Report on an unannounced inspection of

HMYOI Wetherby and the Keppel unit

by HM Chief Inspector of Prisons

6 and 13–17 December 2021

Contents

Introduction

Wetherby is the largest young offender institution (YOI) in the country. It held 143 children – including three girls in the Napier unit – at the time of our inspection, much reduced from its capacity of 266. Our healthy prison test scores show that ground has been lost in the last two years, in part, no doubt, due to the pandemic.

In the Keppel unit, housed within the YOI and designated as a therapeutic provision, inspectors saw a disappointing fall in standards. At the time of the inspection it felt more like another wing of the main prison rather than provision for a vulnerable group of children with a range of complex needs. The unit needed some real grip from the leadership, with the aims re-established and suitable staff selected and trained to recover its distinct purpose.

A fall from a healthy prison test score of good to not sufficiently good in the area of resettlement reflects a deterioration in this area with a team that had become dysfunctional and disaffected. The public protection arrangements – for children who pose high levels of risk to the public – also needed urgent attention to make sure they were effectively monitored.

The governor and his team had managed to get the regime to open up more quickly from COVID-19 restrictions than we have seen on other sites, particularly on the two enhanced wings. Overall though, children were still spending too long in their cells, only being unlocked for an average of six hours on a weekday and fewer than five at weekends.

Leaders had aimed to transform behaviour management systems so that they focused more on rewarding and promoting positive behaviour and less on sanctions. However, adjudications still remained high and the governor's expectations had not yet been absorbed by staff on the wing, where children did not always receive the rewards they had earned and there was still over-reliance on punishment.

Inspectors noted some improvements in the use of de-escalation of incidents and use of force had reduced since our last inspection, although it was very disappointing to see some uses of pain-inducing techniques that could not be justified.

Accommodation on the wings remained prison-like and some of the exercise yards resembled those in a high security jail. Some improvements had taken place with the introduction of showers in some cells and the refurbishment of the new girl's wing on the Keppel unit. There will, however, need to be considerable capital investment to create an environment that is suitable for children.

Leaders had begun to roll out 'community learning' as an adjunct to formal education, but the curriculum had not been sufficiently developed, expectations of the children were not communicated and there were no outcome measures in place to show progress. Leaders needed to do further work to clarify the

meaning of community learning, what the objectives were and how this would be communicated to staff and children.

The closure of places elsewhere and the refusal of some secure children's homes to accept girls with more complex needs – particularly those who were violent – meant that a decision was taken by the Youth Custody Service to develop additional capacity at Wetherby. The YOI had embraced this challenge and had worked hard to provide a more suitable environment for girls. At the time of the inspection they were housed in Napier unit where staff had created a caring and supportive environment.

A leadership team of 27 seemed to far exceed what was needed to manage this prison, which contained just 140 children. A move to a flatter leadership structure would create clearer lines to the governor and his deputy, avoid duplication, improve accountability and allow resources to be deployed elsewhere.

Levels of violence had remained lower than comparator prisons and, in our survey, just 3% of children said they felt unsafe – an impressive reduction from 27% at our last inspection.

The calmer atmosphere at Wetherby should provide the opportunity for children to spend more time out of their cells and be involved in a wider range of purposeful activity. If the governor's vision for positive behaviour management is to be translated into a change in practice on the wing, there needs to be consistent and committed focus from leaders on making sure that good behaviour is recognised and rewarded. Children who are often stuck in long-term patterns of negative behaviour will need to see and feel the benefits of doing the right thing.

The scores from this inspection will have been disappointing to staff at Wetherby and Keppel after what has been a difficult year. There is, however, the opportunity for this establishment to build on the many positives that we highlight in this report, particularly as the disruption from the pandemic begins to recede.

Charlie Taylor
HM Chief Inspector of Prisons
December 2021

About HMYOI Wetherby and the Keppel unit

Task of the establishment
HMYOI Wetherby is an establishment looking after children aged between 15 and 18 years. It is part of the youth custody estate.

Certified normal accommodation and operational capacity (see Glossary of terms)
Children held at the time of inspection: 142
Baseline certified normal capacity: 340
In-use certified normal capacity: 276
Operational capacity: 266

Population of the establishment
- 174 children had arrived in the last six months
- 16 were foreign nationals
- 31% of children were from black and minority ethnic backgrounds
- 28% of children were on remand
- 20 children were released into the community on average each month
- Three-quarters of children had been in the care of their local authority at some point before custody
- 29% of children were excluded from school before custody
- 32% of children were not in education, employment or training before custody.

Establishment status (public or private) and key providers
Public

Physical health provider: Leeds Community Healthcare NHS Trust
Mental health provider: South-west Yorkshire Partnership NHS Foundation Trust
Substance misuse treatment provider: Young People's Drug and Alcohol Support Service (YPDASS)
Prison education framework provider: Novus
Escort contractor: GEOAmey

Prison group/Department
Youth Custody Service

Brief history
A former naval base, Wetherby became a borstal in 1958 and has since changed its role from an open youth custody centre to a closed youth custody centre and is now a dedicated establishment for children between 15 and 18.

Short description of residential units
- Anson is the separation unit.
- Benbow is a 48-bed unit and is the first night and induction centre. One spur of the unit for all restricted status boys.
- Collingwood and Drake are 60-bed units with an enhanced unit for children on gold level of the incentives and earned privileges scheme.

- Exmouth and Frobisher are 60-bed units. (Exmouth closed for renovation).
- Keppel unit is a 48-bed nationally resourced complex needs unit for children referred there by the central placements team.
- Napier is the enhanced support unit. (Three girls were held temporarily on Napier while designated female accommodation on Keppel was being refurbished.)

Name of governor and date in post
Pete Gormley, July 2020

Leadership changes since the last inspection
Craig Lowe, temporary acting governor, September 2019 to July 2020
Andrew Dickinson, governor, October 2016 to September 2019

Prison Group Director
Heather Whitehead

Independent Monitoring Board chair
Catherine Porter

Date of last inspection
March 2019

Section 1 Summary of key findings

1.1 We last inspected HMYOI Wetherby and Keppel unit in 2019 and made 27 recommendations, four of which were about areas of key concern. The establishment fully accepted 26 of the recommendations and partially (or subject to resources) accepted one. It rejected none of the recommendations.

1.2 In January 2021, during the COVID-19 pandemic, we conducted a scrutiny visit at the establishment. We made seven recommendations about areas of key concern.

1.3 Section 8 contains a full list of recommendations made at the last full inspection and scrutiny visit and the progress against them.

Progress on key concerns and recommendations from the full inspection

1.4 Our last inspection of HMYOI Wetherby and Keppel unit 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.

1.5 At our last full inspection, we made two recommendations about key concerns in the area of safety. At this inspection we found that both of those recommendations had not been achieved.

1.6 We made one recommendation about key concerns in the area of purposeful activity. At this inspection we found that this recommendation had been achieved.

1.7 We made one recommendation about key concerns in the area of resettlement. At this inspection we found that this recommendation had not been achieved.

Progress on recommendations from the scrutiny visit

1.8 During the pandemic we made a scrutiny visit to HMYOI Wetherby and the Keppel unit. Scrutiny visits (SVs) focused on individual establishments and how they were recovering from the challenges of the COVID-19 pandemic. They were shorter than full inspections and looked at key areas based on our existing human rights-based *Expectations*. For more information on SVs, visit https://www.justiceinspectorates.gov.uk/hmiprisons/about-hmi-prisons/covid-19/scrutiny-visits/.

1.9 At the SV we made some recommendations about areas of key concern. As part of this inspection, we have followed up those

recommendations to help assess the continued necessity and proportionality of measures taken in response to COVID-19, how well the establishment is returning to a constructive rehabilitative regime, and to provide transparency about the establishment's recovery from COVID-19.

1.10 We made seven recommendations about areas of key concern. At this inspection we found that one of the recommendations had been achieved and six had not been achieved.

Outcomes for children

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

1.12 At this inspection of HMYOI Wetherby, we found that outcomes for children had stayed the same in two healthy prison areas and declined in two.

1.13 At this inspection of Keppel unit, we found that outcomes for children had declined in all healthy prison areas.

1.14 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 Service (HMPPS) National Framework for prison regimes and services.

Figure 1: HMYOI Wetherby healthy establishment outcomes 2019 and 2021

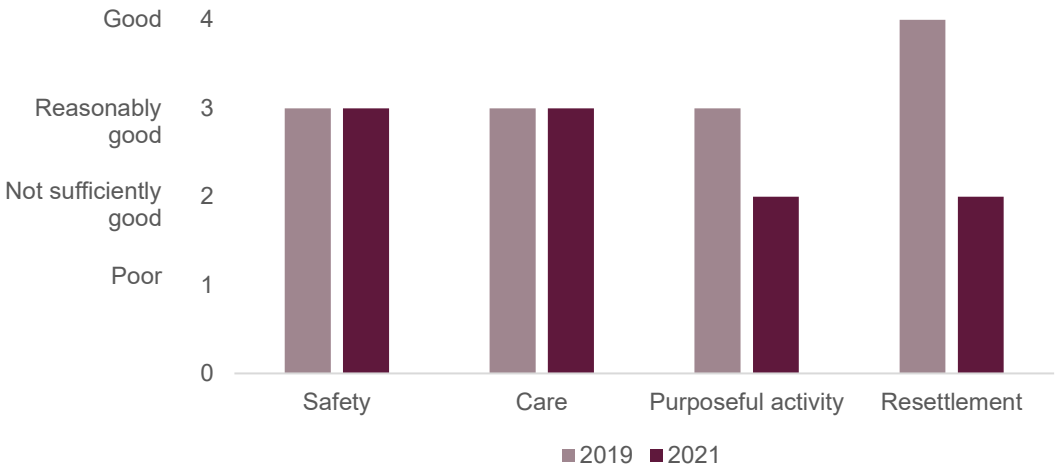
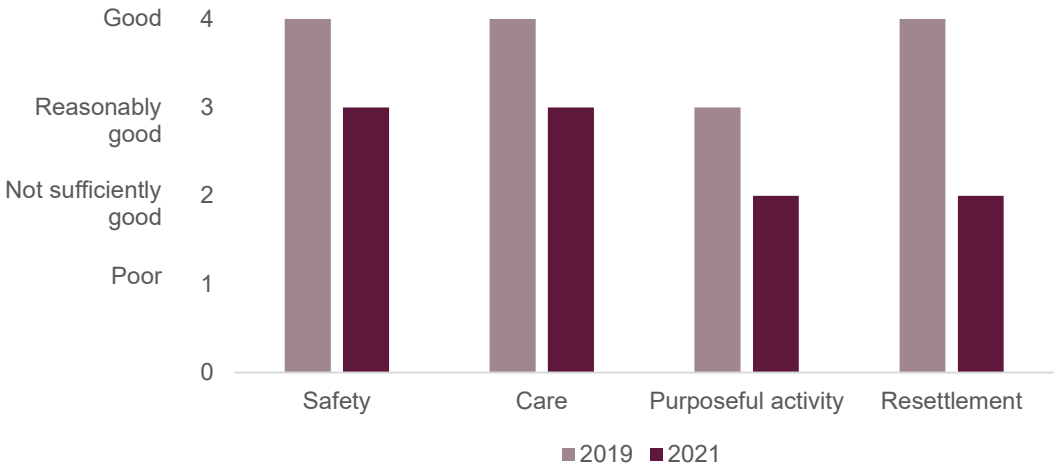


Figure 2: Keppel unit healthy establishment outcomes 2019 and 2021



Safety

At the last inspection of HMYOI Wetherby in 2019, we found that outcomes for children at Wetherby were reasonably good and outcomes for children at Keppel were good against this healthy prison test.

At this inspection we found that outcomes for children at Wetherby and Keppel were reasonably good against this healthy prison test.

1.15 The new escort contractor delivered an improved service and children no longer had to share transport with adult prisoners. Initial safety screening and supervision of children on their first night at both Wetherby and Keppel were good. Most boys did not complete the full induction programme and spent long periods locked up with little to occupy them. The induction for girls was better and they had more time in activities and with their peers during their first week.

1.16 In our survey, just 3% of children at Wetherby and 8% on Keppel said they felt unsafe at the time of the inspection. Safeguarding referrals were robustly investigated by the establishment, although prison leaders failed to refer all allegations relating to staff to the local authority designated officer. Monthly and quarterly safeguarding meetings took place but there was little action planning or analysis of data. Rates of self-harm had increased since our last inspection and scrutiny visit. Children in crisis were well cared for.

1.17 Intelligence was processed promptly, and there was no backlog of intelligence reports, which was positive. However, local security objectives did not reflect key risks in areas of public protection and illicit items. We were also concerned to find that leaders were not aware of the outcome of security actions, including searching. The random

mandatory drug testing positive rate was high and no action had been taken to identify the cause or provide support, which was concerning.

