Report on an unannounced inspection of

HMYOI Parc

by HM Chief Inspector of Prisons

9–19 October 2023

Contents

Introduction 3

What needs to improve at HMYOI Parc 5

About HMYOI Parc 7

Section 1 Summary of key findings 9

Section 2 Leadership 12

Section 3 Safety 14

Section 4 Care 22

Section 5 Purposeful activity 33

Section 6 Resettlement 42

Section 7 Progress on recommendations from the last full inspection report 49

Appendix I About our inspections and reports 51

Appendix II Glossary 54

Appendix III Further resources 56

Introduction

HMYOI Parc is a young offender institution (YOI) for boys aged between 15 and 17, located in the much larger Parc prison near Bridgend in South Wales. Operated by the private contactor G4S, it can hold up to 46 boys on two separate units, although at the time of our inspection just 28 were in residence. Of these, about a third were aged 18, but they remained at the YOI due to national population pressures in the adult estate.

As this report and our recent visits show, the YOI at Parc is the best in England and Wales, and something of a benchmark for the four others currently in operation. When we last inspected in 2022, we found outcomes for young people against all four of our healthy establishment tests to be good, our highest assessment. At this inspection, we found purposeful activity had deteriorated and was now not sufficiently good. However, the quality of outcomes in safety, care and resettlement had been sustained, and remained good, a significant achievement.

After an extended period of stable and successful leadership, the YOI was in a state of transition. A new director had been brought in to lead the prison as a whole, and a new head of the children's unit had recently been appointed, but we were pleased to see that this change was being managed well. In particular, the supportive culture experienced by staff and children at Parc was being maintained, boys generally had reasonable time out of their cells, and there was an excellent and innovative programme of enrichment activity. However, our colleagues in Estyn judged that a more limited curriculum and weaknesses in the quality of teaching meant that the provision of education had declined to 'adequate', which undermined our overall assessment for purposeful activity. These concerns had been identified and partnership arrangements to support improvements in the quality of education provision were being developed.

Parc YOI was a safe institution and boys were treated well, with good care from the moment they arrived. There was a full agenda of initiatives and incentives, as well as an active regime which promoted positive behaviour and helped to reduce violence. Safeguarding and work to prevent self-harm was also effective, although the use of separation had increased and oversight was not good enough.

Living conditions on the units were good and there were active plans to update and refurbish the environment. Systems for redress were also good, and the caring and supportive relationships that staff developed with the boys meant that most problems or issues could be informally resolved. In our survey, most boys said they were helped to maintain family ties, and work to encourage them through their sentence and towards rehabilitation was equally effective.

Good leadership, a dedicated cohort of caring staff who were prepared to work with children as individuals, and an active regime which sought to engage and incentivise boys, defined Parc's success. Our report highlights several priorities which we hope will assist with continuous improvement, but leaders and staff should be congratulated for what they have achieved.

Charlie Taylor
HM Chief Inspector of Prisons
November 2023

What needs to improve at HMYOI Parc

During this inspection we identified 11 key concerns, of which six should be treated as priorities. Priority concerns are those that are most important to improving outcomes for children. They require immediate attention by leaders and managers.

Leaders should make sure that all concerns identified here are addressed and that progress is tracked through a plan which sets out how and when the concerns will be resolved. The plan should be provided to HMI Prisons.

Priority concerns

1. **Some children were separated for too long and their routines were subject to excessive restrictions.** The number of children segregated under YOI rule 49 (see Glossary) had increased and their oversight had deteriorated.

2. **The promotion of equality had not been prioritised and was undermined by the absence of consistent staffing to coordinate and drive the work.** This hindered leaders' understanding of the perceptions of children in this area.

3. **There were inconsistencies in the deployment of education staff, and shortcomings in the quality of teaching and assessment.** There was insufficient oversight of learners' development; many were disengaged and made slow progress towards accreditations, and attainment in a few subjects was low.

4. **Partnership arrangements and key stakeholders had been slow to support the successful transition of education providers.** Partnership arrangements to support improvements in the quality of education provision or to enhance the curriculum were only recently or not yet in place.

5. **There was no reading strategy.** The library did not work with education to promote literacy and children who did want to read could not search for and get a book of their choice.

6. **Some ROTL risk assessments and MAPPA information sharing reports were poor.**

Key concerns

7. **Oversight of health care was inadequate and did not provide sufficient scrutiny of the service to make sure it was safe and effective for all children.**

8. **Children did not have all their health needs assessed and did not have sufficient access to an appropriate range of therapeutic interventions, including speech and language therapy.**

9. **Children's clinical records were poor and did not provide an accurate or comprehensive account of assessment, care and treatment.**

10. **The education curriculum did not consider labour market or learners' needs well enough.** It was not sufficiently vocationally focused, and the education department had too little involvement in the development of education pathways for children.

11. **Self-evaluation of learning and skills, including the use of data, was not good enough to identify areas for improvement.**

About HMYOI Parc

Task of the establishment

To hold sentenced and remanded children aged 15 to 17 years. Due to population pressures in the adult estate, Parc currently also held children aged 18.

Certified normal accommodation and operational capacity (see Glossary) as reported by the establishment during the inspection

Children held at the time of inspection: 28
Baseline certified normal capacity: 46
In-use certified normal capacity: 46
Operational capacity: 46

Population of the establishment

- 50 new arrivals received each year (around four per month).
- Three foreign national children.
- One-third of children from black and minority ethnic backgrounds.
- 35% of children on remand.
- Three children released into the community each month.
- 75% of children reported having been in the care of their local authority at some point before custody.
- 35% of those held were now 18 years old, and 50% will become adults while in custody on their current sentence or remand.
- 40% of children had been excluded from mainstream education prior to custody.

Establishment status (public or private) and key providers

Private: G4S

Physical health provider: Cwm Taf Morgannwg University Health Board
Mental health provider: Cwm Taf Morgannwg University Health Board
Substance misuse treatment provider: G4S
Dental health provider: Time for Teeth
Prison education framework provider: Novus Gower
Escort contractor: GEOAmey

Prison department

Youth Custody Service

Prison Group Director

Sian Hibbs

Brief history

The children's unit in 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 to18, both remand and sentenced, with a further expansion in February 2007 to 64 children. This was then reduced in December 2022 to hold 46 children. Initially the unit housed Welsh children, but since March 2013 the court catchment area has also covered South West England.

Short description of residential units
The children's unit at HMP/YOI Parc consists of two small residential living units and an individualised support unit, providing 46 beds for sentenced and remand children between 15 and 18 years old. The YOI is a separate facility inside the main HMP Parc, and all units and facilities are separated and for use by only children.

E1 - holds 22 children
G1 - holds 24 children
Individualised support unit - holds two children when in use.

Name of director and date in post
Heather Whitehead, Director, August 2023
Sam Kitching, Head of Parc YOI, October 2022

Changes of director since the last inspection
Janet Wallsgrove, Director until August 2023
Jason Evans, Head of Parc YOI until October 2022

Independent Monitoring Board chair
Kelvin Hughes

Date of last inspection
28 March – 8 April 2022

Section 1 Summary of key findings

Outcomes for children

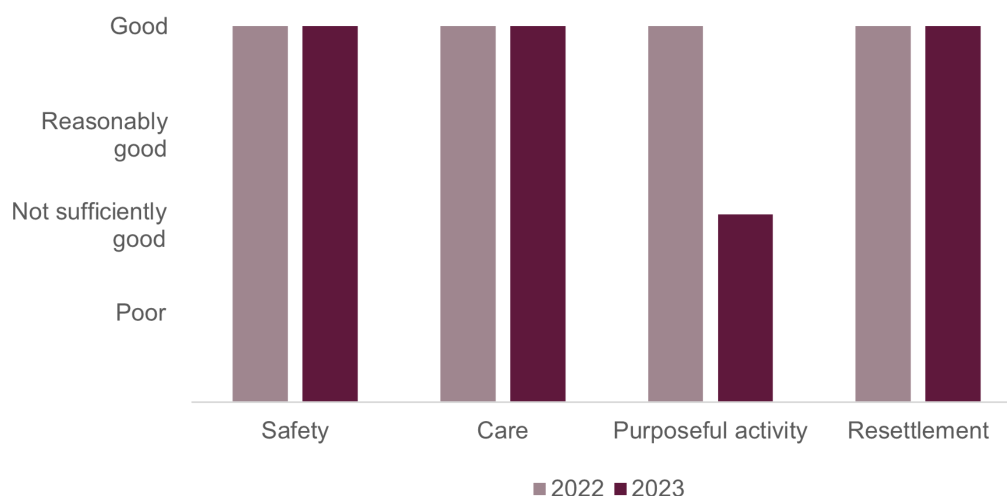
1.1 We assess outcomes for children against four healthy establishment tests: safety, care, purposeful activity and resettlement (see Appendix I for more information about the tests). We also include a commentary on leadership in the establishment (see Section 2).

