Report on an unannounced inspection of

HMYOI Wetherby

by HM Chief Inspector of Prisons

20 November – 7 December 2023

Contents

Introduction

This complex young offender institution (YOI) in Yorkshire holds children with a range of needs, including those in the Keppel Unit, a national resource for the most vulnerable children; provision for a small number of girls; boys on short sentences or remand; and a small number of children who are embarking on very long or life sentences.

Wetherby is one of three different types of institution that hold the seven currently imprisoned girls in England and Wales. Nationally there is not a coherent plan for caring for these girls and what was originally only temporary accommodation at Wetherby after the closure of Rainsbrook secure training centre (STC), has now become the destination for those who STCs and secure children's homes will not, or cannot accommodate. The result has been pressure on staff who, while doing their best, have not had the training or do not possess the expertise to care for these girls, most of whom require specialist provision. As a result, we came across two incidents where a girl was using her clothes to make ligatures and had had her clothing removed by male officers. This is simply not acceptable.

The care for these and for other vulnerable and challenging children was also not good enough. While there was some good provision in the Keppel and Napier units and the segregation unit was better run, some children were being separated on the wing for too long before they were reintegrated. Although some boys chose to self-isolate because they wanted to avoid conflict before moving to the adult estate, some were spending long periods of time away from their peers and receiving little time out of their cells.

There had been laudable efforts by leaders to reduce keep-apart lists and integrate children into larger groups. Although there had been some effective conflict resolution by trained officers, too often they were cross-deployed to other duties. Leaders told us that formal schemes to promote relationships with children through frequent structured contact for every child was barely functioning because there was often a shortage of frontline officers. Given the size of the leadership team, with 24 senior managers and 67 other managers, this was scarcely credible when the jail held just 165 children. In our last report we criticised the size of leadership team that meant lines of responsibility and accountability were opaque, so it was disappointing this had not been rectified.

While there was an impressive breadth in enrichment activities and access to the gym and refurbished library were good, children still spent too much time locked in their cells. Although those on the enhanced Drake unit received around seven hours unlocked per day, separated children could spend up to 23.5 hours a day behind their doors. Overall, it was disappointing to see that time out of cell had not improved since our last inspection and was nowhere near the levels we reported on before the pandemic with evening association and dining out now rare.

There had been some improvements in the provision of education, but English and maths provision remained poor, with too few children having access to high quality teaching. While there was a rudimentary reading strategy in place, the

teaching and encouraging of reading was not good enough with the most need receiving the least support.

The atmosphere in the jail was generally good and most of the children we spoke to described good relationships with staff. Levels of violence had remained too high and the extensive number of meetings which were due to address it were not well coordinated. The use of incentives to motivate good behaviour were, apart from in education, not being used enough to improve behaviour.

Work had been done to improve the accommodation on the Keppel and Napier units, in-cell showers had been fitted in most cells and the exercise yards looked better and had a wider range of activities for children. The living units were showing their age and were not a suitable design or layout to provide for the children at Wetherby.

The dedicated governor has presided over a jail that has become more stable in recent years and in the most part, the prison feels settled. Staff were understandably disappointed with the reduction in our safety score to not sufficiently good, but it was unavoidable given our findings about girls. There will need to be some creative thinking within the Youth Custody Service (YCS) and the prison service to support this particularly vulnerable group.

Charlie Taylor
HM Chief Inspector of Prisons
December 2023

What needs to improve at HMYOI Wetherby

During this inspection we identified 11 key concerns, of which seven 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. **The level of self-harm among girls was extremely high and this resulted in very high levels of use of force and assaults on staff.** There was still no effective model of custody for these very vulnerable children and, despite the best efforts of staff, the YOI was not able to meet their needs. (To Youth Custody Service)

2. **Too many children were separated for too long.** Children who were separated in their own cells on the main wings experienced very little time out of their cell, particularly at weekends.

3. **There was a high number of pain-inducing restraint techniques and strip-searches under restraint.** Many of these incidents were not in accordance with national policy and were not properly authorised. Scrutiny of video footage and support on the scene by leaders were poor.

4. **The implementation of custody support plans was weak.** Many sessions did not take place and those that did were opportunistic or cursory in nature.

5. **Residential units required continuing maintenance. Some cells were cold and in poor repair.**

6. **Children spent too much time alone locked in their cells, particularly at weekends.**

7. **The teaching of English, including reading and mathematics, was not good enough.**

Key concerns

8. **Almost half the complaints about discrimination were responded to late, which undermined children's confidence in the process.**

9. **The quality of risk assessment work by resettlement practitioners was inconsistent. Some assessments lacked depth and not all available interventions and management tools were considered.**

10. **Leaders and managers had not given sufficient oversight of quality assurance procedures to make sure that weaknesses, including those found at the previous inspection, had been fully addressed.**

11. **Waiting times for routine dental treatment were too long and there was no local orthodontic pathway for new referrals.**

About HMYOI Wetherby

Task of the establishment
To hold sentenced and remanded children aged 15 to 18 years. This includes males, restricted status and females.

Certified normal accommodation and operational capacity (see Glossary) as reported by the establishment during the inspection
Children held at the time of inspection: 165
Baseline certified normal capacity: 340
In-use certified normal capacity: 288
Operational capacity: 266

Population of the establishment
- 37% 18 years old
- 17 foreign national children
- 41% from black and minority ethnic backgrounds
- 28% on remand
- 49% with experience of care
- Three girls held during the inspection (2% of the population)

Establishment status (public or private) and key providers
Public

Physical health provider: NHS
Mental health provider: NHS
Substance misuse treatment provider: YPDASS
Dental health provider: Leeds Community Health Care NHS Trust (LCH)
Education framework provider: NOVUS
Escort contractor: GeoAmey

Prison group/Department
Youth Custody Service

Brief history
Formerly a naval base, HMS Ceres, Wetherby was introduced into the prison estate in 1958 as a borstal. Since that time, its role has changed many times from an open youth custody centre to a closed youth custody centre to its current role as a young offender institution.

Short description of residential units
There are eight units:
Anson: specialist unit, risk management
Benbow: closed for refurbishment
Collingwood: induction and first night in custody unit
Drake: mainstream services, enhanced Incentives and earned privileges
Exmouth: mainstream services
Frobisher: mainstream services
Keppel: specialist unit, adapted environment
Napier: enhanced support unit, bespoke accommodation

Name of governor and date in post
Peter Gormley, July 2020 -

Changes of governor since the last inspection
Martin Dobson, temporary deputy governor, February 2023 to date

Prison Group Director
Sonia Brooks, deputy director

Independent Monitoring Board chair
Catherine Porter

Date of last inspection
6–17 November 2021

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 Wetherby, we found that outcomes for children were:

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

1.3 Previously, we inspected HMYOI Wetherby and Keppel unit separately. We inspected HMYOI Wetherby and Keppel unit together at this inspection and will continue to do so at future inspections.

1.4 We last inspected HMYOI Wetherby in 2021, at that inspection we found the outcomes for children were:

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

We last inspected Keppel unit in 2021, at that inspection we found the outcomes for children were:

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

Progress on key concerns and recommendations from the full inspection

1.5 At our last inspection in 2021, we made 19 recommendations, 14 of which were about areas of key concern. The establishment fully accepted 17 of the recommendations and partially (or subject to resources) accepted two. It rejected none of the recommendations.

1.6 At this inspection we found that nine of our recommendations about areas of key concern had been achieved and five had not been achieved. Three recommendations in the area of safety had been achieved and one had not been achieved. One of the recommendations made in care had been achieved and one had not

been achieved. Two recommendations in purposeful activity had been achieved and two had not been achieved. In resettlement, three recommendations had been achieved and one had not been achieved. For a full list of the progress against the recommendations, please see Section 7.

Notable positive practice

1.7 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.

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

1.9 A quarterly newsletter to share information from equality forums was published on children's laptops. This showed the issues raised and changes made as a result. (See paragraph 4.26)

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 In contrast with the other young offender institutions (YOIs) inspected this year, Wetherby has benefited from a stable leadership team led by the well-regarded governor who had been in post for four years. He had a clear understanding of the issues at the site and had set appropriate priorities in the self-assessment report.

2.3 While all institutions holding children are faced with high levels of need, this was particularly so at Wetherby because of several specialist functions. This included the enhanced support unit (Napier) and the Keppel unit for more vulnerable children. In addition, Wetherby held a small number of girls and restricted status children (the equivalent of category A or high security prisoners in the adult estate).

2.4 As with other YOIs, the senior team was very large, consisting of 26 managers. There were also 59 directly employed middle managers in an institution holding 165 children. As at our previous inspection, this large group was unwieldy rather than helping to make progress and lines of accountability were blurred. We were particularly concerned that, despite this resource, oversight in key areas of safety including strip-searching, restraint and separation was not sufficiently robust to make sure the most vulnerable children were held safely.

