Report on an unannounced inspection of

HMYOI Werrington

by HM Chief Inspector of Prisons

24 January and 31 January – 4 February 2022

Contents

Introduction

HMYOI Werrington is a facility for boys under the age of 18, located near Stoke-on-Trent. Capable of holding up to 118, at the time of our inspection just 64 children were in residence. The status of these children ranged from those recently remanded to some who were facing long and sometimes indeterminate sentences. Overall, this was a disappointing inspection which recorded a deterioration in three of our four healthy prison assessments – most notably in safety and purposeful activity, which we now judged to be poor.

Despite the prison making significant progress in reducing the amount of self-harm, the perceptions of safety (as recorded in our detainee survey) were worse than any other young offender institution (YOI). Nearly 40% of children told us that they had felt unsafe at some point during their stay. Incidents of violence were higher than any other establishment in England and Wales and a significant number were serious in nature. Force was used more frequently than comparable institutions and over 400 weapons had been discovered in the preceding 12 months. Work had begun to reduce bullying and violence, but this was only recently initiated and was disorganised. Children had limited confidence in the ability of staff to keep them safe.

The only consistently applied strategy to try to maintain order was a process of creating 'keep apart' lists that sought to separate individuals or groups. We found an incredible 263 such non- associations among a population of just 64 individuals, and the requirements were constantly changing. This ineffective and harmful arrangement was, in effect, a reactive process of risk avoidance, rather than risk management and had come to totally dominate life in Werrington. Our colleagues in Ofsted found that, among many other failings in the education and regime provision, children were allocated to learning not on the basis of need, but on the basis of who they could or could not mix with at any particular moment in time. The approach was corrosive and completely undermined the purpose of the institution.

Despite this, Werrington remained a reasonably respectful prison, although only 60% of young people felt respected by staff. The staff we observed were enthusiastic, if inexperienced. They wanted to do a good job, but their engagement with young people was too often merely transactional. Limited time unlocked, restrictive practice and risk aversion all impeded the vital goal of helping staff to engage more purposefully with the children they were supposed to be supporting.

We were left with the sense that Werrington had lost its way and needed to rediscover a sense of purpose. The prison had managed the consequence of the COVID pandemic well and there were several capital improvement and other projects being delivered. The governor had set out a series of priorities for the establishment, but it was clear to us that more needed to be done to ensure staff were fully committed to these priorities and that plans were delivered. Nevertheless, improvement at Werrington should be expected. There are currently about 400 staff of various grades and disciplines responsible for just

over 60 young people. We hope this report will assist that process of improvement.

Charlie Taylor
HM Chief Inspector of Prisons
March 2022

About HMYOI Werrington

Task of the establishment
To hold sentenced and remanded children aged 15 to 17 years

Certified normal accommodation and operational capacity (see Glossary)
Children held at the time of inspection: 64
Baseline certified normal capacity: 94
In-use certified normal capacity: 94
Operational capacity: 118

Population of the establishment

- 139 new children received in 2021
- 45 sentenced, 19 on remand at the time of the inspection
- 11 foreign national children
- 63% of children from black and minority ethnic backgrounds
- Four children 15 years of age, 17 children 16 years of age, 34 children aged 17 and nine children aged 18.

Establishment status (public or private) and key providers
Public

Physical health provider: Practice Plus Group
Mental health provider: Midlands Partnership NHS Foundation Trust (MPFT), Inclusion team
Psychosocial substance misuse service: MPFT, Inclusion team
Clinical substance misuse intervention: Practice Plus Group
Prison education framework provider: Novus
Escort contractor: GeoAmey

Prison group
Youth Custody Service

Brief history

The institution started life in 1895 as an industrial school and was subsequently purchased by the Prison Commissioners in 1955.

Following implementation of the Criminal Justice Act 1982 it converted to a youth custody centre in 1985 and in 1988 it became a young people's centre.

Short description of residential units
Werrington consists of three main residential units.

The Doulton unit: A wing has 52 cells; B wing has 44 cells. All cells are single occupancy, some with in-cell showers.

The Denby unit
C1 landing is the welfare and development enhancement unit: eight cells occupied by children who require extra support.

C2 landing has 22 cells: 12 are allocated to children on the highest level of the rewards scheme and 10 to children on induction. All cells have showers.

Name of governor and date in post
Keith Attwood, March 2021

Leadership changes since the last inspection
Sonia Brookes OBE, until January 2021
Ian Darlington, acting governor, January – March 2021

Prison Group Director
Heather Whitehead

Independent Monitoring Board chair
Sally Osborne

Date of last inspection
January 2020

Section 1 Summary of key findings

1.1 We last inspected HMYOI Werrington in 2020 and made 20 recommendations, nine of which were about areas of key concern. The prison fully accepted 18 of the recommendations and partially (or subject to resources) accepted two.

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

Progress on key concerns and recommendations

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

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

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

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

Outcomes for children

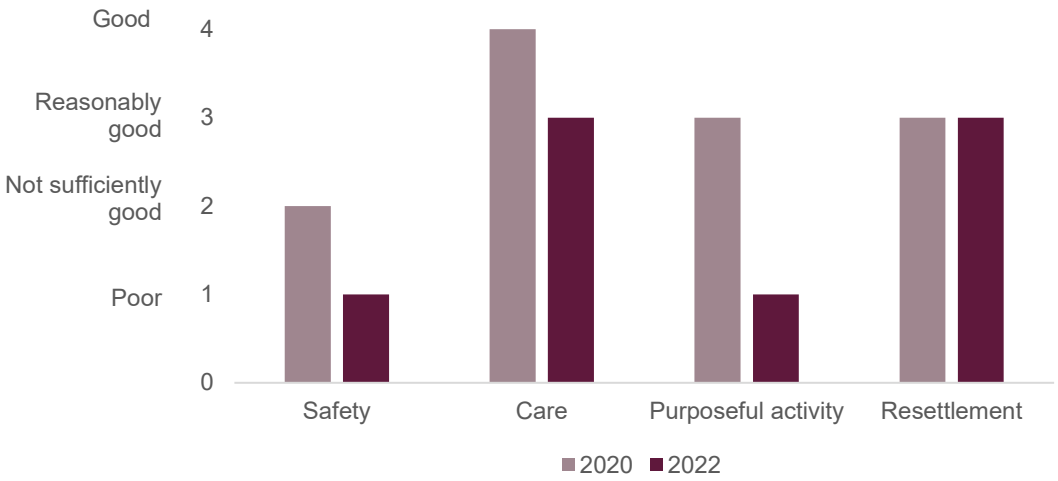
1.8 We assess outcomes for children against four healthy establishment tests (see Appendix I for more information about the tests). We also include a commentary on leadership in the establishment (see Section 2).

1.9 At this inspection of HMYOI Werrington, we found that outcomes for children had stayed the same in one healthy prison area and declined in three.

1.10 These judgements seek to make an objective assessment of the outcomes experienced by those detained and have taken into account

the establishment's recovery from COVID-19 as well as the 'regime stage' at which the establishment was operating, as outlined in the HM Prison and Probation (HMPPS) National Framework for prison regimes and services.

Figure 1: HMYOI Werrington healthy establishment outcomes 2020 and 2022



Safety

At the last inspection of Werrington in 2020, we found that outcomes for children were not sufficiently good against this healthy establishment test.

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

1.11 There was good identification of risk and need and sharing of information about children on reception and their first night at Werrington. Induction was reasonable, but children spent lengthy periods locked up during their first few days.

1.12 Leaders and managers had a good relationship with the local authority and child protection concerns were identified and investigated. Self-harm had reduced by 43% since our last inspection, but the quality of ACCT documents required improvement.

1.13 Processing and dissemination of intelligence were good, but monthly security objectives did not reflect current threats, which was a weakness. Strip-searching of children in reception was routine and often unjustified.

1.14 Perceptions of safety were worse than in other YOIs. In our survey, 16% said they felt unsafe at the time of our inspection. Despite recent reductions, levels of violence over the previous six months were higher than in any other establishment in England and Wales. A significant number of incidents were serious in nature, including group assaults and the use of weapons. Violence had resulted in 32 children attending hospital. During the last 12 months, 399 weapons had been found.

Children told us they carried weapons because they did not have confidence in the ability of staff to keep them safe.

1.15 The conflict resolution team had been re-established, but most children continued to have at least one keep-apart issue. Time spent managing the 263 non-associations (in a population of 66 children) affected all areas of life at Werrington negatively. Efforts to reduce violence and bullying and promote pro-social behaviour were disorganised. There was no consistent process to manage bullying. New behaviour management and reward and sanction strategies had been developed but not yet implemented on the wings.

1.16 The rate of use of force by staff towards children was higher than in all other YOIs and higher than at our last inspection. Most incidents involved the full application of restraint in response to violence. All incidents of force were reviewed by managers who identified learning and good practice. A mentoring programme, which supported new and existing staff with the safe application of MMPR techniques and decision-making during incidents, was positive.

1.17 There was no designated separation unit and children were separated on their wings. Use of separation remained similar to the last inspection. Two children had been separated for more than 50 days. Access to education and other services was not equitable for this group and there was a lack of formal reintegration planning or meaningful behaviour targets.

Care

At the last inspection of Werrington in 2020, we found that outcomes for children were good against this healthy establishment test.

At this inspection we found that outcomes for children were now reasonably good.

1.18 In our survey, only 60% of children said that most staff treated them with respect and 42% that they felt staff cared for them. Many staff were enthusiastic and wanted to provide good care for children but interaction between staff and children that we observed was often transactional. Anxiety about safety and time spent managing keep-apart issues hindered the development of effective relationships.

1.19 Custody support plan (CuSP) and personal officer work were not sufficiently embedded to ensure that all children benefited. This was not helped by the lack of spaces for private conversations.

1.20 Communal areas were clean, but the residential units needed to look less sterile and more age appropriate. Most cells were clean, free of graffiti and adequately equipped but it was noticeable that children did little to personalise their cells. The installation of showers and new toilets in some cells was an improvement since the previous inspection. Older toilets remained badly stained. Food was reasonably good, but

most meals were eaten in cells. Some consultation had taken place and more recently children had been invited to respond to surveys on their laptops which was a good use of the new equipment. Management oversight and quality assurance of complaints were good.

1.21 Equality meetings were well attended and chaired by the governor. A good range of data was presented. Disproportionate treatment was identified but investigations lacked depth and did not always identify the underlying cause. An equality adviser had carried out some consultation and organised celebration events. However, the promotion of equality was too dependent on one individual and not embedded across the establishment. Corporate worship was face to face and the chaplaincy had planned extra sessions to ensure that all children had equitable access.

