearing we observed that there was no advocate available, but there was no consideration of an adjournment when the young person expressed a wish to see an advocate.

6.16 Adjudications were usually staffed by a senior officer and two officers from the SRU. The senior officer coordinated the hearing and read out statements and unit conduct reports. The two officers acted as escorts and conducted a rub down search of the young person prior to the hearing.

6.17 The adjudication room was situated in the separation and reintegration unit (SRU). The room was reasonably sized and dominated by a large fixed circular table. There was ample natural light and a fixed alarm point. A television and video recorder were available for the adjudicator to review evidence from CCTV footage if required. All those involved in the hearings sat around the table on comfortable chairs. This layout served to make the experience less formal. The hearing we observed was conducted well with all the necessary formalities dealt with in an age-appropriate manner. Many of the punishments involved 100% stoppage of earnings, and we saw examples where they had been stopped for up to 21 days. Young people on this level of stoppages were issued with PIN credit to the value of £1 and two first class stamps per week which was inadequate for young people to maintain contact with their families. The vast majority of the sample of completed adjudications we examined had been completed well. However, we did find a few examples where the adjudicator's written account did not satisfy us that the charges had been fully investigated. We were satisfied that requests for witnesses and legal advice had been dealt with correctly.

6.18 There was a comprehensive behaviour management policy which brought together all aspects of disciplinary procedures, including adjudications, rewards and sanctions, minor reports and mediation. The policy set out the need to consider whether procedures at the lower end of the scale could be used before placing young people on a governor's adjudication. However it was unclear how the policy had been disseminated to staff and there had been no training on its application. The use of minor reports was inconsistent. On C unit there had been no minor reports for over three months. Staff on both C and D units told us that they had little confidence in them because they were often not dealt with within the permitted timescale. They considered the rewards and sanctions scheme to be more effective. Staff on A unit were more supportive of the scheme, but the records maintained of minor reports were poor.

6.19 The establishment practised mediation work to resolve disagreements between young people. Each unit had a mediation register. Young people were brought into the office and a member of staff helped them to talk through their differences. This practice was widely used and records demonstrated that it was an effective method of resolving many of the minor conflicts that flared up within this volatile age group.

Use of force

6.20 A use of force meeting was held weekly to review incidents that occurred during the previous week. These meetings were well attended by governor grades and principal officers as well as staff from healthcare, SRU and the control and restraint (C and R) coordinator. Minutes of these meetings provided assurance that each incident was reviewed and any errors or omissions on the documentation were followed up and addressed. Where necessary, individual members of staff were contacted directly to clarify their statements or provide additional information. Any learning points identified were communicated to staff. The committee also reviewed videos which were routinely recorded during planned interventions. This was good practice. A quarterly report was submitted to the committee which highlighted various use of force trends across the establishment. Monitoring also included the reasons force was used, the percentage of young people restrained more than once and staff injuries sustained during restraint, although injuries similarly sustained by young people (see safeguarding section) or staff who were repeatedly involved in restraint incidents were not monitored. Records covering the three month period before the inspection showed that non-compliance and fights were the main reasons for the use of control and restraint.

6.21 Since the start of 2008, there had been a total of 227 use of force incidents. Ninety-five of these involved the use of C and R. If these levels remained constant for the remainder of the year, it would result in final figures for 2008 of 288 and 120 respectively. This would represent a significant reduction on the levels in 2007 when force was used 319 times and C and R on 156 of those occasions. The levels of force compared favourably with many other establishments in the juvenile estate using comparisons prepared by the Youth Justice Board.

6.22 The quality of use of force paperwork was generally good and reflected the high levels of governance in this area. Statements by individual members of staff provided a full account of their involvement and F213s (injury to inmate forms) were routinely filed with the original documentation. Staff were required to record details of any de-escalation techniques employed on an additional checklist that was completed following the use of force against a young person. This section was not always completed and, where it was, the quality was variable. This additional checklist was not part of the quality assurance process overseen by the use of force committee. Procedures included a debrief session for young people delivered by staff.

6.23 There were two special cells in the SRU. Both were clean and presentable with adequate levels of natural light. A review of the documentation authorising the use of this accommodation confirmed that young people were not being routinely strip searched or deprived of their normal clothing. The section in the documentation relating to this had not been completed on a few occasions in 2007.

6.24 There were no cooling off/calm down facilities on the residential units to use as an alternative location for young people following a period of loss of control. However, we were satisfied that risk assessments were carried out to ensure that young people were not automatically taken to the SCU following restraint.

6.25 Special accommodation had only been used on one occasion since the beginning of 2008 to hold a young person. This represented a significant improvement on the figures for 2007 when

special accommodation had been used for this age group 17 times. Six of the 17 uses in 2007 involved periods exceeding two hours, and the longest stay was five hours 30 minutes. A review of this documentation highlighted four occasions when we were not satisfied that the young person had been removed from this accommodation at the earliest opportunity.

Separation and reintegration unit

6.26 Accommodation in the separation and reintegration unit (SRU) consisted of 16 normal cells, two special cells, a staff office, adjudication room, servery and showers. Outside there was a bare exercise yard with no seating provided. It was a shared facility with the young adult population.

6.27 There was a published staff selection policy in place and a pool of staff had been authorised to work in the unit by the governor. The policy stipulated that staff must have passed their probationary period and demonstrated the skills to deal with difficult situations. Normal staffing in the unit for the core day was a senior officer and three officers. The members of staff we met impressed as being suitable for the role.

6.28 The establishment had worked extremely hard to raise standards of cleanliness and to eliminate graffiti in the unit. Part of the strategy to achieve this had been to paint the cells with anti-graffiti paint. This had been largely successful in preventing graffiti, but the paint could be picked off, and this had happened extensively in three of the cells. It was an ongoing challenge with which staff continued to grapple. Standards of cleanliness had also improved, but a few areas, including two cells and the corridor at the far end of the unit, were in need of attention. In-cell toilets were particularly bad and the vast majority had seats missing. The toilets in many of these cells were badly positioned and afforded no privacy from the observation port. To address this, privacy curtains had been installed and were all in place at the time of inspection.

6.29 All normal cells had a fixed bed, a wooden table and store cupboard and a plastic chair. Cell windows were a good size, overlooking the exercise yard and providing sufficient levels of natural light. Cells in an extension that had been added some years earlier also had a single power socket.

6.30 In the six months between March and August 2008, 94 juveniles had spent a night or more in the SCU, six had been held for periods exceeding 20 days and two for 30 days in total. Care plans had not been developed to support their reintegration on normal location.

6.31 On arrival in the unit, young people received a rub down search and were issued with a copy of the unit's rules and routine. Residents had to apply in the morning to have a shower, exercise, phone call, change their library books and so on. These elements of the regime were available on a daily basis and appropriate records maintained. Published rules for the SRU specified that those on the basic level could only use the phone on Wednesday and Sunday which was inappropriate. There were two young people in the SRU at the time of inspection, one of them pending adjudication and one serving a period of seven days' removal from unit. We spoke to both of them and were satisfied that they had received all the publicised entitlements and had been treated well. Staff routinely addressed young people by their first names and appeared comfortable with this.

6.32 Young people located in the separation and care unit did not attend their allocated education or vocational training courses. Staff from education visited the unit each afternoon and provided work for the young people there. This included one-to-one work if necessary. Subject to risk assessment, young people were able to attend PE once a week.

6.33 Safety algorithms had been completed, and reviews of those segregated took place within prescribed timescales. These reviews were all chaired by a governor grade and attended by unit staff, Independent Monitoring Board (IMB) and healthcare. The IMB had not always been informed of the arrangements for these reviews, but this had been addressed. Recent reviews indicated that positive steps were being taken to reintegrate problematic young people on the residential units. We saw examples where they had been allowed to attend education and association as part of a phased return.

6.34 Young people held in the SRU were visited each day by a governor, chaplain, medical professional and a representative from the parent unit. A member of the IMB also attended on a regular basis. Entries by the unit representative in the young person's wing history files were generally good and far better than the daily monitoring entries made by SRU staff. These tended to be purely observational and provided little or no evidence of engagement. Advocates visited young people in the SRU whenever they were on duty.

Recommendations

6.35 Adjudications should be opened and adjourned if a young person who wishes to speak to an advocate has not had the opportunity to do so.

6.36 Young people should not receive punishments which include 100% stoppage of their earnings.

6.37 Records of adjudication should clearly demonstrate that charges have been fully investigated.

6.38 The behaviour management policy should be promulgated among staff and a robust quality assurance system should be put in place to ensure adherence to the policy.

6.39 Cooling off/time out facilities should be provided on each residential unit.

6.40 Before force is used against a young person, staff should use all de-escalation techniques available to them and this should be clear in the use of force documentation and an essential part of the quality assurance system.

6.41 Monitoring of the use of force should include identification of staff who are repeatedly involved in incidents. Control and restraint should not be used merely for non-compliance.

6.42 When completing the documentation authorising the use of special accommodation, the governor should always specify the required level of search and the type of clothing.

6.43 There should be a quality assurance system in place to ensure that young people are removed from special accommodation at the earliest opportunity.

6.44 All young people held in the SRU should have access to their allocated education and vocational training courses, subject to a risk assessment. An individual care plan which addresses their problem behaviour should form the basis of a plan for reintegration to normal location.

6.45 Young people in the SRU should have daily access to telephones.

6.46 Entries by SRU staff in wing history files should demonstrate that young people are being effectively monitored and that staff are engaging with them on a regular basis.

Housekeeping points

6.47 Adjudication tariffs should be more widely publicised to young people.

6.48 Seating should be provided in the SRU exercise yard.

6.49 Cells in the SRU should be repainted as necessary.

6.50 Missing in-cell toilet seats in the SRU should be replaced and toilets descaled.

Good practice

6.51 The use of force committee reviewed video tapes of planned interventions to satisfy themselves that the correct procedures had been followed.

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.

6.52 The rewards scheme was fully explained on induction and well publicised. There was good differential between the levels, which ensured that young people were motivated to achieve the required standards. Reviews were conducted fairly, and young people were encouraged and enabled to make an active contribution. They were given clear targets so that they knew how to progress within the scheme. The regime for young people on the basic level was not overly punitive with the exception of restriction of telephone calls which were limited to once a week.

6.53 The rewards and sanctions scheme was explained in a policy document that had last been updated in June 2008. The three normal privilege levels were in operation: basic, standard and enhanced. At the time of inspection, 6% of the population were on basic, 71% on standard and 23% on enhanced. The scheme was fully explained on induction and prominently publicised on each unit.

6.54 Movement within the scheme was decided at unit review boards. A review board was triggered by a young person being issued with a set number of merits or demerits within a 21-day period. Merits and demerits remained valid for 28 days.

6.55 Young people arriving at the establishment joined at the level that they were on at their previous establishment. It usually took approximately three to four weeks for standard level young people to achieve enhanced status. To be considered for enhanced level, young people had to earn three merits with no demerits over a three-week period. Further, they should not have had a proven adjudication against them during the previous four weeks and should have consistently demonstrated a positive approach towards their sentence plan and activities.