1.18 Levels of violence were lower than at similar establishments. Investigations into violent incidents were limited and did not identify causes or generate actions. Referrals were made to the conflict resolution team for every child who was reported to be involved in a violent incident.

1.19 There were opportunities at Wetherby and Keppel to capture children's interest and motivate them to behave well. However, the vision of a reward culture was not embedded or fully understood by frontline staff or children and we observed inconsistent practice. Staff were not aware of the full scope and range of bullying behaviour. For example, large quantities of canteen (items purchased from the shop) in cells were not investigated to see if the child had legitimately purchased them. This meant bullying and debt could go unnoticed. There was an overreliance on the use of adjudications for low-level matters which could have been managed on residential units.

1.20 Levels of use of force had reduced at Wetherby since our last inspection and were lower than at comparable prisons. Oversight was good, every incident was reviewed within 24 hours and safeguarding referrals were promptly made. We observed instances of the use of pain-inducing techniques on children that were not justified or necessary.

1.21 The use of separation had increased since our last inspection. Periods of separation were longer for children than in similar establishments, and steps to reintegrate children were not always taken at the earliest opportunity. Oversight of children separated from others on the main accommodation required improvement. Most cells on the separation unit were clean and free of graffiti and children spoke positively about staff.

Care

At the last inspection of HMYOI Wetherby in 2019, we found that outcomes for children at Wetherby were reasonably good against this healthy prison test. Outcomes for children at Keppel were good against this healthy prison test.

At this inspection we found that outcomes for children at Wetherby and Keppel were reasonably good against this healthy prison test.

1.22 Relationships between staff and children were good. At both sites, children said in our survey that most staff treated them well. The re-introduction of custody support plan interviews had improved opportunities for staff to discuss children's concerns. However, they were not fully established, which affected the quality and frequency of these sessions.

1.23 Communal areas were clean and well decorated, but exercise yards were poor, with no facilities for activities. Most cells were clean and free of graffiti, however some required decoration and most did not have enough storage for clothes. Many cells had been refurbished with in-cell showers, but some toilets were not screened, and most did not have seats. Access to cleaning materials, clean bedding and clothes was good. Property sent to children was unnecessarily delayed because it had to be sent to another establishment to be X-rayed.

1.24 The introduction of weekly wing consultations and a monthly youth forum were an improvement, but most children were unaware of them. There were opportunities for many children to eat out of their cells, which was positive.

1.25 Equality and diversity work had been given a higher priority in recent months after receiving less attention in the earlier stages of the pandemic. Managers were aware that the needs analysis and strategy did not reflect the current population. In some areas data on treatment or access to services were compared to population data which enabled managers to identify differences in treatment and undertake further investigation. This was an improvement since the scrutiny visit in January 2021 but needed further development. Some consultation was taking place with children about equality and diversity and managers were exploring how protected characteristic forums for children could be reintroduced. There were gaps in support for children with protected characteristics and little guidance for staff on what should be provided. Complaints about discrimination were dealt with reasonably well. Face-to-face support from the chaplaincy had been maintained throughout the pandemic and chaplains continued to play an active role around the establishment.

1.26 Health and substance misuse services had improved and were very good. Patients were satisfied with their care. There was a prison-wide health promotion strategy and a proactive approach to administering immunisations and vaccinations. There was prompt access to a range of age-appropriate primary care services for boys and girls. Waiting times were good, except for the dentist which were too long. Pharmacy services and medicines management were efficient, had innovated and changed clinical procedures, and demonstrated good practice in clinical audit.

1.27 The integrated approach to mental wellbeing delivered systematic, evidence-based pathways of care with notable practice in supporting patients with brain trauma and neuro-diverse needs. More than 60% of prison staff had received bespoke mental health training during the restrictions, which was impressive. Delays in the transfer of patients with complex needs under the Mental Health Act remained unacceptable.

Purposeful activity

At the last inspection of HMYOI Wetherby in 2019, we found that outcomes for children at Wetherby and Keppel were reasonably good against this healthy prison test.

At this inspection we found that outcomes for children at Wetherby and Keppel were not sufficiently good against this healthy prison test.

1.28 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.

1.29 Boys on Wetherby and Keppel spent about six hours unlocked on weekdays and girls about five hours 15 minutes. This was better than at most comparable sites but below our expectations. At weekends children across both sites spent about four hours out of cell which was not enough. Gym provision was very good for boys at Wetherby and Keppel but was less developed for girls. Every child had access to library services at least once a week.

1.30 Leaders and managers were unsuccessful in implementing their ambitious vision to create a curriculum that met the needs of children from challenging backgrounds and with poor previous experiences of formal education. Leaders were not clear about what activities would comprise the community learning component of the curriculum. Consequently, teachers were left to plan and deliver sessions that lacked purpose and too many children failed to achieve tangible benefits.

1.31 Children's access to a broad vocational curriculum had reduced since the previous inspection. Vocational pathways were planned in a logical way that built on and consolidated the knowledge that children gained over time. In contrast the design and teaching of the functional English and mathematics courses had not enabled enough children to learn, develop their knowledge and understanding, and pass their exams. Only a third of children completed courses in these subjects.

1.32 Children on the Keppel unit benefited from a well-structured and taught curriculum in most subjects. Teachers had a detailed knowledge of the children they taught. They understood their complex needs and the factors that triggered poor behaviour.

1.33 Leaders rewarded children for their positive attitudes and behaviour and attendance and engagement improved as a result. When teachers delivered well-planned and structured activities, most lessons were calm and purposeful. Children worked hard in catering and art lessons, stayed fully focused, and clearly enjoyed their lessons. In contrast, there was too much disruption in some English lessons.

Resettlement

At the last inspection of HMYOI Wetherby in 2019, we found that outcomes for children at Wetherby and Keppel were good against this healthy prison test.

At this inspection we found that outcomes for children at Wetherby and Keppel were not sufficiently good against this healthy prison test.

1.34 The uptake of secure video calls was exceptional and about 430 calls were taking place each month. However, in-person visits only took place on weekdays which created difficulties for families who worked and those who had to travel long distances.

1.35 A needs analysis and reducing reoffending strategy were in place but there were weaknesses in leadership in this area. Reducing reoffending meetings had recently restarted after ceasing for a year, but the meetings were limited in scope and did not use data well enough to inform provision. We found evidence of good communication between Wetherby and key prisons in the adult estate which helped to prepare some children well for transfer. Fewer children were accessing release on temporary licence (ROTL) than at the last inspection. ROTL procedures required more structure and oversight. About three-quarters of the children had been in local authority care and the social work team in resettlement gave them good support.

1.36 Sentence plans and reviews were conducted at the appropriate frequency, attendance by youth offending teams and child and adolescent mental health services (CAMHS) was good but attendance by other departments varied. Resettlement practitioners held reasonable case loads and had good knowledge of the needs of the children in their care. The quality of planning meetings remained inconsistent and children we spoke to were often unclear about their plans and targets. Resettlement practitioners continued to lack formal supervision and oversight of their work was limited.

1.37 Children had continued to be assessed for and have access to the range of interventions approved for use by the Youth Custody Service, mostly on a one-to-one basis. The first group work intervention since the pandemic started had recently been reintroduced which was an important step forward.

1.38 Resettlement practitioners undertook some risk management, but the interdepartmental risk management team meeting was no longer an effective forum for discussing and managing risk. PIN phone monitoring was in disarray, calls were not monitored and decisions to monitor some children were indefensible.

1.39 Resettlement practitioners worked well with community partners to support reintegration but outcomes on release were concerning. During the previous 12 months, accommodation was not arranged for many

children in good time before their release and nearly half the children were released without an education or vocational training placement.

Key concerns and recommendations

1.40 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.

1.41 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.

1.42 Key concern: Keppel unit had lost its identity since the previous inspection. Children and staff had experienced unstable leadership, outcomes had declined in all areas and the unit was no longer delivering a distinctive therapeutic environment. Provision was indistinguishable from the rest of the YOI in most areas.

Recommendation: Leaders and managers should better define the purpose of Keppel unit and put services in place that meet the needs of children placed there. (To the governor)

1.43 Key concern: The induction programme for Wetherby and Keppel was rarely completed by boys. They missed important information about life at Wetherby and Keppel and spent too long locked in their cells with little to occupy them.

Recommendation: The induction programme should engage children and ensure they understand the key aspects of life at Wetherby and Keppel. (To the governor)

1.44 Key concern: Intelligence was processed promptly but key areas of security risk remained that were not analysed adequately. For example, leaders were aware of a significant backlog of phone monitoring, but the risks had not been recorded on any security intelligence logs. The monthly security assessments were weak and the impact of this risk on the establishment or the public had not been considered.

Recommendation: Known security risks should be thoroughly analysed to enable an appropriate response to emerging concerns. (To the governor)

1.45 Key concern: Rates of separation had increased since our last inspection, and periods of separation were longer for children than in similar establishments. Reintegration was not always considered or implemented at the earliest opportunity. Oversight of separated children was not adequate and mandatory daily visits were not always taking place. There was less access to education than for their non-separated peers.

Recommendation: Leaders should improve oversight of children separated, ensuring that they can access a regime that is equivalent to that of their non-separated peers and that reintegration takes place at the earliest opportunity. (To the governor)

1.46 Key concern: There were still weaknesses in equality work. The equality needs assessment, strategy and action plan were out of date, and there was no guidance for staff on how to support children from protected groups and data were not used adequately. There was limited consultation with children in protected groups and there was no forum for black and minority ethnic children to discuss negative perceptions with managers. There were key differences in provision and outcomes for the girls in the population.

Recommendation: **Leaders should use data to identify and address inequitable outcomes and provide support to children with additional needs.** (To the governor)

1.47 Key concern: Children did not spend enough time out of cell during the day, particularly at weekends. Management information did not record time out of cell accurately.

Recommendation: The time that children spend out of their cells in activity should be increased, particularly at weekends. (To the governor)

1.48 Key concern: The regime allowed all children time outside every day, but outdoor facilities were poor, and there was no organised exercise. We observed children standing around in bare yards with nothing to do. Children had requested improvements to the range of activities permitted on exercise yards through the youth forum.

Recommendation: Facilities for games and social interaction in outdoor areas and the supervision of outside activities should be improved so that children are enabled and encouraged to make better use of their time outside. (To the governor)

1.49 Key concern: The teaching of English and mathematics on both sites was not developing the skills and knowledge that would help young children to progress and gain necessary qualifications. Teachers were not using information from initial assessments to identify the areas that children needed to work on. In mathematics, teachers and managers seemed unsure of the progress children were making in the skills they had developed. In English, teachers were not using topics that engaged the children's interests. Too many children were not completing their courses and gaining qualifications.

Recommendation: **Managers and teachers of English and mathematics should improve the planning and quality of the teaching in these subjects. They should use the information they collect through initial assessment to identify the specific skills that individual children need to develop, monitor their progress**

and support them to master these skills. English teachers should engage children more effectively in their lessons by using more stimulating resources. (To the governor)

1.50 Key concern**:** Leaders and managers had not thought through effectively what the community learning curriculum should comprise and how to identify if the curriculum achieved the development of the children's personal and social skills.

Recommendation: Leaders and managers should plan and structure the community learning curriculum so that it comprises a linked set of activities that build the personal and social skills of children. They should be clear about how to measure the impact of this curriculum. (To the governor)

1.51 Key concern: Not enough children were progressing into education, training and employment when they were released.

Recommendation: **Engagement and resettlement staff should work more effectively with the prison resettlement practitioners and community partners to enable more children to progress into further education, training or employment when they are released.** (To the governor)

1.52 Key concern: The restriction of visits to weekday evenings resulted in a very low uptake and disadvantaged those who worked, travelled long distances or had childcare responsibilities.

Recommendation: Prison leaders should extend visiting hours across the weekend to provide more equitable opportunities for children to receive face-to-face visits. (To the governor)

1.53 Key concern**:** The resettlement department was dysfunctional. Morale was low and many staff raised concerns about the lack of leadership and an absence of mutual support among staff.

Recommendation: Prison leaders should be visible and sensitive to the needs of their staff, address their views and complaints, and make sure that all resettlement staff have clearly defined roles and receive the support and training they need to fulfil them. (To the governor)

1.54 Key concern: Telephone monitoring was in disarray. Prison staff could not keep up with call monitoring and the backlogs had become unmanageable. Some call monitoring was being routinely allowed by managers with no justifiable reason.

Recommendation: Telephone call monitoring procedures should be reviewed to make sure that all monitoring is justified and legitimate and the backlog in call monitoring should be addressed.