1.22 Health services were child centred and good. Clinical governance in health care was robust. There were several examples of learning and change following incidents and audits, including innovative and enhanced assessment of injuries to victims of group assault. Waiting times and attendance at health appointments were good, but there were still too many occasions when patients did not attend at the appointed time, which led to inefficient use of clinical time.

1.23 Health assessment had been strengthened by a new health passport approach, interface with family members during induction, and innovative sexual health screening. A full range of age-appropriate immunisations and vaccinations was available to patients, including COVID-19. The management of medicines was excellent. Mental health and substance misuse services offered good child-centred care. Dental treatments were available promptly and the range of dental treatments was good, including oral health promotion.

Purposeful activity

At the last inspection of Werrington in 2020, we found that outcomes for children were reasonably good against this healthy establishment test.

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

1.24 Time spent out of cell was recovering from the impact of the COVID-19 outbreak at the end of 2021, but the weekday regime had consistently fallen far short of our expectations over the previous six months. At the time of the inspection, children were spending an average of 4.5 hours out of their cells during the week and as little as two hours at the weekend. Gym provision was good for most children. Children had very limited access to the library services.

1.25 Leaders and managers had a vision to deliver a curriculum that met the needs of children. However, instability in staffing had limited the range of courses available. Allocation of children to courses was not based on need or aspirations but on which children could mix together. This resulted in children becoming frustrated and disengaged. Despite only

15 hours of education a week, children routinely arrived late to lessons and finished early. Behaviour management in many classes was poor. Too many children refused to engage in tasks while in lessons and behaved poorly and disrespectfully towards tutors.

1.26 The curriculum in English and mathematics functional skills classes was unambitious and narrow. In some vocational areas, such as barbering, tutors introduced higher level work for those children who had achieved well. This motivated them and created ambition to further their skills and progress to higher-level studies. A majority of children achieved their qualification but achievement in mathematics and catering was too low. Kinetic Youth workers provided useful sessions that helped children to deal with their own personal barriers which prevented them from participating in education.

1.27 Learning support tutors had effectively helped children who had special educational needs or disabilities to increase their confidence and their knowledge and understanding of English and mathematics.

1.28 A few children undertook a limited range of work roles instead of attending education classes. These included cleaning and servery work in the residential wings, laundry duties and litter picking in the grounds. Children's participation and development was not part of a planned and coherent programme that supported their personal development.

Resettlement

At the last inspection of Werrington in 2020, we found that outcomes for children were reasonably good against this healthy establishment test.

At this inspection we found that outcomes for children remained reasonably good.

1.29 There was good support for families and carers to have contact with children and be kept updated with information about the establishment. Thought had been given to how children could be involved in important family events and there was good use of technology to support this. The use of exceptional circumstance visits was responsive to need and the increased use of photos for and with families was child focused. Uptake of secure video calls was good, but there was scope to extend the number of sessions.

1.30 The needs analysis was out of date and did not reflect the needs of the current population. The reducing reoffending meetings were not well attended and too many actions were not completed. Home detention curfew and early release were used effectively. It was positive that release on temporary licence (ROTL) was being used but further development was needed to ensure that ROTL was always linked to sentence planning goals. Interventions had restarted but the low level of delivery meant that children left Werrington with their identified offending behaviour not addressed. There was no additional provision

for the increasing proportion of children with long or indeterminate sentences.

1.31 Remand and sentenced children had up-to-date plans with appropriate targets. Resettlement practitioners had very good relationships with children and face-to-face contact was frequent and well documented. Resettlement practitioners worked closely with other departments, but residential officers did not attend review meetings.

1.32 Most children at Werrington were looked after by a local authority. Reviews were well attended, but they often took place late. Social workers ensured that children received their monetary and clothing entitlements from the local authorities.

1.33 All children who were high or very high risk and those coming up to release were appropriately discussed at monthly risk management meetings. Phone and mail monitoring was managed very well. Only seven children were on public protection monitoring and there were no backlogs or overdue reviews.

1.34 During the previous six months, all children had been released with an accommodation placement that had been confirmed more than 10 days before release, which was positive. However, less than half had a confirmed education or training place.

Key concerns and recommendations

1.35 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.

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

1.37 Key concern: The use of force and levels of violence among children and against staff were too high. Violence reduction strategies had either been withdrawn or were newly implemented and had only recently generated some limited impact on overall levels of violence.

Key recommendation: An informed and establishment-wide strategy should be implemented to reduce levels of violence.
(To the governor)

1.38 Key concern: Behaviour management processes were confused and did not give staff across the YOI the confidence to challenge children effectively and consistently when necessary. This lack of challenge and inability to require and enforce decent behavioural standards contributed to increased incidents of violent behaviour by children. In the absence of effective behaviour management, leaders had become over-reliant on ‘keep-apart’ arrangements. The list of children who had to be separated had become unmanageable.

Key recommendation: Behaviour management processes should be developed that give all staff the confidence to challenge poor behaviour and promote prosocial behaviour.
(To the governor)

1.39 Key concern: Interaction between staff and children was often transactional. There was limited meaningful time spent addressing children's risks and needs or the support and encouragement that they needed to progress. Opportunities for engagement were hindered by the number of keep-aparts and regime groups that staff had to manage. There was also a lack of places for private discussions on residential units. Personal officer and custody support plan work were not fully embedded.

Key recommendation: Relationships between staff and children should be meaningful and support children's progression.
(To the governor)

1.40 Key concern: The appearance of the wings, particularly Doulton wing, was stark and unwelcoming and not appropriate for children. The design of the units afforded little flexibility for activities for the number of children who could be accommodated. Rooms for private meetings with children were scarce.

Key recommendation: Children should live on age-appropriate wings that are configured and resourced so that children can engage in a full regime of activities that support their rehabilitation.
(To the governor)

1.41 Key concern: Leaders were using data to identify unequal treatment amongst certain protected groups, but further enquiry and subsequent investigations did not identify the underlying cause of these disparities or resolve them.

Key recommendation: Unequal outcomes should be investigated and addressed.
(To the governor)

1.42 Key concern: Patients failing to attend or arriving late for health appointments impaired efficient use of health resources, including some clinicians' time. Several factors contributed to this including reduced capacity in the waiting room during the pandemic, regime restrictions and clashes, and keep-aparts.

Key recommendation: Sustained action should be taken to make sure that health resources are fully used to optimise the health care of patients.
(To the governor)

1.43 Key concern: Children did not spend enough time out of cell during the day, particularly at weekends.

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

1.44 Key concern: The quality of education provided by leaders and managers was not good enough. The curriculum in some areas was unambitious and narrow. The focus was on preparing children for their functional skills exams rather than broadening the curriculum to build on existing skills.

Key recommendation A: Leaders should support staff to deliver a curriculum that develops children's skills in their subject.

Key recommendation B: Staff working on functional skills courses should ensure that the curriculum is ambitious and develops children's knowledge.

1.45 Key concern: Children were not sufficiently motivated to engage in their learning. Allocation to courses was made on the basis of which children could mix together, rather than on children's chosen curriculum pathway. This resulted in many children not taking their preferred course or moving between courses and becoming disengaged and lacking in motivation.

Key recommendation A: Leaders and managers should ensure that children have the opportunity to study their chosen subject.

Key recommendation B: Staff should set high expectations for children. Children should be encouraged and supported to identify and develop the skills that will support them during their time in custody and on release.

1.46 Key concern: There was no support at all for children serving life or indeterminate sentences. Not enough interventions were available to children, many of whom were released with no support to help them reduce their risk and resettle into the community.

Key recommendation: The range of interventions should be broadened to include those aimed at children serving life or indeterminate sentences. Interventions should be sequenced to make sure that all children requiring interventions receive them.
(To the governor)

1.47 Key concern: Too many children were leaving custody with no confirmed education or training placement. Systems for monitoring and addressing this in custody and after release were inadequate.

Key recommendation: Leaders should implement robust systems that ensure recognised educational and training placements are secured when transitioning from custody to the community.
(To the governor)

Notable positive practice

1.48 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.

1.49 Inspectors found five examples of notable positive practice during this inspection.

1.50 MMPR coordinators had developed a mentoring scheme to support staff who were not confident in the application of restraint techniques or in how to respond in a violent situation. Our review of video footage of incidents where force was used showed high levels of competence in the application of physical restraint by staff. (See paragraph 3.44)

1.51 Sexual health screening after 14 days ensured, for new arrivals, that long-term effects of unrecognised and untreated disease at reception were minimised. (See paragraph 4.66)

1.52 Practice Plus Group worked with the YOI family engagement officer to acquire health-related information from parents and carers to inform the health care of their children. Families were able to talk to nurses and be reassured that their children would be looked after. Other age-appropriate initiatives by the family engagement officer to keep families involved with their child included a virtual discussion forum, regular newsletters, and additional contact during times of important family events. (See paragraph 4.70)

1.53 Nurses reviewed CCTV records within 24 hours of all group assaults to check that the victim had not received blows to the back of their bodies or heads. This made sure that post-incident assessment of injuries was comprehensive and reduced the likelihood of complications developing from unassessed injuries. (See paragraph 4.75)

1.54 The speech and language therapist had redesigned the induction timetable given to all children, making it more accessible to those with speech and language difficulties. (See paragraph 4.80)

Section 2 Leadership

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

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 in March 2021. He had set appropriate priorities to improve purposeful activity, safety and relationships, but limited progress had been made. It was concerning that in our staff survey most front-line operational staff disagreed with the governor's priorities. Staff we spoke to said this was because they felt that too little priority had been given to their safety.

2.3 The establishment had recently experienced a significant COVID-19 outbreak which, while well managed, had led to acute staff shortfalls in December 2021 and January 2022. This had affected time out of cell and the delivery of education. Leaders in the Youth Custody Service had authorised additional overtime payments which had succeeded in stabilising the regime.

2.4 Managers had delivered or partially delivered several capital projects including in-cell technology, in-cell showers, refurbishment of the chapel and safeguarding building, and building a training facility. These were positive initiatives but would not fully address the long-term problems including a lack of meeting space, very large living units and dilapidated education facilities.

2.5 At the time of our inspection, conflict among children affected outcomes in all areas negatively. The very high levels of violence against staff and among children impeded the development of relationships and access to education or offending behaviour programmes. Leaders had taken action including appointing a new head of safety and re-establishing a conflict resolution team. However, at the time of our inspection there was no consistency to behaviour management on the wings and a reliance on keeping children apart to avoid conflict.

2.6 Managers were aware of the challenges faced by residential staff, many of whom were relatively inexperienced. Wing coordinators had been introduced to provide additional support, advice and guidance to these staff.

2.7 Ofsted judged leadership and management in education, skills and training to be inadequate. Leaders did not ensure that children received

an education curriculum that met their needs and quality improvement arrangements were ineffective.

2.8 Clinical governance in health care was robust. There were several examples of learning and change following incidents and audits, including innovative and enhanced assessment of injuries to victims of group assault.

