Report on an unannounced inspection of

HMYOI Cookham Wood

by HM Chief Inspector of Prisons

9–13 August 2021

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Introduction

Providing relatively new accommodation, Cookham Wood in Kent is a well-established young offender institution (YOI) that has been largely redeveloped in recent years. The institution can hold up to 188 boys between the ages of 15 and 18, but due to reductions in the population of children in custody during the COVID-19 pandemic, at the time of our inspection there were just 87 boys in residence. Coming from the greater part of south and south-east England, these boys had varying status, ranging from those recently remanded to those serving indeterminate sentences for the most serious of offences. The risks associated with the detention of such young people mean that this is the latest in a series of annual inspections, although there was some interruption during the pandemic.

When we last fully inspected Cookham Wood in 2019, we were concerned to find that outcomes for children were not sufficiently good against any of our four tests of a healthy institution. At this inspection we found they had not improved and had in fact worsened in our purposeful activity test, where outcomes were now poor. For an institution providing services to children this inability to address failings was completely unacceptable. Admittedly the restrictions imposed by the pandemic had not helped, but it was hard to understand why the institution had not been more ambitious in, for example, providing a better regime, perhaps adopting an approach that mirrored more closely that adopted for children in the community or at other YOIs. As it was, we found parts of the prison where more than half of children were locked in cell during the school day and typically spent as little as four hours a day out of cell, and just two hours at weekends.

We found low morale among staff, low standards, low expectations and a lack of energy and creativity that could engage and motivate children to use their time at Cookham Wood usefully, despite holding only half the young people it was resourced to hold. The response to difficulties found between children was invariably limited to keeping them apart, placing further restrictions on the regime. Leaders needed to find ways to move beyond this reactive and limiting approach, starting with energetic and motivational engagement with children, as well as the clear demarcation and enforcement of standards.

The key to this is good local leadership and national leadership through HM Prison and Probation Service (HMPPS). Since we last inspected a new governor and a further six senior managers had been appointed. The governor was beginning to implement a business plan which prioritised reducing violence, the creation of communities and investing in staff. These priorities seemed reasonable, although it was too early to discern progress and we were not convinced that staff were fully aware or engaged with this vision. Their engagement was not, however, optional. Staff needed clarity about what was expected of them and leaders needed to show greater rigour in ensuring policies were understood and delivered. Poor practice and behaviour needed to be challenged consistently, and staff needed to make sure basic standards were maintained.

We encourage close scrutiny by HMPPS, and the provision of support to assist the new governor of Cookham Wood. There needs to be a shared and collective determination that establishes how and when improvements will be made.

Charlie Taylor
HM Chief Inspector of Prisons
September 2021

About HMYOI Cookham Wood

Task of the establishment
HMYOI Cookham Wood is a young offender institution for boys aged 15 to 18.

Certified normal accommodation and operational capacity (see Glossary of terms)
Children held at the time of inspection: 87
Baseline certified normal capacity: 193
In-use certified normal capacity: 188
Operational capacity: 188

Population of the establishment
- Approximately 29 new children were received each month.
- There were 16 foreign national children.
- 79% of children were from black and minority ethnic backgrounds.
- 50% of children were on remand.
- Around 15 children were released into the community each month.
- 62% would become adults while in custody on their current sentence or remand (33%remand, 29% sentenced).
- 75% of children had been excluded from mainstream education before coming into custody.
- 22% of children had experienced being in the care of their local authority at some point before coming into custody.

Establishment status (public or private) and key providers
Public

Physical health provider: Oxleas NHS Foundation Trust
Mental health provider: Central and North West London Foundation Trust
Substance use treatment provider: Open Road
Prison education framework provider: Novus
Escort contractor: Serco

Prison group/Department
Youth Custody Service

Brief history
HMYOI Cookham Wood was built in the 1970s, originally for young men, but its use was changed in the late 1990s, to meet the growing need for secure female accommodation at the time. In 2007/08, it changed its function again, to accommodate 15–17-year-old male prisoners, to reduce capacity pressures in London and the South-East for this age group.

In January 2014, a new purpose-built residential unit was opened, incorporating integrated facilities and designed to meet the needs of the young people and improve safety.

Short description of residential units
One main residential unit is split into A and B wings, with 176 single cells, each with an integral telephone and shower, spread over six self-contained landings. There is one room to accommodate a young person with a disability.

B1 aims to provide additional support to those young people identified as posing a risk to and/or from themselves and others.

B3 is the reverse cohort unit/induction unit.

Cedar unit is separate to the main residential building, holding some children who access release on temporary licence, and enhanced children in full-time education.

Name of governor and date in post
Simon Drysdale, interim governor since October 2020

Leadership changes since the last inspection
Paul Durham was the previous governor, in post at the last inspection.

Prison Group Director
Heather Whitehead

Independent Monitoring Board chair
Keith Morrison

Date of last inspection
9–20 September 2019

Section 1 Summary of key findings

1.1 We last inspected HMYOI Cookham Wood in 2019 and made 32 recommendations, 14 of which were about areas of key concern. The establishment fully accepted 26 of the recommendations and partially (or subject to resources) accepted six.

1.2 Section 7 contains a full list of recommendations made at the last full inspection and the progress against them.

Progress on key concerns and recommendations

1.3 Our last inspection of HMYOI Cookham Wood took place before the COVID-19 pandemic and the recommendations in that report focused on areas of concern affecting outcomes for children at the time. Although we recognise that the challenges of keeping children safe during COVID-19 will have changed the focus for many prison leaders, we believe that it is important to report on progress in areas of key concern to help leaders to continue to drive improvement.

1.4 At our last full inspection, we made four recommendations about key concerns in the area of safety. At this inspection, we found that one of those recommendations had been achieved, and three had not been achieved.

1.5 We made three recommendations about key concerns in the area of care. At this inspection, we found that all three had not been achieved.

1.6 We made four recommendations about key concerns in the area of purposeful activity. At this inspection, we found that one had not been achieved. Ofsted carried out a progress monitoring visit alongside our inspection, to assess the progress that leaders and managers had made towards reinstating a full education, skills and work curriculum. They judged that it was too early to assess whether three recommendations made at the last inspection had been achieved.

1.7 We made three recommendations about key concerns in the area of resettlement. At this inspection, we found that one of those recommendations had been achieved and two had not been achieved.

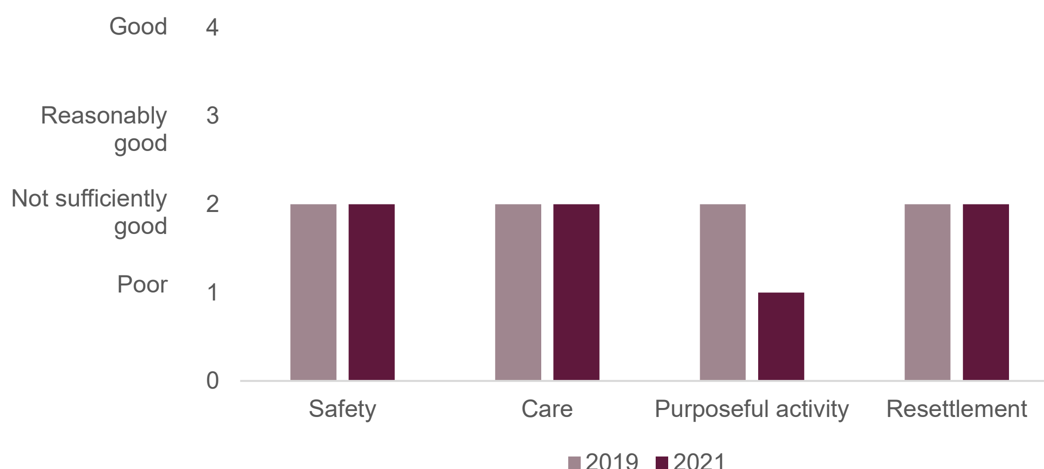
Outcomes for children

1.8 We assess outcomes for children against four healthy establishment tests (see Appendix I for more information). We also include a commentary on leadership in the establishment (see Section 2).

1.9 At this inspection of HMYOI Cookham Wood, we found that outcomes for children had stayed the same in three healthy prison areas, improved in none and declined in one.

1.10 These judgements seek to make an objective assessment of the outcomes experienced by those detained and have taken into account the establishment's recovery from COVID-19 as well as the 'regime stage' at which the establishment was operating, as outlined in the HM Prison and Probation (HMPPS) National Framework for prison regimes and services.

Figure 1: HMYOI Cookham Wood healthy establishment outcomes 2019 and 2021



Safety

At the last inspection of Cookham Wood, in 2019, we found that outcomes for children were not sufficiently good against this healthy establishment test.

At this inspection, we found that outcomes for children remained not sufficiently good.

1.11 The new escort provision from police and court custody had led to fewer children arriving at the prison late at night and had stopped unnecessarily long journeys to multiple destinations, as children were no longer transported with adults. Procedures were in place to ensure the safety of children on arrival and during their first night in custody. Good introductory information about the establishment was provided by staff on the first night unit. However, the remainder of the induction programme, which included important information, was rarely completed by children before they left the unit.

1.12 Children's perceptions of safety had improved, but in our survey 18% of respondents said that they had felt unsafe at some point during their time at Cookham Wood. Child protection and safeguarding referrals were well managed and there were good relationships with the local authority. Safeguarding officers conducted daily checks on the children who were identified as the most vulnerable. However, because of regular cross-deployment of staff to other units, officers had insufficient time to have meaningful engagement with the children.

1.13 The number of incidents of self-harm had reduced and was low. The quality of assessment, care in custody and teamwork (ACCT) case management documents for children at risk of suicide or self-harm had deteriorated. Oversight of this process was poor, and the quality assurance process was ineffective. However, children we spoke to who were at risk of self-harm felt supported by staff.

1.14 Levels of violence had increased since the previous inspection and were very high. Some of these incidents were serious in nature. Staff set low standards on the living units and did not adequately challenge anti-social behaviour, endemic graffiti or the high levels of noise throughout the day and at night. Many residential staff were unaware of the multiple plans, targets and case formulations that children were subject to. There was an over-reliance on keeping children apart in small groups to manage conflict. This and the poor provision of activities and time unlocked for many created an uninspiring living environment.

1.15 Levels of use of force had reduced since the previous inspection. Oversight was good and appropriately challenged poor practice. In many incidents a large number of officers responded and were not swiftly stood down when the situation was under control. On occasion this led to confusion and hindered attempts to deescalate incidents. Body-worn video cameras were well used during incidents.

1.16 Appropriately, the segregation unit had been closed since the previous inspection and children were now separated in their own cell. However, oversight of self-isolation and Rule 49 (good order or discipline) was lacking. The regime that separated children received was not recorded regularly, and when it was it the regime provided was poor. In one case over a nine-day separation, the child did not leave his cell for four days, and on two other days he had left it for just 30 minutes.

Care

At the last inspection of Cookham Wood in 2021, we found that outcomes for children were not sufficiently good against this healthy establishment test.

At this inspection, we found that outcomes for children remained not sufficiently good.

1.17 In our survey, more children than at the time of the previous inspection said that most staff treated them with respect. We found relationships to be better on the specialist units (B1, B3 and Cedar) than elsewhere, but expectations of children generally were too low and we saw too many examples of staff not engaging with children during exercise or association. There was no system to make sure that children had regular, meaningful contact with a named officer, and most residential staff we spoke to were not aware of children’s progress in areas such as education and sentence plans. Peer support was underdeveloped.

1.18 Although the accommodation was modern, communal areas and cells were grubby and untidy. The extensive and offensive graffiti in cells, communal areas and exercise yards was emblematic of the generally poor standards. Most cells were furnished adequately, and children had reasonable access to cleaning materials. Managers had recently introduced laptop computers for children in their cells, which enabled them to submit shop orders, applications and food choices. The quality and quantity of food were reasonable, but children ate most of their meals alone in their cell. Consultation with children had recently restarted, but was not yet effective or influencing meaningful change.

1.19 The promotion of strategic management of equality and diversity remained weak. Equality monitoring data to identify differences in treatment did not lead to action, and investigations into discrimination complaints were either poor or did not take place at all. Equality officers were regularly cross-deployed, so were unable to fulfil their role successfully. We were, however, told that the appointment of a new manager for this team was imminent. The chaplaincy provided good pastoral support and delivered a suitable range of religious services.