2.5 Girls were placed at Wetherby just before our previous inspection and in the ensuing two and a half years national leaders had not developed an effective model of custody for them. Despite the best efforts of local managers and some very committed staff, the YOI was unable to meet the needs of some of the most vulnerable girls in the country.

2.6 While conflict remained a problem, leaders had worked hard to reduce the number of children being kept apart from each other through initiatives including the enhanced support team, Napier and Keppel unit placements, the introduction of a weapons strategy, conflict resolution and incentivised community celebration events. This meant that several units now operated as one ‘community’.

2.7 The lack of spaces in the adult estate had resulted in national leaders delaying the transition of children to the adult estate until just before their 19th birthday. This had substantially altered the population at

Wetherby and 18-year-olds now made up 37% of those held. Leaders had responded well to this considerable challenge by creating new work opportunities and giving support with benefits and employment when they were nearing release.

2.8 Prison and education managers did not make sure that children arrived on time for their lessons, and we observed delays of up to an hour on some days. In addition, leaders in education had not improved the curriculum or standards of teaching in English and mathematics.

2.9 Partnership work between leaders in health care and the prison was effective and had improved services for children which were very good, with the exception of some delays to dental treatment.

2.10 Leaders had made some improvement to exercise yards. However, many of the buildings needed refurbishment. During our inspection the heating on Keppel unit had failed and there were problems with heating on Anson unit as well. This was compounded in some cells by broken windows that could not be closed.

2.11 Leadership in resettlement had improved and the team was supported more effectively and was more cohesive than at the time of our previous inspection.

Section 3 Safety

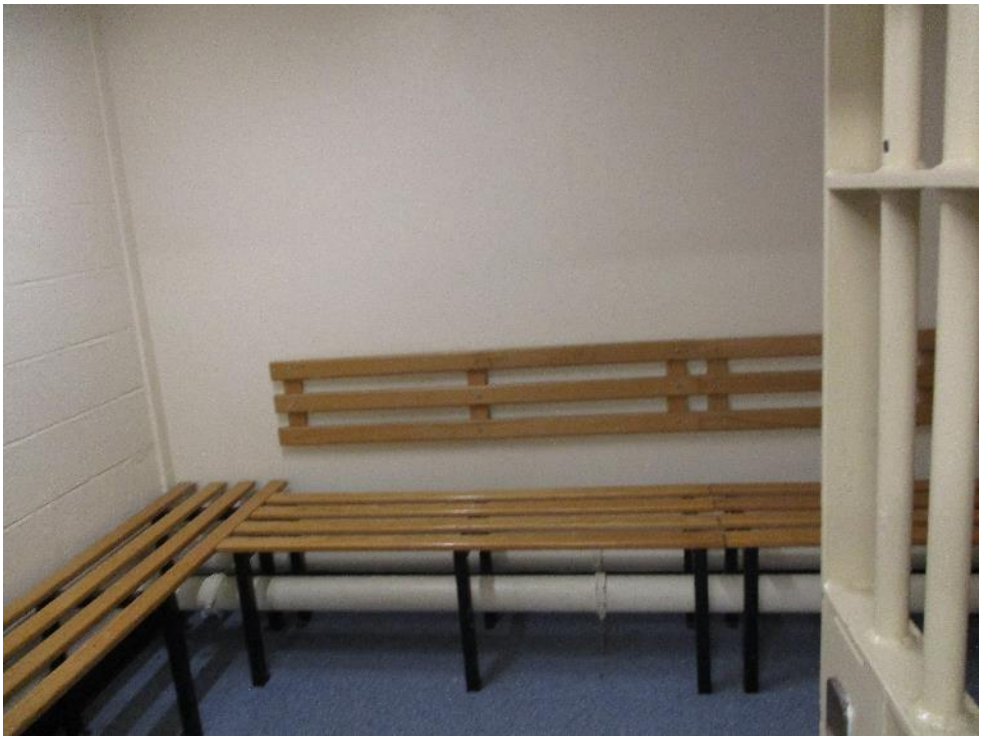
Children, particularly the most vulnerable, are held safely.

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 Wetherby received about seven new arrivals a week. Most children arrived at a reasonable time, but during the previous year 56 children (17% of new arrivals) had arrived after 8pm. Late arrivals prevented children from mixing with their peers before being locked in their cells for the night. A first-night trained member of staff was available during the night to make sure that the risks and needs of the children were properly assessed.

3.2 The reception area was clean and had recently been decorated. Books were available to occupy the children but holding rooms were stark with broken televisions and no information about life at Wetherby. We were told that new furniture had been ordered.



Benches in the reception holding room

3.3 Reception staff were friendly and tried to make sure that children could make a 10-minute call to their family or guardian. A hot meal, drink, shower and change of clothes were offered and a grocery pack which also contained stationery, stamps and an activity book was given to children to take to their cells.

3.4 The first night officer gathered information from the youth justice application framework (YJAF) before children arrived, and risk and need were assessed at a private in-depth interview and a health care screening. Additional checks were made during the first few days.

3.5 In our survey, 77% of children said that they were treated well in reception which was similar to other young offender institutions (YOIs).

3.6 Boys were located on Collingwood unit and girls on Keppel unit. Cells were adequately equipped and had in-cell showers. Laptops were issued on the second day which enabled children to submit their food requests, make applications, order phone credit and order from the prison shop.

Collingwood unit

3.7 Induction had improved since our last inspection. Children on Collingwood received a 10-day induction programme off the unit which was run by Kinetic Youth who helped children to understand the sessions and regime. A comprehensive bespoke induction programme for girls was delivered on Keppel and there was now good management oversight of both processes.

3.8 During induction, a psychologist and other professionals met to formulate a 'My story' for each child, which identified risks and needs.

3.9 Time out of cell on the induction unit was poor at weekends. Children on the gold regime spent less than four hours and silver regime less than three hours out of cell.

3.10 In our survey, 73% on Keppel and 71% on Collingwood compared with 53% at similar YOIs said that during their first few days at Wetherby they were told everything they needed to know about life in the prison.

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.

3.11 During the previous year, 288 safeguarding referrals had been made, 98 of which related to allegations of harm during restraint.

3.12 A dedicated team of staff made sure that good child safeguarding processes were in place. Joint triage by the child protection co-ordinator and designated social worker ensured that appropriate referrals were sent to the local authority designated officer (DO) within 24 hours.

3.13 The head of safeguarding held weekly meetings with the social work manager, who was also a member of the senior management team, and other internal managers to allocate actions. Scrutiny of referrals was good, including a weekly meeting with the governor and quality assurance every two months by the DO who checked that the triage system was working appropriately.

3.14 Although processes were good, children had little confidence in them. In our survey, only 37% said they would report victimisation by other children and 57% said they would report victimisation by staff. Eleven per cent said that they had felt too scared to make a complaint.

Suicide and self-harm prevention

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

3.15 During the previous year, there had been 892 incidents of self-harm and 205 ACCTs (assessment, care in custody and teamwork case management of children at risk of suicide or self-harm) had been opened involving 63 children. These were the highest self-harm rates for all prisons in the country.

3.16 Girls were particularly vulnerable to self-harm. Three girls had accounted for more than half the self-harm incidents in the last year, which had been the key cause of use of force and assaults on staff. Despite the best efforts of staff, who often had to intervene several times a night to remove ligatures, it was clear that the lack of flexibility in the daily regime and long periods locked alone in cells during the night and at weekends did not help to meet the needs of these very vulnerable girls.

3.17 Constant supervision had been used 10 times for girls and twice for boys in the last year and anti-ligature clothing had been used 23 times, mostly with girls. These figures were far higher than in similar YOIs. We had considerable concerns about the use of all male teams to cut the clothes of vulnerable girls under restraint and place them in anti-ligature clothing (see paragraph 3.37).

3.18 The quality of ACCT documents was good, reviews were timely and health professionals always attended. The care plans addressed the needs of the child and children we spoke to told us they felt supported by staff.

3.19 Although parents and guardians of children who self-harmed were informed of ACCT reviews, they were rarely included in the review meetings.

3.20 Safety data were discussed at a weekly safety intervention meeting and monthly joint safety and security meeting, but a safety action plan had only recently been developed and was not comprehensive. For example, leaders had identified that the quality assurance of ACCTs needed improvement, but there was no action to address this.

Security

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

3.21 The security team received a good flow of intelligence from across the site, largely involving weapons and violence. There was also emerging evidence of the availability of drugs and mobile phones. There were some weaknesses in physical security at the site which hindered leaders' ability to address these issues. Staff were not routinely searched and there were gaps in CCTV coverage.

3.22 During the previous 12 months, 26% of suspicion mandatory drug tests conducted had been positive, predominantly for non-prescribed medication and cannabis. Children who tested positive for illicit drugs were appropriately referred to the substance misuse services (see paragraph 4.81).