1.55 Key concern: The interdepartmental risk management team did not review the risk management of children and much of this work had

unofficially devolved to resettlement practitioners. Leaders did not have the required assurance and oversight of the management of children's risks on arrival and in preparing for release.

Recommendation: **The purpose of the interdepartmental risk management meeting should be reviewed and leaders should ensure that the meetings provide effective oversight of children's risk**. (To the governor)

Notable positive practice

1.56 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.

1.57 Inspectors found four examples of notable positive practice during this inspection.

1.58 Fallow time during the COVID-19 restrictions had been effectively used to produce high quality, interactive and child-friendly printed materials that supported self-guided, one-to-one and group psychosocial interventions. (See paragraph 4.72)

1.59 Regular clinical audit of hormonal preparations to aid sleep, prescribed not as intended by the licence for use with this age group, enabled oversight of prescribing to ensure safety and avoid potential reliance on the medicines in the long term. (See paragraph 4.78)

1.60 The safe introduction of a potentially hazardous medicine to a patient at the prison, usually only undertaken in hospital, supported by health care professionals and officers, honoured the wishes of the patient and was unique (See paragraph 4.82)

1.61 The first group intervention to address offending behaviour since the pandemic started was nearing completion, which was a positive step forward. (See paragraph 6.35)

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 governor had been appointed during the pandemic and had spent time addressing conflict within the senior management team. He had set a clear vision for Wetherby based on developing communities and improvement measures. While progress was being made, significant, further work was needed.

2.3 The senior management team consisted of about 25 people which was unwieldy. Many managers had changed role several times since our scrutiny visit. This had hindered progress in some areas.

2.4 Leaders had started to develop a learning culture among staff in areas such as in the use of force and care for vulnerable children. This reinforced the safeguarding of children.

2.5 Leaders had moved more quickly than at other sites to improve time out of cell and education provision. The governor was focused on increasing the number of children who could be unlocked together and had achieved considerable success on Collingwood and Drake units. Notably, violence had remained lower than at other establishments as the regime improved.

2.6 The failure nationally to plan effectively for the small number of girls held in custody had led to Wetherby having to accommodate them at short notice. Local leaders had prepared well for their care. At the time of our inspection, three girls were held on Napier unit while a spur on Keppel unit was refurbished. The care they received from staff was good and at the time of our inspection they were engaged in education and other activities. They received less time out of their cell than boys. Differences in the treatment of girls, including wearing their own clothes, were noticed by boys and needed to be addressed.

2.7 There had been changes in leadership on Keppel unit since our previous inspection which had made sustained improvement challenging. The unit had lost its identity and was no longer delivering a distinctive therapeutic environment (see key concern and recommendation 1.42). Outcomes for children had declined in all four of our healthy prison tests and were now indistinguishable from the main site.

2.8 Residential units were clean and tidy, but the site was in need of significant capital investment. Most units were too big to provide effective care for children and the exercise areas were bleak. The creation of new facilities for girls on Keppel unit highlighted the need for improvements to the boys' accommodation on that unit.

2.9 Senior leaders had made progress in establishing a reward-led culture with incentives for good behaviour, but we found that this was not embedded or delivered consistently on all units. In our staff survey, a significant minority of operational staff disagreed with the governor's priorities.

2.10 Prison and education leaders needed to improve the definition and delivery of the 'community learning' element of the curriculum. At the time of our inspection, these sessions, which comprised more than a third of the education provision, lacked purpose. Many children became disengaged as a result.

2.11 Leadership needed to improve to tackle the very low morale among resettlement staff, provide effective oversight of their practice and address the significant risks in public protection.

2.12 Partnership working between health care and prison staff was particularly effective and had assisted the recovery from the pandemic restrictions. It was creditable that leaders had achieved high rates of staff testing which facilitated a more open regime for children.

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 Under a new escort contract, children were no longer transported with adult prisoners. Travel time and late arrivals had reduced which had been a significant problem at our last inspection.

3.2 Records showed that late arrivals occurred about once every two months and generally involved children arriving from courts in the Cambridge area. The new escort provider for Wetherby and Keppel did not cover this area which was confusing. We saw examples of children arriving at about 2.30am after long waits to be collected, which was inappropriate.

3.3 The reception area was bright and airy, but the holding rooms were austere. Leaders had identified this, and work had started to make them more child-friendly: one room had been painted and contained soft seating.

3.4 Children were provided with a hot meal, drink and a phone call on arrival and could have a shower in reception if they wished. No peer mentors were available to offer support and information to children while they waited and there was little information in the holding rooms about Wetherby or Keppel.

3.5 Notification of any children who were new to Wetherby and Keppel or to custody enabled the first night officer to gather information from various sources, including the court and youth offending team before their arrival. A private first night interview took place when the child arrived, and we saw some very comprehensive assessments on NOMIS (Prison Service electronic records). The interview and the initial health safety screen enabled first night staff to make an accurate assessment of risk and ensure that children were appropriately supervised during their first night in custody.

3.6 We observed night staff on the unit introducing themselves to children and spending time with them to make sure they were settled, which was good. In our survey, 90% of children told us they felt safe on their first night in Wetherby.

3.7 The few boys who were received directly on to Keppel experienced the same first night assessment process but were placed in a cell on

Keppel and not the first night centre. Despite similarly robust assessments, their perception of safety was not as good. In our survey, 69% of boys said that they felt safe on their first night in the unit.

3.8 Girls did not go through reception but went straight to Napier unit where they could shower and have a meal. They experienced the same first night assessment process and appropriate levels of supervision were set.

3.9 All children were required to take a PCR COVID-19 test on arrival and a subsequent test after five days. If both tests were negative, the children could then mix with others. An average of only one boy was received each week which meant that they spent the first seven days on their own. Girls could take daily lateral flow tests and could mix with their peers after the first day if the results were negative. There was no good reason for this difference.

3.10 The induction schedule for boys was comprehensive and most disciplines were required to attend. Records that we viewed and interviews with several children indicated that induction was rarely completed on either site and children were not given some important information. Boys on induction were locked up for long periods with little to occupy them. In our survey, only 66% of boys at Wetherby and 54% on Keppel said they had been told everything they needed to know about the establishment in their first few days (see key concern and recommendation 1.43).

3.11 Induction for girls was better than for boys, primarily because they were unlocked and had more interaction with staff and their peers. Leaders were designing a bespoke process to meet the needs of girls fully, which was positive.

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.

3.12 In our survey, 3% of children at Wetherby and 8% on Keppel said they felt unsafe at the time of the inspection, which was very low.

3.13 During the previous year, there had been 195 safeguarding referrals: three-quarters from Wetherby and the remainder from Keppel. Referrals came from a range of departments and were all robustly investigated by the safeguarding team and on-site social worker. Referrals were investigated swiftly with all evidence requested and appropriately evaluated.

3.14 Of the 195 referrals, 31 allegations of harm to a child had been referred to the local authority designated officer (DO) in the last year. We found examples which met the criteria but had not been referred; these

allegations had been inappropriately screened out by local staff and then investigated internally.

3.15 Leaders had good oversight of all referrals at a weekly departmental meeting, and a further weekly meeting was attended by the governor and the safeguarding team.

3.16 The DO had introduced measures that provided external assurance of safeguarding at Wetherby, including attending monthly MMPR (minimising and managing physical restraint) meetings and reviewing a sample of cases that had not been referred. Prison leaders had a good relationship with the DO and attended quarterly meetings of the Leeds Safeguarding Children's Partnership.

Recommendation

3.17 **Child protection allegations that meet the national criteria should be forwarded to the local authority designated officer for advice or investigation.**

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.

3.18 Levels of self-harm were high with 348 incidents in the previous six months. Half of these had been attributed to one child in crisis but, even excluding these, the rate had increased by 23% since our last inspection. Keppel placements accounted for 86% of all incidents. Records indicated that girls had self-harmed 14 times in the previous six months which, given their low numbers in the establishment, meant they were much more likely to self-harm than boys.

3.19 Children in crisis or at risk of self-harm spoke positively about the support they received at Wetherby and Keppel. One child told us 'It's the best support I have ever had in or out of prison.' Staff we spoke to were very knowledgeable about the children in their care.

3.20 The latest version of ACCT (assessment, care in custody and teamwork case management of children at risk of suicide or self-harm) had been rolled out in July 2021. It was good that 146 staff and a further 103 partnership agency staff had been trained in the new document. 74 documents had been opened in the previous six months. ACCT assessments and reviews were good, all reviews had multidisciplinary attendance and children were supported by appropriate actions in their care map. Daily entries by staff needed improvement. Prison leaders had a sound quality assurance procedure

which identified strengths and weaknesses in ACCT documents to improve standards.

3.21 During 2021, constant supervision had been used on 10 occasions, all for children in the Keppel unit – of which three were for girls. Given the small number of girls held at Wetherby, this represented a higher rate than for boys. No children had been on constant watch in the previous few months. The governance of alternative anti-tear clothing had improved and decisions were thoroughly documented. Alternative clothing had been used on 30 occasions in the last year, 26 of which involved one child. It was used for very short periods, and only one episode had exceeded a day.

3.22 All children on an ACCT were reviewed at the weekly safety intervention meeting and all children who had not made a telephone call or received a visit were discussed to establish if they needed any additional support. Other groups of children would have benefited from this forum.

3.23 Monthly and quarterly safeguarding meetings took place. The safety team distributed information and data on self-harm before each monthly meeting. The data were basic and did little to generate actions to reduce self-harm (see paragraph 3.38).

3.24 Children could contact a number of telephone support lines free of charge from their in-cell phones. When we tested the safer custody telephone line, it was responded to quickly.

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.

3.25 The monthly local tactical assessment gave an overview of security intelligence, but we had significant concerns about the efficacy of public protection measures and the potential impact on children. The tactical assessment did not give an accurate assessment of the large backlog of call monitoring, the high mandatory drug testing (MDT) rate and the increase in finds of illicit items including weapons. Leaders had not planned actions effectively to address these concerns (see key concerns and recommendations 1.44 and 1.54).

3.26 There was no backlog of intelligence reports and these were analysed, collated and disseminated well. However, leaders were unaware of what actions had been completed, for example managers could not provide information on the number of requested searches that had been carried out. This was concerning, particularly as most reports related to violence and disorder (see key concern and recommendation 1.44). During the previous six months, completed searches had recovered 151 weapons, 14 mobile phones and 21 drug finds. The

highest number of finds occurred during the month before our inspection.

3.27 Since the reintroduction of MDT in June 2021, positive rates had been high and higher than we find in similar prisons. The average rate since then had been 17.64%. No action had been taken to identify the cause or provide relevant support, which was concerning. In October 2021, nearly a third of all tests were positive, but no analysis or actions had been identified to reduce the supply of illicit items and support the children involved.

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.

3.28 Several opportunities were available at Wetherby and Keppel to capture children's interest and motivate them to behave well. They could participate in the army and fire cadets, Parkrun (see Glossary of terms), release on temporary licence (ROTL), family visits and community work in local colleges. In some areas, however, staff failed to demonstrate high expectations and positive role modelling for children. For example, breakfast was often placed on the floor of children's cells rather than encouraging them to come out to eat.

3.29 During the previous six months, there had been 819 adjudications, 218 of which had occurred during the previous month. There had been no local analysis of this increase. During the same period there had been 248 minor reports. The sample that we reviewed were of very poor quality and, in many cases, the incident had not been investigated to encourage the child to behave appropriately. Leaders described a restorative justice approach to dealing with misdemeanours, but not all staff understood this approach and there was very little evidence of it in the cases that we reviewed. Some charges concerned low-level matters which could have been managed outside the adjudication process.

3.30 The formal incentives and earned privileges (IEP) scheme had been reviewed since our last inspection. The lowest level of the scheme, red, had been removed and all children were on silver or gold, the highest level. At the time of our inspection, 58 children were on the silver level. Those on gold had the opportunity to progress to one of the enhanced wings on Collingwood and Drake where cells on the ground floor had in-cell showers. The only difference between other designated gold and silver cells across the prison was an additional mattress and a DVD player. However, the regime for children on Collingwood and Drake was better than for those on other wings.

3.31 Leaders told us they were focused on a reward culture at Wetherby, but this was not embedded or fully understood by staff or children. We observed confusion in the application of the behaviour management policy, for example children had been automatically downgraded in the IEP scheme when they had received a proven adjudication and were prevented from eating with others during their first week on the silver regime. Reviews of IEP levels were timely but too often cursory and lacking detail. It was not clear if the child had been present or asked to contribute to the review.

3.32 The instant reward scheme was still not fully developed. Merits to reward good behaviour were still not awarded instantly and children had to save them to exchange for rewards once a week. Prison data showed that too few operational staff issued merits which was a missed opportunity to promote positive behaviour. We saw teachers issuing merits for positive learning outcomes.