2.9 Leadership in casework was good and had led to positive outcomes, including making sure that all children had accommodation in place by the time of their final review.

2.10 During the inspection some leaders and staff spoke of a lack of staff and other resources preventing faster progress in improving outcomes. Our staff survey was sent to more than 400 people employed to care for 66 children at Werrington. The challenge for national and local leaders was to satisfy themselves that these resources were being used in the most effective way.

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 Children no longer routinely travelled to and from court with adult prisoners and there were few late arrivals. On average, there were two new receptions each week.

3.2 The purpose-built reception building was clean and bright.

Reception building

3.3 Holding rooms contained information about Werrington and children had access to clean toilets and showers. Staff were approachable, but there was some inappropriate use of routine strip-searching (see paragraph 3.22).

3.4 Children were given a hot meal and drink and could make a phone call on arrival. Reception staff made good efforts to obtain phone numbers so that new arrivals could let a family member or friend know they were

detained in Werrington. There were no peer mentors to offer support and information in reception.

3.5 Reception staff made good use of information from the Youth Justice Application Framework (YJAF, see Glossary) and interviews with children to make assessments of risk. These were shared with induction officers and placed on YJAF for other staff and professionals to refer to. Examples of perceptive and useful comments in assessments included 'Placement confirmation information and impression gained from meeting X differ substantially' and 'On meeting Y and going through the reception induction he struggles to focus and concentrate when having a conversation with him'.

3.6 Children who arrived with little supporting information were subject to additional checks for their first few days to enable fuller assessments to be made. In our survey, 77% of children said they felt safe on their first night in Werrington.

3.7 Cells on the first night unit had been refurbished since the last inspection and now had in-cell showers. During 2021, the first night and induction centre had been temporarily located on one of the larger wings while the refurbishment was carried out. Managers acknowledged that induction arrangements had not worked well during this period. The first night and induction centre had now returned to a wing of 22 cells, which also accommodated children on the highest level of the rewards system.

In cell shower area, C2 cell

3.8 Children who had just arrived could not mix with their peers until they had tested negative for COVID-19 on arrival and again five days later. Most children spent much of the first week on their own, other than time spent with staff who had to provide a number of different daily regimes. We did not feel that the co-location of newly arrived children with those who had demonstrated the best behaviour was beneficial for either group. Children who were isolating were unable to take part in activities they could hear on the unit and the other children could not act as peer mentors and role models during induction as they had before the pandemic.

3.9 An informative induction programme was delivered, supported by information on each child's in-cell laptop. Electronic case notes recorded the contribution made to induction by different departments. Despite this, less than half the children said in our survey that they were told everything they needed to know about Werrington in their first few days.

Safeguarding of children

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

3.10 At the time of our survey, 16% of children said they felt unsafe and 38% that they had felt unsafe at some time.

3.11 During the previous year, there had been 81 safeguarding referrals, of which 60% involved the restraint of a child. The referrals came from a range of departments, but there were no referrals from front-line staff who had the most contact with children. Referrals were initially investigated by an on-site social worker supported by safeguarding staff where needed. Some safeguarding referrals had led to formal staff investigations.

3.12 Leaders had a good relationship with the local authority designated officer (DO). Allegations of harm to a child by staff had been referred as required to the DO on 28 occasions, but we found examples that met the criteria but had not been referred. The DO reviewed all allegations of harm, including those not referred, which provided a good level of oversight.

3.13 A quarterly safeguarding meeting had only taken place twice in the last year. Attendance was good, including by community agencies, but no documented actions had been completed, which was poor.

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.

3.14 Levels of self-harm were low with 26 incidents in the previous six months, a considerable reduction since our previous inspection. There had been no use of constant supervision or strip-clothing in the last 12 months, which was positive.

3.15 Assessment, care in custody and teamwork (ACCT, see Glossary) was used proactively by staff who identified risk factors or that a child needed support. During the previous year, 85 ACCT documents had been opened, but children whom we spoke to about their care did not feel supported by the ACCT process. The quality of ACCT documents was not good enough, attendance at reviews was not multidisciplinary and care plans were of poor quality.

3.16 Children who needed additional support, for example those on an ACCT or with a disability, were discussed at an effective weekly meeting. The meetings were well attended and actions to support children were generated.

3.17 The safeguarding department produced a useful monthly report for discussion at the safety and security meeting which had recently merged. However, no actions were generated to support continuous improvement.

3.18 Children could contact support services using their in-cell telephones, including Barnardo's and Childline.

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.

3.19 The security department had received almost 4,000 intelligence reports during the previous six months, which was a high number. Information was disseminated efficiently to appropriate departments across the establishment. Security analysts produced a local assessment of prevailing threats, but these were not aligned with monthly intelligence objectives, which was a weakness.

3.20 In the context of rising levels of violence and a need to keep children safe, leaders had become over-reliant on the 'keep-apart' list of

children who were in conflict with each other (see paragraph 3.38). This list had become unmanageable and a child's access to services – including education, sport, offending behaviour programmes and visits – depended more on the presence of other children than their own needs. Most children were moved around the prison in a controlled and time-consuming manner and a door or gate on residential wings could not be opened until a check had been made on which children were unlocked. This created the atmosphere more akin to a high secure environment and reinforced children's belief that they were not safe.

3.21 Weapons were a significant concern at Werrington. During the previous 12 months, records indicated 399 weapon finds, double the previous year and much higher than any other young offender institution. Children told us they carried weapons because they were not confident that staff could keep them safe.

3.22 Too many children were strip-searched in reception (see paragraph 3.20). If a child was returning to custody within three months of their release, they were routinely strip-searched on the authority of the Operational Manager, but there was often no justification or intelligence to support this.

3.23 There was limited intelligence on drug misuse and only two suspicion drug tests had been carried out since the start of the pandemic.

3.24 Leaders had good working links with the police and had set up a weekly crime clinic to review incidents and decide either to proceed with a police referral or to use prison discipline procedures. This helped the prison to make sure that the approach to police referrals was consistent.

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.

3.25 At the time of the inspection, behaviour management systems did not promote good behaviour in children. The rewards and sanctions scheme, called reward, recognition and reparation, had recently been reviewed and had been replaced with a new scheme. A new behaviour management strategy was undergoing consultation and had not yet been implemented.

3.26 These reviews had caused confusion among staff and children about which sanctions or rewards could be awarded. In our survey, 34% of children told us that the rewards or incentives for good behaviour encouraged them to behave and only 22% said that staff let them know when their behaviour was good.

3.27 We observed low-level poor behaviour, such as swearing, go unchallenged by staff. This undermined efforts to promote pro-social behaviour among children.

3.28 During the previous six months there had been 1,404 adjudications; an increase since our last inspection, when 1,128 had taken place. Too many adjudications were taking place that could have been dealt with more informally.

3.29 Records showed that when charges were proved against children disciplinary awards were proportionate. A reasonable level of investigation was carried out by staff conducting the hearings.

3.30 The quality of investigation and the consistency of awards were discussed at monthly adjudication standardisation meetings. The deputy governor also quality assured a selection of completed adjudications each month and shared learning points at these meetings.

3.31 Minor reports (see Glossary) were completed by a custodial manager and quality assured by the head of function. During the previous six months, there had been 203 minor reports compared with 362 at the previous inspection. The approach to minor reports was inconsistent: some leaders on residential units were familiar with the process, while others were not. This had led to disparity in the application of minor reports across the wings and the quality of enquiry was variable.

3.32 Barnardo's continued to provide advocacy before adjudications to children who requested it, and the service was well promoted.

3.33 The welfare development and enhancement unit (WADE) aimed to provide an environment that best meets the needs of children whose complexities may require a phased return to mainstream that is responsive to their risks and needs. A change of role during the pandemic and subsequent refurbishment had prevented the smooth running of the unit. The redeployment of officers had reduced the levels of activity and time unlocked, and some particularly complex children were still unable to mix, despite increased levels of support.

3.34 There had been some notable successes and a few children had been reintegrated on the residential wings. High quality meetings with multi-agency attendance continued to help support these children.

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.

3.35 Levels of violence among children and towards staff were very high. During the previous six months, there had been 105 assaults among

children and 82 assaults on staff. This represented 23 assaults for every 10 children, higher than any other prison in England and Wales.

3.36 A number of these assaults had been serious and had led to 31 children being taken to hospital.

3.37 During the pandemic children had only been allowed to mix in small groups or bubbles, but during summer 2021 leaders had decided to increase the size of the groups to improve access to education and other activities. Leaders believed this had led to the increase in violence among children and towards staff.

3.38 At the time of the inspection, staff had identified 263 keep-aparts (where there was a risk of violence if children mixed) among a population of 66 children (see paragraph 3.20). Staff spent most of their time managing this which affected every aspect of life for the children. The conflict resolution team had worked hard to reduce the escalating violence and had had some success. During November and December 2021 incidents had reduced and were at comparable levels to earlier in the year.

3.39 A new head of safety position had recently been created and a senior leader recruited to focus primarily on children's safety.

3.40 A monthly safety meeting sought to address violence and monitor the effectiveness of behaviour management systems. The meetings were well attended but did not focus on the causes of violence or generate appropriate actions to reduce it.

3.41 Violence reduction and bullying had been managed through a strategy called Peace until November 2020 when it was replaced by two policies. At the time of the inspection neither of these policies was in operation and systems to report serious issues such as bullying had broken down.

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.

3.42 Children had been physically restrained 468 times in the previous six months which was higher than all other YOIs and our last inspection. In our survey, 70% of children said they had been physically restrained at some point at Werrington.

3.43 Oversight and governance of actual use of force incidents was, however, good. All incidents were viewed within 24 hours by a multi-agency team who identified any child protection or safeguarding issues and reported them immediately. Leaders identified poor practice and

addressed this directly with staff. Independent scrutiny was carried out every quarter by the local authority who viewed several incidents.

3.44 Managing and minimising physical restraint (MMPR, see Glossary) practices had been integrated well by leaders in developing a very good mentoring programme for staff who lacked confidence or experience of facing violent situations and applying the specific restraint techniques used with refractory or violent children. Staff who had been mentored told us that their confidence and ability to use MMPR techniques and de-escalate situations had improved.

3.45 In the incidents that we viewed we saw good levels of competence by most staff, good evidence of de-escalation and justified and proportionate use of force. Pain-inducing techniques had been used three times in the last six months to prevent serious injury, which was appropriate.

3.46 Restraint handling plans, which informed staff of injuries or conditions such as asthma or a historic broken wrist, were of good quality and regularly reviewed.

3.47 A summary of the plan was printed and displayed in every wing office, but the full plan was only available online. When questioned, most staff were aware of the plans and could find the abridged version but were unaware of the location of the full plan and the additional safety information it provided.