3.23 Intelligence-led searching was taking place, but leaders had not captured data on the number of requested searches that had been

carried out. In addition to cell searches, intelligence had led to 24 children being strip-searched over the last year (see paragraph 3.40). Most escort risk assessments were informed by medical considerations.

3.24 Leaders had applied proportional security measures to children on restricted status. They received access to a range of activities and time out of their cells equal to other children at the YOI, which was positive.

Behaviour management

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

3.25 Several incentives for good behaviour included: a three-tier incentives and earned privileges (IEP) scheme; Drake, the unit for children on the gold level; ROTL (release on temporary licence) and early release; and a weekly merit scheme to reward positive behaviour. Children could exchange their merits for items from the shop such as confectionery or toiletries. Fifty-four per cent of children were on the gold level of the IEP scheme, almost half of whom lived on Drake unit where children had more time out of cell and could eat meals together regularly.

3.26 However, in our survey, only 35% said the reward scheme encouraged them to behave well and we found that inconsistent application of the scheme undermined its effectiveness. Drake unit remained only half occupied because some children on the gold level living on other units had unresolved conflict issues. These children had a similar regime to those on the lower levels of the incentive scheme. The merit scheme was primarily used by teachers and rarely by wing staff which further reduced its effectiveness. Managers had not conducted weekly assurance checks to make sure that the reward schemes were being applied equitably.

3.27 There were several specialist units at Wetherby. The behaviour management strategy defined the purpose of these units more clearly than at the time of our previous inspection. More vulnerable children could be placed on Keppel unit where they lived in smaller groups and did not have to mix with the main site. Anson was a dedicated separation unit and Napier was an enhanced support unit for children who needed interventions from a number of agencies to meet their needs.

3.28 During the previous six months, there had been 1,323 adjudications. The quality of those we reviewed was variable which had been confirmed by quality assurance checks conducted by the deputy governor. Most charges were dealt with within appropriate time scales but there was little analysis of the data to help leaders address emerging issues.

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.

3.29 In our survey, while 40% of children said they had felt unsafe at Wetherby, 7% said they felt unsafe at the time of the inspection, compared with 21% at other YOIs. Our findings supported this view, with lower rates of violence on the main site where most children lived than at similar YOIs. The violence rate was notably higher on the Keppel unit where the girls lived.

3.30 During the previous 12 months, there had been 443 assaults, 39 of which had been recorded as serious, necessitating external escorts to hospitals.

3.31 Makeshift weapon making and the use of weapons during assaults was a concern. During the last 12 months, 32 assaults had involved the use of a weapon fashioned into a blade, 25 a blunt object and 10 a dangerous liquid. Leaders had introduced a 'weapon strategy' which had reduced the level of weapon finds over the last six months. However, a small number of children we spoke to who were aware of the strategy had found ways to conceal weapons from staff.

3.32 There were several different plans and interventions for children who were perpetrators or victims of violence including the enhanced support team, critical case panel, enhanced support supervision meeting, support team meetings and the safety intervention meeting. Many of these meetings duplicated discussions about the same child, not always with consistent staff at the discussions. The overlapping of meetings and variation in case management caused confusion to staff and children and plans were not always communicated to front-line staff effectively.

3.33 The reduction in the number of 'community' groups that children could attend combined with an increase in group sizes was encouraging integration. The largest group contained 29 children. However, staff shortfalls and regular cross-deployment of conflict resolution practitioners hindered the timely resolution of conflicts between children. The backlog of unresolved conflicts was increasing which affected the period of separation and access to the daily routine for many children.

3.34 The collection of data on violence including disproportionality, age, gender, location and weapons was commendable. However, the investigation of violent incidents was not thorough and leaders did not have an informed understanding of the causes of violence. The data were discussed at the monthly safety and security meetings but led to few actions.

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.

3.35 Use of force rates were similar to those in other YOIs, although notably higher on Keppel unit and very high for girls. During the previous year, 1,126 incidents of use of force had been recorded with 940 occurring on the main site and 186 on Keppel, including 155 involving the very small number of girls.

3.36 Records showed that about one-third of force had been used to prevent self-harm which reflected the presence of girls at the site. In our survey, 68% of children said they had been restrained, 79% of whom said that a member of staff had talked to them about it afterwards. Children were debriefed after most incidents by an MMPR coordinator (managing and minimising physical restraint).

3.37 In our review of recorded video footage, we observed that senior leaders did not routinely attend incidents to provide support to staff nor did they attend planned intervention briefings which resulted in poor management of incidents. Interventions lacked detailed planning and consideration of alternative resolutions, with staff focusing on swift intervention rather than negotiation. We raised with the governor our concerns about incidents where an all-male team was used to cut or remove the clothes from a vulnerable girl (see paragraph 3.17).

3.38 There was not enough oversight of camera footage of use of force. Leaders only reviewed footage referred to them after triage by MMPR coordinators. We reviewed randomly selected body-worn camera footage and observed poor practice, including the restraint of a child which resulted in an injury that had not been referred to senior leaders.

3.39 Pain-inducing techniques had been applied nine times in the last 12 months and on every occasion had been deemed inappropriate by the Independent Review of Restraint Panel. Advice and guidance had been issued to some of the staff involved, but there was a lack of emphasis on broader lessons to be learned from these incidents to prevent recurrence.

3.40 The frequency of strip-searching under restraint was also high. Twenty-four children had been strip-searched in the last 12 months with 12 of those occurring under restraint. Although leaders had recorded the decision to carry out a strip-search, none had recorded the authority to use restraint.

3.41 Most staff completed their use of force paperwork on time and there were few outstanding reports. Records of data collected on the use of force were good but leaders had not used this information to formulate

a plan with time-bound actions and clear lines of accountability to reduce levels of force.

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.

3.42 During the previous 12 months, 262 children had been separated using YOI rule 49 (separation for good order or discipline). The average length of separation had increased to 21 days, which was too long. Two children had been separated for more than 150 days.

3.43 Too many children were separated for long periods because staff shortfalls were delaying conflict resolution for too long (see paragraph 3.33).

3.44 Children on rule 49 received a very limited regime of less than two hours out of their cell a day. Most separated children lived on Anson where record keeping of daily activities was good and they were seen by a governor and nurse each day. Cells were reasonably clean and there was little graffiti, but the cells were too cold. Some face-to-face teaching was taking place which gave some children up to two hours out of their cells a day. This was a positive but inadequate step. Children on Anson spoke well of the staff and it was clear that staff knew them well. Reintegration planning was weak.

3.45 Children on rule 49 on the main units and Keppel received a far less favourable regime than those on Anson, particularly at the weekend when records showed that some children did not leave their cells at all. Case notes recorded on NOMIS demonstrated very little interaction with staff during this time.

Anson exercise yard

Anson cell

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 Most of the relationships between staff and children that we observed were positive. Staff had a good understanding of the children in their care and actively worked with them to try to address their concerns. Three-quarters of children in our survey said that staff treated them with respect and that they had a member of staff they could turn to if they had a problem.

4.2 Constructive relationships between staff and children contributed to more stable living units than at other YOIs. We observed confident staff working well to create well-ordered living units for the children.

4.3 All children, apart from those on induction, were allocated a custody support plan (CuSP) officer who was responsible for working with the child. This did not always happen as intended. Children and officers spoke regularly but CuSP sessions were not a priority in the regime. CuSP meetings often took the form of an opportunistic check-in rather than an in-depth support session working on progression, goals and behaviour.

Daily life

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

Living conditions

4.4 Most children at Wetherby were still accommodated in large, institutional 60-cell wings. The size of the units made it difficult for staff to manage conflict and was not appropriate for this age group. Many of the residential units, including Keppel, needed considerable investment to address faulty electrics, heating and water pressure for flushing toilets.

4.5 Three girls were held at Wetherby during the inspection. The designated unit for girls was part of Keppel unit but one girl was living on another Wetherby unit as leaders sought to best meet her needs. A negative impact of the girls living separately was they did not have any peer contact in the evenings and at weekends.

Girls' unit

4.6 In our survey, 31% of children said they felt cold in their cell. Some children on the main residential wings had cell window vents that were broken and slept in their day clothes to keep warm. Children on Keppel also complained of being cold because of broken cell windows and an unreliable heating system.

4.7 Communal areas in the facility were somewhat shabby but clean and tidy. Cells were generally maintained to a reasonable standard, although a few cells were dirty and untidy indicating that the occupant needed additional support with cleaning. The flooring was damaged in many cells. Some in-cell furniture was damaged and there were small amounts of graffiti in some cells. Leaders had recently reinstated weekly checks of units competing to be the best.

4.8 Children had in-cell laptops and telephones. In-cell showers had been installed in all the residential units, although some units on the upper landings that were not usually occupied did not have showers. Most children could shower in their cells, which was positive. Inadequate ventilation and steam from the showers were causing damp and peeling paint.

