Report on an unannounced short follow-up inspection of

# HMP & YOI Parc (juveniles)

1–5 October 2007

by HM Chief Inspector of Prisons

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1st Floor, Ashley House
Monck Street
London SW1P 2BQ
England

# Contents

# Introduction

Parc is a category B training prison and young offender institution near Bridgend, managed by Group 4 Securicor. This unannounced short follow-up inspection focused solely on Parc's 64-bed unit for remanded and sentenced young men aged 15 to 18 – the only juvenile custodial facility in Wales. In February 2007, the unit expanded from 36 beds and subsequently went through a difficult few months. Our inspection found that the unit was now more settled and was providing a reasonably safe and respectful environment, with plenty of purposeful activity and a sound approach to resettlement.

The unit had expanded without losing its focus on safety and safeguarding. The transition had been challenging, not helped by staff shortages, and there had been a significant increase in bad behaviour and indiscipline. These teething problems had now abated, with a concomitant reduction in adjudications and separation. Young people told us that they rarely felt unsafe. There were few instances of bullying or self-harm, and impressive multidisciplinary meetings sat daily to review the cases of vulnerable young people.

However, we were disappointed that juveniles continued to be transported with adults, and that routine strip searching took place on arrival. We were also concerned to find that some healthcare beds were being used to separate badly behaved young people; we considered this an inappropriate use of scarce specialist accommodation.

Accommodation remained clean and well maintained, and we welcomed the positive effect of communal dining. Relationships between staff and young people remained good, supported by an effective rewards and sanctions scheme, inclusive consultative arrangements, and a complaints system that utilised mediation where appropriate. The personal officer scheme continued to operate effectively, and the small number of racist incident complaints were dealt with appropriately. Healthcare was generally sound, although mental health provision was inadequate, and we identified serious failings with the pharmacy that required immediate rectification.

Young people spent plenty of time out of their cells. The quantity and quality of education had improved since our last inspection, and there was now good support for young people with basic skills needs. However, the curriculum remained narrow, and more help was needed for those with acute special needs. Vocational training opportunities had started to improve, and there was good access to high quality physical education.

Resettlement work remained good, with effective sentence planning and good links to community partners, particularly youth offending teams. While substance misuse services were effective and there was good support to maintain family links, there remained a need to develop appropriate offending behaviour programmes that addressed identified risks and needs.

Since our last inspection, the juvenile unit at Parc had gone through a rapid and difficult expansion, which had been challenging for staff. Commendably, the unit had retained its focus on safety, respectful treatment and resettlement, and had made some improvements to purposeful activity. There is still more to do, but the unit is well placed to contribute effectively to the criminal justice system in Wales. Indeed, the unit's expansion may mark an important

step towards housing all Welsh young people sentenced to custody in their home country, rather than being spread out across both England and Wales.

Anne Owers
HM Chief Inspector of Prisons

December 2007

# Fact page

Task of the establishment:
Young person's unit, located within a category B prison, which provides a local and training facility for both young adults and adults.

Area organisation
Parc is the only private prison in Wales, and is managed by Group 4 Securicor.

Certified normal accommodation
64

Operational capacity
64

Last inspection
Full: 9-13 January 2006

Brief history
The young person's unit first opened as a remand unit with a capacity of 28 beds five years ago, and expanded to 36 beds with a mixture of remanded and sentenced young people. In February 2007, the unit expanded to 64, again a mixture of remanded and sentenced young people.

Description of residential units
The 64 beds are split into two residential areas, one consisting of 28 beds, the other of 36. Both hold sentenced and remanded young people.

# Section 1: Healthy prison assessment

## Introduction

HP1 All inspection reports include a summary of an establishment's performance against the model of a healthy prison. The four criteria of a healthy prison are:

| | |
|---|---|
| Safety | prisoners, even the most vulnerable, are held safely |
| Respect | prisoners are treated with respect for their human dignity |
| Purposeful activity | prisoners are able, and expected, to engage in activity that is likely to benefit them |
| Resettlement | prisoners are prepared for their release into the community and helped to reduce the likelihood of reoffending. |

HP2 Under each test, we make an assessment of outcomes for prisoners and therefore of the establishment's overall performance against the test. In some cases, this performance will be affected by matters outside the establishment's direct control, which need to be addressed by the National Offender Management Service.

...performing well against this healthy prison test.
There is no evidence that outcomes for prisoners are being adversely affected in any significant areas.

...performing reasonably well against this healthy prison test.
There is evidence of adverse outcomes for prisoners in only a small number of areas. For the majority, there are no significant concerns.

...not performing sufficiently well against this healthy prison test.
There is evidence that outcomes for prisoners are being adversely affected in many areas or particularly in those areas of greatest importance to the well being of prisoners. Problems/concerns, if left unattended, are likely to become areas of serious concern.

...performing poorly against this healthy prison test.
There is evidence that the outcomes for prisoners are seriously affected by current practice. There is a failure to ensure even adequate treatment of and/or conditions for prisoners. Immediate remedial action is required.

HP3 This Inspectorate conducts unannounced follow-up inspections to assess progress against recommendations made in the previous full inspection. Follow-up inspections are proportionate to risk. Short follow-up inspections are conducted where the previous full inspection and our intelligence systems suggest that there are comparatively fewer concerns. Sufficient inspector time is allocated to enable inspection of progress and, where necessary, to note additional areas of concern observed by inspectors. Inspectors draw up a brief healthy prison summary setting out the progress of the establishment in the areas inspected. From the evidence available they also concluded whether this progress confirmed or required

amendment of the healthy prison assessment held by the Inspectorate on all establishments, but only published since early 2004.

## Safety

HP4 In 2006, we assessed the juvenile unit as performing reasonably well against this healthy prison test. Previously, we found that the unit provided an age-appropriate and safe environment. But escort arrangements were poor, and young people were routinely strip searched on arrival, sometimes using force. Since the previous inspection, there had been no changes in the transport or strip searching arrangements, and the capacity of the unit had almost doubled, from 36 to 64 beds. The one main recommendation in this area at our last inspection relating to transport had not been achieved. Of the remaining eight recommendations, three were achieved, four partially achieved and one was not achieved.

HP5 Young people continued to share transport with adult prisoners, and this needed to be tracked better.

