Report on an independent review of progress at

HMYOI Parc

by HM Chief Inspector of Prisons

23–31 January 2023

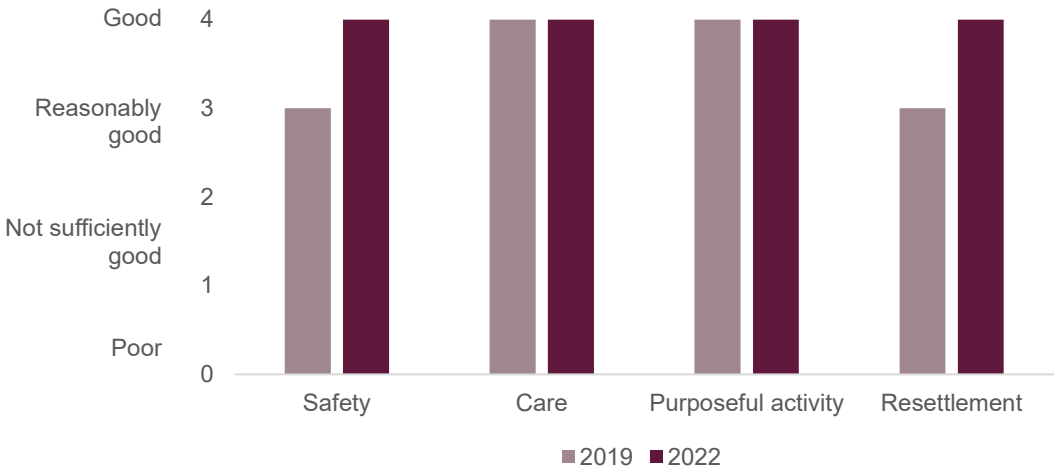
Contents

Section 1 Chief Inspector's summary

1.1 The children's unit at HMP & YOI Parc opened in March 2002 as a 28-cell facility for remanded children aged 15 to 18. In October 2004, it expanded to house 36 children aged 15 to 18, both remand and sentenced, with a further expansion in February 2007 to 64 children. Initially the unit housed Welsh children but since March 2013 the court catchment area has covered Wales and south-west England. In 2022 a new contract reduced the capacity to 46.

1.2 At our previous inspections of HMYOI Parc in 2022 and 2019, we made the following judgements about outcomes for prisoners.

Figure 1: HMYOI Parc healthy prison outcomes in 2022 and 2019



1.3 HMYOI Parc, near Bridgend in South Wales, is a facility for up to 46 children and young adults. At the time of our visit, 27 were held. Our previous inspection was the latest in a succession of positive inspections and we judged outcomes to be good, our highest grade, across all areas. At this independent review of progress (IRP), we reviewed four recommendations made at the previous inspection and found that progress was reasonable or better in three and insufficient in one.

1.4 Unusually for Parc, this visit was made at a time of uncertainty and instability. G4S had recently been awarded a new contract to run the site but this involved the transition of health care and education provision to new providers. While the transition in health care appeared to be progressing well, in education there were staff shortfalls and gaps in provision that needed to be resolved.

1.5 There had also been unplanned changes in key roles, when the head of the unit and two senior managers had left their posts following an investigation initiated by a whistle-blower. These roles had been filled

on an interim basis, but so many changes in a small senior team had been unsettling for staff and had hindered progress.

1.6 Despite these challenges, leaders had made progress in most of the areas that we reviewed: a social worker had returned to the unit to support looked-after children; the prison and the Youth Custody Service had carried out work to prevent Parc from being used as a place of safety for unwell children who should have been in hospital; and leaders had developed support for long- and indeterminate-sentenced children.

1.7 Less positively, we found too little evidence of improvement in promotion of equality and diversity, an area that had been a weakness at Parc for some time. Fundamentally the structures were not in place to identify and address discrimination if it occurred.

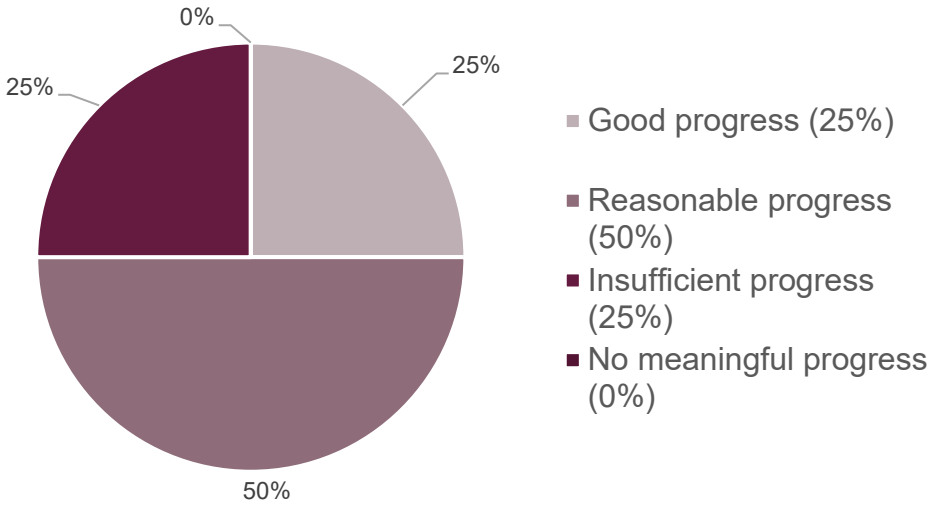
1.8 Parc has many strengths and most of our findings were positive. Filling leadership posts and ensuring a quick transition to the new contract were the most immediate priorities.