1.20 Partnership working and governance structures were in place across the health care providers. Primary care services were well led and the provision was efficient. Primary mental health care interventions were delivered by a well-resourced nursing and multidisciplinary team. However, access to children was limited by the complicated unlock procedures and a lack of suitable rooms to deliver mental health interventions. Despite substantial investment, the Framework for Integrated Care (Secure Stairs) (see Glossary of terms) was not operating effectively. The substance misuse team delivered a range of psychosocial interventions, including ‘through-the-gate’ support for up to three months post-release. Clinical substance misuse interventions were available if the need arose. Pharmacy services were well organised, with improved oversight since the last inspection. Dental provision was good.

Purposeful activity

At the last inspection of Cookham Wood, in 2019, we found that outcomes for children were not sufficiently good against this healthy establishment test.

At this inspection, we found that outcomes for children were now poor.

1.21 Ofsted carried out a progress monitoring visit of the establishment alongside our full inspection, and the purposeful activity judgement incorporates their assessment of progress. Ofsted’s full findings and the recommendations arising from their visit are set out in Section 5.

1.22 The amount of time that children could expect to spend out of their cell was poor, at around four and a half hours a day on weekdays and two hours at weekends. Those who were segregated or isolating received

even less, with a maximum of two hours out of their cells per day throughout the week.

1.23 Access to the library was good, with each child having 30 minutes' access each week. Children who were segregated, isolating because of COVID-19 or had just arrived did not have access and had to order books from a list through wing staff. There were good indoor and outdoor gym facilities. Most children spent three hours a week in the gym and had a good variety of activity.

1.24 Children were not able to access enough hours of education. They could attend classes for a maximum of only 12 hours a week, but in many cases they received far less than this. Too many learners attended activities that did not match their career aspirations or next steps. Attendance at education classes was poor. Children did not undertake enough learning outside formal education lessons. They felt frustrated, justifiably, that they spent too much time in their cell without doing anything purposeful.

1.25 Too many vocational training courses were not delivered or ran intermittently. This was, in part, due to staff vacancies and shortages, both from the prison and the education provider. Too few children developed their mathematics, information and communications technology, or English skills at satisfactory rates. By contrast, there were good standards of learning and work in food hygiene and music technology. Learning support practitioners were used well to support learners with special educational needs and disability.

1.26 The quality of children's written work was, too often, not good enough. Teachers did not correct learners' errors thoroughly.

Resettlement

At the last inspection of Cookham Wood, in 2019, we found that outcomes for children were not sufficiently good against this healthy establishment test.

At this inspection, we found that outcomes for children remained not sufficiently good.

1.27 Despite good in-person and remote visits provision, few children accessed either. In addition, they were frustrated, justifiably, by delays in receiving mail, and in approving telephone numbers.

1.28 Leadership of resettlement had improved. A needs analysis was in place, with an action plan that drove improvement. Case workers held an average caseload of nine children, which was not excessive. However, the allocation of children to case workers by unit created unnecessary inconsistency when children moved units. Leaders had restarted release on temporary licence in late 2020 and there had been 136 events since then, but risk assessments were not good enough.

There had been considerable improvements in support for children transitioning to adult prisons, including the open estate.

1.29 All of the children we reviewed had a sentence or remand plan, although many residential staff and children were unaware of them. Some plans were too generic and not individualised to the child. Review meetings took place regularly, with most being timely, and contact with children was reasonable. However, records of meetings and of contact with children were poor and did not reflect the work undertaken. The limited use of the Youth Justice Assessment Framework system undermined effectiveness and created unnecessary risk.

1.30 There were weaknesses in oversight of public protection. While public protection meetings took place monthly, attendance was limited. Multi-agency public protection arrangements (MAPPA) management levels were not always confirmed before children were released.

1.31 The number of children with current or previous involvement with children's social care was high. Provision on site was good, but community social workers did not always attend the establishment for reviews or sentence planning meetings.

1.32 Release planning for accommodation and education started on arrival, but more work was needed to coordinate release planning across all the pathways. The prison had good oversight of accommodation a month before release.

1.33 The delivery of interventions had restarted following the pandemic restrictions. While interventions were prioritised based on release dates and level of need, some children were released without having their identified offending behaviour needs met.

Key concerns and recommendations

1.34 Key concerns and recommendations identify the issues of most importance to improving outcomes for children and are designed to help establishments prioritise and address the most significant weaknesses in the treatment and conditions of children.

1.35 During this inspection, we identified some areas of key concern and have made a small number of recommendations for the establishment to address those concerns.

1.36 Key concern: The number of violent incidents was high. The response to this was invariably to keep children apart from each other, which had a negative impact on their regime and reinforced the violent behaviour. Staffing unavailability, lack of engagement and redeployment of specialist conflict resolution staff to support the regime compounded the problem.

Recommendation: An effective violence reduction strategy, with a robust action plan, should be implemented to reduce the incidence of violence.
(To the governor)

1.37 Key concern: Too much poor behaviour went unchallenged by staff. This included banging of doors, the blocking of observation panels and shouting out of doors and windows. Expectations of behaviour were not enforced robustly and there was an inconsistent approach to ensuring that even the most basic of standards were met. There was a lack of immediate or longer-term rewards or incentives to reward good behaviour and make sure that children who engaged could consistently progress and attain long-term goals both within the prison – for example, with a more trusted status – or as they moved toward release.

Recommendation: Consistent expectations of behaviour should be set and communicated to children.
(To the governor)

Recommendation: There should be clear pathways for children that properly incentivise education, rehabilitation work and prosocial behaviour.
(To the governor)

1.38 Key concern: The arrangements for separating children did not safeguard children's well-being. Local managers had failed to prevent children from being subject to potentially harmful regimes for extended periods. Oversight arrangements did not enable managers to be better informed of the interactions, education or health care input that these children were receiving. Safeguards for separated children involved a large number of cursory checks, rather than meaningful and dynamic engagement.

Recommendation: Leaders and managers should make sure that children subject to separation can access a regime that is equivalent to that of their non-separated peers.
(To the governor)

1.39 Key concern: Extensive and offensive graffiti in cells, communal areas and exercise yards remained a significant problem and was emblematic of generally poor standards across the prison. During the inspection, children told us that graffiti was a 'normal' feature of the prison. Poor standards of cleanliness in cells and communal areas were not challenged effectively by staff and managers.

Recommendation: The establishment should be well maintained, clean and free of graffiti. (Repeated recommendation S50)
(To the governor)

1.40 Key concern: The promotion of equality and diversity remained weak. Equality monitoring data did not lead to actions or thorough investigations into disproportionate outcomes for some children in protected groups. Investigations into discrimination following receipt of incident report forms were poor and some did not take place at all.

Recommendation: Leaders should make sure that all incidences of discrimination are identified, investigated and addressed.
(To the governor)

1.41 Key concern: The well-resourced mental health services continued to struggle with accessing the children in confidential and therapeutic rooms with allocated officer escorts, resulting in frequently aborted appointments.

Recommendation: Children should be able to access planned mental health care appointments in clinically appropriate and therapeutic environments.
(To the governor)

1.42 Key concern: Time out of cell was too limited, at a daily average of about four and half hours on weekdays and two hours at weekends. Regime restrictions and controlled movement were responsible for many delays affecting the time available to children for education classes, work or recreation.

Recommendation: Opportunities for children to spend time out of their cell in education or other constructive activities, including social time together, should be increased, particularly at the weekend.
(To the governor)

1.43 Key concern: Children were not able to access enough hours or a broad enough range of face-to-face education, and many were justifiably frustrated that they had too few in-cell learning tasks to complete.

Recommendation: Leaders should make sure that they maximise opportunities for children to study, including in-cell study.
(To the governor)

1.44 Key concern: Leaders were not able to offer the subjects that they had planned as part of the curriculum because of shortages of teachers and prison officers. Too often, classes that were offered were delivered intermittently. As a result, not enough children developed their vocational, mathematics, English, and information and communications technology (ICT) skills at satisfactory rates.

Recommendation: Leaders should make sure that the curriculum includes sufficient opportunities for children to develop vocational, mathematics, English and ICT skills.
(To the governor)

1.45 Key concern: Too many children did not attend their allocated classes, or arrived late to lessons.

Recommendation: Leaders across the prison should make sure that they work collaboratively to prioritise education and increase children's attendance at classes.
(To the governor)

1.46 Key concern: Children's written work was, in many cases, of low quality. They wrote answers to theory-based questions that were partially incorrect. In a few cases, children did not take tasks seriously, and their answers to questions were of an inappropriate tone. Teachers usually marked this work as correct, without challenging the children to produce more detailed or accurate answers.

Recommendation: Leaders should make sure that teachers provide children with constructive feedback that helps them to improve their work.
(To the governor)

1.47 Key concern: Despite good in-person and remote visits provision, take-up was low. In addition, children faced long delays in getting telephone numbers approved and receiving letters from their family and friends.

Recommendation: Children should receive support to enable them to maintain contact with their family and friends in the community.
(To the governor)

1.48 Key concern: We found several areas where there was an absence of adequate risk management. ROTL risk assessments were not sufficiently robust; they failed to acknowledge any potential risk of harm posed by the child. MAPPA management levels were not routinely confirmed before release, and contributions to MAPPA meetings were variable. Case workers had no formal training in risk management.

Recommendation: Risk management processes, including ROTL and public protection, should identify and action risks adequately.
(To the governor)

Notable positive practice

1.49 We define notable positive practice as innovative work or practice that leads to particularly good outcomes from which other establishments may be able to learn. Inspectors look for evidence of good outcomes for children; original, creative or particularly effective approaches to problem-solving or achieving the desired goal; and how other establishments could learn from or replicate the practice.

1.50 Inspectors found one example of notable positive practice during this inspection.

1.51 Leaders and minimising and managing physical restraint (MMPR) coordinators alike challenged staff who did not turn on their body-worn video cameras. Staff had to provide justification for not turning their camera on, or turning it on after the incident had started, in their use of force report. Any staff who did not do this or could not justify their actions were challenged appropriately. MMPR coordinators told us that they had seen a rise in the use of body-worn cameras by about 30% since this policy began. (See paragraph 3.42)

Section 2 Leadership

Leaders provide the direction, encouragement and resources to enable good outcomes for children in custody. (For definition of leaders, see Glossary of terms.)

2.1 Good leadership helps to drive improvement and should result in better outcomes for children in custody. This narrative is based on our assessment of the quality of leadership, with evidence drawn from sources including the self-assessment report, discussions with stakeholders and observations made during the inspection. It does not result in a score.

2.2 The establishment had experienced considerable leadership change since the previous inspection. The governor had been in post for 10 months at the time of the inspection. Since his arrival, he had replaced six members of the senior team. This new team faced substantial challenges, including the high levels of violence, weaknesses in behaviour management and low levels of morale, particularly among frontline staff.

2.3 Cookham Wood had experienced higher levels of staff turnover than other young offender institutions over the previous 12 months and there were staffing shortfalls at the time of the inspection. However, the population had reduced considerably, to about half the number at the time of the last inspection. This low population and the still substantial resources available had presented an opportunity to improve outcomes for children.

2.4 The governor had implemented a business plan and set priorities, including reducing violence, creating communities and investing in staff. His vision for children living in stable communities, with strong relationships between staff and children, was appropriate, but so far there was little meaningful evidence of progress toward these goals. The reopening of the regime from pandemic restrictions lacked ambition, although the governor aimed to improve time out of cell (see Glossary of terms) to five hours a day by the end of November 2021. There was no plan to make further improvements beyond this point.

2.5 Management oversight lacked rigour in many key areas, including the residential units, the promotion of equality, behaviour management and use of separation. Low standards, particularly on residential units, were not challenged effectively by leaders and managers. The lack of meaningful incentives, consistent challenge and clear progression routes for children who engaged with the regime meant that there was an over-reliance on keeping children apart to prevent conflict. This had an adverse impact on time out of cell for many children, which was already inadequate – particularly at the weekend.

2.6 Access to, and the quality of, education also needed to improve, to make sure that children could attend the courses they needed, make progress at an acceptable rate and achieve qualifications.

2.7 There was a longstanding lack of rooms for health care, casework, meetings between residential staff and children, and offending behaviour interventions. Several new facilities had been built but were not in use because of outstanding work that needed to be completed by the contractor.

2.8 In partnership with health care staff and Public Health England, leaders and managers had taken action to minimise the spread of COVID-19. During the inspection, there were no cases among children, and COVID-19-related staffing shortfalls were manageable. The establishment had experienced previous outbreaks; no children had been seriously ill, but, tragically, three members of staff had died.

Section 3 Safety

Children, particularly the most vulnerable, are held safely.