HP6 The capacity of the juvenile unit had almost doubled in 2007, but it continued to provide a fundamentally safe environment. Few young people said they had felt unsafe at Parc, and they generally felt supported by staff. We still had some concerns about aspects of the admission procedures, in particular the routine practice of strip searching. This was in contrast to risk assessed strip searching in other areas, with very good monitoring through daily multidisciplinary team meetings.

HP7 The period following the opening of the additional juvenile wing had seen a rapid increase in young people held at a time when some staff were new and there was no substantive manager. The number of discipline-related incidents, including the use of restraint and separation, had peaked during this period. The situation had improved considerably in the two months before our inspection. The use of restraint and the level of adjudications had reduced.

HP8 However, we were concerned to find that some healthcare beds were used for behaviour management. This was a new initiative, which we considered inappropriate.

HP9 Overall, the safeguarding arrangements remained sound. There was no evidence that bullying was a problem, and there were few incidents of self-harm. The daily multidisciplinary team meetings were an effective forum for monitoring individual young people who had self-harmed or had been bullied or were bullies. The safeguarding committee took into account the contributions made by young people at the consultative committees. Young people were no longer automatically monitored under the self-harm and suicide prevention system following receipt of vulnerability assessments from the Youth Justice Board.

HP10 On the basis of this short follow-up inspection, we considered that the juvenile unit was still performing reasonably well against this healthy prison test.

## Respect

HP11 In 2006, we assessed the unit as performing well against this healthy prison test. Previously, we found good relationships and a respectful, well-ordered environment

with generally good healthcare provision. There had been two recommendations on healthcare, which had both been achieved.

HP12 Relationships between staff and young people remained positive. The physical environment continued to be clean and well maintained, and young people were able to maintain good personal standards of hygiene. Young people were still able to take their meals together, which had a civilising effect.

HP13 Approximately 6% of the population were from black and minority ethnic backgrounds. There were few reported racist incidents, and such complaints were investigated properly and closely monitored. There were no patterns or trends that raised concerns.

HP14 The rewards and sanctions scheme was effective in motivating good behaviour, and young people had confidence that they were treated fairly. Complaints were investigated properly and, where possible, an emphasis was placed on mediation.

HP15 Personal officers continued to carry out an important role supporting young people on a day-to-day basis. Problems relating to these officers' attendance at training planning reviews had been resolved by the introduction of a dedicated casework team. This ensured that relevant output from the wing was consistently provided at reviews.

HP16 Young people were able to exercise some influence over the way the unit was run through the inclusive consultative committee.

HP17 Two dedicated young people's support nurses had been appointed since the previous inspection. This initiative ensured access to a wide range of clinical services, and they had made good links with local school health services and health visitors. Dental services were excellent, but mental health services were poor. Healthcare staff and the mental health in-reach team offered support but there was no community adolescent mental health service (CAMHS) input, and young people with serious mental health problems were transferred elsewhere – usually to HMYOI Ashfield.

HP18 Although there was a good service from the pharmacist, we identified serious management irregularities, and auditing procedures were inadequate.

HP19 On the basis of this short follow-up inspection, we considered that the unit was still performing well against this healthy prison test.

## Purposeful activity

HP20 In 2006, we assessed the unit as performing reasonably well against this healthy prison test. Previously, we found education was deficient in several respects, but young people spent much time out of their cells and had daily access to the fresh air. There had been improvements generally, but the curriculum remained narrow, and leadership and management still needed to improve. There had been one main recommendation in this area, which was achieved. Nine out of 10 other recommendations were achieved, and the remaining one partially achieved.

HP21 There was good access to PE and delivery of PE was of a very high standard. There were improved library facilities with good access. Young people continued to receive

ample time unlocked out of their cell, and also got plenty of access to the fresh air on a daily basis, although the outdoor areas remained austere.

HP22 The quality and amount of education delivered had improved. Young people with basic skills needs now received adequate support. Attendance at classes continued to be good, and standards of teaching ranged from outstanding to satisfactory. Behaviour in classes was good and well linked to the rewards and sanctions scheme. Resources for teaching had been increased, and the accommodation had also been improved. Shortcomings in leadership and management had affected overall development of the provision. However, the curriculum was still too narrow, particularly for the more able students, and new initiatives were introduced in an unplanned way. There was insufficient classroom support for young people with acute special needs.

HP23 Opportunities for vocational training had improved, but were still very limited. There were well-advanced plans to improve this.

HP24 On the basis of this short follow-up inspection, we considered that the unit was still performing reasonably well against this healthy prison test.

## Resettlement

HP25 In 2006, we assessed the unit as performing reasonably well against this healthy prison test. Previously, we found that young people were well prepared for release, and this remained the case. There had been one main recommendation in this area and four other recommendations, all of which were achieved.

HP26 The training planning framework remained strong. Reviews provided a firm basis for planning how young people would serve their time constructively and be a preparation for release. Working relationships with community-based colleagues, in particular youth offending teams, were good.

HP27 Young people with substance misuse needs continued to receive good support with effective pre-release planning, and the young people's substance misuse service was well integrated into the good multidisciplinary arrangements.

HP28 The assistance for young people to maintain contact with their families had been increased to match the growth in the population. Access to visits and telephones was better than in comparator juvenile establishments.

HP29 The absence of any offending behaviour programmes was a significant weakness, but there was now work in hand to address this deficit.

HP30 On the basis of this short follow-up inspection, we considered that the unit was still performing reasonably well against this healthy prison test.

# Section 2: Progress since the last report

The paragraph reference number at the end of each recommendation below refers to its location in the previous inspection report.

## Main recommendations (from the previous report)

to the Director HMP & YOI Parc

2.1 The quality and amount of education provided, especially to juveniles, should be improved and monitored as a matter of urgency. (HP46)

Achieved. Measures taken had resulted in improvements in these areas (see education, training and library section).

## Recommendations

to the Youth Justice Board

2.2 The Youth Justice Board's placement system should ensure that young people from Wales are not located in English young offender institutions if there are places available at Parc. (9.54)

Partially achieved. The vast majority of young people held at Parc were Welsh. The unit's capacity had almost doubled to 64 since the previous inspection, with the addition of a second wing, which allowed more Welsh young people to be held in custody in their own country. At the time of the inspection, there were only four young English people in Parc. Each had been placed at Parc as part of a planned process, which involved discussions between the YJB, the relevant youth offending team (YOT) and the prison. Most young people held were sentenced and serving short sentences. The unit was not delivering any offending behaviour programmes and was not resourced to cater for the needs of young lifers and those serving long sentences. Prison staff estimated that there were currently between 20 and 30 young Welsh people in English establishments serving long sentences. We were not convinced that transferring them to a prison in England would ensure that their needs as young people serving long sentences would be met.