Charlie Taylor
HM Chief Inspector of Prisons
January 2023

Section 2 Key findings

2.1 At this IRP visit, we followed up four recommendations from our most recent inspection in May 2022. We judged that there was good progress in one recommendation, reasonable progress in two recommendations and insufficient progress in one recommendation.

Figure 2: Progress on HMI Prisons recommendations from May 2022 inspection (n=4)



Notable positive practice

2.2 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 prisoners; 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.

2.3 Inspectors found no examples of notable positive practice during this independent review of progress.

Section 3 Progress against the key concerns and recommendations

The following provides a brief description of our findings in relation to each recommendation followed up from the full inspection in 2022. The reference numbers at the end of each recommendation refer to the paragraph location in the full inspection report.

Safeguarding of children

Concern: The unit had not had a dedicated social worker for an extended period. This had reduced the support and advocacy available to the increasingly large proportion of children who were in the care of their local authority or who had some involvement with social services. Managers responsible for safeguarding and child protection did not have a source of expertise to refer to on site.

Recommendation: The unit should have a dedicated, on-site social worker.

3.1 After two years, a dispute about costs between the local authority, G4S and the Youth Custody Service (YCS) had been resolved. A social worker had been appointed and started work on the unit during our visit. The social worker was the same member of staff who had been withdrawn from Parc in December 2020 during the dispute and was clear about what the role entailed.

3.2 During the gap in service, casework staff (known as needs, engagement and well-being team workers) supported looked-after children and made sure that local authorities met their obligations to children. In addition, leaders had established a safeguarding team to address safeguarding and child protection issues, including a weekly meeting with the director to discuss all outstanding referrals. Managers had improved links with the YCS safeguarding structures.

3.3 We considered that the prison had made good progress in this area.

Safeguarding of children

Concern: A very sick child who needed to be in hospital had been placed at Parc and segregated for 14 days in 2021 before a move to hospital was arranged.

Recommendation: Children who need a hospital placement should not be sent to prison as a place of safety.

3.4 Since our last inspection, no children remanded under section 35 of the Mental Health Act 1983 had been sent to Parc as a place of safety.

3.5 HMPPS and the YCS had conducted a review of their procedures and several recommendations had been made to prevent very sick children who needed to be in hospital being sent to the prison. Most of these recommendations had not been fully implemented at the time of our review and the criteria for the placement of children in prison remained unchanged.

3.6 These recommendations were, however, wide-ranging and included key external agencies such as HM Courts and Tribunal Service, the Youth Offending Service, the Crown Prosecution Service and the YCS. The case was also referred to the National Independent Safeguarding Board for Wales and the Welsh Government for their consideration.

3.7 There were effective procedures for identifying and supporting children who had complex or severe mental health needs. We saw evidence of a child who had been identified while at Parc and had been moved to a hospital for appropriate long-term care.

3.8 We considered that the prison had made reasonable progress in this area.

Equality and diversity

Concern: There was no oversight or responsibility for equality and diversity work at Parc and analysis of data remained limited. Children we spoke to felt supported by staff and their needs were being met, but gaps in provision could cause risks.

Recommendation: Leaders should provide effective oversight of equality and diversity work at all times and data should be scrutinised thoroughly, considering all protected characteristics.

3.9 Since our last inspection, a new equality and diversity service had been commissioned from the Ethnic Minorities and Youth Support Team (EYST, a voluntary sector organisation based in Swansea). However, the respective roles of prison leaders and the EYST worker were not well defined and the service had yet to reach its full potential. The service had initially been commissioned for three days a week, but the EYST worker was only made available on two days which had affected the rate of progress. In addition, the worker left their post during our visit and the service was suspended.

3.10 Leaders looked at equality data at monthly meetings but did not fully understand how to analyse the figures to identify unequal treatment for investigation. The reports submitted to the equality and safeguarding meetings rarely compared equality data to the wider population which undermined the effectiveness of both forums.

3.11 Consultation with children about equality issues had improved but was undermined in part by conflict among children and the difficulty in mixing large groups. Issues raised at these meetings, including the lack of hair and skincare products for children from a black or minority ethnic background, were not addressed effectively.

3.12 We considered that the prison had made insufficient progress in this area.

Pre-release and resettlement

Concern: Support for the increasing number of children with indeterminate or long-term sentences was underdeveloped and limited compared to other YOIs. More children than at the previous inspection were held on remand or were serving sentences for murder or attempted murder.