3.48 More serious incidents were reviewed at weekly restraint minimisation meetings, which provided an additional layer of safeguarding and monitoring but did not address the level of force used.

3.49 MMPR staff, however, had reviewed practice which highlighted areas where staff could reduce the level of force. This had been fed back into staff training. For example, they had reviewed how staff placed children back in their cells once they had been restrained and focused on reducing the number of occasions when they were placed face down as staff withdrew. This had reduced instances of this particularly restrictive process from about 25% to 9% of all restraints.

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 There was no designated separation unit at Werrington and children who needed to be separated remained on their wing. During the previous six months, 61 children had been separated, similar to our last inspection. The average length of separation had increased to almost two weeks, which was longer than most other YOIs.

3.51 At the time of our inspection, five children were separated. Documentation was appropriate and demonstrated justification for their separation. Timely reviews took place and were well attended by professionals. However, meaningful behaviour targets were not set at the reviews and targets that were set were not within the child's control.

3.52 Two of the five children had been separated for more than 50 days. There were no formal reintegration plans for separated children, but leaders had attempted to reintegrate both children without success. Children who needed a place on an enhanced support unit at Wetherby were not moved as swiftly as we have seen at other establishments.

3.53 The daily regime for separated children was not equal to that for non-separated children. Staff tried to get separated children to spend time out of their cells, but they were often left doing tasks with little benefit to them or meaningful human contact. Kinetic Youth workers (a youth work social enterprise) were used productively with separated children which was good. Statutory daily visits by leaders and health care staff did not always take place.

3.54 There had been no recorded formal oversight of separation since July 2021, which was inadequate.

Section 4 Care

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

Relationships between staff and children

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

4.1 In our survey, just 60% of children said that most staff treated them with respect and only 42% said they felt that staff cared for them. This was reinforced in our one-to-one interviews, but children also said they had a member of staff they could go to if they had a problem.

4.2 Many staff demonstrated knowledge of the children they were working with, they were enthusiastic about their work and wanted to provide good care for children. However, interaction between staff and children was often transactional rather than focusing on their risks and needs or supporting and encouraging them to engage and progress. Practices such as staff taking meals to cells rather than children collecting them from serveries limited opportunities for spontaneous engagement.

4.3 Children were able to mix in larger groups than earlier in the pandemic, but keep-apart issues (see paragraphs 3.20 and 3.38) continued to affect the time that staff could spend with different groups of children. This hindered the development of effective relationships. Many staff had started working at Werrington during the pandemic and had no experience of a more open regime which offered meaningful interaction with children. Managers had identified the challenges faced by residential staff, many of whom were inexperienced. Wing coordinators had been introduced to provide support, advice and guidance and role modelling to residential staff.

4.4 Personal officers had been assigned to children in recent weeks and children requiring additional support had sessions to discuss their custody support plan (CuSP). Electronic case notes showed that some children were participating in informative, useful CuSP sessions with their personal officer, but these were not yet fully embedded and not all children were benefiting from them. This was compounded by limited places on wings for private discussions.

4.5 There were few opportunities for children to be involved in community life, or act as peer representatives or 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

4.6 Most children were accommodated on one of three main wings, two of which had a capacity of between 40 and 50 children. The size of the wings and lack of meeting space afforded limited flexibility for activities for this number of children.

4.7 Most furniture had been moved from the larger communal areas on A and B wings which now looked stark and institutional for the children who lived there. Managers were aware of the shortcomings and were discussing with a graffiti artist designs for the wings and the exercise yards to make them more age appropriate. Communal areas were kept clean and were in a decent state of repair.

Doulton unit

4.8 Refurbishment work had started in 2021 and most accommodation on C wing and some on B wing had been improved by the installation of in-cell showers and new toilets. More were planned for 2022. Communal showers for children in cells without showers were kept clean and in reasonable condition. In our survey, 89% of children said they could have a shower every day compared with 69% in 2020.

4.9 Cells that we viewed were in reasonable condition and largely free of graffiti. A repainting programme was continuing. Few cells had been personalised which contributed to their institutional feel.

Occupied cell on Doulton unit

4.10 Cells had in-cell telephones and were adequately equipped. Children could not have toilet brushes and the toilets had no lids. Despite deep cleaning some toilets looked badly stained.

Badly stained toilet on Doulton unit

4.11 At the end of November 2021 each child had been given a laptop to use while at Werrington. This enabled children to order food and shop purchases, communicate with key departments in the establishment and contact their family and friends using 'email a prisoner' (see paragraph 6.3).

4.12 Children could wear their own clothes and had access to cleaning materials, laundry facilities, clean bedding each week and prison-issue clothing if needed. Towels and underwear could be exchanged each day. Access to stored property and incoming purchases (see paragraph 4.19) was organised well.

Residential services

4.13 In our survey, 46% of children said that the food was good. We found the quality and quantity of food to be reasonably good.

4.14 Children ate most meals in their cells. Eating the afternoon meal together was arranged on a rota basis if staff were available to supervise.

4.15 The standard four-week menu cycle was offered for the evening meal. Children could order meals from their laptop and could choose options which catered for religious and other dietary requirements. Cultural and religious anniversaries were celebrated with special menu items. Lunch consisted of a sandwich, drink, fruit and snacks for children to eat in their cells. Breakfast packs were supplemented by toast each weekday, with beans or spaghetti available on some days. Hot breakfasts were supplied at weekends. The catering manager had recently used in-cell laptops to consult children about a change to the menu.

4.16 The main kitchen, food trolleys and serveries were clean and well maintained, although one oven in the main kitchen had been waiting for repair for several months. Staff and children who served food on the wings wore suitable protective clothing.

4.17 Children could not prepare their own food, but many had stocks of instant noodles, cereal and biscuits in their cells to eat when they were locked up.

4.18 The range of items available for children to buy was reasonable. A first week pack, phone credit and an advance of £3 was offered in reception, all repayable in instalments. Depending on the day they arrived, children could wait up to two weeks to receive their first delivery of ordered goods. Black and minority ethnic children could buy hair and skin products from a separate list.

4.19 Children could order clothes and other personal items from a reasonable choice of companies and could order approved magazines and newspapers.

Consultation, applications and redress

4.20 Some consultation had taken place during the pandemic within the children's designated groups (see paragraph 4.29), including seeking children's ideas for the work being commissioned from a graffiti artist to decorate the wings and yards (see paragraph 4.7). 'You said, we did' boards were used on Doulton unit to share the outcome of consultations. More recently, managers had started to use children's laptops for consultation which gave all children the opportunity to share their views privately. Managers were working towards restarting youth council meetings.

4.21 Since December 2021, children had been able to make applications from their laptops. Managers were starting to receive electronic reports tracking the progress of these applications, which was an improvement.

4.22 Blank complaints forms were accessible to children and, during the previous six months, 165 complaints had been submitted. In our survey, 43% of children who said they had made a complaint thought that complaints were dealt with fairly.

4.23 Management oversight and quality assurance of complaints were very good. Most complaints were replied to within the required time and in nearly all cases the member of staff dealing with the complaint spoke to the child. Responses were quality assured by the safeguarding department and the independent monitoring board and a sample was reviewed by the head of business assurance each month. The sample of responses that we examined were clear and addressed the issues raised. A thorough analysis of complaints was carried out each month.

4.24 Resettlement practitioners met each child soon after their arrival to ensure they understood why they were detained at Werrington and give them key dates in their detention. Children could make free phone calls

to their solicitors and other community professionals supporting them. Videolink for these contacts was introduced during the pandemic on four days each week and was used well. This helped to alleviate the limited provision in the visits room for private legal visits.

4.25 Legal advice was available for children, particularly on immigration issues (see paragraph 4.41). Children could contact Barnardo's advocates from their laptops.

4.26 The library had some legal texts and prison service documents, but children had very limited access to this resource (see paragraph 5.10).

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

4.27 The institution had useful structures and arrangements in place to help promote equality. A monthly equality meeting was well attended and chaired by the governor. This meeting and consultation with children informed an equality action plan which sought to deliver better outcomes for children. These included investigating the perceptions of children with disabilities of feeling less safe and delivering cultural awareness training to staff.

4.28 Good quality data from a range of areas were provided and analysed at this meeting, such as monitoring disproportionate treatment in adjudications and rewards and sanctions. While disproportionality was identified, investigations did not always identify the cause or deliver suitable actions to resolve it. Managers, for example, were aware that black children were far more likely to be involved in group violence and white children more likely to make weapons, but there was no plan to identify and tackle the reasons for this.

4.29 A full-time equality adviser was visible to children and regularly spoke to them about diversity issues. The adviser had restarted consultation forums with groups of children who identified with one or more of the protected characteristics (see Glossary). Three children had been identified as equality and diversity representatives, but they were all located on the same wing and could not mix with other children.

4.30 The adviser provided much high-quality information about diversity in a child-friendly format and involved staff and children in religious festivals, Black History Month and other important cultural events.

4.31 Despite this good work, the equality and diversity strategy was not embedded. The leadership team was over-reliant on this one adviser and events did not take place as planned in the adviser's absence. At the time of the inspection Chinese New Year was celebrated with themed food, but the information and decorations that should also have been provided were not used as the adviser was not in work.

4.32 Functional heads had recently been identified as protected characteristic leads in accordance with the equality action plan. They were responsible for ensuring that consultation took place with their respective groups and findings fed back to the monthly equality meeting.

4.33 Discrimination incident report forms (DIRFs) were available on each wing. Functional heads conducted investigations into equality complaints in their areas and responded to DIRFs. The responses that we examined were comprehensive and addressed the issues reported.

4.34 During the previous six months, 54 DIRFs had been submitted. About two-thirds of DIRF forms were submitted by staff, about half of which were in support of children who had suffered abuse from their peers.

4.35 There were several layers of quality assurance by the equality adviser, the governor and independently by a volunteer from the local youth offending team.

4.36 Five children were taking part in the Ambassadors for Change programme. This was a Youth Justice Board community-based project looking at racial disparity in adults and institutions and how this affected the child's progress in custody.

4.37 Peaceful Communities was another positive programme to improve cultural awareness in staff and help them manage and support children from diverse backgrounds. Twelve members of staff had been identified to undergo this training and children from black and minority ethnic backgrounds had helped to choose and mentor the candidates.

Protected characteristics

4.38 In our survey, 67% of children identified as coming from a racial minority group, 8% from the Traveller community and 21% said they had a disability, either physical, mental or learning needs, that affected their daily life.

4.39 Our survey showed that children's perceptions of treatment were broadly similar irrespective of any protected characteristic.

4.40 Children from black and minority ethnic backgrounds had been consulted recently and some of the issues they had raised had been addressed such as the opportunity to buy hair braiding and cultural products. Important work was being done to raise awareness of different cultures among staff (see paragraph 4.37).