Further recommendation

2.3 There should be sufficient capacity and adequate resources in Wales to ensure that all sentenced Welsh young people (including those serving life sentences and long sentences) can serve their time in custody at an establishment in their home country.

2.4 Juveniles should not travel in escort vehicles with adult prisoners. (9.55)

Not achieved. Staff working in the admissions area informed us that at least 50% of young people arriving at the prison continued to share transport with adults. Previous records that detailed when this occurred were no longer kept. The lack of such records meant that this matter was not properly addressed.
We repeat the recommendation.

Further recommendation

2.5 Records should be kept of all instances where young people share transport with adults. This information should be passed to the YJB monitor and raised with the escort providers.

## Recommendations

To the director

### First days in custody

2.6 New arrivals should be escorted to the juvenile unit as soon as their warrants are checked so that the remainder of the admissions procedures can be carried out on the juvenile unit. (9.56)

Not achieved. Young people continued to be admitted via the main admissions entrance, where they remained until their warrants were checked and they had all received a routine strip search. Normally this process took around 30 minutes for adults, but for the juvenile new arrivals the initial procedures lasted longer, often over an hour.
We repeat the recommendation.

### Additional information

2.7 All young people continued to be admitted to the establishment through the main reception area. Although at times they were in sight and hearing of adult prisoners, they were always under the supervision of a member of staff from the one of the juvenile wings. A holding room had been designated for juveniles-only use. This was clean and sparsely furnished, but had no information on display. We were told that there had previously been posters with general information and an explanation of unit routines, but these had been removed as they had been damaged.

Further recommendation

2.8 Relevant information, in a durable format, should be displayed in the juvenile holding room.

### Residential units

*No recommendations were made under this heading at the last inspection.*

### Additional information

2.9 Communal areas were kept clean and tidy, and an award for cell of the week encouraged young people to keep their cells clean. Cells were adequately furnished, and there were clear arrangements for changing bedding and washing towels and clothes. Young people appeared to take a pride in their appearance. In our survey, 96% of respondents said they were able to shower every day, which was significantly better than the comparator[1] of 53%. Young people ate together at all meals, and were joined at mealtimes by staff. The atmosphere was positive and sociable.

1 The comparator figure is calculated by aggregating all survey responses together and so is not an average across establishments.

## Relationships between staff and young people

*No recommendations were made under this heading at the last inspection.*

## Additional information

2.10 There were good relationships between staff and young people. Everyone used first names, and young people had no hesitation in approaching staff with questions or problems. Staff were responsive but clear in establishing the behaviour they required. Young person's unit community forum meetings were an effective means for young people to raise issues of concern, and minutes of the meetings showed that action was taken on the issues raised.

## Personal officers

*No recommendations were made under this heading at the last inspection.*

## Additional information

2.11 The role of the personal officer had been reviewed since the previous inspection. This review had exposed the difficulties in ensuring that a personal officer always attended the training plan reviews for the young people for whom they were responsible. We were told that this was mainly due to the inflexibility of the staffing schedule. A small casework team had been set up to improve the situation. Team members were responsible for all aspects of the training plan process, including scheduling, information gathering and also the chairing. The caseworkers liaised closely with personal officers, who continued to carry out the day-to-day work with young people. Although this scheme had been running for only a few months, the initial results were promising. Staff told us that it had already enabled a more consistent approach to training planning.

2.12 Young people continued to be positive about their experience of personal offers. In our survey, 63% of respondents said they had met their personal officer within their first week, and 57% said they found them helpful. Although not as good as at the previous inspection, these responses were above the comparators of 41% and 48% respectively.

## Safeguarding

2.13 Juveniles should not be routinely strip searched. This should take place only when appropriately authorised on the basis of thorough risk assessment that has identified a risk of serious harm to the child or others. (9.57)

Not achieved. Young people continued to be routinely strip searched on arrival and departure from the establishment. The searches were carried out in the main admissions area by staff who worked on the juvenile unit. Strip searches also took place on the juvenile unit, but this was not routine and was done on the basis of intelligence, and mostly initiated as a result of suspicion that a young person was in possession of drugs.
We repeat the recommendation.

2.14 Juveniles should never be strip searched using force. (9.58)

Achieved. Records indicated that no young person had been forcibly strip searched since the previous inspection. We were concerned to note, however, that the documentation used contained a section permitting the use of forcible strip searching under certain circumstances.

This gave the process an undue legitimation.
We repeat the recommendation.

2.15 Detailed records should be maintained every time a juvenile is strip searched, and these should be monitored routinely at the safeguarding meeting. (9.59)

Partially achieved. The log of strip searches carried out in the main admissions area did not distinguish juveniles from adults. The records did not specify the occasions when juveniles were searched or provide any background explanation. In contrast to this, the records of strip searches carried out on the juvenile unit contained adequate detail and were well documented. All instances of strip searching on the unit were discussed at the daily multidisciplinary team (MDT) meeting, where staff were able to identify any underlying patterns or trends.
We repeat the recommendation.

## Additional information

2.16 A multidisciplinary team (MDT) meeting took place every morning on the unit. This was chaired by the practice compliance and development manager and attended by staff from all areas in the unit. The meeting took the form of an extended handover, and also provided an opportunity for staff to share new information. The main focus of discussion was on various aspects of safety. All young people currently or actively subject to assessment, care in custody and teamwork (ACCT) self-harm monitoring, anti-bullying or child protection procedures were discussed routinely. Staff also used this meeting to confirm the initial judgement on cell share risk assessments. The MDT was an extremely useful and effective mechanism to keep all staff on the unit up to date on critical information about young people.

2.17 The safeguarding arrangements remained sound. In our survey, only 14% of respondents said they had ever felt unsafe in the prison, which was significantly better than the comparator of 29%. Safety concerns raised at the young person's unit community forum meetings were dealt with at the safeguarding committee. We were also encouraged by the continuing close and transparent working relationship with the local social services department in relation to child protection.

## Child protection

2.18 All staff coming into contact with children on the juvenile unit should be trained in child protection. (9.60)

Partially achieved. All staff who came into contact with children on the unit, except the four most recently appointed, had received child protection training. There were plans to ensure that the new staff completed relevant training promptly.

