Report on an announced inspection of

HMYOI Brinsford

Juvenile Unit

28 July – 1 August 2008

by HM Chief Inspector of Prisons

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Contents

Introduction 5

Fact page 7

Healthy prison summary 9

1 Arrival in custody

Courts, escorts and transfers 19
First days in custody 20

2 Environment and relationships

Residential units 27
Relationships between staff and young people 29
Personal officers 30

3 Duty of care

Safeguarding 33
Bullying 34
Self-harm and suicide 37
Child protection 39
Race equality 40
Foreign nationals 42
Contact with the outside world 44
Applications and complaints 47

4 Health services

51

5 Activities

Education, training and library provision 61
Physical education and health promotion 64
Faith and religious activity 65
Time out of cell 66

6 Good order

Security and rules 69
Discipline 70
Rewards and sanctions 75

7 Services

Catering 77
Canteen/shop 78

8 Resettlement

Resettlement strategy 81
Training planning and remand management 83
Substance use 84

9 Recommendations, housekeeping points and good practice

89

Appendices

I Inspection team 103
II Prison population profile 104
III Summary of juvenile questionnaires and interviews 108

Introduction

This is a report on the inspection of the juvenile unit at Brinsford Young Offenders Institution, in the West Midlands. The unit holds around 100 15 to 18 year olds, only around a fifth of Brinsford's total population. Brinsford has not had a very good inspection record in the past: inspections have repeatedly commented on a negative staff culture and inadequate activity.

It is encouraging to report that this inspection found considerable progress, particularly and importantly in the culture of the establishment, which had steadily improved. Young people reported positively on their relationships with staff, and there was a good personal officer scheme.

Safety, however, continued to be a concern. Over a third of young people in our survey said that they had felt unsafe and had been victimised by another young person, and they specifically identified stairways, holding rooms and the gym showers as places where they felt unsafe. More young people than in other establishments reported shouting, or being shouted at, out of windows. This was in part due to the design of the establishment, which made supervision difficult, but also pointed to the need for better oversight in certain areas, and better implementation of anti-bullying procedures. Procedures for supporting young people on their first night in custody also needed to be strengthened. There was insufficient monitoring of the use of force, and no individual care plans for the sometimes vulnerable young people held in the intervention and assessment unit (IAU). In general, care planning for the most vulnerable young people needed improvement.

While attempts had been made to refurbish and keep clean the rather tired accommodation, ventilation was poor and the provision of curtains and clothing inadequate. There were satisfactory structures for managing race relations, and the survey responses from black and minority ethnic young people, nearly half the population, were broadly in line with those of white young people, with two notable exceptions: more said that they had been victimised by staff, and more said that they had felt unsafe on their first night. These perceptions need to be investigated further. Procedures to support foreign national young people had deteriorated, and interpretation was not sufficiently used, even to support a very vulnerable young man.

Brinsford still did not provide enough time out of cell or activity for its population. Access to association and exercise was inadequate, and time out of cell considerably less than the 10 hours a day we expect, or the 8.5 hours the establishment was recording. There were too few places to provide full-time activity for all young people, and too little vocational training. Attendance at education was poor, although there were some good initiatives and a well-planned curriculum, with satisfactory levels of accreditation.

Resettlement work was reasonable, and a range of voluntary organisations assisted in providing practical help to young people being released. Training planning, however, was confused and insufficiently targeted at individual needs. Substance misuse services were good, reflecting the recent investment in dedicated services for young people. Too little was done to promote and strengthen family contact and links: there were not enough visits, and no family days or proactive work.

This report charts progress in the young people's unit at Brinsford, and in particular the development of a more positive and proactive staff culture. It is still, however, not a sufficiently safe or positive environment; although the planned new building will do something to increase training opportunities. Brinsford's long-term future as a destination for young people remains in

doubt, but it is important that this does not lead to planning blight, and that the young people who are there, for some time to come, have access to the support and activity they need.

Anne Owers **November 2008**
HM Chief Inspector of Prisons

Fact page

Task of the establishment
Brinsford is a young offender institution and a remand centre for juveniles and young adult prisoners up to the age of 21 years. It is purpose built to hold young people either on remand or awaiting appearance at Magistrates or Crown Courts or who are convicted or sentenced. Brinsford forms part of the Prison Service's Juvenile Estate and holds those on remand and those sentenced under detention training orders (DTOs). With effect from June 2008, the capacity for juveniles is 112 and the overall certified normal accommodation is 545. **This inspection was only of the juvenile unit.**

Area organisation
West Midlands

Number held
100 juveniles
443 young adults

Certified normal accommodation
545

Operational capacity
569

Last inspection
February 2007

Brief history
Brinsford opened as a young offender institution and remand centre in November 1991, replacing the former Brockhill remand centre. It is situated on the same site as HMP Featherstone. From April 2000, it changed its role to accommodate a mixed population, including those under the age of 18. All juveniles are housed in separate residential units from other young adult prisoners.

Description of residential units
Unit 1 – Juveniles, both on remand and sentenced under DTOs
Unit 2 – Young adults aged 18-21 years
Unit 3 – Young adults aged 18-21 years
Unit 4 – Young adults aged 18-21 years
Unit 5 - Young adults aged 18-21 years

Health services – 11 beds
Intervention and assessment unit (IAU) – 16 beds

Healthy prison summary

Introduction

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

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

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

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

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

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

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

Safety

HP3 Reception procedures were carried out efficiently, but more needed be done to put new arrivals at ease. Routine strip searching was inappropriate. New arrivals needing detoxification were well cared for. Vulnerability assessments and first night care were inadequate. Young people were not fully occupied during induction. Good

safeguarding data were available, but not used for trend analysis and wider strategic management. Young people at risk of self-harm were well cared for, but there were some procedural shortcomings. Over a third of young people said they had felt unsafe. More needed to be done to ascertain the extent and nature of bullying and improve work with victims and bullies. Child protection procedures were efficient, with good local authority involvement. Young people held in the intervention and assessment unit (IAU) did not have individual care plans even though the unit had sometimes been used to manage vulnerable young people. The establishment was not performing sufficiently well against this healthy prison test.

HP4 Young people did not travel in designated vans and some arrived late after long days at court. They found vans uncomfortable and few had been given information about Brinsford before their arrival, although our survey indicated improved treatment by staff and feelings of safety. Young people were asked to complete a questionnaire about their experiences of courts and escorts and the results informed regular meetings with escort contractors and prison escort and custody services. The video link was underused.

HP5 Reception was clean, but not age-appropriate. Sight lines into the holding rooms were good. The cell-sharing risk assessment was not completed in private and new arrivals were unlikely to divulge anxieties. All were routinely strip searched. Reception procedures were carried out efficiently, but young people were not reassured or given information about what would happen on their first night. New arrivals were usually offered a telephone call and a shower, but this was not always possible for late arrivals.

HP6 Many new arrivals were new to custody, but there was no first night policy to highlight their vulnerability and provide clear guidance to staff on ensuring immediate needs were addressed and young people well cared for. Remand and convicted young people could be allocated to shared cells on their first night, as was the case on the residential units. Initial interviews were held in private and were relaxed, thorough and sensitive, but the written assessments were not informative and some important information was missing. There was no association on the first night and only those sharing a cell could talk to another young person. Useful and important written information provided in cells was not accessible to those with poor literacy skills and was not relayed verbally.

HP7 The induction room was inadequate and basic information poorly presented. Young people were not kept fully occupied during the two-week programme. Too much time was spent locked up and not everyone received important information quickly enough.

HP8 A series of safeguarding meetings took place monthly, supplemented by a weekly strategy meeting. There were comprehensive policies for most of the constituent parts, but arrangements focused mainly on operational issues and there was a lack of strategic management. Attendance at the monthly meetings by community partners was good, but attendance by Brinsford representatives was inconsistent. The quality of the data varied and the information was not analysed in sufficient depth or used to inform overall strategy or improve practice. Some important data, such as the use of force, were not considered and patterns and trends were not identified in important areas such as suicide and self-harm, bullying and child protection. The weekly meeting was intended to consider care planning for young people identified as

requiring individual attention, but dealt almost exclusively with general operational matters. Care planning for the most vulnerable was inadequate.

HP9 The first bullying survey in two years had just been completed and the results were awaited. In our survey, 38% of young people, significantly worse than the comparator of 27%[1], had felt unsafe at some time at Brinsford and cited the layout of the prison, and certain areas, as the main reason. Thirty-five per cent said they had been victimised by another young person. Staff awareness of the extent of bullying and the anti-bullying strategy was mixed. Most young people identified as bullies had been reported by young people rather than staff. Apart from opening an assessment, care in custody and teamwork (ACCT) document, there was no formal care planning for victims and planned work with identified bullies was inconsistent, although programmes delivered by psychology were available for both. While still in its infancy, restorative justice had the commitment of staff at all levels and had been used post-adjudication with young people in conflict with each other. The use of peer supporters was a positive initiative, but their training and supervision needed to be improved.

HP10 The team of ACCT assessors was large and impressively multidisciplinary and the quality of assessments was good. Recorded observations indicated a good level of staff engagement with young people, who described feeling supported. Individual targets were set, but accountability was unclear. Young people on open ACCTs were frequently moved to other locations rather than managed on the residential units. Most reviews were conducted with discipline staff only and there was at best one person from another agency. Lack of healthcare involvement was particularly concerning as this had been highlighted as a significant concern by the Prison and Probation Ombudsman following an investigation into the death of a young adult the previous year.

HP11 The child protection policy was comprehensive and up to date. Most staff working directly with children had been checked through the Criminal Records Bureau and all had received basic child protection training. Sound child protection procedures had been produced jointly with the local authority. The local authority had oversight of the management of child protection, including individual cases, through regular attendance at the monthly child protection committee meetings, which included other community partners. Few referrals proceeded to a case conference. There were no procedures to consider further investigations internally when allegations were made against staff. Young people who made disclosures were supported if necessary by the local authority seconded social worker and healthcare specialists.

HP12 The procedures for allocation to activities were less risk averse than previously. The searching strategy included routine and random strip searching, which was inappropriate. The lack of sufficient activity places adversely affected dynamic security and there was a lack of thorough risk assessment when juveniles and young adults came into contact. Intelligence management systems were underdeveloped, but this was being addressed. Rules were explained in the welcome booklet, but were not displayed on wing notice boards.

HP13 Adjudications were conducted in the intervention and assessment unit (IAU) and the room used was formal and not age appropriate. Adjudicators made some adjustments

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

for age and level of understanding and the advocacy service supported young people on adjudication. The behaviour management policy remained in draft and there was scope to use formal systems less and restorative justice and rewards and sanctions more.

HP14 The use of force was monitored by the safeguarding and use of force committees, but there was no detailed analysis of the data or evidence of action to address identified patterns or trends. Use of force documentation was completed to a good standard. The special cell was rarely used. There was no cooling off or timeout facility, so young people were usually taken to the IAU following restraint.

HP15 The IAU held young people for a variety of reasons, but its use was not properly monitored. It mostly held young people for reasons of indiscipline, but vulnerable young people were occasionally held there. Young people had an initial assessment on location to the IAU and regular multidisciplinary reviews took place, but there were no individual care plans. The unit was clean and the regime was reasonable.

HP16 There was good clinical management, with flexible prescribing for the few young people requiring detoxification. The mandatory drug testing rate for juveniles had been zero over the previous six months. Procedures included strip-searching and officers had not undertaken child protection training.

Respect

HP17 Efforts had been made to refurbish and redecorate residential areas and keep them clean. Access to showers and laundry facilities was inadequate. Relationships between staff and young people were generally good and the personal officer scheme worked well. Chaplains offered good pastoral support. The management of diversity and race relations was supported by the involvement of young people. Efforts to provide care for foreign national young people were adversely affected by the under-use of professional interpreting services. Catering arrangements were good, but there were few opportunities to dine out. The rewards and sanctions scheme functioned well. Applications and complaints were generally dealt with efficiently. Healthcare was generally good. Vulnerable and problematic young people were sometimes placed inappropriately in healthcare. The establishment was performing reasonably well against this healthy prison test.

HP18 The design of the residential areas was the main concern raised by young people in our safety interviews. The environment had been refurbished and redecorated and efforts were made to keep the establishment clean. The outside areas benefited from attractive planting and ground maintenance. Ventilation was poor and particularly evident in the rapidly deteriorating showers. Only a minority of young people had curtains, but all had quilts. There was only one washing machine for 100 young people in the two residential blocks. Apart from underwear, supplies of clothing were inadequate. There were no lockable lockers in double cells. The units held too many young people to allow them to associate together. This restricted access to showers and telephones, which could not be guaranteed every day.

HP19 Relationships had steadily improved. Those we spoke to, including young people from a black and minority ethnic background, generally reported positively on relationships with most staff and said they could approach staff if they needed

something. Most knew their personal officer, but did not always meet them soon after arrival. Wing file entries were good quality and reflected a team approach by unit staff. Personal officers remained responsible for young people whenever they moved location to ensure continuity, but they did not usually attend training planning meetings or ACCT reviews. Young prisoner representatives attended regular consultative meetings with staff.

HP20 Nearly half the population were from black and minority ethnic backgrounds. The diversity and race equality action team (DREAT) carried out its monitoring function well, but lacked involvement from the local community. All residential units had young people acting as race equality representatives, who were well supported by staff, had undertaken training and attended the DREAT. The acting race equality officer was full time, but untrained, as was his assistant. They could not offer much effective training to others. Racist incidents were taken seriously, but all available intelligence was not always used to tackle racist behaviour and develop appropriate interventions. There was no wider diversity or disability policy. A diversity manager had just been appointed, but this work was underdeveloped.

HP21 Hesitant steps to develop policies and procedures for foreign nationals had faltered due to staff inexperience and lack of training. A policy and resource pack had been produced and regular visits from the UK Border Agency were planned, but there was no independent legal advice. One-to-one care met some needs, but staff underestimated the difficulty of coping without professional interpreting services, which were not used in important assessments and when concerns about individuals were raised. Young people were not represented at the foreign national committee meetings, which did not in any event function well.

HP22 The chaplaincy team met the spiritual needs and, to a significant extent, the pastoral needs of young people, including family liaison. All faiths were catered for. Resources were stretched and team members were not always able to attend important planning meetings. They were frustrated by the lack of opportunities to develop additional activities and hampered by the continued bar on them collecting and escorting young people. The chapel was pleasant and welcoming and the multi-faith room met the needs of the growing Muslim population, but it was poorly soundproofed.

HP23 The kitchen was clean and well maintained, but serveries were poorly supervised. The menu provided two hot meals a day, including vegetarian and vegan choices. Few young people said the food was good. Apart from pork, all meat was halal. Breakfast packs were given the day before use. Young people could eat communally only on a rota basis.

HP24 The rewards and sanctions scheme had recently been revised following consultation with young people. They understood how it operated and found it motivational. Staff recognised its value in challenging behaviour, but links with training planning were underdeveloped. Young people about to be demoted to the lowest level had a full review to discuss their behaviour and there was a flexible approach to motivate them to improve and regain their privileges as quickly as possible.

HP25 Wing applications were not recorded or tracked to ensure a timely and appropriate response. Young people generally said applications were dealt with quite well. The complaints system was well used, but survey responses on accessibility and knowing how to make a complaint were poor and young people said they would not use formal systems to resolve issues. A robust quality assurance system for complaint replies

had been introduced and responses were reasonable. Complaints were analysed to identify patterns and trends, but it was not clear how the information was used. Young people used the advocacy service to help them make complaints. The young people's forum was attended by only a small number of wing representatives and it was unclear how issues raised were addressed or followed up.

HP26 Healthcare was developing well to provide an improved service. Care was well integrated with the local health economy, but it was not well integrated with other areas of the prison and attendance at important care planning and safeguarding meetings was inadequate. Not all young people had a secondary healthcare screening. There was a good range of nurse-led clinics, but more age-specific services were required. Young people spent a long time in out-patient waiting rooms before and after appointments and this was an area where they felt particularly unsafe. Young people were sometimes placed in healthcare because of difficulties on the residential unit rather than clinical need. The regime for in-patients was good, but curtailed when the dedicated discipline officer was unavailable. The treatment room on the residential unit was in a terrible condition. This had delayed the introduction of wing-based nursing and led to unnecessary admissions to the in-patient unit. Dental provision was satisfactory. Mental health provision was very good and there were excellent links between the primary mental health team and child and adolescent mental health services.

Purposeful activity

HP27 Young people did not have enough time out of their cells. Access to association and exercise in the fresh air was inadequate and there were insufficient activity places. Education accreditation had improved. Vocational training was limited. Attendance at classes was poor, although punctuality had improved with the introduction of free flow. Behaviour management in lessons was good and focused on keeping young people in education rather than excluding them. Library provision was reasonable, but sessions were often cancelled and there was no access in the evenings or at weekends. The range of physical education (PE) provision had increased and access was good, but many young people refused to attend. The establishment was not performing sufficiently well against this healthy prison test.

HP28 Young people did not spend 10 hours a day out of their cells. Regime monitoring figures showed that they spent between 8.5 and nine hours on weekdays and 7.5 at weekends out of their cells, but this did not reflect the experience of all young people. Everyone spent some time locked up during morning and afternoon activity sessions because there were insufficient activity places. Access to association and time in the fresh air was limited. Association rooms were poorly decorated and equipped. The outside exercise area was unkempt and uninviting. Supervision was inadequate and there was not enough staff engagement with young people during association.

HP29 Young people were assessed for activity during induction, but there were gaps in assessments for specific learning disabilities. There were delays allocating young people to activity after induction. There were too few activity places to provide a full day of purposeful activity for all young people and this inadequacy was compounded by poor attendance. There had been improvements to punctuality at lessons following the introduction of free flow. Young people were sometimes collected too early to be taken back to their residential units, disrupting lesson delivery and planning.

HP30 There was a well planned curriculum with an appropriate focus on literacy and numeracy. The range of vocational provision was limited, but due to increase imminently with the opening of a new unit. Teaching was satisfactory and young people gained skills and achieved good standards of work in some subjects. There was an excellent initiative with West Midlands Fire Service. Teachers and learning support assistants worked well together to support young people who needed additional help and some had made outstanding progress. There was good behaviour management in lessons and a focus on inclusion. Levels of accreditation were slightly low, but satisfactory overall, and some more able young people had achieved a good standard. There was no accredited work-based learning and those under school-leaving age were not receiving full-time education. The library had a good range of books and provision for different interests and cultural backgrounds, but access was poor. Many sessions were cancelled and there was no evening or weekend provision.

HP31 A new PE profile had been introduced in May 2008 and young people had been consulted about developing the provision. The new profile included an appropriate balance of skills acquisition and development, indoor and outdoor activities and recreational PE. Accredited courses had been introduced. Attendance was poor and we were concerned about the practice of holding young people and young adults together in the gym. Young people had good access to PE, but many refused to attend. Some young people did not feel safe in the gym, which may have contributed to refusals to attend. PE was well integrated with other departments.

Resettlement

HP32 The strategic management of resettlement was good, with an effective analysis of need and services developed in response. Good relationships with voluntary organisations contributed to positive resettlement outcomes for young people. The training planning process was underdeveloped. Public protection was managed well. The programmes team worked well to tailor available interventions to meet individual needs. Substance misuse services were good. Visitors were well served by a good visitors' centre. There had been some improvements to visiting times, but entitlements to visits were insufficient and there was little promotion of family contact. Young people could not always use the telephones every day. The establishment was performing reasonably well against this healthy prison test.

HP33 An up-to-date and comprehensive reducing reoffending strategy was based on the resettlement pathways and a good needs analysis that had used aggregated data available through ASSET[2] and other local systems. The strategy was overseen by the resettlement policy committee, which was well established and functioned effectively.

HP34 A wide range of relevant locally accredited short programmes had been developed in accordance with the needs assessment. There was a gap in provision relating to young people convicted of sex offences, who were assessed for their treatment needs, but there were no treatment programmes available at Brinsford to address their particular needs.

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

HP35 Reintegration services were sufficient to ensure young people received the necessary practical help before release. The support of voluntary organisations was used to good effect in relation to accommodation and debt and finance management. Connexions support was good. Release on temporary licence was used for a small number of young people.

HP36 There was an up-to-date and comprehensive public protection policy. Staff identified relevant cases quickly and there was early access to previous convictions. There was a regular management meeting to review and monitor high-risk cases. A large number of young people were subject to public protection procedures. There was good attendance at the multi-agency public protection arrangements (MAPPA) case conferences in the community.

HP37 Training planning meetings lacked input from relevant departments and families and consequently the quality was variable. Reviews were organised effectively and caseworkers played a critical role in running the reviews and supporting young people. Targets set did not meet the needs of the individual. Reviews were held in an unsuitable location that inhibited open discussion. The additional initial sentence planning arrangements running alongside the training planning created unnecessary duplication.

HP38 An up-to-date substance misuse strategy was informed by a regular needs analysis. Substance-dependent young people could access a flexible and needs-based prescribing regime and there was good joint work between service providers to coordinate care for young people with good substance use intervention team (SMIT) and clinical reviews. Substance misuse nurses did not cover weekends and GPs had not undertaken specialist training. Young people could access a range of relevant interventions with age-appropriate materials, but there continued to be problems in access for substance misuse service staff as they were still prevented from escorting young people. Voluntary drug testing was offered appropriately.

HP39 Wing telephones could not be used in private and many young people complained about poor access to them. Young people were given information about visits on arrival and at induction, but little was done to promote family contact. Visits entitlements were inadequate, at less than one a week for sentenced young people who did not get extra privileges, but the length of sessions had been doubled to two hours. There were no evening visits or family days. The visitors' centre was comfortable, bright and offered good support. It was difficult to contact the visits booking line and visits did not always start on time. The visits room was large and noisy and the fixed seating gave limited privacy, but there were refreshments and a supervised play area. Young people were required to wear bibs unnecessarily and 25% were routinely strip searched after a visit.

Main recommendations

HP40 A comprehensive first night policy should be introduced with clear procedures to ensure that young people are, and feel, safe on their first night in custody.

HP41 Residential units should hold no more than 40 young people.

HP42 There should be a vulnerability strategy and a coordinated system of care planning setting out how to identify, assess and meet the needs of the most vulnerable young people.

HP43 All staff should be trained and supported in recognising and challenging bullying behaviour and in the use of the anti-bullying strategy.

HP44 A strategy should be developed to improve the integration of health services with other services and departments in the establishment.

HP45 There should be sufficient activity places to ensure that all young people are purposefully occupied throughout the majority of their day.

HP46 Staff who carry out direct work with young people and have a useful contribution to make should attend relevant training planning reviews or send a detailed report in advance.

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 often travelled with young adults. They found the escort vans uncomfortable and few received information about what to expect on arrival. However, our survey results showed improvement in feelings of safety and treatment by staff during escort. The video link was underused. Some young people arrived after 7pm after long days in court. They completed a questionnaire about their experiences of courts and escorts and managers met regularly with escort contractors and prison escort and custody services to discuss issues raised.

1.2 Young people continued to travel regularly in vans with young adults. Some said they had travelled with adult men and women, but reception and escort staff said this was not the case and we did not see any evidence of this. In our survey, 68% of young people said they had felt safe during their journey and 63% said they had been well treated by escort staff. Both results were significantly better than in the survey carried out in 2007. Only just over half of black and minority ethnic young people compared to nearly three-quarters of white young people said that they had been well treated by escort staff.

1.3 Some young people arrived late. Reception was profiled to accept young people until 8pm, but in May 2008, 11 young people had arrived after 8pm, including seven after 9pm. Late arrivals were reported to the prison escort and custody services (PECS) for investigation and to the Youth Justice Board and the women and young people's group of the Prison Service. Some young people spent long days in court. One young person had finished at court at 10.45am, but had not arrived until 6pm, while another had arrived at 7.15pm, over 7.5 hours after his court appearance.

1.4 Few young people had long journeys, but they found the vans uncomfortable. One of the vans we saw contained large amounts of graffiti. Only 7%, significantly worse than the comparator of 15%, said they had been given enough comfort breaks and only 33%, significantly worse than the comparator of 49%, said their health needs had been looked after. Sixty-nine per cent said they knew where they were going when they left court or were transferred, but only 22% had been given any information about what to expect at Brinsford.

1.5 Court escort and PECS meetings were held quarterly and covered timeliness, late returns and the issue of sharing vans. Meetings were minuted and action plans produced with named people responsible for addressing the issues raised. Young people had the opportunity to complete a questionnaire about their experiences of court and escort staff and the results were raised at the court escort meetings.

1.6 The video link was underused, with just 80 usages to date in 2008 compared to 378 young people who had travelled to court. The facility had been used only eight times for meetings between young people and their solicitor or probation officer, and only nine times for inter-prison visits. Young people going to court were collected from their wing by reception staff and

given breakfast and, if necessary, appropriate clothing. Young people were not handcuffed under escort and were checked regularly by escort staff. Food and drink was provided.