1.2 At this inspection of HMYOI Parc, we found that outcomes for children were:

- good for safety
- good for care
- not sufficiently good for purposeful activity
- good for resettlement.

1.3 We last inspected HMYOI Parc in 2022. Figure 1 shows how outcomes for children have changed since the last inspection.

Figure 1: HMYOI Parc healthy establishment outcomes 2022 and 2023.



Progress on key concerns and recommendations

1.4 At our last inspection in 2022, we made 11 recommendations, four of which were about areas of key concern. The establishment fully accepted seven of the recommendations and partially (or subject to resources) accepted four.

1.5 At this inspection we found that two of our recommendations about areas of key concern had been achieved and two had not been achieved. Neither of the recommendations made in the area of care had been achieved, however, both recommendations on resettlement

had been achieved. For a full list of the progress against the recommendations, please see Section 7.

Notable positive practice

1.6 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.

1.7 Inspectors found nine examples of notable positive practice during this inspection.

1.8 Leaders and managers set clear expectations about children interacting with each other. All new arrivals were allocated to cells on E1. This unit operated as a 'peaceful community' where all children were expected to mix together. Placing new arrivals there introduced them to the expectation that they engage successfully with their peers from the outset.

1.9 The incentives scheme was well-structured and effective, centred on three basic principles that were easy for children to understand and follow, and motivated good behaviour. (See paragraphs 3.20 and 3.21)

1.10 Any concerns arising from use of force incidents were promptly addressed. This was due to rigorous oversight by the lead officer covering minimising and managing physical restraint (MMPR) and a dedicated team of three MMPR advisers, with additional scrutiny from a multidisciplinary team and the use of force committee. (See paragraph 3.29)

1.11 Leaders and staff had developed a strong, caring and supportive culture that enabled the maximum number of children to engage in the many varied activities on offer, and children felt that staff cared and took an active interest in them. Regular discussions of custody support plans (CuSPs) allowed children to develop solid relationships with their CuSP worker. (See paragraphs 4.1-4.4)

1.12 Each complaint was quality assured and involved hearing the child's voice, as they had an opportunity to react on how they thought the process had been and the quality of the response. (See paragraph 4.17)

1.13 Children had very good access to enrichment activity (which was separate to education provision). Most received at least nine hours a week, and generally much more - we saw examples of children regularly getting 25 hours of this activity in a week. The enrichment team had thought about the needs of children and provided activity that was enjoyable, but also helped them to learn. (See paragraphs 5.3-5.5)

1.14 Children received excellent support to help them maintain and build relationships with people important to them. Social visits and secure video calls were used extensively, and the family lounge provided a relaxed environment for visits involving younger siblings or small children. (See paragraphs 6.1-6.6)

1.15 Caseworkers and staff made very effective use of the youth justice application framework (YJAF, see Glossary), which meant that community partners (youth offending teams) were well informed about children's progress at Parc. (See paragraph 6.13)

1.16 Throughcare support from the needs, engagement, wellbeing team (NEWTs), which included follow-up home visits or meetings in the community with children after release, helped in checking on their well-being and re-establishing links with community agencies after release, with evidence of some positive outcomes. (See paragraph 6.26)

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 After a long period of stability, there had been several senior leadership changes since the previous inspection, notably the director, head of the children's unit and head of education. In addition, the new contract for Parc from December 2022 included changes to the health care and education providers.

2.3 While the transfer of any service and its staff to a new employer will always cause some disruption, it was disappointing to see that elements of this disruption were still evident 10 months after the transition. The quality of education had declined substantially from a service that was rated excellent by Estyn in July 2022 to one judged adequate at this inspection. The director and head of education were aware of this challenge and had recently made much-needed improvements to partnership arrangements aimed at addressing the failings, which now included a limited curriculum, lack of specialist teachers and poor access to learning resources.

2.4 Leaders had, however, been successful in maintaining a very supportive culture and good relationships between children and staff that safeguarded largely positive outcomes for children. We met staff who were committed to improving support for the children in their care on residential units, in health care and in education.

2.5 In our staff survey, 63% respondents said that leaders were always approachable and 72% that they always set high standards of behaviour for staff, while 60% reported that poor behaviour from staff was always challenged; 49% said that leaders always celebrated good work and 35% said that they often did. Our findings supported these views. Unit leaders and middle managers were particularly innovative and effective, for example in the development of the excellent enrichment programme that had been implemented since the previous inspection. The exception to this otherwise good oversight was that management of separation had deteriorated.

2.6 The majority of staff at Parc met their manager regularly to see how they were getting on, with 72% reporting receiving very good support from them; this undoubtably contributed to a high performing team with very good morale.

2.7 Leaders and staff worked successfully to overcome the barriers to effective practice we see at other sites. In particular, daily morning meetings and the widespread use of the youth justice application framework (YJAF, see Glossary) ensured that information was shared effectively within the YOI and with professionals in the community. In addition, weekly custody support plan (CuSP) sessions between staff and children helped built trust and address the needs of the children at Parc.

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 Most children arrived at Parc early enough for reception and first night processes to be completed before they were locked up for the night. They were met promptly in the main admissions area by a member of staff from the children's unit and taken to the unit, which ensured they did not have contact with adult prisoners.

3.2 Initial interviews and health care assessments took place in a private, quiet room where children could share information relevant to keeping them, and others, safe without any distractions or risk of being overheard. Staff used the information on the youth justice application framework (YJAF, see Glossary) to prepare for children's arrivals and then recorded their own assessments on it for others to access. Children's risks and needs were identified and addressed during these interviews, and information was shared effectively with other staff when children went to their residential unit.

3.3 Searching was proportionate and strip searching was rare (see paragraph 3.17). Children were offered food and staff made efforts to make sure they could make a phone call to families or carers to let them know they had arrived at Parc.

3.4 Children were allocated to cells on E1 on arrival. E1 operated as a 'peaceful community' (see paragraph 3.26) where all children were expected to mix together. Placing new arrivals there introduced them to the expectation that they engage successfully with their peers from the outset. A more cautious approach was taken if intelligence indicated there were risks that needed to be addressed first.

3.5 Cells for new arrivals were clean and adequately equipped, and children were provided with toiletries, clothing if needed, writing materials and some distraction resources. There was currently no unit peer mentor, but children could usually mix with others soon after arriving.

Cell prepared for a new arrival

3.6 For their first three days, children were monitored every 30 minutes when they were in their cells, or more frequently if required by assessment, care in custody and teamwork (ACCT) case management (see paragraph 3.13). Staff had good knowledge of children who had arrived more recently, and were careful to monitor how they were settling in and start to build relationships with them.

3.7 A dedicated member of staff was responsible for ensuring children had a full induction to the unit. This was organised well and lasted three days, after which children started to attend education. Induction kept children involved in the daily routine and interacting with staff and, whenever possible, with their peers. Their involvement in induction was recorded in their individual records and in our survey, 94% of children, more than at similar young offender institutions (YOIs), said they were told everything they needed to know in their first few days.

3.8 A video tour of the unit for children to view during their first night had been produced recently and was an example of leaders trying to continually improve the early days experience.

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.

3.9 Children were safeguarded primarily through good relationships with staff and a positive culture at the YOI. Daily morning briefings

continued to be an effective forum in which to share relevant information about, and safeguard, children. Staff were aware of their safeguarding responsibilities, and we saw examples of individual staff who had referred themselves for scrutiny after involvement in a use of force incident (see paragraph 3.31).

3.10 Links with the local authority had improved. The unit now had a social worker seconded from the local authority who gave an independent viewpoint to safeguarding and child protection concerns. There were links with the local authority designated officers for children and for adults, which were developing well. Leaders were clear about the benefits this provided.

3.11 Internal management of child protection and safeguarding was good. Record-keeping was clearer and more transparent than previously. Allegations of abuse were referred to the relevant local authority promptly (most were shared with the local authority in which the unit was located and the child's home local authority, with one having responsibility for action in response to the referral) A weekly meeting that included the director of the prison with unit managers and the social worker gave oversight to all open child protection referrals and determined actions needed to progress them as promptly as possible.

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.