Further recommendation

2.19 All new staff who are due to come into contact with children on the unit should receive child protection training before they commence their post.

## Suicide and self-harm prevention

2.20 The approach to managing juveniles on the F2052 system should be reviewed. (3.28)

Achieved. All procedures relating to suicide and self-harm had been reviewed in September 2006 when the new ACCT system was introduced. Young people who had self-harmed or were at risk of self-harm were managed well. There was not a great deal of self-harm, and the majority of ACCT documents were opened as a result of staff concerns rather than incidents of self-harm. Few young people were monitored through the ACCT system for long. There had also been refinements to the way that background information was used to make initial assessments (see following paragraph).

2.21 Formal self-harm monitoring procedures should not be used automatically following a 'vulnerability alert'. (9.61)

Achieved. Although most young people who arrived with a vulnerability alert from the YOT were placed on ACCT self-harm monitoring, this was no longer an automatic measure, but decided following an assessment. This assessment involved a staff interview with the young person, and checks on his background information and any other information available. We were told that in a few cases the vulnerability alert indicated that it was a young person's first time in custody, although staff knew this was inaccurate as these individuals had previously been in the unit. In these circumstances, staff based their decisions about vulnerability on the information they knew to be reliable.

## Bullying and violence reduction

2.22 A survey should be carried out to find out the extent of bullying and the reasons why it is not reported. (9.62)

Partially achieved. Although there had been a survey in September 2006 to determine the scale and type of bullying, the results had not been fully analysed or acted upon. The level of reported bullying remained low, but given our previous concerns about possible under-reporting, the accuracy of the reported levels was still not clear.
We repeat the recommendation.

## Additional information

2.23 We found no evidence that bullying was a serious problem. Our survey results indicated that young people generally felt well supported by staff – 67% of respondents said that staff had checked on them over the previous week to see how they were getting on, which was significantly better than the comparator of 32% and was also an improvement since the previous inspection. In our survey, 14% of young people said they had felt unsafe at some time at Parc, which was significantly better than the comparator of 29%.

## Race equality

*No recommendations were made under this heading at the last inspection.*

## Additional information

2.24 Young people from a black and minority ethnic background made up approximately 6% of the population, which was broadly similar to the previous inspection. Only two racist incident complaint forms had been submitted in the previous six months. Neither was serious, and both involved name-calling. In one of the incidents, a young black person alleged he had been racially abused by a member of staff. This allegation was properly investigated, and not proven. The other case had led to mediation between a member of staff and the complainant.

2.25 Detailed information about racist incident complaints was collated in the monthly safeguarding report, and considered regularly at the safeguarding young people committee. These reports contained clear information on the ethnic background of the young people involved, which helped to identify any significant patterns or trends. The information that we saw showed that racist incident complaints were taken seriously, and handled thoroughly and sensitively

## Contact with the outside world

*No recommendations were made under this heading at the last inspection.*

## Additional information

2.26 In our survey, 86% of respondents said they could use the telephone every day, which was significantly better than the 49% comparator. Similarly, 73% said they received two or more visits a month, which was also significantly better than the comparator of 45%, and 61% said it was easy or very easy for their family and friends to visit, which was significantly better than the comparator of 33%. The unit's family support worker was instrumental in ensuring that links with family were made quickly after the young person arrived. The work with families had been increased to match the growth in the population.

## Applications and complaints

*No recommendations were made under this heading at the last inspection.*

## Additional information

2.27 Complaints were investigated properly with an emphasis, where possible, on mediation. When staff found that a complaint was justified, an apology was made to the young person and remedial action taken.

## Substance use

2.28 There should be population needs assessments to inform the drug strategy and the development plan for the juvenile substance misuse service (JSMS). (8.49)

Achieved. A young people's substance misuse service (YPSMS) delivery and action plan had been produced following a needs assessment. This had performance measures, key service objectives and monitoring and evaluation criteria. The service worked to national specifications and was delivered by a service manager and two substance misuse service workers, one of whom was currently unable to have contact with young people due to pregnancy. This left a gap in the service, which reduced the number of programmes that could be delivered. However, recruitment for another worker was ongoing.

2.29 Specialist clinical advice should be available to doctors treating substance dependent children and young people. (8.52)

Achieved. One of the GPs had a special interest in substance use and was undergoing part two of the Royal College of General Practitioners' course in the management of substance users. Clinical detoxification protocols were in place, but the incidence of young people presenting with a serious drug problem was extremely low and usually confined to those using alcohol and benzodiazepines. Those testing positive to drugs were seen by the doctor the next day, and individual detoxification care plans initiated.

2.30 In light of the number of remands, the structured support for young people should be reviewed, and short duration courses considered. (8.57)

Achieved. Because of the restrictions on staffing levels, the number of courses delivered was limited. The manager and one worker effectively delivered all courses, and the manager's internal and external commitments also limited service delivery. However, there were regular stress management and basic drug and alcohol awareness courses, and additional courses were planned. Service delivery was generally done on a one-to-one basis, and it was planned to expand the limited groupwork when the new worker was recruited.

## Additional information

2.31 Young people needing drug support were well catered for. Despite the staffing limitations, young people with a substance use habit received good care and support. The substance use team was committed and conscientious, and keen to continue to improve services. The manager had excellent local and national professional contacts, and was able to tap into their resources where necessary. She was in regular contact with the local health board substance use lead and RAPt (Rehabilitation of Addicted Prisoners trust) workers.

2.32 All new arrivals had a substance use assessment – within five days for those on remand and within 10 for those on a detention and training order (DTO). The team saw young people assessed as in need of support on a monthly basis, which ensured continuity of support. We were told that alcohol and cannabis were the main substances used, and support was assessed on an individual basis. During their induction, all young people attended the basic drug awareness course. Alcohol, stress management and overdose prevention support were offered. There were excellent links with other young people's units, and teams met regularly to exchange ideas and procedures. Resettlement and throughcare were well established, and the team liaised well with local YOT teams and attended all relevant meetings. A copy of the young person's care plan was sent to his YOT team when he was released.

2.33 The team was fully integrated into the unit team and attended the daily multidisciplinary meetings. The YPSMS team made entries into young people's core record, so that all staff caring for them were kept informed of progress. All young people undergoing detoxification were placed on an ACCT until this was complete.