4.41 Nine foreign national children were held at the time of the inspection, none solely under immigration powers. A caseworker managed liaison with the Home Office, and immigration officers attended to see children when needed. Children were helped to get legal advice on immigration matters and records indicated good use of interpreters for children for whom English was not the first language.

4.42 Children received an additional five pounds a week in phone credit if they did not receive visits and could apply for further credit in an emergency. Video link visits were not available for children whose families lived outside the UK as it was thought that the scheme did not allow for this. However, we had seen good examples of international contact via video visits during recent inspections at other institutions.

4.43 At the time of our inspection no children identified as gay, lesbian or bisexual. Support for children who did identify was provided individually. In the months before our inspection three children had recently identified as gay and specific groups had been arranged for them by Kinetic Youth.

4.44 There were no transgender children at the time of our inspection. A comprehensive policy protected the rights of the child and informed staff and leaders how trans children should be managed in custody.

4.45 Most children who identified as being disabled had neuro-diverse conditions. Leaders had responded to this by inviting the autism awareness bus into the prison to help staff understand how some children perceived the world. Children's mental health week had also been promoted and information provided to staff and children.

4.46 At the time of the inspection, there were no personal emergency evacuation plans (PEEPs) for children needing help during evacuation of a wing. Previous PEEPs that we examined were detailed and staff knew where to find them.

4.47 Gypsy, Roma and Traveller children had last been identified in May 2021 and they had been consulted individually. In our survey, 8% of children identified as Gypsy, Roma and Traveller but they had not been identified by the establishment and were not supported.

4.48 An active chaplaincy was visible around the prison. The coordinating chaplain could facilitate access to a minister for all faiths if required. All separated children or those in crisis were seen by a member of the team each day as well as those who had asked to see the chaplain.

4.49 Bibles were available in a pictorial, child-friendly format which was innovative.

4.50 Corporate worship was open to all faiths face to face which was positive, but the high number of children who could not mix presented difficulties in providing access for all children. In response, the chaplaincy had increased the number of sessions for worship and were

increasing the number of Muslim chaplains who attended the prison to ensure equitable access.

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.

4.51 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

4.52 The establishment, health commissioners and providers worked closely together to deliver good, child-centred services. Practice Plus Group (PPG) was the provider and subcontracted some health services. PPG services were well led, with robust governance and oversight processes which met regulatory standards. A new, informative health needs assessment was available to guide developments in 2022.

4.53 The patient engagement officer had developed imaginative ways of determining children's views through consultation groups on key issues, such as the design of a health passport and health promotion materials. PPG surveyed 5% of patients each month to ascertain user satisfaction with a different clinical service. Results during 2021 had been invariably positive.

4.54 There were only two to three untoward and adverse incidents each month. Learning from these incidents was evident and characterised by innovation and notable positive practices.

4.55 PPG delivered 24-hour nursing cover, seven days a week. Staffing levels and competencies were sufficient to meet the needs of the patients. Staff were well trained and supervised, and their competencies had been extended to improve access to specialist treatments. Health staff were easily recognisable with primary care clinicians in uniform.

4.56 Each patient had a confidential clinical record on SystmOne (electronic clinical records), which met record-keeping standards. Information was shared with other departments involved in the care of the children by consent, or occasionally in their best interests.

4.57 Health professionals knew their patients by sight. We observed compassionate approaches to patients and good-natured relationships. We observed respectful patients, who told us of their satisfaction with health care.

4.58 Patients were seen in private unless risk assessment suggested otherwise. The health centre clinical environment had been enhanced by the provision of three talking therapy rooms on the wings and a therapeutic well-being centre. Preparation of these rooms had unfortunately been interrupted by pandemic restrictions and only limited use was possible (see paragraph 4.81). Infection prevention and control measures had recently been audited and demonstrated high compliance (95%) with required standards.

4.59 We observed health staff responding promptly to medical emergencies. Staff had relevant training, resuscitation kit and other equipment, which was strategically sited in several places, well maintained and checked regularly.

4.60 Patients were consulted about their care during health assessment and treatment and records demonstrated that options were discussed with them. There were appropriate arrangements for ensuring that children had the capacity to understand the choices available and/or to receive support from advocates. Health care staff brought two or three vulnerable children to the attention of prison staff and social workers each month, which reinforced safeguarding.

4.61 The health complaints system was confidential and independent of the prison. Patients registering their concerns were seen promptly face to face, which was good practice. This facilitated rapid resolution and no concerns had proceeded to complaints during the previous year.

Promoting health and well-being

4.62 The promotion of health and well-being across the establishment was being restored in anticipation of the lifting of COVID-19 restrictions. Some activities had endured despite the restrictions, such as a health fair in 2021. Supplementary vitamin D had been added to the diet and/or prescribed to ensure that the physical development of children was not impaired by lack of access to sunlight during the regime restrictions. Health staff worked closely with catering, the gym and other departments to give individual support to patients with special dietary or exercise needs.

4.63 Health champion training had started as part of the education curriculum, so that all children would be encouraged to achieve a qualification and be better prepared to maintain their well-being. The first cohort had successfully completed the course. This novel approach was very good practice.

4.64 An eye-catching ‘health passport’ was given to every child at induction. The content had been designed in consultation with patients and was age appropriate (see paragraph 4.53). It included a guide to health services and space to record information pertinent to maintaining well-being. It was not yet available in languages other than English.

4.65 Nurses made sure that children accessed disease prevention and screening programmes such as blood-borne viruses and COVID-19

testing. They encouraged children to take age-appropriate immunisations and vaccinations such as COVID-19, hepatitis, MMR and meningitis. Children who declined vaccinations were followed up to encourage uptake.

4.66 Health assessment had been enhanced with sexual health screening 14 days after reception. Hospital-standard explicit materials had been developed in consultation with patients, to help them identify signs and symptoms. This innovation arose from mass screening, which indicated that not all sexually transmitted infections were identified at initial assessment.

4.67 Smoking cessation support was available to children and we observed one patient applying his own patches with the supervision of a nurse.

4.68 Effective arrangements were in place to manage communicable diseases. We observed swift and integrated action to curtail a potential outbreak of TB, which was reassuring. Most health services had been maintained throughout the pandemic despite restrictions, and Public Health England had supported the YOI through the recent outbreak, which was managed well.

Primary care and inpatient services

4.69 The full range of CHAT (comprehensive health assessment and treatment) templates was used by nurses to screen and assess patients at reception and during induction. Children received at least annual health checks, which was good.

4.70 Clinicians participated in the family engagement manager's contact with families during induction so that relevant health information about children was acquired (see paragraph 6.1). This was a notable innovation.

4.71 Comprehensive primary care services included specialist contributions from physiotherapy and optometry. Some specialisms, such as asthmatic care and sexual health, were offered by nurses with enhanced skills.

4.72 A GP was available three days a week and a nurse prescriber on other days. There were effective out-of-hours arrangements for PPG managers and clinicians and access to local GP out-of-hours services.

4.73 Patients with longer-term conditions such as asthma, diabetes and epilepsy were carefully monitored. Those with complex needs such as blood disorders, cystic fibrosis or wound care had suitable care plans, and custody staff were given advice on how to support the patients.

4.74 An innovative health applications system had recently started with patients making applications on their laptop computers (see paragraph 4.21). Waiting times and attendance at health appointments were good, but there were still too many occasions when patients did not attend at the appointed time which led to inefficient use of clinical time. Administrators could now check if children intended to come on the day

before the appointment. Clinicians would see patients on the wings if necessary.

4.75 Health staff gave restraint handling advice to custody staff for patients with medical conditions who might be adversely affected by restraint (see paragraph 3.46). Nurses attended potential restraint situations to reinforce safety and saw children after the incident to check for injuries. After one incident, PPG had reviewed CCTV records within 24 hours of all group assaults to check that the victim had not received blows to the back of their bodies or heads. This was best practice.

4.76 Patients received secondary care services, usually at the local general hospital. Long waiting times had developed for some services during the pandemic, such as non-urgent X-rays, but these were slowly returning to normal. PPG was always consulted about security measures on hospital escorts to make sure they were proportionate.

4.77 Patients reaching the age of 18 years had access to social care via a suitable referral and assessment pathway, which had yet to be used. The establishment could not locate a memorandum of understanding with the local authority for the provision of social care.

Mental health

4.78 The mental health and substance misuse service was delivered by Inclusion, an integrated team from Midlands Partnership NHS Foundation Trust (MPFT). They delivered a weekday service and on-call support at weekends. Psychiatric services were subcontracted to Birmingham and Solihull Mental Health Trust.

4.79 The strong and dedicated team were flexible in their approach to making sure that the health needs of patients were met. Supervision for Inclusion staff did not always reflect the MPFT policy, because of pressures arising from the pandemic. However, staff told us they felt well supported. The skill set of the team was good and included mental health nurses, a drama therapist, psychiatrists, psychologists, and the recent addition of a speech and language therapist.

4.80 There was no longer a learning disabilities nurse, but a pathway had been established to ensure that any identified needs were met. The speech and language therapist had redesigned the induction programme to make it more understandable for the children.

4.81 A newly established well-being centre offered three additional therapeutic rooms although not all the space could be used because there was no soundproofing or communications.

4.82 All children were screened for urgent mental health needs when they arrived, and a full CHAT followed within expected timescales. Information was gathered from the community and family members where appropriate.

4.83 About half the population were being supported by the mental health team. An appropriate range of interventions was tailored to patients'

individual needs including emotional regulation and trauma-informed psychotherapy. Inclusion staff attended ACCT meetings and coordinated care with other departments.

4.84 Implementation of Secure Stairs (see Glossary) had progressed since the previous inspection despite the adverse effect of the pandemic and the restricted prison regime. Less than half the custody officers had received training on the ethos of Secure Stairs and they did not have access to reflective practice sessions to help support their work with children displaying complex behaviour.

4.85 At the time of our inspection, 77% of children had a formulation plan (a plan based on a shared, psychologically informed understanding of need) to support officers' work, reinforced by multidisciplinary meetings. Most officers we spoke to on the wings were aware of the formulation documents. A working group was in place to improve the profile of formulation plans, including alternative formats to ensure optimal use.

4.86 Patient records stored on SystmOne were of a good standard and demonstrated that patients had been involved in their care.

4.87 During the previous 12 months, there had been one transfer under the Mental Health Act which had taken place within the expected guidelines, an improvement since our last inspection.

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.

4.88 There was an up-to-date establishment-wide drug and alcohol strategy and effective partnership working with departments to progress the strategy and share information.

4.89 PPG delivered clinical treatment for substance misuse, although this had not been required since our previous inspection. A suitable treatment pathway included access to a prescriber and specialist advice.