1.7 Young people were given 24 hours notice of planned moves unless there were security concerns. Senior managers said young people were rarely transferred out of the area.

Recommendations

1.8 **Young people should not be transported with young adults.**

1.9 **Young people who have completed their court appearance should be transported to their destination within an acceptable and agreed timescale so that they arrive in good time to be properly settled on their first night in custody.**

1.10 **Young people should receive information at court about what is going to happen to them.**

1.11 **Escort vans should be clean, comfortable and free of graffiti.**

1.12 **Greater use should be made of the video link.**

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.

1.13 Reception was clean, but not age-appropriate. Staff were diligent in following up missing information. The cell-sharing risk assessment was not completed in private and young people were routinely strip searched. Young people who arrived late were not always able to make a telephone call or have a shower on their first night. All new arrivals were interviewed in private in the first night centre, but there was no formal first night strategy even though just over half of young people in our survey said they were new to custody. Vulnerability assessments were generally not completed to a good standard. Young people were locked in their cells and only those sharing a cell had an opportunity to talk to another young person. The two-week induction programme did not fully occupy young people and not everyone received important information quickly enough. The induction room was inadequate and basic information was poorly presented.

Reception

1.14 Escort and reception staff dealt quickly with the handover of documents and property. All the necessary documents were usually received by fax or accompanied the young person, including offence details, full ASSET, pre- and post-sentencing reports, previous convictions and Youth Justice Board (YJB) vulnerability alert when appropriate. The number arriving without ASSET documents was monitored, as were occasions when documents did not arrive

within 24 hours once the YJB had been notified. Staff used a telephone service to notify the YJB as necessary.

1.15 Reception was clean, but its design and decoration were the same as in adult prisons and had not been modified to reflect the younger population. Young adults were also held in reception, but the two age-groups were kept separate until both were escorted together to the inmate throughcare and support unit (ITSU).

1.16 Reception staff were polite, but did not introduce themselves to new arrivals and continued to address them by their surnames alone. In our survey, 53% of young people, significantly worse than the comparator of 68%, said they had been well treated in reception. Beyond the reception process itself, staff did not actively engage with young people. Sixty-four per cent, against a comparator of 70%, said they were told what they needed to know when they first arrived. One holding room was used when young people first arrived and the other after they had been searched. Both were opposite the reception counter, well supervised and covered by closed-circuit television cameras. The holding rooms contained a range of information, including on drug support, the Independent Monitoring Board, the Samaritans, the searching procedure and the anti-bullying policy. The second room also had information about the first 24-hours and the property list. Most was in English and all was in the written word. Information on the race equality policy was displayed in six languages and details of what to do in the event of being bullied or threatened was in five languages. Both rooms had direct access to a clean toilet and sink, although there was no soap or means to dry hands. Apart from televisions, there was nothing to help pass the time.

1.17 All young people were seen in reception by a member of healthcare. They were not offered a shower or telephone call in reception as these were usually, but not always, offered when they arrived on the ITSU.

1.18 Young people continued to be strip-searched routinely rather than following a risk assessment (see section on security and rules). In our survey, 70% of young people, significantly worse than the comparator of 81%, said this had been carried out in an understanding way.

1.19 A cell-sharing risk assessment (CSRA) was completed for each new arrival. They were asked if they were new to custody, about current and previous offences, about substance misuse or self-harm issues and whether they understood the terminology used, such as 'homophobic' and 'racially motivated'. The CSRA interview took place at the open reception counter where other officers and young people could overhear, which was unlikely to encourage the young person to disclose any anxieties. They were not given the opportunity to ask questions or speak to an officer in private and were not told specifically what to expect during their first night and induction. We saw one young person's CSRA interview taking place at the same time as another young person was being booked in at the same counter and a nurse was talking to a young adult in a nearby holding room. On another occasion, we saw an officer interrupt the CSRA to answer the telephone and then to help with a strip search.

1.20 Two young adult reception orderlies worked in the area, but did not have direct contact with young people to provide peer support or information.

1.21 Reception staff completed a checklist of all new arrivals. This covered the time of the court appearance, leaving court and arriving at Brinsford. The time the young person moved to the ITSU was supposed to be included, but was not, so it was difficult to check how long they spent in reception. We saw some young people waiting for up to an hour to be taken to the ITSU, but in our survey, 70% of young people, against a comparator of 78%, said they had spent less than two hours in reception.

First night

1.22 All newly arrivals went to the ITSU on their first night, which separately accommodated both young people and young adults. The unit had four shared cells for young people, although these could be used as singles if indicated as necessary by the CSRA. These cells were often also used for young adults when their side was full. The cells were clean, but the wooden bunk-beds were covered in graffiti and the toilets were not properly screened. Young people on remand shared with convicted young people. There were no lockable cupboards to store personal items.

1.23 There was a dedicated staff group, but staff shortages often meant they were allocated to work elsewhere or that other staff were allocated to the unit. Two staff told us they were unfamiliar with procedures because they did not usually work on the unit. Officers were polite, but did not introduce themselves and addressed young people by their surnames alone.

1.24 Each young person was interviewed in private by an officer to complete a vulnerability assessment (T1V). The interview we observed was carried out in a relaxed and friendly way. The officer introduced himself and explained what he was doing. He confirmed the information in the CSRA and completed the necessary forms, taking time to ask how the young person was feeling and recording current and previous offences and any issues relating to substance misuse, self-harm, mental and physical health and family. The officer explained what would happen the following day after the young person had left the unit, what support was available to him and how to cope with custody. The young person was given the opportunity to ask questions. Staff said they did not always have enough time to complete the documentation properly when young people arrived late.

1.25 Many of the completed forms consisted simply of yes/no responses, with little evidence that the officer had read the ASSET and pre-and post-court information. Important information contained in some documents was not mentioned in the vulnerability assessment. In one case, documents indicated that a young person had tried to kill himself in the previous two years, but the vulnerability assessment simply noted 'no' to any history of self-harm. The ASSET information also reported the recent death of the young person's grandmother, which was not mentioned in the vulnerability assessment

1.26 Copies of the forms were included in the individual's wing file. Young people who arrived without ASSET documents were automatically observed regularly throughout their first night. Staff on the unit decided whether a young person needed extra support from a peer supporter or staff and he could also be placed on self-harm monitoring or additional observations. There was no published strategy outlining first night procedures or to help staff identify risk factors (see main recommendation HP40).

1.27 Each young person was given plastic crockery and cutlery, a selection of toiletries and a bag of fruit squash, sweets, writing paper and envelopes, although they were not told how long these were supposed to last. All were given something to eat. Young people were usually offered a free telephone call and, depending on what time they arrived, some had a shower, although many said they had had to wait until the following day. Staff said some young people who arrived late either could not get through to their families or preferred not to disturb them late at night. In our survey, 51% of young people, significantly worse than the comparator of 81%, said they had been able to make a telephone call to their family or friends. They continued to be locked in their cells without association or, unless they were sharing, the opportunity to talk to their peers. We also saw young people new to custody locked in their cells without the cell call bell system being explained to them.

1.28 There was a range of information on display in the unit, but young people had little opportunity to read it. Information left in each cell included a copy of the information booklet. Each cell had a television, but nothing else to pass the time. Staff said young people could request reading material. The unit was staffed all night, but there was no dedicated first night officer to help young people settle in. In our survey, 81% of young people said they had felt safe on their first night, although significantly more black and minority ethnic young people than white young people had felt unsafe.

1.29 A published fast track protocol for late first night receptions instructed that only the CSRA and vulnerability assessment had to be completed and that other paperwork could be completed the following day. We found unsigned compacts and uncompleted disability forms in some wing files on the induction landing, where young people had moved after one or two nights on the ITSU.

1.30 The day after their arrival, young people were seen individually by a substance misuse worker, chaplain and probation and bail officers.

Induction

1.31 A2 was the induction landing and contained 28 cells, eight of which were shared. New arrivals were welcomed by one of the officers, most, but not all, of whom wore name badges. A peer supporter was based on the wing.

1.32 The induction programme lasted two weeks. Young people were not kept occupied throughout this time and sessions were interspersed with routine activities. We were shown two different rooms used for induction, one described as the dedicated induction room and the other as the wing association room. Both were devoid of any displays, with bare walls and no attempt to make them attractive environments.

1.33 Just over half of respondents to our survey said they were new to custody. Despite this, not all young people received timely information about the regimes and services available. The timetable called for an officer to deliver a basic package of information every day to all young people who had arrived on the wing the day before. However, not all new arrivals attended because they had to attend court, had a legal visit or were elsewhere for other reasons. Of the four young people we saw attending the presentation, one had already been on the wing for five days and one for two days.

1.34 The presentation was given in the association room and lasted about an hour. It covered a great deal of information, including wing routines, visits, the rewards and sanctions scheme, association, health services, the personal officer scheme, letters and telephones, canteen and food and where to get help. The session was relaxed and friendly, but the information was simply read out by an officer, with no creative use of other media. The officer said the wing peer supporter usually attended, but was elsewhere in the prison. There was no planned discussion, but young people could ask questions. They were not given paper or pens to make notes.

1.35 The timetable allowed for the session to continue in the afternoon, but staff said this was rarely necessary. Staff from other disciplines attended on different days to give information about subjects such as complaints and resettlement. Young people also had assessments and one-to-one sessions with education, the young person's substance misuse service (YPSMS) and healthcare and attended a gym induction. The programme also included a training planning meeting 10 days after arrival. Staff said that young people were locked in their cells at other times. Two of the young people who attended the induction presentation we observed were

doing so for the second time simply 'to get out of their cell'.

1.36 The sessions attended by each young person were supposed to be recorded in a wing log, but this was not up to date. Each wing file contained an induction checklist started by staff on the ITSU and completed by staff on A2, but some sections for A2 staff were blank.

1.37 In our survey, 46% of young people, significantly worse than the comparator of 61%, said they had been on induction within their first week and only 35%, against a comparator of 51%, said it had covered everything they needed to know. Young people completed an induction feedback and review form, which included questions about reception and the first night, but their comments had not been analysed or put to use.

Recommendations

1.38 **The design and decoration of reception should be age-appropriate.**

1.39 **All staff should introduce themselves to, and engage positively with, young people.**

1.40 **New arrivals should be addressed by their preferred name.**

1.41 **Information for new arrivals should be provided in languages other than English and in media other than the printed word.**

1.42 **The cell-sharing risk assessment should be completed free from interruption and in private.**

1.43 **Reception staff should give young people specific information about what to expect after the reception procedures have been completed.**

1.44 **The means to pass the time should be provided in reception holding rooms.**

1.45 **Young people should be offered a telephone call and a shower in reception.**

1.46 **Young people should be taken to the inmate throughcare and support unit as soon as they have finished the reception procedure.**

1.47 **Peer support should be available to young people in reception.**

1.48 **Officers should wear name badges.**

1.49 **The quality of vulnerability assessments should be improved to reflect fully the information received about the young person.**

1.50 **Some out of cell activity should be provided on the inmate throughcare and support unit, particularly for young people on their first night in custody. This should include time for young people to read information on display in the unit.**

1.51 **All young people should receive well-planned induction information in a suitable environment the day after their arrival.**

1.52 **Young people should be fully occupied by a structured and comprehensive induction programme.**

1.53 **The induction feedback and review forms should be evaluated and used to develop the programme as necessary.**

Housekeeping points

1.54 Reception staff should record the time the young person moves to the inmate throughcare and support unit on their checklist.

1.55 Soap and the means to dry hands should be provided in the toilets for young people in reception holding rooms.

1.56 The graffiti on bunk beds in the inmate throughcare and support unit should be removed and lockable cupboards provided.

1.57 New arrivals should be told how long their reception pack is to last before they can make a purchase form the shop.

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 The accommodation was poorly designed and young people cited the unsafe layout as a key concern in our safety interviews. Sentenced and remanded young people sometimes shared cells. Important information about young people contained in ASSET documents was not available to residential staff. A rolling refurbishment and redecoration programme alleviated some of the gloomier areas, and parts of the grounds were attractively planted. Poor ventilation was particularly noticeable in the showers, quickly undermining recent repainting. Access to showers was unpredictable. Only a minority of cells had curtains, but all young people had quilts and a flask. Young people were issued with plenty of cleaning materials, but some of the dirt in cells was ingrained. There was only one washing machine for 100 boys on two blocks.

2.2 Each block had 56 spaces, mostly singles, with 14 double cells on block A and 12 on block C. The doubles comprised two adjacent cells, with bunks in one and the toilet in the other. No single cells were double occupied. All cells had a toilet and washbasin. During the inspection, there were 48 occupants on block A and 53 on block B. In order to manage these large numbers safely, they were split into smaller groups for association periods, which restricted access to showers (see main recommendation HP41).

2.3 Remand and sentenced young people lived alongside each other on the landings and even shared a double cell, although subject to risk assessment. Cell-sharing and first night risk assessments and vulnerability assessments were on files sampled. Entries in the vulnerability assessments were sometimes sparse, with more detailed entries on the main prison file. Entries sometimes referred to the ASSET record (see section on arrival in custody), but these were not usually copied on the wing file, leaving wing staff with only partial knowledge.

2.4 The accommodation was poorly designed and did not create a safe or respectful environment. There were often two officers on a landing, but this was not always sustained and the poor sightlines were labour intensive. In our safety interviews with 20 young people, the layout of the accommodation was the main concern raised. Sightlines, lighting and ventilation were poor and in some areas the fabric looked fatigued. A programme of refurbishment and redecoration was underway and the environment was cleaner than we had previously seen, with less rubbish strewn around. Parts of the grounds were pleasant and imaginatively planted, in contrast to the small exercise area (see section on time out of cell).

2.5 Cells varied in appearance. Some, mostly occupied by longer-term level one (enhanced) young people, were well maintained and appointed, while others showed signs of rapid turnover and lack of care. The screening of the toilet areas was insufficient considering young people were sometimes required to eat in their cell (see section on catering). Furniture was not uniform. Some contained newer wooden furniture, but they still had no lockable cupboards even in the double cells. Televisions were provided. The published offensive displays policy was not rigorously enforced.

2.6 Most communal areas had recently been redecorated and impressive graphic designs on corridor walls testified to the talent of some of the young people. Association rooms on the landings contained a television, some games and some soft seating and had windows along one wall, but were small and cheerless. One of the small landing association rooms was used for dining out. Folding benches and tables for meal times were stacked on one side and each spur took turns to eat communally (see section on catering). Officers in the nearby office did not have clear sightlines into the room, but young people were supervised by an officer who stood in the doorway at mealtimes. A separate toilet for general use on the landing was not much used. There was a telephone on each landing and in the main association area.

2.7 In our survey, 44% of young people, significantly better than the comparator of 31%, said cell call bells were normally answered within five minutes.

Hygiene, clothing and possessions

2.8 Each of the two landings on a block had a shower room with four showers, but access was not predictable and only just under half of young people in our survey said they could shower every day. The showers were cleaned by the landing cleaner, supervised by a landing cleaning officer. Although recently painted, paint was peeling in some areas. Ventilation was poor and the showers were always steamy and clammy.

2.9 Washing facilities were limited, with only one washing machine and dryer on A block to meet the needs of the 100 young people on both blocks. The A block cleaners said it was easy for them and their friends to get access, but this was not the case for new arrivals, the less influential and those on C block. The limited clothing allowance aggravated demand as those with easy access used the machine to wash only a few personal items. A lot of young people routinely washed larger items and draped them out to dry in their cells. Improvements to the electrical system were awaited before additional washing machines could be installed. Kit was laundered externally once a week, although young people were reluctant to send valued items such as quilt covers and own clothing as items went missing and could not instantly be replaced.

2.10 Cleaning materials were supplied at least weekly and each cell had cleaning equipment. Even in relatively clean cells, the toilets were filthy with ingrained staining. Unidentified substances clung to some ceilings. Walls were marked with graffiti and repeated applications of toothpaste, used as adhesive.

2.11 Clothing was quite restricted. Only remand and enhanced regime young people could wear their own clothing and two sets were allowed in possession. Socks and underwear were not so restricted and only basic regime boys could be denied their own footwear. Most young people wore prison-issue track suits or a mixture of their own and prison clothing. Outdoor jackets were issued only to those working outdoors.

2.12 Quilts, rather than prison blankets, were standard issue. Enhanced and standard regime young people were supposed to have curtains, but few did. Some had draped a towel or clothes over the window to provide some shade, but most had no cover. Boys complained of the heat, particularly in cells fitted with new windows that did not open. Older windows could be opened a couple of inches.

2.13 Following consultation with young people, the list of permitted possessions had recently been expanded, as had the availability of newspapers, magazines and catalogues, including hobby materials. Permission for kettles in cells awaited electrical improvements. All new arrivals were given a flask.

Recommendations

2.14 **Remanded young people should not share cells with sentenced young people.**

2.15 **A copy of the ASSET record, combining risk and planning information to date, should be included on wing files to keep wing staff fully informed.**

2.16 **A programme of regular deep cleaning should deal with ingrained dirt, graffiti or debris in cells.**

2.17 **Young people should be able to shower daily.**

2.18 **Ventilation in the shower areas should be improved.**

2.19 **Young people should be able to launder their clothing and bedding weekly.**

2.20 **Young people sharing cells should have secure lockers.**

2.21 **Curtains should be standard issue.**

2.22 **All young people should have an outdoor jacket.**

Housekeeping point

2.23 The establishment's policy on offensive displays should be enforced.

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.

2.24 Young people, including those from a black and minority ethnic background, generally reported positively on relationships with most staff. Young people's representatives attended regular consultative meetings with staff.

2.25 Relationships between staff and young people had steadily improved. In our survey, 78% of young people said most staff treated them with respect and the responses of black and minority ethnic young people were similar. Respondents were more positive than at the last inspection about staff checking on them in the previous week.

2.26 Responses to other questions about relations with staff were mixed. The use of first names on cell cards and in conversation was variable, but no staff were heard to address young people disrespectfully and young people said most staff were approachable. Staff wore labelled polo shirts to soften the uniform.

2.27 Young people's representatives were involved in regular consultative meetings, including monthly meetings with staff in their residential blocks. Representatives of both sections also met managers quarterly in a combined council. Representatives attended race equality and foreign national meetings and some attended the bi-monthly diversity and race equality meeting. Any young person could apply to become a representative. They received minutes of meetings, which were also available in the library and on the intranet, but the names of representatives, roles and minutes were not displayed around the accommodation areas.

2.28 Two advocates employed by Barnardo's shared what amounted to a little over a full-time post. Two of their main tasks were advising young people subject to adjudication and helping with complaints. They also contributed to a restorative justice initiative (see section on discipline). A recurring problem was that young people they were advising were moved without notice.

Recommendations

2.29 **The names, photographs and role of young people's representatives should be displayed on notice boards alongside minutes of consultative meetings.**

2.30 **Young people's preferred names should be routinely used and recorded.**

2.31 **Advocates who have been working with young people should be notified of their pending transfer to enable them to make arrangements, such as referral to advocates at the next establishment.**

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.

2.32 There was a good personal officer scheme. Wing files indicated that young people did not always meet their personal officer soon after arrival, but frequent engagement with various unit officers was recorded, although there were some gaps. Personal officers sometimes shared information with other departments, but there was no evidence of contact with families. Personal officers did not usually attend training planning review meetings or reviews of young people on self-harm monitoring.

2.33 There was a good personal officer scheme that was described in a 2007 document. Most young people knew their personal officer and the designated cover. They were supposed to be told who their personal officer was during induction and the personal officers' names were displayed outside cell doors, but wing files indicated that personal officers did not always introduce themselves within the first weeks, although they did show a series of useful contacts with landing officers. Continuity of personal officer work was ensured as they maintained responsibility for young people when they moved location.

2.34 Officers tended to work as a team on the same landing and could deal with any issues in the absence of the personal officer, although this did not ensure continuity of understanding. Wing file entries averaged a few each week from various wing officers and other departments in the

prison. Personal officer entries were not always made weekly. Some entries and signatures were hard to read. Managers monitored the quality of personal officer work and there were some reminders in wing files from senior officers about personal officer entries. Personal officers did not make regular contact with families or carers and were not routinely involved in training planning reviews with young people (see main recommendation HP46), although they did sometimes exchange information with other departments.

Recommendation

2.35 **Personal officers should engage and make regular, legible entries in wing records in accordance with the establishment's policy.**

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 There was no single safeguarding committee, but meetings covering each constituent part of safeguarding took place monthly. Attendance by community partners was good, but Brinsford representation was inconsistent. These meetings were complemented by weekly strategy meetings that were intended to discuss young people identified as requiring additional individual care planning. However, few young people were considered and the meeting focused on operational issues. There was a unifying policy statement and separate policies had also been published on most relevant areas. The overall arrangements lacked coherence and links between the different areas were not clear. The data supplied to the sub-meetings varied in quality and there was little evidence that it was analysed or used to inform an overall strategy. A social worker seconded from the local authority ensured that looked after children and children in need received appropriate support.

3.2 Each month, a series of safeguarding meetings took place in the visitors' centre. The first meeting covered child protection, followed by suicide and self-harm, public protection, anti-bullying and restorative justice. All were chaired by the head of safeguarding, except for the public protection committee, which was chaired by a probation officer. Apart from the recently constituted restorative justice meeting, separate policies had been published to cover each area. Separate minutes were also kept. Holding the meetings in the visitors' centre made it more convenient for staff based outside the prison to attend. The meeting structure aimed to ensure that relevant personnel were able to attend and to allow cases relevant to more than one area to be dealt with consistently. Representatives from the local social services, the youth offending teams and the Samaritans regularly attended, but attendance by prison staff, particularly healthcare and residential, was mixed.

3.3 An overall safeguarding policy and procedure contained terms of reference for each sub-committee and described how the meeting structure should allow staff to work in an integrated and coordinated way to safeguard and protect the welfare of children. The policy also explained the function of the weekly safeguarding strategic team meeting. This had been intended to deal with individuals who needed additional help, but actually dealt with very few cases and most of the discussion tended to focus on operational business. There was no vulnerability strategy or coordinated system of care planning setting out how to identify, assess and meet the needs of the most vulnerable young people (see main recommendation HP42).

3.4 A variety of different information was supplied to each meeting. Some good quality statistical data were produced, but tended to be descriptive and not routinely analysed. Potentially useful information submitted monthly to the Youth Justice Board on the use of force, including injuries sustained, was not routinely examined. Use of the special cell and strip clothing was not routinely monitored. There also appeared to be no straightforward method of comparing events over time. The material was often presented in different formats, which was confusing and made it difficult to establish a clear picture of safeguarding. There was no standard mechanism

for carrying out risk assessments when juveniles mixed with young adults, as they regularly did in a number of areas.

3.5 The two main weaknesses within the committee structure were the lack of overall strategic coherence and of any clear method of monitoring the casework carried out.

3.6 An experienced social worker seconded from the local authority was based full time in the prison. Approximately half of her time was taken up with child protection matters, with the remainder spent ensuring that looked after children and children in need received appropriate support from relevant community-based agencies. She worked well with staff from a range of departments and was assertive in ensuring that young people received support. There was also the equivalent of 2.5 probation officers who worked directly with young people, mostly related to the planning processes or assessment work.

Recommendations

3.7 **Regular reports should be submitted to the safeguarding committees covering each safeguarding area. They should set out an analysis of safeguarding areas and identify patterns and trends for consideration and action.**

3.8 **Weekly safeguarding meetings should focus on the care of young people identified as particularly vulnerable or in need of individual care planning.**

3.9 **Statistical information should be gathered on all relevant safeguarding areas in a standard format and used to provide trend analysis. This should include the use of force, all injuries sustained by young people, incidents of strip searching and the use of separation and the special cell. All relevant departments should be represented at all safeguarding meetings.**

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 Over a third of young people said they had felt unsafe at some time at Brinsford. Staff awareness of the extent of bullying and procedures for managing it as set out in the anti-bullying strategy was mixed. The monthly 'reducing aggression and violence efficiently' strategy meeting was well attended, but the trends identified in the detailed bullying data provided were not sufficiently analysed. Most young people identified as bullies were reported by their peers rather than staff. Planned work with young people identified as bullies to tackle their behaviour was inconsistent. There was no formal care planning for victims unless staff concern resulted in the opening of an assessment, care in custody and teamwork (ACCT) document. The use of peer supporters was a positive initiative, but their training and supervision was insufficiently robust.