6.56 Those on the enhanced level were rewarded with additional association, private cash and a play station for in-cell use. They also had exclusive use of an enhanced association room which had been provided on each unit. These rooms were comfortable with leather suites, two further play stations and the only pool table on the units. Those on enhanced also had the opportunity to attend physical education (PE) more frequently, as well as having access to a DVD library. Overall there was good differential between the levels to act as a motivational tool for young people. This was confirmed in our survey, with 72% of respondents confirming that the different levels motivated them to change their behaviour, which was significantly better than the comparator of 61%.

6.57 Young people on standard level who had received three demerits within a 21-day period were considered for basic level. We were satisfied that this was not automatic, as any merits earned during that period would also be taken into account, as would the reasons for the demerits. Any serious breach of discipline could result in an urgent referral to the review board.

6.58 Those on basic level could still attend education and the gymnasium each day and could shower after PE. They were issued with improvement targets and had to maintain a diary. A monitoring sheet was opened and staff had to make daily entries. The quality of these was generally poor and provided little evidence of engagement. All young people on the basic level were reviewed after seven days. They only received association at the weekends and were unlocked to use the telephone once a week, which was an inappropriate punishment.

6.59 Review boards were chaired by the unit manager, and at least one other member of staff was present along with the young person. A written contribution was made by the personal officer who had to reflect entries made in the wing history file. Advocates could also attend if required or assist in preparing written representations on the young person's behalf. Appeals were considered by a principal officer, and there were examples where they had been upheld.

6.60 We reviewed unit history files and monitoring booklets for young people on the basic level and concluded that decisions were fair and based on patterns of behaviour. We also found that the scheme was being consistently applied across all residential units. Our main concern was that multiple demerits could be issued for the same or similar reasons within a short space of time by the same member of staff. This was a particular problem in education where a young person could get several demerits in the same class for minor misdemeanours such as throwing paper. Some safeguards were in place, as the unit manager had to sanction a demerit before it counted, and we saw examples where this worked well. This arrangement was not foolproof, however, as we found examples where inappropriate demerits had been counted.

6.61 In our survey findings, 59% of respondents against the comparator figure of 56% reported that, in their experience of the reward scheme, they had been treated fairly.

Recommendations

6.62 Entries in basic monitoring sheets should demonstrate engagement by staff.

6.63 Young people on basic level should have daily access to telephones.

6.64 Multiple demerits should not be awarded for the same or similar misdemeanours within a short period of time.

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 The quality and quantity of food was adequate and there was a system in place for young people to comment on the catering arrangements. All young people could dine in association in the separate dining hall except for breakfast. Cells were not a suitable environment in which to dine. Meals were sometimes served too early. The kitchen and serveries were clean and well organised and supervision of the serving of meals was good.

7.2 Food was prepared in a central kitchen and delivered to unit serveries. The kitchen area was clean, and there were ample freezer and cold storage areas. Halal products were stored in a separate freezer unit just outside the main kitchen. The menu was on a four-week cycle and included the opportunity to have five portions of fruit and vegetables every day. The lunch and tea meals were served too early – 15 minutes earlier than the published times during the inspection. This was before midday for lunch and before 5pm for tea.

7.3 There was a cold packed breakfast of cereal, bread and jam. During the week this was issued in the morning, but at weekends it was issued the previous evening. Unsurprisingly, young people frequently ate their breakfast soon after it was delivered and were then hungry at the start of the next day. The sinks in cells were supplied with drinking water and young people were supplied with a flask so they could make a hot drink during lock up periods.

7.4 During the week young people generally had soup and a sandwich for lunch and a hot evening meal. At weekends this was reversed. When the evening meal was served, young people were provided with an additional snack, usually a chocolate biscuit.

7.5 The meals we saw and tested were varied, and portion size was appropriate for this age group.

7.6 All young people had the opportunity to dine outside their rooms except for breakfast, and there was good supervision of mealtimes by staff. Cells were not a suitable environment in which to take any meals, particularly as toilets were only partially screened. The unit serveries were clean and staff supervised the serving of food to ensure that everyone received a similar portion. Every young person was allocated seating in the dining room based on his room location to avoid groups gathering to intimidate others for food.

7.7 Food comment books were available on each unit and young people made use of them. The books were checked daily by catering staff and any complaints were referred to the catering manager. Sometimes catering staff annotated the comments with a response, but this did not always occur.

Recommendations

7.8 The midday meal should be between noon and 1.30pm and the evening meal should be served between 5pm and 6.30pm.

7.9 Young people should have the opportunity to eat all their meals, including breakfast, out of their cells.

7.10 Catering staff should respond in writing to comments made in the food comments book, indicating any action taken.

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.

7.11 Young people were generally satisfied with the variety of goods available through the establishment shop. There were some arbitrary restrictions on items thought to present a risk to safety and a lack of healthy snacks. Good staff supervision ensured that young people could collect their ordered goods safely.

7.12 Young people were given full information about the canteen order system on induction. Young people could order canteen supplies once a week. The forms were issued each Monday and collected every Tuesday. Deliveries took place every Thursday. If a young person arrived after Tuesday they might have to wait for over a week before they could order canteen.

7.13 There was a reasonable variety of products available from the establishment shop. In our survey, 57% of young people stated that the shop sold a wide enough range of goods to meet their needs against a comparator of 47%. In focus groups, young people complained that they could not order items sold in jars or tins. Young people could not order fruit and healthy snacks were greatly outnumbered by those high in fats and sugars.

7.14 There was an additional list of items of particular interest to Muslim young people and available to all. Young people were able to order supplies for match model making and drawing pencils and paper but there were no other hobby items on the canteen list. Clothing and other items could be ordered from a selection of catalogues. An administration fee of 50 pence was charged on items ordered from catalogues which was inappropriate. Newspapers and magazines could be ordered but any publications containing potentially pornographic material were properly censored.

7.15 Canteen was issued to young people once a week. Each young person collected their own canteen and signed for their goods. Staff supervised the issue of canteen vigilantly to ensure that young people were not bullied into giving others their canteen.

Recommendations

7.16 Young people should be able to place orders and receive items from the shop at least once a week.

7.17 Young people should be able to purchase items supplied in glass jars or tins subject to risk assessment.

7.18 There should be a greater range of healthy snacks, including fruit, available to be purchased through the shop.

7.19 The range of hobby items available through the shop should be increased in consultation with young people.

7.20 Young people should not be charged an administration fee when they order from a catalogue.

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 The management arrangements for resettlement had recently begun to improve after a period of drift. The resettlement policy committee was beginning to function more effectively and was well attended. However, a needs analysis had not been carried out to inform the draft strategy. Allocation of responsibility for individual resettlement pathways was beginning to improve the development of reintegration services. Public protection was managed well. There was a range of relevant short programmes in which young people could participate and sufficient reintegration services, including a pre-release course, to ensure that young people received necessary practical help before they were released.

8.2 A reducing re-offending strategy was being developed and was due to be published in November 2008.The draft document was comprehensive and detailed, but no needs analysis had been carried out to inform the content.

8.3 The resettlement policy committee, which covered both the juvenile and young adult populations, was chaired by the head of offender management. The committee had been meeting monthly since May 2008. Prior to that, for a period of four or five months, meetings had not taken place regularly, and the management arrangements had been allowed to drift.

8.4 Membership of the committee consisted of functional heads and appropriate front line managers. There were no representatives from the community. Minutes of the committee meetings reflected improving management performance. Staff had recently been allocated lead roles for each of the resettlement pathways. The lead staff were beginning to identify where there were particular problems and trying to identify long- and short-term solutions. An example of this was the lack of provision for finance, benefit and debt advice. Contact was being made with the local Citizens Advice Bureau in an attempt to introduce specialist input. In the meantime, young people who had financial difficulties were being encouraged to use a telephone helpline.

8.5 The head of the on-site youth offending team (YOT) attended a quarterly regional forum in the community. This involved other YOT managers and representatives from custodial settings and provided the establishment with a useful strategic link.

8.6 Release on temporary licence (ROTL) was being used on a limited, but regular, basis. The majority of licences were granted to young people to attend high quality placements run by The Prince's Trust. A small number of work placements were available in the community, but they were not often used and none of them was being used at the time of the inspection.

8.7 Records indicated that very few young people were registered as no fixed abode on release and establishment staff adopted a robust line with community YOTs. The in-house YOT staff

identified at an early stage potential difficulty in placing a young person in suitable accommodation. All these cases were passed to the in-house YOT manager to deal with and, if they remained unresolved, to the head of offender management. We came across a recent example where the community-based YOT appeared to fail to provide adequate support for a young person just prior to discharge. This situation was dealt with very assertively by the establishment-based YOT and a formal complaint was subsequently made via senior staff.

8.8 There was a range of short locally-accredited programmes for young people. There were generic cognitive skills based courses which covered anger management, victim awareness and alcohol awareness. They were delivered by a joint team of psychologists and officers. Referrals came mainly from training plan reviews. There were clear procedures to ensure that young people were properly assessed and allocated places on the basis of need.

8.9 A short pre-release course was available to all young people during the last two weeks of their sentence. Most young people participated. This programme had a strong practical emphasis and enabled young people to rehearse interview techniques and complete housing and benefit forms.

8.10 Relateen delivered a useful service by providing relate counsellors for young people who had relationship problems with family or partners. This complemented the work being carried out on the parenting course.

8.11 The public protection work being carried out was generally thorough. All relevant cases were identified on admission, and all multi-agency public protection arrangements (MAPPA) cases were monitored at the monthly risk management meeting. This forum was chaired by the head of offender management and was well attended by all key staff based within the establishment and the police liaison officer. Young people subject to MAPPA who were due for release were prioritised for consideration. Records of the committee indicated that risk assessment information on these young people was being gathered and shared appropriately. There were good links with relevant community-based agencies, and representatives from the establishment usually attended conferences held in the community on high-risk MAPPA 3 cases.

8.12 Young people who were subject to other public protection measures such as risk to children, harassment or hate crimes were not considered at the risk management meeting. These cases were also efficiently identified on admission and, where appropriate, restrictions were imposed on the individual's mail, telephone calls or visits. These cases were only reviewed on a six-monthly basis which was unsatisfactory, as it did not allow a quick enough response if there was a change in circumstances and the level of restrictions imposed needed to be altered.

Recommendations

8.13 Efforts should be made to engage with appropriate community-based agencies with a view to securing their representation at the resettlement policy committee.

8.14 The use of ROTL should be extended to provide more young people with a wider range of opportunities.

8.15 All public protection cases should be reviewed at the risk management meetings.

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.

8.16 All young people were subject to the same efficient planning procedures. The reviews which we observed were conducted well, young people were well supported through the process, but the venue was too small to accommodate the large number of people which was sometimes required. There was not always sufficient input to the reviews from specialist departments, but the new arrangements to provide short-term cover to allow personal officers to participate in reviews were innovative. The management of young people sentenced to indeterminate sentences was adequate.

8.17 All young people, regardless of the length of their sentence and whether short- or long-term convicted or on remand, were subject to the same planning process. Reviews were conducted by the in-house YOT staff and two specialist detention and training order (DTO) officers. These staff were supported by an administration officer and together they dealt with all aspects of the planning process. This included scheduling the meetings within the relevant timescales and preparing the documentation. The community-based YOT worker was always given the opportunity to chair the review, but this task was usually carried out by one of the in-house YOT workers or DTO officers.

8.18 The reviews we observed were all conducted well and there was evidence of good engagement with young people who appeared unwilling or unable to participate. There was an appropriate balance between discussion of the young person's behaviour and achievements in custody and reintegration planning. The targets set were reasonably tailored to meet individual need and were reviewed appropriately.