4.9 Children were provided with clean sheets, clothes and cleaning materials each week. Clothing was of a reasonable standard and children had recently been provided with new winter coats. The quality of towels was poor.

4.10 New seating and outdoor exercise equipment had been installed in the yards. A large bike track had also been built, but children were disappointed that there were few opportunities to use it.

Occupied cell

Residential services

4.11 In our survey, 50% of children said that the food was good.

4.12 Children could use their laptops to access menus which provided nutritional information and listed allergens. Children with food allergies and special diets were appropriately catered for. Evening meals were divided into portions in the main kitchen to ensure fairness and consistency. The quantity and quality of the evening meal were reasonably good, but some children said they felt hungry and would have liked larger portions.

4.13 Children on Drake and Collingwood units were able to routinely eat outside their cells daily. On other units groups ate out in rotation but keep-apart issues prevented some children from eating out of their cells more than about once every three weeks. We observed staff serving meals at cell doors, which was poor practice. The evening meal was delivered hot from the main kitchen and kept warm in the unit serveries, but some meals were cold by the time they were given to children at their cell door.

4.14 Children were consulted about food through surveys and the youth council, which was attended by the catering manager. A new healthy menu had been introduced in March 2023, but many children did not like the food. Children were surveyed and the menu was changed incorporating their feedback.

4.15 Catering staff had become aware of a number of children on the autistic spectrum who had difficulty with food. They were working with health care staff to determine the best way of meeting the children's nutritional needs.

4.16 The standard menu for the children's estate was offered, with a four-week cycle of choices for the evening meal. Children could choose from six options, including meals which catered for religious and other dietary requirements. Religious and cultural events were celebrated with a special menu.

4.17 Breakfast packs were small, consisting of a small bag of cereal with milk and tea. Children were provided with two snack bars each day.

4.18 A reasonable range of products were available for children to buy from the shop. The canteen list featured a wide range of confectionery, soft drinks and toiletries. However, children told us that they would like more options such as condiments, healthy food options and more hair products, particularly for black children. Children also told us they were worried that canteen prices might increase.

Consultation, applications and redress

4.19 The youth council had been relaunched in February 2023 with committed and enthusiastic staff leadership. Informal wing consultations were held regularly and issues raised were discussed at the youth council which was attended by staff and senior managers.

Minutes of these meetings indicated that children were able to raise issues and that these were actively addressed. Where issues could not be resolved, children were informed of the reasons.

4.20 Only four or five children usually attended council meetings. Attendance was affected by conflicting appointments or keep-apart issues with other children.

4.21 In-cell technology allowed children to make applications on their laptops (or on kiosks on their units if the laptop was broken). Children we spoke to liked using the technology and said the system worked well. Data were collated by the digital services team. Applications were tracked for timeliness and responses were generally timely.

4.22 During the previous six months, 301 complaints had been submitted. In our survey, 87% of children said they knew how to make a complaint. Complaint forms were submitted through a paper-based system to maintain confidentiality.

4.23 Management oversight and quality assurance of complaints were good and 10% of all responses were quality assured. Most responses to day-to-day issues, such as property concerns, were polite, showed a good level of investigation and focused on resolving the problem promptly. The response usually stated whether the complaint had been upheld or not. However, some responses to complaints from children who were subject to segregation and constant supervision did not adequately address the concerns raised. During the inspection leaders suggested that all complaints raised by segregated children could be quality assured in future to provide an additional level of safeguard.

4.24 Children could access information on their legal rights and sentencing on their in-cell laptops. Information was also available in the library and children could request additional materials if they were not available. Booking processes for legal visits were efficient and children could meet their legal representatives in private. Barnardo's met all children and gave them information about children's rights. Children could contact Barnardo's using their in-cell phones, to request support with complaints and legal matters.

Equality and diversity

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

Strategic management

4.25 Overall, equality work had improved since the last inspection. The team was well resourced with an equality adviser, an officer and, more recently, an analyst. The team had a good understanding of the protected characteristics encompassed in the population and gathered accurate and comprehensive information. They had started to develop an understanding of the needs of children in some but not all protected groups.

4.26 There had been a strong focus on making sure that the child's voice and experience were heard. Equality representatives had been introduced and an application system on the children's laptops gave them direct access to the equality team. Consultation had improved: there were now focus groups for some protected characteristics, such as black and minority ethnic children and faith, but not for disabilities and sexuality. Consultations were well structured and the outcome of focus groups was shared with all children through a quarterly newsletter called 'Change it or Explain It'. This described the issues raised and changes that had been made. A good explanation was given if changes could not be effected.

4.27 Just over a third of the population were from a black and minority ethnic background. The quarterly focus groups for these children enabled them to express their point of view and experience. Children told us of improvements, albeit sometimes slow, and gave examples of having their hair cut or access to hair products. Leaders had taken some action, such as putting videos on laptops to help children provide some level of self-care, and they continued to work on a long-term solution.

4.28 Both boys and girls spoke of unfair treatment due to their gender, for example girls were allowed to wear their own clothes while boys were not. There was limited work to understand the perceptions of different genders.

4.29 Just under three-quarters of the population had a disability, most of which were hidden disabilities. A recently appointed neurodiversity lead had encouraging plans to improve understanding and support for children with neurodivergent needs, but these had yet to be fully implemented (see paragraph 5.19).

4.30 About 10% of children were foreign nationals. A member of the resettlement team was the point of contact for the Home Office

casework team, which visited the prison regularly to meet new arrivals and discuss their status and next steps. Most children spoke English as their first language; there was evidence of interpreting and translation services being used where needed.

4.31 The data to identify disproportionality were good and all the protected characteristics were covered. Routine matters such as separation and use of force were reviewed, but also ad hoc data such as mandatory drug testing or closed visits to make sure that treatment was equitable. However, investigations to address the reasons for disproportionality were rarely sufficiently thorough. Some action was taken to address identified issues but this was inconsistent.

4.32 Our survey found that children's perceptions of their treatment were generally similar, whatever their protected characteristic.

4.33 The number of discrimination incident report forms (DIRFs) submitted had increased since the last inspection. During the previous six months, 67 had been submitted, 42 from the main site and 25 from Keppel. None had been submitted by girls. Almost half the responses were late, which undermined children's confidence in the process. The quality of the investigations that we reviewed was mostly good and there was an internal quality assurance process, although no external scrutiny.

4.34 Most DIRFs concerned race and almost three-quarters were submitted by staff about behaviour they had observed between children. Some children told us that discriminatory behaviour was not challenged consistently by staff, such as verbally abusive racial insults by other children. Leaders had recently amended the DIRF forms, so that staff had to describe what action they had taken. There were longer-term plans to deliver training with 'Show Racism the Red Card', an anti-racism educational charity.

4.35 An equality strategy contained important improvements, some of which were being delivered, including hearing the voice of the child (see paragraph 4.26). However, neither the strategy nor the action plan reflected the needs of the population, such as supporting children with hidden disabilities or the use of racial abuse among children. Equality work was supported by a monthly equality action group meeting which had reasonable attendance including a child equality representative, which was positive.

Faith

4.36 The faith facilities were adequate. Additional screening had been put into the multi-faith area, which allowed girls to worship together for Muslim prayers.

4.37 Communal worship was too limited and attendance depended on which residential unit children came from and whether they were in conflict. There was no rota and children were only made aware of whether they would be attending on the day before. Faith leaders told us that, on

average, children had the opportunity to attend a service every four weeks.

4.38 The chaplaincy was well integrated and provided good pastoral care for children. We observed several examples of members of the chaplaincy spending time with children who were separated or going through difficulties.

Health services

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

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

Strategy, clinical governance and partnerships

4.40 Leeds Community Health Care NHS Trust (LCH) was the lead provider of health services. They subcontracted child and adolescent mental health services (CAMHS) to South West Yorkshire Partnership NHS Foundation Trust (SWYFT) and GP services to Crossley Street Medical Practice.

4.41 A new health needs analysis to inform service delivery was due to be published in the next few months and was eagerly anticipated by the service.

4.42 NHS England (NHSE) held regular contract review meetings and were content with the delivery of services by LCH. They also met the provider and the senior management team each week to discuss operational issues and services for children exhibiting high-risk behaviours and self-harm. A broad range of governance meetings covered essential areas and facilitated collaborative working.

4.43 NHSE felt that the admission of girls had caused additional challenges, particularly with the substantial increase in levels of self-harm. There was a high level of vulnerability and complex health presentations for both boys and girls at Wetherby.

4.44 The overall quality of health provision remained good with an appropriate range of child-focused services and 24-hour nursing presence. The service was very well led and delivered by a conscientious and skilled staff group. Children we spoke to were satisfied with the quality of health care and we observed caring and professional interactions. Access to the service had considerably improved, mainly with an allocated officer to escort children to some of

their appointments. There were still some delays when this officer was not on duty.