3.11 The Brinsford reducing aggression and violence efficiently strategy (BRAVES) meeting was one of a series of monthly safeguarding meetings (see section on safeguarding). The meetings

were well attended and information about bullying along with other violence reduction data was monitored monthly. Bullying information was compared month by month, but there was no cumulative analysis or evidence that patterns or trends were analysed to inform policy or practice. A noticeable proportion of the anti-bullying strategy reports were for young people from black and minority ethnic backgrounds, some of which cited faith as the underlying cause. The significance of this had not been tested through formal analysis and monitoring. There was also information on bullying incidents relating to debt accrued through trafficking, but this had not been considered as a valuable source of information for further strategic development.

3.12 The violence reduction strategy, updated in May 2008, contained a number of clear policies, including response to victims and perpetrators and 'whistle blowing'. However, what had been agreed strategically did not match what was happening in practice. The establishment was not undertaking an annual survey of young people and the outcomes of previous surveys had not been taken forward by the anti-bullying and safeguarding committees. The first bullying survey in two years had taken place just before the inspection and the results were awaited. In our survey, 38% of young people, significantly worse than the comparator of 27%, said they had felt unsafe at some time at Brinsford and 35% said they had been victimised by another young person.

3.13 The anti-bullying procedures set out in the strategy had three stages, ranging from monitoring with a review after 72 hours (level one) to removal from enhanced employment, monitoring of canteen and checking of property (level two) and finally to removal to the intervention and assessment unit (IAU) for a period of segregation (level three). Few young people went beyond stage one. Monitoring was often recorded as 'no bullying issues observed or reported', although regular management checks required better observations and further reviews were scheduled. We were told the anti-bullying coordinator would undertake one-to-one work with a young person on level three. Only one young person was on level three, but no such intervention was taking place as the coordinator was on paternity leave.

3.14 Staff awareness of bullying and the anti-bullying strategy was mixed, which led to inconsistencies in how the scheme operated. Some awareness training had taken place and some staff were confident in identifying bullying behaviour and using the systems to tackle it, while others were less sure and appeared to accept behaviour that could have been interpreted as bullying. Of the 42 young people identified as bullies to date in 2008, 38 were placed on level one of the strategy and most had been reported by other young people rather than through staff observation. Some young people identified as bullies continued to receive privileges, including one young person on level two who was released on temporary licence without this being directly linked to his resettlement plan. This risked weakening the zero tolerance message on bullying.

3.15 The strategy required staff to report suspected incidents on an anti-bullying incident report form, but none were available for inspection and staff perception was that the anti-bullying strategy forms were the single source of information about suspected or known bullying. One member of staff had raised suspicions of bullying in an observation book and asked staff to monitor the situation, but this had not led to an incident or anti-bullying strategy form being raised. Systems for identifying potential bullying from unexplained injury reports (F213s) were underdeveloped.

3.16 In our survey, 63% of young people said they would be able to tell someone if they were being victimised. Although this showed a significant improvement on the previous survey, only 25%, significantly worse than the comparator of 40%, said they would be taken seriously by staff if they did so. In our groups, young people did not report bullying as a significant problem, but said any young person in debt should expect to be targeted. They described the physical

layout and structure of Brinsford as the issues that gave them the most cause for concern for their safety, with the gym showers, holding rooms and stairways deemed vulnerable areas. They also said closed-circuit television cameras were sometimes covered and cited the way meals were served and the existence of gangs as other areas of concern (see appendix 3).

3.17 In our survey, 47% of young people, significantly worse than the comparator of 27%, said other young people shouted at them through the window, but only 6% found it threatening. Forty-one per cent, significantly worse than the comparator of 28%, said they shouted through the window at others. They said staff did not stop this and that they were not placed on report or marked down in the rewards and sanctions scheme for such behaviour.

3.18 Wing files had information about issues for victims and interventions were available, but there was no formal care planning for them unless staff concern resulted in the opening of an ACCT document. Peer supporters were used to give information and reassurance, but the selection process was not sufficiently robust and supervision was minimal. One of the two mentors on the young people's peer support scheme was on level one of the anti-bullying strategy.

3.19 The psychology department provided support for the reducing aggression and violence strategy through data analysis of violent and bullying incidents and ensuring that interventions were available to bullies and victims. However, referral to interventions did not form part of the anti-bullying strategy review process. Target setting was recorded only at the first review and routinely comprised 'refrain from bullying'. The interventions were adaptable to individual need and delivered in a group or one-to-one. Six identified bullies and nine victims had undergone some form of intervention. To meet need, 15 additional officers had been trained to work one-to-one with bullies under supervision by the psychology team. The most recent graduate of the one-to-one intervention, who had been on level two of the strategy, said he had found the intervention helpful.

Recommendations

3.20 **Bullying data should be expanded to include information on the ethnic and faith background of victims and perpetrators, as well as recording bullying incidents related to debt. The anti-bullying strategy should then address these issues.**

3.21 **Target-setting for young people on the anti-bullying strategy should relate to the individual's behaviour and take place at the commencement of the procedure. Meaningful activities and interventions should be identified and recorded clearly and the young person's progress against the targets should form part of the review.**

3.22 **Anti-bullying monitoring records should include evidence of what behaviour has been observed.**

3.23 **The violence reduction strategy should be reviewed and practice brought in line with the strategy.**

3.24 **Internal bullying surveys should take place annually and the results analysed to inform policy and practice.**

3.25 **All unexplained injuries should be investigated as potential bullying incidents and this should be monitored by the Brinsford reducing aggression and violence efficiently strategy committee.**

3.26 **Victims of bullying should be supported through clear individual care plans. Managers should monitor the implementation of the plans and ensure consistently good quality.**

3.27 **The selection process for, and training of, peer supporters should be reviewed and overseen by a senior member of the Brinsford reducing aggression and violence efficiently strategy committee. Formal supervision of peer mentors should be introduced.**

3.28 **Identified bullies or victims should be referred for interventions that match their individual needs.**

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.

3.29 Assessment, care in custody and teamwork (ACCT) procedures were well understood by staff. The team of ACCT assessors was large and multidisciplinary and the quality of assessments was good. Care maps included individualised targets, but did not clarify staff accountability. Staff engaged with young people being monitored and supported them well. There was also a peer support scheme. Young people subject to ACCT procedures were frequently moved to other locations, often healthcare, rather than managed on the residential units. Parents or carers were not automatically informed when their children were being monitored for self-harm. Most reviews were conducted without relevant specialist input and often with discipline staff only.

3.30 The suicide and self-harm prevention meeting formed part of the series of monthly safeguarding meetings (see section on safeguarding). The meetings were well attended, but there was no consistency in the representation from healthcare and no residential staff involvement.

3.31 The suicide prevention coordinator (SPC) was a part-time senior officer and his deputy was a full-time prison officer. Their work covered juveniles and young adults. They quality assured ACCT documents and collated detailed information on incidents of self-harm and open ACCT documents, which was reviewed monthly at the suicide and self-harm prevention meetings. There were no examples of action taken or the strategy or policy being changed as a result of trends highlighted.

3.32 The establishment had experienced a death in custody of a young adult in March 2007. Some recommendations from the subsequent investigation related to both young adults and juveniles. These included the need for healthcare involvement in ACCT reviews, but only one of the 15 ACCT documents we looked at indicated any inclusion of healthcare staff in a review. It was unclear who was responsible for reviewing progress against the action plan. The previous deputy head of safeguarding had a copy of the action plan relating to actions recommended to the governor, while the head of healthcare had one relating to actions

recommended to the primary care trust. To date in 2008, 46 ACCT documents had been opened on young people.

3.33 The young people's peer support scheme provided reassurance and information to new arrivals (see section on arrival in custody). The training for peer supporters included recognising signs of distress and sources of support.

3.34 ACCT procedures were well integrated and understood by staff and a large multidisciplinary team of assessors. The quality of assessments was good, while that of ACCT monitoring was reasonable. Recorded observations indicated that staff talked to young people assessed as at risk, and those on open ACCT documents described feeling supported. Care maps did not usually include any specific activity for the young person, despite the fact that its value had been highlighted in the suicide prevention strategy. Individual targets were set, but accountability was unclear. Most reviews were conducted with only discipline staff present.

3.35 Young people subject to ACCT procedures were frequently moved off the residential unit. Two of the four young people on ACCTs during the inspection were being cared for in the healthcare centre and there was strong pressure from residential staff to transfer a third.

3.36 As there was no strategy or separate approach to the care of young people who were vulnerable due to their age, offence or poor coping strategies, ACCT procedures were used as a generic system to pick up anyone deemed vulnerable. One young man received during the inspection was profoundly deaf and unable to speak. He did not appear at risk of self-harm or suicide, but was placed on an ACCT because he was identified as vulnerable (see main recommendation HP42).

3.37 The SPC informed the youth offending team (YOT) worker, usually by telephone, whenever an ACCT was opened as well as emailing the suicide and self-harm strategy to YOT managers. It was left to the YOT worker to decide whether or not to inform the next of kin. Some individual cases were discussed at the weekly safeguarding team meetings and any referrals for bullying or child protection were made.

Recommendations

3.38 **The head of safeguarding should lead on actions arising from death in custody reports and monitor their completion. This should include a joint approach between the primary care trust and the governor to deliver the actions identified.**

3.39 **Care maps should include targets for activity for the young person.**

3.40 **Targets set should name the person accountable and the actions should be time bound. The subsequent review should assess whether targets have been met and set new and relevant targets.**

3.41 **Reviews should be multidisciplinary and the healthcare team regular contributors.**

3.42 **Individual assessments and care planning should replace routine use of ACCT documents for individuals with no evident self-harming issues.**

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

3.43 The child protection policy was comprehensive. Almost all staff working directly with young people had enhanced Criminal Records Bureau checks and all had received basic child protection training. There were close links with the local authority and sound child protection procedures had been produced jointly. The local authority had oversight of the management of child protection, including individual cases, through regular attendance at the monthly child protection committee meetings, which also included community partners. Few referrals proceeded to a case conference and there were no procedures to consider further investigations internally when allegations were made against staff. Young people who made disclosures were supported if necessary by the local authority-seconded social worker and healthcare specialists.

3.44 The child protection policy and procedures had been developed in close collaboration with Staffordshire Social Services. The policy covered all relevant aspects of child protection, including recent developments concerning the local authority designated officer. It also set out the procedures for staff to raise concerns about the safety or welfare of any young person.

3.45 The child protection committee met monthly, chaired by the head of safeguarding. There was good attendance by outside agencies, including the police and social services and representatives from VOICE and the YMCA. Brinsford staff attending included healthcare, education, safeguarding and residential areas. Records indicated useful discussions of individual cases and developmental matters. Outside participants played an active part and points they raised about procedural problems were acted on. The establishment-based social worker seconded from the local authority submitted a monthly report detailing the number and nature of cases with which she was involved. The number of child protection referrals generated each month varied, but was usually in single figures. The statistics were provided in a monthly snapshot, making it difficult to analyse patterns or trends over time.

3.46 All initial child protection referrals were sent to the local social services. If the local authority decided to investigate further, the establishment-based social worker, who was independent of Brinsford, began to make further enquiries. Subsequent decisions on whether or not to proceed to a strategy meeting were then taken. Senior local authority staff spoke positively about the open working relationship with Brinsford-based staff.

3.47 The child protection log was locked in the governor's office and contained the names and contact details of the local social services and police. The log had been analysed by an MA social work student between January 2007 and January 2008. During this period, of the 32 child protection referrals recorded, 58% were allegations made by young people against staff and 23% were allegations young people made against each other. The remainder were mainly historical. Of the cases examined, four had progressed to a case conference and two to some form of further enquiry. None of the cases had resulted in any further action by the local authority and there was no procedure to consider whether the allegations against staff, although not a child protection concern, warranted an internal investigation.

3.48 All staff appointed to work directly with young people had enhanced Criminal Records Bureau checks and a longstanding retrospective check of staff was almost complete. All discipline staff in direct contact with young people had completed the initial juvenile awareness staff programme (JASP) training, which included a basic module on child protection, and about two-thirds had completed the JASP 2 module, which covered the subject in more detail. Previously delivered local child protection training had not been run for some time, but was due to be reinstated shortly.

3.49 All young people who made child protection referrals were interviewed by the social worker. Anyone disclosing abuse was also given the opportunity of speaking to one of the establishment nurses, who had been trained to deal with sexual abuse.

Recommendation

3.50 **There should be a procedure to consider whether allegations against staff that do not proceed as a child protection concern warrant an internal investigation. The decision should be made in conjunction with the local authority designated officer.**

Race equality

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

3.51 Nearly half the population were from black and minority ethnic backgrounds. Some sound building blocks had been put in place for race equality and the bi-monthly diversity and race equality action team meeting was chaired by the governor. All residential units had young people acting as race equality representatives. They were well supported by staff and their views were acted on. However, commitment needed to be strengthened with a wide training programme. Racist incidents were taken seriously, but needed to be evaluated and dealt with by improved collaboration between departments. A diversity manager had just been appointed, but there was no diversity or disability policy.

Diversity

3.52 Diversity issues were included on the DREAT agenda, but the wider diversity agenda had yet to be developed by the arriving F grade manager. There was a decency charter, but no diversity policy and a disability statement, but no detailed policy. There were no cells adapted to meet the needs of young people with a disability.

3.53 The disability liaison officer (DLO) was based on the young adults' side and had no training and only occasional and unpredictable facility time. Some standard questions were asked on reception, but the DLO could not predict when he would have time to follow up any reported needs. No formal multi-departmental care plan was produced for a young person who arrived during the inspection with hearing and speech impairment. However, his needs were communicated to other departments within 24 hours and some steps were taken to meet them, including installing a teletext television in his cell. He was risk-assessed to share a cell and, in

the absence of his cell-mate, to be monitored by one of the wing orderlies, partly to ensure that he was escorted if a fire alarm sounded.

Race equality

3.54 Forty-five per cent of young people were from black and minority ethnic backgrounds. In our survey, 40% of black and minority ethnic young people, significantly worse than the 8% of white young people, said they had been victimised by staff. Their responses were also significantly worse about treatment by escort staff and feeling safe on their first night.

3.55 Within the race equality structure there were a number of points at which differential impact or perceptions could come to light. Young people acting as race equality representatives from all units attended the bi-monthly diversity and race equality action team (DREAT) meeting chaired by the governor and attended by other functional heads. In line with the race equality policy, it routinely monitored the race equality action plan, impact assessments, ethnic monitoring and racist incident reporting, as well as other aspects of diversity. Ethnic monitoring was done well, although one area of concern had not been identified through ethnic monitoring (see section on bullying). Race equality representatives had a preparatory meeting with the race equality officer (REO) and assistant REO and received minutes. They had participated with managers in a two-day race equality training in 2007, which had helped them to understand processes such as ethnic monitoring and impact assessments and which had involved additional consultation forums. These consultative exercises had resulted in change, including, as suggested by young people, a single complaints box in a less conspicuous area.

3.56 A January 2008 version of the race equality action plan was detailed, timed and drew on a range of sources, including impact assessments and a largely positive 2007 visitors' survey. A number of shortcomings had delayed progress. In the previous 12 months, there had been little training for staff or young people in race equality or diversity, although this was in the current training plan. The REO's post was full time across the whole establishment. However, the acting REO was untrained in the general responsibilities of the role and his assistant, who was also the complaints clerk, also had little training. Both had been trained in, and had implemented, the recently revised Prison Service ethnic monitoring system. Assistants on the units were being recruited, but needed training. The community engagement strategy included a list of external contacts, many of whom assisted with resettlement, but had little direct involvement with internal processes and did not attend DREAT meetings. The 2007-08 race equality annual report listed a number of positive building blocks, but development had slowed pending arrival of the new diversity manager.

3.57 Racist incident report forms (RIRFs) were collected from complaint boxes and stocks replenished daily by the REO and his assistant. Their names and photographs were posted alongside the boxes. Seventy RIRFs had been logged for the whole establishment to date in 2008, similar to the whole of 2007. The REO believed this reflected increased confidence in the process. There was no analysis to separate complaints from juveniles and young adults. At least 15 of 50 RIRFs we looked at related to juveniles. Most were written by them and the few written by staff were usually on behalf of a young person. Once logged, the complainant was notified of when he should expect a reply. Replies were often close to the 28-day deadline, but indicated that complainants and witnesses were interviewed. Typewritten replies were given to complainants and were invariably respectful.

3.58 The predominant subject of complaints was allegations of verbal abuse by one young person towards another. Investigations were often inconclusive and the usual outcome was that all parties were reminded of the zero tolerance policy. After a couple of months in post, the REO had concluded that further training and more sophisticated intelligence gathering and analysis

could lead to more robust findings and interventions. For example, the same young person's name appeared in three racist incident reports and each time he had been reminded of the policy and wing files and observation books had been noted to make other staff aware. However, there did not appear to be any systematic collaboration with other relevant staff, such as the anti-bullying coordinator, to develop a strategy to deal with him.

3.59 No independent external body checked a percentage of the reports. The governor checked and counter-signed all reports, adding occasional comment.

3.60 There were few displays raising the profile of the DREAT and celebration of diversity was also limited.

Recommendations

3.61 **The training plan to widen diversity training, including race equality training, for most staff should be implemented as quickly as possible.**

3.62 **Logging of racist incident report forms should allow easy identification of those relating to young people, and should include intelligence gathering and analysis of repeat incidents and those involved.**

3.63 **The race equality officer should collaborate with other departments, including the anti-bullying coordinator, to improve intelligence and develop appropriate interventions for perpetrators or victims.**

3.64 **Collaboration with independent community groups should be strengthened to include independent monitoring of a proportion of racist incident report forms and attendance at relevant meetings.**

3.65 **A diversity policy and action plan should be developed and implemented as a matter of urgency.**

Housekeeping point

3.66 The diversity and race equality action team should have photograph notice boards.

Good practice

3.67 *Young people's wing representatives had participated alongside managers in two-day race equality training.*

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.

3.68 Staff responsible for the welfare of foreign national young people had put together a policy and resource pack, but lacked necessary training and experience. Some identified needs were met with one-to-one care and regular visits were planned with a local UK Border Agency enforcement office. However, there was no regular source of independent specialist legal advice and staff underestimated the difficulty of coping without professional interpreting and the value of regular peer support meetings.

3.69 Eleven young people were listed as foreign nationals, although young people themselves were not always clear about their status. Policy and procedures to address their needs had been slow to develop. Resource packs for young people and staff had been developed and a foreign nationals policy written, but some sections were unclear and the material was not comprehensive, reflecting the lack of training and experience of staff. Resources included a list of staff and young people able to speak different languages and an expanding compilation of everyday phrases that bilingual young people translated. Staff visited other establishments to increase their understanding of working with foreign nationals.

3.70 Resources were concentrated in one area and the small group of young people who were foreign nationals were located on a single landing. Two foreign national coordinators and four assistants covered foreign nationals throughout the prison and had a resource office on the young adults' side. They had received little relevant training and the time detailed to these duties was unpredictable. Monthly foreign national committee meetings were held, but the coordinators were not always able to attend, young people were not always represented and the purpose and effectiveness of meetings was not clear. There were no regular peer support meetings. Staff had made useful contact with a UK Border Agency local enforcement office and intended to set up regular visits. There was no regular source of independent specialist legal advice for foreign nationals.

3.71 There was only limited translated information. A touch screen point on the landing contained general, but not local, prison information in several languages. Staff we spoke to knew about the telephone interpreting service, but had not used it.

3.72 One of the foreign national young people spoke virtually no English. He received sympathetic and caring treatment, was referred promptly for English for speakers of other languages (ESOL) classes and received one-to-one tutoring. A dictionary was ordered for his private use. However, there was no indication in his wing file, including on risk assessments and compacts he signed, that a professional interpreter had been used. Reception staff had called the interpreting line, but no one able to speak his language had been available. A young adult who spoke his language was inappropriately called up to help with his healthcare interview. There was only about one entry a week in his file, compared to a few a week in other files, and these usually noted how quiet he was and the language barrier. One entry indicated that he was unusually quiet and withdrawn and the writer feared he might be being bullied, but this was not followed up by an interview with an interpreter. Staff had facilitated a telephone call to someone after he arrived, but he was not listed for a free monthly international telephone call home, even though he had received no social visits for nearly four months (see also section on health services).

Recommendations

3.73 **Designated staff working with foreign nationals should receive appropriate training, following which the policy should be updated.**

3.74 **The role and function of the monthly foreign national committee meetings should be established and clear terms of reference agreed. Coordinators should always attend and young people should always be represented.**

3.75 **Further sources of translated material should be identified, including within the Prison Service and UK Border Agency, and following needs assessment the establishment should translate essential local information.**

3.76 **Foreign nationals should be able to attend regular peer support groups with relevant staff.**

3.77 **Resources for foreign nationals should include access to independent specialist legal advice.**

3.78 **A professional interpreting service should be used when necessary to ensure that young people have understood essential information on arrival, when completing assessments and during any planning meetings concerning their care. All staff should receive guidance on when to use a professional interpreting service.**

3.79 **Personal officers should check that young people with limited understanding of English understand rules and are able to get entitlements.**

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.

3.80 Wing telephones could not be used in private and many young people complained about poor access to them. Young people received information about visits on arrival and during induction, but little was done to promote family contact. There were no evening visits or family days and it was difficult to access the visits booking line. Visits entitlements were inadequate for sentenced young people who did not get extra privileges, but the length of sessions had been doubled to two hours. Children aged 10 and over were classed as adults for visiting. Visits did not start at the advertised time. A good visitors' centre was available and a community transport service was provided. The visits room was large, noisy when busy, and all seating was fixed and regimented, but refreshments were available and there was a supervised play area. Young people had to wear bibs, which was unnecessary, and were randomly strip searched after visits, which was inappropriate.

Mail and telephones

3.81 Young people could have two free letters a week and could have stamped addressed envelopes sent in. Outgoing mail was collected each morning and sent out the same day. Incoming mail reached the wings by the afternoon and was handed out by staff. Five per cent of letters were read randomly along with any targeted by security. Legal letters opened by mistake by staff were not recorded.

3.82 There were three telephones on each wing, but these could not be used in private. Young people did not have daily evening association (see section on time out of cell), but we saw

wing staff letting young people use the telephones at various times of the day, although this would not allow them to speak to family or friends who were out at work or school. In our survey, 28% of young people, significantly worse than the comparator of 52%, said they could use the telephone every day and 50%, significantly worse than the comparator of 32%, said they had problems accessing the telephone. Some wing files indicated that young people had been allowed to call a family member when they had no telephone credit.

Visits

3.83 Personal officers we spoke to said they did not usually have contact with parents, carers or the social workers of any young people in local authority care. Young people had access to advocates who could advise them and help with contact.

3.84 Young people were given information about visits on the day of their arrival and a letter about visits to send free of charge to their next of kin. Visits were also covered at induction, although this did not always take place the day after arrival (see section on first days in custody). Young people could not exchange unused visiting orders for extra telephone credit or letters. Apart from letters, telephone calls and visits, nothing appeared to be done to help young people maintain, or re-build, family ties.

3.85 In our survey, 55% of young people, significantly better than the comparator of 33%, said it was easy for their family and friends to visit and 45% said they had two or more visits a month. Sentenced young people on the standard and basic level of the rewards and sanctions scheme could have two visiting orders (VOs) a month and one privilege visiting order (PVO). At less than one visit a week, this was inadequate. Young people on the enhanced level could have an extra PVO, which had to be used on weekdays. Young people on remand could have a visit at every session without the need for VOs. Some of the information for visitors printed on both types of VO was wrong.

3.86 Visits were shared with young adults and available every afternoon except Wednesday and Friday from 2pm to 4.30pm. There were no evening visits. All visits had to be booked through a dedicated telephone number. This was available only on weekday mornings and afternoons and many visitors complained that it took a long time to speak to the booking clerk. When we tested the line, it took eight attempts to speak to the clerk. There was no facility to leave a message or queuing system.

3.87 All visitors under 18 years had to be accompanied by someone over 18. Children aged 10 and over were classed as adults in terms of using one of the three seats available at each set of fixed seating. Children under 10 were expected to sit on someone's lap. No loose chairs or high chairs were provided. There were no family days.

3.88 A community transport service provided transport from Birmingham and surrounding areas. This could be booked by a free telephone number. A comfortable and bright visitors' centre outside Brinsford was managed by the help and advice line for offenders' wives, partners and families (HALOW). It provided a range of facilities, support and information and was open at least an hour before visits and after the end of sessions. A supervised and well-equipped play area was provided. First time visitors were given a hand-out advertising the 'at risk' telephone number to which they could report any concerns.

3.89 All visitors booked in at the visitors' centre and then simply queued outside the main gate. No seating was provided for older or disabled visitors or those carrying babies. After an initial search in the gate house, visitors waited to be escorted to the visits room. Only four seats were provided.

3.90 Staff said any visitor indicated by the drug dog was given the choice of a closed visit or leaving only when this was justified by additional security information. However, the VO told visitors that 'if the drug dog gives a positive indication the whole party will be required to have a closed visit'. There were six closed visit booths, but they were not enclosed and did not allow any privacy if more than one cubicle was in use.