8.19 Attendance at reviews varied. Community YOT workers were always present and unit staff usually attended. We were given an estimate that family members were present at approximately 40% of the reviews. This relatively low attendance rate for families may have been related to the distance from their home area but the establishment had not considered investigating this with families. Attendance by personal officers had improved with the introduction of a new arrangement. When a training plan review was due, a template for written comments was issued to the personal officer. His or her attendance at the review was given priority, and the caseworker came to the unit to replace the officer. This meant that senior officers could not decline to release the officer because it would leave the unit under-staffed. If the officer was exceptionally unavailable, he or she delivered an oral briefing, with written comments, to the caseworker who attended in their place. We were told that personal officers were currently attending about half the reviews. Officers reported positively on the support they felt able to give young people who had difficulty articulating, and on the opportunity to meet family members occasionally. Representatives from education and the young people's substance misuse team would sometimes attend, but this was not guaranteed or regular. It was rare for there to be a representative from the healthcare department. Reports were not routinely sent when representatives did not attend.

8.20 All planning meetings were held in small offices adjacent to the residential units. These very small areas were too cramped to accommodate more than five or six people at a time. The planning arrangements for convicted young people and those on remand were the same. The

onerous scheduling standards for remand cases required meetings to be convened at an earlier stage than convicted cases. Telephone conferences were used successfully in these cases.

8.21 We were impressed to find that a representative from the establishment attended most of the first reviews in the community.

Young people sentenced to indeterminate sentences

8.22 The traditional, adult-focused life sentence planning (LSP) documentation and management system was being used to record and manage work with young people sentenced to indeterminate sentences. This approach had been designed for use with adults and was not wholly suited to the needs of a population of young people. Despite these limitations, the documentation which was available was completed appropriately and filed centrally for easy access by relevant staff.

8.23 The arrangements in place for young people sentenced to indeterminate sentences were adequate. Individual cases were dealt with efficiently through the standard planning process and transfers were handled properly. Young people moved on to establishments in the young adult estate only after the lifer officer, the internal YOT, the community YOT and the Youth Justice Board's Placement and Casework Service had discussed the move.

8.24 At the time the inspection took place, there were four young people subject to detention for public protection (DPP) sentences. There was an effective system in place to identify quickly young people who were serving an indeterminate sentence and DPPs. These young people were allocated a lifer-trained officer, who acted for them in a key worker capacity.

Recommendations

8.25 All staff based in the establishment who work directly with young people should attend their planning reviews. There should always be a representative from the education department.

8.26 The venue for planning reviews should be adequate to accommodate the number of participants.

8.27 Efforts should be made to ascertain the reasons for the low level of attendance by families at reviews with a view to seeking remedies for improvement.

8.28 An age-appropriate documentation and management system should be introduced to meet the needs of young people sentenced to life and detention for public protection.

Good practice

8.29 *Personal officer attendance at training plan reviews was given priority. To ensure their release from duties on the unit, a member of the caseworking team came to the unit to replace them. The caseworker attended the review only if the personal officer was not available, and with the benefit of an oral briefing and written submission from the personal officer.*

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.

8.30 There was a comprehensive substance misuse strategy based on an up-to-date needs analysis. Opiate detoxification regimes were not sufficiently flexible to meet complex needs. Alcohol detoxifications were provided almost twice as often as opiate detoxifications. While positive random mandatory drug test rates were low, young people were routinely strip searched prior to testing. Psychosocial interventions were comprehensive and took account of a wide range of needs. There was good joint working. There was no provision of nicotine replacement therapy. Young people did not have the opportunity to undertake voluntary drug testing.

8.31 Following an initial screening conducted by healthcare workers at reception, newly arrived young people in need of opiate detoxification were usually given first night symptomatic relief. They were then fully assessed and seen by the doctor the following day. A 14-day opiate detoxification regime using buprenorphine (Subutex) was prescribed for all opiate-dependent young people. Four such programmes had been provided in the six months prior to the inspection. Other symptomatic relief was also prescribed where necessary. The buprenorphine regime was not flexible and did not cater for young people presenting with more complex needs requiring maintenance prescribing or polydrug dependencies. Naltrexone was available for relapse prevention, but it was seldom used.

8.32 Young people undergoing opiate detoxification were located on the induction unit and were given opportunities to participate in everyday activities. If young people were assessed as alcohol dependent, they were detoxified on a seven-day programme. The first three days were spent under close medical supervision in the inpatient area of the healthcare centre. Seven alcohol detoxes had been provided in the six months prior to the inspection.

8.33 The positive rate for mandatory drug testing (MDT) for the six months prior to the inspection was zero. Young people whom we spoke to confirmed that drugs were not easy to obtain in the establishment and indeed many of them said that the drug-free environment had significantly helped them overcome existing drug problems.

8.34 MDT procedures were the same for young people as they were for adults. All selected young people were required to undergo a full strip search before providing a sample for random drug testing. Risk assessments were not carried out before these procedures.

8.35 Nicotine replacement therapy to help smoking cessation was routinely denied to young people as the local primary care trust would not fund it.

8.36 The establishment's commitment to a strategic approach to tackling substance use was evident in the documentation and in the practice of the young people's substance misuse service (YPSMS). Psychosocial interventions were comprehensive and took account of a wide range of needs. There were insufficient rooms to conduct one-to-one sessions adequately.

8.37 A very clear and comprehensive substance misuse strategy was in place. Alcohol was included in the strategy, which was informed by an annual needs analysis conducted by a member of the

psychology department. The needs analysis identified targets for the strategic action plan and made recommendations for future research within the establishment. These documents were not only good examples of coordinated strategic planning, but were also clearly informing day-to-day practice in substance use supply and demand reduction. The drug strategy team met bi-monthly with good representation from across the establishment.

8.38 The YPSMS team worked closely with the healthcare team in the coordination of clinical and psycho-social treatment and in the provision of drug and alcohol education. The team comprised seven workers and a manager.

8.39 A range of drugs education groupwork sessions was provided for all young people, lasting a week during induction. Subjects covered were drug and alcohol awareness, healthy living, communicable diseases and harm reduction.

8.40 If young people were identified with specific substance problems at initial screening, they received a comprehensive assessment by YPSMS within ten days of arrival. A care plan was drawn up for all young people with substance misuse problems. Those with more complex needs received one-to-one key working and, where appropriate, were encouraged to join more in-depth drugs awareness groups targeted at specific problem drugs. The psychology team was preparing an 'alcohol and offending' group to start in the near future. As the young people worked through these groups, they were also seen on a one-to-one basis by their YPSMS key worker to address individual issues. The work of the YPSMS was highly praised by the young people we spoke to: they said that as well as 'telling them straight' about the dangers of drug use, the team workers were understanding, non-judgmental and very supportive.

8.41 The facilitation of one-to-one work was problematic at times due to limited room availability. One of the small rooms in the YPSMS portakabin was used for storing chairs. Space was also limited in the education block and on the units. One-to-one sessions were, therefore, often held in large open rooms like the dining area, which was not conducive to confidentiality.

8.42 Working protocols existed with all local youth offending teams. Where possible, community workers were invited into the establishment for pre-release meetings to agree resettlement plans. All young people were released with a file detailing their resettlement plan.

8.43 There was no provision for voluntary drug testing for young people. There was a compliance testing option which purported to be similar in its supportive role. However the compliance test protocol document stated that if young people received a positive test, they 'may be liable to punitive action under any resultant adjudication process'. The compliance test could also be used as an alternative to adjudication where a young person had provided a positive MDT sample. Use of this option was rare given the lack of MDT positive test results in recent months.

Recommendations

8.44 Clinical services should be extended to offer a more flexible regime incorporating stabilisation, detoxification and maintenance provision.

8.45 Full MDT strip searches should not be undertaken without prior risk assessments.

8.46 Nicotine replacement therapy should be made available to young people who need it.

8.47 Sufficient and suitable rooms should always be made available for one-to-one key working.

8.48 A voluntary drug testing programme should be established.

Section 9: Recommendations, housekeeping points and good practice

The following is a listing of recommendations, housekeeping points 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 recommendations

To the Governor

9.1 Reception procedures should be improved so that new arrivals do not spend a long time waiting in holding rooms. (HP43)

9.2 There should be a review of the roles of the safeguarding and violence reduction committees to improve the coordination of all aspects of safeguarding. (HP44)

9.3 Residential units should hold no more than 40 young people so that they can be managed safely. (HP45)

9.4 Young people should be able to exercise in the open air every day. (HP46)

9.5 An analysis of the resettlement needs of the young people population should be carried out. The results should be used to inform the resettlement strategy. (HP47)

Recommendations

To the Youth Justice Board

Courts, escorts and transfers

9.6 Young people should arrive by 7pm so that they can be properly assessed and helped to settle in on their first night in custody. (1.6)

9.7 All relevant information about new arrivals should be sent to the establishment in advance of their arrival. (1.7)

Recommendation

To the YJB and NOMS

Training planning and remand management

9.8 An age-appropriate documentation and management system should be introduced to meet the needs of young people sentenced to life and detention for public protection. (8.28)

Recommendation — To the UK Border Agency

Foreign nationals

9.9 The establishment should liaise with UKBA to ensure that caseworkers within the Criminal Casework Directorate identify themselves and provide contact details on their communications. (3.80)

Recommendation — To the YJB and the Governor

Safeguarding

9.10 Alternative arrangements should be made in discussion with the Youth Justice Board for the placement of particularly vulnerable young people if they cannot be managed safely on normal location. (3.9)

Recommendations — To the Governor

Courts, escorts and transfers

9.11 Information about late arrivals and the number of young people who have shared transport with adults should be collected and monitored and included in regular meetings with the escort providers to address the issues. (1.8)

9.12 The establishment should work with courts to promote the use of video link for court appearances where appropriate. (1.9)

First days in custody

9.13 Reception staff should address new arrivals by their preferred name. (1.28)

9.14 Insiders should be routinely on duty in reception and should meet new arrivals as part of first night procedures. (1.29)

9.15 Information leaflets given to young people in reception and on induction should be available in a range of different media and languages to meet the needs of the population. (1.30)

9.16 The electrical boxes and switches in the dining area should be made inaccessible to young people. (1.31)

9.17 Young people should be able to make a telephone call in reception in private. (1.32)

9.18 There should be a quality assurance system in place to ensure that vulnerability assessments and risk management plans are of a consistently good standard. (1.33)

9.19 First night accommodation should be clean and suitably equipped. (1.34)

9.20 There should be a designated room for delivery of the induction classes. (1.35)

9.21 Young people should be fully occupied during their induction programme. (1.36)

Residential units

9.22 Cell toilets should be deep cleaned regularly. (2.13)

9.23 Sentenced and remanded young people should not share cells. (2.14)

Personal officers

9.24 Records should reflect important aspects of personal officer work undertaken with young people. (2.21)

9.25 Personal officers should attend all meetings relating to the care of the young people they are responsible for. (2.22)

Safeguarding

9.26 The terms of reference of the safeguarding committee should be clarified so that all aspects of safeguarding are properly managed and coordinated. (3.6)