4.90 Children received a prompt CHAT assessment by a substance misuse recovery worker and were given harm minimisation advice to help them stay safe.

4.91 Substance misuse recovery workers delivered age-appropriate short- and long-term interventions including harm reduction, drug awareness and the impact of drug dealing on offending behaviour. Programmes met each patient's needs and were delivered through one-to-one sessions. An appropriate range of resources was available to support this work. Pandemic restrictions had prevented group sessions from

being held. Detailed child-centred care plans were devised in consultation with patients.

4.92 Staff were often hindered in carrying out interventions because of limited access to patients and lack of appropriate therapeutic space. They were, however, tenacious and flexible in their approach to overcome these issues.

Medicines optimisation and pharmacy services

4.93 The pharmacy delivered services in a safe and effective manner. Medicines were supplied by HMP Oakwood. Medicines management was nurse led and exemplary, despite the absence of a pharmacist.

4.94 Suitable medicines were available to treat minor ailments without a prescription and there were protocols to provide more potent medicines without the need to see a doctor. Prescribing and administration were recorded efficiently on SystmOne which also held up-to-date in-possession risk assessments. The GP and prescribing nurse were easily accessible. A wide and suitable range of medicines were available in the emergency stock cupboard.

4.95 The supply chain for medicines was secure and reliable, and stock reconciliation procedures were good.

4.96 Medicines were administered three times a day and there was provision for night-time administration to patients in their cells. About one-third of patients received their medicines in possession, with the remainder receiving supervised administration. We observed queues for the collection of medicines which were supervised by custody officers and were generally well managed. There was good rapport between nurses and patients. Spot checks were undertaken for in-possession medications as appropriate.

4.97 A health care partnership meeting was held at regular intervals, but there was no representation from a pharmacist. PPG leaders agreed in discussion to introduce regular pharmacist involvement in clinical governance meetings to facilitate professional advice to staff managing the pharmacy and medicines and to ensure the appropriate resolution of concerns.

Dental services and oral health

4.98 Patients were able to access dental treatments and oral health promotion equivalent to NHS dentistry in the community, and appropriate referrals were made to specialist services. Electronic patient records were exceptional.

4.99 Timely access to scheduled dental appointments was not always facilitated by the establishment, resulting in inefficient use of clinical time. However, waiting times were good and there was a clear pathway for triage for children needing urgent care.

4.100 The dental suite met infection prevention and control standards and equipment was well maintained. Oxygen was not available in the suite, which could cause delay in an emergency.

4.101 Pandemic working rules required custody staff attending the dental suite to have access to specialised PPE (see Glossary) in case of emergencies or aerosol generating procedures. At the time of the inspection the PPE was not located in the vicinity of the dental suite. This could have compromised safety or caused delays in entering the suite.

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 Time spent out of cell had been slowly improving through the second half of 2021 but had been badly affected by a COVID-19 outbreak in December 2021. When the inspection took place, the time that children were unlocked was recovering, but the weekday regime had been consistently short of our expectations over the preceding six months. At the time of the inspection, children were spending an average of about 4.5 hours out of their cells on weekdays and as little as two hours at weekends, which was not enough.

5.2 The core day was split into two halves which mirrored one another. One half of the population attended education in the morning and the other half in the afternoon. On the other half of the day children had exercise, gym and showers (if they had no in-cell shower). If staffing allowed, evening gym sessions were offered on a rota basis and children on the highest reward level had association. Children who could not mix with others had an individual, more limited regime.

5.3 Daily periods in the fresh air were offered and coats were provided for children to wear if they wished. During the inspection, time outside was replaced with time in an association room for one group because damage to the exercise yard made it unsuitable for use. We saw instances of children who were unlocked on their own opting to spend their 'exercise' time playing a game with an officer indoors.

5.4 Children living on C2 wing on the highest level of the reward scheme fared best in terms of time unlocked, but they commented that they sometimes missed parts of their regime if staff were focusing on the induction population with whom they shared the wing. We observed some slippage in regime for these children, for example they were collected late for their early morning gym session.

5.5 Physical education facilities were good and included a large sports hall, a well-equipped gym, and an all-weather outdoor games area. Showers had been refurbished. Six PE instructors and two sports and games officers delivered a range of activities. Children told us they would like more opportunity to use the outdoor all-weather games area.

Sports hall

All weather outdoor sports area

5.6 Most children could attend gym activities each day during the week. Children who were not mixing with others had an opportunity to attend at least once a week. Records of attendance were monitored so that children who did not take part in physical exercise could be encouraged to attend.

5.7 PE staff had good links with other parts of the YOI and were delivering some accredited courses with health care and the resettlement team.

5.8 Community links had been maintained. Although matches had not been possible during the pandemic, the YOI remained part of a local football league. Planning for a twinning project with Birmingham City football club was in progress and due to start in March 2022. Participation in the airborne initiative (a residential outward-bound course) was due to start in April after an 18-month gap.

5.9 Children on C2 could take part in the Parkrun scheme at weekends. This encouraged them to run or walk together with staff and promoted health and participation in an activity that could be continued after release.

5.10 The library was a well-equipped resource with books to suit a range of reading abilities and languages, but children had had very limited access to it during the pandemic. There had been gaps in library staffing and there were still no regular weekday timeslots for children to attend. Kinetic Youth workers took small groups to the library at weekends to borrow books and a remote ordering service had been in place during COVID restrictions. We were not able to find out how many children used the library.

Education, skills and work activities

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.

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

Overall effectiveness:	Inadequate
Quality of education:	Requires improvement

Behaviour and attitudes:	Inadequate
Personal development:	Requires improvement
Leadership and management:	Requires improvement

5.12 Education managers had a good understanding of the key weaknesses in their provision, particularly in English and mathematics. The recent appointment of staff to key roles had started to improve the teaching of the curriculum, although it was too early to see the full impact of this. The actions of leaders and managers to improve the quality of the service focused too much on implementing the actions rather than assessing the impact. As a result, there was little evidence that the quality of education was improving quickly enough.

5.13 There were enough activity places for all children, although children were selected for courses on the basis of which children they could or could not mix with, rather than on the chosen curriculum pathway. This resulted in a majority of children not taking their preferred course and they became disengaged and lacking in motivation. When children could not be allocated to courses where their safety was assured, they participated in one-to-one English and mathematics lessons with a tutor in their residential wings. Leaders and managers did not make sure that children attended lessons on time. Too often they arrived late and were collected early. In a minority of cases, when children arrived at the class, prison staff continued to hold conversations with them while tutors were trying to start the lesson. This undermined the authority of the tutor.

5.14 Children who did not participate in classroom-based education were allocated to individual sessions with a tutor on their accommodation wings. These children behaved well and were motivated to learn. They responded well to the tutor and completed the activities that were planned for them.

5.15 Children who had an identified learning difficulty or disability were supported exceptionally well. The effective use of diagnostic assessments, combined with the careful deployment of learning support assistants, helped children to remain focused in classes and make good progress with their learning.

5.16 The education provider's Inclusion team ensured that each child's needs were accurately assessed and understood by staff. Information was captured quickly by the team when children entered the prison. Managers were tenacious in contacting community partners, which ensured, for example, that they received the child's education, health and care plan (EHCP).

5.17 Tutors used strategies to support the children, based on their EHCP and other assessments. This information was comprehensive and informed the children's learning plan. Information was shared with prison managers and education staff to help them understand the specific needs of each child. This helped children to settle into prison

life, and staff were aware of what could trigger negative behaviour or anxiety in the children.

5.18 Leaders' and managers' rationale for the curriculum was appropriate. They knew to which adult prisons children would progress to serve the remainder of their sentence and they used this information to ensure that the curriculum aligned with that found in those prisons, including courses in barbering and catering. When children were released, leaders and managers had a broad understanding of the education and employment opportunities available. However, restrictions in the prison regime during the pandemic had limited more meaningful engagement with potential employers.

5.19 A few children worked in prison services, mainly wing cleaning, litter picking and the laundry. They were supervised by prison staff rather than instructors, and there were no planned activities to improve children's personal development skills.

5.20 The curriculum for English and mathematics functional skills was unambitious and narrow. Tutors planned individual programmes of learning to develop knowledge and skills which had been identified during the children's induction to education. While this helped to prepare children for their functional skills exams, little was planned to broaden the curriculum further to build on existing skills. This was compounded by insufficient time being allocated to English and mathematics lessons.

5.21 In vocational areas, some tutors integrated English and mathematics well into their lessons. For example, in the multi-skills lesson tutors used work-related projects to help children develop and apply their knowledge of perimeter and area. Children's knowledge of these concepts was embedded. In the employability course, the tutor used dictionaries well with children at the start of the session to review new words linked to British values, the theme of the session. Similarly, on the facilities management course, children learned the technical vocabulary linked to PPE (see Glossary). On other vocational courses, tutors failed to use opportunities to reinforce English and mathematics. In a hospitality lesson, the children did not work from a recipe which limited the development of skills such as weighing ingredients. The English tutor was not included in a radio production lesson focused on preparing a script for a news report. The tutor's presence would have helped children to develop their speaking and listening skills and to write the text for the recording.

5.22 Managers had very limited knowledge of the progress children made on courses and did not evaluate the impact of the curriculum fully.

5.23 Children's behaviour was very poor. They were often rude and defiant towards tutors' requests. Tutors did not challenge children well enough when they did not comply with the prison's expected behaviour. When children were challenged by tutors for laying on a sofa in the barista class, having their feet on furniture or swearing, children routinely challenged staff back. Tutors did not have sufficient skills to be able to

manage this level of behaviour. This consistent disruption limited the progress children could make in lessons.

5.24 Kinetic Youth workers delivered useful sessions to address the barriers which prevented children from participating in education courses or the wider regime. For example, course sessions focused on improving behaviour by considering racism, drug awareness, toxic masculinity, homophobia, and mental/physical health. British values and equality and diversity were core features of the project. However, too few children were allocated to the course which limited the impact of the programme considerably.

5.25 Children had an age-appropriate understanding of British values and how these related to wider contexts. They knew what behaviour was expected of them and how they should treat others. However, the behaviour and attitudes they exhibited each day often fell short of this understanding.

5.26 Many children were frustrated by regime restrictions and/or the education pathway they studied. They did not receive enough feedback from managers on why their application for a chosen activity had not been successful. As a result, they did not know if they needed to make any adjustments to their approach, attitude or behaviour to access that activity successfully.

5.27 Children benefited from engaging in a wide range of extra-curricular activities. Themed events such as 'National Storytelling Week' and 'Holocaust Memorial Day' were carefully planned to enhance children's experience and understanding of life in the modern world. The prison used its links well with specialist charitable and sporting organisations to introduce children to new concepts such as yoga and sign language.