Early days in custody

> Expected outcomes: Children transferring to and from custody are safe and treated decently. On arrival children are safe and treated with respect. Their individual needs are identified and addressed, and they feel supported on their first night. Induction is comprehensive.

3.1 A new escort contract for bringing children from police and court custody and moving them between prisons had started since the last inspection. Children were now generally moved in small people-carriers, rather than large cellular vehicles. A key benefit of this was that they were no longer transported with adult prisoners; this largely eliminated unnecessarily long journeys to multiple adult establishments and made journey times much shorter. We found evidence of only one child arriving after 8pm in the last six months, which was much better than we had found at previous inspections, when this had been a regular occurrence.

3.2 On arrival, children were greeted initially by officers, who conducted a private welfare check of each child to identify any vulnerabilities, including any history of self-harm (see paragraph 3.16) and gang affiliations, before locating them in a holding room. Health care staff conducted an initial safety screen in a well-appointed private room (see paragraph 4.46).

3.3 Leaders had recently tried to improve the comfort of the holding rooms, with the introduction of bean bags for children to sit on. However, the rooms were still stark and there was little to occupy children while they waited to be seen. There was a file in each holding room which contained useful information about the establishment in an accessible format, but this did not cater for those who could not read or for whom English was not their first language.

3.4 There was no routine strip-searching on arrival, but children were scanned using a body orifice security scanner before they were issued with prison clothing. All new arrivals were given a pack of basic groceries and toiletry items before they were moved to the wing, where they could make a telephone call and have a shower.

3.5 The first night and induction unit had been moved from A3 to B3 since the last inspection, and this was also the designated reverse cohort unit (see Glossary of terms).

Induction unit

3.6 All children were given a PCR test on their first night in custody, and then another on their sixth day at the establishment. They were moved off the unit after 10 days if they did not display any symptoms or the test results came back negative. This was undermined by long delays in receiving results (up to 10 days), caused by poor administration within Cookham Wood.

3.7 First night safety procedures were good. All new arrivals were checked hourly by staff through the night and handover procedures were effective. In our survey, 84% of children who responded said that they had felt safe on their first night at the establishment.

3.8 Children spent their first day in custody with wing-based induction staff, who gave them crucial information, such as how to book a visit, make a complaint or use a laptop computer (see paragraph 4.11) to make applications. In our survey, 66% of children who responded said that they had been told everything they needed to know about life at the establishment, which was better than at the time of the last inspection. However, the remainder of the induction programme, which included other important information, was rarely completed by children before they left the unit.

3.9 Health care and gym staff always attended their specified induction slots to see the children. However, for all other departments, including education and resettlement, staff either did not attend or did so sporadically, which made it hard to plan a regime for the different cohorts of children. In the sample of records that we looked at, we found no evidence that the children, one of whom was very vulnerable,

had had any induction meetings apart from with induction, gym and health care staff.

Safeguarding of children

Expected outcomes: The establishment promotes the welfare of children, particularly those most at risk, and protects them from all kinds of harm and neglect.

3.10 There was a good children's safeguarding and child protection policy, which was well promoted among staff, children and visitors. Oversight was effective, with a well-attended weekly meeting that looked at the day-to-day management of the most vulnerable children, and also a strategic monthly meeting that analysed safeguarding data, including incidents of violence, use of force, self-harm and separation.

3.11 In the previous 12 months, there had been 60 referrals to the local authority designated officer (DO) at the local authority, which was much lower than at the time of the last inspection. Of these, 50 had been related to use of force incidents and, appropriately, most of these referrals had been generated from the internal oversight of use of force (see section on use of force).

3.12 Reports were made through safeguarding team incident reports (STIRs), and those deemed serious enough were sent for investigation by the DO, who attended the prison monthly; there had been four instances in the last 12 months where the DO had taken further action. STIRs came in from prison staff, Barnardo's staff (who provided advocacy services for children), local youth offending teams, children and their families. There were two local authority social workers on site who quality-checked the process, and the DO also sampled a cross-section.

3.13 A team of safeguarding officers conducted detailed initial assessments and investigations into the STIRs before submission to the DO. They also paid daily visits to every child who had been identified as vulnerable. However, because of regular cross-deployment of safeguarding officers to other units, these checks had become cursory, which meant that the officers had insufficient time to have meaningful conversations with the children.

3.14 In our survey, although the number of respondents who said that their emergency call bell was answered within five minutes had increased from 15% to 42%, this was still worryingly low. There was no system for managers to check response times and we found no evidence that this took place.

Suicide and self-harm prevention

Expected outcomes: The establishment provides a safe and secure environment which reduces the risk of self-harm and suicide. Children at risk of self-harm and suicide are identified at an early stage and given the necessary support. All staff are aware of and alert to vulnerability issues, are appropriately trained and have access to proper equipment and support.

3.15 The number of recorded incidents of self-harm had decreased considerably, from 95 in the six months before the previous inspection to 13 in the same period currently, and was lower than in comparable prisons. The number of assessments, care in custody and teamwork (ACCT) case management documents opened during the same period had also reduced, from 88 to 39. Children in crisis that we spoke to felt well supported and cared for by staff.

3.16 Children were screened on arrival for any history of self-harm (see also paragraph 3.2) and this was used as part of an initial risk assessment, which was a proactive way to identify children who needed additional support.

3.17 If such support was needed, a multi-agency enhanced support team (EST) was put in place. This team met the child and then established further support actions and a formulation – a document which helped staff to identify triggers and any other needs that vulnerable children might have. These formulations were comprehensive but poorly communicated, and we found that wing staff and children had little knowledge of either their existence or purpose, which undermined the effectiveness of the EST.

3.18 The quality of the ACCT documents that we saw had deteriorated since the last inspection. Officers completed daily observation records, but actions from care plans were left incomplete following multiple reviews, and these reviews rarely generated further actions. Critical sections of the document, such as 'risks', 'triggers' and 'protective factors', were left blank and the quality assurance process had failed to identify these issues or drive any improvements.

3.19 A new version of the ACCT document had been introduced recently, but there had been little training for staff in what the changes were, how to complete the document and who was responsible for completing each section. This had led to confusion and a lack of ownership by the staff who were responsible for the process and had contributed to the poor quality of entries and care plans.

3.20 There had been no incidents of self-harm that had been classed as serious, and the constant watch cell had been used only twice in the previous six months. As the segregation unit had been decommissioned (see paragraph 3.45), there was now only one purpose-built constant watch cell on the B3 landing; this meant that

children on an ACCT or in need of the highest level of supervision were not moved to the segregation unit, which was an improvement on the situation at the time of the previous inspection.

Security

Expected outcomes: Children are kept safe through attention to physical and procedural matters, including effective security intelligence and positive relationships between staff and children.

3.21 Security procedures continued to limit opportunities for children to develop and progress. The complicated unlock procedures in place to reduce violence meant movements from the wings to areas such as education, health care, visits or offender management meetings were routinely late.

3.22 There had been 3,968 information reports submitted to the security department during the last 12 months and this information had been managed well and acted on appropriately. A comprehensive local tactical assessment was compiled each month, identifying key risks to prison security and the children. A briefing for staff was also published monthly on the prison's intranet.

3.23 Little time was given to discussing security in the monthly safeguarding meeting, and there were few security-related actions.

3.24 Cookham Wood shared a police intelligence officer with nearby HMP Rochester and had a good relationship with other police forces in the South-East area. Since the last inspection, stronger links had been formed with the Metropolitan Police and there was now, for example, a better flow of information on gang issues.

3.25 Random mandatory drug testing had restarted in October 2020, following its cessation during the pandemic. Since then, there had been only one positive test result. The security department had recently received large amounts of information about children using an illicit substance and had responded appropriately, with a coordinated programme of searching and several children identified for suspicion drug testing. Of the six tests conducted in the previous month, five of the children had either tested positive or refused to be tested, and had been charged under the prison rules appropriately.

3.26 There was no routine strip-searching of children; if there was a justifiable reason for this type of search to be conducted, a senior leader had to give authorisation.

Behaviour management

Expected outcomes: Children live in a safe, well-ordered and motivational environment where their good behaviour is promoted and rewarded. Unacceptable behaviour is dealt with in an objective, fair and consistent manner.

3.27 The behaviour management policy contained three main elements: an instant reward and sanction scheme, the incentives scheme with three different levels, and the adjudication system which dealt with the most serious incidents of poor behaviour. The governor's vision was that this would be underpinned by consistent staffing: this would allow them to build relationships with children, provide a stable environment and motivate them to engage. In practice, however, staff were frequently cross deployed and there were few meaningful incentives for those who behaved well or engaged in education or rehabilitation activities. Instead, staff relied on keeping children apart in small groups to manage conflict (see key concern and recommendation 1.36). This and the poor provision of activities and time unlocked meant that there was little to motivate children to use their sentence usefully.

3.28 The instant reward and sanctions scheme used green and yellow cards to recognise good and poor behaviour. Green cards could be exchanged for additional telephone or shop credit; yellow cards led to immediate sanctions, which were normally the loss of either dining out privileges or association. However, these activities were not delivered consistently for any children. Despite this scheme, poor behaviour, such as blocking observation panels, graffiti, threats shouted out of windows and doors, and kicking doors during lock-up periods, often went unchallenged, and appeared to be accepted as the norm by staff. (see key concern and recommendation 1.37).

3.29 A database of yellow and green cards was maintained, but it was not analysed to provide assurance that it was being used equitably or to identify emerging trends or hotspots of poor behaviour.

3.30 Many aspects of the incentives scheme were not functioning. In part this was due to COVID-19 restrictions. The lowest level was not in use and televisions were no longer removed following poor behaviour. In addition, the limited regime meant that there were few differences between the higher and standard levels of the scheme. The lack of distinction between the different levels was demotivating, and in our survey only 39% of children who responded said that the incentives available encouraged them to behave well. Demotion to the standard level was an administrative process following poor behaviour, and we found no evidence of any reviews before demotion.

3.31 Adjudications were heard by either a governor or, in serious cases, a visiting judge, and there had been 805 in the previous six months. The most frequent charges concerned violence, damage to property and threatening behaviour. Formal analysis of adjudication data had ended

at the beginning of the pandemic and there was currently no quality assurance process in place.

3.32 Adjudication records we examined showed a reasonable level of enquiry, although we considered there to be many that could have been dealt with less formally. At the time of the inspection, there were around 100 outstanding adjudications, which had been remanded for several reasons; this was far too many and undermined the behaviour management process.

Bullying and violence reduction

Expected outcomes: Everyone feels safe from bullying and victimisation. Active and fair systems to prevent and respond to bullying behaviour are known to staff, children and visitors.

3.33 The population had reduced by 40% since our previous inspection. Taking into account the reduced population, the rate of assaults on children had increased by nearly 70% and was a significant concern. The numbers of assaults and serious assaults on children were higher than in similar establishments. Violence had caused 49 recorded injuries in the previous 12 months, resulting in 29 admissions to hospital accident and emergency departments (see key concern and recommendation 1.36). The recording of incidents was good, and we found a correlation between entries in wing observation books and reported incidents. A wide range of data was reviewed at safety meetings to identify any emerging issues and to review each act of violence.

3.34 Proportionally, the number of assaults on staff in the previous six months had risen slightly since the previous inspection. In the 12 months leading up to this inspection, there had been 140 reported assaults on staff, 10 of which had been deemed serious (see key concern and recommendation 1.36).

3.35 In our survey, however, fewer children than at the time of the last inspection said that they had felt unsafe at the prison at some time (18% versus 39%), and just 5% now said that they currently felt unsafe. Children told us that this was in part due to the measures put in place to reduce the transmission of COVID-19. Many felt safer in small groups where they only had to mix with friends (see paragraph 3.27), and because staff were present whenever they were unlocked.

3.36 Despite these perceptions, we observed assaults and fights throughout the inspection, often erupting simply in response to name calling or because children on the units were from different sub-groups. Paradoxically, the act of reducing group sizes to reduce violence had created yet more division and conflict among the children. Of concern was the frequency of multiple perpetrator assaults, where two or more children would attack a lone child simultaneously. This had been identified in the safety meeting as a major risk, especially as the prison

moved toward full landing 'communities' rather than the current small groups of between one and 10 children. Throughout the residential units, staff strictly controlled the unlock of any cell door while children from a different sub-group were on the landing. This reflected a lack of staff confidence in managing individual children, and the widespread belief that children would attack each other at any opportunity (see key concern and recommendation 1.36).