Recommendation

3.33 **Those carrying out adjudications and minor reports should fully explore the circumstances of the alleged offence before finding guilt.**

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.

3.34 Prison data indicated that the rates of violence during the previous six months had been lower at Wetherby and Keppel than the average for similar prisons. There had been an increase in violence during the previous month, but it was not clear if leaders had taken action in response.

3.35 All children involved in incidents of violence were interviewed, but interviews were limited to asking the child what had happened rather than identifying the cause, addressing concerns and learning lessons. Referrals were, however, made to the conflict resolution team for every child reported to be involved in a violent incident as perpetrator or victim. At the time of our inspection, the team had received 130 referrals and delivered 66 interventions, including courses to support children to manage conflict. There was no additional formal support for victims.

3.36 Four full-time conflict resolution staff had been allocated to work with the safeguarding team and four child peer mentors had been recruited to support the staff.

3.37 Leaders were not sufficiently focused on the full range of bullying behaviour. Systems to monitor the number of personal items in each cell were not used, presenting a risk that children could be bullied for

canteen or personal items without the knowledge of staff. We found children who had not ordered anything for several weeks with a large quantity of canteen products in their cells. Managers were not aware of this until we raised our concerns.

Excess canteen supplies in a child's room

3.38 There was little action planning or analysis at the monthly and quarterly safeguarding meetings to inform future strategy and effect change. For example, there was no detailed analysis of the causes and drivers of violence which were often attributed to 'shout-outs' or arguments.

3.39 The weekly safety intervention meeting was not an effective forum for providing additional support to children who were vulnerable or displaying anti-social behaviour. There was no systematic way of referring children to the meeting for additional support. We found examples of children who would have benefited from targeted support through this process.

3.40 The behaviour management and violence reduction strategies were largely procedural. They were not sufficiently focused on the issues at Wetherby and contained out-of-date information, for example

references to three levels of the IEP scheme and to Target (an intervention to provide tailored support to the victims of antisocial behaviour) which was no longer in operation. Some staff demonstrated apathy towards encouraging positive behaviour and reducing the potential for violence.

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.

3.41 During the previous six months, force had been used 377 times at Wetherby, fewer than all comparable sites and at our last inspection. Use of force was also lower at Keppel than all comparable sites except Wetherby but had increased since our last inspection. Force had been used 50 times a month per 100 children compared to 26 at our last inspection. Use of force against girls was high: there had been 12 instances in the short time that they had been at Wetherby and Keppel. One girl accounted for seven of these incidents. Since their move to Napier unit, force had only been used once on a girl, which was positive.

3.42 During the previous six months, pain-inducing techniques had been used six times at Wetherby and three times at Keppel. These were the highest levels of use in all comparable prisons. In our review of prison records and video footage, we saw some proportionate use to remove weapons from children, but in about half our sample the use of pain-inducing techniques was not justified or necessary.

3.43 Oversight of the use of force was good. An MMPR coordinator viewed every incident on the day and reported inappropriate use of force to safeguarding immediately. Incidents of concern were reviewed at the weekly restraint minimisation meeting which was led by the governor or deputy governor. The meetings were well attended, including by health care, social workers and agencies such as Barnardo's.

3.44 In the footage of incidents that we viewed, the use of force was justified and MMPR techniques were well applied. We saw evidence of de-escalation, but some incidents were rushed with little attention to minimising the force used. Leaders had identified this and learning points had been taken forward in training.

3.45 A very small backlog of use of force paperwork enabled MMPR coordinators to quality assure incidents quickly. Debriefs of children who had been restrained took place within 24 hours and complaints from the child were quickly reported to the safeguarding team.

3.46 Once a month the restraint minimisation meeting included a wide range of statistical information on the use of force. The DO attended to provide independent scrutiny of the incidents discussed at the meeting.

3.47 Despite the good multi-agency attendance and comprehensive data presented, the meeting did not produce any strategy or actions to reduce the level of force used on either site.

3.48 Additional MMPR coordinators had recently been recruited and there were now 15 covering both sites. This enabled more frequent staff training and improved supervision of spontaneous incidents.

3.49 Body-worn video camera footage was available for nearly all incidents and the number of cameras had been increased from 42 to 84 since our last inspection. There was footage of the start of the incident in only about half the incidents which was crucial in helping leaders and coordinators to assess the justification for the use of force. This had been identified and raised as a learning point for staff during refresher training.

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.

3.50 During the previous 12 months, children had been separated on 108 occasions, 13% of which were for children on Keppel. Separation rates at Wetherby and Keppel were lower than in similar establishments, but periods of separation were longer: during the previous six months, the average length of stay for Wetherby was 18.8 days and 11.6 for Keppel. Reintegration was not always considered or implemented at the earliest opportunity (see key concern and recommendation 1.45).

3.51 The recording of data on separation had improved since our last inspection and now included children separated in the separation unit and on normal location. However, these data did not break down the population by gender, which was a significant omission since the placement of girls at Wetherby.

3.52 Prison leaders held a weekly meeting to discuss all children who were separated on Rule 49 (see Glossary of terms). The meetings were well attended and discussion of options to reintegrate children was thorough. However, if a decision was made at the meeting, it was usually not implemented until the child's next review.

3.53 At the time of our inspection, three children were separated on Rule 49 on the main residential units. Oversight of these children was not adequate and documentation, including reviews, needed improvement. Mandatory daily visits by leaders, the chaplaincy and health care did not always take place (see key concern and recommendation 1.45).

3.54 Each child who was separated had access to a telephone, shower and time in the open air. Access to education depended on the number of children on separation and was not equivalent to their peers.

3.55 The conditions in the separation unit were good; cells were clean and free of graffiti. A gym had been built and there was a communal space on the ground floor, but we only saw this in use on one occasion.

Separation unit communal space

Separation unit gym

3.56 Relationships between staff and children on the separation unit were good, and children spoke positively about staff.

3.57 There had been no quarterly oversight meetings since July 2021, which was poor.

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 Relationships between staff and children were generally good. In our survey, more than three-quarters of children on both sites said that most staff treated them with respect and that they had a member of staff they could turn to if they had a problem. During the pandemic, staff had worked with children in smaller 'family' groups, which they said had enabled them to get to know the children better. We observed many positive interactions where staff showed a good understanding of the needs of individual children.

4.2 All children had a designated personal officer who met them regularly to review their progress. In addition, custody support plan (CuSP) interviews had been re-introduced on both sites after the easing of pandemic restrictions. These interviews gave staff additional opportunities to talk to children about their needs and behaviour. However, the quality of these sessions varied. In some cases, staff established a good rapport and offered well targeted support, for example by helping a boy to prepare for his move to an adult prison. Other meetings were more perfunctory, and some sessions were missed or delayed.

4.3 Staff at Wetherby had implemented a conflict resolution programme as pandemic restrictions ended. On Collingwood and Drake units this programme had been successful, enabling children to mix safely and participate in regime activities together. On other units it was less developed, for example on Frobisher wing children were divided into five groups that could not mix, restricting their access to the regime.

4.4 There were few opportunities for children to contribute to life at the establishment. A small number were designated as peer mentors, but this role was not well defined and there had been no recent training for mentors.

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

4.5 Most children at Wetherby were accommodated in large 60-bed wings, which were not appropriate for this age group. At the time of our inspection, the wings were at about half capacity. A programme of refurbishment was in progress, and it was good that showers had been installed in ground floor cells on two of these wings. Children in cells without showers had daily access to communal shower rooms, which were in reasonable condition and regularly cleaned. Cells in Keppel were larger and better furnished than those at Wetherby and already had showers installed. All children on both sites could now shower every day, which they appreciated.

Refurbished shower on C wing

4.6 Most cells that we viewed were in reasonable condition and free of graffiti. With the exception of the separation unit, all cells had telephones - which was an important improvement since our last inspection. Most were well decorated, and children were encouraged to personalise their cell by putting up photographs or artwork that they produced in education classes. Cleaning materials were readily available and time was set aside in the regime for domestic cleaning. However, some cells needed re-decoration and furniture was old and in poor condition. Not all cells had chairs, and most did not have enough storage for clothes. Many mattresses were worn and in need of replacement. On the first night wing, cells were cramped, and some toilets were not screened. Many cells in Wetherby lacked toilet seats.

Prepared first night cell on the induction spur

4.7 Children had good access to cleaning materials, clean bedding and clothes. They received a pack with sufficient sheets, towels and underwear each week, and could obtain more if they needed them. However, children complained that the sheets and clothes were old and worn. Access to stored property was good, but there was no X-ray machine at Wetherby and children's parcels had to be sent to another prison to be examined. This caused unacceptable delays and some loss of children's property.

4.8 Communal areas were spacious, clean and well decorated. Children were able to spend time outside each day, but the outdoor exercise areas were poor, with no seating or facilities for exercise. Children had asked for games supervision to be provided, but this was not available (see key concern and recommendation 1.48). One wing yard was being refurbished, and a rubber playing surface had been installed, but this was not yet in regular use for sports.

Residential services

4.9 In our survey, 39% of children at Wetherby said that the food was good, while in Keppel the figure was higher at 55%. The children we spoke to did not complain about the quality of food, but some said they would like larger portions. We found both the quantity and quality of food served at the evening meal to be reasonably good.

4.10 Children were able to eat outside their cells on most days on the two largest units, which was a positive development. On other units, and in Keppel, groups ate out in rotation, so all children could eat out at least once a week. Children were regularly consulted about food through surveys and the youth forum, which was attended by the catering manager.

4.11 The standard menu for the children's estate was offered, with a four-week cycle of choices for the evening meal. Children could choose from six options, including meals which catered for religious and other dietary requirements. Each month, a special menu celebrated a cultural or religious event and these were popular with children. At lunch, children received a sandwich and snacks to eat in their cells. Breakfast packs were small, consisting only of a small bag of cereal with milk and tea. The main kitchen, food trolleys and serveries were clean and well maintained. Children could not prepare their own food in most areas.

4.12 A reasonable range of products were available for children to buy from the shop, including hair and skin products for black and minority ethnic children. The list featured a wide range of confectionery, biscuits and soft drinks, but children told us they would like more healthy eating options.

Consultation, applications and redress

4.13 Staff had recently re-started consultation events after the pandemic restrictions, which was a positive development. Informal wing consultations were held each month, and the issues raised were discussed at a youth council, attended by staff and senior managers. Minutes of these meetings showed that children were able to raise issues that concerned them, but few of them were resolved. For example, there had been no progress on children's requests for a better range of activities to be allowed on exercise yards (see key concern and recommendation 1.48). The consultation process was not promoted well enough. Typically, only four or five children attended, and many of the children we spoke to were not aware of these meetings or their wing representative.

4.14 The applications process was managed on each wing and managers had started to collect data on the outcome of applications, although children told us that they usually applied informally to a member of wing staff. A roll-out of new in-cell technology for children to make applications on-line was scheduled for soon after the inspection.

4.15 During the previous six months, 116 complaints had been submitted. In our survey, 90% of children said they knew how to make a complaint, and more than half the children on both sites said that responses to complaints were fair. Only 9% of children on Keppel said that complaints were dealt with within seven days compared with 78% at the previous inspection.

4.16 Management oversight and quality assurance of complaints were good. The responses that we examined were polite and addressed the complainant's issue well. Most children received a response within the required time, and in many cases a member of staff had visited them to discuss the complaint. The quality of responses was monitored by a senior officer, and the deputy governor reviewed a sample each month.

4.17 Case workers met each child to ensure that they understood their legal position and the earliest date for release, which was good practice. They also provided information about licence conditions at a pre-release meeting. Barnardo's met all children at induction and gave them information about children's rights. Children could then contact Barnardo's using their in-cell phones, to request support with complaints and legal matters.

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

4.18 The priority given to equality and diversity work had reduced during the pandemic while restricted regimes were in place. The equality needs assessment, strategy and action plan were out of date (see key concern and recommendation 1.46). Managers had identified these weaknesses and greater emphasis had been given to equality and diversity work in the months preceding the inspection. The contribution made by the full-time on-site equality adviser and the support from the central team were positive.

4.19 Monthly equality action group (EAG) meetings had started in October 2021 with the involvement of senior managers (including the governor and deputy governor), better participation from across the establishment and more focus on progress with key actions. Meetings had previously taken place quarterly, but attendance had been limited and the meetings had not been driving progress.

4.20 Data prepared for the EAG meetings included identification of disproportionate outcomes which were investigated further. This was an improvement since our scrutiny visit in January 2021 when no

analysis for disproportionality was being undertaken. However, this analysis was only conducted for race and not for other protected characteristic groups (see Glossary of terms).

4.21 Children did not attend EAG meetings, although some had been appointed as diversity representatives. They had not yet received any training and were uncertain what their role entailed. Residential staff and some children were aware of who the representatives were.