4.45 Technical problems remained with IT and collecting accurate data which had been escalated to senior managers within LCH and NHSE. The service was keeping local spreadsheets to record their activity while the problems were being investigated.

4.46 Recruitment had been a challenge but had improved particularly within CAMHS which was now almost fully recruited. The primary care service used regular locum and bank staff to cover their vacancies while recruiting to these positions. Staff received very good training and clinical and managerial supervision with a focus on safeguarding and child protection which supported good standards of practice.

4.47 During the six months to the end of November 2023, 233 clinical incidents had been reported via Datix (an electronic clinical incident reporting and tracking system), 150 of which were due to self-harm which was high. There was good oversight and learning from adverse incidents.

4.48 Feedback from children about services, regular audits and involvement in the youth council informed service delivery. At the time of the inspection, representatives from each wing were being recruited for a patient forum which was to start soon.

4.49 All teams were co-located in a large open-plan office which promoted good communication and joint working. Daily multidisciplinary handovers and complex case reviews also encouraged integrated working and child-centred care. This was further embedded through representation at key meetings with other departments.

4.50 Most health services were delivered on the wings from suitable consultation and treatment rooms which met infection prevention and control standards. However, the waiting room in the main health care department was in need of redecoration.

4.51 Emergency resuscitation equipment was in good order and subject to regular, documented checking. Health staff had appropriate life support training.

4.52 Most complaints still arrived through the establishment system despite a well-advertised separate health care process. During the previous six months, six complaints had been received. They had been fully investigated and all the children were seen to resolve any concerns promptly.

4.53 Patient records were written comprehensively and in line with expected standards.

4.54 SystmOne, the electronic clinical record, was used by all health teams.

Promoting health and well-being

4.55 There was a whole-prison approach to promoting health and a jointly produced health and well-being strategy. The health teams worked with the health and well-being custodial manager to implement age-appropriate health promotion interventions, screening and advice. There were several examples of positive work with the catering manager to look at specific dietary needs, and bespoke sessions with the gym leading to improved health outcomes for some children.

4.56 Information about national campaigns was available to children in an accessible format. It was produced in different languages and in a variety of ways such as notice boards, newsletters and electronic messaging.

4.57 A proactive approach to promoting the importance of child health immunisations and vaccinations had led to good uptake.

4.58 Blood-borne virus testing and sexual health screening were offered and there was access to sexual health services. Barrier protection and related health advice was available, including on release.

4.59 Smoking cessation support was available and nicotine replacement patches were offered.

Primary care and inpatient services

4.60 All children were assessed for immediate health needs by a clinician within two hours of arrival and received child-friendly leaflets about health services and how to access them. Telephone interpreting services were available.

4.61 Subsequent assessments using CHAT (comprehensive health assessment tools) were completed within recommended timescales, including physical health, substance misuse, mental health and neuro-disability assessments.

4.62 Care plans were created using these data and were reviewed at least every three months by a multidisciplinary team. Services were offered again if they had been declined and relevant information was sent to the resettlement practitioner to inform release planning.

4.63 A good range of allied health professionals visited and waiting times were reasonable apart from long waits to see the optician and dentist at 11 and 15 weeks respectively. Additional sessions had been booked to help reduce these waits.

4.64 Nurse-led triage clinics were effective and urgent needs were prioritised. Dedicated GP clinics were held on each wing and children could be seen within a week for a routine appointment. All children could access urgent appointments when needed, irrespective of location. Out-of-hours cover was provided through NHS 111.

4.65 Children with long-term conditions such as asthma, diabetes and epilepsy received very good care from an experienced non-medical prescriber and other primary care staff. They also consulted the GP and community specialists for a coordinated approach when needed. Children participated in their own care and received regular reviews.

4.66 External health care appointments were well managed by the administrator with clinical oversight, and few were cancelled as a result of limited prison escort capacity.

4.67 Thirty-five per cent of children had reached the age of 18 years and there was now a formal partnership agreement for adult social care if needed.

Mental health

4.68 The CAMHS provision operated seven days a week and had improved considerably since our last inspection. Most vacancies had been filled and the team had good leadership and management, a clear structure and defined pathways.

4.69 The integrated CAMHS team comprised a highly skilled and competent multidisciplinary team that included psychologists, psychiatrists, learning disability and mental health nurses, occupational therapists and nurse associates. Staff were allocated to specialist pathways and worked flexibly and collaboratively to make sure that children received timely and appropriate care.

4.70 A trauma-informed approach was clearly embedded throughout the service and had influenced practice across health care. Staff took the opportunity to educate custodial staff, particularly in understanding the behaviours of the most vulnerable and complex children. Officers were invited to health-led learning events.

4.71 Children's mental health needs were assessed during their reception health screening, with specialist follow up within 72 hours. Following assessment, allocation and interventions were agreed at weekly multidisciplinary meetings, or sooner in urgent cases.

4.72 Due to the age, vulnerability and complexity of the cohort of children, the team maintained oversight of all children but delivered specific therapeutic interventions to about 80 children based on their individual needs. The team had no waiting list except for a small number of children waiting for diagnostic assessments for autism.

4.73 The most complex patients received enhanced monitoring and case management. Staff worked closely with custodial staff to manage children's risks and needs. They actively contributed to all ACCT reviews.

4.74 A dedicated team supported children with neurodevelopmental needs. This included those who had diagnoses of attention deficit hyperactivity disorder, autism spectrum disorder and learning disabilities. They

undertook initial screening for children with potential neurodiverse conditions.

4.75 The team now had a robust pathway to the harmful sexualised behaviours service provided by regional forensic CAMHS. There were six patients on this pathway.

4.76 Mental Health Act referrals and assessments took place in a timely manner. However, transfers were often delayed by bed pressures.

Substance misuse

4.77 In our survey, 44% of children said they had a problem with drugs on arrival and 80% said they had been helped with their drug and alcohol problems at Wetherby against respective comparators of 25% and 52%.

4.78 The young people's drug and alcohol support service (YPDASS) worked in partnership with the prison and shared information in line with the prison-wide drug and alcohol strategy.

4.79 YPDASS offered a range of psychosocial interventions, reflecting the needs of the population. Robust clinical arrangements were in place to support detoxification, which was rare. At the time of our inspection, no children were requiring opiate substitution therapy or alcohol detoxification.

4.80 Children's needs were assessed during reception health screening followed up by specialist assessments if needed. There were no waiting lists. All children were allocated to one of three pathways, which determined the service level offered and the frequency of reviews.

4.81 The team had a skilled and knowledgeable staff group who provided a good range of one-to-one interventions based on individual needs. They used a range of creative and appealing methods, for example games, competitions and quizzes, to educate children on the risks associated with substance use. They offered all children harm reduction advice, which was reiterated before release.

4.82 The team responded to information and intelligence from the prison and other health care teams by seeing patients promptly, for example following positive drug tests or symptoms indicating substance use.

4.83 The service received very good feedback from children, which showed their increased awareness of substance misuse, but also highlighted the good relationships they had with YPDASS staff. Because of this, they benefited from word-of-mouth referrals leading to increased engagement with other children.

Medicines optimisation and pharmacy services

4.84 Pharmacy services and the management of medicines were effective. The pharmacy team consisted of skilled pharmacy technicians and a pharmacist who provided good clinical oversight of medicines and led

on essential clinical audits. A monthly multidisciplinary medicines management meeting reviewed prescribing trends, any medicine incidents and local operating procedures. Medication returned for disposal and drug alerts were well managed.

4.85 Two senior pharmacy technicians led a team of technicians who made sure that reconciliation of medicines was timely following reception and that prescriptions were continuous and age appropriate. There were robust processes for the timely re-ordering of medicines.

4.86 A range of over-the-counter medicines were available and the regular GP presence on site, with other prescribers, meant that children had timely access to appropriate treatment.

4.87 The main pharmacy room which had been refurbished was clean and tidy and medicines were stored securely. The treatment rooms on the wings where medicines were administered were also of a good standard. Medicine cabinets were very well organised, with clear differentiation of supervised and stock medicines. Daily monitoring of drug refrigerators ensured that heat-sensitive items were stored within the correct temperature range. The room temperature was also recorded each day. Stock was checked and ordered each day if needed and received promptly.

4.88 Children could access urgent medicines and the in-possession policy allowed some children to take appropriate responsibility for their medication following a risk assessment, such as inhalers and ointments.

4.89 Medicine administration was completed competently four times a day by nurses or pharmacy technicians. Missed doses were recorded and followed up as necessary. Officers supervised medication queues well.

4.90 A reasonable range of patient group directions enabled nurses to administer specific medications, including vaccinations and medications for treating minor ailments, without an individual prescription.

Dental services and oral health

4.91 Primary dental services were delivered one day a week and oral health was promoted. There had been lengthy waits for routine dental appointments which had reduced to 15 weeks, but this was still too long. The service was working to reduce this further and managers monitored sessions closely to identify the issues and make improvements.