3.37 Conflict resolution continued to be delivered following incidents of violence. Trained officers interviewed those involved to ascertain the triggers for the incident. However, the availability of these staff members was inconsistent because of regular cross-deployment. Wherever possible, they mediated between parties to resolve issues, but the most common outcome was to check which landing sub-group would be safest for the children to move to, and often involved a move to other landings (see key concern and recommendation 1.36).

The use of force

Expected outcomes: Force is used only as a last resort and if applied is used legitimately by trained staff. The use of force is minimised through preventive strategies and alternative approaches which are monitored through robust governance arrangements.

3.38 The rate of use of force per 100 children had reduced by around 25% since the last inspection. In the previous year, there had been 748 recorded incidents involving the use of force on children, which was similar to comparable establishments.

3.39 We reviewed several incidents and were impressed with the focus on de-escalation. However, at times, the initial incident management was disorganised, which led to far too many staff attending, creating unnecessary confusion and risking escalating the incident, as children reacted to the large staff presence. Although there had been some complex and chaotic incidents, children had been restrained appropriately, using minimal force, and returned quickly to their cell doors, where further dialogue and reassurance from staff had usually led to the child being released to walk into their cell. Closed-circuit television and the use of body-worn cameras provided good footage of incidents on the landings, although important in-cell footage was often lacking.

3.40 Staff from the Barnardo's advocacy service saw each child who had been restrained for the first time, and referred safeguarding issues directly to the DO through a separate process. All children involved in a restraint were interviewed in private by the prison's safeguarding team within 24 hours, to discuss what had happened, why and to identify any further support needs.

3.41 Oversight of use of force was very good. A restraints minimisation meeting took place weekly and every incident was reviewed by the

minimising and managing physical restraint (MMPR) coordinators. We were confident that they recognised both good and poor practice with equal rigour and challenged staff of all grades on their decision making when they considered this to be necessary. Identified actions were followed up at subsequent meetings and it was evident that the prison took the use of restraint seriously. The completion rate of restraint dossiers was far better than at the time of the last inspection and there were few outstanding currently.

3.42 Leaders and MMPR coordinators alike challenged staff who did not turn on their body-worn video cameras. Staff had to provide justification for not turning their camera on, or turning it on after the incident had started, in their use of force report. Any staff who did not do this or could not justify their actions were challenged appropriately. MMPR coordinators told us that they had seen a rise in the use of body-worn cameras by about 30% since this policy began.

3.43 Staff training had been reinstated as soon as was allowed, and the prison was on target for MMPR training levels.

3.44 Restraint handling plans were drawn up in conjunction with health care staff whenever there was a risk of exacerbating existing injuries in the event of a restraint. There were eight plans in place at the time of the inspection, and information on each was available at key locations, such as residential units, the MMPR department and the orderly office.

Separation/removal from normal location

Expected outcomes: Children are only separated from their peers with the proper authorisation, safely, in line with their individual needs, for appropriate reasons and not as a punishment.

3.45 Appropriately, leaders had closed the segregation unit, which had been in a poor condition at the time of the previous inspection. Children could be placed on Rule 49 (good order or discipline) and separated, or they could isolate themselves because they feared interacting with other children (this was managed through self-isolation documents). This took place mainly in their normal cell, but some children were moved to B1, which was being used to house more vulnerable children at the time of the inspection.

3.46 In our survey, 58% of respondents said that they had been kept locked up and stopped from mixing with other young people as a punishment. Children had been separated 157 times over the previous six months, which, given the reduction in the population, represented an increase since the previous inspection. The average length of separation was nine days, although this included some long stays, of up to 55 days.

3.47 Frontline staff and first-line managers did not always understand when support and monitoring documents for children who had decided to self-isolate should start, which led to a delay in support for some children. For those separated on Rule 49, managers often did not start

planning for a return to a normal regime until the 72-hour review meeting, which was too late (see key concern and recommendation 1.38).

3.48 While there had been some improvement in the integrity of data on separation since the previous inspection, oversight of the experience of separated children was poor. Self-isolation and Rule 49 documentation was in disarray. Deficiencies included first night welfare checks rarely taking place, and daily checks by managers, health care staff and the chaplaincy often not being recorded or taking place (see key concern and recommendation 1.38).

3.49 Managers told us that separated children received an equivalent regime to other children. We found that this was not the case; separated children and the staff responsible for their care reported consistently that activity periods were far shorter, and some did not take place at all. Time out of cell for separated children was not recorded regularly on Rule 49 or self-isolation documentation, and when it was it contained insufficient detail. In one case, where the documentation had been completed over a nine-day separation, the child had not left his cell for four days, and on two other days he had left it for just 30 minutes (see key concern and recommendation 1.38).

Section 4 Care

Children are cared for by staff and treated with respect for their human dignity.

Relationships between staff and children

> Expected outcomes: Children are treated with care by all staff, and are expected, encouraged and enabled to take responsibility for their own actions and decisions. Staff set clear and fair boundaries. Staff have high expectations of all children and help them to achieve their potential.

4.1 In our survey, 82% of respondents said that most staff treated them with respect, which was more than at the time of the previous inspection. Interactions we observed were generally respectful, but too often we saw staff not engaging with children during exercise and association periods. We found relationships to be better on the specialist units (B1, B3 and Cedar) than elsewhere.

4.2 As at the time of the previous inspection, children spent too much time locked in their cells. This affected their relationships with staff because there was little time to build trust and respect. In addition, there was no system to make sure that children had regular, meaningful contact with a named officer, and most residential staff we spoke to were unaware of how the children in their care were progressing in education or other areas of life at the establishment.

4.3 In our staff survey, a large majority of the frontline operational staff who responded said that their morale was low or very low. This and regular cross-deployment had led to a lack of ownership on some units. Too many members of staff had low expectations of children and accepted poor standards of behaviour and cleanliness on residential units. This was not effectively challenged by managers.

4.4 The care of many more challenging or vulnerable children was undermined by the numerous plans and support documents they could be subject to. Many busy frontline staff were overwhelmed by the number of plans in place and were unaware of their contents. Instead they were understandably focused on delivering the regime and managing the many children who needed to be kept apart from one another. This disconnect between support plans and targets put in place by specialist staff and those officers working most closely with children on the living units needed to be addressed (see also 3.17).

4.5 Peer support had lapsed during the pandemic and there were few areas where children were trusted to contribute to life at the establishment.

Daily life

Expected outcomes: Children live in a clean and decent environment and are aware of the rules and routines of the establishment. They are provided with essential basic services, are consulted regularly and can apply for additional services and assistance. The complaints and redress processes are efficient and fair.

Living conditions

4.6 Most children lived in the one main house block, which consisted of six different landings: B1, B2, B3 (induction), A1, A2 and A3. At the time of the inspection, eight children lived on Cedar unit, which was mostly used for those who were accessing or working towards release on temporary licence. All children lived in single cells.

4.7 Although the accommodation was modern, communal areas and cells were grubby and untidy, and exercise yards were bleak. As we have commented in our previous seven inspection reports, extensive and offensive graffiti in cells, communal areas and exercise yards remained a significant problem and was emblematic of generally poor standards across the prison. During the inspection, children told us that graffiti was a 'normal' feature of the prison. This went unchallenged by staff and managers, and no yellow cards, for example (see paragraph 3.28), had been issued to children in the last three months for writing graffiti on their cell walls (see key concern and recommendation 1.39).

Graffiti in a shower in a child's cell

Exercise yard

4.8 There was a residential action plan which attempted to address some of these issues. Cells were being refurbished and some showers had been painted with specialist resin which allowed graffiti to be wiped off more easily. However, progress was slow and much more needed to be done to ensure decent living conditions at Cookham Wood (see key concern and recommendation 1.39).

4.9 Most cells that we viewed were furnished adequately, with a chair and storage for clothes. Some children had been able to personalise their cells with photographs, but there were few other 'homely' items.

4.10 All cells contained showers, with a curtain covering the area, and access to cleaning materials was reasonable. Noisiness at night continued to be an issue, in our survey just 39% of children who responded said that it was normally quiet enough for them to relax or sleep at night.

4.11 Managers had recently introduced laptop computers for children in their cells. These enabled children to do a range of things, such as: contact reception to ask about parcels and stored property; find out their release date; order from the shop; submit a general application; and watch a range of suitable videos and dramas. As a result, children now received quicker responses to their enquiries.

4.12 Children who lived on Cedar unit had better living conditions than those who lived on the main houseblock. Cells on this unit were cleaner and contained softer furnishings, such as rugs; the association room was bright and comfortable; and the outdoor exercise space was more suitable for children.

Cedar unit association room

Residential services

4.13 The quality and quantity of the food were reasonable, but mealtimes were too early. As the various groups on each unit were managed differently, some children had their hot meal delivered to their door by staff and others were able to collect it from the servery and then return to eat it their cell. Children had too few opportunities to eat communally with other children or staff, and most children ate most of their meals alone in their cell.

4.14 The main kitchen, refrigerators and food trolleys used to take food to the house blocks were reasonably clean. The menu cycle met a range of dietary needs and it was now much easier for children to select and amend their food choices from the menu by using their laptop computers. The kitchen provided extra portions to enable staff to eat with the children, on the few occasions that they ate out of their cells, which was positive.

4.15 The catering manager had recently introduced a weekly cooking session for a small number of children on B2, where they could prepare basic meals, such as wraps and pizzas, which were then cooked off the wing. Initial feedback from those participating was positive and managers planned to facilitate sessions on the other units.

4.16 There was a reasonable range of approximately 400 items available to order from the shop, which also included hair and skin products specifically for black and minority ethnic children.

Consultation, applications and redress

4.17 Consultation with children had stalled in response to the pandemic. A team of 'junior leaders', who had demonstrated some positive behaviour on the wings, had recently been recruited and monthly meetings with some senior managers had restarted. However, not every unit was represented and consultation with these children was not yet effective or influencing meaningful change. Furthermore, the role of a junior leader was under-promoted, and post holders told us that their capacity to share information about the meetings and communicate any ideas or changes with other children was limited because of the lack of time out of cell (see section on time out of cell) and the fact that group sizes were smaller than before the pandemic.

4.18 There had been 75 complaints submitted in the previous six months. Children's awareness about how to submit a complaint was reasonable, with 84% who responded to our survey saying that they knew how to submit a complaint. However, only 30% of those who had made a complaint said that it had been dealt with fairly, and 25% that it had been dealt with within seven days.

4.19 The tracking process for complaints made sure that most children received replies within the required time. However, the responses given did not always address the issues raised, and often did not involve a face-to-face conversation with the child concerned. Most complaints

were about difficulties in getting access to stored property, but some were about problems with family contact and requests for more time in education.

4.20 Children were now better informed about how to get advice from Barnardo's about legal rights and services, and most told us that they used their in-cell telephones to make contact if they needed to. The facilities and privacy for in-person and video legal visits was appropriate.

4.21 Children could submit applications using the electronic kiosks on their landing and could now also use also their own personal laptop computers in their cells to do this (see paragraph 4.11). This system had improved the timeliness of responses to applications and also allowed children to check for updates on their queries with other departments in the prison.

Equality and diversity

Expected outcomes: The establishment demonstrates a clear and coordinated approach to eliminating discrimination, promoting equitable outcomes and fostering good relations, and ensures that no child is unfairly disadvantaged. This is underpinned by effective processes to identify and resolve any inequality. The diverse needs of each child are recognised and addressed.

Strategic management

4.22 The promotion of equality and diversity remained weak. Although there was now a dedicated diversity and inclusion team, and a local strategy and action plan, progress had been limited due to confusion about who was the senior lead in this area and regular cross-deployment of the equality officers, which meant that they were unable to fulfil their role successfully (see key concern and recommendation 1.40).

4.23 Although it had been difficult for the team to plan for workshops and events because of the risk of cross-deployment, some celebratory events had taken place. The diversity and inclusion team had arranged an event for Black History Month and had recently run some workshops for staff and children, titled 'Let's talk', which included sessions about race, gender and how different characteristics interact with each other. There were imminent plans to appoint a new manager to this team, to develop this area further.

4.24 At the time of the inspection, four children had been identified as diversity and inclusion representatives on the wings. Although they had started some workbooks which focused on exploring the different protected characteristics (see Glossary of terms), language and discriminatory attitudes, their overall impact in promoting diversity and inclusion was limited by a general lack of encouragement and endeavour across the prison, or because of limited consultation and

support from senior leaders (see key concern and recommendation 1.40).