3.12 Children at risk of self-harm received good support from staff. There had been no deaths, near misses that needed investigation or self-harm injuries requiring hospital treatment since the last inspection. The rate of self-harm had increased slightly since the last inspection and was similar to most other YOIs holding children. There had been 23 instances of self-harm in the previous 12 months, involving 13 children. Leaders' own monitoring had developed since the previous inspection and had picked up the increase. They described children’s frustration following involvement in other incidents as a cause of the increase.

3.13 Fifty-five assessment, care in custody and teamwork (ACCT) case management documents had been opened in the previous 12 months, which was an increase from 19 at the last inspection. Leaders had identified that many of these were open not because of acts of self-harm but due to an increasing number of children arriving with a history of previous self-harm, being in custody for the first time and threats to harm themselves. Few ACCTs remained open for extended periods, and care was taken to make sure that issues had been resolved before closure and that there was post-closure follow-up.

3.14 There were timely reviews with a consistent case coordinator responsible for each child supported on an ACCT. Care map actions were completed before ACCTs were closed. Cameras in CCTV cells were no longer used to conduct checks at night. However, the timing of some staff checks during the day and at night remained too predictable. Local quality assurance had identified this and leaders had a plan to remedy it, as well as some weaknesses in the recording of quality interaction with children in the ACCTs.

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.

3.15 In the past 12 months, 835 intelligence reports had been submitted, including 145 on inappropriate behaviour and 93 on the discovery of weapons. However, the response to intelligence-led cell searches was a weakness; only two out of the 12 cell searches requested by the security department had taken place, and neither had uncovered any unauthorised items or contraband.

3.16 While there was a steady flow of security-related information, most security data from the children's unit was integrated with that from the adult site. This limited the ability of leaders and managers in the children's unit to identify and address security threats there effectively.

3.17 No children had been strip searched since the beginning of the year. Leaders had reviewed strip-searching processes and now applied rigorous vigilance to make sure that it only ever occurred in cases of critical necessity and only under the authority of a senior manager.

3.18 Risk assessments for external escorts were informed by medical considerations, which demonstrated commitment to maintaining the safety and well-being of children.

3.19 There were few concerns about substance misuse among children, with a 0% positive mandatory drug testing (MDT) rate at the YOI.

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.

3.20 The incentives scheme was well-structured and underpinned by effective relationships between staff and children. In our survey, 71% of children found the reward system fair, and 88% said that staff usually acknowledged their positive behaviour. This consistent praise and

challenge from staff who children trusted was key to motivating them to engage with activity and behave well.

3.21 Leaders had collaborated closely with the children to create a child-friendly and responsive rewards and sanctions strategy. The scheme centred on three basic principles: maintaining clean and tidy cells, attending education punctually, and doing so consistently. Those core principles were easy for children to understand and follow, and reaching the highest level of the reward scheme was achievable within just two weeks. Most children we spoke to were motivated by the increased time outside their cells and use of additional recreation facilities in 'gold' rooms offered to those on the higher levels of the scheme.

Gold room for E1

3.22 Leaders had explored several initiatives to further reduce violence, including a violence reduction summit where children were encouraged to share their views on how to keep safe. As a result, a promising weapons strategy had been implemented nine months previously, although its impact had not yet been assessed.

3.23 There had been 467 adjudications in the last 12 months, which was similar to the last inspection; 372 had resulted in a guilty outcome, 52 were dismissed or not proceeded with and 43 were adjourned. The majority of adjudications were related to charges of assault, damage to property or fighting. While adjudications were generally conducted promptly, some lacked thorough investigation into the incident. The senior manager of the children's unit quality assured the adjudication records.

3.24 Staff from Barnardo's were on site full-time and provided advocacy to children during adjudications when they needed it. Children we spoke to were aware of the services they offered, and there was an abundance of child-friendly literature to enhance the face-to-face support provided.

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.

3.25 Rates of violence were relatively low and had remained consistent with the previous inspection; they were notably lower than those in similar YOIs. There had been 86 reported assaults in the last 12 months, of which six required hospital attendance. Most incidents were investigated swiftly and a challenge support and intervention plan (CSIP, see Glossary) opened if necessary. However, a small number of serious assaults involving both staff and children had not been investigated locally because they had been referred to the police.

3.26 Positively, E1 had been transformed into a ‘peaceful community’ where leaders emphasised the importance of children fully integrating with each other. Children signed compacts to commit to associating with each other without resorting to violence. The ethos of the unit was supported by an integrated and agile conflict resolution team who applied a combination of immediate and more longer-term conflict resolution interventions, which resolved issues swiftly.

3.27 There had been 75 conflict resolution referrals in the last 12 months, of which 57 had resulted in a positive outcome. This initiative was commendable, and approximately 15 to 20 children were able to engage in most activities together, surpassing what we have typically seen recently in similar YOIs.

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.

3.28 There were 235 recorded incidents of the use of force in the last 12 months. In our survey, 81% of children said they had experienced restraint. Although rates of the use of force were slightly higher than at the previous inspection, they had been reducing over recent months.

3.29 The oversight of use of force was managed effectively by the minimising and managing physical restraint (MMPR) lead and a dedicated team of three MMPR advisers, demonstrating a high level of

vigilance. A multidisciplinary team, which included a social worker, reviewed all use of force video recordings within 24 hours. The use of force committee provided an additional layer of scrutiny, reviewing all incidents weekly. This rigorous oversight ensured that any concerns arising from these incidents were promptly addressed.

3.30 It was noteworthy that no pain-inducing techniques had been applied to children in the past two years. In the last 12 months, 10 serious injury warnings (SIWs) were referred to the designated officer and national SIWs panel; all were thoroughly investigated, resulting in a few recommendations for prison staff to learn from. Leaders and managers took their responsibility for minimising the use of force very seriously, with a focus on continuous improvement. The use of body-worn cameras had improved, and most staff switched their cameras on promptly when there was an incident.

3.31 The well-attended monthly monitoring and review group meeting reviewed relevant use of force data diligently. Leaders had a clear understanding of specific children and staff involved when force was used, and the underlying reasons why force had been used. In instances where a concern was raised, managers made referrals to the local authority for investigation.

3.32 There were prompt debriefs following use of force incidents. In our survey, 100% of children who had been restrained confirmed that a member of staff had talked with them about it afterwards.

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.

3.33 The number of children separated using YOI rule 49 (see Glossary) had increased since the last inspection, but oversight had deteriorated. In the last 12 months, 44 children had been separated, compared with five in the six months before the last inspection. Their experience of separation varied substantially; while some separated children received a varied daily routine, including education, enrichment activities and up to nine hours out of their cells, others had a much more restricted routine of about 90 minutes a day out of their cell.

3.34 Reintegration planning did not commence at the point of separation. Reviews of separation were often chaired by different managers, which created inconsistencies and sometimes delayed progress. As a result, the time for which children were separated had increased substantially to an average of 24 days, with the longest separation lasting over 170 days (and ongoing). The safety team had records of other children who had been separated for 99, 50 and 75 days, which was far too long.

3.35 Some key rule 49 documentation was missing, incomplete or overdue. Some children we spoke to said they chose not to attend their reviews, which was also mostly unrecorded.

3.36 G1 was the unit for children required to be separated in small groups or from all peers on rule 49 (usually after a disagreement or incident of violence). During our inspection, it held three groups of children mixing in small groups and four children who could not mix with any other children and separated on rule 49. Two children on rule 49 resided on the two-cell intensive support unit (ISU). The children on the ISU had individualised routines. We observed notable care provided to these children by the staff and heard high praise for them from the children.

3.37 The monthly monitoring and review group (see paragraph 3.31) had not identified the stark increase in the use of separation at the YOI since the last inspection.

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 The relationships between staff and children were very good. In our survey, 80% of children said that they felt cared for by staff, 87% that staff treated them with respect and 93% that there was a member of staff they would turn to if they had a problem. The children we spoke to said that staff treated them well; they felt that staff were interested in them, cared about what happened to them and wanted to help them.

4.2 We observed a caring, supportive culture where staff were prepared to go out of their way to help children, spoke to them politely and found time for them. We saw children actively seek out staff to spend time with them, and it was clear that staff gave the time to get to know the children well. This culture supported good outcomes for children in many areas of our healthy prison tests. It enabled the maximum number of children to engage in the many varied activities on offer, as these nurturing relationships allowed staff to address most problems and mixing issues effectively.

4.3 There were clear boundaries and children generally respected them. When occasionally a child would swear in conversation, this was normally challenged and was often followed by an apology, showing mutual respect.