4.22 During the pandemic, consultation with children about equality and diversity had taken place within family bubbles, most recently in October 2021. During these consultations, 29 children from Wetherby and 13 from Keppel unit were asked their views on a series of questions about equality and diversity. This gave managers some insight into children's views but there was limited consultation in protected groups.

4.23 During the previous six months, 32 discrimination incident report forms (DIRFs) had been submitted, 10 from Keppel and 22 from Wetherby. Just over a third had been submitted by children and there was evidence that Barnardo's advocates had supported them to do this. The remainder had been submitted by staff, many of which concerned the use of discriminatory language by children. Investigations were documented well and indicated that both the alleged perpetrator and complainant had been spoken to. In a minority of the DIRFs that we reviewed, follow-up actions were not sufficiently focused on addressing the behaviour complained about, for example a member of staff whose behaviour fell short of the expected standard had not been referred for refresher training. All DIRFs were signed off by the governor or deputy governor. There was no external oversight, but a scrutiny panel including other prisons in the area reviewed a sample of completed DIRFs every two to three months.

Protected characteristics

4.24 Identification of children with protected characteristics was good, but there were no policies or guidance for staff on available support.

4.25 Just over a third of children living on Wetherby main site and 19% of the Keppel population were from a black and minority ethnic background. In our survey, children living on the Wetherby site reported similar perceptions to white children.

4.26 During one-to-one interviews, black and minority ethnic children at Wetherby, described discrepancies in their treatment. They said that white children were less likely to be punished for poor behaviour, staff dealt more quickly with white children's requests, and sometimes made inappropriate comments to black and minority ethnic children. In the absence of a forum for these children, it was difficult for them to raise these concerns with managers (see key concern and recommendation 1.46).

4.27 One child who was interviewed said that some staff were prejudiced about Travellers and that he was subject to more disciplinary charges than other children. Again, there was no forum for this group. In our survey, three children from Keppel and one from Wetherby identified themselves as being from a Gypsy or Irish Traveller background which was not consistent with the prison data.

4.28 Three children on Keppel unit and 13 at Wetherby were foreign nationals, none of whom was held solely under immigration powers. A manager in the casework team managed liaison with the Home Office, and immigration officers attended when needed to see children. Children were helped to get legal advice for immigration matters. Electronic case notes showed good use of interpreters at meetings for a child whose English was limited and parents were also identified who required interpretation support to participate in discussions about their child. The availability of additional phone credit for contact with family overseas was not widely known about and few children had used it. Most foreign national children had family in the UK.

4.29 In our survey, 21% of children at Wetherby and 65% on Keppel said that they had a disability, and 80% and 73% respectively that they were getting the support they needed. The analysis presented to the December 2021 EAG meeting showed that 34% of children at Wetherby and 59% on Keppel had been identified, mostly by health care and education staff, as having one or more disabilities. Many children had a learning disability or difficulty which was managed by the education team and children with mental health disabilities were given individual support by the mental health team. No children had personal emergency evacuation plans (PEEPs) at the time of the inspection, and it was not clear where responsibility lay for preparing a PEEP.

4.30 In July 2021, Wetherby had started to receive girls at short notice because of the failure nationally to plan effectively for the small number of girls held in custody. At the time of the inspection, three girls were living temporarily on Napier enhanced support unit while their permanent unit on one spur of Keppel was refurbished.

4.31 Differences in the treatment of girls and boys needed attention. The girls had a better induction and spent more time in activity and with their peers during their first week at Wetherby. They had a reasonable regime on Napier unit but less time out of cell and less access to the gym than boys (see paragraph 5.5). Girls were able to wear their own clothes which boys had noticed and raised as unfair. Access for some boys to the enhanced support available on Napier unit was prevented by the girls' temporary use of three of the five cells. Activities where boys and girls could mix, if they wished, were managed carefully (see key concern and recommendation 1.46).

4.32 Very few children disclosed that they were gay, lesbian or bisexual. No transgender children had been placed at Wetherby or Keppel for several years. Support for LGBTQ+ children would be provided on an individual basis and there was some contact with community organisations which could offer advice and support.

4.33 The chaplaincy had remained on site and visible to children throughout the pandemic, initially on a rota basis. It was positive that from the start of COVID-19 restrictions statutory duties (for example meeting new receptions) had been completed face to face rather than through locked doors. As restrictions eased, children could spend time with chaplains in the multi-faith room for pastoral and spiritual support, either in their family bubbles or individually. Children who had been bereaved were supported and virtual attendance at funerals was facilitated. Chaplains participated in strategy meetings and a range of supportive meetings for individual children.

4.34 At the time of the inspection, children were able to attend worship on a rota. Children who lived on units where the whole unit associated together could attend as one group, and on other units they attended in their family bubbles. Faith-based materials were given to children who wanted them each week until full access to worship was possible.

4.35 A chaplaincy youth worker from the Message Trust (a UK Christian charity) worked in tandem with the chaplaincy. He supported children to explore and develop their Christian faith and provided pastoral support to children of any faith.

4.36 The official prison visitors scheme coordinated by chaplains had restarted. At the time of the inspection, six volunteers were visiting five children and other volunteers were waiting to be matched with appropriate 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.

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

Strategy, clinical governance and partnerships

4.38 Leeds Community Healthcare NHS Trust (LCH) was commissioned to deliver health services, some of which they subcontracted to other providers. Partnership working with the prison was seamless and supported by timely advice from the UK Health Security Agency (formerly Public Health England). Health and substance misuse services had improved, were child centred and met the needs of the patients.

4.39 Minor and serious untoward incidents were recorded on Datix (LCH electronic tracking system). Most of these involved minor anomalies or

errors in medicines management (about 20 a month). Learning from adverse events was disseminated at monthly health care team meetings to improve practice and supported by the quick-read Learning from Datix monthly digest.

4.40 Patients in our survey and in conversation expressed satisfaction with their care, with no adverse comments. The Trust-wide consumer survey conducted by LCH (the Family and Friends Test) yielded seven or eight comments a month, 95% of which were positive. We saw commendations from patients, received after they had left the prison, which was unusual.

4.41 Health care professionals (HCPs) supported work in other prison departments such as the separation unit, and in safety procedures such as ACCT reviews and safeguarding meetings. Shared understanding of the circumstances of individual children facilitated seamless care.

4.42 Clinicians were easily recognisable, knew their patients by name and were mindful of their dignity. Patients were seen in private unless precluded by a risk assessment. Relationships between HCPs and patients were therapeutic.

4.43 The health needs assessment had become outdated during COVID-19 restrictions. However, the range of skills of the HCPs met the needs of the children, and nurses were available 24 hours a day to provide care. Most HCPs were trained and/or experienced in child and adolescent care, which was subject to formal and informal supervision of practice. The co-location of HCPs in a large room helped communication, although the room was sometimes noisy.

4.44 SystmOne (electronic clinical record) was used by all disciplines, including drug recovery workers, and was a mutual source of confidential information underpinning joint working.

4.45 We observed problems in reconciling management information arising from SystmOne and local clinical information, which we have not encountered in other prisons. The provider was working to address these issues. Quality assurance processes had been built in to ensure completion of timely assessments, which was impressive.

4.46 A limited number of clinical rooms were in use in the health centre. Most health services were delivered on the wings from suitable consultation and examination rooms. Facilities were clean and a recent infection control compliance audit was being addressed.

4.47 Standardised equipment for use in medical emergencies, including automated external defibrillators and suitable PPE (see Glossary of terms), was strategically placed in several areas of the prison and HCPs were appropriately trained to use it. Management oversight of the kit had improved since 2019 with regular, documented checking.

4.48 Consent was sought from patients at appropriate points in their care, and the process of consent was subject to clinical audit which was compliant with standards.

4.49 An average of only one of seven complaints received each month from January to October 2021 expressed dissatisfaction, while the remainder involved concerns and compliments. Most patients expressing unhappiness were seen face to face on the same day to resolve the issue quickly.

Promoting health and well-being

4.50 A prison-wide health promotion strategy was in place to promote health and well-being and plans for a fully integrated well-being team had started. Health promotion campaigns reflected national health programmes.

4.51 Appropriate information about the health care services was given to children. Each child was seen by the enthusiastic health promotion HCP and individual packages were drawn up to improve the child's health and well-being.

4.52 An age-appropriate range of vaccines were readily available, including influenza. Administration of COVID-19 vaccines reflected the national programme in the community. If children initially declined vaccinations, they were given additional information to encourage them to participate.

Primary care and inpatient services

4.53 The primary care services were well led. At the time of the inspection, there were staff shortages which were filled by short-term staff until newly recruited HCPs started. We found no evidence that shortages had affected the service delivered to patients.

4.54 All children received an initial health screen by a nurse on arrival and appropriate action was taken, including referrals. More detailed assessments were carried out within expected timescales and reviewed at a minimum of three-monthly intervals. Care planning needed further development.

4.55 A daily 'virtual' ward meeting was attended by HCPs from all areas of health. Patients of concern were reviewed to make sure that their needs were met and that staff were aware of them.

4.56 There was good access to an appropriate range of clinics supported by an effective appointments system for children in both Keppel and Wetherby. Daily clinics with nurses were available and the small number of patients with long-term health conditions were managed by a lead nurse. Female patients had suitable access to sexual and reproductive health services. With the exception of dental services, waiting times were excellent. Access to hospital appointments was well managed.

4.57 A triage process assisted access to both male and female GPs. GP services were subcontracted to a local practice which delivered five clinics a week (including Saturday). They could also be contacted at other times and the NHS 111 service was used out of hours.

4.58 During the pandemic, primary care services had been delivered on the wings. This had helped to reduce the number of patients who did not attend their appointments. Analysis was being undertaken to reduce non-attendance further.

4.59 Transitions to the community or transfer placements were well planned. Patients were seen before leaving, relevant interventions were carried out and information provided. Patients were supported to register with a GP where appropriate and summary discharge reports were produced to accompany the patients.

4.60 About 20% of children had reached the age of 18 years. There was no formal partnership agreement for adult social care, but the on-site social work team employed by Leeds City Council worked well with the prison and LCH, to make sure that social care needs were identified, assessments carried out and necessary interventions put in place.

Recommendation

4.61 **A memorandum of understanding should be in place between the prison, local authority and social care provider to formalise arrangements for adult prisoners needing support.**

Mental health

4.62 The mental health service delivered by South-West Yorkshire Partnership NHS Foundation Trust had improved. Psychologically informed approaches to the care of children were evident in many areas of the prison.

4.63 Boys and girls were screened for urgent mental health needs when they arrived and a full assessment followed within three days. Neurological and developmental needs were assessed within 10 days if necessary. A full range of standardised tools were available to support accurate formulation and/or diagnosis.

4.64 Since January 2021, 220 prison staff had received two days of bespoke mental health training despite the COVID-19 restrictions. This had familiarised officers with the role of the CAMHS (child and adolescent mental health services) and they were adopting language associated with psychological understanding. In some areas, for example, officers had started to appreciate their key role in formulating descriptions of the needs of children in their care and engaging CAMHS in planning suitable responses. At the time of the inspection, 94% of referrals for CAMHS assessment had resulted in therapy with a mental health professional.

4.65 Since 2019, successful recruitment had been carried out to fill vacancies in the team and a wide range of professionals were available

to patients: CAMHS, forensic CAMHS, learning disability, nursing, psychiatry, psychology, social work and speech and language therapy.

4.66 About half the population were being supported by the mental health team. The model of care was now psychologically led with clear pathways of care for patients. Therapies were evidence-based, tailored to individual need and included emotional regulation, neurodiversity, trauma and sexually harmful behaviours. Psychiatric treatment was innovative. Patient care plans and records were good and demonstrated individuals' involvement in their care. No room was available to accommodate group therapies, which was inefficient.

4.67 Mental health professionals supported prison meetings and case discussions, and some prison officers benefited from supervision of practice by psychologists. Although the care programme approach (mental health services for people diagnosed with a mental illness) was not used, the team worked closely with prison staff to ensure continuity of care on the release or transfer of patients.

4.68 The three most recent transfers under the Mental Health Act had occurred within the guidelines, but delays remained for patients with complex needs. After a long delay, one recent case had been escalated to national level for resolution as prison and health staff had become extremely concerned about the welfare of a patient with complex needs. Prison staff and HCPs had coped remarkably well to keep the patient safe during this period of challenging and intensive care.

Recommendation

4.69 **Patients requiring admission to hospital under the Mental Health Act should be transferred in accordance with the contemporary Department of Health and Social Care guidelines**.

Substance misuse 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.

4.70 The young persons' drug and alcohol support service (YPDASS) offered child-centred care to boys and girls. The service worked closely with clinical colleagues and prison departments to deliver integrated care to their patients. They contributed effectively to prison safety, safeguarding and drug strategy meetings.