4.25 Equality action team meetings were held monthly, but with poor attendance from other departments. The collection of equality monitoring data to identify differences in treatment between protected groups had improved and some were shared at monthly safety review meetings. However, these data did not lead to useful investigations or follow-up actions into disproportionate outcomes for some children in protected groups (see key concern and recommendation 1.40).

4.26 In the previous six months, 32 discrimination incident report forms (DIRFs) had been submitted. Four of these had been submitted by children, two of which, appropriately, had involved support from Barnardo's. However, investigations into DIRFs were poor and some did not take place at all. One child had moved on from Cookham Wood without receiving a response to the issue they had raised. There was no quality assurance process and no independent external scrutiny of DIRFs to identify these weaknesses (see key concern and recommendation 1.40).

Protected characteristics

4.27 There was no consultation for children in protected groups at the time of the inspection. Some members of the senior leadership team had been identified as leads for the nine protected characteristics, but they were not yet clear about what their role involved or how they might be effective.

4.28 At the time of the inspection, 79% of children were from a black and minority ethnic background, of whom 46% were black or black British – an increase since the previous inspection. In both our survey and the focus groups we held, children from a black and minority ethnic background generally reported similar treatment to their white counterparts.

4.29 Approximately 30% of the population were Muslim. The perceptions of children from this group were generally the same as those of their non-Muslim counterparts. However, in our survey, fewer Muslim than non-Muslim children said that there was a member of staff they could turn to if they had a problem (57% versus 94%).

4.30 Foreign national children were identified on arrival, and those who needed help to understand English were able to use a professional telephone interpreting service. Support for this group had improved. There were three foreign national children at the time of the inspection. They all told us that, on arrival, they had been given support from staff or case workers to contact family members if they needed it. They were able to meet the Home Office immigration enforcement officer, who visited the prison each month. Foreign national groups for children had been running before the pandemic, and the prison had plans to restart these soon after the inspection.

4.31 In our survey, 21% of children declared a disability. Of these, 60% said that they had been verbally abused by other children, and 62% that they would report bullying or victimisation by other children to staff. Four children had a personal emergency evacuation plan (PEEP), and staff knowledge of the individual needs of these children varied. Three children who were on a PEEP needed a review of their plan, but staff had not yet identified this.

4.32 In our survey, of those who had a religion, 92% of respondents said that their religious beliefs were respected, and 69% that they could speak to a chaplain of their faith in private if they wanted to.

4.33 The chaplaincy was well integrated into the prison, provided good pastoral support and delivered a suitable range of religious services. There were weekly services for Anglican, Roman Catholic and Muslim children, although, as a result of the COVID-19 restrictions, only five children could attend each service. For those children who were unable to attend worship, the chaplaincy visited them to deliver religious artefacts such as the Qur'an, prayer beads and the Bible. The team had also successfully celebrated Ramadan with 19 children.

Health services

Expected outcomes: Children are cared for by services that assess and meet their health, social care and substance misuse needs and promote continuity of health and social care on release. The standard of health service provided is equivalent to that which children could expect to receive elsewhere in the community.

4.34 The inspection of health services was jointly undertaken by the Care Quality Commission (CQC; see Glossary of terms) and HM Inspectorate of Prisons under a memorandum of understanding agreement between the agencies. The CQC found no breaches of the relevant regulations.

Strategy, clinical governance and partnerships

4.35 Central and North West London Foundation Trust and Oxleas NHS Foundation Trust ('Oxleas') had provided mental health and primary care services, respectively, since 2014. Health care services were reasonably well embedded into the prison. However, despite being raised in previous HM Inspectorate of Prisons reports and in partnership and local quality board meetings, the longstanding concerns about the lack of access to the children, due to officer availability and delayed movement, and of confidential therapeutic space for delivering planned mental health interventions remained unresolved. This problem was exacerbated with the introduction of the Framework for Integrated Care (Secure Stairs) model in 2018, which increased the mental health team to 19 whole-time-equivalent staff (see key concern and recommendation 1.41).

4.36 A health needs assessment had been published in November 2019 which identified the needs before the reduction in the number of children, so resources were high at the time of the inspection.

4.37 Each health provider had separate complaint systems, incident reporting platforms and governance structures; this made the communication of lessons learned cumbersome, with each team having separate briefing meetings. Incidents and actions from previous deaths in custody had been well managed, as had the few complaints which had been submitted in the year to date. Answers had been prompt, polite and addressed the concerns raised.

4.38 COVID-19 outbreaks had been well managed, supported by a local outbreak control policy and Public Health England support.

4.39 Staff were on site from 7.30am until 9pm, with a lesser service at weekends. All health care teams were well resourced, supported and supervised, in line with each trust's policy, and reflective practice was well embedded. Staff we spoke to, including the GP, dentist and optometrist, said that they felt well supported. All staffing teams utilised the single health records for the children, and those we sampled were of a good standard.

4.40 Information-sharing agreements were in place to support the sharing of patient information and risks. However, we saw examples where joint working would have been expected within the Secure Stairs framework but remained separate; for example, all health care providers were delivering discharge plans which were separate from each other and from those of the prison.

4.41 Attempts were made to consult children, to inform service provision, with continuous review of mechanisms to improve the low engagement.

4.42 Medical equipment was serviced and calibrated annually. Emergency responses were undertaken by qualified staff, who attended with emergency equipment bags that were checked regularly and well stocked. Codes 'red' and 'blue' were used effectively to call the emergency service, which was an improvement since the last inspection.

Promoting health and well-being

4.43 Although there was no overarching health and well-being strategy, there was evidence of planned health education throughout the year from the national calendar, and joint working with the gym staff. There were clinics for age-appropriate health interventions, such as weight management, smoking cessation and childhood vaccinations. Children who were eligible were offered a COVID-19 vaccination, although there was a general reluctance to take this up, despite continuous attempts by staff to promote this service.

4.44 Children received a health information leaflet and sexual health urine screening on arrival. Health promotion leaflets were available, but their availability around the wings was low.

Primary care and inpatient services

4.45 Primary care services were well led and well resourced. The number of 'did not attend' appointments was unknown, as most were just rebooked for the next available appointment. However, it appeared that the location of the primary care clinics rooms, close to the wings, made access easier than for other services.

4.46 All children were screened on arrival using a national child health assessment tool, which included a neuro-disability assessment to identify possible dysfunction. Health care assistants undertook a sight and hearing screening.

4.47 Health care applications were made electronically through laptop computers (see 4.11) or an electronic kiosk. These were managed promptly by the primary care administrator; this carried some risks because of their lack of clinical experience, but discussions had taken place to improve oversight of this.

4.48 There was a good range of primary care clinics, appropriate to the needs of children, including asthma, optometry, GP consultations, nurse-led clinics and physiotherapy.

4.49 A sub-contracted GP practice provided four sessions a week, including Saturday mornings for emergencies, which was sufficient to meet need. Routine GP appointments were available within one to seven days and the NHS 111 service was used out of hours. The very few long-term conditions among the population were managed by the GPs, with referral to specialists if needed, and care plans were in place for these children.

4.50 External hospital appointments were rarely cancelled by the prison because of operational pressures, as few were needed, given the large reduction in the population.

4.51 Social care provision had not changed since the last inspection. There was no partnership agreement with the local authority, no identified domiciliary care provider available for those who arrived with additional care needs and no trained peer support. We saw no evidence of unmet needs at the time of the inspection, but this situation carried potential risks.

Recommendation

4.52 **A memorandum of understanding should be developed with the local authority and social care provider, to make sure that arrangements are in place if a child needs social care.**

Mental health

4.53 The health and well-being team delivered primary and secondary mental health care alongside the Secure Stairs framework. Staff were on site six days a week, with reduced hours at weekends. The team had a diverse skills mix and included nurses, a nurse prescriber, a psychiatrist, psychologists, social workers, an occupational therapist, speech and language therapists, art therapists, a family therapist and a support worker.

4.54 Children received a comprehensive mental health assessment on arrival, using the comprehensive health assessment tool (CHAT). Staff gathered appropriate information from community teams to undertake an initial 'snapshot' of integrated care needs (a 'formulation') These formulations were undertaken with the child, under the Secure Stairs framework, usually within seven days of their arrival.

4.55 Oxleas offered low-level sleep hygiene and anxiety support, while the health and well-being team delivered psychological support to 51 of the children on a one-to-one basis. A range of group work programmes had been suspended during the pandemic, and discussions with the prison to resume groups were in the early stages. In our survey, 66% of respondents said that it was easy to see a mental health worker.

4.56 Secondary mental health care was delivered using the care programme approach; however, no children were receiving this level of care at the time of the inspection. Since the last inspection, four children had been transferred to secure facilities, with all transfers taking place within the required 14-day timescale from their second assessment.

4.57 A weekly clinical team meeting was multidisciplinary, and there were twice-daily handover meetings to make sure that all referrals and emerging risks were highlighted and addressed in a timely manner. The team delivered care plans for children with specialist support needs, such as speech and language therapy, but full formulations and ongoing reviews were not yet embedded consistently, despite being well resourced. Most officers we spoke to on the wings were not aware of either the whereabouts or contents of the formulation documents.

4.58 Health and well-being interventions, including the rollout of the Secure Stairs framework, were being adversely affected by the lack of access to the children and of space to deliver assessments and interventions (see also paragraph 4.35, and key concern and recommendation 1.41).

4.59 Prison operational staff completed training modules on mental health awareness during their induction and during their suicide and self-harm training. The Framework for Integrated Care (Secure Stairs) training for staff also included the use of a trauma-informed approach to supporting the children.

Substance use treatment

Expected outcomes: Children with drug and/or alcohol problems are identified at reception and receive effective treatment and support throughout their stay in custody.

4.60 There was an up-to-date drug and alcohol strategy, and members of the substance misuse team attended regular prison drug strategy meetings. Despite working in close proximity to the health and well-being team, they operated independently, although some joint assessments were facilitated where a dual diagnosis (co-existing mental health and substance misuse problems) was identified.

4.61 The Forward Trust delivered clinical treatment for substance misuse; however, no children were receiving clinical treatment at the time of the inspection. A nurse based at nearby HMP Rochester was available daily to attend for any clinical assessments where the need was identified, and a 24-hour on-call substance misuse doctor could also attend as required.

4.62 The Forward Trust sub-contracted Open Road to deliver the psychosocial substance misuse service, which was delivered five days a week. A team manager supported three recovery workers, one of whom was waiting for a start date following recent recruitment.

4.63 All children were assessed on arrival by a recovery practitioner, to identify any substance misuse issues using the CHAT. They were receiving one-to-one interventions following the suspension of groups during the COVID-19 restrictions, and staff completed person-centred care plans with children they supported. Recovery workers offered age-appropriate short- and long-term interventions, including harm reduction, drug awareness and the impact of drug dealing offending behaviour.

4.64 The substance misuse team had supported prison-led family days before the pandemic, but these were not currently running. Recovery workers facilitated an evening drop-in session on the residential units weekly during association time, to offer advice and support. Peer mentors were not currently in place because of the COVID-19 restrictions.

4.65 One recovery worker provided a specialist service to support children with substance misuse issues in their transition back to the community. They could be referred to this support three months before their release, and the same recovery worker also provided advice and practical support for three months afterwards. This provided a seamless service and stability for these children during their transition.

Medicines optimisation and pharmacy services

4.66 Medicines management and oversight had improved. Services were well organised and medicines were supplied by the pharmacy at HMP

Rochester when required. Medicines were stored appropriately, and stock was checked and ordered each week. There had been no incident reports about delayed arrivals of medicines in the previous six months.

4.67 The pharmacy team, which now included a paediatric pharmacist, visited once a month and carried out essential audits. The medicines and therapeutics committee met regularly to review standing operational instructions, the formulary (a list of medications used to inform prescribing) and prescribing trends, and included a pain management consultant.

4.68 Prescribing was age appropriate. Most medicines were administered twice a day, which was not always in line with therapeutic dosing. However, managers were aware of this and there was ongoing discussion about increasing the number of medicines held in-possession and how to make sure that these were stored safely, as there were no in-cell lockable cupboards.

4.69 Staff administering medicines did not routinely ask the children for formal identification, and officers supervising medicine administration did not check that children had this in their possession before escorting them to the medicine hatches. We raised this issue during the inspection and processes improved immediately. The queues were managed safely, but some medicines administrations took a long time to complete because of the restricted flow of children caused by the limitations on the mixing of groups due to both COVID-19 and gang issues.

4.70 Nurses used patient group directions (which enable them to supply and administer prescription-only medicine) on a limited basis. Over-the-counter medicines administered by nurses were recorded appropriately on SystmOne (the electronic clinical record). Although almost all medicines were not in-possession, some children kept medicines such as inhalers and ointments in their cells.