4.92 Staff tried to complete the treatment needed at the first appointment but, if further intervention was required, children were offered the next available appointment. Children with urgent needs were triaged by primary care staff, appropriate pain relief and antibiotics were prescribed and they were seen at the next clinic.

4.93 The service met the required clinical standards associated with infection control, decontamination, servicing of equipment, tool checks and waste management. However, the cleaning service provided by the prison was not always thorough enough for a clinical environment.

4.94 The service no longer had a local orthodontic treatment pathway to refer to. Interim arrangements had been made by commissioners for an orthodontist to deliver clinics on site for those patients who were already undergoing treatment. However, there was no referral pathway for new patients.

4.95 There was no written local operating procedure to capture the arrangements between the dental service and the orthodontist such as scheduling, and record-keeping. However, the head of health care had made a start on capturing this more formally.

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 Most children at Wetherby received between three and five hours out of their cell on weekdays. Children in Keppel received between four and six hours out of cell each day and those on the gold unit (Drake) received between six and seven, with an additional two hours delivered up to three days a week. While the average time out of cell for separated children was recorded as two hours, we found those separated on normal location (rather than Anson unit) could receive as little as 30 minutes a day out of their cell.

5.2 The key reason for these differences was whether children could mix with other children. Children on Napier received about three hours out of their cells on weekdays because several children were unable to mix without incident. The same applied to children on Exmouth and Frobisher where staff had to manage multiple groups.

5.3 During November 2023, records showed that girls received about an hour less out of their cells on weekdays than boys on both Keppel and the main residential units.

5.4 The daily routine did not always run to time because movements across the facility needed to be managed safely. Children could spend nearly an hour moving to education or work and this time out of cell was not meaningful or productive.

5.5 At weekends the regime was more limited. In our survey, just 37% of children said they had more than two hours out of their cell on a Saturday and Sunday. This was a serious cause for concern for children who spoke to us about the length of time that they spent bored and unoccupied.

5.6 Leaders monitored time out of cell, but we found that this consistently overestimated the reality for most children.

Sensory room Napier unit

5.7 The gym facilities were excellent, with a range of activity spaces across the site. Children were offered recreational gym twice a week and those on an education pathway could receive up to nine hours a week. In our survey, 54% of children said they were able to access the gym or play sports more than once a week compared with 30% at other YOIs.

5.8 A range of vocational training was available through the gym, including a healthy living course and assisting sports and physical activity. Completion rates for these courses were high. In addition, a football twinning programme was available with Leeds United Football Club and the Duke of Edinburgh Award.

5.9 Children on Keppel could take part in a park run every other week, which reflected the community programme and encouraged children to run together over two or five kilometres.

5.10 The library had been refurbished and offered a good environment for children. Most children could use the library each week, but it was more difficult for children receiving outreach education. The library was well stocked with a range of fiction, non-fiction and educational books, as well as a selection of magazines. Some materials more specific to girls were available.

5.11 Leaders had developed a reading strategy and it was good that an easy-to-read version was available to children. Some initiatives were in place to encourage recreational reading, such as financial and other incentives for writing multiple book reviews, world book night and competitions. However, there was a lack of structured support for emergent readers (see paragraph 5.22).

Library

Education, skills and work activities

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

Ofsted inspects the provision of education, skills and work in custodial establishments using the same inspection framework and methodology it applies to further education and skills provision in the wider community. This covers four areas: quality of education, behaviour and attitudes, personal development and leadership and management. The findings are presented in the order of the learner journey in the establishment. Together with the areas of concern, provided in the summary section of this report, this constitutes Ofsted's assessment of what the establishment does well and what it needs to do better.

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

Overall effectiveness:	Requires improvement
Quality of education:	Requires improvement

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

5.13 Leaders and managers had high expectations that children, including those most difficult to engage, would develop their knowledge, vocational and personal skills in order to play a valuable role in society. They had provided enough places for children to access education and training. Despite this, managers did not routinely make sure that the small number who received individual tuition were able to receive their full entitlement.

5.14 Leaders and managers had provided children with a welcoming, high-quality learning environment. They had recently re-decorated all the classrooms and refurbished them with new college-style furniture. Workshops had sufficient space and enough modern equipment for practical activities. Leaders had invested recently in new information and communication technology (ICT) equipment including the upgraded virtual campus (prisoner online access to community education, training and employment opportunities). The virtual campus was available in all learning areas, including the vocational workshops. Teachers used it regularly to enhance learning, for example using health and safety and cooking demonstration videos in catering and unique question generators in mathematics.

5.15 Support and progress coaches carried out comprehensive induction interviews with children new to the YOI which accurately identified their starting points. Using this information on individual children's educational history, they explored in detail with children their previous attainment, interests and any special educational needs. Coaches gave helpful advice to children on the options open to them for education and training and they created high quality personal learning and support plans. Managers used these plans effectively to inform the rapid allocation of children to activities. Pay rates rewarded good behaviour and were broadly fair and equitable.

5.16 Novus delivered education and vocational training in the YOI. Leaders and managers had introduced a curriculum which included the core subjects of English, mathematics and ICT alongside a beneficial personal, social, health and economic (PSHE) programme. Together these satisfied the core educational needs of the children. Managers had planned an additional vocational training curriculum informed by a review of employment opportunities. This was suitable for the large majority of children who were over 16 years of age. Children developed a range of basic vocational skills in construction, hotel and catering, barbering and cycle maintenance. In English and mathematics teachers did not use children's starting points sufficiently well when planning learning. As a result, children were not always provided with opportunities to develop new knowledge and skills. However, in vocational training teachers provided activities that ensured that children were highly motivated and made good progress. Managers

had been successful in limiting the number of withdrawals and most children achieved qualifications on the courses they started.

5.17 Leaders and managers did not provide an ambitious curriculum in English and mathematics. Too many children were studying at a level they had already achieved and as a result were not making progress in developing important new knowledge. Teachers in English and mathematics did not use interesting teaching methods to engage and maintain the interest of children in learning. As a consequence, particularly in mathematics, children's behaviour was often disruptive, which distracted others in the group and hindered their progress. Teachers did not always adapt their teaching strategies to meet the individual needs of children. Managers did not plan effectively to meet the needs of the small number of children studying English and mathematics at an advanced level. However, teachers working with children with particularly complex needs in the Napier unit used a variety of engaging resources, which met their individual needs so that they developed new skills and knowledge.

5.18 Children studying vocational subjects benefited from teachers who had much relevant industrial experience and planned interesting tasks. They enjoyed learning new skills and made good progress. For example, in barbering, children learned to wash and care for hair before developing cutting techniques. These skills were sufficient for those released on temporary license to offer a basic barbering service at a local centre for homeless people. In catering, children quickly learned barista, food preparation and customer service skills so that, under supervision, they provided the workforce for the staff coffee and lunch bar.

5.19 In too many cases for children based on the main unit, teachers did not give enough consideration to the needs of children who had education and health care plans to make sure that they made as much progress as possible towards their planned outcomes. Support for other children with special educational needs and/or disabilities (SEND) was largely effective. Teachers received individual guidance from support staff which enabled them to provide relevant support for children with SEND and most of these children made as much progress as their peers. However, the comprehensive plans of the recently appointed neuro-diversity manager to deliver wide-ranging training to staff across the YOI had yet to make an impact (see paragraph 4.29).

5.20 Leaders and managers provided a well-planned internal work programme for young people over the age of 18 years who had a choice of full-time employment or a combination of part-time work and part-time education. The employment opportunities, which included cleaning, recycling and orderly roles, reflected the processes and demands of typical work opportunities which the young people would face on release. Staff advertised vacancies with detailed job and person descriptions and young people applied for those roles which interested them. Prison staff interviewed the applicants and allocated a supervisor to those successful in gaining a position. The supervisor reviewed and discussed frequently the performance of the young

people and provided helpful advice on how to improve. As a result, young people developed good employability skills which prepared them well for seeking employment on release.

5.21 Leaders and managers did not have enough oversight of staff performance to take timely action to improve the quality of teaching. Although extensive quality assurance procedures existed in education, managers had failed to address the prime weakness identified at the previous inspection. The quality of the planning and teaching of English and mathematics was still not good enough. Managers did not routinely compare the differences in the pass rates or attendance at lessons of different teaching groups. As a consequence, they did not have a good understanding of where weaknesses in the provision lay or take effective action to improve these areas.

5.22 Managers had been slow to introduce initiatives to develop and extend children's reading. English lessons included library time, which often involved group reading and raised children's confidence. However, other actions to develop children's reading skills had not had a sufficient impact. For example, education staff had not received enough relevant training in how to use phonics to help children learn to read. Only recently had managers started to assess new arrivals for their existing reading skills. Managers did not know the extent of the reading deficit among other children. Managers had plans to offer non-readers peer support through the Shannon Trust (provides peer-mentored reading plan training and resources to prisons) but at the time of inspection the plan had not been implemented. Outside education, instructors and other prison staff did not have the necessary expertise or experience to help children develop their reading skills. As a result, not enough children improved these skills.