5.28 Most children participated in an employability programme that helped them prepare for release. In addition, engagement staff worked closely with individual children to address specific development needs. This included providing interview techniques for those who had secured training on release and information on disclosure of offences to potential employers.

5.29 Engagement staff worked well with community youth offending teams and careers services which helped children when they were released. However, prison staff recognised that this community support required improvement to promote successful resettlement and they had plans to rectify this.

5.30 Career planning failed to meet all children's needs. Not all children attended education programmes that reflected their career aspirations. This was compounded by a restricted regime, security restrictions relating to keeping certain children separated and continued poor behaviour. When career reviews took place, they focused on target setting and not on the skills children needed to develop to make informed and realistic decisions about their future.

Recommendation

5.31 **Prison staff should make sure that children arrive promptly to lessons.**

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 More than half the children at Werrington were more than 50 miles from home. A family engagement manager provided good support to families and carers with children at Werrington. This included early contact with parents and carers to gain and share information about their child (see paragraph 4.70), and a regular newsletter emailed to families which was also provided in other languages.

6.2 Contact arrangements were responsive to need and technology was used well. On-line video calls had been used so that children could be involved in significant family events. One child had had a farewell call with a seriously ill family member and another was able to meet his new-born child for the first time. Exceptional circumstances visits had been used appropriately when family situations required a private visit. Other positive initiatives included an increased use of photographs of children that could be sent to families for special occasions and the introduction of an online forum for families every two months which education staff also participated in.

6.3 Children had in-cell phones and had received additional phone credit throughout the pandemic. They could use their laptops to communicate with their approved contacts using the secure 'email a prisoner' service. Take up of the secure video calls facility was good, with all available slots filled. There was, however, scope to increase the number of sessions and enhance the opportunity for contact using this facility.

6.4 In-person visits took place on weekdays and at weekends for up to six sets of visitors at a time. Use of these visits was still relatively low. In response to feedback from families, unbooked visits slots were now offered to those who had indicated they would welcome extra visits at short notice. Children who did not have any visits were identified each month and the reasons for this explored.

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 In our survey, only 29% of children said that their experiences at Werrington had made them less likely to offend in the future. The reducing reoffending policy set out leaders' priorities but lacked clarification on how they would be achieved. The corresponding action plan did not align with the policy and contained many unaddressed action points.

6.6 The needs analysis to inform interventions for children had not been fully reviewed for more than 18 months, was out of date and did not accurately reflect the requirements of the current population. Leaders were, therefore, poorly prepared to plan appropriate interventions to help prepare children for release.

6.7 Focus on reducing reoffending had weakened since our last inspection which leaders attributed to the pandemic restrictions. There were, however, signs of improvement. The quarterly reducing reoffending meetings had restarted after a pause during restrictions and the committee had met three times in the previous six months. Important members of the senior management team had not, however, attended all these meetings, which needed to improve.

6.8 Short updates from committee members were useful but did little to inform strategic oversight of reducing reoffending. The meetings needed to be more wide-ranging, for example to monitor and discuss important data on employment, equitable access to release on temporary licence (ROTL), education and training on release or the number of children on waiting lists for interventions.

6.9 The resettlement team included eight resettlement practitioners (RPs) each holding between eight and 10 cases which was manageable. They knew their cases well. Five of the RPs were uniformed staff and three non-uniformed which afforded a good mix of skills. Formal training for the RPs had reduced but they felt well supported by their managers and their peers. It was encouraging that they continued to receive regular supervision from team managers.

6.10 Resettlement leaders had continued to focus on strengthening joint working and communication with community youth offending services. They convened a number of youth offending management boards which served as a positive way of escalating concerns about children quickly.

6.11 Early release, home detention curfew (HDC) and ROTL continued to be used and managed effectively. During the previous six months, 10

children had been released on HDC and 21 under the early release scheme. Applications for HDC and early release that had been rejected were declined appropriately by managers with good record keeping. Prison records also indicated that negative outcomes were explained to the child in a responsive way, which was helpful.

6.12 The pace of providing ROTL opportunities to children had picked up, with few delays after national ROTL restrictions had been lifted.

6.13 During the previous six months, 96 ROTLs events had taken place which children we spoke to found positive and engaging. However, they did not always reflect sentence plan objectives. All approvals for ROTL had applied to the same group of four children, which was inequitable.

6.14 ROTL was not promoted to children and it was a missed opportunity that some children who were eligible never received it. Decisions to reject ROTL received insufficient scrutiny from senior managers. In our survey, only 33% of children said that staff were helping them to achieve their sentence targets against the comparator of 67%. Some children we spoke to attributed this to a lack of equitable access to ROTL. Leaders agreed to review the sifting process to give more children access to ROTL and to monitor this at meetings.

6.15 About half the children transitioned to adult prisons after their 18th birthday, while the remainder were released to the community at the end of their sentence. The resettlement team had developed its support for transitions through strengthened links with young adult prisons such as Brinsford and Swinfen Hall. In our survey, 41% of children said they had a say in what would happen to them when they moved on from Werrington.

6.16 Video information packages to help children prepare to transition to young adult prisons had not progressed, but managers remained committed to producing them. It was impressive that leaders had overcome the problems we saw at the last inspection with confirming young adult places for 18-year olds.

6.17 RPs had started to use a tracker to collate consistent data on outcomes after children left Werrington, but there was not yet enough to inform meaningful analysis of resettlement outcomes for children.

Recommendations

6.18 **The needs analysis should be fully reviewed to enable leaders to plan appropriately to reflect the needs of the current population.**

6.19 **The remit of the reducing reoffending meeting should be broadened to make sure that monitoring of data is comprehensive and to provide strategic oversight to leaders.**

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.

6.20 At the time of the inspection, one-third of the children were on remand, with the majority either convicted and sentenced or awaiting sentencing. Children spent an average of 22 months at Werrington.

6.21 Children saw their RPs twice a week and sometimes more frequently. All children spoke highly of their RP. It was evident in the sample of cases that we looked at that RPs knew the children on their caseloads well and made good use of P-Nomis (Prison Service electronic records) and the Youth Justice Application Framework (see paragraph 3.5) to maintain high quality records of meetings, updates and contact notes, which was excellent.

6.22 In our survey, 63% of children said they had a plan and 93% of these said they knew what they had to do to achieve their objectives or targets.

6.23 Remand and sentenced children had plans that were reviewed frequently by the RPs and the child's community youth offending team (YOT) worker. Most YOTs were still not attending these meetings in person but this was starting to improve. Residential staff who worked with the children did not attend reviews, which was disappointing. The plans that were being implemented at the last inspection were now fully embedded. They were user friendly for children and involved the child in incorporating meaningful targets that they could work towards.

6.24 All the assessments that we reviewed were up to date, and final planning meetings took place on time with good discussion of the child's needs. In one (unique) case where significant shortfalls were identified at the final planning meeting, a second final planning meeting was convened to ensure that all matters were fully addressed for the child before release. This was impressive.

Public protection

6.25 In response to our previous recommendation, the well-attended monthly risk management meetings chaired by the resettlement manager now appropriately monitored all children who were high or very high risk of harm and those approaching release.

6.26 The management of MAPPA (multi-agency public protection arrangements) was also reviewed at these meetings which made sure that all category and risk levels for children were identified six months before release. This informed community agencies such as social

workers, YOTs or probation which were central to supporting children after release.

6.27 Pin-phone and mail monitoring for children subject to public protection measures or restricted status were managed very well. Seven children were on public protection monitoring at the time of the inspection and there were no backlogs or overdue reviews.

6.28 The MAPPA Fs (information sharing forms) that we examined gave a reasonable overview of the child's behaviour at Werrington and linked behaviour to resettlement plans, which was useful.

Indeterminate and long-sentenced children

6.29 Fifteen children (eight at the previous inspection) were serving indeterminate sentences or remanded for offences that could result in such a sentence. A further 15 children had sentences of more than four years and it was evident that the number of children with long sentences was increasing.

6.30 RPs gave well-meaning one-to-one support to these children, but formal support had dwindled. The delivery of training such as life sentence awareness for staff and children had not been restarted, which was disappointing.

6.31 There were no interventions for children with life/indeterminate sentences. This was remiss given the increase in the number of children subject to these tariffs.

Looked-after children

6.32 In our survey, 66% of children identified as having experienced care which had increased from 46% at the previous inspection. Only 35% of these children had had an initial review by the prison social worker within 20 days and there was no procedure to monitor and address this deficiency.

6.33 Communication between local authorities and social workers ensured that children received their statutory monetary and clothing entitlements. Any associated problems were escalated to secure a resolution.

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.

6.34 RPs worked closely across multi-agency teams including YOTs and the social workers on site and there was good evidence of family involvement in sentence planning.

6.35 There had been 26 releases from Werrington over the previous six months. No child had been released without accommodation and all children had their release address confirmed at least 10 days before release. Eleven had been released with no education or training place, which was poor.

6.36 Finance, benefit and debt services still needed improvement and plans to address this at our previous inspection had not come to fruition. RPs gave practical advice when needed but were unable to facilitate bank accounts for children which was an omission.

6.37 Children were told who was meeting them at the gate, and releases were well planned. Discreet bags to carry personal possessions and a change of non-prison clothes were also made available.

Interventions

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

6.38 Children had access to only three of the six interventions approved by HMPPS for use in the youth custody estate. They comprised motivation to engage, feeling it, and anger and/or emotional management. The interventions team was understaffed and only seven children had received an intervention in the previous six months. Prison leaders were in the process of addressing this.

6.39 RPs and prison psychologists carried out screening for suitability for interventions, but the sequencing of interventions required improvement. It was unclear which children were prioritised for interventions and there was no coordinated system for senior leaders to monitor this. Many children were transferred or released with no interventions at all. Some children told us this made them feel that they were not being helped.

6.40 Celebration of course completions had been limited during the pandemic, but RPs continued to work hard to ensure that families were informed and included wherever it was practically possible. There were clear plans to return to inclusive celebrations once restrictions were lifted.

6.41 Two children were involved in ROTL placements with the Restart Dogs project which trained puppies to become assistance dogs for people with autism. The children valued this course which helped them work towards educational credits.

Health, social care and substance misuse

6.42 All children on release were offered health checks, medicines to take home as required, and practical harm minimisation advice, including condoms. Practice Plus Group passed relevant information to receiving GPs or helped children to locate a GP.

6.43 The substance misuse team had effective links with the resettlement team to coordinate planned and effective transition for children. However, not all those released were seen and offered harm minimisation advice.

Section 7 Summary of key concerns and recommendations

Key concerns and recommendations

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

7.1 Key concern: The use of force and levels of violence among children and against staff were too high. Violence reduction strategies had either been withdrawn or were newly implemented and had only recently generated some limited impact on overall levels of violence.