4.71 Officers provided pain relief at night for children experiencing dental pain.

Recommendation

4.72 **Medicines should be administered in line with national standards and at times which facilitate optimum therapeutic effect.**

Dental services and oral health

4.73 A local dentist provided an appropriate range of NHS dental treatments, including oral health advice and disease prevention. They operated one session a week, supported by a dental nurse, but could attend five days a week for any urgent appointment requests.

4.74 The dentist oversaw all applications and allocated appointments based on clinical need, and there was no waiting list for new assessments at the time of the inspection. An air filtration system had been installed

recently, and it was hoped that aerosol generating procedures could resume soon. A small number of children were waiting for these procedures and had received appropriate interim care to reduce pain and the risk of infection. The dentist recorded comprehensive records of interventions on SystmOne.

4.75 The dental suite was fit for purpose, and although there was no separate decontamination area, the facilities met infection control standards. The dental suite was cleaned, and tools were audited, during each session, with comprehensive records to document checks. Emergency drugs and oxygen stored in the room were also audited weekly by dental staff. Dental equipment was maintained and certified appropriately.

Section 5 Purposeful activity

Children are able, and expected, to engage in activity that is likely to benefit them.

Time out of cell

Expected outcomes: Children spend most of their time out of their cell, engaged in activities such as education, leisure and cultural pursuits, seven days a week.

5.1 Children could expect, on average, around four and a half hours per day out of their cell during the week and two hours at weekends, which was insufficient. The regime differed greatly depending on their location. Children on Cedar unit could expect eight hours per day out of cell during the week and around six hours at weekends, which was far better than for those on the B1 landing, who received an average of three and a half hours during the week and one hour and 55 minutes at weekends (see key concern and recommendation 1.42).

5.2 In the roll checks we conducted during the day, we found 35% of children across the prison locked in their cells and taking no part in activities. There was a large disparity between the units; on Cedar unit, no children were locked in their cells, whereas 55% of children were locked up on B wing (see key concern and recommendation 1.42).

5.3 Most children received our expectation of one hour in the open air each day, which was an improvement since the last inspection. In our survey, 67% of respondents said that they could spend time outside in the fresh air most days, which was better than at the time of the last inspection.

5.4 The library was bright and well appointed, and provision was good, with each child having 30 minutes' access each week. Any unit that missed this opportunity because of staff shortages was visited by the librarian, who had produced a list of books, with a picture of the cover and a synopsis of content, and discussed them with the children so that they could select any that interested them.

5.5 Children who were isolating because of COVID-19 or had just arrived, as well as those who were segregated for any reason, only had access to the book lists and missed the valuable input from the librarian.

5.6 The library service facilitated family contact through Storybook Dads, whereby children who were also fathers recorded themselves reading a story for their children. Work with the Shannon Trust, a charity which helps children in custody learn to read, had also started; one child had been appointed as a peer mentor and one learner was being supported.

5.7 The amount of gym time that a child could access had increased since the last inspection. Children could now have three hours in the gym per week, split into two sessions of one and a half hours. In our survey, 71% of respondents said that they went to the gym or played sports once a week or more, which was far higher than at the time of the last inspection. Children who missed a session unavoidably were offered extra time at weekends.

5.8 Gym staff offered children the chance to use the well-appointed gym and either the sports field or AstroTurf pitch in each session. This was greatly appreciated by the children and made sure that they remained engaged with a good variety of activity.

Sports field

5.9 As a result of staff shortages, there were no qualifications that children could attain in the gym. However, leaders and managers had recruited Sports Connect, a provider which delivered health and education programmes through sport. A total of 89 children had taken part in this programme, which included sports coaching, gym classes and also more diverse topics such as driving theory revision and qualifications in manual handling and fire safety.

Education, skills and work activities

This part of the report is written by Ofsted inspectors. From May 2021 Ofsted began carrying out progress monitoring visits to prisons to assess the progress that leaders and managers were making towards reinstating a full education, skills and work curriculum. The findings and recommendations arising from their visit are set out below.

5.10 Ofsted assessed that leaders were making insufficient progress towards ensuring that staff taught a full curriculum and provided support to meet children's needs, including the provision of remote learning.

5.11 Children were not able to access enough hours or a broad enough range of face-to-face education. They could attend classes for a maximum of only 12 hours a week, but in many cases received far less than this. In too many cases, leaders were not able to offer the subjects that they had planned as part of the curriculum. They had temporarily closed some vocational subjects because of staff shortages. In other cases, leaders could only offer vocational training intermittently because there were not sufficient prison staff available to run these classes safely. As a result, too few children developed their vocational skills and achieved accredited qualifications (see key concern and recommendations 1.43 and 1.44).

5.12 Not enough children developed their mathematics, English, and information and communications technology (ICT) skills at satisfactory rates. They studied these subjects infrequently, in part because of a lack of specialist teaching staff. Children made many spelling and punctuation errors in their written work, but teachers did not correct these. Leaders had ambitious plans to develop the ICT curriculum through introducing courses in coding, but it was too early to judge the impact of these (see key concern and recommendation 1.44).

5.13 Children were allocated to learning promptly, but in too many cases they did not study subjects linked to their career goals or next steps, although leaders had recently begun to rectify this problem. Too many children did not attend their allocated classes, or arrived late to lessons. Leaders had devised systems to monitor these issues closely, but they did not use the information that this provided to improve attendance and punctuality (see key concern and recommendation 1.45).

5.14 Children did not complete enough learning activities in addition to their planned classroom hours. In many cases, they felt frustrated, justifiably, that they had too few in-cell learning tasks to complete. Leaders had developed well-considered plans to supplement learning

hours via classes carried out on accommodation units. However, leaders and teachers had not fully developed or implemented these sessions. In too many cases, teachers planned activities that were not challenging enough. Leaders did not combine on-unit learning with the prison regime well enough.

5.15 Children's written work was, in too many cases, of low quality. They wrote answers to theory-based questions that were partially incorrect. In a few cases, children did not take tasks seriously, and their answers to questions were of an inappropriate tone. Teachers usually marked this work as correct, without challenging the children to produce more detailed or accurate answers. In a few subjects, such as peer mentoring, teachers marked work more carefully. They provided constructive feedback, which enabled children to improve the quality of their work (see key concern and recommendation 1.46).

5.16 Leaders had correctly identified the weaknesses of the provision. They had recently undertaken in-depth quality assurance activities, and as a result had devised appropriate plans to improve the education they offered. However, they had not made sure that all teachers tracked the progress of children consistently and thoroughly.

5.17 Leaders had considered children's needs carefully when they had returned to the classroom earlier in the COVID-19 pandemic. Teachers had initially focused on children's personal and social development – for example, to improve their ability to work cooperatively in classes. In a few classroom subjects, such as music technology and food hygiene, children worked enthusiastically and produced good-quality work. They valued the challenge that their teachers provided in these subjects.

5.18 Children who were new to the establishment benefited from a timely and sensitive induction to the education department. Staff reviewed children's previous educational experience, their future needs and their additional learning support needs. However, too many children did not benefit from sufficient follow-up guidance to help them plan their learning pathway.

5.19 Specialist staff produced comprehensive learning support plans for children with special educational needs and/or disabilities (SEND). These contained appropriate strategies to help teachers and learning support practitioners work with children with SEND. Leaders made sure that there was a comprehensive network of specialists available for these children. These children benefited from working with speech and language specialists, youth workers and personal tutors. In a small number of cases, however, children with identified SEND needs did not feel well supported during classroom activities.

5.20 A small number of children had recently undertaken education, work and training activities via release on temporary licence (ROTL). They had benefited from opportunities to take part in activities such as work shadowing. As a result of their ROTL activities, a few children had been offered jobs on release from custody.

Section 6 Resettlement

Children are effectively helped to prepare for their release back into the community and to reduce the likelihood of reoffending.

Children, families and contact with the outside world

Expected outcomes: Managers support children in establishing and maintaining contact with families, including corporate parents, and other sources of support in the community. Community partners drive training and remand planning and families are involved in all major decisions about detained children.

6.1 The pandemic had had a negative impact on children's ability to maintain contact with their family and friends. In our survey, 58% of respondents said that they received visits from family and friends, compared with 81% at the time of the previous inspection. It was concerning that only 6% of the latter group received a visit once a week or more, compared with 51% at the time of the previous inspection (see key concern and recommendation 1.47).

6.2 Leaders and managers had invested both in in-person visits and secure video calls (see Glossary of terms), but few children accessed either. In July 2021, only 36 visits had taken place, out of 150 slots available. The situation for secure video calls was even worse for the same time period; of 404 potential slots, only 34 had taken place. The reasons for this poor uptake were, in part, related to the environment in which video calls took place and a lack of knowledge about recent improvements. For example, children could now hug family members who had undergone a lateral flow test during in-person visits. Similarly, recent upgrades to the secure video calls software had improved the experience. Fundamentally, however, children and their families needed more support and encouragement to access the provision (see key concern and recommendation 1.47).

Visits hall

6.3 All children had a telephone in their cell, but it took far too long for telephone numbers to be approved. Case workers checked all numbers with youth offending teams in the community. A lack of response was not followed up for two weeks, and in some cases not escalated to a manager for up to a month. In addition, children were frustrated, justifiably, by delays in receiving letters; we found post that had not been distributed for over a week (see key concern and recommendation 1.47). More positively, children could now use the new in-cell laptop computers (see paragraph 4.11) to email their families.

6.4 Family therapy was available, but this was delivered by a worker based on B2, which mean that it was accessed mainly just by children on that unit.

Pre-release and resettlement

Expected outcomes: Planning for a child's release or transfer starts on their arrival at the establishment. Resettlement underpins the work of the whole establishment, supported by strategic partnerships in the community and informed by assessment of a child's risk and need. Ongoing planning ensures a seamless transition into the community.

6.5 Oversight of resettlement had improved. There was now a detailed needs analysis, which fed into a resettlement action plan that was leading to improved outcomes in some areas. The action plan was overseen by staff who attended the resettlement meeting, and this had

continued throughout the pandemic. However, there were still regular gaps in attendance – for example, by the substance misuse team.

6.6 The resettlement team included 10 full-time-equivalent resettlement practitioners (case workers), both operational and non-operational. Resettlement practitioners held an average caseload of nine children, which was not excessive, but all of them lacked the necessary training to be fully effective. Children were allocated a resettlement practitioner based on their physical location in the prison, which created unnecessary inconsistency if a child moved units. There was reflective supervision in place for resettlement practitioners that aimed to help them develop and improve their future practice.

6.7 Early release and home detention curfew procedures were managed appropriately. In the previous six months, half of the eligible children had been granted early release, and the decisions we reviewed had been appropriate.

6.8 The work involved in transitioning 18-year-olds to the adult estate had improved considerably since the last inspection and leaders had good oversight of this. Each such child met staff from the receiving prison before transitioning, to support their move. Leaders had worked with a number of prisons in a project to film several prisons, to enable these children to visualise their new surroundings. Recently, there had been success in transitioning four children to open conditions, which included a release on temporary licence (ROTL) visit to the establishment before transitioning.

6.9 ROTL had stopped at the onset of the pandemic, but prison leaders had been swift to reinstate it in September 2020. Since then, there had been 136 ROTL events for 13 children, all with a good focus on resettlement or further progression. However, ROTL risk assessments were not sufficiently robust; they failed to acknowledge any potential risk of harm posed by the child, and we found two examples where risks were evident but had not been included in the risk assessment. A more recent risk assessment had showed some improvement (see key concern and recommendation 1.48).

Training planning and remand management

Expected outcomes: All children have a training or remand management plan which is based on an individual assessment of risk and need. Relevant staff work collaboratively with children and their parents or carers in drawing up and reviewing their plans. The plans are reviewed regularly and implemented throughout and after a child's time in custody to ensure a smooth transition to the community.

6.10 In our survey, only 49% of respondents said that they had a training or remand plan, and children we spoke to could not all easily recollect their plans. Of those in our survey who knew they had a plan, nearly all

understood what they needed to do to achieve their targets and 67% said that staff were helping them achieve this.

6.11 Resettlement practitioners made sure that training and remand planning review meetings took place regularly, and most were timely. The meetings were almost always attended by the designated youth offending team, and also the child's parents, where appropriate. In one case we looked at, involving a child due to transition to the adult estate, probation staff had also attended. However, there was poor attendance by residential staff, which may have been linked to a lack of understanding of training or remand among staff.