## Health services

2.34 The young person's support nurse should have structured nursing/healthcare assistant support to allow her to develop her psychiatric nursing skills and to take the juvenile health service forward. (9.63)

Achieved. The young person's support nurse (YPSN) had completed her psychiatric nurse

training and an additional full-time registered general nurse had been recruited. Both nurses were piloting a new shift system, which had improved young people's access to health services. Both nurses worked on split shifts, from 7am until 9.30pm from Monday to Friday, which provided greater continuity and meant that health support was available for most of the core day.

2.35 There should be a strategy to help 15-year-olds who are not permitted to purchase tobacco and prevent the practice of borrowing from others, and greater promotion of smoking cessation services for young prisoners. (9.65)

Achieved. Smoking was prohibited in the unit. All smokers were identified through the initial or secondary screening process and offered smoking cessation support through nicotine replacement therapy and psychological support.

## Additional information

2.36 Health services for young people were well structured, with good access to a wide range of clinical services. There were regular clinics from visiting health professionals, including a dentist, optician, sexual health consultant and chiropodist. Access to the doctor was very good, with little delay. Dental services were excellent and young people were seen at the next available clinic. Relationships between the young people and the dedicated nurses were professional, yet relaxed. The nurses operated an open-door policy, which worked effectively. They attended the morning multidisciplinary meeting and shared information where appropriate.

2.37 All new arrivals were seen in reception for an initial health screen. This was followed by a secondary screening within 48 hours, although there were some delays in completing this. The reception room was adequate, but there was no emergency bell system. There were health rooms on E1 and G1 with adequate accommodation, but the door on the G1room could not be unlocked from the inside, which left the nurse vulnerable.

2.38 The two nurses had links with local school health services and health visitors, and could obtain advice and guidance where necessary. Immunisation histories were checked and additional vaccinations initiated where appropriate. There were good relationships with local health promotion and public health bodies.

2.39 There were inpatient facilities for young people in a separate three-bedded unit in the main inpatient area. This was not ideal, but met the short-term needs of young people. We were concerned, however, that these beds were also used for separation of young people who were disruptive. This was unsatisfactory for the young person and those adults in the inpatient unit, and caused unnecessary stress.

2.40 Pharmacy services were generally good, although there were several irregularities in their management. For example, the pharmacy dispensed private prescriptions for staff. Medicines sent to wing treatment rooms had not been received, and some medications no longer required on wings were left outside the pharmacy and subsequently went missing. Healthcare staff entered the pharmacy when pharmacy staff were on duty, which was disruptive at busy times. Healthcare staff did not follow the policy covering use of the out-of-hours medicines cupboard. There were also occasions when pharmacy staff were asked to supply medication following the verbal instruction of a doctor relayed by a third party. Overall, pharmacy auditing procedures were inadequate.

2.41 Mental health services were poor with no specific child and adolescent mental health services (CAMHS) in place. Healthcare staff did their best to support young people with mental health needs and they managed them well. The primary mental health team provided necessary support, and the in-reach team for adults often offered assistance. Any child in crisis and seriously ill was transferred to another young people's establishment (usually HMP Ashfield). Community teams with clients in the unit regularly came to see them and provided clinical and practical support. However, staff were extremely concerned at the lack of a structured service to care for all young people with mental health needs.

Further recommendations

2.42 Secondary health screening should be completed within 48 hours.

2.43 The reception health room should have an emergency bell.

2.44 Inpatient beds for young people should not be used for non-health purposes.

2.45 The pharmacy door should be kept locked at all times, including opening hours. A proper record of the names, times and purpose for which the pharmacy is entered out of hours should be kept and maintained on a daily basis.

2.46 All medicines should be locked in appropriate storage facilities.

2.47 Prescribing for all prison staff should cease.

2.48 The pharmacy should ensure that wing health staff sign for all medications issued to wing treatment rooms. Any alleged disappearance of medication should be fully investigated, and the processes and outcome of any investigation recorded and audited.

2.49 Specialist psychiatric support for young people should be introduced as a matter of urgency.

Housekeeping point

2.50 The lock on the nurses' room on G1 should be replaced to enable the door to be unlocked from the inside.

## Education, training and library provision

2.51 Results of literacy and numeracy tests should inform teaching plans. (9.66)

Partially achieved. This now took place in some cases, but was not carried out uniformly.

Further recommendation

2.52 Initial assessments should be used in all cases to match young people's education plans to their needs

2.53 Specialist assessment for learning difficulties, such as dyslexia, should be available. (9.67)

Achieved. All young people were now assessed for basic skills. If concerns were identified, there was further diagnostic testing for specific learning difficulties, including dyslexia.

2.54 There should be more IT equipment for education and printers should function. (9.68)

Achieved. There had been considerable spending on updating and increasing the IT equipment, including the printers.

2.55 Teachers should ensure that young people understand the education targets set for them. (9.69)

Achieved. Young people had a better understanding of their targets than previously, and teachers made greater use of them in sessions.

2.56 There should be greater provision of basic skills and vocational skills training. (9.70)

Achieved. Young people with basic skills needs now received appropriate support. There had been an increase in vocational skills training, including the introduction of an industrial cleaning course and a cookery and hospitality programme, which included food hygiene. There were well-developed plans for a multi-skilling workshop, to include basic plumbing.

2.57 Induction should be provided for new teaching staff. (9.71)

Achieved. There was an appropriate programme of induction for new teachers, including shadowing an experienced member of staff. New teachers were now also given time to get to know young people before they became responsible for their classes.

2.58 All teaching staff should be appropriately qualified. (9.72)

Achieved. Teaching staff were now appropriately qualified, and unqualified basic skills staff were undertaking a level two basic skills teaching course.

2.59 Quality assurance arrangements for teaching should be improved. (9.73)

Achieved. Regular classroom observations now took place. Teachers also received helpful written feedback with suggestions for improvement.

2.60 Information on careers and links with external providers should be improved. (9.74)

Achieved. Careers Wales advisers offered a regular programme of careers guidance to all young people. Each young person was also offered a personal guidance interview.

2.61 An overall strategy for education budget plans, linked to curriculum development and quality improvement, should be drawn up and implemented. (9.75)

Partially achieved. There had been some progress in this area, but more work was still needed.

Further recommendation

2.62 The work on linking curriculum development and quality improvement to education budget planning should be developed further.

### Additional information

2.63 Overall, young people achieved satisfactory standards, but staff sickness absence had a negative impact on their attainment, which was not as good as at the last inspection.