Key recommendation: An informed and establishment-wide strategy should be implemented to reduce levels of violence.
(To the governor)

7.2 Key concern: Behaviour management processes were confused and did not give staff across the YOI the confidence to challenge children effectively and consistently when necessary. This lack of challenge and inability to require and enforce decent behavioural standards contributed to increased incidents of violent behaviour by children. In the absence of effective behaviour management, leaders had become over-reliant on 'keep-apart' arrangements. The list of children who had to be separated had become unmanageable.

Key recommendation: Behaviour management processes should be developed that give all staff the confidence to challenge poor behaviour and promote prosocial behaviour.
(To the governor)

7.3 Key concern: Interaction between staff and children was often transactional. There was limited meaningful time spent addressing children's risks and needs or the support and encouragement that they needed to progress. Opportunities for engagement were hindered by the number of keep-aparts and regime groups that staff had to manage. There was also a lack of places for private discussions on residential units. Personal officer and custody support plan work were not fully embedded.

Key recommendation: Relationships between staff and children should be meaningful and support children's progression.
(To the governor)

7.4 Key concern: The appearance of the wings, particularly Doulton wing, was stark and unwelcoming and not appropriate for children. The design of the units afforded little flexibility for activities for the number of children who could be accommodated. Rooms for private meetings with children were scarce.

Key recommendation: Children should live on age-appropriate wings that are configured and resourced so that children can engage in a full regime of activities that support their rehabilitation.
(To the governor)

7.5 Key concern: Leaders were using data to identify unequal treatment amongst certain protected groups, but further enquiry and subsequent investigations did not identify the underlying cause of these disparities or resolve them.

Key recommendation: Unequal outcomes should be investigated and addressed.
(To the governor)

7.6 Key concern: Patients failing to attend or arriving late for health appointments impaired efficient use of health resources, including some clinicians' time. Several factors contributed to this including reduced capacity in the waiting room during the pandemic, regime restrictions and clashes, and keep-aparts.

Key recommendation: Sustained action should be taken to make sure that health resources are fully used to optimise the health care of patients.
(To the governor)

7.7 Key concern: Children did not spend enough time out of cell during the day, particularly at weekends.

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

7.8 Key concern: The quality of education provided by leaders and managers was not good enough. The curriculum in some areas was unambitious and narrow. The focus was on preparing children for their functional skills exams rather than broadening the curriculum to build on existing skills.

Key recommendation A: Leaders should support staff to deliver a curriculum that develops children's skills in their subject.

Key recommendation B: Staff working on functional skills courses should ensure that the curriculum is ambitious and develops children's knowledge.

7.9 Key concern: Children were not sufficiently motivated to engage in their learning. Allocation to courses was made on the basis of which children could mix together, rather than on children's chosen curriculum pathway. This resulted in many children not taking their preferred course or moving between courses and becoming disengaged and lacking in motivation.

Key recommendation A: Leaders and managers should ensure that children have the opportunity to study their chosen subject.

Key recommendation B: Staff should set high expectations for children. Children should be encouraged and supported to identify and develop the skills that will support them during their time in custody and on release.

7.10 Key concern: There was no support at all for children serving life or indeterminate sentences. Not enough interventions were available to children, many of whom were released with no support to help them reduce their risk and resettle into the community.

Key recommendation: The range of interventions should be broadened to include those aimed at children serving life or indeterminate sentences. Interventions should be sequenced to make sure that all children requiring interventions receive them. (To the governor)

7.11 Key concern: Too many children were leaving custody with no confirmed education or training placement. Systems for monitoring and addressing this in custody and after release were inadequate.

Key recommendation: Leaders should implement robust systems that ensure recognised educational and training placements are secured when transitioning from custody to the community. (To the governor)

Recommendations

7.12 Recommendation (5.31): Prison staff should make sure that children arrive promptly to lessons. (Directed to the governor)

7.13 Recommendation (6.18): The needs analysis should be fully reviewed to enable leaders to plan appropriately to reflect the needs of the current population. **(**Directed to the governor)

7.14 Recommendation (6.19): The remit of the reducing reoffending meeting should be broadened to make sure that monitoring of data is comprehensive and to provide strategic oversight to leaders. (Directed to the governor)

Section 8 Progress on recommendations from the last full inspection report

Recommendations from the last full inspection

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

Safety

Children, particularly the most vulnerable, are held safely.

At the last inspection in 2020, the experience of children during their early days at Werrington had improved and was good. The governor had prioritised work to reduce the number of children who needed to be kept apart from each other for safety reasons. This focus had improved access to the regime for all children. There had been significant recent improvement in the oversight of separation. The WADE unit provided care and support for children who would otherwise be locked in their cells. Self-harm had risen but care for children was reasonably good. Safeguarding processes were reasonable. However, we continued to have concerns about the high levels of violence at the establishment. In addition, use of force had increased and there were weaknesses in incident management and de-escalation. Outcomes for children were not sufficiently good against this healthy establishment test.

Key recommendations

Managers should revise the behaviour management schemes to ensure consistent implementation and reduce the incidence of poor behaviour. (S41)
Not achieved

A strategy should be implemented to reduce violence across the establishment and to provide effective management of children perpetrating or subjected to bullying and violence. (S42)
Not achieved

Managers should ensure that staff who are trained and competent to manage incidents attend and supervise all incidents where use of force has been applied. (S43)
Achieved

All use of force incidents should be clearly recorded and robust quality assurance of incidents should ensure that concerns about technique and proportionality are properly investigated. (S44)
Achieved

Recommendations

Child protection allegations should be referred to the designated officer within 24 hours. (1.18)
Not achieved

The increase in levels of self-harm should be investigated and a reduction strategy implemented. (1.27)
Achieved

Near miss incidents should be thoroughly investigated and subsequent recommendations should be reviewed. (1.28)
Achieved

Care

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

At the last inspection in 2020, relationships between staff and children were respectful and we saw staff from different areas working in a caring way with children. However, children consistently reported that some staff were dismissive of their concerns. Residential units and cells remained clean and free of graffiti. The food was reasonable. Consultation with children was now good and the complaints system worked well. Equality and diversity had improved and were the focus of all departments. The discrimination incident report form (DIRF) system worked well. The chaplaincy provision remained good. Health care and substance misuse services had improved and were very good. Outcomes for children were good against this healthy establishment test.

Key recommendation

Children should be transferred to mental health care facilities in line with national NHS guidelines. (S45)
Achieved

Recommendations

Forums should be organised for children from each of the protected characteristic groups enabling the prison to understand and respond to the views of children from these groups. (2.38)
Not achieved

The former wing treatment rooms should be refurbished to ensure that they are appropriate therapeutic and soundproofed environments for mental health and related interventions. (2.76)
Partially achieved

Purposeful activity

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

At the last inspection in 2020, time out of cell was better than at other YOIs and very few children were locked up during the school day. Access to the gym and library was very good and children had access to a wide range of enrichment activities. Effective joint working between prison and education managers had increased attendance to over 90%. The curriculum provided a good range of vocational pathways, all of which included English, mathematics and ICT. Support for children with additional learning needs was good. Slow progress affected achievement in English and mathematics, but this was better in other subjects. Separated children now received regular outreach education. Most teaching was effective, but teachers needed support to improve behaviour management in some sessions. Outcomes for children were reasonably good against this healthy establishment test.

Key recommendation

Managers should establish measures for rapid intervention to support teachers when classes are affected by significant and continuing disruption to ensure that children's education is not interrupted. (S46)
Not achieved

Recommendations

Managers should provide training for staff who have to collect children from classes, to ensure that this is done with respect for the teacher and minimum disruption to the class. (3.27)
Not achieved

Staff development programmes should continue to focus on behaviour management and the need to manage challenging behaviour. (3.35)
Not achieved

Teachers should ensure that their marking of written work indicates clearly what children need to do to improve their work. (3.36)
Not achieved

Instructors should set clear expectations for children in all vocational areas, which reflect the standards which apply in work situations outside the prison. (3.37)
Not achieved

Managers should ensure that the progress of children in functional skills classes is carefully monitored, so that they move more quickly to assessment and progression to the next level. (3.47)
No longer relevant

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 2020, children received reasonably good support to maintain contact with families and facilities for visits had improved. Joint working between managers had improved, but many sentence planning review meetings lacked input from across the establishment. Contact between resettlement practitioners and children was good and plans were now more child friendly. Release on temporary licence (ROTL) was used effectively and home detention curfew (HDC) was well managed. Transition to the adult estate was well planned but was undermined by a lack of engagement from receiving establishments. Public protection arrangements needed to be more robust. Despite the efforts of the resettlement team, children did not always have education, training or employment arranged for release. Outcomes for children were reasonably good against this healthy establishment test.

Key recommendations

Eighteen-year olds held in children's establishments should be able to transition to the most suitable prison for them in the adult estate in a safe and timely manner. (S47)
Achieved

All departments working with a child should attend their planning review meetings to contribute information about the child and how they would help them to progress. (S48)
Not achieved

There should be timely, stringent oversight of release arrangements for all children who present high, or very high, risk of harm to others. (S49)
Achieved

Recommendation

Children who are remanded or sentenced and facing a long period in custody should have access to formal staff and peer support to help them progress through their sentence. (4.25)
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:

Martin Lomas	Deputy chief inspector
Angus Jones	Team leader
David Foot	Inspector
Angela Johnson	Inspector
Esra Sari	Inspector
Donna Ward	Inspector
Elenor Ben Ari	Researcher
Rachel Duncan	Researcher
Helen Ranns	Researcher
Joe Simmonds	Researcher
Paul Tarbuck	Lead health and social care inspector
Noor Mohamed	Pharmacist
Catherine Raycraft	Care Quality Commission inspector
Steve Lambert	Ofsted inspector
Nigel Bragg	Ofsted inspector
Sheila Willis	Ofsted inspector

Appendix II Glossary

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/

Assessment, care in custody and teamwork (ACCT)
Case management of children at risk of suicide or self-harm. Used proactively by staff after identifying risk factors or support needed by a child.

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.

Custody Support Plan (CuSP)
A support plan developed through weekly meetings between a child and their CuSP officer.

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.

Minor reports
A procedure for dealing with alleged breaches of the YOI rules. These alleged breaches are less serious than those dealt with through the adjudication system and the maximum punishment is lower. Minor reports are completed by a custodial manager.

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).

Secure Stairs
Secure Stairs (the Framework for Integrated Care) addresses the needs of children in secure children's homes, secure training centres and young offender institutions. This framework allows for a joined-up approach to assessment, sentence/intervention planning and care, including input from mental health staff regardless of previous diagnosis, as well as from social care and education professionals and the operational staff working in the setting.

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.

Youth Justice Application Framework (YJAF)
An electronic system that facilitates information sharing across youth justice practitioners and interviews with children to make assessments of risk.

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.

Establishment staff survey

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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