6.12 We reviewed 15 cases, and all had an up-to-date assessment and training or remand plan. While all objectives were reasonably appropriate, we found some to be too generic and not individualised to the child. Plans were not always written in a way that was easy for children to understand.

6.13 We found that resettlement practitioners knew the children on their caseloads well, and the children we spoke to were mostly positive about their resettlement practitioners.

6.14 Records of meetings and of contact with children were poor and did not reflect the actual work undertaken. We found the entries in P-Nomis (electronic case notes) to be insufficiently detailed and there was little use of the Youth Justice Assessment Framework system. This inhibited information sharing, which undermined effectiveness and created unnecessary risk, but also did not reflect the work undertaken by resettlement practitioners. Leaders had introduced a monthly quality assurance process for P-Nomis records and contact; this reviewed the quantity of recorded contact but was not raising standards in the quality of entries.

Public protection

6.15 The management of public protection was poor. Public protection meetings took place monthly; attendance was still limited to resettlement, security and education staff. The meeting appropriately identified prisoners who required discussion; however, minutes lacked depth of discussion and did not routinely confirm the multi-agency public protection arrangements (MAPPA) level for eligible children (see key concern and recommendation 1.48).

6.16 All children received an initial screening to identify public protection issues, but referrals to confirm MAPPA management levels before release were not timely. We found that most had been sent only two months before release, instead of the required six months, which meant that there was limited time in which to escalate this to the relevant agencies. The contribution of resettlement practitioners to MAPPA meetings was variable (see key concern and recommendation 1.48).

6.17 At the time of the inspection, there were no children on offence-related monitoring, and we found that there was no system for interpreting telephone calls conducted in a foreign language.

Indeterminate and long-sentenced children

6.18 At the time of the inspection, there were three children serving indeterminate sentences, but there were a further 18 children on remand for offences that could attract an indeterminate sentence. Since the start of the pandemic, weekly meetings between staff responsible for indeterminate-sentenced children and the health and well-being team had stopped and not restarted. There was no current arrangement to support these children.

Looked after children

6.19 At the time of the inspection, the number of children with current or previous involvement with children's social care was high, at 71. Just over half of these children were currently involved with children's social care and 10 children were subject to full or interim care orders.

6.20 Looked after children were identified on arrival by on-site social workers, who alerted the relevant local authority to placements and reminded them of their statutory responsibilities to the child while in custody. Since the onset of the pandemic, community social workers had not routinely attended sentence planning meetings. On-site social workers routinely visited those on full care orders, to make sure that their needs were being met. Resettlement caseworkers facilitated the reviews of these children, and worked closely with the external social workers to make sure that they received the support they needed.

6.21 The social workers also screened children for referral to the National Referral Mechanism and encouraged local authorities to refer them when required. In the previous six months, 59 children had been identified as potentially needing a referral, 14 children had been proven definitively to be victims of exploitation and a further 10 children had been initially reviewed as potential victims but were waiting for a conclusive decision.

Reintegration planning

Expected outcomes: Children's resettlement needs are addressed prior to release. An effective multi-agency response is used to meet the specific needs of each individual child to maximise the likelihood of successful reintegration into the community.

6.22 Plans for release and reintegration into the community were reasonable. Children's individual needs were assessed as part of the remand or training plan on arrival and discussed at review meetings. In our survey, 44% of respondents said that someone was helping them to prepare for when they left, which was an improvement from the last inspection.

6.23 Release planning involved several departments and community agencies. However, the plans concentrated mainly of accommodation and education outcomes, and although other work was taking place, it was not coordinated across all resettlement pathways.

6.24 The education department had a team of engagement and resettlement staff who worked with children to make plans for release. They worked on a range of resettlement-focused activities, including holding open training placements, where possible, and helping with CV building and career planning. Outcomes for children were not collected systematically or discussed at resettlement meetings.

6.25 Leaders had good oversight of accommodation a month before release. A total of 87 children had been released from the establishment over the previous six months; only two of these had been homeless and had ended up in transient accommodation. This had been because they had turned 18 while in custody and there had been last-minute changes in circumstances that could not have been foreseen; we found adequate evidence of escalation for both of these individuals.

6.26 Practical arrangements for release were in place for each child. There was a small stock of non-prison clothing for children who needed some additional clothes, and they were provided with a suitable bag for their possessions. A named person was identified to collect them on the day of release.

Interventions

Expected outcomes: Children can access interventions designed to promote successful rehabilitation.

6.27 There was a range of accredited programmes. Interventions were delivered by either trained facilitators or, for more complex cases, the prison psychology department.

6.28 Interventions had stopped at the start of the pandemic and been restarted in September 2020. They had since been given mainly on a one-to-one basis, which limited the number of children that could complete programmes. Since restarting, there had been 25 programme completions; however, there was still a waiting list of 61 children at the time of the inspection. Children were reviewed and prioritised based on release dates and level of need, but this meant that some had been released without having their identified offending behaviour needs met.

6.29 Finance, benefit and debt provision was underdeveloped. While children were able to open bank accounts, not all departments were aware of this facility.

Section 7 Summary of key concerns and recommendations

The following is a list of repeated and new concerns and recommendations in this report.

Key concerns and recommendations

7.1 Key concern (1.36): The number of violent incidents was high. The response to this was invariably to keep children apart from each other, which had a negative impact on their regime and reinforced the violent behaviour. Staffing unavailability, lack of engagement and redeployment of specialist conflict resolution staff to support the regime compounded the problem.

Key recommendation: An effective violence reduction strategy, with a robust action plan, should be implemented to reduce the incidence of violence. (To the governor)

7.2 Key concern (1.37): Too much poor behaviour went unchallenged by staff. This included banging of doors, the blocking of observation panels and shouting out of doors and windows. Expectations about behaviour were not enforced robustly and there was an inconsistent approach to ensuring that even the most basic of standards were met. There was a lack of short- and long-term incentives to make sure that children who engaged could consistently progress and attain long-term goals, such as peer support roles, release on temporary licence (ROTL) and education outcomes.

Key recommendation: Consistent expectations of behaviour should be set and communicated to children. (To the governor)

Key recommendation: There should be clear pathways for children that properly incentivise education, rehabilitation work and prosocial behaviour. (To the governor)

7.3 Key concern (1.38): The arrangements for separating children did not safeguard children's well-being. Local managers had failed to prevent children from being subject to potentially harmful regimes for extended periods. Oversight arrangements did not enable managers to be better informed of the interactions, education or health care input that these children were receiving. Safeguards for separated children involved a large number of cursory checks, rather than meaningful and dynamic engagement.

Key recommendation: Leaders and managers should make sure that children subject to separation can access a regime that is equivalent to that of their non-separated peers. (To the governor)

7.4 Key concern (1.39, repeated recommendation S50): Extensive and offensive graffiti in cells, communal areas and exercise yards remained

a significant problem and was emblematic of generally poor standards across the prison. During the inspection, children told us that graffiti was a ‘normal’ feature of the prison. Poor standards of cleanliness in cells and communal areas were not challenged effectively by staff and managers.

Key recommendation: The establishment should be well maintained, clean and free of graffiti. (To the governor)

7.5 Key concern (1.40): The promotion of equality and diversity remained weak. Equality monitoring data did not lead to actions or thorough investigations into disproportionate outcomes for some children in protected groups. Investigations into discrimination following receipt of incident report forms were poor and some did not take place at all.

Key recommendation: Leaders should make sure that all incidences of discrimination are identified, investigated and addressed. (To the governor)

7.6 Key concern (1.41): The well-resourced mental health services continued to struggle with accessing the children in confidential and therapeutic rooms with allocated officer escorts, resulting in frequently aborted appointments.

Key recommendation: Children should be able to access planned mental health care appointments in clinically appropriate and therapeutic environments. (To the governor)

7.7 Key concern (1.42): Time out of cell was too limited, at a daily average of about four and half hours on weekdays and two hours at weekends. Regime restrictions and controlled movement were responsible for many delays affecting the time available to children for education classes, work or recreation.

Key recommendation: Opportunities for children to spend time out of their cell in education or other constructive activities, including social time together, should be increased, particularly at the weekend. (To the governor)

7.8 Key concern (1.43): Children were not able to access enough hours or a broad enough range of face-to-face education, and many were justifiably frustrated that they had too few in-cell learning tasks to complete.

Key recommendation: Leaders should make sure that they maximise opportunities for children to study, including in-cell study. (To the governor)

7.9 Key concern (1.44): Leaders were not able to offer the subjects that they had planned as part of the curriculum because of shortages of teachers and prison officers. Too often, classes that were offered were delivered intermittently. As a result, not enough children developed their vocational, mathematics, English, and information and communications technology (ICT) skills at satisfactory rates.

Key recommendation: Leaders should make sure that the curriculum includes sufficient opportunities for children to develop vocational, mathematics, English and ICT skills. (To the governor)

7.10 Key concern (1.45): Too many children did not attend their allocated classes or arrived late to lessons.

Key recommendation: Leaders across the prison should make sure that they work collaboratively to prioritise education and increase children's attendance at classes. (To the governor)

7.11 Key concern (1.46): Children's written work was, in many cases, of low quality. They wrote answers to theory-based questions that were partially incorrect. In a few cases, children did not take tasks seriously, and their answers to questions were of an inappropriate tone. Teachers usually marked this work as correct, without challenging the children to produce more detailed or accurate answers.

Key recommendation: Leaders should make sure that teachers provide children with constructive feedback that helps them to improve their work. (To the governor)

7.12 Key concern (1.47): Despite good in-person and remote visits provision, take-up was low. In addition, children faced long delays in getting telephone numbers approved and receiving letters from their family and friends.

Key recommendation: Children should receive support to enable them to maintain contact with their family and friends in the community. (To the governor)

7.13 Key concern (1.48): We found several areas where there was an absence of adequate risk management. ROTL risk assessments were not sufficiently robust; they failed to acknowledge any potential risk of harm posed by the child. MAPPA management levels were not routinely confirmed before release, and contributions to MAPPA meetings were variable. Case workers had no formal training in risk management.

Key recommendation: Risk management processes, including ROTL and public protection, should identify and action risks adequately. (To the governor)

Recommendation

7.14 Recommendation (4.52): A memorandum of understanding should be developed with the local authority and social care provider, to make sure that arrangements are in place if a child needs social care. (To the governor)

7.15 Recommendation (4.72): Medicines should be administered in line with national standards and at times which facilitate optimum therapeutic effect.

Section 8 Progress on recommendations from the last full inspection report

Recommendations from the last full inspection

The following is a summary of the main findings from the last full inspection report and a list of all the recommendations made, organised under the four tests of a healthy establishment. If a recommendation has been repeated in the main report, its new paragraph number is also provided.

Safety

Children, particularly the most vulnerable, are held safely.

At the last inspection, in 2019, reception processes at Cookham Wood were reasonable but a full induction was undermined by excessive periods of lock-up. Safeguarding had improved since the previous inspection. There was good care for children at risk of self-harm. Levels of violence remained too high. Management of the perpetrators of violence and support for victims were reasonable but undermined by redeployment of the conflict resolution team. The instant rewards and sanctions system was less effective. Use of force was high and there were weaknesses in oversight. The regime for separated children was poor despite good efforts by staff on Phoenix and Bridge units. Living conditions on Phoenix unit remained poor. Outcomes for children were not sufficiently good against this healthy establishment test.

Key recommendations

Clear and consistent standards and expectations of behaviour should be set and communicated to children. Poor behaviour by children should be challenged by staff. (S45)
Not achieved

Managers should ensure that conflict resolution work is prioritised to reduce levels of violence at Cookham Wood. (S46)
Not achieved

Oversight of use of force should ensure that staff using MMPR are trained to do so and all safeguarding concerns are identified. (S47)
Achieved

Children separated on rule 49 should have their needs identified and met. (S48)
Not achieved

Recommendations

Children should have an induction that keeps them fully occupied and provides them with all they need to know about life at Cookham Wood. (1.6)
Not achieved

Good behaviour should be incentivised regardless of the child's location. (1.29)
Not achieved

Separated children should receive a regime that is equivalent to their non-separated peers. (1.55)
Not achieved

Care

Children are cared for by staff and treated with respect for their human dignity.

At the last inspection, in 2019, on most wings staff simply did not have the time to develop meaningful relationships with the children in their care. Communal areas and cells were grubby, and graffiti remained a significant problem. Cells were reasonably well equipped, and children appreciated the in-cell showers and telephones. Food remained reasonably good, but most children ate all their meals in their cells. Consultation was reasonable but weaknesses remained in the complaints system. The promotion of equality was inadequate which was a significant concern in an establishment holding such a diverse population. Child-focused health services remained good. Outcomes for children were not sufficiently good against this healthy establishment test.