2.64 Most young people had access to a range of appropriate accreditation, including in catering and hospitality, art and literacy and numeracy. A recent well-planned and delivered introduction to Learn Direct courses had extended opportunities to gain suitable accreditation in computing, the internet and driving. Young people enjoyed these courses as they could see the relevance to their everyday lives. However, they sometimes missed sessions due to poor communication between teachers and wing staff. Although young people could complete courses, such as GCSEs, that they had already started, there were few opportunities for higher level courses on the curriculum at Parc. Young people benefited from visits from external agencies, and also worked with a local theatre group on issues concerning substance misuse. The unit had received a business partnership award for this work in August 2007.

2.65 The current curriculum was too narrow, with too few opportunities for young people to prepare for working life, but there were well-developed plans to improve vocational provision (see also paragraph 2.56). There was no programme of personal, social and health education.

2.66 Teachers expected young people to behave well and most of them did so. Work in education and training counted towards increased opportunities for association and enrichment activity that young people could earn under the rewards and sanction scheme. Poor behaviour occurred in the few classes where teachers gave some young people low-level activities while they concentrated on those who were more interested in the subject. As a result, some young people felt less engaged, were unchallenged and became bored, and did not behave well.

2.67 Young people had benefited from recent improvements in the initial assessment of their literacy and numeracy, and extra help with their basic skills. All young people took a Basic Skills Agency test on entry, which a specialist teacher assessed to pick up any gaps and for further diagnostic testing, where necessary. Young people received sensitive feedback on their results and could discuss what they needed to do to improve. Teachers were told the results of these assessments, but not all kept copies in their files or used them to inform their lesson planning. This meant that not all young people with basic skills needs were engaged in classroom activity. Teachers did not get enough in-class support for the many young people with acute special educational needs, which made it difficult to meet their needs.

2.68 The quality of teaching ranged from outstanding to satisfactory. Teachers carefully assessed, tracked and recorded young people's progress in most classes. Most set targets for achievement, although they were not allocated time to discuss these individually. As a result, young people did not have the chance to focus on what they needed to do to improve their performance. Despite support from curriculum leaders, and considerable spending on new equipment in music and IT, not all teachers had access to or used a wide enough range of activities and resources to engage young people.

2.69 As well as the new induction programme (see paragraph 2.57), teachers benefited from a wide range of training, including child protection. Education staff contributed well to sentence planning and review processes. Teachers generally used good quality displays in classrooms to celebrate young people's achievement. Teachers showed good awareness of diversity issues, and young people took part in a project linked to a prison in Barbados.

2.70 The young people's education unit had recently moved into better accommodation, and young people benefited from learning in an improved environment. However, shortcomings in leadership and management remained. Managers did not involve teachers in decision making and in the development of the unit. There were no formal arrangements for teachers to share good practice in teaching strategies or in classroom management. Managers did not give education staff sufficient access to information and communications technology, including the internet, equipment and support. This made it difficult for them to plan and research, and make their sessions more accessible to young people.

2.71 Managers did not regularly collect data on the achievement of young people, so could not identify and direct improvements to those individuals or groups not achieving as well as they should have been or teaching areas where there was poor attainment.

2.72 A new library established on the education unit was well resourced and managed, and an improvement from the last inspection. Young people could borrow books regularly, and a librarian from the main library visited once a week to restock and take requests for additional books.

Further recommendations

2.73 There should be more opportunities for young people to gain higher levels of formal accreditation.

2.74 A formal programme of personal, social and health education should be introduced.

2.75 The curriculum should include more vocational provision and preparation for working life.

2.76 The quality of teaching and learning should be improved. Teachers should use a wider range of appropriate resources and activities to engage all young people, and use initial assessment to inform lesson planning so that all young people work at the appropriate level.

2.77 The quality of support for additional needs should be improved.

2.78 The quality of leadership and management should be improved, and teachers should be given more opportunities to be involved in quality improvement.

## Physical education and health promotion

*No recommendations were made under this heading at the last inspection.*

## Additional information

2.79 Young people received good opportunities to take in physical education, and the PE pathway was of a very high quality. The quality of teaching in PE was outstanding.

## Faith and religious activity

*No recommendations were made under this heading at the last inspection.*

## Additional information

2.80 There were arrangements for young people to take part in communal worship. In our survey, 60% of respondents said they had access to a chaplain within 24 hours of arriving at Parc, which was significantly better than the comparator of 41%.

## Time out of cell

2.81 Young people should be able to use the exercise yard for supervised outdoor activities. (9.64)

Not achieved. The exercise yards remained austere, and young people tended to simply stand in groups and talk when outside. There were plans to provide new exercise areas as part of the redevelopment of Parc, which was awaiting planning permission.
We repeat the recommendation.

## Additional information

2.82 Association was provided regularly each day, and we observed staff engaging with young people on a positive basis during these periods. Although exercise was a sterile experience, young people had the opportunity to go out into the fresh air at three set times during the day.

## Discipline

*No recommendations were made under this heading at the last inspection.*

## Additional information

2.83 We were told that, for a five to six month period following the opening of the additional juvenile wing in February 2007, it had been difficult to maintain the previous effective balance between care and control in the unit. The additional wing had rapidly filled with young people as soon as it became operational. Many of the staff at that time were also new and inexperienced. This period also coincided with an absence of a substantive manager. These factors combined to have an unsettling effect, with low staff morale and poor behaviour from young people. The number of discipline-related incidents that included the use of restraint and separation peaked at 28 instances in May 2007 and dropped to eight in June. However, the situation had improved considerably in the two months before our inspection, and figures for August 2007 showed a 40% drop in the use of restraint over the previous month. A new unit manager had been appointed and there were plans to create an additional middle manager post. The relatively positive staff attitude we saw indicated that morale was rising, and the use of restraint on young people, as well as the level of adjudications, had reduced since May 2007.

2.84 One measure introduced earlier in 2007 to deal with the increasing number of disruptive young people was to use three cells in the healthcare unit for behaviour management. Although we were pleased that the adult segregation unit had not been used to deal with disruptive juveniles, it was not appropriate to use medical beds for non-medical purposes (see paragraph 2.39 and recommendation 2.44).