3.91 Visits were advertised to start at 2pm, but most sessions started late. We saw some visitors arriving in the visits hall at 2.15pm and others at 2.40pm. The visits room was large and all seating fixed and regimented. Young people had to sit on an identified chair and wear a fluorescent bib even though visitors' hands had been stamped. They could not leave their seats. Young people also wore orange sweatshirts to distinguish them from young adults in the room, although they were usually seated in an identified area. The hall was very full on the day we visited and was well supervised, but noisy. The fixed furniture allowed little privacy. Refreshments were available from a staffed refreshment bar. A well-equipped play area was supervised at every session.

3.92 Staff working in the visits room were not drawn from a regular pool, but knew if any young person or adult in the room was subject to child or public protection measures. Twenty-five per cent of young people were randomly strip-searched after their visit, which was inappropriate (see section on security and rules).

3.93 The establishment was part of the West Midlands children and families of offenders project 'families do matter', but this was not advertised within Brinsford. Information about the project was displayed in the visitors' centre. A fundamental part of the project was to increase the number of visits and visitor data were monitored and compared to the other prisons in the project. The report for the first quarter of 2008 showed that Brinsford had reduced the total number of visits sessions by half, having combined two one-hour sessions into a single visit. It had, however, increased the number of visits available at every session from 40 to 50 in mid April 2008, with the intention to increase to 63.

Recommendations

3.94 **Young people should have daily access to wing telephones and be able to make calls in private.**

3.95 **Personal officers should liaise with parents/guardians and significant others to encourage young people to maintain contact.**

3.96 **Young people should be allowed to exchange unused visiting orders for extra telephone credit or letters.**

3.97 **Evening visits and family days should be provided.**

3.98 **Siblings and partners under the age of 18 should be permitted to visit unless a risk assessment indicates this is inappropriate.**

3.99 **Access to the visits booking line should be improved and visitors should be able to book their next visit before the current visit ends.**

3.100 **There should be a designated family liaison officer to ensure that children and young people are encouraged and enabled to maintain contact with their family and friends.**

3.101 **Visits should start at the advertised time.**

3.102 **Children under the age of 18 should not be considered as adults for visiting purposes.**

3.103 **Visitors should know that closed visits will not be based solely on a drug dog indication.**

3.104 **Closed visit facilities should allow visits to be made in private.**

3.105 **The seating in the visits room should be improved to provide privacy for young people and their visitors and to allow easy contact between them.**

3.106 **Young people should not have to wear a bib in the visits room.**

Housekeeping points

3.107 Legal letters opened in error should be recorded.

3.108 Seating should be provided for visitors waiting to get into the prison and the visits room.

3.109 Information on visiting orders should be accurate.

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.

3.110 Wing applications were not recorded or tracked so there was no audit trail to ensure they were dealt with in a timely way. Young people generally felt applications were dealt with quite well. Complaints were dealt with efficiently and responses were reasonable. A robust quality assurance system for replies had been introduced and some improvements to the system had been made following consultation with young people. There was some analysis of complaints, but it was not clear how this information was used. Young people used the advocacy service to help them make complaints. The monthly young people's forum was attended by only a small number of wing representatives and knowledge of it was not widespread.

3.111 Information about complaints was published on wing notice boards, where there were also notices about complaints to the Ombudsman and the Independent Monitoring Board (IMB). These notices were not available in a range of languages. Information about complaints was also provided at the touch screen point on the induction landing.

3.112 Young people in focus groups were frustrated that general application forms had to be obtained from wing offices each morning, but changes brought in during the inspection meant they could also collect general applications from the servery at mealtimes. They felt the application system worked well. However, completed application forms were not logged or tracked so managers could not assess whether applications were dealt with appropriately and in good time.

3.113 A complaints coordinator appointed in September 2007 was responsible for emptying complaints boxes, replenishing the stock of forms and logging and tracking complaint replies. She also explained the complaints and racist complaints procedures at induction. Robust cover arrangements were not in place to ensure complaint boxes were emptied daily in the coordinator's absence. Confidential access complaints and complaints about staff were forwarded to the governor. The coordinator had not attended child protection training to ensure that she was able to filter any child protection referrals appropriately.

3.114 Following consultation with the young people, complaints boxes were now appropriately situated on each of the landings. There were separate boxes in the large association room for applications to the IMB and advocates. Complaint boxes had a good supply of all complaint forms and confidential access envelopes.

3.115 In our survey, 75% of young people, significantly worse than the comparator of 83%, said they knew how to make a complaint and 503 had been made in the first six months of 2008. The coordinator monitored complaints by subject, number and ethnicity of the complainant and this information was forwarded to the governor and residential senior manager each month. Complaints were not a standing agenda item at senior management meetings, so it was not clear what action was taken in response to identified patterns or trends.

3.116 The head of residence conducted a management check of a sample of complaint replies each quarter and his findings were clearly recorded. When complaints were issued to staff to reply, the date the response was required by was clearly indicated and a checklist was attached to assist staff in providing a complete and appropriate response. Forms were not routinely returned to young people if there were procedural errors such as use of the incorrect form.

3.117 Most replies were acceptable and some were respectful, appropriate and thorough. A number were in the third person and on two the respondent had failed to print their name. Young people used advocates to help them make complaints and advocates contacted the complaints coordinator and tracked them on their behalf.

3.118 Monthly young people's forums were held and were attended by a wing senior officer and the YMCA worker. Only a small number of wing representatives attended and not all young people we spoke to were aware of the meetings and their purpose. The minutes did not clearly demonstrate how identified actions and issues had been followed up and addressed.

Recommendations

3.119 **Information about applications and complaints should be published in a range of languages.**

3.120 **A recording system that provides an audit trail of the progress of applications should be developed to ensure they are answered in a timely way. This system should be subject to quality assurance.**

3.121 **The complaints coordinator should receive child protection training.**

3.122 **Analysis of complaints should be routinely monitored by the senior management team and patterns and trends appropriately acted on.**

3.123 **Minutes of the young people's consultative meeting should be published to all young people and should make clear what action has been taken to address identified issues,**

and action plans produced if required.

Housekeeping points

3.124 Cover should be available for the complaints coordinator during periods of absence.

3.125 Complaint replies should be directly addressed to the young person.

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 The health service provided nursing care 24 hours a day. The service was developing well. The South Staffordshire Primary Care Trust (PCT) had taken over commissioning in October 2006 and had produced several useful documents, including a comprehensive prison health delivery plan. Not all young people had a secondary health screening. Wing-based nursing could not be introduced until the treatment room was completely refurbished, which impacted on in-patient admissions and hampered integration with residential units. The in-patient unit was sometimes used inappropriately for young people who did not have a clinical need. Mental health provision was very good, with joint working between the primary mental health team and the child and adolescent mental health services. Although healthcare had good links with the PCT, it was not well integrated with other departments in the establishment.

4.2 The South Staffordshire PCT had been responsible for commissioning and providing healthcare services for Brinsford and for the five other prisons in the area since October 2006. A prison health delivery plan (a joint planning framework between Brinsford and the PCT) for January 2008/March 2009 had been published in November 2007. Service level agreements (SLAs) were in place with the Prison Service and other commissioned providers for the necessary healthcare services, including dentistry, optician, physiotherapy, podiatry, GPs and in-reach. A health needs assessment for 2007/08 had been published in June 2007 and looked at areas including physical, mental and sexual health and identified some gaps in service provision. A prison mental health needs assessment had been published in June 2008.

4.3 The healthcare manager was a member of Brinsford's senior management team (SMT). Relationships with the PCT were strong and staff felt well supported. There were regular meetings between health services and the PCT manager. The healthcare manager attended the quarterly prison health partnership board meetings as well as other regular healthcare meetings. Healthcare services were not well integrated with other departments in the prison. A weekly multidisciplinary meeting was held in healthcare chaired by the primary mental health team and attended irregularly by staff from education, probation, in-reach, the young person's substance misuse service (YPSMS), the suicide prevention team and a governor. Healthcare staff were not regular attendees at all monthly safeguarding meetings (see section on safeguarding) and were not represented at training planning meetings. They were not routinely invited to assessment, care in custody and teamwork (ACCT) reviews (see main recommendation HP44).

4.4 The healthcare department was on the ground floor of a two-storey building. It consisted of a corridor housing various offices, an out-patient area and an in-patient area. The noise levels were high across the department, with noise transmitting easily between the in-patient and out-patient areas as they were separated by gates rather than solid doors. There was also a small treatment room on the young people's residential unit. This did not meet the required standard of a clinical room in that it was poorly equipped, in a poor state of repair, dirty and did not satisfy infection control guidelines. This prevented the full use of the room to develop wing-based nursing and improve support to young people and discipline staff on the wings and therefore contributed to the high number of unnecessary admissions to the in-patient unit (see

section on in-patients).

4.5 The small medical room in reception was dirty, with a badly stained floor and torn chairs. The desk blocked access to the alarm bell. During the inspection, the chairs were replaced, the desk repositioned and health promotion posters put up. The condition of the flooring was not addressed.

4.6 The out-patient environment was generally clean and health information posters and leaflets were clearly visible and available. The healthcare treatment room was a busy multifunction room and was cluttered with an assortment of medical supplies and equipment. We saw one young person's examination by a nurse interrupted by a number of other staff entering the room. We were told this room was about to be divided into a GP surgery and a separate dedicated area for controlled drug administration. The two waiting rooms in healthcare were dirty, poorly ventilated and bleak and the only furniture consisted of soiled upholstered chairs. There was no healthcare information or health promotion information and no toilet facilities. The GP surgery was clean, well furnished and contained all the necessary equipment.

4.7 The in-patient area was satisfactory and the poor shower facilities were being upgraded with the installation of three separate shower cubicles and an adapted bath. There were no adapted cells for young people with disabilities either in healthcare or on the residential wing.

4.8 A large in-patient association room was well decorated and inviting. It contained several comfortable sofas and armchairs, a large dining table that was also used for art and other activities, a snooker table, air hockey table and other games. The in-patients helped to maintain the beautifully kept adjoining garden area.

4.9 The dental surgery was spacious and clean, but ventilation was poor. Cross infection control procedures were generally satisfactory apart from a split in the upholstery on the dental chair seat and the clean and dirty work surface areas were not demarcated.

4.10 Medicines were stored in locked metal cabinets in the treatment room in the healthcare unit.

Clinical governance

4.11 Clinical governance arrangements were in place and included the management and accountability of staff. The new staffing structure was due to become fully operational in September 2008.

4.12 The head of healthcare was an experienced registered general nurse (RGN) and was supported by two clinical managers. The clinical manager for physical health (out-patients) was an RGN. Under her leadership were a further 8.5 RGNs, a part-time healthcare assistant (HCA), a part-time dental surgery assistant and a part-time administrative assistant. There was one vacancy for a part-time evening RGN. The clinical manager for in-patients and primary mental health was a RMN and learning disability nurse who was to take up her position in September 2008. The in-patient and primary mental health team consisted of 5.5 RMNs and seven HCAs. GP services were provided by a community NHS provider and consisted of two male GPs who provided a combined two-hour surgery on weekdays for young people and young adults.

4.13 Emergency equipment was located in the main treatment room and consisted of a red resuscitation bag containing all the necessary equipment and a green bag containing dressings and burns material. The oxygen cylinders were kept at strategic positions around the establishment. There were two automatic defibrillators, one located in healthcare and the other

on one of the residential wings. All emergency equipment was checked and signed for according to a protocol and records were kept.

4.14 Clinical records were all paper-based and kept in lockable metal filing cabinets in the administrators'/nurses' office in the out-patient area. Records were generally well maintained and entries were legible, signed and dated. There were several examples of excellent integrated care where in-reach and primary mental health were aware several weeks in advance of a young person's discharge and had written to the appropriate team in the community with a plan set out for aftercare. Medical records of released young people were kept in a storage room in healthcare. They were filed in boxes and easily retrievable should the young person return.

4.15 Dental records were stored in a lockable filing cabinet in the dental surgery. Details of dental treatment were entered on the patient's clinical record. There was a need for additional space for storage of old dental records.

Primary care

4.16 Outside the core day (7am to 8.30pm), healthcare was staffed by one nurse and a HCA who together provided cover for the whole establishment. Weekend cover was provided by three staff who were on duty until 9pm and two staff who provided night cover.

4.17 All new arrivals were seen in reception. Interactions between healthcare staff and young people were polite and respectful. Information about ethnicity and any disabilities was often not recorded and there was no evidence that telephone interpreters were used when a young person could not speak English. Records showed that a young adult had been used to interpret, which was unacceptable. A secondary health screen was completed the following day unless the young person had been transferred from another establishment. This meant that not all young people had the opportunity to meet the healthcare team and find out how to access services. During the secondary health screen, further assessments were made including immunisation, vaccination, mental health and sexual health needs. Appropriate steps were taken to start or complete an immunisation programme if indicated.

4.18 The usual procedure to see a health professional was for the young person to ask discipline staff for an application, which was later handed by officers to the wing nurse. This system was not confidential and did not ensure that the application actually arrived at the required destination. We were told that young people occasionally slipped their applications under the treatment room door. Once the application had been received, the nurse called up the individual and conducted a triaging process at the next treatment round or arranged for the young person to be brought to healthcare to be seen by the appropriate professional.

4.19 Morning medications were given out between 8am and 8.30am by the named nurse on the young people's unit. This was an opportunity for the young person to ask questions and check up on various appointments, but the state of the treatment room meant these consultations were at a distance from across the hatch and the process was not confidential. Other treatment times were noon and 5pm. Young people came for their medication one at a time and received their medication through the hatch. Any young person requiring medication outside these hours was given it by the nurse individually.

4.20 In our survey, responses to questions about access to the doctor, nurse and dentist were significantly worse than the comparators, but this was not reflected in the views of the young people we spoke to. Figures on access to NHS hospital out-patient appointments and in-house appointments were difficult to obtain because statistics did not differentiate between young

adults and juveniles. In the previous three months, there had been 214 in-house appointments for all young people and of these 30 had failed to attend. Healthcare staff believed this was due to a lack of escorting staff or discipline staff bringing the young people to healthcare too late for their appointments.

4.21 Young people wishing to see the GP were generally seen within three days, slightly longer than the recommended NHS 48-hour access for primary care. Young people with urgent needs were seen the same day. Out-of-hours GP cover was provided by a NHS out of hours service, which also conducted a routine surgery on Sunday morning to see young people who had arrived since Friday's reception.

4.22 Young people and young adults attending the out-patient department were locked in separate waiting rooms. We saw young people waiting long periods for their appointments. Several young people said it was not unusual to wait from 9am to 11.30am, which led to extreme boredom and poor behaviour as the waiting rooms were devoid of reading material or activities. Several young people said they had felt unsafe and described a frightening barricade incident the previous week.

4.23 There was a good skill mix of registered general and mental health nurses. There was a good range of nurse-led clinics, including smoking cessation, immunisation and vaccination, blood-borne viruses, substance misuse and sexual health. The blood-borne virus clinic had a particularly long waiting list and young people were often released before they were seen. We were told that the clinic was often cancelled when the nurse was required for other duties. There was a sexual health nurse-led clinic, but no in-house provision for young people to be seen by a genito-urinary medicine (GUM) consultant. Young people with these needs had to be taken to the local NHS out-patient department. There were no age-appropriate nurse-led clinics for young people with conditions such as acne, epilepsy or asthma.

4.24 There were no nurses specialising in the care of young people with disabilities. We reviewed the clinical records of one Vietnamese young person who had completed the reception process with the help of a young adult interpreter (see above). He had not received a secondary health screen and there were no other entries in his clinical record, despite being fitted for court on two subsequent occasions.

4.25 Healthcare contained a wide range of health promotion leaflets, posters and information sheets from various members of healthcare that included contact names. There were also age-appropriate health promotion games about sexual health issues, nutrition and healthy living. The health promotion action group met quarterly and covered key areas such as smoking, nutrition, exercise, sexual health and dental health in targeted initiatives. There was also an annual health fair. All the information was in English only, despite 11% of young people not having English as a first language.

4.26 Long-term conditions such as asthma, diabetes and epilepsy were managed individually by the GP and nurse because the numbers with such conditions were few. This arrangement seemed to satisfy the needs of the young people. The paper-based register seemed reliable, but collating, retrieving and utilising the data was hampered by the lack of an IT system.

4.27 Visiting professionals included an optician who visited only when there were 20 young adults and juveniles on the waiting list. This could take several months and some young people were released before they were seen. Other visiting professionals were a physiotherapist, chiropodist, dentist and psychiatrist. Access to these clinics was satisfactory.

4.28 Young people were advised how to complain and details of the procedure were clearly written

on the back page of the healthcare information booklet given to all new arrivals. Complaints were managed by the healthcare manager and the complaints system was linked to the NHS. In the previous six months, there had been only one healthcare complaint and this had been responded to politely and appropriately within 24 hours.

Pharmacy

4.29 The pharmaceutical services were provided by an off-site supply only service from the area pharmacy. This arrangement was to cease at the end of August 2008 following a successful tender for the new contract. There was no pharmacy involvement in medicine administration, clinics or health promotion activities and consequently young people had no access to a complete pharmaceutical service. It was reported that the new contract would specify that a pharmacist visit the prison for one hour a week and technician support be provided weekly.

4.30 Medicines were stored in locked metal cabinets in the treatment room in the healthcare unit. Medicines taken to the wings were stored in green canvas bags that were not lockable and were unsecured. Medicines were generally stored in an orderly way and were well labelled. We were told there were agreed stock lists, but saw no evidence of these. Since the regular visits from the registered technician had stopped, there was no indication of regular date checks and a few items had date expired.

4.31 Patient information leaflets were available. Controlled drugs were stored in accordance with safe custody regulations and record-keeping was accurate.

4.32 It was not clear what records were made for young people not receiving prescribed medication who requested special sick treatment. We were told that a note would be made of what had been supplied and nursing staff would make a record in the young person's medical record later in the day. We did not see a copy of the children's British National Formulary in the treatment room on the young people's unit.

4.33 The PCT had input into the prison prescribers' forum, the prison operational group meetings and the prison clinical governance meetings. There was an in-possession policy that was used with a risk assessment tool. Patient group directions (PGDs) had been implemented by the PCT and nursing staff had been trained in their use.

Dentistry

4.34 The dental surgery had been inspected by the PCT in October 2007. There were copies of relevant policies and protocols. Young people were informed on reception of the availability of dental treatment. An application for treatment could be submitted to the wing nurse at any time. The applications were triaged by a healthcare nurse and copies forwarded to the dental surgery assistant (DSA), who was responsible for managing the waiting list and appointments. Urgent patients were seen at the next available dental session or before if necessary, either by the prison dentist, who was available on call, or a healthcare nurse or doctor for pain relief. Non-urgent patients were usually seen within two to four weeks. The dentist was on call for out-of-hours emergencies and arrangements were in place for the local dental access centre to provide urgent treatment in the dentist's absence and for the on-call GP to see out-of-hours emergencies. There was no surgery cover for the dentist's annual leave.

4.35 Dental provision was satisfactory and a full range of NHS treatment was available. Failed appointments were unusual and generally filled on the day. For patients undergoing orthodontic treatment on admission, the dentist made arrangements for this treatment to

continue with the outside practitioner. Tooth brushing advice was given individually during treatment sessions, although there was no evidence that the dentist delivered dietary or smoking cessation advice. Oral health promotion sessions delivered by the DSA were being rolled out to all young people during induction in addition to groups in education. Oral health information leaflets were available in the surgery.

Secondary care

4.36 Relationships with external NHS providers were good. In the previous six months, there had been 13 NHS out-patient appointments for young people and only one had been cancelled due to lack of escorting staff.

In-patients

4.37 The 11 in-patients beds all had closed-circuit television coverage and were not part of the certified normal accommodation. Six of the cells had moulded furniture. One cell could be used as a constant watch cell as it had an optional gated door. There were two young people in the in-patient department at the time of the inspection. The in-patient log did not include the patients' dates of birth or the reasons for admission, making audit difficult. At least 11 of the 17 admissions in the previous six months had been for reasons such as poor coping skills on the wing, bullying, behavioural problems, vulnerability, learning difficulties and anger management issues. The in-patient manager believed that sometimes up to 80% of admissions were inappropriate and had designed a clinical audit tool that was awaiting ratification by the PCT to look at this.

4.38 In-patients enjoyed good levels of time out of cell and purposeful activity. The education department attended three times a week between 9am and 11am and young people could attend the gym. Various other activities were available such as art therapy, a media group, Scrabble, games, gardening and interactive health promotion games. Dining out was encouraged.

4.39 There was a dedicated discipline officer detailed to the in-patient area, but this officer was occasionally diverted to other duties. This adversely affected time out of cell, including association, dining out and other activities, and meant that the healthcare team that cared for a diverse mix of in-patients (juveniles, young adults, violent, vulnerable and those with conduct and mental health disorders) was not always supported by a discipline officer during the full core day from 8am to 8pm to help keep the whole area safe.

Mental health

4.40 Mental health services were very good, with excellent joint working between the primary mental health team and the in-reach child and adolescent mental health services (CAMHS). The two teams ensured a cohesive approach to mental health services. The primary mental health team consisted of three RMNs (2.5 whole time equivalents) providing a weekday 9am to 5pm service offering one-to-one counselling for problems such as bereavement, poor coping skills, self-harm and mild depression. However, provision for young people who had been victims of sexual and physical abuse was delivered by an in-patient nurse who had not received appropriate training.

4.41 Referrals to the primary mental health team could be self-referrals or through reception, in-reach, the young person's substance misuse service (YPSMS), the intervention and assessment unit (IAU), the residential unit, chaplaincy or education. The primary mental health

team members had their own caseloads. In the year to date, there had been 60 referrals of young people, with around eight to 10 young people on each team member's caseload. Referrals were prioritised according to need, but the waiting time was generally six weeks and some young people left before they were seen. The primary mental health team also made daily visits to the IAU to see any young people needing their expertise. The primary mental health team did not deliver any mental health awareness training to the discipline officers.

4.42 Forensic CAMHS/in-reach services were commissioned by the South Staffordshire PCT and provided by Birmingham and Solihull Mental Health Foundation Trust. The team consisted of a psychiatrist who provided two sessions a week, two full-time RMNs, one full-time approved social worker (ASW), one clinical psychologist providing three sessions a week, one occupational therapist providing four sessions a week, one art psychotherapist on a six-month project and one administrative assistant providing five sessions a week. There was a good skill mix that included dual diagnosis (substance misuse and mental illness) as well as attention deficit hyperactivity disorder (ADHD) expertise. The occupational therapist and art psychotherapist conducted group work sessions with in-patients covering areas such as social awareness and life skills. The psychologist provided one-to-one sessions with young people with post traumatic stress disorder (PTSD) as a consequence of physical or sexual abuse, trauma and/or neglect. The psychologist also provided one-to-one sessions for young people with learning disabilities or who were autistic.

4.43 Referrals to the in-reach team were usually made from the primary mental health team, directly from secondary services when the young person was known outside, transferred from in-reach in other prisons or by the youth offending teams in the community. CAMHS was developing links with the youth courts. Following referrals, young people were generally seen within two weeks. All young people were seen whether on remand or sentenced according to need. There seemed to be good information-sharing with healthcare. CAMHS staff wrote in the young person's wing file if there was information they felt should be shared. Consent for sharing information was obtained from the young person on initial assessment.

4.44 CAMHS staff reported that they attended a variety of multidisciplinary meetings, including the monthly safeguarding, suicide prevention, multi-agency public protection arrangement, YPSMS, multidisciplinary meetings, ACCT, detention and training order, remand and good order or discipline case reviews. However, minutes and documentation showed that their attendance was sporadic. Mental health support outside the normal weekday working pattern was only through the in-patient RMNs.

Recommendations

4.45 **The noise levels in the healthcare department should be addressed urgently to prevent noise transmission between the in-patient and out-patient areas through the gated doors.**

4.46 **The healthcare waiting rooms should be completely refurbished to the standard equivalent to that in the community.**

4.47 **The treatment room in healthcare should be immediately altered to ensure that patients receiving medication do not enter the room.**

4.48 **The treatment room on the young people's unit should be completely refurbished so that it can be used to its full potential, including wing-based nursing.**

4.49 There should be a dedicated treatment room in healthcare for nurse triaging, dressings and treatments, with a notice on the door indicating when the room is in use to allow the patient a degree of confidentiality and privacy.

4.50 There should be at least one cell in healthcare and on the residential wing adapted for young people with disabilities.

4.51 Reception screening should include information about ethnicity and any disabilities.

4.52 A professional interpreting service should be used to complete any medical questionnaires or consultations and other young people should not be used to interpret clinical interviews.