5.23 Leaders and managers had developed a wide-ranging personal development curriculum which enabled children to build their confidence, resilience and personal skills. Staff provided a curriculum based on the three themes of health and well-being, relationships and living in the wider world. Children enjoyed these lessons and participated in discussions about parenthood, healthy relationships, managing money and eating healthily, which prepared them well for adulthood. Children also benefited from high quality enrichment activities, such as the Duke of Edinburgh award scheme or, when released on temporary licence, charity work helping elderly people and homeless people. This developed their interests and understanding of good citizenship.

5.24 Leaders did not ensure that children had been taught sufficiently to protect themselves from the full range of risks associated with radicalisation and extremism. The PSHE curriculum ensured that children became aware of the dangers associated with exploitation and gang membership, particularly knife crime, but it did not have an appropriate focus on other threats such as religious or political extremism. As a result, children's knowledge and understanding of these risks was not good enough.

5.25 Managers did not prioritise punctuality. Too often, children did not leave the accommodation units until well after the start time for lessons which consequently often started late, curtailing learning time. Similarly, prison staff did not collect children at regular times to return to the units after lessons. Teachers could not be certain when officers would collect children which meant that learning frequently finished early and children waited for long periods. As a result of the inconsistent and uncertain movement times, children did not develop the discipline of time-keeping which they would need to succeed in further studies and employment on release.

5.26 There was good attendance at lessons and vocational training. However, in English and mathematics lessons attendance was low. Children in personal development and vocational sessions showed good behaviour and respect for one another. They were purposefully engaged and enjoyed developing new skills in areas such as managing money and removing and reassembling bike mechanisms. Teachers working with children in the Napier unit created a warm and welcoming learning environment. These children were highly engaged and proud of what they had learned.

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 Children were held some distance from their home area. More than three-quarters of the population were at least 50 miles away from home and some much further. There were good efforts to promote schemes that supported families in applying for financial assistance to visit their children.

6.2 Leaders had improved the social visit provision, with slots available at evenings and weekends, when it was more practical for families to attend. In our survey, 77% of the population said that they received visits and 56% said they were able to receive visits from family or friends once a week or more, compared with 35% at other YOIs and 9% at our last inspection.

Visits hall

6.3 A visit rota system was in place which meant that only certain wings could book visits on particular days. This resulted in many slots going unused, especially during the week. Visitors spoke well of their treatment by prison staff, but they were justifiably frustrated at the lack of facilities to buy hot drinks or food. The vending machines were sometimes unreliable.

6.4 During 2023, leaders had reinstated themed family visits once a month. These visits were more relaxed than social visits: children were allowed to move around freely and interact more with their family members. However, they were short, lasting just over an hour.

6.5 There had been a sharp decline in the use of video visits. At the time of the inspection, an average of 38 sessions a month were used compared to 430 at our last inspection. Leaders were unsure what had led to this decline, but children told us that the sessions did not operate on time, were short in duration and they were not sure how to access them.

6.6 Leaders had recently introduced a weekly allowance of at least five pounds so that children could make regular contact through their in-cell phones. The children we spoke to were appreciative of this.

6.7 There was good support for children who were fathers and social workers made sure that their views were reflected as part of their child's plans. The chaplaincy ran a Time for Dads course to provide support and guidance for fathers. So far in 2023, one course had been held with five participants.

6.8 A family therapist had been appointed recently which was a welcome further source of support to children and their families. The therapist's role was to help families overcome difficulties, maintain strong family ties during custody and support the release process.

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.

6.9 Work to reduce reoffending had been strengthened since the last inspection. Leaders had updated the reducing reoffending strategy earlier in 2023, informed by a needs analysis of the population. Work to deliver the strategy was overseen by a multidisciplinary group that met quarterly and progress was tracked. Developments included Department for Work and Pensions (DWP) input for 18-year-olds, emphasis on purposeful release on temporary licence (ROTL), themed visits and open days for youth offending teams (YOTs) and probation services.

6.10 Population pressures in the adult estate meant that more children than previously stayed at Wetherby beyond their 18th birthday. At the time of the inspection, 37% of the population were aged 18. Most of the population were sentenced with 28% on remand and a small number waiting to be sentenced.

6.11 The resettlement team was fully staffed and resettlement practitioners' (RPs) caseloads were manageable. RPs and case administrators received relevant training for their roles. In the continuing absence of Youth Custody Service training for RPs, leaders had arranged for them to attend modules of prison offender manager training and a manual for new staff had been developed. Children and 18-year-olds received good support from RPs and the social workers who worked with them. RPs had regular supervision from one of three hub managers with the fourth managing the case administration team.

6.12 Home detention curfew (HDC), transitions, parole and early release processes were managed well. Few children were eligible for HDC and, of the eight HDC releases in the previous year, one had left after their earliest HDC date while issues about his foreign national status were resolved.

6.13 A small group of children were eligible for ROTL. Nineteen, including two girls, had taken part in 368 ROTLs over the previous year to complete voluntary community work, the Duke of Edinburgh award, family contact, work experience, attend college open days and interviews or attend pre-release planning meetings at their YOT office. Overall, the cases that we reviewed indicated a risk-aware approach to ROTL with good contributions from internal and community partners, good assessment and a logical approach to determining suitability. Some RPs were more confident than others in recording risk assessment analysis (see paragraph 6.17).

6.14 Open days for YOTs and probation services were a good initiative to build relationships with these partners and aid joint working.

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.

6.15 Records indicated prompt contact by RPs with children who were initially seen a day or two after their arrival. Children said that they liked the consistency of having the same RP throughout. In our interviews, children confirmed that they saw their RP at least every two weeks. Some saw their RPs each week and more frequently during their trial,

before and after sentence and at other significant points in their detention.

6.16 Most children described RPs as responsive and helpful and always checking in with them. Slight variations in the RPs' approach to case management appeared to have created an impression that some were more helpful than others. This was compounded by inconsistent personal officer support and CuSP sessions for children to seek help with minor issues, with RPs often becoming involved instead (see paragraph 4.3). There was evidence of RPs appropriately challenging or praising behaviour and frequently updating the YOT and parents or carers. It was also evident that YOTs maintained contact with children between review meetings.

6.17 Regular remand or sentence planning review meetings took place with YOTs in attendance but there was limited involvement from residential staff. Parents and carers were encouraged to participate and, if a child declined to attend, the RP encouraged them to make a contribution and gave them feedback about the meeting.

6.18 The cases that we reviewed had up-to-date resettlement or remand plans which were appropriate and realistic. They all contained contributions from other teams working with the children (education, CAMHS and post-programme reviews if they had completed one) (see paragraph 6.37). Almost all resettlement plans referred to an intervention to reduce the risk of re-offending. Some plans that included an intervention screening were of better quality because they expanded on individual areas of risk and support and interventions that would help to manage and reduce risks.

6.19 Children confirmed to us their involvement in the planning process, but they did not always know if they had agreed objectives or what they were. The sharing of objectives with children was not routinely recorded on electronic case notes and, while leaders expected RPs to send objectives to children on their in-cell laptops, some RPs preferred to provide paper copies.

6.20 At the time of the inspection, 55 children needed to move to an adult prison. Transition work started in good time and usually involved the 18-year-old having at least one conversation with a member of staff from the prison they were moving to. Some prisons arranged to visit Wetherby before the transfer for a conversation and two adult prisons involved prisoner peer mentors in phone and video-link contacts, which was good. In common with other YOIs, the lack of access to OASys (offender assessment system) records limited the sharing with adult sites of the useful information about children recorded on the youth justice application framework (YJAF) system.

Public protection

6.21 Children with public protection concerns were identified on arrival. Prompt contact was made with YOTs and necessary actions taken to safeguard others.

6.22 Fewer children were subject to communications monitoring than at the last inspection and the backlog of phone calls that needed to be listened to had been substantially reduced. Staffing difficulties sometimes meant that calls were not listened to as promptly as they should have been, with some recent delays of up to three weeks. Monitoring was reviewed regularly and few children remained on monitoring for a sustained period. Staff used up-to-date lists of those subject to mail and email monitoring and contact restrictions.

6.23 The interdepartmental risk management team (IDRMT) meeting was now operating well and met monthly to consider relevant children. However, despite discussion of individual children, multi-agency public protection arrangements (MAPPA) levels were not always confirmed in time for release. Initial MAPPA eligibility was quickly identified and RPs approached YOTs or probation for confirmed levels six months before release. There was no escalation process when levels were not provided and leaders addressed this during the inspection.