Key recommendations

Staff should have the time to develop meaningful relationships with the children in their care. (S49)
Not achieved

The establishment should be well maintained, clean and graffiti free. (S50)
Not achieved (Recommendation repeated, 1.39)

Managers should ensure that the diverse needs and entitlements of children are met. (S51)
Not achieved

Recommendations

All areas of the prison should be consistently cleaned, and all graffiti removed. (2.16)
Not achieved

Delays in answering cell bells should be investigated and monitored to ensure that all cell bells are answered within five minutes. (2.17)
Not achieved

Emergency response arrangements should be improved, and ambulances called without delay when necessary. (2.52)
Achieved

A memorandum of understanding should be developed with the local authority and social care provider to ensure that arrangements are in place if a child requires social care. (2.53)
Achieved

The transfer of patients to community mental health services under the Mental Health Act should occur within the national guideline timescale. (2.71)
Achieved

The oversight of medicines management should be strengthened by improved attendance at medicines and therapeutics committee meetings and improved audit schedules. (2.83)
Achieved

Purposeful activity

Children are able, and expected, to engage in activity that is likely to benefit them.

At the last inspection, in 2019, time out of cell remained limited for most children. Library and gym facilities were good but access to the gym was restricted. Leaders and managers understood the shortcomings of the education provision and an action plan was in place. However, this had not yet improved outcomes for children. Chronic poor punctuality undermined teaching, learning and behaviour management. Most children in mainstream education and outreach did not receive the education hours that they were entitled to. Only 50% of children who started courses completed them and achieved the target qualification. This was worse in functional skills and particularly bad in mathematics. Outcomes for children were not sufficiently good against this healthy establishment test.

Key recommendations

The issues of controlled movement in small groups around the prison should be resolved to ensure that all children receive their entitlements and time out of cell is increased to 10 hours a day. (S52)
Not achieved

Senior leaders should implement a new system so that children arrive on time for learning and skills sessions, are ready to learn and receive at least their minimum statutory entitlement to learning. (S53)
Not assessed at this inspection

Senior leaders should eliminate poor behaviour in non-vocational sessions so that violence or disturbance to lessons ceases. They should deal effectively with the culture of violence and antagonism in the prison. (S54)
Not assessed at this inspection

Senior leaders should find out why so few children gain their target qualification in any subject and take decisive actions to ensure that all children's attainment improves substantially. (S55)
Not assessed at this inspection

Recommendations

Prison and education leaders should ensure that children's allocation to learning pathways is determined by what best matches their aspirations or previous experience. (3.15)
Not assessed at this inspection

Prison and education leaders should ensure that the engagement and resettlement team provide comprehensive support to children during and after their time in the prison. (3.16)
Not assessed at this inspection

Prison leaders should review the risk assessment process to establish how more children can take up vocational courses. (3.17)
Not assessed at this inspection

Education leaders should maintain their focus on developing the skills of teaching staff, ensuring particularly that all teachers manage instances of poor behaviour or bad language well. (3.24)
Not assessed at this inspection

Prison and education leaders should improve the quality of outreach provision and extend the time that children can access it. (3.25)
Not assessed at this inspection

Resettlement

Children are effectively helped to prepare for their release back into the community and to reduce the likelihood of reoffending.

At the last inspection, in 2019, children and families work had improved since the previous inspection, although visits facilities remained basic. Casework was not coordinated with the rest of the establishment and oversight of resettlement required significant improvement. Only half the children knew they had a training or remand plan. Many of the plans that we reviewed lacked focus on resettlement and risk management in the community. Cedar unit (the resettlement unit) was a good initiative and there was frequent use of release on temporary licence (ROTL). However, ROTL risk assessments required improvement. Long running weaknesses in the management of public protection continued. Access to a potentially good range of interventions was undermined by staff shortages. The lack of suitable accommodation on release remained a serious concern. Outcomes

for children were not sufficiently good against this healthy establishment test.

Key recommendations

All 18-year-olds held in children's establishments should be able to transition to the adult estate in a safe and timely manner. (S56)
Achieved

The casework department should deliver a coordinated approach to resettlement to meet children's needs before release. (S57)
Not achieved

Risk management and public protection processes should ensure safe release planning for children leaving custody. (S58)
Not achieved

Recommendations

Appropriate resource should be allocated to ensure swift security clearance of the contact numbers of children's family members. (4.6)
Not achieved

Managers should ensure that ROTL risk assessments are comprehensive, taking full account of potential risk in the community. (4.18)
Not achieved

Children leaving custody should be provided with suitable accommodation in time for other elements of release planning to be completed. (4.36)
Achieved

Managers should ensure that children are able to access the appropriate interventions before release to promote successful rehabilitation. (4.41)
Not achieved

Appendix I About our inspections and reports

Her Majesty's Inspectorate of Prisons is an independent, statutory organisation which reports on the treatment and conditions of those detained in prisons, young offender institutions, secure training centres, immigration detention facilities, police and court custody and military detention.

All inspections carried out by HM Inspectorate of Prisons contribute to the UK's response to its international obligations under the Optional Protocol to the UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). OPCAT requires that all places of detention are visited regularly by independent bodies – known as the National Preventive Mechanism (NPM) – which monitor the treatment of and conditions for detainees. HM Inspectorate of Prisons is one of several bodies making up the NPM in the UK.

All Inspectorate of Prisons 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. For children's establishments the tests are:

Safety
Children, particularly the most vulnerable, are held safely.

Care
Children are cared for by staff and treated with respect for their human dignity.

Purposeful activity
Children are able, and expected, to engage in activity that is likely to benefit them.

Resettlement
Children are effectively helped to prepare for their release back into the community and to reduce the likelihood of reoffending.

Under each test, we make an assessment of outcomes for children and therefore of the establishment's overall performance against the test. There are four possible judgements: in some cases, this performance will be affected by matters outside the establishment's direct control, which need to be addressed by Her Majesty's Prison and Probation Service (HMPPS).

Outcomes for children are good.
There is no evidence that outcomes for children are being adversely affected in any significant areas.

Outcomes for children are reasonably good.
There is evidence of adverse outcomes for prisoners in only a small number of areas. For the majority, there are no significant concerns. Procedures to safeguard outcomes are in place.

Outcomes for children are not sufficiently good.
There is evidence that outcomes for children are being adversely affected in many areas or particularly in those areas of greatest importance to their well-being. Problems/concerns, if left unattended, are likely to become areas of serious concern.

Outcomes for children are poor.
There is evidence that the outcomes for children are seriously affected by current practice. There is a failure to ensure even adequate treatment of and/or conditions for children. Immediate remedial action is required.

Our assessments might result in one of the following:

Key concerns and recommendations: identify the issues of most importance to improving outcomes for children and are designed to help establishments prioritise and address the most significant weaknesses in the treatment and conditions of children.

Recommendations: will require significant change and/or new or redirected resources, so are not immediately achievable, and will be reviewed for implementation at future inspections.

Examples of notable positive practice: innovative work or practice that leads to particularly good outcomes from which other establishments may be able to learn. Inspectors look for evidence of good outcomes for children; original, creative or particularly effective approaches to problem-solving or achieving the desired goal; and how other establishments could learn from or replicate the practice.

Five key sources of evidence are used by inspectors: observation; surveys of children and staff; discussions with children; discussions with staff and relevant third parties; and documentation. During inspections we use a mixed-method approach to data gathering and analysis, applying both qualitative and quantitative methodologies. Evidence from different sources is triangulated to strengthen the validity of our assessments.

Other than in exceptional circumstances, all our inspections are unannounced and include a follow up of recommendations from the previous inspection.

All inspections of prisons are conducted jointly with Ofsted or Estyn (Wales), the Care Quality Commission and the General Pharmaceutical Council (GPhC). Some are also conducted with HM Inspectorate of Probation. This joint work ensures expert knowledge is deployed in inspections and avoids multiple inspection visits.

This report

This report provides a summary of our inspection findings against the four healthy establishment tests. There then follow four sections each containing a detailed account of our findings against our *Expectations. Criteria for assessing the treatment of children and conditions in prisons* (Version 4, 2018) (available on our website at https://www.justiceinspectorates.gov.uk/hmiprisons/our-

expectations/children-and-young-people-expectations/). The reference numbers at the end of some recommendations indicate that they are repeated and provide the paragraph location of the previous recommendation in the last report. Section 7 lists all recommendations made in the report. Section 8 lists the recommendations from the previous full inspection (and scrutiny visit where relevant), and our assessment of whether they have been achieved.

Findings from the survey of children and a detailed description of the survey methodology can be found on our website (see Appendix III: Further resources). Please note that we only refer to comparisons with other comparable establishments or previous inspections when these are statistically significant. The significance level is set at 0.01, which means that there is only a 1% chance that the difference in results is due to chance.

Inspection team

This inspection was carried out by:

Charlie Taylor	Chief inspector
Angus Jones	Team leader
David Foot	Inspector
Paul Rowlands	Inspector
Rebecca Stanbury	Inspector
Donna Ward	Inspector
Joe Simmonds	Researcher
Shannon Sahni	Researcher
Heather Acornley	Researcher
Alec Martin	Researcher
Tania Osborne	Lead health and social care inspector
Dayni Johnson	Care Quality Commission inspector
Jo White	Care Quality Commission inspector
Saul Pope	Ofsted inspector
Allan Shaw	Ofsted inspector

Appendix II Glossary of terms

We try to make our reports as clear as possible, and this short glossary should help to explain some of the specialist terms you may find. If you need an explanation of any other terms, please see the longer glossary, available on our website at: http://www.justiceinspectorates.gov.uk/hmiprisons/about-our-inspections/

Care Quality Commission (CQC)
CQC is the independent regulator of health and adult social care in England. It monitors, inspects and regulates services to make sure they meet fundamental standards of quality and safety. For information on CQC's standards of care and the action it takes to improve services, please visit: http://www.cqc.org.uk

Certified normal accommodation (CNA) and operational capacity
Baseline CNA is the sum total of all certified accommodation in an establishment except cells in segregation units, health care cells or rooms that are not routinely used to accommodate long stay patients. In-use CNA is baseline CNA less those places not available for immediate use, such as damaged cells, cells affected by building works, and cells taken out of use due to staff shortages. Operational capacity is the total number of prisoners that an establishment can hold without serious risk to good order, security and the proper running of the planned regime.

Leader
In this report the term 'leader' refers to anyone with leadership or management responsibility in the youth custody estate. We will direct our narrative at the level of leadership which has the most capacity to influence a particular outcome.

Protected characteristics
The grounds upon which discrimination is unlawful (Equality and Human Rights Commission, 2010).

Reverse cohort unit (RCU)
Unit where newly arrived prisoners are held in quarantine for between seven and 10 days.

Secure Stairs
The Framework for Integrated Care (Secure Stairs) aims to support trauma-informed care and formulation-driven, evidence-based, whole-systems approaches to creating change for children and young people within the children and young people secure estate. The implementation of this Framework includes staff across the whole secure setting in their intervention with children and young people. This is achieved through the provision of an environment where the day to day care of children and young people is underpinned by a focus on their relationship with staff, and an understanding of trauma/ attachment principles. All interventions should be driven by a 'formulation' approach, which takes into account the child or young person's life

experience, rather than concentrating on labels, categories or diagnoses, or settings, and one which draws from evidence-based interventions.

Secure video calls
A system commissioned by HM Prison and Probation Service (HMPPS). This system requires users to download an app to their phone or computer. Before a visit can be booked, users must upload valid ID.

Time out of cell
Time out of cell, in addition to formal 'purposeful activity', includes any time children are out of their cells to associate or use communal facilities to take showers or make telephone calls.

Appendix III Further resources

Some further resources that should be read alongside this report are published on the HMI Prisons website (they also appear in the printed copies distributed to the establishment). For this report, these are:

Establishment population profile

We request a population profile from each establishment as part of the information we gather during our inspection. We have published this breakdown on our website.

Survey of children – methodology and results

A representative survey of children in the establishment is carried out at the start of every inspection, the results of which contribute to the evidence base for the inspection. A document with information about the methodology and the survey, and comparator documents showing the results of the survey, are published alongside the report on our website.

Survey of staff – methodology and results

Establishment staff are invited to complete a staff survey. The results are published alongside the report on our website.

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