9.27 The safeguarding policy should be agreed with the Local Safeguarding Children Board without delay. (3.7)

9.28 Injuries sustained during restraint should be monitored by the safeguarding committee. (3.8)

Bullying

9.29 Reporting procedures for bullying incidents should be properly adhered to. There should be a quality assurance system to monitor the procedures and this should include checks on all potential sources of information such as observation books, complaints and security information reports. (3.21)

9.30 Monitoring records at all stages of the anti-bullying procedure should provide evidence of engagement between staff and young people. (3.22)

9.31 Efforts should be made to improve the take up of support for victims of bullying. (3.23)

Self-harm and suicide

9.32 Managers should ensure that weaknesses in work practices relating to ACCT, which are identified through quality assurance checks, are remedied. (3.36)

9.33 All incidents of self-harm or attempted self-harm should be recorded, and aggregated data should be routinely analysed to establish patterns or trends. This management information should be monitored by the appropriate strategic management committee. (3.37)

9.34 ACCT reviews should be multidisciplinary and staff who have regular contact with the young person should attend. This should always include the personal officer. (3.38)

9.35 There should always be staff on duty who are first aid trained. (3.39)

9.36 The establishment should ensure that parents or carers are notified when a young person is being formally monitored for self-harm, unless a decision has been made not to do so in the best interests of the young person and in accordance with Frasier competency guidelines. (3.40)

9.37 A peer support scheme should be introduced for young people at risk of self-harm. (3.41)

Child protection

9.38 All staff working with young people should be trained in child protection and have enhanced CRB clearance. (3.52)

9.39 The child protection policy should be revised in conjunction with the Local Safeguarding Children Board to ensure that it is helpful and relevant to staff working with the population at Stoke Heath. (3.53)

9.40 There should be clear procedures and support systems in place to ensure that staff report legitimate concerns about the treatment of children and young people by staff, and to give assurance that the position and prospects of the reporting member of staff are not prejudiced. (3.54)

9.41 Analysis of child protection referrals should be improved to include identification of patterns and trends. (3.55)

Diversity

9.42 The establishment should have an overarching equality and diversity policy to meet identified needs of the young population, to be taken forward by a diversity manager. (3.69)

9.43 All staff should be up to date with diversity training. (3.70)

9.44 The disability liaison officer(s) should be enabled to conduct an impact assessment of provision for people with a range of disabilities. (3.71)

Foreign nationals

9.45 A link with an independent, specialist source of immigration advice should be developed. (3.81)

Contact with the outside world

9.46 Managers should investigate whether there are delays in the delivery of mail as reported by young people. (3.97)

9.47 Young people should be escorted to the visits hall in good time so that their visit is not delayed or curtailed. (3.98)

9.48 The path from the visitors' centre to the gate should be paved to allow ease of access for pushchairs and wheelchairs. (3.99)

9.49 Refreshments should be provided in the visitors' centre. (3.100)

9.50 Refreshments should be available in the visits hall during the morning sessions at weekends. (3.101)

9.51 Dog handlers should ensure that dogs do not make contact with the person they are searching. (3.102)

9.52 Closed visits should not be imposed purely on the basis of a drug dog, but only if there is additional supporting evidence. (3.103)

9.53 Young people should not be strip searched following a visit unless there is intelligence indicating that it is necessary, supported by a risk assessment. (3.104)

Applications and complaints

9.54 The applications log should be kept up to date, recording date of application and outcome. (3.109)

9.55 Up-to-date information about all complaints procedures, in a format suitable for the young population, should be publicised. (3.110)

Legal rights

9.56 The library should have access to the internet and a printer to trace up-to-date legal reference materials. (3.114)

9.57 Legal visitors should be surveyed to see if current needs are being met. (3.115)

Health services

9.58 Healthcare staff should attend multidisciplinary meetings such as training planning reviews and pre-release meetings. (4.42)

9.59 The unsuitable conditions in the pharmacy should be addressed. (4.43)

9.60 The need for more appropriate facilities for the administration of medication and appropriate space for healthcare consultations on the units should be addressed. (4.44)

9.61 There should be a computer available in the reception healthcare room. (4.45)

9.62 Bathing facilities should be available for inpatients with impaired mobility. (4.46)

9.63 RMNs and RGNs should have separate job descriptions based on their specific skills and competencies. (4.47)

9.64 A pharmacist should make regular visits to the prison and should be available for consultations with young people. (4.48)

9.65 All clinical information (both hard copy and electronic) should be available to healthcare staff during consultations and treatment. (4.49)

9.66 Healthcare staff should be available to attend reception promptly when young people arrive. (4.50)

9.67 Young people should be given an age-appropriate leaflet outlining health services available in the establishment. (4.51)

9.68 Young people should be able to make confidential written applications for healthcare appointments. (4.52)

9.69 Accurate dental triaging should be carried out by an appropriately trained person. (4.53)

9.70 Triage algorithms should be available to and routinely used by staff when they are assessing patients. (4.54)

9.71 Patients attending for emergency treatments should be offered check-up appointments. (4.55)

9.72 Treatments involving laboratory fees should not be delayed. (4.56)

9.73 The use of stock medication should be minimised, with named patient medicine issued wherever possible. (4.57)

9.74 The medicines and therapeutics committee should develop a special sick policy, with a list of approved medicines, which should be reviewed by them on a regular basis to ensure that all appropriate medicines can be supplied. Patient group directives should be produced to allow the supply of more potent medicines by the nursing staff where appropriate. (4.58)

9.75 The medicines and therapeutics committee should introduce a policy for provision of medicines for discharge and for court appearances. (4.59)

9.76 Young people should be invited to a discharge clinic prior to release. (4.60)

9.77 The beds in healthcare should not form part of the establishment's certified normal accommodation. (4.61)

9.78 Admissions to the inpatient unit should be based on clinical need and subject to audit. (4.62)

9.79 All inpatients should have a care plan which is regularly evaluated and updated. (4.63)

9.80 Young people in the inpatient unit should have access to a therapeutic regime and not spend long periods of time locked up. (4.64)

9.81 Mental health nurses should have protected time to conduct mental health clinics. (4.65)

Education, training and library provision

9.82 Behaviour management should be improved to enable young people to learn more effectively. (5.13)

9.83 Young people should be brought to and collected from lessons punctually. (5.14)

9.84 Input by Connexions and Careers Wales should be increased. (5.15)

9.85 Learning support assistants should be allocated effectively. (5.16)

9.86 The availability of higher level qualifications should be increased. (5.17)

9.87 Daily newspapers should be available in the library. (5.18)

9.88 Young people should have access to the library at weekends. (5.19)

Physical education and health promotion

9.89 Attendance at core PE lessons should be improved. (5.27)

9.90 The establishment should make efforts to ascertain why young people refuse to attend PE and address the problems. (5.28)

9.91 Monitoring the use of the gymnasium should be improved. (5.29)

9.92 The classroom used for Sports Academy work should be suitable for the purpose. (5.30)

9.93 Modesty screens should be installed in the gymnasium showers. (5.31)

Time out of cell

9.94 Young people should have at least 10 hours' time out of cell per day. (5.44)

9.95 Activities at the weekend should be timetabled so that they do not clash with opportunities to exercise in the open air. (5.45)

Security and rules

9.96 The searching policy should be reviewed. Young people should not be routinely strip searched and all strip searches should be carried out only on the authorisation of the duty governor following a rigorous risk assessment. (6.12)

Discipline

9.97 Adjudications should be opened and adjourned if a young person who wishes to speak to an advocate has not had the opportunity to do so. (6.35)

9.98 Young people should not receive punishments which include 100% stoppage of their earnings. (6.36)

9.99 Records of adjudication should clearly demonstrate that charges have been fully investigated. (6.37)

9.100 The behaviour management policy should be promulgated among staff and a robust quality assurance system should be put in place to ensure adherence to the policy. (6.38)

9.101 Cooling off/time out facilities should be provided on each residential unit. (6.39)

9.102 Before force is used against a young person, staff should use all de-escalation techniques available to them and this should be clear in the use of force documentation and an essential part of the quality assurance system. (6.40)

9.103 Monitoring of the use of force should include identification of staff who are repeatedly involved in incidents. Control and restraint should not be used merely for non-compliance. (6.41)

9.104 When completing the documentation authorising the use of special accommodation, the governor should always specify the required level of search and the type of clothing. (6.42)

9.105 There should be a quality assurance system in place to ensure that young people are removed from special accommodation at the earliest opportunity. (6.43)

9.106 All young people held in the SRU should have access to their allocated education and vocational training courses, subject to a risk assessment. An individual care plan which addresses their problem behaviour should form the basis of a plan for reintegration to normal location. (6.44)

9.107 Young people in the SRU should have daily access to telephones. (6.45)

9.108 Entries by SRU staff in wing history files should demonstrate that young people are being effectively monitored and that staff are engaging with them on a regular basis. (6.46)

Rewards and sanctions

9.109 Entries in basic monitoring sheets should demonstrate engagement by staff. (6.62)

9.110 Young people on basic level should have daily access to telephones. (6.63)

9.111 Multiple demerits should not be awarded for the same or similar misdemeanours within a short period of time. (6.64)

Catering/canteen/shop

9.112 The midday meal should be between noon and 1.30pm and the evening meal should be served between 5pm and 6.30pm. (7.8)

9.113 Young people should have the opportunity to eat all their meals, including breakfast, out of their cells. (7.9)

9.114 Catering staff should respond in writing to comments made in the food comments book, indicating any action taken. (7.10)

9.115 Young people should be able to place orders and receive items from the shop at least once a week. (7.16)

9.116 Young people should be able to purchase items supplied in glass jars or tins subject to risk assessment. (7.17)

9.117 There should be a greater range of healthy snacks, including fruit, available to be purchased through the shop. (7.18)

9.118 The range of hobby items available through the shop should be increased in consultation with young people. (7.19)

9.119 Young people should not be charged an administration fee when they order from a catalogue. (7.20)

Resettlement strategy

9.120 Efforts should be made to engage with appropriate community-based agencies with a view to securing their representation at the resettlement policy committee. (8.13)

9.121 The use of ROTL should be extended to provide more young people with a wider range of opportunities. (8.14)

9.122 All public protection cases should be reviewed at the risk management meetings. (8.15)

Training planning and remand management

9.123 All staff based in the establishment who work directly with young people should attend their planning reviews. There should always be a representative from the education department. (8.25)

9.124 The venue for planning reviews should be adequate to accommodate the number of participants. (8.26)

9.125 Efforts should be made to ascertain the reasons for the low level of attendance by families at reviews with a view to seeking remedies for improvement. (8.27)

Substance use

9.126 Clinical services should be extended to offer a more flexible regime incorporating stabilisation, detoxification and maintenance provision. (8.44)

9.127 Full MDT searches should not be undertaken without prior risk assessments. (8.45)

9.128 Nicotine replacement therapy should be made available to young people who need it. (8.46)

9.129 Sufficient and suitable rooms should always be made available for one-to-one key working. (8.47)

9.130 A voluntary drug testing programme should be established. (8.48)

Housekeeping points

First days in custody

9.131 All areas of reception and all equipment should be maintained in a safe, clean and hygienic state – particularly holding rooms, the searching area and the kitchen. (1.37)

9.132 The televisions should be relocated so that they can be viewed from the seating area. (1.38)

Bullying

9.133 Analysis of bullying surveys should distinguish between the two populations held. (3.24)

9.134 The quality and effectiveness of stage 2 interventions for identified bullies should be subject to evaluation. (3.25)