4.71 A team of highly experienced and competent drug support workers delivered bespoke packages of care to their patients through revised care pathways.

4.72 All new arrivals at the prison were screened for alcohol and drug issues and received a comprehensive assessment within five days. All

children were offered access to the 'universal' pathway: education on addictions and how to avoid them. About 60% of the population with more complex needs were offered targeted or specialist therapy. During the recent restrictions YPDASS had produced high-quality, age-related materials to improve the engagement of patients in therapy (see notable positive practice 1.58). Rooms used to accommodate substance misuse group therapies prior to the restrictions were not currently available.

4.73 At the time of the inspection, no child was in receipt of opiate substitution therapy (OST). OST was available if required, as was nicotine replacement therapy. Treatment for alcohol withdrawal was available but rarely required.

4.74 SystmOne included CHAT (comprehensive health assessment tool) screening and assessment materials, and a full range of standardised assessment tools, as required. Individual recovery plans and case notes were focused and up to date. Care for patients with addictions and mental health conditions was suitably shared between the respective teams.

4.75 YPDASS worked closely with the offender management team to coordinate the preparation of patients for release or transfer to ensure continuity of support. Preparation included advice on how to minimise risks associated with substance misuse. YPDASS also liaised with community agencies to introduce patients to support agencies.

Medicines optimisation and pharmacy services

4.76 Patients who were on medication as they entered the prison were able to continue their treatments with minimal interruption following prompt checks on prescribing. Medicines were kept in stock or could be obtained on the same day.

4.77 Medicines were supplied through a secure chain, stock management was very good, and medicines were stored safely and tidily. Stock was monitored regularly, including ambient and fridge temperatures, stock levels and rotation to make sure the medicines were in date. A regular, well-attended multidisciplinary medicines management group monitored trends and incidents to ensure safety.

4.78 The use of hormonal preparations to aid sleep (for example melatonin) was subject to clinical audit. Some preparations were not licensed for this age group and oversight was an important safety measure (see notable positive practice paragraph 1.59). During medicine administration we observed patients asking questions about their medicines which were immediately answered by pharmacy technicians.

4.79 The LCH formulary was being used to guide prescribing by GPs, nurse prescribers and others. Most medicines were supplied on a named-patient basis, some by patient group directions (see Glossary of terms). More common over-the-counter remedies were also available.

4.80 About 85% of medicines were administered to patients, who were observed taking them, which was appropriate. Patients who were responsible with medicines had them in possession. In-possession risk assessments were up to date, and cells were checked to see that medicines were not being stockpiled.

4.81 Medicines were administered three times a day on each wing block, with good supervision of medicine queues by officers. Pharmacy staff were alert to situations in which boys and girls were not taking medicines as prescribed and took steps to follow them up to check compliance.

4.82 Patients were involved in decisions about their medicines, for example one boy had declined to start on a recommended medicine, which required hospital admission. Enhanced supervision by several clinical disciplines and prison officers was put in place while the boy remained in the prison to ensure that the medicine was safely introduced. This had not been done before (see notable positive practice paragraph 1.60).

4.83 Patients were seen before release, transfer or a court appearance, and arrangements were made to supply medicines or prescriptions for up to 14 days to preserve continuity of treatment.

Dental services and oral health

4.84 LCH delivered two dental clinical sessions a week with NHS treatments equivalent to the community. Further information was appropriately sought from the mental health team where needed to support this process by confirming that the patient had capacity to consent.

4.85 A clear pathway was in place for triage and for patients needing urgent care. The appointment system had been adapted to meet COVID-19 restrictions and the number of dental sessions had reduced. Timely access was not always facilitated by the prison. Waiting times for routine dental treatment were too long and, in our survey, only 31% of children said it was easy to see a dentist.

4.86 The dental suite needed repair to meet infection control standards. Not all prison officers in attendance chose to wear PPE or had received the testing of specific face masks needed to ensure that they fitted correctly, to help protect them when certain dental procedures were being carried out during the pandemic.

Recommendation

4.87 **The dental suite should be maintained in a good state of repair to ensure safety and compliance with infection control standards.**

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 Boys at Wetherby and Keppel had an average of six hours a day out of their cells on weekdays and girls about five hours 15 minutes. This was better than at most other children's prisons but did not meet our expectation of 10 hours a day. Most children at Wetherby and Keppel spent four hours out of cell at weekends, which was not enough, and spent long periods in their cells with little to occupy them (see key concern and recommendation 1.47).

5.2 Children in some areas of the prison fared much worse. Those on Frobisher unit were divided into five distinct groups which could not mix without incident and there were several children on Benbow who could not mix. Staff had to run several regimes for these groups, each of which received about three hours out of their cell during the week and two hours at weekends.

5.3 Records that we examined described a better picture than we observed, stating that all boys were unlocked for about 6.5 hours a day during the week. However, when we observed children eating breakfast out of their cells, only about 40 were involved although records showed that most of the boys were out. Similarly, children were locked in their cells for a roll check in the evenings when records showed they were eating out together. These inaccuracies prevented managers from identifying and addressing problems with the regime.

5.4 There were five separate gyms around both sites, and all children had access to a well-appointed gym. Ten physical education instructors and eight sports and games officers provided a wide range of activities and delivered vocational training with several community agencies.

5.5 Children in Wetherby could access 7.5 hours in the gym during the week and children on Keppel six hours. The girls, however, shared a gym with Anson unit and were only guaranteed two hours during the week, although staff tried to facilitate more time when possible.

5.6 Children who were segregated on Anson unit were given access to the gym for two one-hour sessions a week, which was positive.

5.7 A range of vocational training was available through the gym. The active IQ course was an accredited level three sports-based

programme which taught eight children at a time about health and fitness. The Duke of Edinburgh's Award Scheme was available and Leeds United Football Club delivered a UEFA B licence coaching course.

5.8 The twinning project with Wakefield Trinity Rugby League Club included opportunities for children to be released on licence to take part in community work or engage in activity such as climbing the Three Peaks. The project also encompassed life skills, substance misuse and violence which was positive.

5.9 Children on Keppel could still take part in the Parkrun scheme at weekends (see Glossary of terms), which reflected the community programme and encouraged children to run together over two or five kilometres, promoting health and community living.

5.10 The library had recently closed for refurbishment. The librarian and education staff made sure that all children had access to books remotely and were seen at least once a week. All restrictions on the number of books children could have had been removed and the prison had provided additional funds to buy more of the most popular titles.

5.11 Literacy was promoted using the Diffusion books series (provided by Diffusion, a national charity) which were available at different levels starting at entry level two and three for English and progressing to level one. The books aimed to improve children's confidence in reading and tested their comprehension as they progressed.

5.12 Storybook Dads was also available through the library (a programme for parents to record themselves reading a story to send to their children). This scheme had been thoughtfully expanded at Wetherby to include younger siblings, which was a good initiative to promote family ties. Children could also video themselves reading in a Storybook Dads' room which was softly decorated in a child-friendly manner and then send out a DVD, which was good.

Education, skills and work activities

This part of the report

This part of the report is written by Ofsted inspectors using Ofsted's inspection framework, available at https://www.gov.uk/government/publications/education-inspection-framework.

Ofsted inspects the provision of education, skills and work in custodial establishments using the same inspection framework and methodology it applies to further education and skills provision in the wider community. This covers four areas: quality of education, behaviour and attitudes, personal development and leadership and management. The findings are presented in the order of the learner journey in the establishment. Together with the key

concerns and recommendations, provided in the summary section of this report, this constitutes Ofsted's assessment of what the establishment does well and what it needs to do better.

5.13 Ofsted made the following assessments about the education, skills and work provision:

Overall effectiveness:	Requires improvement
Quality of education:	Requires improvement
Behaviour and attitudes:	Requires improvement
Personal development:	Requires improvement
Leadership and management:	Requires improvement

5.14 Leaders and managers had an ambitious vision to create a curriculum to meet the individual needs of children from very challenging backgrounds and with poor previous experience of formal education. They made sure that children received their mandatory entitlement to the core curriculum, which included a main vocational subject, English, mathematics, digital skills and personal development. They intended to supplement this core curriculum with community learning aimed at developing children's personal and social skills through thematic enrichment activities.

5.15 However, leaders and managers had not yet been successful in implementing this vision. They readily acknowledged that they did not have a settled view on what the community learning curriculum would consist of in terms of activities and they were not clear about how they were going to evaluate its impact. Consequently, teachers were left to plan and deliver sessions that lacked purpose and too many children did not engage well in these sessions.

5.16 Children's access to a broad vocational curriculum had reduced since the previous inspection. Difficulties in recruiting teaching staff to some subjects, such as multi-skills construction and small animal care, had been compounded by the COVID-19 restrictions, still in place at the time of the inspection. Leaders and managers had attempted to mitigate this by introducing new subjects, such as barbering, but this fell short of a curriculum that met the career aspirations of all the children, many of whom expressed a desire to follow a career in one of the construction trades.

5.17 There were enough purposeful activity spaces for all the children at Wetherby and Keppel, although this was within the context of a considerably reduced number of children at the time of the inspection.

5.18 Leaders and managers had started to change the culture of the establishment to place greater priority on the role of education in the rehabilitation of the children. Staff at all levels understood that they needed to get children into learning activities as soon and for as long as possible. For example, residential managers of units were less risk

averse in recommending that children returned to education after they had been excluded for violent or disruptive behaviour. Attendance at education had improved as a result and fewer children were receiving education in their cells because they had been removed from classes.

5.19 Education and learning and skills managers placed far greater emphasis on the benefits that children could acquire from their efforts and positive attitude than on sanctioning them for poor behaviour. Children earned rewards as the best learner or for being part of the best learner group of the week. Their behaviour in classrooms had improved and they held each other to account for poor behaviour in order to secure their rewards.

5.20 Oversight of the quality of teaching had only very recently been strengthened to make sure that leaders and managers had a good understanding of which areas required improvement. Managers were undertaking joint learning walks with education managers to view sessions and the governor had started to chair the performance review group. It was too early to identify the impact of these measures on the quality of education.

5.21 Teachers were experienced practitioners in their vocational fields. They drew skilfully on this experience to give children a feel for working in areas such as catering and the uniformed services. Recent focused professional development had improved teachers' skills and knowledge of how to support children with special educational needs.

5.22 The curriculum in vocational subjects on the main site was planned and delivered effectively to build the knowledge and skills of children steadily. Children on the hospitality and catering course completed a food safety certificate before they learned basic knife skills, vegetable preparation and preparing soups and sauces. They applied these skills by preparing meals in the bistro and serving at the counter and on tables.

Admirals coffee shop

5.23 Teachers in hospitality and catering reinforced key concepts and terminology through effective questioning and coaching during lessons to help children remember and apply this information in the future. For example, children used technical terms such as 'mirepoix' and 'brunoise' confidently and knew that they referred to the rough chopping and fine dicing of vegetables.

5.24 The curriculum in arts, the most popular vocational area, was broad; offering children the chance to develop skills in media, drama and music. The content of these courses had been well thought out to appeal to children. A project entitled 'life in lyrics' enabled children to develop pictures of musicians whom they admired, use the lyrics from their songs, and present their work using mixed media.

5.25 Teachers on the Keppel unit had designed an effective, therapeutic curriculum to support the progress of children with complex and challenging needs. They had a detailed knowledge of the children on the unit, which was updated twice a day in staff briefings. Teachers successfully adapted their teaching styles and behaviour management skills to make sure that children could engage in and benefit from their learning.

5.26 Children developed a range of skills in critical thinking, problem solving and team working on the personal development course at Keppel. They engaged in group activities, such as building vehicles and airborne structures out of everyday stationery items, developing their respect and responsibility for those around them. Teachers on this course used assessment particularly well to help children reflect on the development of their skills and how they could improve.

5.27 Teachers took good account of the objectives and support needs identified in children's education and health care plans. They used this information well to design individual packages of support for children and to adapt their teaching strategies, such as the pace at which they taught and the resources they used, to increase children's engagement in their learning.

5.28 The planning and teaching of English and mathematics required improvement. Teachers did not use information from initial assessments to identify areas for development if children were to progress. In mathematics, teachers too often taught to the exam specification which resulted in those children who already knew the information they were being taught becoming bored and distracted (see key concern and recommendation 1.49).

5.29 Curriculum managers in English and mathematics did not have a clear overview of children's progress and were unable to target teachers' efforts at addressing gaps in children's knowledge and skills. Some of the topics that teachers used in English failed to capture the imagination of children and motivate them to learn. As a result, too many children did not complete their qualifications in these subjects.