Recommendation: There should be an appropriate range of support to meet the risks and needs of children serving indeterminate or long sentences.

3.13 Support for children who were serving indeterminate or long sentences had improved. All children now had a resettlement plan that included actions to help them transition to the adult estate. These plans were detailed and included the same targets as the child's sentence plan which was good.

3.14 However, the decision taken nationally to hold young adults up to the age of 19 had hindered the effectiveness of the resettlement plans, particularly the transition arrangements to the adult estate. Leaders had decided to assess the young adults for adult sentence plan targets which they hoped would hasten allocation to a suitable prison where risk of reoffending could be addressed and progress maintained.

3.15 There was still very little in place for children who were on remand and likely to receive an indeterminate or long sentence.

3.16 A new mentoring system had been introduced for a risk-assessed adult prisoner to meet children and young adults due to transfer to the adult estate to discuss what they should expect. This was a good initiative and children told us they found it helpful.

3.17 We considered that the prison had made reasonable progress in this area.

Section 4 Summary of judgements

A list of the HMI Prisons recommendations followed up at this visit and the judgements made.

Recommendations

The unit should have a dedicated, on-site social worker.
Good progress

Children who need a hospital placement should not be sent to prison as a place of safety.
Reasonable progress

Leaders should provide effective oversight of equality and diversity work at all times and data should be scrutinised thoroughly, considering all protected characteristics.
Insufficient progress

There should be an appropriate range of support to meet the risks and needs of children serving indeterminate or long sentences.
Reasonable progress

Appendix I About this report

HM Inspectorate of Prisons (HMI 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, court custody and military detention.

All visits 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.

Independent reviews of progress (IRPs) are designed to improve accountability to ministers about the progress prisons make towards achieving HM Inspectorate of Prisons' recommendations between inspections. IRPs take place at the discretion of the Chief Inspector when a full inspection suggests the prison would benefit from additional scrutiny and focus on a limited number of the recommendations made at the inspection. IRPs do not therefore result in assessments against our healthy prison tests. HM Inspectorate of Prisons' healthy prison tests are safety, respect, purposeful activity and rehabilitation and release planning. For more information see our website: https://www.justiceinspectorates.gov.uk/hmiprisons/our-expectations/

The aims of IRPs are to:

- assess progress against selected key recommendations
- support improvement
- identify any emerging difficulties or lack of progress at an early stage
- assess the sufficiency of the leadership and management response to our main concerns at the full inspection.

This report contains a summary from the Chief Inspector and a brief record of our findings in relation to each recommendation we have followed up. The reader may find it helpful to refer to the report of the full inspection, carried out in April 2022 for further detail on the original findings (available on our website at https://www.justiceinspectorates.gov.uk/hmiprisons/).

IRP methodology

IRPs are announced at least three months in advance and take place eight to 12 months after a full inspection. When we announce an IRP, we identify which recommendations we intend to follow up (usually no more than 15). Depending on the recommendations to be followed up, IRP visits may be conducted jointly with Ofsted (England), Estyn (Wales), the Care Quality Commission (England), Care Inspectorate Wales, Healthcare Inspectorate wales and the General Pharmaceutical Council. This joint work ensures expert knowledge is deployed and avoids multiple inspection visits.

During our three-day visit, we collect a range of evidence about the progress in implementing each selected recommendation. Sources of evidence include observation, discussions with prisoners, staff and relevant third parties, documentation and data.

Each recommendation followed up by HMI Prisons during an IRP is given one of four progress judgements:

No meaningful progress
Managers had not yet formulated, resourced or begun to implement a realistic improvement plan for this recommendation.

Insufficient progress
Managers had begun to implement a realistic improvement strategy for this recommendation but the actions taken since our inspection had not yet resulted in sufficient evidence of progress (for example, better and embedded systems and processes).

Reasonable progress
Managers were implementing a realistic improvement strategy for this recommendation and there was evidence of progress (for example, better and embedded systems and processes) and/or early evidence of some improving outcomes for prisoners.

Good progress
Managers had implemented a realistic improvement strategy for this recommendation and had delivered a clear improvement in outcomes for prisoners.

When Ofsted attends an IRP its methodology replicates the monitoring visits conducted in further education and skills provision. Each theme followed up by Ofsted is given one of three progress judgements.

Insufficient progress
Progress has been either slow or insubstantial or both, and the demonstrable impact on learners has been negligible.

Reasonable progress
Action taken by the provider is already having a beneficial impact on learners and improvements are sustainable and are based on the provider's thorough quality assurance procedures.

Significant progress
Progress has been rapid and is already having considerable beneficial impact on learners.

Ofsted’s approach to undertaking monitoring visits and the inspection methodology involved are set out in the *Further education and skills inspection handbook*, available at https://www.gov.uk/government/publications/education-inspection-framework.

Inspection team

This independent review of progress was carried out by:

Angus Jones	Team leader
David Foot	Inspector
Emma King	Researcher
Helen Downham	Researcher

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/

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

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