the Howard League for Penal Reform

Analysis of the Inspectorate of Prisons Reports on Young Offender Institutions holding children in custody

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This is an analysis of the key weaknesses identified in the most recent Inspectorate reports for the following 15 Prisons and Young Offenders Institutions that have children in custody:[1]

Ashfield, Brinsford, Castington, Cookham Wood, Downview (Josephine Butler Unit), East Wood Park (Mary Carpenter Unit), Foston Hall (Toscana Unit), Feltham, Huntercombe, New Hall (Rivendale Unit), Parc, Stoke Heath, Warren Hill, Werrington and Wetherby.

Details of YOI	Key issues	Comments
Name: Ashfield **Date of Inspection:** 26-29 August 2008 **Gender/Age**: Male (15-18) **Operational Capacity/Actual Capacity:** 400/387	Court, escorts and transfers	**Page 16-17:** Frequent late arrival (2.10), given bags to urinate in instead of comfort breaks. (2.13)
	Personal officers	**Page 21**: Failure to visit young people whilst in segregation. (2.38)
	Self-harm and suicide	**Page 22:** Initial assessments not always comprehensive, reviews not sufficiently thorough or timely. (2.43) Formulaic, did not address identified needs. Didn't include social workers, YOT workers or families – distance from families cited. (2.44, 2.45)
	Child protection	**Page 22:** Previous policy published by not signed off by NOMS and local authority. (2.46) Children protection log not formally or regularly scrutinised by an independent source. (2.48) No onsite social worker – prison staff carrying out tasks in which they were inevitability less skilled. (2.49)

[1] Note: The reports analysed are the most recent reports on the HMIP website after 2007. Hindley and Low Newton have not been analysed as the most recent reports on the HMIP website precede 2007.

Details of YOI	Key issues	Comments
	Race equality	**Page 24**: 31% of black and ethnic minority young people said they had been victimised by staff - significantly worse than 15% comparator. (2.61)
	Complaints procedure	**Page 25**: Inadequate complaints procedure. (2.71)
	Security and rules	**Page 32**: All new arrivals routinely strip searched. All young people routinely strip-searched as part of a full cell search. Given that half of all cells were searched each month, most young people can be expected to be strip-searched every second month. (2.111)
	Discipline	**Page 32**: Young people held in the special cell over night. In 2 instances young people were held there long after their behaviour had settled. (2.118) **Page 34**: Incidences of spontaneous use of force remained high. (2.129) Staff working in segregation unit unsure how to deal with challenging young people. Not all had received mental health awareness training. (2.130) Young people in segregation unable to leave the unit to attend education, gym or religious services. (2.131)
	Rewards and sanctions	**Page 35:** Young people on basic regime could only make calls when on association, thus restricting their access to telephones and ability to maintain contact with family and friends. (2.137) Platinum level criteria included that the young person should have no findings of guilt on adjudication – resulted in automatic exclusion of some young people regardless of progress. (2.140)
	Resettlement	**Page 38**: Irregular reviews to address the needs of looked-after young people. No senior social workers. (2.152) Parole applications delayed. (2.154)

Details of YOI	Key issues	Comments
	Training planning and remand management	**Page 40**: Failure to integrate work of in-house YOT with casework team. (2.164) Lack of support for young people serving indeterminate/life sentences. (2.165, 2.166)
Name: Brinsford **Date of Inspection:** 28 July – 1 August 2009 **Gender/Age**: Male (15-18) **Operational Capacity/Actual Capacity:** 112/100	Arrival in custody	**Pages 20-21**: Routine strip searching rather than following a risk assessment, no formal first night strategy, vulnerability assessments not completed to a good standard. (1.13) Assessments carried out in the open making it difficult for young people to voice concerns. (1.19) **Page 22**: Vulnerability assessments – insufficient time to complete for later arrivals, important information often missed out e.g. previous self-harm. (1.24, 1.25)
	Residential units	**Page 27**: Entries in vulnerability assessments sometimes sparse. Failure to share knowledge between staff. (2.3) Insufficient screening in toilet areas, particularly as your people were sometimes required to eat in their cell. (2.5) **Page 28**: More than half of young people said that they could not shower every day. (2.8)
	Personal officers	**Pages 30 – 31**: No regular contact between personal offices and families/carers. Not routinely involved in training planning reviews. (2.34)
	Safeguarding	**Page 33**: No single safeguarding committee (but meetings covering each constituent part of safeguarding took place monthly). Inconsistent Brinsford representation. Lack of coherence. (3.1) Variety of information supplied to meetings but not routinely analysed. Use of special cell and strip clothing not routinely monitored. Difficult to establish a clear picture of safeguarding. (3.4)