4.4 Custody support plans (CuSPs) were prominent, and children received regular sessions with a consistent CuSP worker, who was an officer who worked on the child's unit. These sessions lasted for at least 45 minutes a week and were recorded in some depth on the child's electronic record. Children told us they appreciated these meetings, and staff said that they learned a lot about the children and the meetings helped in managing the children’s day-to-day issues.

4.5 There were no children identified as peer workers, but the level of engagement with staff and the willingness of children to ask staff for help negated most of the need for this support.

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

G1 communal area

4.6 Communal areas were clean and tidy. Each child had a cell to themselves. The cells were graffiti-free and in good condition, except that the windows, which were sometimes scratched, contained rubbish between the two panes, and children were not able to regulate the temperature in their cell.

4.7 All cells had built-in TV and furniture, and also a screened toilet area. None of the in-cell toilets we looked at had a toilet seat, and most were heavily scaled and needed cleaning. Staff successfully encouraged children to keep their cells clean through one-to-one conversations and support for those who needed it, as well as weekly competitions.

4.8 There was good access to showers; in our survey, 100% of children said they could shower every day. The showers, however, were tired, with flaking paint and needed improvement. These concerns were due to be addressed in a forthcoming refurbishment programme that included the introduction of in-cell showers and renovation of the cell windows.

4.9 Children also had good access to laundry facilities. Night staff generally washed and dried their clothes, but children could do their own washing if they chose. In our survey, 94% of children said they normally had enough clean suitable clothes for the week.

4.10 Children could go outside for exercise at various times through the day, generally in breaks between education classes, and then for around 30 minutes at the end of the day. The exercise yards had artificial grass and murals on the walls, as well as tables and seating, but they were still austere; one had a roof cage, which reduced natural light.

4.11 Access to property was a concern for children. They waited far too long to receive items sent in by families and anything that was stored; this was a source of much frustration. Leaders were responding to these concerns, however, and the management of property was due to be brought in house from the adult prison.

Residential services

4.12 In our survey, 94% of children told us that they got enough food at mealtimes, compared with only 37% at similar prisons. The menu provided four options, including a good selection of vegetables and healthy choices. There were two hot options a day, which children liked, and extra items, such as cereal and noodles, were available on request. Meals during the week were cooked in the staff kitchen and were of high quality, but those at weekends came from the main kitchen for the adult site and were not as good. The chefs from the staff facility decided the menu choices for the whole week, which meant that children's options were not repetitive and had a wider variety of healthy food.

4.13 There were some self-cook facilities on the wings, which children used regularly, and events such as 'platinum breakfast', where those on the highest level of the reward and sanctions scheme cooked their own breakfast at weekends with supplies from the prison kitchen. They could also cook for staff and did so most weekends, when staff sat and ate breakfast with the children. This was incredibly popular and much enjoyed by children. Children could also eat their meals together every day, which was positive.

4.14 The shop was good. In our survey, 94% of children said that the shop sold things that they needed, against the comparator of 55%. Children told us that they could get most things they wanted, and that staff would help if they needed something that was not on the list.

Consultation, applications and redress

4.15 There was a reasonable amount of formal consultation with children. A monthly forum was held with different children attending each time that covered topics such as food, the shop and the issues that affected their daily lives. Major changes were also the subject of formal groups; for example, the forthcoming refurbishment of the unit had been discussed

and children had made an input into the colour choices and layout of the cell furniture, which they told us they liked.

4.16 Formal consultation was not, however, the primary way the child's voice was heard at Parc; the good relationships, visibility and engagement by the staff and regular CuSP sessions (see paragraph 4.4) meant that leaders and staff knew the issues that frustrated children and took action to address them.

4.17 There had been 36 complaints submitted in the previous six months. They were all answered thoroughly and politely. In the selection we reviewed, we found responses where the investigator had gone beyond the level of enquiry we usually see to make sure the child got a suitable reply. The quality assurance process was also very good. Each complaint was reviewed, and the child had the opportunity to make a written response and grade how they felt the complaint had been handled, which was notable practice. However, only around 60% of responses were sent to children within Parc’s seven-day target.

4.18 Children could make applications through the electronic kiosk or on paper, and responses were generally swift. Children told us that applications were sorted out quickly, except for property issues (see paragraph 4.11), and, as with complaints, we observed that most of the children's needs were addressed through the day by staff who cared and responded to their verbal requests effectively.

4.19 Children’s access to legal representation and their legal rights was good: face-to-face legal visits were available each weekday, there was a video-link suite for court appearances and video visits when children's legal representatives could not attend in person. The needs, engagement, well-being team (NEWTs, see paragraph 4.27) dealt with any appeal paperwork and Barnardo's staff, who provided an advocacy service, were available to provide advice when necessary.

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

4.20 Leaders' commitment to equality and diversity was undermined by a lack of resource or staff devoted to this priority. While there was a manager responsible for equality and diversity, work was mostly carried out on an ad hoc basis by those with other roles. This meant progress in addressing the deficiencies we identified at the previous inspection had been slow. Partnership with a community organisation had not delivered the hoped-for resources and improvements. The lack of

dedicated staff was a barrier to involving children more, gaining a better understanding of their perceptions, and raising the profile of equality and diversity.

4.21 The use of data to identify disproportionate outcomes, particularly in relation to ethnicity, had improved and was discussed at the unit's monthly monitoring and review group meeting (see paragraph 3.31). This had identified some areas for further investigation; for example, the over representation of white children in the ACCT process and the overrepresentation of black children subject to challenge, support and intervention plans (CSIPs, see Glossary and paragraph 3.25). Leaders had held forums with both groups to try and understand the reasons for this difference.

4.22 A unit manager had responsibility for work in this area, and a strategy and action plan set out the priorities for the unit and events to be celebrated during the year. There was evidence that children were consulted at monthly 'Beyond Differences' meetings and that actions were progressed afterwards, but there was limited child and staff attendance at these meetings. There was some work to promote diversity in enrichment activities and education but little coordination with the residential team to ensure that children were aware of and participated in different events throughout the year.

4.23 Children had ready access to discrimination incident reporting forms (DIRFs), and 21 had been submitted over the previous 12 months. The quality of investigation, however, was inconsistent and internal quality assurance was not robust. There was no review by an external agency to support improvement.

Protected characteristics

4.24 Information about each child's known protected characteristics (see Glossary) was held on a 'strengths and culture' database. One of the unit's strengths was the knowledge staff had of the children for whom they were responsible, allowing individual needs in general to be met.

4.25 One-third of children were from a minority ethnic background. Some shared their view that the predominately white staff group did not understand how they perceived racism. More needed to be done to explore these views and share the monitoring data produced each month. Minority ethnic children appreciated new shop arrangements which gave them access to hair and skin care products they had requested; these items were also included in toiletries given to new arrivals.

4.26 Few children were formally identified as having a disability, although staff often spoke about children as having neurodiverse needs. Assisted living plans were used for those who had specific needs. Staff were aware of these plans and the support each child required.

4.27 Needs, engagement and well-being team caseworkers (NEWTs) were aware of children who were foreign nationals, of whom there were

three during the inspection. The foreign nationals officer from the main prison provided specialist input for them. Access to immigration legal advisers if needed was facilitated via the NEWTs or Barnardo's advocates. Telephone and in-person interpretating had been used when required by a child or their parents.

4.28 It was rare for the unit to receive children who spoke Welsh as their first language; there had been one in the previous year. Information and forms were available in Welsh, and Welsh-speaking unit staff were known and, for example, one would be assigned as the CuSP officer for a child who spoke Welsh.

4.29 When the inspection took place, there were no children who identified as gay, lesbian or bisexual, and no trans children. Individual support was offered to these children if needed.

4.30 All the children who identified as having a religion reported that their religious beliefs were respected. They had access to the chaplaincy on the main prison site and could attend group worship there, suitably separated from adult attendees. Mixing issues between children meant some could not attend every week. Religious instruction was offered and children were included in religious festivals and celebrations. Food prepared for religious festivals, for example, was taken to children by their chaplain to make sure that they received it. A volunteer from the Message Trust, a Christian charity, spent time on E1 and G1 weekly for Bible studies and music classes.

4.31 Chaplains visited the unit daily to carry out their statutory duties (including checking on separated children and welcoming new arrivals), and engage with any children who wanted to talk to them. Support for children who were experiencing family ill health or bereavement was managed well, with a focus on enabling children to attend final visits or funeral services for close family members. For those not able to attend in person, a welcoming private room was used to stream services with a chaplain in support.

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.