5.30 The community learning curriculum, which comprised a third of the timetable, lacked a clear purpose and focus. The choice of topics and activities appeared random, for example children undertook activities based on the theme of the winter solstice but were unable to explain why they were doing this. In many instances these sessions seemed to be an extension of free association time. It was difficult to discern the tangible personal and social skills development achieved through community learning, which was the stated purpose of this curriculum (see key concern and recommendation 1.50).

5.31 When teachers delivered well-planned and structured activities, most lessons were calm and purposeful. Attendance and punctuality were good. Children worked hard in catering and art lessons, remained focused and clearly enjoyed their lessons. However, in English, mathematics and community learning sessions, too much low-level disruption distracted children from their learning.

5.32 The procedure for getting a child through induction and the allocations board and into education was swift. Engagement and resettlement officers provided effective oversight and support for children's educational journey while they were at the establishment. Their work with the establishment's resettlement practitioners was less effective as less than half the children went into education, training or employment on release (see key concern and recommendation 1.51).

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 In our survey, 67% of children at Wetherby and 68% at Keppel said that someone had helped them to keep in contact with family or friends. All children now had in-cell telephones, but the focus on initiatives to build family relationships had diminished since the last inspection. Many of the previous activities and programmes had ceased to run, and there was no longer a dedicated family worker to support this key work.

6.2 During the pandemic restrictions, face-to-face visits with friends or family had been reduced to just one hour in the evenings Monday to Friday and children could only have a visit on an allocated day according to the unit on which they lived. This limited opportunities for visits and uptake was unsurprisingly low. The absence of visits at weekends put at a disadvantage children whose families worked during the week, travelled long distances or had other childcare responsibilities (see key concern and recommendation 1.52).

6.3 Prison managers had made very good use of the secure video calls facility (see Glossary of terms). An average of 430 took place each month, which was excellent. Although no substitute for visits in person, this facility supported children to keep in touch with friends and family.

6.4 Only two children from Napier unit had participated in a family day in the last six months. It was disappointing that prison leaders had not facilitated more opportunities for children on both sites to participate.

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 Work to reduce reoffending had deteriorated at Wetherby and Keppel and staff morale in the resettlement department was low. Many members of staff spoke of a stressful working environment. We heard descriptions of bullying, racism, and a lack of constructive leadership. Leaders committed to addressing this as a priority (see key concern and recommendation 1.53).

6.6 The needs analysis was conducted in April 2021 but leaders were not aware if it remained relevant. Reducing reoffending meetings had restarted in the last few months but had previously not taken place for more than a year. The meetings were well attended but important data were not examined. There was no action plan and managers did not oversee this area effectively.

6.7 Staff retention was poor and there were five vacancies among the resettlement practitioners (RPs) at the time of the inspection. There were fewer children at the prison than previously and the case load of about 15 cases that each RP held was manageable. However, managers frequently asked RPs to carry out tasks not related to resettlement. This was less manageable and regularly diverted their attention away from focusing on the children in their case loads. Leaders agreed to address this when we raised it as a concern.

6.8 Social workers continued to work in pods with RPs but their relationships and the sharing of information were weak.

6.9 Social workers and RPs maintained good links with youth offending teams (YOTs) who had continued to visit to see children and support them at meetings.

6.10 Concerns at our previous inspection that a lack of training and supervision of resettlement practitioners had resulted in weaknesses in information sharing, risk management and personal development were reinforced at this inspection. RPs received very little training to prepare for their roles and learned their tasks informally from each other. This caused them anxiety and uncertainty about the quality of their work. Most practitioners were enthusiastic and child centred in their approach, but it was evident that their role had not been defined or explained to them (see key concern and recommendation 1.53).

6.11 Most of the children we interviewed were able to name their RP without prompting and were content with the levels of contact and support that they provided. The recorded contact levels that we looked at were variable. In the best cases, there was contact on average every two weeks and a detailed entry of that contact on NOMIS. In some cases, contacts were inconsistent and NOMIS entries indicated a more opportunistic, unplanned contact resembling little more than a welfare check. NOMIS entries indicated that the in-cell phones introduced since the last inspection had provided a useful means of contact but were relied on too much in some cases. To their credit, some RPs on Keppel had maintained face-to-face contact to a high level. Children told us that it was easy to see their RP, usually by asking an officer on their wing. The lack of management oversight of these contacts was

disappointing and there were notably no management entries in the NOMIS records.

6.12 The application of release on temporary licence (ROTL) had restarted on 1 June 2021 and had been used 229 times in the last six months, but only for 10 children. The cases that we reviewed showed a good appreciation of risk but the purpose of ROTL was much less clear. In too many cases ROTL appeared to be used as a reward rather than a progressive and purposeful stage of sentence planning. Leaders agreed to review the ROTL process.

6.13 During the previous 12 months, seven out of 12 home detention curfew (HDC) applications had been approved: four at Wetherby and three at Keppel. HDC had been approved appropriately, mostly with no unnecessary delays.

6.14 Despite creditable attempts to prepare children for transfer to adult prisons, transition to the adult estate was a challenging process. The placements team no longer allocated spaces in adult prisons to children who turned 18 and the onus of finding a place had devolved to managers at Wetherby to negotiate with adult prisons.

6.15 Most children were transferred to adult prisons with a comprehensive handover and a telephone call between the child and the receiving prison offender manager. However, children subject to restricted status received no such preparation because of security concerns, which was concerning.

6.16 During the previous six months, 70% of the children released had returned to the family home and 25% to supported accommodation. Data on the progress of children after release had been collated but had not been examined by leaders who remained unable to assess the long-term effectiveness of resettlement.

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.

6.17 In our survey, 56% of children at Wetherby and Keppel knew they had a training or remand plan. Most of the children whom we interviewed were unclear about having a sentence plan although, when prompted, some could describe activities relating to their plans. In our survey, 83% at Wetherby and 100% at Keppel said they understood how to achieve the targets in their sentence plans and 75% at Wetherby and 67% at Keppel said that staff were supporting them to achieve their objectives or targets.

6.18 The completion of sentence plan reviews was inconsistent. We examined too many plans with unclear objectives and not written in a child-friendly way. Little attention was paid to sequencing the planned interventions. We found one case in which sentence plan objectives reflected the child's custody at Feltham which he had left nearly a year previously.

6.19 Progress against sentence plan targets was adequate in only about half the cases we inspected. All sentence plans contained multiple targets, most frequently involving education, and this was the area of which children had the most understanding when we spoke to them.

Public protection

6.20 The interdepartmental risk management team meeting (IRMT) was no longer an effective forum to consider risk as we observed on our scrutiny visit. Leaders did not have sufficient oversight to monitor and escalate concerns about risks to and from children. This was mitigated by the work of RPs, but over-reliance on them to manage risk was not appropriate when it should have been controlled at a senior management level. When we raised this, leaders agreed to review the format of IRMT meetings (see key concern and recommendation 1.55).

6.21 MAPPA forms (multi-agency public protection arrangements) that we reviewed were inconsistent and did not inform risk management. None of the forms was dated on completion or at countersigning. RPs compiled the reports and it was not clear that contributions from other departments were routinely sought.

6.22 MAPPA management levels for children nearing release had been identified but were recorded in different places and were not always easily located. This inconsistency increased the risk of staff identifying an out-of-date MAPPA level in error to conduct a risk assessment.

6.23 Telephone monitoring for public protection was in disarray. Prison staff could not keep up with call monitoring and the backlogs had become unmanageable. The delays in monitoring risked prolonged harm to members of the public and meant that some children remained subject to monitoring for too long. Some call monitoring was sanctioned by managers for no justifiable reason which added to the backlogs.

Indeterminate and long-sentenced children

6.24 At the time of our inspection, 13 children were serving indeterminate sentences and four others were remanded for offences that could attract an indeterminate sentence. Another 35 were serving sentences of four years or longer. Apart from annual life sentence reviews, sentence planning was broadly the same for these as for other children.

Looked-after children

6.25 In our survey, 64% of children at Wetherby and 76% on Keppel said that they had been in local authority care. Prison records confirmed this.

6.26 Looked-after children and those who were care leavers continued to be identified by one of four social workers who alerted the relevant local authority to children arriving at Wetherby or Keppel. They persistently reminded local authorities of their statutory responsibilities to the child while in custody, including the receipt of pocket money.

6.27 Looked-after reviews were facilitated by resettlement practitioners and social workers. The written records of reviews that we looked at were comprehensive.

6.28 Social workers continued to inform adult prisons receiving children of their care leaver status. The promising course targeting support for care leavers which was in place at our previous inspection was no longer running, which was disappointing.

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.

6.29 Planning for reintegration was weaker than at the last inspection. During the previous six months, 153 children had been released from Wetherby and 29 from Keppel, none of whom had been released homeless.

6.30 Requests for suitable addresses were sent to children well ahead of their HDC eligibility date so that alternatives for any unsuitable addresses could be identified in good time. Other important areas of resettlement such as education and training were poorly organised. Of all children released in the previous six months, 38% at Wetherby and 44% at Keppel had been released with no education or training placement. Prison leaders attributed this to the pandemic and the difficulty of getting children to appointments to secure their places.

6.31 No pre-release courses were delivered to help children prepare for their resettlement. Support to manage finance and debt was limited to a leaflet.

6.32 In2Out (a charity that aims to reduce reoffending among children as they leave custody) continued to support children released to the North of England by pairing them with a mentor, which was commendable. The number of children using this service had reduced by about a quarter when compared to the same period before the previous

inspection. Prison leaders attributed this reduction to the pandemic and the restrictions on social contact.

6.33 Resettlement practitioners made sure that children knew who would meet them on release. All children and 18-year-olds were released with suitable clothes and collected by an appropriate adult, which was creditable.

Interventions

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

6.34 An interventions screening was completed for all children at Wetherby and Keppel by their resettlement practitioner. The interventions team used this information to determine the most suitable intervention for the child. Participation in interventions was based on children's risk, need, and date of release or transition from Wetherby/Keppel. Managers said that other work would be identified as more important for some children, for example with the child and adolescent mental health service (CAMHS).

6.35 During 2021, 55 children had taken part in interventions approved for use in the youth custody estate. Most had been one-to-one interventions, but the first group intervention since the start of the pandemic was nearing completion at the time of the inspection, which was positive (see notable positive practice paragraph 1.61). It was noteworthy that four children from different units at Wetherby and Keppel were part of this group. Work with children to address harmful sexual behaviour was undertaken by the forensic CAMHS team.

6.36 The Youth Custody Service psychology team supported prison-wide initiatives such as custody support planning, conflict resolution, enhanced support services and integrated care. They also delivered approved interventions to more complex children and worked individually with children on behaviour management needs, offending behaviour, assessment of risk and progression. A counselling psychologist service was also available.

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 (1.42): Keppel unit had lost its identity since the previous inspection. Children and staff had experienced unstable leadership, outcomes had declined in all areas and the unit was no longer delivering a distinctive therapeutic environment. Provision was indistinguishable from Wetherby in most areas.

Recommendation: Leaders and managers should better define the purpose of Keppel unit and put services in place that meet the needs of children placed there. (To the governor)

7.2 Key concern (1.43): The induction programme for Wetherby and Keppel was rarely completed by boys. They missed important information about life at Wetherby and Keppel and spent too long locked in their cells with little to occupy them.

Recommendation: The induction programme should engage children and ensure they understand the key aspects of life at Wetherby and Keppel. (To the governor)

7.3 Key concern (1.44): Intelligence was processed promptly but key areas of security risk remained that were not analysed adequately. For example, leaders were aware of a significant backlog of phone monitoring, but the risks had not been recorded on any security intelligence logs. The monthly security assessments were weak and the impact of this risk on the establishment or the public had not been considered.

Recommendation: Known security risks should be thoroughly analysed to enable an appropriate response to emerging concerns. (To the governor)

7.4 Key concern (1.45): Rates of separation had increased since our last inspection, and periods of separation were longer for children than in similar establishments. Reintegration was not always considered or implemented at the earliest opportunity. Oversight of separated children was not adequate and mandatory daily visits were not always taking place. There was less access to education than for their non-separated peers.

Recommendation: Leaders should improve oversight of children separated, ensuring that they can access a regime that is equivalent to that of their non-separated peers and that

reintegration takes place at the earliest opportunity. (To the governor)

7.5 Key concern (1.46): There were still weaknesses in equality work. The equality needs assessment, strategy and action plan were out of date, and there was no guidance for staff on how to support children from protected groups and data were not used adequately. There was limited consultation with children in protected groups and there was no forum for black and minority ethnic children to discuss negative perceptions with managers. There were key differences in provision and outcomes for the girls in the population.

Recommendation: **Leaders should use data to identify and address inequitable outcomes and provide support to children with additional needs.** (To the governor)

7.6 Key concern (1.47): Children did not spend enough time out of cell during the day, particularly at weekends. Management information did not record time out of cell accurately.