Child protection

9.135 The monthly meetings to monitor outstanding child protection cases should be properly minuted to ensure accountability. (3.56)

Diversity

9.136 The toilet for disabled people in the visits hall should be cleaned and checked daily. (3.72)

Health services

9.137 Staff should be told how to use the refrigerator thermometer correctly and temperatures should be monitored. (4.66)

9.138 The healthcare room in reception and the healthcare waiting room should have age-appropriate displays and information available to make them more welcoming to young people. (4.67)

9.139 Young people should receive advance notice of internal healthcare appointments. (4.68)

9.140 Separate waiting lists should be maintained for young people and young adults. (4.69)

9.141 Oral health promotion should be available. (4.70)

Discipline

9.142 Adjudication tariffs should be more widely publicised to young people. (6.47)

9.143 Seating should be provided in the SRU exercise yard. (6.48)

9.144 Cells in the SRU should be repainted as necessary. (6.49)

9.145 Missing in-cell toilet seats in the SRU should be replaced and toilets descaled. (6.50)

Good practice

Child protection

9.146 The telephone numbers of Childline and the National Youth Advocacy Service were added to every young person's individual PIN system on arrival. (3.57)

Diversity

9.147 The two part-time disability liaison officers had set up a good system as a basis for care planning and, as an early step towards impact assessment, had tried to push a wheelchair around parts of the establishment. (3.73)

9.148 The librarian had developed his own simple reading assessment document, with the aim of guiding people to manageable and interesting reading material, rather than reaffirming reading difficulty. (3.74)

Discipline

9.149 The use of force committee reviewed video tapes of planned interventions to satisfy themselves that the correct procedures had been followed. (6.51)

Training planning and remand management

9.150 Personal officer attendance at training plan reviews was given priority. To ensure their release from duties on the unit, a member of the caseworking team came to the unit to replace them. The caseworker attended the review only if the personal officer was not available, and with the benefit of an oral briefing and written submission from the personal officer. (8.29)

Appendix 1: Inspection team

Nigel Newcomen	Deputy Chief Inspector of Prisons
Fay Deadman	Team leader
Ian Macfadyen	Inspector
Eileen Bye	Inspector
Lucy Young	Inspector
Ian Thomson	Inspector
Mandy Whittingham	Health services inspector
Paul Roberts	Substance use inspector
Martyn Rhowbotham	Ofsted lead inspector
Steve Miller	Ofsted inspector
Michael Skidmore	Researcher
Anne Fragniere	Observer

Appendix 2: Young people population profile

Population breakdown by:

(i) Status	Number of juveniles	%
Sentenced	135	82.82
Convicted but unsentenced	11	6.75
Remand	17	10.43
Detainees (single power status)	0	0
Detainees (dual power status)	0	0
Total	163	100

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

Sentence	4 mths	6 mths	8 mths	10 mths	12 mths	18 mths	24 mths	Total
Age								0
15 years	2	2			1			5
16 years	4	5	1	7	4	11	3	35
17 years	14	3	2	7	7	11	6	50
18 years	1	2	5	2	5	10	7	32
Total	21	12	8	16	17	32	16	122

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

Sentence	Under 2 yrs	2–3 yrs	3–4 yrs	4–5 yrs	5 yrs +	Total
Age						0
15 years		1				1
16 years		1	1			2
17 years	1	6	9	2	1	19
18 years		1	2			3
Total	1	9	12	2	1	25

(iv) Number of extended sentences under Section 228 (extended sentence for public protection)

Sentence	Under 2 yrs	2–3 yrs	3–4 yrs	4–5 yrs	5 yrs +	Total
Age						
15 years						
16 years	1				1	2

17 years					1	1
18 years						
Total	1				2	3

(v) Number of indeterminate sentences by age

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

(vi) Length of stay for unsentenced by age

Length of stay	<1 mth	1–3 mths	3–6 mths	6–12 mths	1–2 yrs	2 yrs +	Total
Age							
15 years	1	2					3
16 years	5	4					9
17 years	9	8	1				18
18 years		1					1
Total	15	15	1				31

(vii) Main offence	Number of juveniles	%
Violence against the person	40	24.54
Sexual offences	9	5.52
Burglary	26	15.95
Robbery	39	23.93
Theft and handling	4	2.45
Fraud and forgery	1	0.61
Drugs offences	5	3.07
Driving offences	5	3.07
Other offences	19	11.66
Breach of community part of DTO	6	3.68

Civil offences	0	0
Offence not recorded/ Holding warrant	9	5.52
Total	163	100

(viii) Age	Number of juveniles	%
15 years	6	3.68
16 years	53	32.52
17 years	96	58.9
18 years	8	4.9
Total	163	100

(ix) Home address	Number of juveniles	%
Within 50 miles of the prison	81	49.7
Between 50 and 100 miles of the prison	66	40.49
Over 100 miles from the prison	7	4.29
Overseas	0	0
NFA	9	5.52
Total	163	100

x) Nationality	Number of juveniles	%
British	158	96.93
Foreign nationals	5	3.07
Total	163	100

(xi) Ethnicity	Number of juveniles	%
White		
British	122	74.85
Irish		
Other White		
Mixed		
White and Black Caribbean	12	7.36
White and Black African	4	2.46

White and Asian		
Other Mixed	1	0.41
Asian or Asian British		
Indian	4	2.46
Pakistani	1	0.61
Bangladeshi		
Other Asian	3	1.84
Black or Black British		
Caribbean	11	6.75
African	1	0.61
Other Black	3	1.84
Chinese or other ethnic group		
Chinese		
Other ethnic group	1	0.61
Total	163	100

(xii) Religion	Number of juveniles	%
Baptist		
Church of England	16	9.81
Roman Catholic	48	29.46
Other Christian denominations	1	0.61
Muslim	11	6.75
Sikh	1	0.61
Hindu		
Buddhist		
Jewish		
Other	1	0.61
No religion	85	52.15
Total	163	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 by HM Inspectorate of Prisons as part of an annual report on the juvenile estate.

Choosing the sample size

At the time of the survey on 15 September 2008, the juvenile population at HMYOI Stoke Heath was 189. Questionnaires were offered to 91 juveniles.

Completion of the questionnaire was voluntary. Refusals were noted and no attempts were made to replace them. No respondents refused to complete a questionnaire.

Interviews were carried out with four respondents with literacy difficulties.

Methodology

Every attempt was made to distribute the questionnaires to each respondent on an individual basis. This gave researchers 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; or
- 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 traced back to them in line with child protection requirements.

Response rates

In total, 84 respondents completed and returned their questionnaires. This represented 44% of the juvenile population. The response rate is 92%. Three questionnaires were not returned and four were returned blank.

Comparisons

The following document details the results from the survey. All missing responses are excluded from the analysis. All data from each establishment have been weighted 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 all 14 prisons/units since 2005. In addition, this document shows statistically significant differences between the responses of juveniles surveyed at HMYOI Stoke Heath in 2007 and the responses of this 2008 survey.

In addition, a further comparative document is attached. Statistically significant differences between the responses of white juveniles and those from black and minority ethnic groups are shown.

In all the above documents, statistically significant differences are highlighted. Statistical significance merely indicates whether there is a real difference between the figures, that is 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. Orange shading has been used to show a significant difference in juveniles' background details.

It should be noted that, for statistical comparisons to be made between the most recent survey data and those of the previous survey, both sets of data have been coded in the same way. This may result in percentages from previous surveys looking higher or lower. However, both percentages are true of the populations they were taken from, and the statistical significance is correct.

Summary

A summary of the survey results is attached. This shows a breakdown of responses for each question as well as examples of comments made by juveniles. Percentages have been rounded and therefore may not add up to 100%.

No questions have been filtered within the summary, so all percentages refer to responses from the entire sample. The percentages of certain responses within the summary, for example 'Not sentenced' options across questions, may differ slightly. This is due to different response rates across questions, meaning that the percentages have been calculated from different totals (all missing data are excluded). The actual numbers will match up as the data are cleaned to be consistent.

Percentages shown in the summary may differ by 1 or 2 % from that shown in the comparison data as the comparator data have been weighted for comparison purposes.

Summary of juvenile survey results

Section One: About you

Q1 What is your age?

14 or under	0%
15	7%
16	25%
17	62%
18	6%

Q2 Do you usually live in this country? *(England, Ireland, Scotland or Wales)*

Yes	95%
No	5%

Q3 Is English your first language?

Yes	94%
No	6%

Q4 What is your ethnic origin?

White - British	76%
White - Irish	0%
White - Other	1%
Black or Black British - Caribbean	5%
Black or Black British - African	0%
Black or Black British - Other	0%
Asian or Asian British - Indian	2%
Asian or Asian British - Pakistani	4%
Asian or Asian British - Bangladeshi	0%
Asian or Asian British - Other	1%
Mixed Race - White and Black Caribbean	6%
Mixed Race - White and Black African	2%
Mixed Race - White and Asian	1%
Mixed Race - Other	0%
Chinese	0%
Other ethnic group	1%

Q5 Do you have any children under the age of 18?

Yes	10%
No	90%

Q6 Have you ever been in either foster care or children's home?

Yes	24%
No	76%

Q7 Are you on a care order now?

Yes	14%
No	86%

Section Two: About your sentence

Q1 Which wing or houseblock are you currently living on?

Q2 Are you sentenced?

Yes	80%
No - awaiting trial	11%
No - awaiting sentence	10%
No - awaiting deportation	0%

Q3 What is the length of your sentence?

Not sentenced	21%
Four months	12%
Six months	10%
Eight months	9%
12 months	15%
18 months	13%
Two years	13%
Two to four years	4%
Four years or more	4%

Q4 Approximately how long do you have left to serve (if you are serving life, please use the date of your next parole board)?

Not sentenced	22%
Less than two months	31%
Two to six months	22%
Six months to one year	17%
One year or more	9%

Q5 How long have you been in this establishment?

Less than one month	25%
One to six months	55%
Six to 12 months	18%
One to two years	2%
Two years or more	0%

Q6 Have you been to any other YOI during this sentence?

None	82%
One	10%
Two	5%
Three	4%
More than three	0%

Q7 How many times have you been in a YOI, secure children's home or secure training centre before, either sentenced or on remand?

None	48%
Once	23%
Two to five	25%
More than five	5%

Section Three: Courts, transfers and escorts

In questions 1 to 9 please refer to the most recent journey you have made, either from court or between establishments.

Q1 On your most recent journey, was the van clean?

Yes	44%
No	44%
Don't remember	11%
Not applicable	1%

Q2 On your most recent journey, was the van comfortable?

Yes	6%
No	88%
Don't remember	6%
Not applicable	0%

Q3 Did you feel safe on your most recent journey?

Yes	74%
No	17%
Don't remember	7%
Not applicable	1%

Q4 Did you have enough comfort breaks on your most recent journey?

Yes	16%
No	63%
Don't remember	11%
Not applicable	10%

Q5 Were your health needs looked after on your most recent journey, either from court or between establishments?

Yes	47%
No	33%
Don't remember	15%
Not applicable	5%

Q6 How long did you spend in the van?

Less than one hour	9%
One to two hours	61%
Two to four hours	23%
More than four hours	6%
Don't remember	1%

Q7 How did you feel you were treated by the escort staff?