2.85 The accommodation in the healthcare unit had been used for behavioural reasons on 11 occasions in the previous six months. Normally this was for a matter of hours, but in some instances it had been used overnight. Authority for use of this facility had to be sought from the head of the unit or the duty director and the controller. However, there was an absence of any proper governance relating to this procedure, which was a form of segregation. In the light of improved stability and in a relatively small and well-resourced unit, young people who needed to be separated from others temporarily should be managed within the unit.

Further recommendation

2.86 The practice of behavioural separation should take place on the juvenile unit with proper governance.

## Rewards and sanctions scheme

*No recommendations were made under this heading at the last inspection.*

## Additional information

2.87 An effective rewards and sanctions scheme was in place, and regular reviews were supported by some very good entries on young people's personal files. These also demonstrated regular contact between the young people and their key worker (personal officer). Young people took an active interest in what was written about them in their files. This, combined with the clear differentiation between the reward levels, had a motivational effect on their behaviour.

## Training planning and remand management

2.88 The juvenile substance misuse service should introduce age-appropriate groupwork to meet the needs of children and young people. (9.76)

Achieved. The YPSMS had introduced a number of age-appropriate interventions, including groupwork (see paragraph 2.32).

## Additional information

2.89 We observed one training planning meeting. Although this was well attended and competently chaired, the young person concerned was not present. He had opted to go to the gym instead, as his opportunity for PE was otherwise limited. Surprisingly, this request had been granted and the young person missed his review. Although this was not usual, young people should not be hindered from attending their reviews by competing activities.

2.90 Our survey responses about the planning process were positive. Sixty three per cent of respondents said they met their personal officer within the first week, 55% said they could see their training plan, and 75% knew how to get in touch with their YOT worker. Although these figures were not as high as at the previous inspection, they were significantly above the comparators of 41%, 35% and 57% respectively.

2.91 A wider examination of the documentation supporting the training plan process, and a discussion with an experienced visiting YOT worker, indicated that working relationships between YOT workers in the community and in the prison were good, and the overall planning arrangements remained sound.

2.92 There were currently no offending behaviour programmes for juveniles delivered in the establishment. The director had released funding to appoint two psychologists, one of whom was already in post, whose initial task was to research the most appropriate interventions for the population.

# Section 3: Summary of recommendations

The following is a list of both repeated and further recommendations included in this report. The reference numbers in brackets refer to the paragraph location in the main report.

## Recommendation to the Youth Justice Board

3.1 There should be sufficient capacity and adequate resources in Wales to ensure that all sentenced Welsh young people (including those serving life sentences and long sentences) can serve their time in custody at an establishment in their home country. (2.3)

## Recommendation to the Prisoner escort and custody service

3.2 Juveniles should not travel in escort vehicles with adult prisoners. (2.4)

## Recommendations to the Director

### Courts, escorts and transfers

3.3 Records should be kept of all instances where young people share transport with adults. This information should be passed to the YJB monitor and raised with the escort providers. (2.5)

### First days in custody

3.4 New arrivals should be escorted to the juvenile unit as soon as their warrants are checked so that the remainder of the admissions procedures can be carried out on the juvenile unit. (2.6)

3.5 Relevant information, in a durable format, should be displayed in the juvenile holding room. (2.8)

### Safeguarding

3.6 Juveniles should not be routinely strip searched. This should take place only when appropriately authorised on the basis of thorough risk assessment that has identified a risk of serious harm to the child or others. (2.13)

3.7 Juveniles should never be strip searched using force. (2.14)

3.8 Detailed records should be maintained every time a juvenile is strip searched, and these should be monitored routinely at the safeguarding meeting. (2.15)

### Child protection

3.9 All new staff who are due to come into contact with children on the unit should receive child protection training before they commence their post. (2.19)

## Bullying and violence reduction

3.10 A survey should be carried out to find out the extent of bullying and the reasons why it is not reported. (2.22)

## Health services

3.11 Secondary health screening should be completed within 48 hours. (2.42)

3.12 The reception health room should have an emergency bell. (2.43)

3.13 Inpatient beds for young people should not be used for non-health purposes. (2.44)

3.14 The pharmacy door should be kept locked at all times, including opening hours. A proper record of the names, times and purpose for which the pharmacy is entered out of hours shouls be kept and maintained on a daily basis. (2.45)

3.15 All medicines should be locked in appropriate storage facilities. (2.46)

3.16 Prescribing for all prison staff should cease. (2.47)

3.17 The pharmacy should ensure that wing health staff sign for all medications issued to wing treatment rooms. Any alleged disappearance of medication should be fully investigated, and the processes and outcome of any investigation recorded and audited. (2.48)

3.18 Specialist psychiatric support for young people should be introduced as a matter of urgency. (2.49)

## Education, training and library provision

3.19 Initial assessments should be used in all cases to match young people's education plans to their needs. (2.52)

3.20 The work on linking curriculum development and quality improvement to education budget planning should be developed further. (2.62)

3.21 There should be more opportunities for young people to gain higher levels of formal accreditation. (2.73)

3.22 A formal programme of personal, social and health education should be introduced. (2.74)

3.23 The curriculum should include more vocational provision and preparation for working life. (2.75)

3.24 The quality of teaching and learning should be improved. Teachers should use a wider range of appropriate resources and activities to engage all young people, and use initial assessment to inform lesson planning so that all young people work at the appropriate level. (2.76)

3.25 The quality of support for additional needs should be improved. (2.77)

3.26 The quality of leadership and management should be improved, and teachers should be given more opportunities to be involved in quality improvement. (2.78)

### Time out of cell

3.27 Young people should be able to use the exercise yard for supervised outdoor activities. (2.81)

### Discipline

3.28 The practice of behavioural separation should take place on the juvenile unit with proper governance. (2.86)

## Housekeeping point

3.29 The lock on the nurses' room on G1 should be replaced to enable the door to be unlocked from the inside. (2.50)

# Appendix I: Inspection team

| | | |
|---|---|---|
| Ian Macfadyen | - | Inspector |
| Angela Johnson | - | Inspector |
| Samantha Booth | - | Researcher |
| Rachel Worsley | - | Researcher |

**Specialist inspectors**

| | | |
|---|---|---|
| Bridget McEvilly | - | Healthcare |
| Margot Nelson-Owen | - | Healthcare |
| Jill Williams | - | Pharmacy |
| Stella Butler | - | Ofsted |
| Claire Yardley | - | Estyn |

# Appendix II: Juvenile population profile

| (i) Status | Number of juveniles | % |
|---|---|---|
| Sentenced | 46 | *82* |
| Remand | 10 | *18* |
| Total | 56 | *100* |