Recommendation: The time that children spend out of their cells in activity should be increased, particularly at weekends. (To the governor)

7.7 Key concern (1.48): The regime allowed all children time outside every day, but outdoor facilities were poor, and there were no organised exercise activities. We observed children standing around in bare yards with nothing to do. Children had requested improvements to the range of activities permitted on exercise yards through the youth forum.

Recommendation: Facilities for games and social interaction in outdoor areas and the supervision of outside activities should be improved so that children are enabled and encouraged to make better use of their time outside. (To the governor)

7.8 Key concern (1.49): The teaching of English and mathematics on both sites was not developing the skills and knowledge that would help young children to progress and gain necessary qualifications. Teachers were not using information from initial assessments to identify the areas that children needed to work on. In mathematics teachers and managers seemed unsure of the progress children were making in the skills they had developed. In English, teachers were not using topics that engaged the children's interests. Too many children were not completing their courses and gaining qualifications.

Recommendation: **Managers and teachers of English and mathematics should improve the planning and quality of the teaching in these subjects. They should use the information they collect through initial assessment to identify the specific skills that individual children need to develop, monitor their progress and support them to master these skills. English teachers should engage children more effectively in their lessons by using more stimulating resources.** (To the governor)

7.9 Key concern (1.50)**:** Leaders and managers had not thought through effectively what the community learning curriculum should comprise and how to identify if the curriculum achieved the development of the children's personal and social skills.

Recommendation: Leaders and managers should plan and structure the community learning curriculum so that it comprises a linked set of activities that build the personal and social skills of children. They should be clear about how to measure the impact of this curriculum. (To the governor)

7.10 Key concern (1.51): Not enough children were progressing into education, training and employment when they were released.

Recommendation: **Engagement and resettlement staff should work more effectively with the prison resettlement practitioners and community partners to enable more children to progress into further education, training or employment when they are released.** (To the governor)

7.11 Key concern (1.52): The restriction of visits to weekday evenings resulted in a very low uptake of visits and disadvantaged those who worked, travelled long distances or had childcare responsibilities.

Recommendation: Prison leaders should extend visiting hours across the weekend to provide more equitable opportunities for children to receive face-to-face visits. (To the governor)

7.12 Key concern (1.53)**:** The resettlement department was dysfunctional. Morale was low and many staff raised concerns about the lack of leadership and an absence of mutual support among staff.

Recommendation: Prison leaders should be visible and sensitive to the needs of their staff, address their views and complaints, and make sure that all resettlement staff have clearly defined roles and receive the support and training they need to fulfil them. (To the governor)

7.13 Key concern (1.54): Telephone monitoring was in disarray. Prison staff could not keep up with call monitoring and the backlogs had become unmanageable. Some call monitoring was being routinely sanctioned by managers with no justifiable reason.

Recommendation: Telephone call monitoring procedures should be reviewed to make sure that all monitoring is justified and legitimate and the backlog in call monitoring should be addressed. (To the governor)

7.14 Key concern (1.55): The interdepartmental risk management team did not review the risk management of children and much of this work had unofficially devolved to resettlement practitioners. Leaders did not have the required assurance and oversight of the management of children's risks on arrival and in preparing for release.

Recommendation: **The purpose of the interdepartmental risk management meeting should be reviewed and leaders should ensure that the meetings provide effective oversight of children's risk**. (To the governor)

Recommendations

7.15 Recommendation (3.17): Child protection allegations that meet the national criteria should be forwarded to the local authority designated officer for advice or investigation. (To the governor)

7.16 Recommendation (3.33): Those carrying out adjudications and minor reports should fully explore the circumstances of the alleged offence before finding guilt. (To the governor)

7.17 Recommendation (4.61): A memorandum of understanding should be in place between the prison, local authority and social care provider to formalise arrangements for adult prisoners needing support. (To the governor)

7.18 Recommendation (4.69): Patients requiring admission to hospital under the Mental Health Act should be transferred in accordance with the contemporary Department of Health and Social Care guidelines. (To the governor)

7.19 Recommendation (4.87): The dental suite should be maintained in a good state of repair to ensure safety and compliance with infection control standards. (To the governor)

Section 8 Progress on recommendations from the last full inspection and scrutiny visit reports

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, early days work at Wetherby and Keppel was very good. Child protection systems were effective and the management of children in crisis was good. Behaviour management processes focused too heavily on punishment, although numerous incentives were available to motivate good behaviour. While still too high, levels of violence had marginally reduced and were lower than comparators. The strategy to reduce violence further was very effective and conflict resolution work was very good. The use of force was high and, although governance had improved, there was still insufficient focus on de-escalation. Oversight of children segregated in the segregation unit and on residential units was better. Keppel continued to hold children with some of the most complex needs and managed them safely. Outcomes for children at Wetherby were reasonably good against this healthy establishment test. Outcomes for children at Keppel were good against this healthy establishment test.

Key recommendations

The use of force should only be used as a last resort. The application of pain-inducing techniques should only be used when there is an immediate risk of serious physical harm to the child, staff or others. (S41)
Not achieved

Behaviour management systems should be simplified and the emphasis should be on reward to motivate positive behaviour. (S42)
Not achieved

Recommendations

All child protection referrals should meet national safeguarding protocols and should be forwarded to the local authority designated officer for investigation. (1.16)
Not achieved

The use of strip-clothing and bedding for children in crisis should be justified on every occasion and a record kept of the decision-making process. (1.23)
Not achieved

Supervision of children on A3 landing in the segregation unit should be strengthened. (1.60)
Not achieved

Care

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

At the last inspection in 2019, relationships between staff and children were good and a strength at both Wetherby and Keppel. Living conditions at both sites had improved and were reasonably good. The provision of in-cell phones and showers on Keppel was excellent. In contrast, children at Wetherby could not shower or phone home every day. There were limited opportunities for children to eat together or prepare their own food. Consultation arrangements were underdeveloped. Equality and diversity work was being prioritised and outcomes for children with protected characteristics were generally good. Health services were child focused and remained good. Outcomes for children at Wetherby were reasonably good against this healthy establishment test. Outcomes for children at Keppel were good against this healthy establishment test.

Recommendations

All children at Wetherby should be able to access a shower and telephone call each day. (2.13)
Achieved

Children at both Wetherby and Keppel should be able to buy clothes. (2.20)
Achieved

Consultation arrangements should be developed to ensure that children's voices are heard and they can contribute to positive change in the establishment. (2.28)
Not achieved

An equality needs analysis should be conducted and used to inform the equality policy and action plan. Performance against the plan should be monitored at the equality action group. (2.35)
Not achieved

Data on all protected characteristics should be analysed for evidence of disproportionality to ensure fair treatment and equal access to services and opportunities on offer. (2.46)
Not achieved

An effective monitoring system should be in place to ensure that all emergency resuscitation equipment is in good order. (2.61)
Achieved

There should be sufficient staff to ensure that all aspects of the service are delivered. (2.62)
Achieved

There should be a whole-prison strategy to support health promotion, including healthy eating. (2.71)
Achieved

Children should have timely access to the optician and dentist. (2.82)
Partially achieved

Failure-to-attend rates for clinics should continue to be investigated and reduced. (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 had improved but was still insufficient for children at Wetherby. PE provision was very good. Leadership and management of learning and skills were good. A strong ethos of improving the engagement of children in education had significantly reduced the need for outreach provision. The provision for learners had been extended and there were sufficient spaces for every child. Attendance was good but more needed to be done to manage unauthorised absences and monitor children who had been withdrawn from education. Most children behaved well in the classroom and there were good opportunities for personal development. Achievement rates for those who completed courses were high. Outcomes for children at Wetherby and Keppel were reasonably good against this healthy establishment test.

Key recommendation

The core day should allow reasonable time for all children to complete domestic tasks. (S43)
Achieved

Recommendations

All children should be able to shower, phone home, and exercise in the open air every day. (3.12)
Achieved

Leaders and managers should continue to improve attendance rates to a consistently high level by analysing the impact of unauthorised absences and targeting actions to decrease it. (3.24)
Not achieved

Leaders and managers should evaluate the progress that children who are removed from class or transferred from prison make during their time at Wetherby and Keppel. (3.25)
Partially achieved

Leaders and managers should improve the education, training and employment prospects of young learners on release. (3.26)
Not achieved

More children should benefit from the use of ROTL to develop valuable personal, social and employment related skills and more should leave the prison with a positive ETE destination. (3.27)
Not achieved

Teachers should ensure that they consolidate and check learners' knowledge and understanding of topics taught before they move on to a new activity. (3.36)
Not achieved

Teachers should improve the clarity of the progress targets they set for children, ensuring that they are fully understood. (3.37)
Not achieved

Children should have the opportunity to undertake learning activities which support them to develop their written skills further. (3.48)
Partially achieved

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, there was a good focus on initiatives to build and maintain family ties. The resettlement strategy was based on an up-to-date needs analysis, and casework was resettlement and child focused. Training for caseworkers did not fully equip them to identify, manage and reduce risk. Children on Keppel unit had good, structured contact with their caseworkers. Sentence planning reviews were of good quality. Public protection arrangements were sound. The establishment provided a range of interventions for children. Home detention curfew and early release arrangements were managed well. Reintegration was hampered by the late confirmation of suitable release addresses and too many children were released with no education or employment outcome. Outcomes for children at Wetherby and Keppel were good against this healthy establishment test.

Key recommendation

Release planning should be comprehensive and coordinated to reduce risk on return to the community. (S44)
Not achieved

Recommendations

The role of casework should be defined and caseworkers provided with training and support to fulfil all elements of the role. (4.16)
Not achieved

All children should be able to complete interventions which address their needs while in custody. (4.35)
Not achieved

Recommendations from the scrutiny visit

The following is a list of the recommendations made in the scrutiny visit report from January 2021. If a recommendation has been repeated in the main report, its new paragraph number is also provided.

Newly arrived children should have consistent meaningful human contact throughout their first few days, including safe contact with their peers.
Not achieved

Body-worn video cameras should be routinely activated by staff at the outset of an incident and this should be robustly monitored by prison leaders.
Not achieved

Managers should ensure that monitoring and quality assurance of ACCT processes and documentation are carried out regularly.
Achieved

Children who are referred for secure in-patient transfer under the Mental Health Act should receive a swift assessment in line with national guidelines and subsequent transfers should take place within 14 days.
Not achieved

Children should attend and participate in sentence or remand planning meetings with the case worker, youth custody team and residential staff.
Not achieved

Leaders should increase the amount of time children spend engaged in activity out of their cells, in particular the weekend regime should be improved.
Not achieved

The backlog in telephone monitoring should be addressed as a matter of urgency to ensure that risk is managed and the public are protected.
Not achieved

Leaders and managers should continue to increase the hours of education, skills and work that children receive, ensuring that they access a full curriculum as soon as possible by attending classes or by remote learning.
Achieved

Leaders, managers and tutors should encourage learners to complete their education packs by reviewing their contents to make them more engaging and provide support to those who need help completing them.
No longer relevant

Teachers should provide more specific and helpful feedback on learners' written and other assessed work to enable them to improve their knowledge and skills.
Partially achieved

Leaders and managers should increase their level of oversight of teaching and learning to provide themselves with assurance of their quality.
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 II: 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
Esra Sari	Inspector
Donna Ward	Inspector
David Foot	Inspector
Angela Johnson	Inspector
Steve Oliver-Watts	Inspector
Martyn Griffiths	Inspector
Tamara Pattinson	Inspector
Chelsey Pattison	Inspector
Paul Tarbuck	Lead health and social care inspector
Cat Raycraft	Care Quality Commission inspector
Charles Searle	Ofsted inspector
Elenor Ben-Ari	Researcher
Isabella Raucci	Researcher
Helen Ranns	Researcher
Joe Simmonds	Researcher
Annie Bunce	Researcher
Alec Martin	Researcher

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.

Parkrun
A not-for-profit organisation supporting over 700 communities to coordinate free volunteer-led 5k and 2k events for walkers and runners.

Patient group directions
Enable nurses to supply and administer prescription-only medicine.

Personal protective equipment (PPE)
Safety equipment including masks, aprons and gloves, worn by frontline workers during the COVID-19 pandemic.

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

Rule 49
Young Offender Rule 49 enables managers to segregate any child who, by their behaviour, presents a risk to the maintenance of good order or discipline or who is themselves at risk of harm from other children.

Secure video calls
A secure video calling 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.

Any enquiries regarding this publication should be sent to us at the address below or: hmiprisons.enquiries@hmiprisons.gsi.gov.uk

This publication is available for download at: http://www.justiceinspectorates.gov.uk/hmiprisons/

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3rd floor
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England