Very well	23%
Well	40%
Neither	23%
Badly	5%
Very badly	2%
Don't remember	6%

Q8 Did you know where you were going before you got to this establishment?

Yes	79%
No	21%
Don't remember	0%

Q9 Before you arrived here did you receive any written information about what would happen to you?

Yes	20%
No	70%
Don't remember	11%

Section Four: Your first few days here

Q1 Did you have any of the following problems when you first arrived at this establishment? (Please tick all that apply to you.)

Had no problems	24%	*Needing protection from other prisoners*	9%
Coming off drugs	23%	*Letting family know where you are*	19%
Alcohol problems	14%	*Money worries*	13%

Had no tobacco	55%	*Feeling low/upset/needing someone to talk to*	23%
Loss of transferred property	6%	*Getting your property*	8%
Housing problems	4%	*Health problems*	15%

Q2 When you first arrived at this establishment, did your property arrive at the same time as you?

Yes	77%
No	14%
Don't remember	8%

Q3 Were you told what you needed to know by the staff when you first arrived

Yes	73%
No	25%
Don't remember	2%

Q4 How long were you in reception?

Less than two hours	45%
Two hours or longer	51%
Don't remember	5%

Q5 Were you seen by a member of healthcare staff in reception?

Yes	87%
No	13%
Don't remember	0%

Q6 When you were searched was this carried out in an understanding way?

Yes	80%
No	15%
Don't remember	5%

Q7 Overall, how well did you feel you were treated in reception?

Very well	10%
Well	44%
Neither	32%
Badly	13%
Very badly	1%
Don't remember	0%

Q8 Were you able to make a telephone call to your family/friends on your first day of arrival?

Yes	87%
No	13%
Don't remember	0%

Q9 Did you have access to the following people/services within the first 24 hours of arriving at this establishment?

Chaplain	39%
Someone from healthcare	51%
A listener/Samaritans	12%
The prison shop/canteen	9%
Don't remember	16%
Did not have access to any of these services	21%

Q10 Did you feel safe on your first night at this establishment?

Yes	79%
No	21%
Don't remember	0%

Q11 How soon after your arrival did you go on an induction course?

Have not been on an induction course 24%
Within two days 28%
Within the first week 27%
More than a week 17%
Don't remember 5%

Q12 Did the induction course cover everything you needed to know about the establishment?

Have not been on an induction course 25%
Yes 62%
No 7%
Don't remember 6%

Section Five: Daily life here

Q1 How easy or difficult is it for you to attend religious services?

Do not want to attend 21%
Very easy 44%
Easy 21%
Neither 6%
Difficult 0%
Very difficult 0%
Don't know 9%

Q2 Does the shop/canteen sell a wide enough variety of products?

Have not bought anything yet 5%
Yes 57%
No 38%

Q3 What is the food like at this establishment?

Very good 0%
Good 20%
Neither 25%
Bad 27%
Very bad 28%

Q4 Have you talked to an advocate since you have been at this establishment (an outside person to help you with the authorities)?

Yes 32%
No 42%
Don't know what an advocate is 26%

Q5 Are you normally able to have a shower every day if you want?

Yes 89%
No 11%
Don't know 0%

Q6 Is your cell call bell normally answered within five minutes?

Yes 30%
No 60%
Don't know 10%

Section Six: Healthcare

Q1 What do you think of the overall quality of the healthcare?

Have not been to healthcare 7%
Very good 31%
Good 38%
Neither 13%

Bad 7%
Very bad 4%

Q2 Is it easy to see the following people if you need to?

	Yes	*No*	*Don't know*
The doctor	46%	26%	28%
The nurse	68%	15%	16%
The dentist	19%	34%	48%
The optician	19%	26%	55%

Q3 Have you had any problems getting your medication?

Not taking any medication 48%
Yes 20%
No 33%

Q4 Have you received any help with any alcohol problems?

Not had any alcohol problems 56%
Yes 24%
No 20%

Q5 Have you received any help with any drug problems?

Not had any drug problems 52%
Yes 32%
No 16%

Section Seven: Rewards, sanctions and complaints

Q1 What level of the reward scheme are you now on?

Don't know what the reward scheme is 4%
Enhanced (Top) 24%
Standard (Middle) 59%
Basic (Bottom) 11%
Don't know 2%

Q2 Do the different levels of the reward scheme make you change your behaviour?

Don't know what the reward scheme is 4%
Yes 72%
No 24%

Q3 Do you feel you have been treated fairly in your experience of the reward scheme?

Don't know what the reward scheme is 4%
Yes 59%
No 37%

Q4 Do you know how to make a complaint?

Yes 45%
No 55%

Q5 Is it easy to make a complaint?

Not made a complaint 55%
Yes 39%
No 6%

Q6 Do you feel complaints are sorted out fairly?

Not made a complaint 56%
Yes 12%
No 32%

Q7 Have you ever been encouraged to withdraw a complaint?

Not made a complaint 56%
Yes 10%
No 34%

Section Eight: Discipline and respect

Q1 Have you had a 'nicking' (adjudication or minor report) since you have been in this establishment?

Yes 57%
No 39%
Don't know 4%

Q2 If you have been physically restrained (C and R), how many times has this happened since you have been in this establishment?

Not been restrained 75%
Once 18%
Twice 1%
Three times 2%
More than three times 4%

Q3 If you have spent a night in the segregation/care and separation unit, how were you treated by staff?

Not been to the segregation unit 68%
Very well 1%
Well 9%
Neither 7%
Badly 4%
Very badly 11%

Q4 Do most staff treat you with respect?

Yes 76%
No 24%

Section Nine: Safety

Q1 Have you ever felt unsafe in this establishment?

Yes 41%
No 59%

Q2 If you have ever felt unsafe, in which areas of this establishment do you/have you ever felt unsafe? (Please tick all that apply to you.)

Never felt unsafe	61%	*At meal times*	10%
Everywhere	6%	*At healthcare*	5%
Segregation unit	4%	*Visits area*	8%
Association areas	10%	*In wing showers*	23%
Reception area	5%	*In gym showers*	19%
At the gym	22%	*In corridors/stairwells*	9%
In an exercise yard	11%	*On your landing/wing*	11%
At work	6%	*In your cell*	5%
At education	16%		

Q3 Has another trainee or group of trainees victimised (insulted or assaulted) you in this establishment?

Yes 29%
No 71%

Q4 If you have felt victimised by a trainee/group of trainees, what did the incident(s) involve? (Please tick all that apply to you.)

Insulting remarks (about you or your family or friends)	21%	*Drugs*	0%
Physical abuse (being hit, kicked or assaulted)	9%	*Having your canteen/property taken*	3%
Sexual abuse	0%	*Because you were new here*	9%
Your race or ethnic origin	3%	*Being from a different part of the country than others*	8%

Q6 Has a member of staff or group of staff victimised (insulted or assaulted) you in this establishment?

Yes	14%
No	86%

Q7 If you have felt victimised by a member of staff/group of staff, what did the incident(s) involve? (Please tick all that apply to you.)

Insulting remarks (about you or your family or friends)	9%	*Drugs*	1%
Physical abuse (being hit, kicked or assaulted)	0%	*Having your canteen/property taken*	1%
Sexual abuse	0%	*Because you were new here*	1%
Your race or ethnic origin	3%	*Being from a different part of the country than others*	1%

Q9 If you were ever victimised in future, who would you tell?

No-one	39%	*Teacher/Education staff*	5%
Personal Officer	41%	*Gym staff*	3%
Wing Officer	19%	*Listener/Samaritan/Buddy*	7%
Chaplain	9%	*Another trainee*	7%
Healthcare staff	7%	*Family/friends*	26%

Q10 Do you think staff would take it seriously if you did tell them that you had been victimised?

Yes	38%
No	35%
Don't know	27%

Q11 When you first arrived here, did other young people shout through the windows at you?

Yes	57%
No	43%

Q12 Did you find this shouting threatening?

Yes	17%
No	40%
Not been shouted at	44%

Q13 Do other young people shout through the windows at you now?

Yes	42%
No	58%

Q14 Do you find this threatening?

Yes	9%
No	32%
Do not get shouted at now	59%

Q15 Do you shout through the windows at others?

Yes	35%
No	65%

Q16 Have staff checked on you personally in the last week to see how you are getting on?

Yes	32%
No	68%

Section Ten: Activities

Q1 How old were you when you were last at school?

14 or under	37%
Over 14	63%

Q2 Please answer the following questions about school:

	Yes	*No*	*Not applicable*
Have you ever been excluded from school?	92%	5%	3%
Did you use to truant from school?	68%	26%	6%

Q3 Are you doing education in this establishment?

Yes	90%
No	10%

Q4 Is education helping you?

Yes	67%
No	23%
Not doing education	11%

Q5 Do you feel you need help with reading, writing or maths?

Yes	23%
No	77%

Q6 Were teachers understanding with any school problems you had when you first arrived?

Yes	45%
No	26%
Not applicable	29%

Q7 Please answer the following questions about work or training:

	Yes	*No*	*Not applicable*
Are you learning a skill or trade?	49%	46%	5%
Are you in a job here?	13%	79%	9%

Q8 On average how many times do you go to the gym each week (Monday to Sunday)?

Don't want to go	9%
None	13%
Once or twice	11%
Three to five times	53%
More than five times	8%
Don't know	8%

Q9 On average, how many times do you go on association or free time each week (Monday to Sunday)?

Don't want to go	2%
None	6%
Once or twice	5%
Three to five times	4%
More than five times	80%
Don't know	2%

Q10 Can you go outside for exercise every day?

Don't want to go	5%

Yes 6%
No 79%
Don't know 10%

Section Eleven: Keeping in touch with family and friends

Q1 Are you able to use the telephone to speak to someone in your family every day?

Yes 84%
No 15%
Don't know 1%

Q2 Have you had any problems getting access to the telephones?

Yes 16%
No 81%
Don't know 2%

Q3 Have you had any problems with sending or receiving letters?

Yes 33%
No 63%
Don't know 4%

Q4 How easy or difficult is it for your family and friends to get to this establishment to visit you?

Very easy 6%
Easy 26%
Neither 15%
Difficult 23%
Very difficult 22%
Don't know 7%

Q5 How many times have you been visited by family or friends in the last month?

Don't get visits 20%
Less than one 6%
One 20%
Two 19%
Three 11%
More than three 21%
Don't know 4%

Q6 Do you arrive on time for a visit?

Don't get visits 22%
Yes 51%
No 27%

Q7 How are you and your family/friends treated by visits staff?

Don't get visits 21%
Very well 21%
Well 35%
Neither 21%
Badly 4%
Very badly 0%

Section Twelve: Resettlement

Q1 When did you first meet your personal officer?

Still have not met him/her 21%
In first week 57%
More than a week 14%
Don't remember 8%

Q2 Do you feel helped by your personal officer?

Still have not met him/her	22%
Yes	59%
No	19%

Q3 Do you know what targets you have been set in your training/sentence plan?

Yes	57%
No	24%
Don't know	11%
Have not got a plan	8%

Q4 If you want, can you see your plan?

Yes	38%
No	6%
Don't know	47%
Have not got a plan	8%

Q5 Has your YOT/social worker/probation officer been in touch since you arrived at this establishment?