Strategy, clinical governance and partnerships

4.32 Primary care and pharmacy services had been provided by Cwm Taf Morgannwg University Health Board since December 2022. Dental care was provided by Time for Teeth. Child and adolescent mental health services were still provided through the All-Wales Forensic Adolescent Consultation and Treatment Service (FACTS) within Cwm Taf Health Board. The health needs assessment had been published in

2021 and required updating. There was an action plan to address identified needs, but this too required updating.

4.33 Despite assurances at our last inspection, partnership boards and local governance meetings still lacked clear governance of the children's service, which led to inadequate oversight and scrutiny of the care provided. Additionally, there was very limited evidence of internal audits or consistent management checks by the designated health manager. We were advised that this would be rectified, and an oversight document was produced during our visit. Reported incidents had been investigated and there was evidence that lessons learned had been shared, but we were not confident that all incidents had been reported.

4.34 The two longstanding primary care staff had left since our last inspection and there were vacancies for a physical and a mental health nurse. Staffing had lacked stability and continuity, but there was an enthusiastic primary care bank nurse who was well known to the children.

4.35 Compliance with mandatory staff training was up to date with appropriate training and documented clinical supervision.

4.36 The treatment room was in good condition and also served as the medicines administration room. Medications were stored correctly, and stock levels were monitored.

4.37 The standard of entries on SystmOne (the electronic clinical records system) was inadequate and they were not focused on the particular needs of children in prison. Care plans were adequate but lacked evidence that children had been involved. Some mental health and substance misuse records continued to be held separately, creating risks and potential overlap.

4.38 An automated external defibrillator was sited appropriately and checked regularly. The bag containing emergency equipment was checked daily. We found that it was missing some equipment and this was remedied promptly when we alerted the bank nurse. An ambulance was called automatically in emergencies, which was good practice.

4.39 The health complaints process was well advertised. We were told that there had been no written complaints in the last 12 months, and that staff addressed any concerns raised by children at the time.

4.40 Staff were confident to make safeguarding referrals, attended the prison safeguarding meeting and had established links with the health board safeguarding team for advice and support.

Promoting health and well-being

4.41 There was no local health promotion strategy or action plan, which was a gap. There was a wide range of health promotion material across the unit, but it was poorly displayed, lacked a coherent theme and not in child-friendly language.

4.42 New arrivals were screened promptly for hepatitis B and sexually transmitted infection and could be referred to the sexual health team if necessary. Children who smoked were assessed on arrival and provided with nicotine replacement lozenges at reception, but there was no psychological support.

4.43 Children were offered a range of childhood vaccinations, including for measles, mumps and rubella (MMR). All children who had been due those immunisations were up to date.

4.44 An outbreak control plan was in place on the children's unit with contact details for reporting.

Primary care and inpatient services

4.45 A nurse screened all new arrivals using the national comprehensive health assessment tool (CHAT). The nurse saw them in a room that was shared with prison staff, which meant that the screening was not private and therefore not in line with national health standards for confidentiality. Subsequent CHAT assessments were not always completed in line with national standards as they were sometimes late or omitted (see paragraphs 4.54 and 4.59).

4.46 The nurse-led primary care service offered a range of services, including for long-term conditions. The health care team from the adult prison provided nursing cover out of hours. Two GPs, one male and one female, visited the unit regularly to see patients, which meant that children could see a GP of their preferred gender. The visits reduced the need to transfer children through the adult prison to the main health care unit. The GP service was delivered six days a week and included out-of-hours provision. Urgent GP appointments were available on the day, and routine appointments took place on the unit.

4.47 All children were referred to the optometry service which attended once a month, with a maximum wait of four weeks. The physiotherapist had one child on the caseload at the time of our inspection and routine appointments were offered promptly.

4.48 There were infrequent secondary care appointments to the local hospital and the children had good access them.

4.49 At the time of the inspection, no child was receiving social care. Staff could not recall the last time that such services had been required, but they understood how to make a referral if necessary.

Mental health

4.50 The mental health service consisted of a full-time primary care mental health nurse - a Health Board post that had been unfilled for several months - and an experienced full-time children's mental health nurse who managed the more complex and severe mental health conditions; this post was covered by a specific nurse seconded from FACTS.

4.51 There were limited associated therapies to meet all the needs of the children, such as psychotherapy, art therapy or speech and language therapy, which was a missed opportunity for early intervention.

4.52 Primary care interventions previously undertaken by the primary mental health nurse were no longer available due to staffing shortfalls, but the children's mental health nurse filled some of the gaps temporarily. Joint working with substance misuse services for children with a dual diagnosis of mental health and substance misuse needs was evident, and the children's nurse covered visits to children at risk of self-harm and those who were segregated.

4.53 The service had access to a children's psychiatrist who provided remote assessments and reviews. However, the psychiatrist did not undertake all the prescribing directly but instead made prescribing recommendations to the GPs, which was not always in line with good practice.

4.54 The immediate mental health needs of children were assessed on their arrival with a further CHAT assessment within seven days; the children's nurse currently undertook these due to the staffing vacancies, but the CHAT neurodiversity screening was not always completed and sometimes missed altogether.

4.55 Care and risk assessment plans were written for those on the secondary care caseload and stored on a separate records system. These were not then uploaded to SystmOne, which was a risk to continuity of care and good communications between teams.

4.56 Neurodivergent assessments, diagnostics and prescribing were available for children, but could take a while to complete. There were no children on antipsychotics, and those requiring monitoring for attention deficit hyperactivity disorder medicines had physical monitoring.

4.57 We did not receive any data on transfers of children to secure mental health beds and were told that there had not been any in the previous three months. Release plans for children with mental health needs were infrequent and managed through the youth offending team.

Substance misuse

4.58 Substance misuse services were in transition having recently transferred to Dyfodol who delivered the psychosocial interventions. The primary care service provided clinical prescribing as required. There were a drug and alcohol strategy and action plan, supported by regular local meetings, and an outline of service provision was available.

4.59 All children were assessed for withdrawal during their initial assessments and CHATs were completed, but not always within the expected timescales. Nurses used the withdrawal scales to assess children arriving from court, but were not specifically trained to assess

children's substance misuse needs. It had been many years since any child had required opiate substitution therapy for acute withdrawal, but GPs could prescribe this if required.

4.60 A dedicated and experienced drugs worker saw all new arrivals and provided individual harm reduction advice. The drug worker's caseload included 60% of the children. The records we reviewed showed they had a comprehensive assessment, care plan and evidence that planned interventions were undertaken. Care plans and case records were held on the G4S IT records and not in the clinical records.

4.61 Interventions were child focused and a wide range were available. Although waiting lists were not used and reporting into governance structures was not evident, this did not appear to be affecting personalised care. There were no dedicated rooms for staff to see the children, which limited effectiveness as the spaces used instead were not appropriate for meaningful safe discussions. There was no feedback from the children to inform service development as yet.

4.62 There was some evidence of bespoke joint working with the mental health service but no regular formal discussion with them. Communication between the two services was hindered by the fact that they stored individual care plans on separate IT systems.

4.63 Pre-release planning was good, focusing on relapse prevention and harm reduction. Referral into community services was supported through the youth offending team worker and the family worker.

Medicines optimisation and pharmacy services

4.64 Medicines were provided by a pharmacy based in the adult prison. The service for children was managed by a principal pharmacist.

4.65 Medicines arriving with children were passed to the pharmacy team, who requested additional information from the child's GP if required. These were then prescribed and reissued. In one instance, there was a one-week delay in issuing a prescription while information was obtained, but the child had not been kept informed of this, which was poor.

4.66 At the time of the inspection, three children were in receipt of medication. They were unlocked in time to receive medication from the nurse before going to education, and subsequent doses were delivered at 11.45am and 5pm. Medicines administration took place at a hatch that opened on to the main corridor and was not confidential. There was good supervision of the children when they attended the hatch for medication.

4.67 Risk assessments for children receiving medicines in possession were undertaken on the basis of needs, and updated or reviewed with each prescription. None of the children on medication at the time of the inspection had them in possession. Storage of medicines was well managed, and prescribed medication was issued from named boxes.

4.68 Out-of-hours prescribed medicines could be acquired through the onsite pharmacy if needed. As at the last inspection, access to pain relief at weekends and overnight was sometimes delayed and children had raised this with nursing staff. Delays were reviewed through incident reporting and any concerns addressed.

4.69 The medicines management meetings and agenda did not explicitly identify the needs of children, which was a gap. The meetings included formulary and prescribing, trends in incident reporting and the outcome of audits.

Dental services and oral health

4.70 All children were referred to the dentist on arrival, which was good practice. The dental service was based in the adult prison and delivered a daily service from Monday to Friday. There were ring-fenced slots for the children and no waiting list for routine appointments. Children who required treatment had scheduled appointments and waiting times were short.