Details of YOI	Key issues	Comments
	Bullying	**Page 34:** Over a third of young people said thy have felt unsafe at Brinsford. (3.10) Staff awareness of bullying and the anti-bullying scheme was mixed – led to inconsistencies in how the scheme was operated. (3.14)
	Self-harm	**Page 37**: No consistency in the representation from health care and no residential staff involvement at the suicide and self-harm prevention meetings. (3.30) Near death in custody of a young adult in March 2007 resulting in a recommendation for the need of healthcare involvement in ACCT reviews – only 1 of the 15 ACCT documents examined indicated any inclusion of healthcare staff in a review. (3.32) **Page 38**: ACCT used as a generic system to pick up anyone deemed vulnerable – no strategy or separate approach to the care of young people who were vulnerable due to their age, offence or poor coping strategies. (3.36)
	Child protection	**Page 39**: No procedure to consider investigations internally when allegations were made against staff. (3.43) No procedure to consider whether allegations against staff, although not a child protection concern, warranted an internal investigation. (3.47)
	Race equality	**Page 41**: 40% of black and ethnic minority young people said they had been victimised by staff (in comparison to 8% of white young people). Their responses were also significantly worse about treatment by escort staff and feeling safe on their first night.
	Contact	**Page 44:** Wing telephones could not be used in private. Little done to promote family contact. Young people had to wear bibs during visits and 25% (3.92) were randomly strip searched after visits. (3.80) 50% of young people said they had problems accessing the telephone. (3.82) Number of visits inadequate (3.85) and visits difficult to book (3.86).

Details of YOI	Key issues	Comments
	Health services	**Page 51**: Poor integration with other departments in the prison. Not regular attendees at all monthly safeguarding meetings and were not represented at training planning reviews. Not routinely invited to ACCT reviews. (4.3) Poor standard of cleanliness and upkeep in healthcare department. (4.4- 4.9) Problems with access to healthcare (4.20) and time taken to be seen (4.22).
	Education	**Page 61:** Too few activity places, limited vocational training, poor attendance at education. (5.1) Not possible to identify all young people with specific learning disabilities as there were insufficient qualified staff. (5.2)
	Faith and religious activity	**Page 65:** Difficulties with capacity. (5.32-5.35)
	Time out of cell	**Page 66**: Young people did not spend 10 hours a day out of their cell – recorded figures of around 8.5 hours during the week and 7.5 at weekends. Young people did not get daily association or exercise in the fresh air. (5.43) Only 5% of young people said they had association more than 5 times a week (significantly worse than the comparator of 46%). (5.44)
	Security and rules	**Page 69:** Published searching strategy required all new arrivals and 25% of young people leaving visits to be strip-searched. (6.1)
	Discipline	**Page 70**: Adjudications were held in the Intervention and Assessment Unit which was formal and not age appropriate.
	Rewards and sanctions	**Page 75:** Poorly kept paper work – points often deducted without supporting entries in wing file to explain why. (6.56)

Details of YOI	Key issues	Comments
	Training planning and remand management	**Page 83**: Quality of the planning was not consistent and tended not to address individual need. (8.14) Lack of co-ordinary between the training plan reviews and the initial planning reviews. (8.16) Attendance at reviews by staff based in the establishment was poor and personal officers were rarely present. Representation by education staff was erratic and healthcare staff did not appear to have ever attended a review. (8.19)
	Substance use	**Page 85:** Substance misuse nurses did not cover weekends and GPs have not undertaken specialist training. Mandatory drug testing rates for juveniles was 2% over the previous 6 months and procedures included strip searching. (8.28) **Page 86:** Mandatory drug testing was conducted by intervention and assessment unit officers who had not undertaken child protection training. Children and young people could be held for up to 5 hours and all were strip searched without risk assessment.
Name: Castington **Date of Inspection:** 19-23 January 2009 **Gender/Age**: Male (15-17) **Operational Capacity/Actual Capacity:** Unknown/132	Child Protection	**Pages 10-11:** Comprehensive child protection policy but not being implemented. Not all staff trained in juvenile awareness staff programme and less than 50% had been Criminal Records Bureau cleared (HP9). Child protection referrals were not analysed and there was no independent oversight of investigations relating to allegations concerning staff. **Page: 37** Not all staff were trained in child protection including those in key positions. (3.44) No independent involvement in investigations concerning allegations against staff. Majority of referral investigated internally. (3.49) Only 58% of staff overall trained in child protection (translating to 87% working with juveniles). (3.53) No in-house specialist counselling service for young people who disclosed historic abuse. (3.54)
	Bullying	**Page 11:** Inconsistent approach. Logging system for potential victims not used. (HP10)