Yes	82%
No	18%

Q6 Do you know how to get in touch with your YOT/social worker/probation officer?

Yes	52%
No	48%

Q7 Do you want to stop offending?

Yes	72%
No	3%
Don't know	4%
Not sentenced	22%

Q8 What is most likely to stop you offending in the future? (Please tick all that apply to you)

Not sentenced	22%	*Having a mentor (someone you can ask for advice)……..*	1%
Nothing it is up to me	18%	*Having a YOT/social worker that you get on with*	9%
Making new friends outside	10%	*Having children*	12%
Going back to live with my family	17%	*Having something to do that isn't crime*	29%
Getting a place of my own	21%	*This sentence*	25%
Getting a job	64%	*Getting into school/college*	31%
Having a partner (girlfriend or boyfriend)	25%	*Talking about my offending behaviour with staff*	4%
Staying off alcohol/drugs	27%	*Anything else*	6%

Q9 Have you had a say in what will happen to you when you are released?

Yes	38%
No	42%
Don't know	20%

Q10 When you are released, will you be living with a family member?

Yes	69%
No	17%
Don't know	14%

Q11 Have you had any help with finding accommodation?

Yes	19%
No	31%

Don't know 4%
Not needed any help 46%

Q12 Are you going to school or college on release?

Yes 38%
No 33%
Don't know 28%

Q13 Has anyone from this establishment spoken to you about going to college on release?

Yes 31%
No 58%
Don't know 6%
Have not needed any help 5%

Q14 Do you have a job to go to on release?

Yes 28%
No 58%
Don't know 14%

Q15 Have you done anything during your time in this establishment that you think will help you to get a job on release?

Yes 47%
No 45%
Don't know 8%

Q16 Has anyone spoken to you in this establishment about getting a job on release or about New Deal?

Yes 21%
No 67%
Don't know 7%
Have not needed any help 5%

Q17 Do you have a Connexions personal adviser?

Yes 32%
No 42%
Don't know 26%

Q18 Is there anything you would still like help with before you are released?

Yes 36%
No 48%
Don't know 16%

Q19 Have you done anything, or has anything happened to you, in this establishment that you think will make you less likely to offend in the future?

Not sentenced 23%
Yes 44%
No 33%

Juvenile Survey Responses HMYOI Stoke Heath 2008

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

Any percent highlighted in blue is significantly worse than the juvenile comparator.

Any percent highlighted in orange shows a significant difference in prisoners' background details

Percentages which are not highlighted show there is no significant difference

		HMYOI Stoke Heath	juvenile comparator		HMYOI Stoke Heath 2008	HMYOI Stoke Heath 2007
	Number of completed questionnaires returned	**84**	**1028**		**84**	**82**
SECTION 1: ABOUT YOU (Not tested for significance)						
1.1	Are you 18 years of age?	**6%**	**13%**		**6%**	**12%**
1.2	Do you usually live in this country?	**95%**	**97%**		**95%**	**98%**
1.3	Is English your first language?	**94%**	**92%**		**94%**	**95%**
1.4	Are you from a minority ethnic group? (including all those who did not tick White British, White Irish or White Other category)	**23%**	**33%**		**23%**	**29%**
1.5	Do you have any children?	**10%**	**9%**		**10%**	**17%**
1.6	Have you ever been in care? (either foster care or children's home)	**24%**	**28%**		**24%**	**31%**
1.7	Are you on a care order now?	**14%**	**13%**		**14%**	**12%**
SECTION 2: ABOUT YOUR SENTENCE (Not tested for significance)						
2.2	Are you sentenced?	**80%**	**79%**		**80%**	**80%**
2.3	Is your sentence 12 months or less?	**45%**	**39%**		**45%**	**44%**
2.4	Do you have less than six months to serve?	**53%**	**55%**		**53%**	**59%**
2.5	Have you been in this prison less than a month?	**25%**	**22%**		**25%**	**10%**
2.6	Have you been to any other YOI during this sentence?	**18%**	**31%**		**18%**	**31%**
2.7	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?	**48%**	**40%**		**48%**	**42%**
SECTION 3: COURTS, TRANSFERS AND ESCORTS						
For your most recent journey, either to or from court, or between prisons, we want to know:						
3.1	Was the van clean?	**44%**	**47%**		**44%**	**35%**
3.2	Was the van comfortable?	**6%**	**13%**		**6%**	**8%**
3.3	Did you feel safe?	**74%**	**69%**		**74%**	**64%**
3.4	Did you have enough comfort breaks?	**16%**	**14%**		**16%**	**12%**
3.5	Were your health needs looked after?	**47%**	**49%**		**47%**	**54%**
3.6	Did you spend more than four hours in the van?	**6%**	**10%**		**6%**	**7%**
3.7	Were you treated well/very well by the escort staff?	**63%**	**63%**		**63%**	**65%**
3.8	Did you know where you were going when you left court or when transferred from another establishment?	**79%**	**82%**		**79%**	**71%**
3.9	Did you receive written information about what would happen to you before you arrived?	**20%**	**25%**		**20%**	**25%**
SECTION 4: YOUR FIRST FEW DAYS HERE						
4.1	Did you have any problems when you first arrived?	**76%**	**71%**		**76%**	**80%**
4.2	When you first arrived here did your property arrive at the same time as you?	**77%**	**80%**		**77%**	**82%**
4.3	Were you told what you needed to know by the staff when you first arrived?	**73%**	**74%**		**73%**	**54%**
4.4	Were you in reception for less than 2 hours?	**44%**	**82%**		**44%**	**41%**
4.5	Were you seen by a member of healthcare staff in reception?	**87%**	**89%**		**87%**	**94%**
4.6	When you were searched was this carried out in an understanding way?	**80%**	**80%**		**80%**	**77%**
4.7	Were you treated well/very well in reception?	**54%**	**70%**		**54%**	**43%**
4.8	Were you able to make a telephone call to your family/friends on your first day here?	**87%**	**81%**		**87%**	**76%**

Key to tables

		HMYOI Stoke Heath	juvenile comparator		HMYOI Stoke Heath 2008	HMYOI Stoke Heath 2007
	Any percent highlighted in green is significantly better than the juvenile comparator					
	Any percent highlighted in blue is significantly worse than the juvenile comparator.					
	Any percent highlighted in orange shows a significant difference in prisoners' background details					
	Percentages which are not highlighted show there is no significant difference					
	Number of completed questionnaires returned	**84**	**1028**		**84**	**82**
Did you meet any of the following people within your first 24 hours?						
4.9a	The chaplain?	**39%**	**39%**		**39%**	**33%**
4.9b	Someone from healthcare?	**51%**	**54%**		**51%**	**61%**
4.9c	A Listener or The Samaritans?	**12%**	**14%**		**12%**	**11%**
4.9d	Did you have access to the prison shop/canteen within the first 24 hours of your arrival?	**9%**	**19%**		**9%**	**18%**
4.10	Did you feel safe on your first night here?	**79%**	**84%**		**78%**	**70%**
4.11	Did you go on an induction course within your first week?	**54%**	**65%**		**54%**	**58%**
4.12	Did the induction course cover everything you needed to know about the prison?	**62%**	**54%**		**62%**	**50%**
SECTION 5: DAILY LIFE HERE						
5.1	Is it easy/very easy for you to attend religious services?	**65%**	**52%**		**65%**	**55%**
5.2	Does the shop/canteen sell a wide enough range of goods to meet your needs?	**57%**	**47%**		**57%**	**49%**
5.3	Do you find the food here good/very good?	**20%**	**26%**		**20%**	**9%**
5.4	Have you talked to an advocate since you have been here (an outside person to help you with the authorities)?	**32%**	**33%**		**32%**	**36%**
5.5	Are you normally able to shower everyday if you want to?	**89%**	**55%**		**89%**	**34%**
5.6	Is your cell call bell normally answered within five minutes?	**30%**	**31%**		**30%**	**29%**
SECTION 6: HEALTHCARE						
6.1	Do you think the overall quality of the healthcare is good/very good?	**69%**	**58%**		**69%**	**61%**
6.2a	Is it easy for you to see the Doctor?	**46%**	**48%**		**46%**	**50%**
6.2b	Is it easy for you to see the Nurse?	**69%**	**68%**		**69%**	**83%**
6.2c	Is it easy for you to see the Dentist?	**19%**	**23%**		**19%**	**18%**
6.2d	Is it easy for you to see the Optician?	**19%**	**19%**		**19%**	**12%**
6.3	Have you had any problems getting your medication?	**20%**	**15%**		**20%**	**11%**
6.4	Have you received any help with any alcohol problems?	**24%**	**21%**		**24%**	**28%**
6.5	Have you received any help with any drugs problems?	**32%**	**32%**		**32%**	**33%**
SECTION 7: REWARDS, SANCTIONS AND COMPLAINTS						
7.1	Are you on the enhanced (Top) level of the reward scheme?	**24%**	**24%**		**24%**	**14%**
7.2	Do the different levels make you change your behaviour?	**72%**	**61%**		**72%**	**56%**
7.3	Do you feel you have been treated fairly in your experience of the reward scheme?	**59%**	**56%**		**59%**	**44%**
7.4	Do you know how to make a complaint?	**45%**	**81%**		**45%**	**82%**
7.5	Is it easy to make a complaint?	**39%**	**40%**		**39%**	**36%**
7.6	Do you feel complaints are sorted out fairly?	**12%**	**17%**		**12%**	**15%**
7.7	Have you ever been made to or encouraged to withdraw a complaint?	**10%**	**9%**		**10%**	**9%**
SECTION 8: DISCIPLINE AND RESPECT						
8.1	Have you had a 'nicking' (adjudication or minor report) since you have been here?	**58%**	**59%**		**58%**	**58%**
8.2	Have you been physically restrained (Cand R) since you have been here?	**25%**	**27%**		**25%**	**27%**
8.3	If you have spent a night in the segregation/care and separation unit, did the staff treat you well/very well?	**10%**	**13%**		**10%**	**6%**
8.4	Do most staff treat you with respect?	**76%**	**75%**		**76%**	**60%**