4.71 Dental hygiene advice and oral health promotion were offered at every contact. Children who experienced dental pain were provided with over-the-counter analgesia and were seen in an emergency appointment to minimise delays.

4.72 Children who had commenced orthodontic treatment in the community were referred to the orthodontist to ensure continuity of care, which was good.

4.73 Infection prevention and control measures were followed, and there were regular audits to monitor standards. The surgery had a separate decontamination room with clean and dirty areas that were clearly labelled.

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 The amount of time children spent out of their cells through the day and at weekends was good, and mostly exceeded our expectation of 10 hours a day. Children on the highest levels of the rewards and sanctions scheme averaged around 11 hours and 15 minutes each weekday and 10 hours and 30 minutes at weekends. Children on the lowest level averaged more than nine hours each weekday.

Exercise yards

5.2 Time out of cell included five hours of purposeful activity in education each weekday, including Fridays, which we do not always see at other children's prisons. In our roll checks, we found just one or two children locked in their cells during the core day; leaders were aware of the reasons for these absences and had approved them.

5.3 In our survey, many children reported that the enrichment programme was the best thing about Parc. We found that access to enrichment activity (separate to education) was very good; most children received at least nine hours a week, and generally much more - we saw examples of children regularly getting 25 hours of this activity in a week. A wide range of activity was available, and children had a choice of what they could do. The enrichment team had thought about the needs of children and tried to provide activity that was enjoyable but also helped them to learn. The long list of activities included a youth

club, with events such as self-esteem workshops, a film club, team games and life skills sessions, which addressed topics such as the environment, drugs and alcohol, and sexual health.

5.4 The enrichment team, which was led by a committed and enthusiastic manager, also provided activity outside of the normal working hours of the prison, for example, a fitness bootcamp at 7am and outside activity through the lunch hour. There was also a strong focus on the Duke of Edinburgh's Award scheme, where children could earn a bronze award.

5.5 We were impressed to see the work of the enrichment team with some children who had complex neurodiverse needs. In one instance, this had led to a child learning to read, and he was very proud to show the team his new skill and read to several of them.

5.6 The library was opened on one day a week by staff from the main library; they were very understaffed and so the service was limited to an order and drop-off service. Children could ask for a book but, as there was no catalogue, the librarian had to find a suitable title, which was not always ideal. They did drop off a selection of books in the library for children to look at and take away, but that was the extent of the provision.

5.7 There was no work by the library to promote literacy, and no links with the education provider to make sure that children could access books on topics that were part of the current curriculum.

The library

5.8 The gym was used as part of the education curriculum and by the enrichment team. Outside of education, children could expect a minimum of four hours gym per week, but most had more. In our

survey, 75% of children, against the comparator of 40%, said they went to the gym or played sports at least once a week.

The gym

5.9 There was an artificial grass sports pitch and a small gym, which was in almost-constant use by various groups of children. The equipment was becoming tired, and some needed replacing or refurbishment.

5.10 There were several collaborations with outside agencies, such as the Dallaglio RugbyWorks, Tennis Wales, Levelling the Playing Field (a not-for-profit organisation to help increase the number of children from minority communities taking part in sport) and Street Games (a charity aiming to change attitudes through sport). The children we spoke to were very enthusiastic about these collaborations, especially with RugbyWorks.

5.11 The gym team was delivering some sports qualifications and was hoping to expand this to more in-depth programmes and qualifications.

Education, skills and work activities

Arolygiaeth Ei Fawrhydi dros Addysg a Hyfforddiant yng Nghymru
His Majesty's Inspectorate for Education and Training in Wales

Inspection of the provision of education and educational standards, as well as vocational training in YOIs for young people, is undertaken by Estyn, the office of His Majesty's Inspectorate for Education and Training in Wales, working under the general direction of HM Inspectorate of Prisons. Estyn is independent of, but funded by, the National Assembly for Wales. The purpose of Estyn is to inspect quality and standards in education and training in Wales.

Expected outcomes: All children are expected and enabled to engage in education, skills or work activities that promote personal development and employability. There are sufficient, suitable education, skills and work places to meet the needs of the population and provision is of a good standard.

5.12 Estyn made the following assessments about the learning and skills and work provision:

- Standards: adequate
- Well-being and attitudes to learning: adequate
- Teaching and learning experiences: adequate
- Care, support and guidance: good
- Leadership and management: adequate

Standards

5.13 Many learners, including those from minority ethnic groups, achieved accreditations that were matched suitably to their starting points. A very few learners developed advanced skills, such as strong descriptive writing skills, or completed level 2 accreditations or AS levels.

5.14 In skills sessions, around half of learners made suitable progress in developing their literacy and numeracy skills. A few emergent readers developed their reading skills appropriately, for example with the support of the Shannon Trust literacy programme. However, overall, the pace of learners' progress towards meaningful accreditations in literacy and numeracy was too slow and the rate of attainment was low.

5.15 In practical subjects or through enrichment activities, many learners developed valuable skills and made products of good quality, such as in cooking or carpentry. They worked well independently or with peers in a few subject areas to practise and hone their skills in familiar contexts. For example, in music technology, many learners selected and used the most appropriate software for their compositions without

assistance. In health and well-being sessions, they worked safely and independently towards their fitness goals. In a few sessions, such as citizenship lessons, learners developed their thinking skills well as they explored concepts of conflict and community.

5.16 Overall, however, there was too much variability in the progress that a minority of learners made toward short- or long-term learning goals. This was due to various factors, such as learners' attitudes to learning, shortcomings in the quality and consistency of teaching, or weaknesses in how meaningfully the curriculum model and accreditation pathways supported their long-term education, training or employment needs and interests.

Well-being and attitudes to learning

Education

5.17 Learners felt safe in their classes and learning environment. Their rates of attendance were high.

5.18 There had been some disruption to the consistency of teaching recently. Some subjects had not had a regular tutor, including literacy and numeracy. Where learners had consistent teachers, most developed respectful and productive working relationships with them and behaved well. However, where teaching had been disrupted, for example, because of the use of temporary cover teachers or due to staff illness, a majority of learners were disengaged and did not want to learn. This had a significant negative impact on the rate of their progress and their outcomes in some subjects.

5.19 A very few learners showed an overall disinterest in learning. In some cases, they disrupted the learning of others and reduced their peers' progress.

5.20 Many learners participated well, enjoyed learning and showed pride in their work, particularly in practical subjects, such as carpentry, health and well-being, art and music. For example, learners enjoyed assembling and painting objects in carpentry to give as gifts for their families, writing comic-book stories, or using music technology to record their own compositions. In citizenship classes, many learners engaged in discussion of current world events and developed an awareness of a range of perspectives.

Teaching and learning experiences

5.21 Overall, the quality of teaching was too variable, and it was weak in a minority of sessions. In part, this was due to tutors having to cover subject areas or groups with which they were unfamiliar or difficulties retrieving teaching materials from digital sources. However, there were also weaknesses in their practice.

5.22 Generally, tutors had worked conscientiously to create positive learning environments with relationships based on respect. In many sessions, they set clear expectations and boundaries.

5.23 Where teaching was effective, many tutors had a sound understanding of the children's learning needs. They used their understanding to prepare well-planned sessions with clear learning objectives, which they shared with the learners. Tutors considered learners' strengths and areas for development, enabling them to work collaboratively or independently as best suited to the situation. They used a range of teaching techniques that helped to maintain a purposeful pace. This allowed nearly all learners in the group to engage with the topics and tasks. They used a range of suitable resources and activities that built on each other to help learners make connections and make progress. In a few cases, tutors helped learners understand and evaluate equality and diversity issues and challenge stereotypical views effectively. They used skilful questioning techniques to help learners investigate key elements of the topic and express their opinions respectfully.

5.24 In cases where teaching was less effective, tutors did not have a clear understanding of learners' needs. As a result, these sessions were not effectively planned, and they lacked challenge, pace and interest. This led to learners becoming disengaged and making slow progress.

5.25 Where appropriate, tutors used baseline assessments to understand learners' starting points. In a few cases, they provided focused verbal feedback during sessions, encouraging and challenging learners. In a few subjects, they provided written feedback that commented appropriately on achievement and future steps. However, overall, feedback did not explain clearly enough to learners how to improve their work and make consistent progress.