(ii) Number of DTOs by age & sentence (full sentence length inc. the time in the community)

| Sentence | 4 mths | 6 mths | 8 mths | 10 mths | 12 mths | 18 mths | 24 mths | Total |
|---|---|---|---|---|---|---|---|---|
| Age | | | | | | | | |
| 15 years | 2 | 0 | 0 | 0 | 1 | 1 | 0 | *4* |
| 16 years | 1 | 2 | 1 | 2 | 1 | 1 | 2 | *10* |
| 17 years | 3 | 3 | 3 | 0 | 4 | 4 | 4 | *21* |
| 18 years | 0 | 0 | 2 | 0 | 1 | 0 | 0 | *3* |
| Total | 6 | 5 | 6 | 2 | 7 | 6 | 6 | *38* |

(iii) This number of determinate sentences under section 53(2) or section 91 (by age & sentence length)

| Sentence | Under 2 yrs | 2-3 yrs | 3-4 yrs | 4-5 yrs | 5 yrs + | Total |
|---|---|---|---|---|---|---|
| Age | | | | | | |
| 15 years | 0 | 0 | 0 | 0 | 0 | 0 |
| 16 years | 1 | 0 | 0 | 0 | 0 | 1 |
| 17 years | 0 | 2 | 0 | 0 | 0 | 2 |
| 18 years | 0 | 0 | 0 | 0 | 0 | 0 |
| Total | 1 | 2 | 0 | 0 | 0 | 3 |

(iv) Length of stay for unsentenced by age

| Length of stay | <1 mth | 1-3 mths | 3-6 mths | 6-12 mths | 1-2 yrs | 2 yrs + | Total |
|---|---|---|---|---|---|---|---|
| Age | | | | | | | |
| 16 years | 3 | 0 | 0 | 0 | 0 | 0 | *3* |
| 17 years | 4 | 2 | 0 | 0 | 0 | 0 | *6* |
| 18 years | 1 | 0 | 0 | 0 | 0 | 0 | *1* |
| Total | 8 | 2 | 0 | 0 | 0 | 0 | *10* |

| (v) Main offence | Number of juveniles | % |
|---|---|---|
| Violence against the person | 17 | *30.3* |
| Burglary | 7 | *12.5* |
| Robbery | 14 | *25* |
| Theft and handling | 3 | *5.3* |
| Fraud and forgery | 1 | *1.7* |
| Drugs offences | 4 | *7.1* |
| Other offences | 5 | *8.9* |
| Breach of community part of DTO | 3 | *5.3* |
| Civil offences | 2 | *3.5* |
| Total | 56 | *100* |

| (vi) Age | Number of juveniles | % |
|---|---|---|
| 15 years | 5 | *8.9* |
| 16 years | 4 | *7.1* |
| 17 years | 33 | *58.9* |
| 18 years | 4 | *7.1* |
| Total | 56 | *100* |

| (vii) Home address | Number of juveniles | % |
|---|---|---|
| Within 50 miles of the prison | 49 | *87.5* |
| Between 50 and 100 miles of the prison | 4 | *7.1* |
| Over 100 miles from the prison | 2 | *3.5* |
| Overseas | 1 | *1.7* |
| Total | 56 | *100* |

| (x) Religion | Number of juveniles | % |
|---|---|---|
| Church of England | 4 | *7.1* |
| Roman Catholic | 2 | *3.5* |
| Other Christian denominations | 4 | *7.1* |
| Muslim | 2 | *3.5* |
| Other | 22 | *39.2* |
| No religion | 22 | *39.2* |
| Total | 56 | *100* |

# Appendix III: Summary of juvenile questionnaires and interviews

## Juvenile survey methodology

A voluntary, confidential and anonymous survey of a representative proportion of the juvenile population was carried out for this inspection. The results of this survey formed part of the evidence base for the inspection.

### Choosing the sample size

The baseline for the sample size was calculated using a robust statistical formula provided by a government department statistician. Essentially, the formula indicates the sample size that is required and the extent to which the findings from a sample of that size reflect the experiences of the whole population.

At the time of the survey on 28 August 2007, the juvenile population at HMYOI Parc was 52. All young people were sampled.

### Selecting the sample

Completion of the questionnaire was voluntary. Refusals were noted and no attempts were made to replace them. Two respondents refused to complete a questionnaire.

Interviews were carried out with any respondents with literacy difficulties. In total, four respondents were interviewed.

### Methodology

Every attempt was made to distribute the questionnaires to each respondent on an individual basis. This gave researchers an opportunity to explain the independence of the Inspectorate and the purpose of the questionnaire, as well as to answer questions.

All completed questionnaires were confidential – only members of the Inspectorate saw them. In order to ensure confidentiality, respondents were asked to do one of the following:

- have their questionnaire ready to hand back to a member of the research team at a specified time;
- to seal the questionnaire in the envelope provided and hand it to a member of staff, if they were agreeable; or
- to seal the questionnaire in the envelope provided and leave it in their room for collection.

Respondents were not asked to put their names on their questionnaire although their responses could be identified back to them in line with child protection requirements.

### Response rates

In total, 47 respondents completed and returned their questionnaires. This represented 90% of the juvenile population. The response rate was 90%. In addition to the two respondents who refused to complete a questionnaire, one questionnaire was not returned and two were returned blank.

## Comparisons

The following document details the results from the survey. All missing responses are excluded from the analysis. All data from each establishment has been weighted, in order to mimic a consistent percentage sampled in each establishment.

Presented alongside the results from this survey are the comparator figures for all juveniles surveyed in young offender institutions. This comparator is based on all responses from juvenile surveys carried out in all 14 prisons/ units since 2005. In addition, this document shows statistically significant differences between the responses of juveniles surveyed at HMYOI Parc in 2005 and the responses of this 2007 survey.

In the above document, statistically significant differences are highlighted. Statistical significance merely indicates whether there is a real difference between the figures, i.e. the difference is not due to chance alone. Results that are significantly better are indicated by green shading, results that are significantly worse are indicated by blue shading, and where there is no significant difference there is no shading.

It should be noted that, in order for statistical comparisons to be made between the most recent survey data and that of the previous survey, both sets of data have been coded in the same way. This may result in percentages from previous surveys looking higher or lower. However, both percentages are true of the populations they were taken from, and the statistical significance is correct.