6.24 RPs provided relevant information to MAPPA boards to inform decisions on children being considered for management at the higher MAPPA levels and took part in these meetings with community partners. Overall, the written contributions that RPs provided for MAPPA board discussions were reasonably good and offered relevant information and good insight into the presentation of the individual. Some were of very good quality with analysis of information and suggestions for safeguards or restrictions that could be used to manage risks in custody and the community. Leaders were receptive to the suggestion that other RPs could benefit by learning from these good examples.

Indeterminate and long-sentenced children

6.25 At the time of the inspection, the number of children with indeterminate sentences (19), or potentially facing one (18), had increased. They were subject to the same sentence and remand management planning arrangements as other children, together with the processes required for those serving life sentences. Some had completed an intervention while at Wetherby.

6.26 Leaders were aware of this change in the population and had recently organised a workshop with the Howard League to help children understand what they could expect at different points in their sentence. The contribution of an ex-prisoner on life licence after starting their sentence in a YOI was particularly useful in explaining their progression to release.

Looked-after children

6.27 Nearly half the population were looked-after children and another 32% were eligible for leaving care support. Four social workers seconded from community teams were based at the YOI and worked alongside RPs to identify children and 18-year-olds who were entitled to support from their local authority while in custody and on release. This

represented robust advocacy but, similar to other YOIs, not all local authorities made the contribution that was required of them.

6.28 Looked-after child reviews took place but few children had regular face-to-face contact with their home local authority social worker or personal adviser between formal reviews. The levels of financial support also varied between local authority areas.

6.29 'The Clear Approach', a supportive intervention for care leavers developed by the Care Leavers Association, was taking place with support from the dedicated social work team and Leeds Beckett University. After the fourth intervention had completed, funding for 100 social visits for children in care and care leavers had been provided by an external organisation.

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.

6.30 Discussions about release arrangements were timely and good quality release plans were prepared. Children approaching release were aware of the arrangements being made.

6.31 A pilot project for children released to the Greater Manchester area (the largest population group in the YOI) offered them and their families useful through-the-gate support from Barnardo's. Children on Keppel unit could take part in an In2Out programme (a charity that aims to reduce reoffending among young people aged 15 to 21). The programme took the form of a life skills challenge in preparation for independent living and children could undertake enrichment sessions and join the mentoring scheme which provided support before and after release.

6.32 Prison records showed that 70% of those released over the last year from a custodial sentence or on bail returned to their permanent or home address. The remaining 30% needed more help, and often escalation, by the YOI to make sure that accommodation was provided in time for release. During the previous year, 24% of children had been released to supported accommodation, 5% to approved premises and two 18-year olds had been released to temporary or hostel accommodation, which was poor. The on-site social work team leader had written to heads of children's services 22 times during the previous year on behalf of children for whom suitable accommodation needed to be identified as release approached.

6.33 For most children released from a sentence, accommodation was confirmed in time to support other elements of release planning. In 17% of cases, however, accommodation was not certain when the final release planning meeting took place which made plans for education,

training or employment and continuing support from other agencies harder to finalise.

6.34 Records showed that nearly three-quarters of children released had education, training or employment arranged. Attempts to monitor the success of release arrangements were hampered by limited feedback from YOTs. More positively, post-release and post-transition visits to children by RPs were encouraged and provided short-term follow up on the outcome of arrangements made and what had worked.

6.35 A DWP worker saw 18-year-olds being released to discuss work and benefits and arranged the necessary community appointments. Those who needed it were helped to open a bank account but this was not yet available to under 18s.

6.36 RPs made sure that all those released had someone suitable to meet them as they left the YOI and they could ask to have their stored clothes washed and mobile phone charged before release. Clothing, toiletries and plain bags were available for those who needed them.

Interventions

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

6.37 Children had access to the interventions approved for use by the YCS and input from the forensic psychology and forensic CAMHS teams. Unusually, three respondents to our survey identified interventions as the most positive thing at Wetherby with two citing specific interventions.

6.38 Screening for interventions was completed by RPs and reviewed at a monthly programmes allocation meeting. Sequencing took account of factors such as needing to work with the forensic CAMHS team, focusing on a specific educational need or a likely transition to the adult estate.

6.39 Interventions were delivered in groups or individually. Problems with children mixing together made it more difficult to run groups but one Life Minus Violence group (LMV, addresses violent behaviour) and two JETS (thinking skills) groups had successfully completed, with a third in progress. Individual children had also engaged with Feeling It (emotional awareness) and A-Z (motivation). Others with more complex needs had worked with the on-site forensic psychology team to complete Timewise (aggression in custody), EMDR (eye movement desensitisation and reprocessing, used to help recovery from distressing events), LMV, A-Z and Feeling It.

6.40 Families and friends were invited to celebrations to mark the completion of interventions and to post-programme reviews with YOT, probation and case workers to discuss the impact of the intervention and identify any further work needed.

6.41 Children completed specialist work to address harmful sexual behaviours delivered by the forensic CAMHS team (see paragraph 4.75) and family therapy work (see paragraph 6.8).

Health, social care and substance misuse

6.42 Transitions to the community or transfer placements were well planned. All children were seen before leaving, relevant interventions were carried out in good time and information provided. They were supported to register with a GP where appropriate and summary discharge reports were produced. Arrangements were made to supply medicines or prescriptions when needed to preserve continuity of treatment.

6.43 CAMHS worked closely with prison staff and community agencies to ensure effective discharges and transfers.

6.44 YPDASS actively supported release and transfer planning by providing handovers to receiving prisons and making referrals to community substance misuse services. Occasionally, they attended appointments in the community with patients to encourage engagement, which was positive.

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 in 2021, outcomes for children were reasonably good against this healthy prison test.

Key recommendations

Leaders and managers should better define the purpose of Keppel unit and put services in place that meet the needs of children placed there.
Achieved

The induction programme should engage children and ensure they understand the key aspects of life at Wetherby and Keppel.
Achieved

Known security risks should be thoroughly analysed to enable an appropriate response to emerging concerns.
Achieved

Leaders should improve oversight of children separated, ensuring that they can access a regime that is equivalent to that of their non-separated peers and that reintegration takes place at the earliest opportunity.
Not achieved

Recommendations

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

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

Care

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

At the last inspection in 2021, outcomes for children were reasonably good against this healthy prison test.

Key recommendations

Leaders should use data to identify and address inequitable outcomes and provide support to children with additional needs.
Not achieved

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

Recommendations

Patients requiring admission to hospital under the Mental Health Act should be transferred in accordance with the contemporary Department of Health and Social Care guidelines.
Not achieved

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

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

Purposeful activity

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

At the last inspection in 2021, outcomes for children were not sufficiently good against this healthy establishment test.

Key recommendations

The time that children spend out of their cells in activity should be increased, particularly at weekends.
Not achieved

Managers and teachers of English and mathematics should improve the planning and quality of the teaching in these subjects. They should use the information they collect through initial assessment to identify the specific skills that individual children need to develop, monitor their progress and support them to master these skills. English teachers should engage children more effectively in their lessons by using more stimulating resources.
Not achieved

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

Engagement and resettlement staff should work more effectively with the prison resettlement practitioners and community partners to enable more children to progress into further education, training or employment when they are released.
Achieved

Resettlement

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

At the last inspection in 2021, outcomes for children were not sufficiently good against this healthy establishment test.

Key recommendations

Prison leaders should extend visiting hours across the weekend to provide more equitable opportunities for children to receive face-to-face visits.
Achieved

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

Telephone call monitoring procedures should be reviewed to make sure that all monitoring is justified and legitimate and the backlog in call monitoring should be addressed.
Not achieved

The purpose of the interdepartmental risk management meeting should be reviewed and leaders should ensure that the meetings provide effective oversight of children's risk.
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; children and staff surveys; discussions with children; discussions with staff and relevant third parties; and documentation. During inspections we use a mixed-method approach to data gathering and analysis, applying both qualitative and quantitative methodologies. Evidence from different sources is triangulated to strengthen the validity of our assessments.

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

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

This report

This report 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:

Charlie Taylor	Chief inspector
Angus Jones	Team leader
Angela Johnson	Inspector
Dionne Walker	Inspector
Esra Sari	Inspector
Donna Ward	Inspector
Dawn Mauldon	Inspector
Emma Roebuck	Inspector
Emma King	Researcher
Sam Rasor	Researcher
Sam Moses	Researcher
Jasjeet Sohal	Researcher
Helen Ranns	Researcher
Alex Scragg	Researcher
Helen Downham	Researcher
Maureen Jamieson	Health inspector
Si Hussain	CQC inspector
Allan Shaw	Ofsted
Jonny Wright	Ofsted
Steve Hailstone	Ofsted

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/

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

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

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

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

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.

Social care package
A level of personal care to address needs identified following a social needs assessment undertaken by the local authority (i.e. assistance with washing, bathing, toileting, activities of daily living etc, but not medical care).

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

Appendix III Further resources

Some further resources that should be read alongside this report are published on the HMI Prisons website (they also appear in the printed 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.