5.26 Nearly all learners, including those who were segregated, had access to 25 hours of curriculum a week and appropriate associated qualifications. The curriculum offered essential skills, citizenship and practical subjects, such as music, art, health and well-being, and carpentry. However, the curriculum model and qualification offer were not cohesive enough. For example, these was not a sufficient vocational focus to meet the learners' future training and employability needs. In many areas, tutors followed the qualifications' specifications and materials appropriately. However, they did not always contextualise the curriculum well enough to enable learners to apply these skills, for example, to their practical studies or everyday life. The restriction on using tools in practical subjects hindered learners from developing specific manual skills.

Care, support and guidance

5.27 Staff had a caring and supportive ethos and positive mindset towards their learners. They worked effectively together with operational staff to provide extensive out-of-class enrichment activities (see paragraph 5.3). This work had a significantly beneficial impact on learners’ well-being.

5.28 Education managers used information from the initial induction process to identify, where possible, children’s known additional learning needs and other information that could be relevant to their education. They also carried out their own helpful education induction, which included a discussion of children’s learning aspirations, an initial literacy, numeracy and digital skills assessment, and a profiler to indicate a range of other learning traits.

5.29 Staff used information from the induction process to generate an appropriate individual learning record that acted as a reference baseline and ongoing reporting document, and was shared electronically between teaching staff and other prison teams. However, overall target-setting in individual learning and work plans was not sharp enough. Processes to communicate information about learners' additional learning needs or the support and teaching strategies tutors could use with them were undeveloped. For example, tutors did not have straightforward access to IT systems and could not share information as effectively as they might.

5.30 Learners received helpful advice on the next steps, interventions and support from the resettlement team, and this led to high numbers moving on successfully to meaningful destinations on release. Release on temporary licence was used effectively to benefit a few learners to access relevant training or employment.

5.31 Education staff worked effectively with operational staff and the child's caseworker to help manage learners' behaviour and general welfare. For example, education managers attended multidisciplinary teams to identify which learners could benefit from interventions to help them manage their emotions. However, day-to-day information about individual children’s welfare and behaviour was not always

communicated effectively to tutors. This affected their ability to adjust their teaching approaches accordingly.

5.32 Managers reviewed a range of education data at weekly meetings to determine if children were on track to meet their qualification outcomes. However, analysis and evaluation of progress and outcomes for learners with additional learning needs was underdeveloped.

Leadership and management

5.33 The education provision had experienced protracted uncertainty as a result of the transition between contracted education providers. This led to significant challenges, such as the loss of staff, access to resources, and changes in responsibilities and processes that were once well-understood. Despite this, leaders, managers and staff across the prison had worked well together to make sure that most children received access to education provision for at least five hours a day.

5.34 The newly appointed head of learning and skills had recently set about stabilising the situation with others in the partnership and the prison management team. She had worked hard to build staff morale, provide clarity of vision and re-instil a sense of purpose. In a short time, the head of learning and skills had begun valuable work to introduce a culture of honest self-evaluation. This included helpful assurance processes, such as observations of teaching and learning, reviews of learners' work and learner surveys, some of which were beginning to provide suitable first-hand evidence of the quality of provision.

5.35 As a result of the initial reviews of quality, the head of learning and skills had very quickly established the main strengths and areas for development of provision, such as in the quality of teaching, curriculum offer and accreditation arrangements. She had started to prioritise this work appropriately. For example, she had already introduced a universal professional learning programme focusing on teaching and leadership, and an appraisal system designed to support improvements to professional practice. She had also begun to rebuild valuable links across the prison's teams to improve education's involvement in allocation to education pathways and rehabilitation and release planning. However, it was too soon to judge the impact of much of the work to address the initial shortcomings identified in the quality of provision or contribution to learners' outcomes. For example, labour market needs did not inform the curriculum offer well enough, and the education department had little involvement in the allocation of children to pathways, which was based on their behaviour and risk rather than their education needs.

5.36 Leaders used data well to monitor progress against key performance indicators. However, data were not analysed well enough to support the precision of self-evaluation findings, for example, on the impact of the provision on learners' outcomes, including groups of children, and the timeliness of their progress.

5.37 Partnership arrangements had been strengthened recently and this was beginning to have a tentative impact on the direction of travel. However, 10 months after the change of contracts, many of the challenges of the transitional period continued to impact negatively on the quality and continuity of provision, and children's progress in learning. For example, staff shortages persisted, new data systems were not well-used or understood, tutors did not have full access to their teaching materials and learner records, and there was uncertainty about access to some physical resources. A few curriculum managers were firefighting daily operational matters, making it difficult for them to drive forward quality strategically.

5.38 To offset staff shortages, curriculum managers from the adult education provision had been redeployed to the children’s unit to secure a daily education offer. Nonetheless, education staff in the children’s unit and the adult education provision were not always working well enough together on the curriculum. Education staff in the children’s unit had little physical space to collaborate, which hindered their opportunity to plan and operate a cohesive curriculum. Overall, the curriculum and accreditation arrangements did not consider children’s future education, training or employability needs and interests well enough. In addition, it had taken too long for the educational partners to make the most of and embed the potential benefits of partnership arrangements, such as sharing teaching staff and resources, to strengthen the curriculum offer and learning experiences. There was no prison-wide reading strategy.

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 About two-thirds of children were held over 50 miles from their home area. Despite the challenges that this presented, Parc continued to provide some impressive help to children to maintain contact with their families, including excellent support from the family liaison workers.

6.2 In our survey, 94% of children said someone had helped them to keep in touch with family or friends, and 75% of those who said they received visits had them at least once a week, compared with just 26% at similar YOIs.

6.3 Both social visits and secure video calls were used extensively. Following analysis of data and consultation with families, the social visits schedule had been changed and there were now two-hour slots in the morning and afternoon on both Saturday and Sunday. This was especially helpful for families travelling long distances as they could stay nearby overnight and visit on both days. As a result, there had been a large increase in the number of social visits with over 670 in the last year compared with 195 at our last inspection.

Visitors centre (left) and visits hall

6.4 The prison now made better use of the family lounge, which provided a more relaxed environment with sofas and a games area for younger children. This room was used for monthly family days and for more private visits between children and their siblings or their own children.

Family lounge

6.5 The number of secure video calls had also increased and there had been over 1,500 in the last 12 months compared with 1,303 at our last inspection. In our survey, 92% of those who had secure video calls had them at least once a week, against the comparator of 28%. The timings of calls were arranged flexibly to fit in with families.

6.6 All family work was based on the individual needs of children. For example, those who were fathers were supported to plan the time they spent with their child by doing specific activities that focused on developing parenting skills, such as learning shapes and nursery rhymes. Where appropriate, families were also involved in sentence planning and review meetings and were invited to attend celebration events for children who completed Duke of Edinburgh's Awards.

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.

6.7 To help reduce population pressures in the adult estate, 35% of those held at Parc were now 18 years old. About half of the children were sentenced or on a recall; the rest were unsentenced.

6.8 All children, including the small number serving long or indeterminate sentences, received very good support from their needs, engagement and well-being team (NEWT) caseworker. Most NEWTs were experienced, accessible to children and knew those they were supporting very well. When we asked children in our survey what the most positive thing was for them about the YOI, one said:

'… getting support from staff and NEWT workers'.

6.9 Home detention curfew (HDC) and early release processes were managed reasonably well, but there were some delays for a few children. One child had been released almost six months after their HDC eligibility date due to problems finding accommodation in sufficient time. This was disappointing given the good progress they had made while at Parc.

6.10 Use of release on temporary licence (ROTL) had increased and there had been 26 instances for around 10 children in the last year, compared with two in the six months before our last inspection. Escorted ROTL focused suitably on progression and reintegration. For example, a child had used it to visit an approved premises, and another had completed a driving theory test. However, we were concerned that some ROTL risk assessments lacked analysis and simply listed interventions that the child had completed rather than commenting on their general behaviours or attitudes that demonstrated any learning. Assessments in addition, did not consider the range of information held by other departments to inform risk management in particular contributions from youth offending teams were often absent.

6.11 As part of the excellent enrichment offer (see paragraph 5.3), five children had also used escorted ROTL to complete the Duke of Edinburgh's Award bronze award, which involved an overnight walking expedition. Families were invited in to attend celebration events following completion of the award, which was positive (see paragraph 6.6).

6.12 Open days for youth offending teams (YOTs) taking on the responsibility for children in the community had been well received and

helped the prison to build relationships with community partners. At these events, practitioners had a tour and met staff from various departments.

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.

6.13 New arrivals were allocated to a NEWT caseworker (see paragraph 6.8) who met them shortly after they arrived. Contact between children and their caseworker was meaningful, with caseworkers challenging children's views appropriately when necessary. They encouraged children to be their own advocates during review meetings, and there was evidence that the work to meet sentence and remand planning goals was done collaboratively alongside children. Evidence of this work on youth justice application framework (YJAF, see Glossary) records was exemplary and demonstrated good practice.