4.53 A secondary health screen should be completed for all young people regardless of their status.

4.54 The application (care pathway) procedure should be confidential. The young people should put their applications into a locked healthcare box that is opened daily by the wing nurse.

4.55 There should be dedicated discipline staff attached to the healthcare unit to ensure that young people are on time for their appointments, and are taken back without delay and to supervise the healthcare area.

4.56 Nurses should be given protected time to run clinics.

4.57 The range of nurse-led clinics should be extended to include age-relevant specialties such as epilepsy, acne and asthma.

4.58 There should be nurses specialising in the care of young people with disabilities.

4.59 Information about healthcare and health promotion leaflets should be available in a range of relevant languages.

4.60 An IT system should be introduced for health services.

4.61 The optician should provide regular sessions so that all young people on the waiting list have the opportunity to be seen before they are released.

4.62 Bags used to transport medication should be secure and kept locked when not in use.

4.63 Supplies of non-prescription remedies such as paracetamol should be recorded for all patients and there should be an auditable record particularly for those patients who do not have a current prescription and administration record charts.

4.64 The responsible pharmacist should have professional control of the stock supplied. Agreed levels of stock should be adhered to and stock levels kept to a minimum.

4.65 The pharmacist should be supported to develop pharmacy-led clinics and medicine use reviews for the population.

4.66 A dental hygienist or therapist should be employed.

4.67 **Admission to healthcare should be solely on clinical need and the decision to admit made only by the clinical team.**

4.68 **The in-patient unit should be supported by a dedicated discipline officer during the full core day.**

4.69 **Primary mental health should include provision for young people who have been victims of sexual and physical abuse.**

4.70 **There should be more primary mental health provision so that all young people referred are seen before they are released.**

4.71 **Mental health awareness training should be provided for discipline and other staff such as education and gym.**

4.72 **Healthcare staff should consistently attend safeguarding and other relevant meetings.**

4.73 **Timed appointments should be introduced to reduce waiting times at clinics.**

Housekeeping points

4.74 A children's British National Formulary should be available in the young people's treatment room.

4.75 Stock cupboards should be routinely checked for out-of-date medicines.

4.76 A means of ventilation should be provided for the dental surgery.

4.77 The dental chair should be reupholstered.

4.78 Additional lockable storage cabinets should be provided for historic dental clinical records.

4.79 Cross infection procedures should be reviewed in the dental surgery and clean and dirty areas clearly demarcated.

4.80 Improved quality toothbrushes should be available to buy.

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 There were too few activity places to provide a full day of purposeful activity for all young people. There was a well planned curriculum, but vocational training was limited. There was an excellent initiative with West Midlands Fire Service. Attendance at education was poor. Young people usually got to lessons on time following the introduction of free flow, although there were some problems getting to the Acorn Centre on time and young people were sometimes collected too early. Teaching was satisfactory and young people gained skills and achieved good standards of work in some subjects. Teachers and learning support assistants worked well together to support young people who needed additional help, some of whom had made outstanding progress. Behaviour was managed well and was generally good. Levels of accreditation were slightly low, but satisfactory overall and some more able young people had achieved a good standard of accreditation.

5.2 All young people received an initial assessment of their literacy and numeracy levels during induction. An individual interview was carried out with an information, advice and guidance worker and this formed the basis of deciding their learning programme and for developing their individual learning plan (ILP). A further diagnostic assessment was carried out in the education department. However, it was not possible to identify all young people with specific learning disabilities as there were insufficient qualified staff to do this. Some young people waited too long to start their allocated courses. Some of the delay was due to security clearance, but a four-week rolling programme meant young people had to wait for one programme to finish and the next one to start.

5.3 The curriculum was satisfactory overall. There was an appropriate focus on literacy and numeracy and more able young people were able to take courses in a range of GCSE subjects. There was also a range of subjects to help young people's personal development and a small number of vocational courses and practical subjects such art and domestic cookery. The range of vocational provision was limited, but due to increase substantially with the opening of the Rowan Centre. There was currently no accredited work-based learning for young people.

5.4 While the curriculum was planned well, a severe shortage of places meant too many young people were not allocated to any activity for some of the day. Data concerning activity places were difficult to interpret. However, it was estimated that Brinsford had only 60% of the places it needed to provide full-time activity for all young people. In the face of this shortfall, the establishment was making efforts to ensure that the provision available was shared so that all

young people were allocated to some activity. However, in our survey, only 74% of young people, significantly worse than the comparator of 83%, said they were allocated to education (see main recommendation HP45).

5.5 There was no provision specifically to meet the needs of young people under school leaving age who should have been engaged in full-time education. The timetable for core and other subjects was structured to enable young people to learn basic skills in groups with others of similar ability and this worked well. Some young people enjoyed learning practical skills and team building through an exciting evening course provided by the West Midlands Fire Service.

5.6 Attendance at education was poor at approximately 75%. It was difficult to track attendance data due to the way it was collected, but reasons for poor attendance included a number of authorised absences such as health visits and legal visits, which suggested poor timetabling. Punctuality at lessons had improved with the introduction of free flow and was now good at lessons in the education block. Some time was still lost due to late arrivals at workshops in the Acorn Centre in the afternoon. Additionally, young people were sometimes collected to be taken back to their residential units before the end of the session, which sometimes prevented a useful summary being delivered.

5.7 The levels of accreditation overall were satisfactory and had improved. There was an appropriate focus on improving young people's abilities and confidence in literacy and numeracy and many young people gained useful qualifications. The needs of more able young people were well catered for through the successful implementation of an appropriate programme of GCSEs and some had achieved very good results. Accreditation of young people's vocational achievements was relatively low and opportunities to accredit the skills gained through real work in the prison were lost. However, almost all young people left Brinsford with some accreditation.

5.8 All young people were seen by careers specialists in a one-to-one interview as part of induction. They also received an R2R handbook outlining possible career opportunities.

5.9 The quality of teaching and learning was satisfactory with some good features. Some lessons were planned well and contained innovative and challenging tasks. Young people worked well in these lessons and made good progress. They gained skills in a range of practical subjects such as painting and decorating, woodwork and cookery. The standards of work in art and cookery were good. Young people were proud of these achievements and spoke about their work with confidence and enthusiasm. Progress was not recorded on individual learning plans (ILPs) and tutors made insufficient use of ILPs to plan and support learning.

5.10 Young people benefited from good support in lessons from learning support assistants (LSAs). Those who needed additional help were supported very well in literacy and numeracy in the foundation room where they often made outstanding progress. Teachers and LSAs had developed good relationships with young people, which contributed to the largely effective management of behaviour. They managed inappropriate behaviour skilfully and calmly and behaviour was generally good, although inappropriate language was not always challenged consistently. Few young people were sent back to their residential units for poor behaviour.

5.11 The management of learning and skills was satisfactory. There were good working relationships between the partners, In Training Ltd, Derby College and Connexions. There were good links between learning and skills and other aspects of the regime. The establishment and its partners had a commitment to the expansion of the learning and skills provision. Detailed work had taken place to prepare for the opening of the Rowan Centre, where there would be significant new developments and changes aimed at improving the

quality of the learning and skills provision. It was too soon to judge the effectiveness of these.

Library

5.12 There was a good range of books to interest and inform young people, but few magazines or newspapers. There were books reflecting young people's different ethnic and cultural heritages, as well as materials to support vocational learning. Young people could not use the library in the evening or at weekends and planned daytime sessions were sometimes cancelled. There were well developed plans for an officer to work in the library to ensure that young people could always be escorted from the wings and so reduce the number of times they missed their library sessions.

5.13 Good use was made of displays of young people's work to promote reading. This included book reviews and poetry describing life experiences.

Recommendations

5.14 **There should be enough appropriately qualified staff to identify young people with learning disabilities to ensure that their individual needs are met.**

5.15 **All young people should be allocated without delay to courses to meet their assessed needs.**

5.16 **Accredited work-based learning should be introduced as part of the development of the Rowan Centre.**

5.17 **There should be adequate provision to meet the needs of young people under school leaving age.**

5.18 **Better use should be made of individual learning plans to plan and support learning.**

5.19 **Attendance at education should be improved.**

5.20 **Young people should be taken to their lessons and collected at times that ensure lessons start and finish in accordance with the published timetable.**

5.21 **Access to the library should be improved and should include access in the evenings and at weekends.**

Housekeeping point

5.22 Magazines and newspapers should be available in the library.

Good practice

5.23 *Some young people developed practical skills and experienced team building through an evening course provided by the West Midlands Fire Service.*

Physical education and health promotion

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

5.24 The physical education (PE) profile had been re-evaluated in May 2008 and young people had been consulted about developing the provision. Accredited courses had recently been introduced. Facilities were suitable and the new profile included an appropriate balance of skills acquisition and development, indoor and outdoor activities and recreational PE. PE was well integrated with other departments. Young people were sometimes held in the gym with young adults for short periods and there was evidence that some did not feel safe there, which may have contributed to poor attendance.

5.25 The PE profile had been re-evaluated in May 2008. PE was integrated well with the main education programme and young people had good access to PE, including in the evenings and at weekends. However, attendance at PE was poor at approximately 70% and many young people refused to attend. In our survey, only 1% of young people, significantly worse than the comparator of 12%, said they went to the gym more than five times a week. Managers were aware of these issues and had begun to consider how to address them.

5.26 Until recently, there had been few accredited courses available. New courses had recently been introduced, such as Heartstart and Active IQ, but there had not been time for much accreditation to be achieved. Good links had been developed across the regime, including with healthcare, psychology and the young person's substance misuse service (YPSMS). There were PE-based courses for smoking cessation and steroid awareness.

5.27 Formal systems had been introduced recently to gain the views of young people on what activities they would like to see and quality assured action plans had been produced.

5.28 Facilities were suitable and included an outdoor pitch, a good standard sports hall, a weights room and a cardiovascular fitness suite. PE staff had extended the programme available and appropriately restricted the number of weight sessions that young people could attend each week. A good range of minor games was available and inter-wing sporting competitions had been developed. Showers were satisfactory, although there were no modesty screens. Young people and young adults were held together for short periods in the gym, which was inappropriate. There was evidence that some young people did not feel safe in the gym and this may have contributed to poor attendance (see section on bullying).

Recommendations

5.29 **Opportunities for accreditation in PE courses should be increased.**

5.30 **Young people should be consulted about why so many refuse to attend PE and the results used to resolve problems and improve attendance.**

5.31 **Showers in the gym should be placed in cubicles and properly supervised by staff.**

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 contributed significantly to pastoral support, including family liaison. Resources within the team were stretched and chaplains were not always able to attend important planning meetings for young people. They were frustrated by the lack of opportunities to develop additional activities. Team members were not permitted to escort young people to and from the chapel. The chapel was pleasant and welcoming, but there were soundproofing problems in the multi-faith room.

5.33 Nearly half of the young people recorded no religion on arrival. A third indicated Christianity and nearly a fifth said they were Muslim. All faiths were catered for. Regardless of identified spiritual needs, pastoral needs were high and the main issue was family problems. The chaplaincy team was therefore busy inside and beyond the walls of the establishment. Young people thought highly of the care they received at times of crisis.

5.34 The chaplaincy resources had not kept up with the expanding population and the team was struggling to cope with the necessary daily rounds as well as attending induction sessions, responding to individual applications quickly and undertaking proactive work. In our survey, 31% of young people, significantly worse than the comparator of 41%, said they had access to a chaplain within 24 hours of arrival. The chaplain, the only full-time post, was supported by part-time and sessional staff, while volunteers helped with services, meetings and the Alpha course. Some team members were at Brinsford only a few hours a week, but felt the need for a better grounding and training in how the establishment operated. The expertise of one of the team in helping young people at risk of self-harm was particularly valued by staff and young people, but he was in only one day a week.

5.35 There was limited capacity to attend important planning meetings for young people where the chaplains could have made a useful contribution, such as assessment, care in custody and teamwork (ACCT) reviews and training planning meetings. The organisation and coordination of the workload was demanding and the team could not easily cover the chaplain's post when he took a holiday, as happened during the inspection. The chaplain was not a member of the senior management team (SMT). The team was awaiting a new manager and lines of communication were not sufficiently clear in the interim. A recent change to the regime had had a significant impact on the numbers attending the Christian service. The unavailability of the chaplain, who was on holiday, combined with the lack of line management representation on the SMT, led to a delay in this being rectified.

5.36 Three Muslim chaplains visited, but after taking their turn in the normal rota of duties and taking the Friday Muslim prayers had no time for constructive group work. Some planned work around spiritual reflection, designed to appeal to non-religious young people, had been shelved due to lack of resources.

5.37 Members of the team were key-trained, but were not allowed to escort young people to and from the chaplaincy. Instead, they were dependent on normal regime movements or arranged escorts, which inhibited crisis interviews and other activities.

5.38 The Christian chapel was of ample size, comfortable and welcoming. It was often used for meetings as well as services. A multi-faith room was housed in a temporary building and used mainly by the Muslim population, with an anteroom for ablutions. The accommodation was reasonable, but sound-proofing was poor. Escorts waiting in another anteroom could easily be overheard during the service.

Recommendations

5.39 **Members of the chaplaincy team should receive appropriate training about the establishment to enable them properly to fulfil their role.**

5.40 **Members of the chaplaincy team should be allowed to escort young people to and from the chaplaincy.**

5.41 **The chaplaincy team should be better integrated into the wider work of the prison and enabled to develop constructive interventions with young people and attend important planning meetings relating to their care.**

5.42 **Soundproofing in the multi-faith room should be improved.**

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.

5.43 Young people did not spend 10 hours a day out of their cells. Regime monitoring figures recorded around 8.5 to nine hours unlock during the week and 7.5 at weekends. Young people did not get daily association or exercise in the fresh air. Association rooms were poorly decorated and equipped and the exercise area was littered, with nowhere to sit. Supervision and interaction on exercise and during association periods was inadequate.

5.44 Young people did not spend 10 hours a day out of their cells. We were given a number of different core days, some unlocking at 7.30am and others at 8am. Regime monitoring figures recorded around 8.5 to nine hours unlocked on weekdays and 7.5 at weekends. This figure assumed that all young people were unlocked for association every day, but this was not the case. Core days were published on wings and the young people knew when they were due to dine out, have association and exercise. Association was allocated by rota and time unlocked could be reduced by one hour 15 minutes or more, depending on whether young people associated in the main wing association room, on their landing or not at all. In our survey, only 5% of young people, significantly worse than the comparator of 46%, said they had association more than five times a week.

5.45 Evening association was timetabled to run from 6.30pm to 7.45pm. Young people using the main wing association room got the full allocation, but those on landing association were often divided into two groups with each allowed to associate for only 30 minutes.

5.46 Staff kept daily records of which wing had association and the numbers attending gym. Young people were generally not locked in their cells before or after activities such as education. When young people were not allocated to activity, staff gave them the opportunity to use this

time to shower, make telephone calls or clean their cell.

5.47 However, there was some time during the core day when young people were locked up. On one morning of the inspection, we found 11 young people locked in their cell from a population of 104 and four locked up in the afternoon from a population of 100. Wing staff knew what the young people were doing and the reason why they were locked up. Each young person had a daily 'regimes register'. This recorded his location, status and rewards and sanctions level, what he had done on and off the wing, whether he had showered, used the telephone, had exercise, association or dined out and whether he had attended education, visits, healthcare, court or gym. It was not possible to identify the actual time out of cell or why a shower had not been taken because not all forms were fully completed.

5.48 There was a large main association room and smaller association rooms on the landings. The main room was equipped with easy chairs, a pool table, table tennis and darts boards. There were football tables and air-hockey tables in the main and smaller rooms, but many were broken. There were large screen televisions in the association rooms. None of the rooms was attractively decorated. Wing staff said board games were available, but young people were unaware of this.

5.49 Young people we spoke to in the main association room were bored. Apart from pool and darts, no activities were taking place. The television was on but no one appeared to be watching. The exercise area off the main room was open to young people having association there, but it was littered and had no seating. We saw some young people going from window to window of adjoining cells talking to the young people in them. Some young people said they were asking for tobacco. The association room was supervised by two officers, but there was only limited engagement with young people and supervision of the exercise area was poor.

5.50 A separate room with games consoles was provided for young people on the enhanced regime.

5.51 Young people on landing association were not allowed to go into each other's cells. We saw some playing pool with supervising officers, but no other activities.

5.52 The published timetable allowed exercise in the open air for two landings in the morning and two in the afternoon. Young people who were at activities off the wing missed out on these sessions. No waterproof clothing was provided. In our survey, only 15% of young people, significantly worse than the comparator of 30%, said they went outside for exercise every day. Daily records were kept and many staff said exercise was rarely cancelled. However, records for June and July showed it had been cancelled at least 12 times for reasons including staff shortages, poor weather, rewards and sanctions reviews, cell searching and lack of time after delivery of canteen.

5.53 The minutes of young people's meetings recorded damage to association equipment and a principal officer stating that damaged items would not be replaced. In the minutes of May 2008, young people complained about not getting their full association and said they wanted 'more competitions especially at weekends'. The June 2008 minutes recorded a lack of landing association, which was explained by a principal officer as due to 'a lack of staff'.

Recommendations

5.54 **Young people should be out of their cell for at least 10 hours every day.**

5.55 Association and exercise should be cancelled only in exceptional circumstances and a full explanation given to young people.

5.56 All young people should have at least one hour of association and one hour in the open air every day.

5.57 Association rooms should be appropriately decorated and contain undamaged association equipment.

5.58 Association and exercise should be properly supervised by staff.

5.59 All young people should have warm weatherproof clothing and shoes to go out in all weather conditions.

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 The procedures for allocation to activities were less risk averse. Intelligence management systems were not sufficiently robust, but work was underway to address this. The published searching strategy required all new arrivals and 25% of young people leaving visits to be strip searched, which was inappropriate. The lack of sufficient activity places adversely affected dynamic security. Rules were explained in the welcome booklet, but were not clearly displayed on wing notice boards. Risk assessments when juveniles and young adults came into contact with each other were not sufficiently robust.

6.2 The security department was small and staffed by a principal officer, three full-time and two part-time senior officers and two administrative officers. The senior officers were also responsible for visits. A full-time intelligence analyst had been in post only about four weeks and had not yet attended the required training.

6.3 The security committee met monthly, chaired by the head of operations and was reasonably well attended. A monthly intelligence briefing was published and discussed at the meeting. Residential senior officers, including those on the young people's unit, contributed to the briefing by providing an overview of incidents, security information reports (SIRs) and observation book entries from their unit. The quality of these reports varied and overall intelligence assessments and subsequent objectives were not always clearly identified. The security department was aware of this and had revised the report. From July 2008, the report would be compiled by the security department to ensure a consistent approach to the monitoring and assessment of intelligence.

6.4 In the first six months of 2008, an average of 28 SIRs had been submitted. Those we sampled were effectively and promptly actioned. The wing observation book on the young people's unit was well used, but it was not always apparent whether an SIR was submitted following an entry. Staff did not routinely inform the security department when a young person was involved in a bullying incident or placed on the anti-bullying strategy. The weekend before the inspection, a routine security check of the observation book had identified that six young people had been placed on level one of anti-bullying measures, but security had not been informed. The absence of sufficient activities to keep young people occupied meant that not all elements of dynamic security were in place.

6.5 The security department had support from the local police and described a positive relationship with their police liaison officer. The department produced and circulated to all departments a list of identified gang members.

6.6 The security department had adopted a less risk-averse approach to allocating young people to activities. The policy was to presume young people were suitable for any activity unless

clearly identified risks prevented them from doing so. However, the searching strategy included unnecessary security restrictions. All new arrivals and 25% of young people leaving visits were strip searched. Routine and target cell searching was conducted by wing staff. The published strategy included instructions to searching staff to leave cells tidy.

6.7 The rules of the prison were included in the welcome booklet. Information about rules and mandatory procedures were published on a large notice board adjacent to the servery, but was difficult to read. Young people signed a rewards and sanctions compact that indicated the standard of behaviour required. There was no behaviour management policy to support staff in dealing with unacceptable behaviour (see section on rewards and sanctions), but we spoke to a number of staff who understood the importance of thoroughly explaining rules and procedures to young people.

6.8 There were some areas of the prison where juveniles and young adults could encounter one another, including during movements, visits and session changes at physical education. Not all of these activities had been thoroughly risk assessed.

Recommendations

6.9 **Residential managers should ensure that security information reports are submitted in relation to entries in the wing observation book where appropriate and particularly in relation to bullying incidents.**

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

6.11 **Information and displays on the rules should be presented in a more user-friendly format.**

Discipline

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

6.12 Adjudications were conducted in the main adjudication room in the intervention and assessment unit (IAU), which was formal and not age appropriate. Young people could be supported by the advocacy service. Restorative justice was beginning to be used to resolve conflicts. The use of force was monitored by the safeguarding and use of force committees, but there was no detailed analysis of the data or evidence of action taken as a result of identified patterns or trends. Use of force documentation was completed to a good standard. The special cell was rarely used. The IAU held young people for a variety of reasons, but its use was not properly monitored. Cells and communal areas were very clean. The regime was

reasonable, but there was no access to gym activities. Young people in the unit were assessed by psychology and had regular multidisciplinary reviews, but they did not have individual care plans.

Disciplinary procedures

6.13 A total of 323 adjudication hearings involving young people had taken place in the first six months of 2008. In our survey, 35% of young people, significantly better than the comparator of 58%, said they had been adjudicated on since they had been at Brinsford.

6.14 The governor chaired a bi-monthly adjudications standardisation meeting. A monthly ethnic monitoring return for adjudication hearings was completed each month by IAU staff. However, there was no record of this data or any other monitoring of disciplinary procedures being monitored and evaluated at the standardisation meeting.

6.15 The psychology and programmes department compiled a comprehensive report for the monthly 'Brinsford reducing aggression and violence efficiently' strategy meeting. This included monitoring the number of assaults and fights involving young people each month. This information was available only from April to June 2008, as the committee felt that figures compiled before this date were not accurate. In this period, there had been 10 proven adjudications for assaults involving young people and 37 for fighting. The report analysed the incidents by location, severity and ethnicity. The three meetings held from April to June 2008 had not been attended by a manager from the young people's unit, which would have ensured that appropriate action was taken in response to identified trends and concerns.

6.16 Adjudications were heard in the main adjudication room in the IAU. The room was formal and not age-appropriate, with a long table separating the governor from the young person. All young people were asked whether they could read and write at the start of proceedings. In the adjudication we observed, efforts were made to put the young person at ease and check his understanding throughout. He was asked for and addressed by his preferred name. The hearing was adjourned to ensure that all the witnesses asked for were able to attend. Young people were not seen by a member of healthcare staff before adjudication, but we were told that the adjudication would be adjourned for a medical assessment if governors were concerned about a young person's health.

6.17 Young people were also asked if they required an advocate at an adjudication hearing and advocacy staff provided through Barnardo's visited to offer their support to young people about to attend a hearing.

6.18 In a three-month sample of adjudications in 2008, there were several examples where it was not clear whether the young person had been given the opportunity to ask questions of the reporting officer. Requests for legal advice had been considered and adjudications adjourned to facilitate this where appropriate. Punishments appeared to be consistent and the use of removal from wing was low, with only three young people located in the IAU for this reason in 2008. There had been no adjudication appeals from young people in 2008.

6.19 A full-time restorative justice coordinator had been appointed in January 2008. Approximately 60 staff from a range of disciplines had attended level one restorative justice training and a further 19 had attended level two. A poster describing the restorative justice principles in age-appropriate language was displayed in the IAU. Following a proven adjudication for a fight, assault or racial conflict, young people were offered the opportunity to take part in a restorative justice meeting and there were a number of examples where they had effectively engaged in

the process. The establishment also used a 'stand up' restorative justice approach on the residential wings to defuse and de-escalate potential conflict, although staff did not always inform the restorative justice coordinator of this, which made it difficult to keep an accurate record of how often restorative justice was used on the wings and evaluate its effectiveness.

6.20 Minor reports were conducted on the residential unit. The minutes of the standardisation meetings indicated that the prison had trained a pool of staff to conduct minor reports, but they were used infrequently. The minor report log showed 12 minor reports had been conducted in 2008.

Use of force

6.21 In the first six months of 2008, there had been 65 incidents of use of force against young people. Control and restraint had been used in 43 of these incidents. Use of force paperwork was completed for all incidents, including those described as pushes, pulls or shoves. In our survey, 28% of young people said they had been physically restrained at Brinsford.

6.22 A use of force committee chaired by the head of operations met monthly and use of force was a standing agenda item at the monthly safeguarding committee, where a monthly report on it was discussed. Although the monthly safeguarding report had identified patterns in the use of force, the meeting had not conducted any further detailed analysis and there was no evidence that action had been taken as a result.