Key to tables

		HMYOI Stoke Heath	Juvenile comparator		HMYOI Stoke Heath 2008	HMYOI Stoke Heath 2007
	Any percent highlighted in green is significantly better than the juvenile comparator					
	Any percent highlighted in blue is significantly worse than the juvenile comparator.					
	Any percent highlighted in orange shows a significant difference in prisoners' background details					
	Percentages which are not highlighted show there is no significant difference					
	Number of completed questionnaires returned	**84**	**1028**		**84**	**82**
SECTION 9: SAFETY						
9.1	Have you ever felt unsafe in this prison?	**42%**	**25%**		**42%**	**36%**
9.3	Has another young person or group of young people victimised (insulted or assaulted) you here?	**29%**	**22%**		**29%**	**29%**
If you have felt victimised by another young person/group of young people, did the incident involve:						
9.4a	Insulting remarks?	**21%**	**12%**		**21%**	**23%**
9.4b	Physical abuse?	**9%**	**9%**		**9%**	**10%**
9.4c	Sexual abuse?	**1%**	**1%**		**1%**	**3%**
9.4d	Racial or Ethnic abuse?	**4%**	**3%**		**4%**	**8%**
9.4e	Drugs?	**0%**	**1%**		**0%**	**1%**
9.4d	Having your canteen/property taken?	**3%**	**4%**		**3%**	**5%**
9.4e	Because you were new here?	**9%**	**6%**		**9%**	**11%**
9.4f	Being from a different part of the country than others?	**8%**	**6%**		**8%**	**11%**
9.6	Has a member of staff or group of staff victimised (insulted or assaulted) you here?	**14%**	**19%**		**14%**	**33%**
If you have felt victimised by a member of staff/group of staff members, did the incident involve:						
9.7a	Insulting remarks?	**9%**	**11%**		**9%**	**23%**
9.7b	Physical abuse?	**0%**	**4%**		**0%**	**6%**
9.7c	Sexual abuse?	**0%**	**1%**		**0%**	**0%**
9.7d	Racial or Ethnic abuse?	**3%**	**2%**		**3%**	**1%**
9.7e	Drugs?	**1%**	**1%**		**1%**	**3%**
9.7f	Having your canteen/property taken?	**1%**	**2%**		**1%**	**3%**
9.7g	Because you were new here?	**1%**	**3%**		**1%**	**3%**
9.7h	Being from a different part of the country than others?	**1%**	**2%**		**1%**	**3%**
9.9	If you were being victimised by another young person or a member of staff would you be able to tell anyone about it?	**61%**	**62%**		**61%**	**77%**
9.10	If you did tell a member of staff that you were being victimised do you think it would be taken seriously?	**38%**	**40%**		**38%**	**41%**
9.11	When you first arrived here did other young people shout through the windows at you?	**58%**	**35%**		**58%**	**56%**
9.12	Did you find this shouting threatening?	**17%**	**11%**		**17%**	**23%**
9.13	Do other young people shout through the windows at you now?	**42%**	**26%**		**42%**	**41%**
9.14	Do you find this threatening now?	**9%**	**5%**		**9%**	**13%**
9.15	Do you shout through the windows at others?	**35%**	**27%**		**35%**	**38%**
9.16	Have staff checked on you personally in the last week to see how you are getting on?	**32%**	**36%**		**32%**	**36%**
SECTION 10: ACTIVITIES						
10.1	Were you under the age of 14 when you were last at school?	**37%**	**40%**		**37%**	**36%**
10.2a	Have you ever been excluded from school?	**92%**	**88%**		**92%**	**91%**
10.2b	Have you ever truanted from school?	**68%**	**73%**		**68%**	**78%**
10.3	Are you doing any education here?	**90%**	**83%**		**90%**	**95%**
10.4	Is education helping you?	**67%**	**58%**		**67%**	**77%**
10.5	Do you feel you need help with reading, writing or maths?	**23%**	**30%**		**23%**	**36%**
10.6	Were the teachers understanding with any school problems when you first arrived?	**45%**	**49%**		**45%**	**67%**

Key to tables

	Any percent highlighted in green is significantly better than the juvenile comparator	HMYOI Stoke Heath	juvenile comparator		HMYOI Stoke Heath 2008	HMYOI Stoke Heath 2007
	Any percent highlighted in blue is significantly worse than the juvenile comparator.					
	Any percent highlighted in orange shows a significant difference in prisoners' background details					
	Percentages which are not highlighted show there is no significant difference					
	Number of completed questionnaires returned	**84**	**1028**		**84**	**82**
SECTION 10: ACTIVITIES cont.						
10.7a	Are you learning a skill or trade?	**49%**	**54%**		**49%**	**47%**
10.7b	Are you in a job here?	**13%**	**33%**		**13%**	**4%**
10.8	Do you go to the gym more than 5 times each week?	**8%**	**10%**		**8%**	**1%**
10.9	Do you go on association more than 5 times each week?	**81%**	**50%**		**81%**	**14%**
10.10	Can you go outside for exercise everyday?	**6%**	**34%**		**6%**	**3%**
SECTION 11: KEEPING IN TOUCH WITH FAMILY AND FRIENDS						
11.1	Are you able to use the telephone to speak to someone in your family every day?	**84%**	**54%**		**84%**	**30%**
11.2	Have you had any problems getting access to the telephones?	**16%**	**32%**		**16%**	**27%**
11.3	Have you had any problems with sending or receiving mail?	**33%**	**29%**		**33%**	**43%**
11.4	Is it easy/very easy for you family and friends to get here to visit you?	**32%**	**37%**		**32%**	**30%**
11.5	Do you get 2 or more visits each month?	**51%**	**46%**		**51%**	**49%**
11.6	Do you arrive on time for a visit?	**52%**	**67%**		**52%**	**56%**
11.7	Are you and your family/friends treated well/very well by visits staff?	**55%**	**60%**		**55%**	**53%**
SECTION 12: RESETTLEMENT						
12.1	Did you meet your personal officer within your first week here?	**58%**	**45%**		**58%**	**48%**
12.2	Do you feel helped by your personal officer?	**59%**	**51%**		**59%**	**51%**
12.3	Do you know what targets you have been set in your training/sentence plan?	**57%**	**59%**		**57%**	**59%**
12.4	If you want, can you see your training/sentence plan?	**39%**	**37%**		**39%**	**40%**
12.5	Has your YOT/social worker/probation officer been in touch since you arrived here?	**82%**	**82%**		**82%**	**74%**
12.6	Do you know how to get in touch with your YOT/social worker/probation officer?	**52%**	**60%**		**52%**	**57%**
12.7	Do you want to stop offending?	**72%**	**71%**		**72%**	**69%**
12.9	Have you had a say in what will happen to you when you are released?	**38%**	**45%**		**38%**	**36%**
12.10	When you are released will you be living with a family member?	**69%**	**67%**		**69%**	**73%**
12.11	Have you had help with finding accommodation?	**19%**	**25%**		**19%**	**27%**
12.12	Are you going to school or college on release?	**39%**	**40%**		**39%**	**36%**
12.13	Has anyone spoken to you about going to college on release?	**31%**	**38%**		**31%**	**28%**
12.14	Do you have a job to go to on release?	**28%**	**28%**		**28%**	**31%**
12.15	Have you done anything during your time here that you think will help you to get a job on release?	**47%**	**46%**		**47%**	**38%**
12.16	Has anyone from here spoken to you about getting a job on release or about New Deal?	**21%**	**24%**		**21%**	**16%**
12.17	Do you have a Connexions personal adviser?	**32%**	**36%**		**32%**	**36%**
12.18	Is there anything you would still like help with before you are released?	**36%**	**36%**		**36%**	**46%**
12.19	Have you done anything or has anything happened to you here that you think will make you less likely to offend in the future?	**44%**	**41%**		**44%**	**36%**

Key Question Responses (Ethnicity): HMYOI Stoke Heath 2008

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.

Key to tables

Any percent highlighted in green is significantly better than the responses from White juveniles

Any percent highlighted in blue is significantly worse than the responses from White juveniles

Percentages which are not highlighted show there is no significant difference

		BME juveniles	White juveniles
	Number of completed questionnaires returned	**20**	**64**
2.2	Are you sentenced? **Not tested for significance**	**74%**	**82%**
2.6	Have you been to any other YOI during this sentence? **Not tested for significance**	**26%**	**16%**
1.6	Have you ever been in care? (foster care/children's home) **Not tested for significance**	**21%**	**25%**
1.7	Are you on a care order now? **Not tested for significance**	**16%**	**13%**
3.7	Were you treated well/very well by the escort staff?	**66%**	**63%**
4.2	When you first arrived here did your property arrive at the same time as you?	**61%**	**82%**
4.6	Please answer the following question about your first few days here: When you were searched wa this carried out in an understanding way?	**63%**	**84%**
4.7	Were you treated well/very well in reception?	**53%**	**54%**
4.1	Did you feel safe on your first night here?	**84%**	**77%**
4.11	Did you go on an induction course within your first week?	**31%**	**60%**
5.1	Is it easy/very easy for you to attend religious services?	**83%**	**59%**
5.2	Does the shop/canteen sell a wide enough range of goods to meet your needs?	**56%**	**58%**
5.3	Do you find the food here good/very good?	**37%**	**14%**
6.1	Do you think the overall quality of the healthcare is good/very good?	**58%**	**72%**
8.1	Have you had a 'nicking' (adjudication or minor report) since you have been here?	**59%**	**57%**
8.2	Have you been physically restrained (Cand R) since you have been here?	**37%**	**22%**
8.3	If you have spent a night in the segregation/care and separation unit, did the staff treat you well/very well?	**16%**	**8%**
5.4	Have you talked to an advocate since you have been here (an outside person to help you with the authorities)?	**34%**	**32%**
7.1	Are you on the enhanced (Top) level of the reward scheme?	**28%**	**24%**
7.3	Please answer the following question about the reward scheme: Do you feel you have been treated fairly in your experience of the reward scheme?	**53%**	**61%**
7.6	Please answer the following question about complaints: Do you feel complaints are sorted out fairly?	**12%**	**13%**
5.5	Are you normally able to shower everyday if you want to?	**88%**	**89%**
5.6	Is your cell call bell normally answered within five minutes?	**28%**	**31%**
8.4	Do most staff treat you with respect?	**66%**	**79%**
9.1	Have you ever felt unsafe in this prison?	**36%**	**43%**
9.3	Has another young person or group of young people victimised (insulted or assaulted) you here?	**19%**	**31%**
9.4d	If you have felt victimised by a prisoner/group of prisoners, what did the incident(s) involve: Racial or Ethnic abuse?	**6%**	**4%**
9.6	Has a member of staff or group of staff victimised (insulted or assaulted) you here?	**13%**	**15%**
9.7d	If you have felt victimised by a staff/group of staff, what did the incident(s) involve: Racial or Ethnic abuse?	**0%**	**4%**
9.9	If you were being victimised by another young person or a member of staff would you be able to tell anyone about it?	**38%**	**67%**
9.16	Have staff checked on you personally in the last week to see how you are getting on?	**36%**	**31%**
10.3	Are you doing any education here?	**100%**	**87%**
10.4	Is education helping you?	**75%**	**65%**
10.7	Are you learning a skill or trade?	**62%**	**45%**
10.7	Are you in a job here?	**16%**	**13%**
10.8	Do you go to the gym more than five times each week?	**28%**	**1%**
10.9	Do you go on association more than 5 times each week?	**84%**	**80%**
1010	Can you go outside for exercise everyday?	**12%**	**5%**
11.2	Have you had any problems getting access to the telephones?	**12%**	**18%**
11.3	Have you had any problems with sending or receiving mail?	**16%**	**39%**
11.5	Do you get 2 or more visits each month?	**61%**	**48%**
11.7	Are you and your family/friends treated well/very well by visits staff?	**59%**	**54%**
12.1	Did you meet your personal officer within your first week here?	**50%**	**60%**
12.2	Do you feel helped by your personal officer?	**59%**	**59%**
12.3	Do you know what targets you have been set in your training/sentence plan?	**56%**	**57%**
12.9	Please answer the following questions on preparation for release: Have you had a say in what will happen to you when you are released?	**28%**	**41%**
12.14	Please answer the following questions on preparation for release: Do you have a job to go to on release?	**29%**	**28%**
12.15	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?	**59%**	**44%**
12.18	Please answer the following questions on preparation for release: Is there anything you would still like help with before you are released?	**53%**	**32%**
12.19	Have you done anything. Or has anything happened to you here that you think will make you less likely to offend in the future?	**53%**	**41%**