6.14 In our survey, 100% of children who said they had a plan for their time in prison said they understood what they needed to do to achieve their targets, and that staff were supporting them to achieve these. Our interviews supported this; children were overwhelmingly positive about their NEWT caseworkers, describing them as supportive and helpful.

6.15 Sentence and remand planning meetings took place regularly and children understood what they needed to do to achieve their objectives. In the 12 cases that we reviewed, assessments were completed to a good standard and commented on factors such as immaturity, friendship groups and the environment as potential contributors to offending. Records demonstrated a good level of contact with YOTs, and in our interviews, children confirmed that YOT workers regularly attended planning meetings in person and kept in contact well. Where appropriate, families were also encouraged to attend.

6.16 Most planned transitions of children from Parc to the adult estate were managed reasonably well. Planning now began six months after the child turned 18, and decisions on which prisons to consider were multidisciplinary and often involved family members. Most children moved in sufficient time, but the process for some was frustrated by refusals from the adult estate. In one case, a child had been refused a move from three adult prisons, which delayed their transition by around five months.

6.17 Before transfer, Parc shared information with the adult prison and, where possible, prison offender managers (POMs) spoke directly to the young person by telephone. NEWTs caseworkers had good contact

with adult services, including probation. However, the lack of access to OASys (offender assessment system) records limited Parc's ability to share the extensive information about children recorded on YJAF with the adult sites.

Public protection

6.18 Children with public protection concerns were identified on arrival and there was prompt contact with YOTs to establish risks and needs. At the time of the inspection, 11 children were subject to multi-agency public protection arrangements (MAPPA), an increase from seven at the last inspection. They all required management at the higher risk levels, which meant that many agencies, such as the police, probation and YOTs, needed to be involved to manage the risk of harm.

6.19 Despite some active communication between YOTs and the prison, a small number of children did not have their MAPPA levels confirmed before release; managers needed to address this problem. Written contributions from the prison to MAPPA meetings in the community were adequate, but some lacked analysis of risk, despite the NEWTs' vast knowledge of children they were managing.

6.20 The risk management plans that we viewed were of a good quality and considered current, future, custody and community risk issues. Plans were reviewed with other agencies before release.

6.21 Very few children required telephone or mail monitoring. In the few examples we reviewed, monitoring was mostly timely, and recordings were readily available to NEWTs to inform risk management.

Indeterminate and long-sentenced children

6.22 Three children were serving long sentences of over four years or on remand for offences that potentially carried a long sentence. They all received good support from their YOT and NEWT caseworker (see paragraph 6.8) who regularly reminded them about their future ROTL or parole eligibility dates to encourage them to remain motivated. Some mentoring from a risk-assessed prisoner on the adult site at Parc had just resumed, but was not yet focused on supporting children on long sentences.

Looked after children

6.23 In our survey, 75% of children said they had experienced local authority care. The designated social worker had returned to Parc and now facilitated looked after children (LAC) reviews, which were well attended. They also challenged local authorities to make sure that LAC children received their entitlements of clothing and money, although there were large differences in what was available from local authorities; for example, while Gloucestershire and Cardiff gave their children £20 a week, children looked after by Newport and Bridgend received £5 a week. Too few looked after children had regular face-to-face contact from their home local authority social worker.

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.

6.24 All children had accommodation to go to after leaving Parc. In the last year, 18 of the 34 children released went to live with family in the community and the remaining 16 went to children's homes or supported accommodation. Most children had a release address confirmed in sufficient time for their release.

6.25 Sixty-eight per cent of the children released in the last 12 months went into education, training or employment. Securing a placement for those aged 18 was more difficult and, as a result, outcomes for them were less positive. Four of those released from Parc who were all aged 18 left without education, employment or training to go to; they were all allocated to the probation service.

6.26 Since February 2023, leaders had developed the throughcare support available from NEWTs to children after release and there was evidence of some positive outcomes. Of those released, 19 children had been contacted via telephone or video call and, of these, nine home visits or professionals meetings had been arranged in the community. This had been especially helpful for those released from Parc who did not have any regular contact with probation and needed some additional support to link in with agencies.

Interventions

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

6.27 There were sufficient offending behaviour programmes for children who needed them. The psychology team now co-delivered some accredited interventions with NEWTs, which was a positive development. The needs of the population at Parc were regularly reviewed to decide on the most appropriate interventions to schedule for the coming months.

6.28 NEWTs had recently completed the first group of 'Feeling it' (an intervention designed to help children identify and manage their emotions) with five children. The psychology team had delivered 'Life minus violence' (a one-to-one intervention for those with the highest level of risk for violence) and 'Timewise' (aimed at children involved in violence while in custody) to two children.

Health, social care and substance misuse

6.29 Health care staff liaised with the NEWTs workers before a child was released to ensure that links with community services were in place. Where appropriate, children were given medication to take home, and they all received a summary of their care for the GP.

Section 7 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.

Safety

Children, particularly the most vulnerable, are held safely.

At the last inspection of HMYOI Parc in 2022, we found that outcomes for children were good against this healthy establishment test.

Recommendations
Observational checks on children should not be carried out at predictable intervals. (Repeated recommendation.)
Not achieved

Managers should make sure that debriefs following restraint are comprehensible and useful to children.
Achieved

Care

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

At the last inspection of HMYOI Parc in 2022, we found that outcomes for children were good against this healthy establishment test.

Key recommendations

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

Leaders should provide effective oversight of equality and diversity work at all times and data should be scrutinised thoroughly, considering all protected characteristics.
Not achieved

Recommendations
Windows should be free of graffiti and dirt, and maintenance should be carried out on broken air vents.
Not achieved

Consultation should include the views of all children and actions should be addressed in a timely manner.
Achieved

Children should have access to a wider range of therapeutic interventions, including speech and language therapy.
Not achieved

Children should have prompt access to pain relief at the weekend and overnight.
Not achieved

Purposeful activity

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

At the last inspection of HMYOI Parc in 2022, we found that outcomes for children were good against this healthy establishment test.

No recommendations

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 of HMYOI Parc in 2022, we found that outcomes for children were good against this healthy establishment test.

Key recommendations

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

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

Appendix I About our inspections and reports

HM 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, 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 HM 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 identification of **areas of concern**. Key concerns identify the areas where there are significant weaknesses in the treatment of and conditions for children. To be addressed they will require a change in practice and/or new or redirected resources. Priority concerns are those that inspectors believe are the most urgent and important and which should be attended to immediately. Key concerns and priority concerns are summarised at the beginning of inspection reports and the body of the report sets out the issues in more detail.

We also provide examples of **notable positive practice** in our reports. These list 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.

Inspections of young offender institutions in Wales are conducted jointly with Estyn, Healthcare Inspectorate Wales and the General Pharmaceutical Council (GPhC). This joint work ensures expert knowledge is deployed in inspections and avoids multiple inspection visits.

This report

This report outlines the priority and key concerns from the inspection and our judgements against the four healthy prison 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/). Section 7 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 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
Becca Stanbury	Inspector
Dionne Walker	Inspector
Helen Downham	Researcher
Emma King	Researcher
Alex Scragg	Researcher
Sarah Goodwin	Health inspector
Tania Osborne	Health inspector
Mamta Arnott	Estyn inspector
Steve Bell	Estyn inspector
Penny Lewis	Estyn 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/

AssetPlus
Youth Justice Board assessment documentation completed by youth offending teams.

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.

Challenge, support and intervention plans (CSIPs)
Used to manage those prisoners who are violent or pose a heightened risk of being violent. These prisoners are managed and supported on a plan with individualised targets and regular reviews. Not everyone who is violent is case managed on CSIP. Some prisons also use the CSIP framework to support victims of violence.

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

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

Rule 49 of YOI Detention Centre Rules
Authorises children to be segregated from the main population.

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

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

Youth justice application framework (YJAF)
An online platform used exclusively by youth justice services and the secure estates to communicate effectively (including sharing AssetPlus assessments and case management entries) and download formal documents and templates.

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 reports 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.

Crown copyright 2024

This publication, excluding logos, is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3 or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: psi@nationalarchives.gsi.gov.uk.

Where we have identified any third party copyright information you will need to obtain permission from the copyright holders concerned.

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/

Printed and published by:
HM Inspectorate of Prisons
3rd floor
10 South Colonnade
Canary Wharf
London
E14 4PU
England

All images copyright of HM Inspectorate of Prisons unless otherwise stated.