6.23 Eighty-five per cent of staff had attended control and restraint refresher training in the previous 12 months. Completed use of force documentation was held in the security department. In the sample we reviewed, there were no examples where force had been used inappropriately. In the majority of incidents, the paperwork had been completed thoroughly and officers involved gave a detailed account of the circumstances leading up to the incident and their attempts to de-escalate the situation. There were, however, cases where the documentation was not certified and one case where the paperwork had been inappropriately certified by the authorising officer.

6.24 Planned use of force incidents were videoed, but the most recent planned use did not appear to have been recorded. In one planned use of force, the intention was to conduct a strip search using force, but the situation had been resolved when the young person handed over a weapon. There was no cool down or timeout facility. A member of healthcare staff and the duty governor saw all young people after force had been used against them, but a thorough debrief giving them the opportunity to reflect on the incident was not conducted.

6.25 The prison had one special cell in the IAU. Its use did not appear to be monitored and this was not part of the remit of the safeguarding committee. The special cell had been used once in April 2008 when a young person who had caused considerable damage to his cell during the night was held for about 17 hours. The related documentation was complete, but entries by staff were largely observational and did not provide evidence of engagement with the young person, who was on an open assessment, care in custody and teamwork (ACCT) document. A member of the Independent Monitoring Board had visited the young person and talked with him for 20 minutes, but the detail of this conversation and any comments made by the young person were not recorded in the observation log. The young person retained his clothing while in the special cell.

6.26 Data obtained from the secretariat indicated that special accommodation had not been used for young people in 2007, but documentation in the IAU showed two occasions when a young person had been located in a healthcare safer cell in strip clothing and one further occasion

when a young person had been located in the special cell for less than an hour during the night after damaging his cell.

Intervention and assessment unit

6.27 Brinsford had a single intervention and assessment unit (IAU) for young adults and juveniles. It operated as a traditional segregation unit holding young people for reasons relating to indiscipline, but was also sometimes used for vulnerable young people seeking protection. It was difficult to obtain clear information about the number of young people held there, the reasons and for how long. This lack of data collection, monitoring and analysis was a significant gap in the management of the IAU.

6.28 The IAU log and data obtained from the secretariat showed that 71 young people had been held in the unit in the first six months of 2008. The majority were there for good order or discipline reasons. The log showed that four young people had been held there for refusal to locate and three for their own protection. The reason for one young person was described as a 'location problem' and one young person had been held in the IAU for 23 days for reasons described as 'reduced risk cell'. It was not possible to examine this young person's IAU wing file because he had been transferred. A joint working protocol between healthcare and the IAU appeared to suggest that vulnerable young people would be located in the IAU when there was no available accommodation in healthcare. This protocol was unsigned and residential managers were unaware of it.

6.29 The IAU was managed by a dedicated selected staff group of two senior officers and 12 officers. Staff had attended mental health awareness training and pro-social modelling. In our survey, 15% of young people who had spent a night in the IAU said staff had treated them very well or well. Young people in focus groups reported that they had been treated fairly. No young people were held in the IAU during the inspection.

6.30 Staff said strip searches on admission to the unit were not routine, but were informed by a risk assessment and authorised by a principal officer. Of the nine entries made in the IAU in 2008, the reason for the decision was not clearly evidenced. In eight of the nine recorded cases, a strip search had been carried out.

6.31 The communal areas and cells were very clean, with accommodation on two floors. There were no designated juvenile cells. The unit had three safer cells, three reduced risk cells and one unfurnished cell. All cells on the lower level had in-cell electricity. There were two showers and two telephones, to which young people had daily access. The one exercise yard in use was austere, but work was underway to add a decorative sport-themed mural.

6.32 The regime was reasonable. Education staff visited each afternoon and a new classroom was about to open. However, young people on the IAU rarely attended classes in the education department or communal worship. There was a small supply of library books. The cardiovascular equipment had been removed and not replaced.

6.33 A separate wing file was opened when a young person was located in the IAU. The psychology department saw new arrivals to the unit to conduct an assessment. Weekly review boards were consistently well attended by a multidisciplinary team, but there were no detailed care plans and it was not always clear how the initial assessment had been followed up. Staff said personal officers visited to see young people and support their return to normal location. There was one example of such a visit recorded in a young person's IAU log, but other files did not make clear that these visits took place. One young person had been returned to normal location using a staged approach, which involved him regularly participating in wing-based

association before his relocation to the wing, but this practice was not consistent.

Recommendations

6.34 **The adjudication standardisation meeting should monitor information related to adjudication hearings and awards to inform tariff reviews and to identify and address any emerging patterns or issues.**

6.35 **Adjudication hearings on young people should be conducted in a more age-appropriate setting.**

6.36 **All young people subject to adjudication should be seen before the hearing to ascertain whether they are fit to defend themselves.**

6.37 **Young people should always be given the opportunity to ask questions of the reporting officer and this should be recorded in adjudication documentation.**

6.38 **Further evaluation of the restorative justice scheme should be conducted to assess its success in reducing incidents of violence.**

6.39 **All use of force documentation should be appropriately certified by a staff member who did not authorise the use of force.**

6.40 **There should be a time out facility for young people who temporarily lose self-control and present a risk of harm to themselves or others.**

6.41 **The use of the special cell should be monitored by the safeguarding committee.**

6.42 **Staff should thoroughly record all interactions with young people in the special cell.**

6.43 **The use of force and safeguarding committees should clearly state what follow-up action is taken in response to identified trends in the use of force.**

6.44 **All planned interventions should be video recorded.**

6.45 **Young people should be thoroughly debriefed and given an opportunity to talk about a use of force incident with an appropriate member of staff as soon as possible afterwards. Records of this should be retained.**

6.46 **Records of the use of the intervention and assessment unit, including the number of young people located there, the reasons and the length of stay, should be collated, monitored and analysed by the senior management team.**

6.47 **The role and function of the intervention and assessment unit should be clarified. It should not be used as a location for vulnerable young people.**

6.48 **The register of strip searches should include all new admissions to the unit and evidence as to why a strip search was authorised.**

6.49 **Young people located in the intervention and assessment unit should be visited daily by their personal officer or wing staff and these visits should be recorded in their unit file.**

6.50 **All young people located in the intervention and assessment unit should have individual care plans.**

6.51 **Young people should usually be able to attend normal education classes and church services unless a thorough risk assessment has deemed this inappropriate.**

6.52 **Young people located in the intervention and assessment unit should have access to gym facilities.**

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.

6.53 The rewards and sanctions scheme had recently been revised. Young people understood the scheme and were motivated to engage with it. Staff recognised its value in challenging behaviour, but links with the training planning process were underdeveloped. Less than a third of young people were on the highest level of the scheme. Young people about to be demoted to the lowest level participated in a full review to discuss their behaviour and a flexible approach was taken to motivate them to regain their privileges as soon as possible.

6.54 The rewards and sanctions scheme had recently been revised and a new scheme introduced in May 2008. It was advertised on the wing notice board, but the published notices were not available in a range of languages. Young people signed a compact and were issued with a guide to the scheme.

6.55 In our survey, 30% of young people said they were on level one (enhanced) of the scheme. Staff said the scheme had been revised in consultation with young people as it was felt that in the previous scheme young people could progress to the top level while still demonstrating challenging and inappropriate behaviour on the wing. Movement within the revised scheme was based on points that young people could earn or lose for keeping their cells clean, positive engagement with staff and their peers and cooperating with their training plan. Bonus points were also available each day. Young people who scored over 130 points in two consecutive weeks could apply through their personal officer to be considered for the top level.

6.56 At the end of the week, individual points totals were published. The policy did not require personal officers or wing staff to explain to young people how they had gained or lost points that week. Staff said young people could ask to see their wing files and an explanation of their weekly points score would be provided on request. However, we examined a number of wing files that did not contain the most recent weekly points sheets and we saw many daily entries where points had been deducted that were not signed. Point deductions were not always supported by corresponding entries in wing files. For example, one young person had been deducted points for displaying a poor attitude, but there was no detail in the wing file to identify specific examples of this behaviour.

6.57 The behaviour management strategy was available only in draft form. There was scope to use adjudications less and restorative justice and the rewards and sanctions scheme more.

However, staff recognised the value of the scheme in challenging inappropriate behaviour and staff from a range of disciplines, including education, made entries in daily points logs. Staff were appropriately using the scheme to challenge young people who were not attending their allocated activity, but links with training plan targets were less apparent.

6.58 Young people we spoke to understood the scheme and were sufficiently motivated by the differentials between the three levels to engage with it. The young people's residential unit had a number of privileges for those on the top level that were limited in number. For example, there were four premier cells equipped with wooden furniture that were allocated to young people who consistently attained the maximum points score, but it was not clear how staff ensured that location in these cells was equitably managed.

6.59 The published policy stated that a review would be carried out where a young person on the top level was found to be involved in a serious incident such as being placed on stage two or three of the anti-bullying strategy. We saw one example of such a review. It appeared from the paperwork that downgrading to level two (standard) was automatic and there was no evidence that the incident or young person's behaviour giving cause for concern had been discussed.

6.60 There were seven young people on level three (basic). Those we spoke to understood why they had been demoted to this level and had attended a review chaired by a wing manager where their behaviour had been discussed and targets for improvement set. There was some flexibility in the scheme. For example, one young person had his in-cell television despite being on level three and had regained this privilege in recognition of a significant improvement in his attendance at education.

Recommendations

6.61 **Published notices about the rewards and sanctions scheme should be available in a range of languages.**

6.62 **Young people should routinely be told by their personal officer or wing staff how they have gained or lost points each week.**

6.63 **The draft behaviour management policy should be published and its effectiveness monitored by the senior management team.**

6.64 **Entries in a young person's points sheet should be signed.**

6.65 **A quality assurance system should be introduced to ensure that rewards and sanctions documentation is fully completed in accordance with the published policy.**

6.66 **Managers should ensure that there is a transparent system to afford equal access to privileges available to young people on level one.**

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 kitchen was clean and well maintained. The menu provided two hot meals a day and included vegetarian and vegan choices, but did not distinguish any healthy options. All meat was halal except pork. Breakfast packs were given the day before use. Few young people said the food was good. Staff supervision at serveries needed to be improved. Young people could eat communally only on a rota basis.

7.2 The kitchen was large, clean and well maintained. All areas conformed to the relevant safety and hygiene regulations and the kitchen was regularly visited by an environmental health officer.

7.3 Breakfast packs were given the day before use and milk was provided in the mornings. Packs contained bread and jam, but there were no facilities for making toast. The menu was on a three-week cycle, with four choices, including hot choices, for lunch and the evening meal. Choices included vegetarian and vegan meals, but the menu did not distinguish any healthy options. Special dietary needs were catered for when necessary. All meat was halal except pork. Fruit and vegetables were provided daily, but the menu had not been overseen by a dietician or nutritionist.

7.4 Lunch was served from noon to 12.30pm and the evening meal supposedly from 5pm to 5.30pm, although it was served at 4.45pm twice during the inspection. Food was taken to wing serveries in heated trolleys and catering staff attended the serveries on a rota to ensure that food was properly managed. Food temperature checks were recorded and monitored by catering staff. Young people working on the serveries had been health checked and were properly dressed. Servery areas were kept clean and tidy and the serving of food was supervised by staff, although we observed some examples of young people managing to get extra portions.

7.5 In our survey, only 13% of young people, significantly worse than the comparator of 24%, said the food was good or very good. Many young people complained to us about the quantity and quality of meals and the minutes of the council forum from May 2008 recorded complaints about insufficient potatoes, chips and rice. We found the quality and quantity satisfactory. Surveys took place every six months, but the last one had generated a poor response and was due to be repeated. The catering manager also attended the young people's consultation meetings. Food comment books were provided, but all the comments we saw had been made by staff. Catering staff read and signed the comments made.

7.6 Young people could eat together in wing association rooms only on a rota basis and at other times ate in their cells with poorly screened toilets. Each cell had drinking water and every young person had a flask for hot water overnight.

Recommendations

7.7 **Meal choices should be planned in consultation with a nutritionist.**

7.8 **Breakfast should be served on the morning it is eaten.**

7.9 **Lunch should be served no earlier than noon and the evening meal not before 5pm.**

7.10 **Non-halal meat should be available.**

7.11 **Staff supervising the serving of meals should ensure that this is done effectively and fairly.**

7.12 **Young people should be able to eat out for every meal.**

Housekeeping points

7.13 Healthy food options should be highlighted on the menu.

7.14 Young people should be encouraged to use the food comment books.

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.

7.15 The shop list was limited, but the contractor was due to change. New arrivals had to wait too long before they could place their first order. Consultation with young people had led to a number of improvements.

7.16 An external contractor supplied listed items once a week. The contract was about to change. Reception snack packs were offered to new arrivals to last them until they were able to receive an order. Young people under the age of 18 were not permitted tobacco. Young people were issued the shop list on Mondays with a note of credit available, and ordered items were delivered to each cell by wing staff on Saturdays. We met one young person who had not arrived in time to place an order and did not anticipate receiving any shop order until nearly two weeks after his arrival. Late orders were permitted if faxed to the contractor by Thursday morning.

7.17 The shop list was fairly limited, with some 200 items. It included a lot of sweets and biscuits, but only a few food items of substance such as noodles. Black and minority ethnic young people reported negatively on the range in our survey. Thrice-yearly surveys were undertaken as well as consultation groups. Following consultation, some adjustments had been made or were under consideration. A separate catalogue of items requested by Muslim young people and available to anyone had been added. Fresh fruit was under consideration. Requested body-building supplements had been considered, but rejected and a note from healthcare, based on a nutritionist's advice, had been circulated explaining why these were not a healthy

option for young people.

Recommendations

7.18 **The shop list should be expanded, taking into account healthy food options and the needs of black and minority ethnic young people.**

7.19 **New arrivals should be able to buy items from the shop within a day of arrival.**

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 Resettlement was managed successfully. The resettlement policy committee was well established and functioned effectively and was based on a good quality needs analysis. There was a reasonably wide range of relevant short programmes for young people and sufficient reintegration services to ensure that they received the practical help they required. The support of voluntary organisations was used to good effect. Connexions support was good. Release on temporary licence was used for a small number of young people. Public protection was well managed. Young people convicted of a sexual offence were assessed for their treatment needs, but, with no resource available, waited until they were transferred for an appropriate referral.

8.2 An up-to-date and comprehensive reducing reoffending strategy based on the resettlement pathways had just been published. The policy document contained a needs analysis that was based on aggregated data obtained from the establishment's local inmate database system, combined with information from the ASSET profiles compiled by youth offending teams. This helped to establish which of the seven pathways required a need for intervention, which for young people at Brinsford were attitudes, thinking and behaviour and education, training and employment. Both areas were being actively addressed. Although information was not collected under the ASSET profile in relation to finance, benefit and debt, this need had already been identified and services were provided by the Citizens Advice Bureau. A part-time worker had been in post for the past 15 months and take-up of this service had been high.

8.3 The resettlement policy committee was chaired by the head of offender management and met monthly. Membership consisted of functional heads and relevant front line managers. Representatives from the community also attended regularly on request. Records indicated that each of the resettlement pathways was dealt with systematically and regularly at the committee meetings. A pathway lead had been designated for each area, which appeared to be an effective way of ensuring that the different work streams were managed effectively. The head of offender management held a monthly meeting involving representatives from the various voluntary organisations working with the establishment. This was a useful forum and helped to ensure that existing and new services continued to target resources effectively and avoid duplication or overlap. Representatives from Barnardo's and Trail-Blazers were due to attend the next meeting to discuss partnership work.

8.4 Release on temporary licence was used on a limited, but regular, basis. One young person was on a placement with a conservation scheme and there had recently been examples of young people appropriately given the opportunity to attend college interviews.

8.5 In our survey, 47% of young people, significantly better than the comparator of 36%, said

someone had spoken to them about going to college on release and 58%, significantly better than the comparator of 36%, said they were going to school or college on release. Young people from the Birmingham area received good vocational support from the Connexions service.

8.6 Records indicated that few young people were registered as of no fixed abode on release, which may have reflected that many returned to live with a family member. Young people who did require assistance with housing could receive this through NACRO and the DePaul Trust. Both organisations had staff based in the establishment.

8.7 Public protection work was of a good standard. The overall procedures covered young adults as well as juveniles. Relevant cases were identified on admission and subsequently monitored and reviewed at a monthly committee meeting. There were 22 young people subject to public protection measures. This area of work was led by a probation officer. She obtained comprehensive background information quickly and through the committee and made sure this was used to impose or reduce restrictions on mail, telephones or visits appropriately. All young people dealt with under public protection procedures were interviewed by the probation officer who made sure they understood the conditions to which they were subject. When young people who presented a high risk were due to be released, establishment-based staff maintained close links with community-based colleagues. There was a trigger system to identify these cases six months before release so that any outstanding work could be completed before discharge. Representatives from Brinsford always attended case conferences on individuals assessed to require multi-agency public protection arrangements (MAPPA) 2 or 3.

8.8 There was a wide range of short programmes covering anger management, problem solving and various aspects of offending behaviour. These were all based on a cognitive skills approach and had been validated locally as effective interventions. The type of course delivered was subject to regular review. Given the reduction of the juvenile population, a decision had been made to replace the staff-intensive accredited JETS programme with a number of shorter programmes that could be delivered more flexibly and better meet the needs of the changing population. The content of some courses had also been modified in the light of experience. About 60 young people a year were given the opportunity to participate in one of these courses. There were effective procedures for identifying and assessing suitable candidates and sound referral mechanisms.

8.9 At any one time, a small number of young people convicted of a sexual offence were held at the establishment. They were subject to detailed risk assessments carried out by a member of the psychology department who was experienced in this field. In some cases, a need for casework was identified and attempts were made to transfer these young people to suitable establishments where this work could be undertaken after they turned 18. They were not able to access a sex offender treatment programme during their time at Brinsford. There was no on-site chartered psychologist.

8.10 A pre-release course previously delivered by the education department had been discontinued following changes in the contract. A new project designed to help young people take responsibility for their own resettlement needs, the road to resettlement programme, had just been introduced. It was too early to determine the success of this initiative.

Recommendations

8.11 **Young people convicted of a sexual offence and who have been assessed as requiring**

treatment should have their treatment needs met without delay.

8.12 **A pre-release course should be developed based on assessed need.**

Good practice

8.13 *The use of aggregated ASSET data to produce an accurate needs analysis was innovative. The application of this data helped to allow services to be designed for the needs of a changing population.*

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.

8.14 All young people, whether sentenced or on remand, were subject to the same planning process. Reviews were organised efficiently, but the quality of the planning was not consistent. Targets set tended to be standard ones that did not address individual need. Members of the casework team played a central role in training planning arrangements and in supporting young people, but input from specialist departments was limited. The unsuitable location for reviews reduced the scope for open discussion. The additional sentence planning arrangements created unnecessary duplication and diluted the impact of initial reviews.

8.15 All young people, regardless of the length of their sentence and whether convicted or on remand, were dealt with under the same planning process. Members of the casework team dealt with most aspects of the planning process, arranged meetings within the relevant timescales and prepared the relevant documentation. Meetings were normally chaired by the community youth offending team (YOT) workers.

8.16 We observed four meetings. Three were training planning reviews and one was a sentence plan review. The quality of training plan reviews was mixed, with some engaging the young person and others where caseworkers were under-prepared and limited background information about the young person was produced. There was a corresponding system of initial planning. These initial planning reviews were conducted well. They were chaired by a governor and, unlike the training plan meetings, were well attended by specialists from within the prison. As a result, the targets set at the initial planning meetings were detailed and individualised, which was in contrast to the much more standardised targets set at the training plan reviews. It was unclear why the two systems operated separately, but the lack of coordination undermined the training planning system.

8.17 Some of our survey results indicated that young people were not sufficiently involved in the planning process. Only 46% said they knew the targets set and only 24%, significantly worse than the comparator of 35%, said they could see their training plan.

8.18 Attendance at the planning meetings was low, but the community-based YOT worker always attended. Formal records were not kept of the proportion of reviews attended by families, but caseworkers we spoke to estimated this was only about 15%.

8.19 Attendance at reviews by staff based in the establishment was poor. Personal officers were rarely present, which was a pity as they often had the best knowledge of the young person. Caseworkers interviewed the young people in advance, but complained that they did not always have sufficient time to brief themselves in advance, which was reflected in some not being fully prepared for meetings. Representation by education staff was erratic and healthcare staff did not appear to have ever attended a review. Written contributions from specialist departments were not always provided and those that were did not always contain sufficient detail (see main recommendation HP46). The planning documentation was poor, many of the files were disorganised and some of the handwritten records difficult to read.

8.20 Arrangements for young people on remand were at least equivalent to those for convicted young people. The planning process involved meetings convened earlier than for those who had been convicted. All young people were interviewed on admission by a probation officer. Anyone requiring assistance with issues related to their legal status was referred to the bail information officer who interviewed young people daily.

8.21 Building work in the legal visits area meant planning reviews were held in an open part of the main visits area. This meant more than one meeting could take place simultaneously and made it impossible to conduct private discussions. This inhibited participants from talking freely and had an adverse effect on the overall review.

8.22 All young people were seen by a nurse two days before release and given a doctor's letter with a summary of their care and a week's supply of medication if indicated and appropriate. Young people who did not receive their medication in possession were not given any medication. Young people who were not registered with a GP were given an NHS Direct card with advice on how to register with a GP. A young person receiving daily medication who was not registered with a GP could therefore be without medication until he registered with a GP and waited for an appointment. Young people with ongoing mental health needs were referred to the community CAMHS.

Recommendations

8.23 **The training planning and initial planning procedures should be combined to produce an integrated planning arrangement.**

8.24 **Efforts should be made to increase attendance of family members at planning reviews.**

8.25 **Targets set at planning reviews should address individual assessed need.**

8.26 **Planning reviews should be conducted in private.**

8.27 **Young people who do not have a GP should be given help to register with one before release.**

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.

8.28 Substance-dependent young people could access a flexible and needs-based prescribing regime and their care was well coordinated, but substance misuse nurses did not cover weekends and GPs had not undertaken specialist training. An experienced team of young person's substance misuse service workers offered a wide range of interventions and service users had developed age-appropriate materials locally. The mandatory drug testing rate for juveniles was 2% over the previous six months. Procedures included strip-searching. Officers had not undertaken child protection training.

8.29 The substance misuse strategy document had recently been revised and the annual delivery plan for the young person's substance misuse service (YPSMS) agreed. A detailed needs analysis, conducted by the YPSMS every six months, informed service provision. Tobacco, cannabis and alcohol were the main substances used by young people, followed by stimulants.

8.30 Substance misuse strategy meetings took place monthly and were chaired by the head of offender management. Appropriate departments were represented. The YPSMS lead was a member of the senior management team. She coordinated the different strands of the strategy well and linked in with community planning groups.

8.31 A range of joint working protocols with other services had been developed and the YPSMS attended relevant multidisciplinary meetings internally. Weekly substance misuse intervention team (SMIT) meetings facilitated joint care planning and care coordination. Substance misuse awareness training for discipline staff had been developed, but not yet implemented.

8.32 Young people received a healthcare screen on arrival and reception nurses had undertaken part one of the Royal College of General Practitioners (RCGP) training. Patient group directions (PGDs) for first night symptom relief had been implemented and one for alcohol treatment was being developed. New arrivals received a comprehensive assessment by a substance misuse nurse the following morning, but this did not include weekends. The clinical substance misuse team consisted of a grade 6 lead nurse and a grade 5 substance misuse nurse, with another post vacant. There were plans to provide weekend cover.

8.33 During the previous three months, 12 young people had undergone alcohol and stimulant detoxification and three had been reduced or maintained on methadone or buprenorphine. Comprehensive clinical management protocols were in place and the range of prescribing options for opiate-dependent young people also included lofexidine and naltrexone. Treatment was flexible and based on individual need and a good level of patient consultation and involvement was evident. Weekly clinical reviews, which included the YPSMS worker, provided the opportunity to assess progress and plan future treatment.

8.34 GPs worked as part of the multidisciplinary team, but they had not undertaken part 2 of the RCGP training and a local specialist substance misuse treatment lead had not been identified. The national clinical adviser provided clinical supervision to the substance misuse nurse manager.

8.35 Controlled drugs were administered and consumption supervised in the out-patient department. The environment was crowded and young people were not supervised by discipline staff while in the holding room.

8.36 A small number of young people requiring a high degree of monitoring were admitted to healthcare as in-patients. The majority spent their first night on the ITSU before being moved onto the residential unit. Wing officers, nurses and YPSMS workers provided a good level of care and support, but only those prescribed controlled drugs had daily contact with substance

misuse nurses.

8.37 Young people with substance and mental health problems could access a range of primary and secondary mental health services, where practitioners were experienced in treating dual diagnosis clients. Weekly multidisciplinary meetings facilitated effective care coordination.

8.38 The YPSMS consisted of a manager, a team leader, two staff and an officer, with one vacancy. The team was skilled and experienced and enjoyed a high profile. The service benefited from a purpose-built unit containing group and interview rooms, but civilian staff were still not allowed to escort clients and a considerable amount of time was wasted waiting for discipline staff to be available. All new arrivals were seen within three days and usually within 24 hours. Young people on remand received a brief intervention together with their initial assessment.

8.39 All young people received substance misuse awareness input, including smoking cessation advice, during their induction, which was co-facilitated by physical education staff. Auricular acupuncture sessions had been stopped due to lack of funding and there were some delays in accessing nicotine replacement therapy. Young people could also undertake an alcohol and cannabis awareness and a crack/cocaine workshop. Pre-release sessions, including information on overdose prevention, ran weekly. The team was due to implement a steroids awareness module with physical education staff and hoped to develop a more intensive alcohol intervention with the psychology department. The impressive range of age-appropriate materials included a DVD on substance misuse and gangs developed by young people locally.

8.40 Structured one-to-one work was supplemented with work packs. Care plans were of good quality and reviewed at the fortnightly SMIT meetings where the clinical substance misuse and mental health in-reach service, psychology, education and safeguarding all provided input. All parents/carers received introductory welcome letters inviting contact from the service. The service also offered information to clients' partners.

8.41 The team prioritised initial and final training planning meetings and submitted progress reports if it could not attend. Good links had been established with youth offending teams and community agencies and the main catchment areas provided resettlement and aftercare programmes for young people after release. All young people were given overdose prevention advice and information before leaving the establishment.

8.42 All young people could access voluntary drug testing and 59 had signed testing compacts. The scheme was non-punitive and testing took place with the required frequency.

8.43 Mandatory drug testing (MDT) was conducted by intervention and assessment unit (IAU) officers who had not undertaken child protection training. Testing facilities were next to the reception area and satisfactory, but children and young people could be held for up to five hours and all were strip searched without risk assessment. No young person had tested positive during the previous six months, which called into question the appropriateness of MDT for this age group.

Recommendations

8.44 **The establishment should implement the substance misuse awareness training programme for operational staff.**

8.45 **Health services should improve first night treatment of young people dependent on alcohol.**

8.46 Clinical substance misuse services should be extended to provide weekend cover and increased input on the residential wing.

8.47 GPs should undertake specialist training in the management of substance misuse.

8.48 Specialist clinical advice should be available to doctors treating substance-dependent children and young people.

8.49 The establishment should ensure that young people are supervised while waiting to be seen in the out-patient department.

8.50 Escorting arrangements to and from the YPSMS unit should be improved.

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

Good practice

8.52 *The young person's substance misuse service (YPSMS) had developed a comprehensive range of interventions and young people were involved in designing age-appropriate materials.*

Section 9: Recommendations, housekeeping points and good practice

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

Main recommendations

To the Governor

9.1 A comprehensive first night policy should be introduced with clear procedures to ensure that young people are, and feel, safe on their first night in custody. (HP40)

9.2 Residential units should hold no more than 40 young people. (HP41)

9.3 There should be a vulnerability strategy and a coordinated system of care planning setting out how to identify, assess and meet the needs of the most vulnerable young people. (HP42)

9.4 All staff should be trained and supported in recognising and challenging bullying behaviour and in the use of the anti-bullying strategy. (HP43)

9.5 A strategy should be developed to improve the integration of health services with other services and departments in the establishment. (HP44)

9.6 There should be sufficient activity places to ensure that all young people are purposefully occupied throughout the majority of their day. (HP45)

9.7 Staff who carry out direct work with young people and have a useful contribution to make should attend relevant training planning reviews or send a detailed report in advance. (HP46)

Recommendations

to the Youth Justice Board and NOMS

Courts, escorts and transfers

9.8 Young people should not be transported with young adults. (1.8)

9.9 Young people who have completed their court appearance should be transported to their destination within an acceptable and agreed timescale so that they arrive in good time to be properly settled on their first night in custody. (1.9)

9.10 Young people should receive information at court about what is going to happen to them. (1.10)

9.11 Escort vans should be clean, comfortable and free of graffiti. (1.11)

Courts, escorts and transfers

9.12 Greater use should be made of the video link. (1.12)

First days in custody

9.13 The design and decoration of reception should be age-appropriate. (1.38)

9.14 All staff should introduce themselves to, and engage positively with, young people. (1.39)

9.15 New arrivals should be addressed by their preferred name. (1.40)

9.16 Information for new arrivals should be provided in languages other than English and in media other than the printed word. (1.41)

9.17 The cell-sharing risk assessment should be completed free from interruption and in private. (1.42)

9.18 Reception staff should give young people specific information about what to expect after the reception procedures have been completed. (1.43)

9.19 The means to pass the time should be provided in reception holding rooms. (1.44)

9.20 Young people should be offered a telephone call and a shower in reception. (1.45)

9.21 Young people should be taken to the inmate throughcare and support unit as soon as they have finished the reception procedure. (1.46)

9.22 Peer support should be available to young people in reception. (1.47)

9.23 Officers should wear name badges. (1.48)

9.24 The quality of vulnerability assessments should be improved to reflect fully the information received about the young person. (1.49)

9.25 Some out of cell activity should be provided on the inmate throughcare and support unit, particularly for young people on their first night in custody. This should include time for young people to read information on display in the unit. (1.50)

9.26 All young people should receive well-planned induction information in a suitable environment the day after their arrival. (1.51)

9.27 Young people should be fully occupied by a structured and comprehensive induction programme. (1.52)

9.28 The induction feedback and review forms should be evaluated and used to develop the programme as necessary. (1.53)

Residential units

9.29 Remanded young people should not share cells with sentenced young people. (2.14)

9.30 A copy of the ASSET record, combining risk and planning information to date, should be included on wing files to keep wing staff fully informed. (2.15)

9.31 A programme of regular deep cleaning should deal with ingrained dirt, graffiti or debris in cells. (2.16)

9.32 Young people should be able to shower daily. (2.17)

9.33 Ventilation in the shower areas should be improved. (2.18)

9.34 Young people should be able to launder their clothing and bedding weekly. (2.19)

9.35 Young people sharing cells should have secure lockers. (2.20)

9.36 Curtains should be standard issue. (2.21)

9.37 All young people should have an outdoor jacket. (2.22)

Relationships between staff and young people

9.38 The names, photographs and role of young people's representatives should be displayed on notice boards alongside minutes of consultative meetings. (2.29)

9.39 Young people's preferred names should be routinely used and recorded. (2.30)

9.40 Advocates who have been working with young people should be notified of their pending transfer to enable them to make arrangements, such as referral to advocates at the next establishment. (2.31)

Personal officers

9.41 Personal officers should engage and make regular, legible entries in wing records in accordance with the establishment's policy. (2.35)

Safeguarding

9.42 Regular reports should be submitted to the safeguarding committees covering each safeguarding area. They should set out an analysis of safeguarding areas and identify patterns and trends for consideration and action. (3.7)

9.43 Weekly safeguarding meetings should focus on the care of young people identified as particularly vulnerable or in need of individual care planning. (3.8)

9.44 Statistical information should be gathered on all relevant safeguarding areas in a standard format and used to provide trend analysis. This should include the use of force, all injuries sustained by young people, incidents of strip searching and the use of separation and the

special cell. All relevant departments should be represented at all safeguarding meetings. (3.9)

Bullying

9.45 Bullying data should be expanded to include information on the ethnic and faith background of victims and perpetrators, as well as recording bullying incidents related to debt. The anti-bullying strategy should then address these issues. (3.20)

9.46 Target-setting for young people on the anti-bullying strategy should relate to the individual's behaviour and take place at the commencement of the procedure. Meaningful activities and interventions should be identified and recorded clearly and the young person's progress against the targets should form part of the review. (3.21)

9.47 Anti-bullying monitoring records should include evidence of what behaviour has been observed. (3.22)

9.48 The violence reduction strategy should be reviewed and practice brought in line with the strategy. (3.23)

9.49 Internal bullying surveys should take place annually and the results analysed to inform policy and practice. (3.24)

9.50 All unexplained injuries should be investigated as potential bullying incidents and this should be monitored by the Brinsford reducing aggression and violence efficiently strategy committee. (3.25)

9.51 Victims of bullying should be supported through clear individual care plans. Managers should monitor the implementation of the plans and ensure consistently good quality. (3.26)

9.52 The selection process for, and training of, peer supporters should be reviewed and overseen by a senior member of the Brinsford reducing aggression and violence efficiently strategy committee. Formal supervision of peer mentors should be introduced. (3.27)

9.53 Identified bullies or victims should be referred for interventions that match their individual needs. (3.28)

Self-harm and suicide

9.54 The head of safeguarding should lead on actions arising from death in custody reports and monitor their completion. This should include a joint approach between the primary care trust and the governor to deliver the actions identified. (3.38)

9.55 Care maps should include targets for activity for the young person. (3.39)

9.56 Targets set should name the person accountable and the actions should be time bound. The subsequent review should assess whether targets have been met and set new and relevant targets. (3.40)

9.57 Reviews should be multidisciplinary and the healthcare team regular contributors. (3.41)

9.58 Individual assessments and care planning should replace routine use of ACCT documents for individuals with no evident self-harming issues. (3.42)

Child protection

9.59 There should be a procedure to consider whether allegations against staff that do not proceed as a child protection concern warrant an internal investigation. The decision should be made in conjunction with the local authority designated officer. (3.50)

Race equality

9.60 The training plan to widen diversity training, including race equality training, for most staff should be implemented as quickly as possible. (3.61)

9.61 Logging of racist incident report forms should allow easy identification of those relating to young people, and should include intelligence gathering and analysis of repeat incidents and those involved. (3.62)

9.62 The race equality officer should collaborate with other departments, including the anti-bullying coordinator, to improve intelligence and develop appropriate interventions for perpetrators or victims. (3.63)

9.63 Collaboration with independent community groups should be strengthened to include independent monitoring of a proportion of racist incident report forms and attendance at relevant meetings. (3.64)

9.64 A diversity policy and action plan should be developed and implemented as a matter of urgency. (3.65)

Foreign nationals

9.65 Designated staff working with foreign nationals should receive appropriate training, following which the policy should be updated. (3.73)

9.66 The role and function of the monthly foreign national committee meetings should be established and clear terms of reference agreed. Coordinators should always attend and young people should always be represented. (3.74)

9.67 Further sources of translated material should be identified, including within the Prison Service and UK Border Agency, and following needs assessment the establishment should translate essential local information. (3.75)

9.68 Foreign nationals should be able to attend regular peer support groups with relevant staff. (3.76)

9.69 Resources for foreign nationals should include access to independent specialist legal advice. (3.77)

9.70 A professional interpreting service should be used when necessary to ensure that young people have understood essential information on arrival, when completing assessments and during any planning meetings concerning their care. All staff should receive guidance on when to use a professional interpreting service. (3.78)

9.71 Personal officers should check that young people with limited understanding of English

understand rules and are able to get entitlements. (3.79)

Contact with the outside world

9.72 Young people should have daily access to wing telephones and be able to make calls in private. (3.94)

9.73 Personal officers should liaise with parents/guardians and significant others to encourage young people to maintain contact. (3.95)

9.74 Young people should be allowed to exchange unused visiting orders for extra telephone credit or letters. (3.96)

9.75 Evening visits and family days should be provided. (3.97)

9.76 Siblings and partners under the age of 18 should be permitted to visit unless a risk assessment indicates this is inappropriate. (3.98)

9.77 Access to the visits booking line should be improved and visitors should be able to book their next visit before the current visit ends. (3.99)

9.78 There should be a designated family liaison officer to ensure that children and young people are encouraged and enabled to maintain contact with their family and friends. (3.100)

9.79 Visits should start at the advertised time. (3.101)

9.80 Children under the age of 18 should not be considered as adults for visiting purposes. (3.102)

9.81 Visitors should know that closed visits will not be based solely on a drug dog indication. (3.103)

9.82 Closed visit facilities should allow visits to be made in private. (3.104)

9.83 The seating in the visits room should be improved to provide privacy for young people and their visitors and to allow easy contact between them. (3.105)

9.84 Young people should not have to wear a bib in the visits room. (3.106)

Applications and complaints

9.85 Information about applications and complaints should be published in a range of languages. (3.119)

9.86 A recording system that provides an audit trail of the progress of applications should be developed to ensure they are answered in a timely way. This system should be subject to quality assurance. (3.120)

9.87 The complaints coordinator should receive child protection training. (3.121)

9.88 Analysis of complaints should be routinely monitored by the senior management team and patterns and trends appropriately acted on. (3.122)

9.89 Minutes of the young people's consultative meeting should be published to all young people

and should make clear what action has been taken to address identified issues, and action plans produced if required. (3.123)

Health services

9.90 The noise levels in the healthcare department should be addressed urgently to prevent noise transmission between the in-patient and out-patient areas through the gated doors. (4.45)

9.91 The healthcare waiting rooms should be completely refurbished to the standard equivalent to that in the community. (4.46)

9.92 The treatment room in healthcare should be immediately altered to ensure that patients receiving medication do not enter the room. (4.47)

9.93 The treatment room on the young people's unit should be completely refurbished so that it can be used to its full potential, including wing-based nursing. (4.48)

9.94 There should be a dedicated treatment room in healthcare for nurse triaging, dressings and treatments, with a notice on the door indicating when the room is in use to allow the patient a degree of confidentiality and privacy. (4.49)

9.95 There should be at least one cell in healthcare and on the residential wing adapted for young people with disabilities. (4.50)

9.96 Reception screening should include information about ethnicity and any disabilities. (4.51)

9.97 A professional interpreting service should be used to complete any medical questionnaires or consultations and other young people should not be used to interpret clinical interviews. (4.52)

9.98 A secondary health screen should be completed for all young people regardless of their status. (4.53)

9.99 The application (care pathway) procedure should be confidential. The young people should put their applications into a locked healthcare box that is opened daily by the wing nurse. (4.54)

9.100 There should be dedicated discipline staff attached to the healthcare unit to ensure that young people are on time for their appointments, and are taken back without delay and to supervise the healthcare area. (4.55)

9.101 Nurses should be given protected time to run clinics. (4.56)

9.102 The range of nurse-led clinics should be extended to include age-relevant specialties such as epilepsy, acne and asthma. (4.57)

9.103 There should be nurses specialising in the care of young people with disabilities. (4.58)

9.104 Information about healthcare and health promotion leaflets should be available in a range of relevant languages. (4.59)

9.105 An IT system should be introduced for health services. (4.60)

9.106 The optician should provide regular sessions so that all young people on the waiting list have the opportunity to be seen before they are released. (4.61)

9.107 Bags used to transport medication should be secure and kept locked when not in use. (4.62)

9.108 Supplies of non-prescription remedies such as paracetamol should be recorded for all patients and there should be an auditable record particularly for those patients who do not have a current prescription and administration record charts. (4.63)

9.109 The responsible pharmacist should have professional control of the stock supplied. Agreed levels of stock should be adhered to and stock levels kept to a minimum. (4.64)

9.110 The pharmacist should be supported to develop pharmacy-led clinics and medicine use reviews for the population. (4.65)

9.111 A dental hygienist or therapist should be employed. (4.66)

9.112 Admission to healthcare should be solely on clinical need and the decision to admit made only by the clinical team. (4.67)

9.113 The in-patient unit should be supported by a dedicated discipline officer during the full core day. (4.68)

9.114 Primary mental health should include provision for young people who have been victims of sexual and physical abuse. (4.69)

9.115 There should be more primary mental health provision so that all young people referred are seen before they are released. (4.70)

9.116 Mental health awareness training should be provided for discipline and other staff such as education and gym. (4.71)

9.117 Healthcare staff should consistently attend safeguarding and other relevant meetings. (4.72)

9.118 Timed appointments should be introduced to reduce waiting times at clinics. (4.73)

Education, training and library provision

9.119 There should be enough appropriately qualified staff to identify young people with learning disabilities to ensure that their individual needs are met. (5.14)

9.120 All young people should be allocated without delay to courses to meet their assessed needs. (5.15)

9.121 Accredited work-based learning should be introduced as part of the development of the Rowan Centre. (5.16)

9.122 There should be adequate provision to meet the needs of young people under school leaving age. (5.17)

9.123 Better use should be made of individual learning plans to plan and support learning. (5.18)

9.124 Attendance at education should be improved. (5.19)

9.125 Young people should be taken to their lessons and collected at times that ensure lessons start and finish in accordance with the published timetable. (5.20)

9.126 Access to the library should be improved and should include access in the evenings and at weekends. (5.21)

Physical education and health promotion

9.127 Opportunities for accreditation in PE courses should be increased. (5.29)

9.128 Young people should be consulted about why so many refuse to attend PE and the results used to resolve problems and improve attendance. (5.30)

9.129 Showers in the gym should be placed in cubicles and properly supervised by staff. (5.31)

Faith and religious activity

9.130 Members of the chaplaincy team should receive appropriate training about the establishment to enable them properly to fulfil their role. (5.39)

9.131 Members of the chaplaincy team should be allowed to escort young people to and from the chaplaincy. (5.40)

9.132 The chaplaincy team should be better integrated into the wider work of the prison and enabled to develop constructive interventions with young people and attend important planning meetings relating to their care. (5.41)

9.133 Soundproofing in the multi-faith room should be improved. (5.42)

Time out of cell

9.134 Young people should be out of their cell for at least 10 hours every day. (5.54)

9.135 Association and exercise should be cancelled only in exceptional circumstances and a full explanation given to young people. (5.55)

9.136 All young people should have at least one hour of association and one hour in the open air every day. (5.56)

9.137 Association rooms should be appropriately decorated and contain undamaged association equipment. (5.57)

9.138 Association and exercise should be properly supervised by staff. (5.58)

9.139 All young people should have warm weatherproof clothing and shoes to go out in all weather conditions. (5.59)

Security and rules

9.140 Residential managers should ensure that security information reports are submitted in relation to entries in the wing observation book where appropriate and particularly in relation to bullying incidents. (6.9)

9.141 The searching policy should be reviewed. Young people should not be routinely strip searched

and such searches should be carried out only on the authorisation of the duty governor following a rigorous risk assessment. (6.10)

9.142 Information and displays on the rules should be presented in a more user-friendly format. (6.11)

Discipline

9.143 The adjudication standardisation meeting should monitor information related to adjudication hearings and awards to inform tariff reviews and to identify and address any emerging patterns or issues. (6.34)

9.144 Adjudication hearings on young people should be conducted in a more age-appropriate setting. (6.35)

9.145 All young people subject to adjudication should be seen before the hearing to ascertain whether they are fit to defend themselves. (6.36)

9.146 Young people should always be given the opportunity to ask questions of the reporting officer and this should be recorded in adjudication documentation. (6.37)

9.147 Further evaluation of the restorative justice scheme should be conducted to assess its success in reducing incidents of violence. (6.38)

9.148 All use of force documentation should be appropriately certified by a staff member who did not authorise the use of force. (6.39)

9.149 There should be a time out facility for young people who temporarily lose self-control and present a risk of harm to themselves or others. (6.40)

9.150 The use of the special cell should be monitored by the safeguarding committee. (6.41)

9.151 Staff should thoroughly record all interactions with young people in the special cell. (6.42)

9.152 The use of force and safeguarding committees should clearly state what follow-up action is taken in response to identified trends in the use of force. (6.43)

9.153 All planned interventions should be video recorded. (6.44)

9.154 Young people should be thoroughly debriefed and given an opportunity to talk about a use of force incident with an appropriate member of staff as soon as possible afterwards. Records of this should be retained. (6.45)

9.155 Records of the use of the intervention and assessment unit, including the number of young people located there, the reasons and the length of stay, should be collated, monitored and analysed by the senior management team. (6.46)

9.156 The role and function of the intervention and assessment unit should be clarified. It should not be used as a location for vulnerable young people. (6.47)

9.157 The register of strip searches should include all new admissions to the unit and evidence as to why a strip search was authorised. (6.48)

9.158 Young people located in the intervention and assessment unit should be visited daily by their personal officer or wing staff and these visits should be recorded in their unit file. (6.49)

9.159 All young people located in the intervention and assessment unit should have individual care plans. (6.50)

9.160 Young people should usually be able to attend normal education classes and church services unless a thorough risk assessment has deemed this inappropriate. (6.51)

9.161 Young people located in the intervention and assessment unit should have access to gym facilities. (6.52)

Rewards and sanctions

9.162 Published notices about the rewards and sanctions scheme should be available in a range of languages. (6.61)

9.163 Young people should routinely be told by their personal officer or wing staff how they have gained or lost points each week. (6.62)

9.164 The draft behaviour management policy should be published and its effectiveness monitored by the senior management team. (6.63)

9.165 Entries in a young person's points sheet should be signed. (6.64)

9.166 A quality assurance system should be introduced to ensure that rewards and sanctions documentation is fully completed in accordance with the published policy. (6.65)

9.167 Managers should ensure that there is a transparent system to afford equal access to privileges available to young people on level one. (6.66)

Catering

9.168 Meal choices should be planned in consultation with a nutritionist. (7.7)

9.169 Breakfast should be served on the morning it is eaten. (7.8)

9.170 Lunch should be served no earlier than noon and the evening meal not before 5pm. (7.9)

9.171 Non-halal meat should be available. (7.10)

9.172 Staff supervising the serving of meals should ensure that this is done effectively and fairly. (7.11)

9.173 Young people should be able to eat out for every meal. (7.12)

Canteen/shop

9.174 The shop list should be expanded, taking into account healthy food options and the needs of black and minority ethnic young people. (7.18)

9.175 New arrivals should be able to buy items from the shop within a day of arrival. (7.19)

Resettlement strategy

9.176 Young people convicted of a sexual offence and who have been assessed as requiring treatment should have their treatment needs met without delay. (8.11)

9.177 A pre-release course should be developed based on assessed need. (8.12)

Training planning and remand management

9.178 The training planning and initial planning procedures should be combined to produce an integrated planning arrangement. (8.23)

9.179 Efforts should be made to increase attendance of family members at planning reviews. (8.24)

9.180 Targets set at planning reviews should address individual assessed need. (8.25)

9.181 Planning reviews should be conducted in private. (8.26)

9.182 Young people who do not have a GP should be given help to register with one before release. (8.27)

Substance use

9.183 The establishment should implement the substance misuse awareness training programme for operational staff. (8.44)

9.184 Health services should improve first night treatment of young people dependent on alcohol. (8.45)

9.185 Clinical substance misuse services should be extended to provide weekend cover and increased input on the residential wing. (8.46)

9.186 GPs should undertake specialist training in the management of substance misuse. (8.47)

9.187 Specialist clinical advice should be available to doctors treating substance-dependent children and young people. (8.48)

9.188 The establishment should ensure that young people are supervised while waiting to be seen in the out-patient department. (8.49)

9.189 Escorting arrangements to and from the YPSMS unit should be improved. (8.50)

9.190 The adult-oriented procedures of mandatory drug testing are not appropriate for children and young people and should not be applied. (8.51)

Housekeeping points

First days in custody

9.191 Reception staff should record the time the young person moves to the inmate throughcare and support unit on their checklist. (1.54)

9.192 Soap and the means to dry hands should be provided in the toilets for young people in reception holding rooms. (1.55)

9.193 The graffiti on bunk beds in the inmate throughcare and support unit should be removed and lockable cupboards provided. (1.56)

9.194 New arrivals should be told how long their reception pack is to last before they can make a purchase form the shop. (1.57)

Residential units

9.195 The establishment's policy on offensive displays should be enforced. (2.23)

Race equality

9.196 The diversity and race equality action team should have photograph notice boards. (3.66)

Contact with the outside world

9.197 Legal letters opened in error should be recorded. (3.107)

9.198 Seating should be provided for visitors waiting to get into the prison and the visits room. (3.108)

9.199 Information on visiting orders should be accurate. (3.109)

Applications and complaints

9.200 Cover should be available for the complaints coordinator during periods of absence. (3.124)

9.201 Complaint replies should be directly addressed to the young person. (3.125)

Health services

9.202 A children's British National Formulary should be available in the young people's treatment room. (4.74)

9.203 Stock cupboards should be routinely checked for out-of-date medicines. (4.75)

9.204 A means of ventilation should be provided for the dental surgery. (4.76)

9.205 The dental chair should be reupholstered. (4.77)

9.206 Additional lockable storage cabinets should be provided for historic dental clinical records. (4.78)

9.207 Cross infection procedures should be reviewed in the dental surgery and clean and dirty areas clearly demarcated. (4.79)

9.208 Improved quality toothbrushes should be available to buy. (4.80)

Education, training and library provision

9.209 Magazines and newspapers should be available in the library. (5.22)

Catering

9.210 Healthy food options should be highlighted on the menu. (7.13)

9.211 Young people should be encouraged to use the food comment books. (7.14)

Good practice

Race equality

9.212 Young people's wing representatives had participated alongside managers in two-day race equality training. (3.67)

Education, training and library provision

9.213 Some young people developed practical skills and experienced team building through an evening course provided by the West Midlands Fire Service. (5.23)

Resettlement strategy

9.214 The use of aggregated ASSET data to produce an accurate needs analysis was innovative. The application of this data helped to allow services to be designed for the needs of a changing population. (8.13)

Substance use

9.215 The young person's substance misuse service (YPSMS) had developed a comprehensive range of interventions and young people were involved in designing age-appropriate materials. (8.52)

Appendix 1: Inspection team

Anne Owers	HM Chief Inspector of Prisons
Fay Deadman	Team leader
Ian Macfadyen	Inspector
Eileen Bye	Inspector
Joss Crosbie	Inspector
Andrea Walker	Inspector
Margot Nelson-Owen	Healthcare inspector
Sigrid Engelen	Drugs inspector
Samantha Booth	Researcher
Rachel Murray	Researcher
Martyn Rhowbotham	Ofsted
Allan Hatcher	Ofsted
Clare Yardley	Estyn

Appendix 2: Prison population profile

Population breakdown by:

(i) Status	Number of juveniles	%
Sentenced	84	85
Convicted but unsentenced	3	3
Remand	12	12
Detainees (single power status)	0	0
Detainees (dual power status)	0	0
Total	**99**	**100**

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

Sentence	4 mths	6 mths	8 mths	10 mths	12 mths	18 mths	24 mths	Total
Age								**0**
15 years		3	1		2	2		**8**
16 years	4	1	3	2	4	3	3	**20**
17 years	5	7	7	5	7	4	4	**39**
18 years	1	1				1		**3**
Total	**10**	**12**	**11**	**7**	**13**	**10**	**7**	**70**

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

Sentence	Under 2 yrs	2-3 yrs	3-4 yrs	4-5 yrs	5 yrs +	Total
Age						**0**
15 years						**0**
16 years		3	1			**4**
17 years			1	1	2	**4**
18 years						**0**
Total	**0**	**3**	**2**	**1**	**2**	**8**

(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						
17 years		1		1	2	4
18 years						
Total		**1**		**1**	**2**	**4**

(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					
18 years		1			**1**
Total		**1**			**1**

(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							
16 years	4	2	2				**8**
17 years	4	2		1			**7**
18 years							
Total	**8**	**4**	**2**	**1**			**15**

(vii) Main offence	**Number of juveniles**	**%**
Violence against the person	16	16
Sexual offences	4	4
Burglary	11	11
Robbery	30	31
Theft & handling	11	11
Fraud and forgery	0	0
Drugs offences	2	2
Driving offences	4	4

Other offences	16	16
Breach of community part of DTO	5	5
Civil offences		
Offence not recorded/ Holding warrant		
Total	**99**	**100**

(viii) Age	Number of juveniles	%
15 years	8	8
16 years	33	33
17 years	54	55
18 years	4	4
Total	**99**	**100**

(ix) Home address	Number of juveniles	%
Within 50 miles of the prison	83	84
Between 50 and 100 miles of the prison	11	11
Over 100 miles from the prison	4	4
Overseas	0	0
NFA	1	1
Total	**99**	**100**

(x) Nationality	Number of juveniles	%
British	88	89
Foreign nationals	11	11
Total	**99**	**100**

(xi) Ethnicity	Number of juveniles	%
White		
British	52	53
Irish	1	1
Other White	1	1
Mixed		
White and Black Caribbean	4	4

White and Black African		
White and Asian	2	2
Other Mixed	1	1
Asian or Asian British		
Indian	5	5
Pakistani	8	8
Bangladeshi		
Other Asian	4	4
Black or Black British		
Caribbean	17	17
African	4	4
Other Black		
Chinese or other ethnic group		
Chinese		
Other ethnic group		
Total	**99**	**100**

Appendix 3: Summary of juvenile questionnaires and interviews

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

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

At the time of the survey on 24 June 2008, the juvenile population at HMYOI Brinsford was 103. The sample size was 81. Overall, this represented 79% of the juvenile population.

Selecting the sample

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

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

Interviews were carried out with any respondents with literacy difficulties. In total, four respondents were interviewed.

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
- seal the questionnaire in the envelope provided and leave it in their room for collection

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

Response rates

In total, 69 respondents completed and returned their questionnaires. This represented 67% of the juvenile population. The response rate was 85%. In addition to the six respondents who refused to complete a questionnaire, two 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 has been weighted in order to mimic a consistent percentage sampled in each establishment.

Presented alongside the results from this survey are the comparator figures for all juveniles surveyed in young offender institutions. This comparator is based on all responses from juvenile surveys carried out in 14 juvenile establishments since 2005. In addition, this document shows statistically significant differences between the responses of juveniles surveyed at HMYOI Brinsford in 2007 and the responses of this 2008 survey. 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, i.e. the difference is not due to chance alone. Results that are significantly better are indicated by green shading, results that are significantly worse are indicated by blue shading and where there is no significant difference, there is no shading.

It should be noted that, in order for statistical comparisons to be made between the most recent survey data and that 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.

Juvenile Survey Responses HMYOI Brinsford 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 (1) A comparison between the responses from all juveniles surveyed in this establishment with all those surveyed for the juvenile comparator, (2) A comparison with the last survey results from this establishment. Due to changes to the questionnaire not all questions are comparable.

Key to tables

		HMYOI Brinsford	Juvenile Comparator		HMYOI Brinsford 2008	HMYOI Brinsford 2007
(green)	Any percent highlighted in green is significantly better than the juvenile comparator / the last survey data					
(blue)	Any percent highlighted in blue is significantly worse than the juvenile comparator / the last survey data					
	Percentages which are not highlighted show there is no significant difference between the 2008 survey and the juvenile comparator / or between the 2007 and the 2008 survey data					
	Number of completed questionnaires returned	69	977		69	90
	SECTION 1: ABOUT YOU (Not tested for significance)					
1.1	Are you 18 years of age?	**10%**	**15%**		**10%**	**10%**
1.2	Do you usually live in this country?	**93%**	**97%**		**93%**	**100%**
1.3	Is English your first language?	**85%**	**92%**		**85%**	**94%**
1.4	Are you from a minority ethnic group? (including all those who did not tick White British, White Irish or White Other category)	**51%**	**28%**		**51%**	**50%**
1.5	Do you have any children?	**6%**	**9%**		**6%**	**15%**
1.6	Have you ever been in care? (either foster care or children's home)	**21%**	**28%**		**21%**	**25%**
1.7	Are you on a care order now?	**6%**	**12%**		**6%**	**12%**
	SECTION 2: ABOUT YOUR SENTENCE (Not tested for significance)					
2.2	Are you sentenced?	**76%**	**80%**		**76%**	**81%**
2.3	Is your sentence 12 months or less?	**45%**	**39%**		**45%**	**39%**
2.4	Do you have less than six months to serve?	**50%**	**55%**		**50%**	**56%**
2.5	Have you been in this prison less than a month?	**24%**	**21%**		**24%**	**15%**
2.6	Have you been to any other YOI during this sentence?	**24%**	**31%**		**24%**	**24%**
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?	**51%**	**41%**		**51%**	**37%**
	SECTION 3: COURTS, TRANSFERS AND ESCORTS					
3.1	We want to know about the most recent journey you have made either to or from court or between establishments? Was the van clean?	**36%**	**45%**		**36%**	**29%**
3.2	We want to know about the most recent journey you have made either to or from court or between establishments? Was the van comfortable?	**7%**	**11%**		**7%**	**7%**
3.3	We want to know about the most recent journey you have made either to or from court or between establishments? Did you feel safe?	**68%**	**66%**		**68%**	**52%**
3.4	We want to know about the most recent journey you have made either to or from court or between establishments? Did you have enough comfort breaks?	**7%**	**15%**		**7%**	**4%**
3.5	We want to know about the most recent journey you have made either to or from court or between establishments? Were your health needs looked after?	**32%**	**49%**		**32%**	**43%**
3.6	Did you spend more than four hours in the van?	**6%**	**8%**		**6%**	**3%**
3.7	Were you treated well/very well by the escort staff?	**63%**	**64%**		**63%**	**48%**
3.8	Did you know where you were going when you left court or when transferred from another establishment?	**69%**	**80%**		**69%**	**76%**
3.9	Did you receive written information about what would happen to you before you arrived?	**22%**	**24%**		**22%**	**24%**

Comparison with Juvenile benchmark and previous survey results.

Key to tables

Key	Description
Green	Any percent highlighted in green is significantly better than the juvenile comparator / the last survey data
Blue	Any percent highlighted in blue is significantly worse than the juvenile comparator / the last survey data
(none)	Percentages which are not highlighted show there is no significant difference between the 2008 survey and the juvenile comparator / or between the 2007 and the 2008 survey data

		HMYOI Brinsford	Juvenile Comparator		HMYOI Brinsford 2008	HMYOI Brinsford 2007
	Number of completed questionnaires returned	69	977		69	90
	SECTION 4: YOUR FIRST FEW DAYS HERE					
4.1	Did you have any problems when you first arrived?	70%	70%		70%	56%
4.2	When you first arrived here did your property arrive at the same time as you?	90%	81%		90%	83%
4.3	Were you told what you needed to know by the staff when you first arrived?	64%	70%		64%	55%
4.4	Were you in reception for less than 2 hours?	70%	78%		70%	82%
4.5	Were you seen by a member of healthcare staff in reception?	82%	89%		82%	79%
4.6	When you were searched was this carried out in an understanding way?	70%	81%		70%	74%
4.7	Were you treated well/very well in reception?	53%	68%		53%	55%
4.8	Were you able to make a telephone call to your family/friends on your first day here?	51%	81%		51%	81%
4.9a	Did you have access to a chaplain within the first 24 hours of you arriving at this prison?	31%	41%		31%	41%
4.9b	Did you have access to someone from healthcare within the first 24 hours of you arriving at this prison?	54%	56%		54%	53%
4.9c	Did you have access to a Listener/Samaritans within the first 24 hours of you arriving at this prison?	12%	14%		12%	17%
4.9d	Did you have access to the prison shop/canteen within the first 24 hours of you arriving at this prison?	6%	18%		6%	16%
4.10	Did you feel safe on your first night here?	81%	81%		81%	72%
4.11	Did you go on an induction course within your first week?	46%	61%		46%	56%
4.12	Did the induction course cover everything you needed to know about the prison?	35%	51%		35%	39%
	SECTION 5: DAILY LIFE HERE					
5.1	Is it easy/very easy for you to attend religious services?	49%	52%		49%	57%
5.2	Does the shop/canteen sell a wide enough range of goods to meet your needs?	41%	49%		41%	30%
5.3	Do you find the food here good/very good?	13%	24%		13%	2%
5.4	Have you talked to an advocate since you have been here (an outside person to help you with the authorities)?	34%	33%		34%	27%
5.5	Are you normally able to shower everyday if you want to?	47%	56%		47%	9%
5.6	Is your cell call bell normally answered within five minutes?	44%	31%		44%	40%
	SECTION 6: HEALTHCARE					
6.1	Do you think the overall quality of the healthcare is good/very good?	47%	57%		47%	32%
6.2a	Is it easy for you to see the Doctor?	32%	50%		32%	32%
6.2b	Is it easy for you to see the Nurse?	58%	70%		58%	61%
6.2c	Is it easy for you to see the Dentist?	19%	24%		19%	14%
6.2d	Is it easy for you to see the Optician?	14%	19%		14%	10%
6.3	Have you had any problems getting your medication?	21%	15%		21%	19%
6.4	Have you received any help with any alcohol problems?	19%	26%		19%	20%
6.5	Have you received any help with any drugs problems?	36%	35%		36%	39%

Comparison with Juvenile benchmark and previous survey results.

Key to tables

(green)	Any percent highlighted in green is significantly better than the juvenile comparator / the last survey data	HMYOI Brinsford	Juvenile Comparator		HMYOI Brinsford 2008	HMYOI Brinsford 2007
(blue)	Any percent highlighted in blue is significantly worse than the juvenile comparator / the last survey data					
	Percentages which are not highlighted show there is no significant difference between the 2008 survey and the juvenile comparator / or between the 2007 and the 2008 survey data					
	Number of completed questionnaires returned	69	977		69	90
	SECTION 7: REWARDS, SANCTIONS AND COMPLAINTS					
7.1	Are you on the enhanced (Top) level of the reward scheme?	30%	24%		30%	17%
7.2	Do the different levels make you change your behaviour?	57%	60%		57%	54%
7.3	Do you feel you have been treated fairly in your experience of the reward scheme?	52%	53%		52%	46%
7.4	Do you know how to make a complaint?	75%	83%		75%	84%
7.5	Is it easy to make a complaint?	30%	42%		30%	39%
7.6	Do you feel complaints are sorted out fairly?	10%	17%		10%	8%
7.7	Have you ever been made to or encouraged to withdraw a complaint?	6%	9%		6%	10%
	SECTION 8: DISCIPLINE AND RESPECT					
8.1	Have you had a 'nicking' (adjudication or minor report) since you have been here?	35%	58%		35%	43%
8.2	Have you been physically restrained (Cand R) since you have been here?	28%	27%		28%	17%
8.3	If you have spent a night in the segregation/care and separation unit, did the staff treat you well/very well?	15%	10%		15%	4%
8.4	Do most staff treat you with respect?	78%	74%		78%	68%
	SECTION 9: SAFETY					
9.1	Have you ever felt unsafe in this prison?	38%	27%		38%	39%
9.3	Has another young person or group of young people victimised (insulted or assaulted) you here?	35%	23%		35%	29%
9.4a	If you have felt victimised by a prisoner/group of prisoners, what did the incident(s) involve: Insulting remarks?	18%	14%		18%	17%
9.4b	If you have felt victimised by a prisoner/group of prisoners, what did the incident(s) involve: Physical abuse?	21%	8%		21%	14%
9.4c	If you have felt victimised by a prisoner/group of prisoners, what did the incident(s) involve: Sexual abuse?	3%	1%		3%	1%
9.4d	If you have felt victimised by a prisoner/group of prisoners, what did the incident(s) involve: Racial or Ethnic abuse?	9%	3%		9%	5%
9.4e	If you have felt victimised by a prisoner/group of prisoners, what did the incident(s) involve: Drugs?	6%	1%		6%	3%
9.4d	If you have felt victimised by a prisoner/group of prisoners, what did the incident(s) involve: Having your canteen/property taken?	10%	5%		10%	12%
9.4e	If you have felt victimised by a prisoner/group of prisoners, what did the incident(s) involve: Because you were new here?	10%	8%		10%	6%
9.4f	If you have felt victimised by a prisoner/group of prisoners, what did the incident(s) involve: Being from a different part of the country than others?	7%	7%		7%	5%
9.6	Has a member of staff or group of staff victimised (insulted or assaulted) you here?	25%	20%		25%	21%
9.7a	If you have felt victimised by a staff/group of staff, what did the incident(s) involve: Insulting remarks?	14%	12%		14%	8%
9.7b	If you have felt victimised by a staff/group of staff, what did the incident(s) involve: Physical abuse?	12%	4%		12%	8%
9.7c	If you have felt victimised by a staff/group of staff, what did the incident(s) involve: Sexual abuse?	3%	1%		3%	0%
9.7d	If you have felt victimised by a staff/group of staff, what did the incident(s) involve: Racial or Ethnic abuse?	9%	2%		9%	1%
9.7e	If you have felt victimised by a staff/group of staff, what did the incident(s) involve: Drugs?	3%	1%		3%	2%
9.7f	If you have felt victimised by a staff/group of staff, what did the incident(s) involve: Having your canteen/property taken?	7%	1%		7%	5%
9.7g	If you have felt victimised by a staff/group of staff, what did the incident(s) involve: Because you were new here?	9%	2%		9%	4%
9.7h	If you have felt victimised by a staff/group of staff, what did the incident(s) involve: Being from a different part of the country than others?	6%	2%		6%	2%
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?	63%	62%		63%	48%
9.10	If you did tell a member of staff that you were being victimised do you think it would be taken seriously?	25%	40%		25%	26%
9.11	When you first arrived here did other young people shout through the windows at you?	39%	36%		39%	43%
9.12	Did you find this shouting threatening?	19%	13%		19%	22%
9.13	Do other young people shout through the windows at you now?	47%	27%		47%	40%
9.14	Do you find this threatening now?	6%	7%		6%	13%
9.15	Do you shout through the windows at others?	41%	28%		41%	30%
9.16	Have staff checked on you personally in the last week to see how you are getting on?	33%	34%		33%	19%

Comparison with Juvenile benchmark and previous survey results.

Key to tables

Key	Description	HMYOI Brinsford	Juvenile Comparator		HMYOI Brinsford 2008	HMYOI Brinsford 2007
(green)	Any percent highlighted in green is significantly better than the juvenile comparator / the last survey data					
(blue)	Any percent highlighted in blue is significantly worse than the juvenile comparator / the last survey data					
	Percentages which are not highlighted show there is no significant difference between the 2008 survey and the juvenile comparator / or between the 2007 and the 2008 survey data					
	Number of completed questionnaires returned	69	977		69	90
	SECTION 10: ACTIVITIES					
10.1	Were you under the age of 14 when you were last at school?	42%	42%		42%	41%
10.2a	Have you ever been excluded from school?	84%	88%		84%	76%
10.2b	Have you ever truanted from school?	61%	74%		61%	74%
10.3	Are you doing any education here?	74%	83%		74%	98%
10.4	Is education helping you?	55%	57%		55%	57%
10.5	Do you feel you need help with reading, writing or maths?	37%	31%		37%	29%
10.6	Were the teachers understanding with any school problems when you first arrived?	45%	51%		45%	58%
10.7a	Are you learning a skill or trade?	42%	52%		42%	46%
10.7b	Are you in a job here?	4%	33%		4%	8%
10.8	Do you go to the gym more than 5 times each week?	1%	12%		1%	1%
10.9	Do you go on association more than 5 times each week?	4%	46%		4%	0%
10.10	Can you go outside for exercise everyday?	15%	30%		15%	6%
	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?	28%	52%		28%	9%
11.2	Have you had any problems getting access to the telephones?	50%	32%		50%	62%
11.3	Have you had any problems with sending or receiving mail?	28%	32%		28%	26%
11.4	Is it easy/very easy for you family and friends to get here to visit you?	55%	33%		55%	42%
11.5	Do you get 2 or more visits each month?	45%	47%		45%	56%
11.6	Do you arrive on time for a visit?	63%	66%		63%	64%
11.7	Are you and your family/friends treated well/very well by visits staff?	53%	60%		53%	51%
	SECTION 12: RESETTLEMENT					
12.1	Did you meet your personal officer within your first week here?	19%	42%		19%	19%
12.2	Do you feel helped by your personal officer?	39%	48%		39%	30%
12.3	Do you know what targets you have been set in your training/sentence plan?	46%	59%		46%	70%
12.4	If you want, can you see your training/sentence plan?	24%	35%		24%	13%
12.5	Has your YOT/social worker/probation officer been in touch since you arrived here?	82%	79%		82%	82%
12.6	Do you know how to get in touch with your YOT/social worker/probation officer?	43%	57%		43%	48%
12.7	Do you want to stop offending?	68%	71%		68%	73%
12.9	Have you had a say in what will happen to you when you are released?	36%	42%		36%	38%
12.10	When you are released will you be living with a family member?	81%	66%		81%	74%
12.11	Have you had help with finding accommodation?	19%	25%		19%	21%
12.12	Are you going to school or college on release?	58%	36%		58%	42%
12.13	Has anyone spoken to you about going to college on release?	47%	35%		47%	27%
12.14	Do you have a job to go to on release?	31%	26%		31%	20%
12.15	Have you done anything during your time here that you think will help you to get a job on release?	34%	44%		36%	51%
12.16	Has anyone from here spoken to you about getting a job on release or about New Deal?	22%	24%		22%	13%
12.17	Do you have a Connexions personal adviser?	26%	35%		26%	23%
12.18	Is there anything you would still like help with before you are released?	33%	39%		33%	40%
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?	37%	42%		37%	45%

Key Question Responses (Ethnicity) HMYOI Brinsford 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

Key		BME juveniles	White juveniles
(green)	Any percent highlighted in green is significantly better than the responses from White juveniles		
(blue)	Any percent highlighted in blue is significantly worse than the responses from White juveniles		
(white)	Percentages which are not highlighted show there is no significant difference between the responses from BME juveniles and White juveniles		
	Number of completed questionnaires returned	**35**	**34**
2.2	Are you sentenced? **Not tested for significance**	**69%**	**82%**
2.6	Have you been to any other YOI during this sentence? **Not tested for significance**	**25%**	**24%**
1.6	Have you ever been in care? (foster care/children's home) **Not tested for significance**	**14%**	**26%**
1.7	Are you on a care order now? **Not tested for significance**	**8%**	**2%**
3.7	Were you treated well/very well by the escort staff?	**51%**	**74%**
4.2	When you first arrived here did your property arrive at the same time as you?	**88%**	**92%**
4.6	Please answer the following question about your first few days here: When you were searched was this carried out in an understanding way?	**62%**	**80%**
4.7	Were you treated well/very well in reception?	**48%**	**59%**
4.1	Did you feel safe on your first night here?	**67%**	**94%**
4.11	Did you go on an induction course within your first week?	**41%**	**50%**
5.1	Is it easy/very easy for you to attend religious services?	**50%**	**47%**
5.2	Does the shop/canteen sell a wide enough range of goods to meet your needs?	**25%**	**60%**
5.3	Do you find the food here good/very good?	**8%**	**18%**
6.1	Do you think the overall quality of the healthcare is good/very good?	**38%**	**56%**
8.1	Have you had a 'nicking' (adjudication or minor report) since you have been here?	**43%**	**28%**
8.2	Have you been physically restrained (Cand R) since you have been here?	**35%**	**20%**
8.3	If you have spent a night in the segregation/care and separation unit, did the staff treat you well/very well?	**17%**	**13%**
5.4	Have you talked to an advocate since you have been here (an outside person to help you with the authorities)?	**39%**	**29%**
7.1	Are you on the enhanced (Top) level of the reward scheme?	**35%**	**25%**
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?	**43%**	**61%**
7.6	Please answer the following question about complaints: Do you feel complaints are sorted out fairly?	**14%**	**6%**
5.5	Are you normally able to shower everyday if you want to?	**38%**	**56%**
5.6	Is your cell call bell normally answered within five minutes?	**45%**	**43%**
8.4	Do most staff treat you with respect?	**77%**	**79%**
9.1	Have you ever felt unsafe in this prison?	**40%**	**37%**
9.3	Has another young person or group of young people victimised (insulted or assaulted) you here?	**38%**	**32%**
9.4d	If you have felt victimised by a prisoner/group of prisoners, what did the incident(s) involve: Racial or Ethnic abuse?	**13%**	**6%**

Key to tables

		BME juveniles	White juveniles
(green)	Any percent highlighted in green is significantly better than the responses from White juveniles		
(blue)	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 between the responses from BME juveniles and White juveniles		
9.6	Has a member of staff or group of staff victimised (insulted or assaulted) you here?	40%	**8%**
9.7d	If you have felt victimised by a staff/group of staff, what did the incident(s) involve: Racial or Ethnic abuse?	**13%**	**6%**
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?	**57%**	**67%**
9.16	Have staff checked on you personally in the last week to see how you are getting on?	**24%**	**44%**
10.3	Are you doing any education here?	**81%**	**68%**
10.4	Is education helping you?	**57%**	**51%**
10.7	Are you learning a skill or trade?	**44%**	**41%**
10.7	Are you in a job here?	**7%**	**2%**
10.8	Do you go to the gym more than five times each week?	**0%**	**2%**
10.9	Do you go on association more than 5 times each week?	**2%**	**6%**
1010	Can you go outside for exercise everyday?	**19%**	**8%**
11.2	Have you had any problems getting access to the telephones?	**54%**	**45%**
11.3	Have you had any problems with sending or receiving mail?	**37%**	**20%**
11.5	Do you get 2 or more visits each month?	**40%**	**50%**
11.7	Are you and your family/friends treated well/very well by visits staff?	**50%**	**56%**
12.1	Did you meet your personal officer within your first week here?	**20%**	**18%**
12.2	Do you feel helped by your personal officer?	**38%**	**39%**
12.3	Do you know what targets you have been set in your training/sentence plan?	32%	**61%**
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?	**37%**	**37%**
12.14	Please answer the following questions on preparation for release: Do you have a job to go to on release?	**28%**	**33%**
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?	**33%**	**39%**
12.18	Please answer the following questions on preparation for release: Is there anything you would still like help with before you are released?	**37%**	**28%**
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?	**27%**	**47%**