Details of YOI	Key issues	Comments
	Suicide and self harm	**Page 11:** Large number of ACCT monitoring documents opened in previous 12 months (91 for juveniles), although many were precautionary and opened for short periods. Quality of ACCTs varied considerably. Evidence of engagement with young people in ACCT processes was also limited. No listener peer support scheme or equivalent.
	Injuries following control and restraint	**Page 11:** Young people had sustained seven confirmed fractures and three suspected fractures to their wrists (half to juveniles) during use of force incidents in the previous two years. Conclusion that C&R had not always been applied properly. (HP14) See also page 72.
	Healthcare	**Page 12:** Detox regimes lacked flexibility and were not patient centred. Joint work between healthcare, CARATS and YPSMS was not structured. (HP17) **Page 51:** Healthcare accommodation was poor and delayed the development of clinical services. Report expressed urgent need for this to be addressed – nothing done despite previous recommendations. (4.1)
	Legal services	**Page 14:** Legal services officer has no hours allocated for the role. (HP28)
	Education	**Page 17:** Inability to access nationally accredited psychology programmes. (HP 48)
	Arrival in custody	**Page 21:** Young people were strip searched each time they passed through reception, in addition to passing through a fixed metal detector, and searched with a handheld detector. Strips searches of juveniles were not based on a risk assessment. Reports by young people of being asked to squat during reception search. 68% of juvenile respondents said that they were searched in an understanding way (significantly worse than the comparator of 79%). (1.21) Initial interviews not carried out in a private place. (1.30)
	Accommodation and facilities	**Page 25**: Privacy – toilet screens in cells inadequate for share occupancy. (2.5)
	Cell bell	**Page 26:** Speed at which cells bells answered worse than in 2006. (2.8)

Details of YOI	Key issues	Comments
	Staff-prisoner relationships	**Page 28:** 46% of juveniles responding to survey said that there was someone that they could speak to if they were being victimised (significantly worse than 61% comparator). (2.33)
	Personal officers	**Page 29:** No specific training or ongoing supervision or guidance from managers. (2.37)
	Safeguarding	**Page 31:** Strategic management of safeguarding did not operate effectively. Limited analysis and not all safeguarding related areas were monitored. No multidisciplinary care planning for the most vulnerable people. Not all staff Criminal Records Bureau checked. (3.1) Out of date safeguarding strategy and based on previous structures. (3.2) Capacity of strategic committee to oversee all aspects of safeguarding effectively was affected by the fact that regular reports in relation to bullying, self-harm and child protection referrals were not prepared and analysis of data was limited. (3.4) Operation safeguarding committee established to have case discussions about young people who gave cause for concern but no agreed criteria to trigger such case discussion. Minutes did not indicate an in-depth discussion and no coherent strategy to identify and case manage the most vulnerable young people. (3.6)
	Bullying and violence reduction	**Page 32:** Information relating to violence reduction and anti-bullying was collected but not effectively evaluation thus the opportunity to understand the extent of violence and bulling was not fully used. (3.15) **Page 34:** Some bullying allegations were perfunctory and/or did not examine the issues in detail. Lack of clarity about when an individual became subject to an anti-bullying programme. (3.23)

Details of YOI	Key issues	Comments
	Self-harm and suicide	**Page 35:** ACCT data collected but not sufficiently analysed for trends. Quality of ACCTs varied, quality of assurance system was inadequate and had little impact on practice. (3.31) Poor management of suicide prevention – co-ordinator was a main grade prison officer with limited experience. (3.33) **Page 36:** No effective quality insurance systems for managing ACCTs. Specific issues were not incorporated into the safe custody continuous improvement plan and examples of concerns raised in reports continuing to be repeated in practice. (3.38) Considerable variance in quality of ACCT documents. Many had little or no link between the assessment and care maps and objectives often vague. (3.39)
	Diversity	**Page 39:** No overarching diversity policy.
	Race equality	**Page 40:** Negative perception of black and minority ethnic young prisoners about their experience at Castington. (3.68)
	Applications and complaints	**Page 43:** Monitoring and analysis of complaints were not used to identify patterns and trends. Responses to complaints were often curt and did not address the complaint. (3.98) **Page 44:** Few responses contained an apology, even when merited. (3.103) No analysis by type or trend of complaints. (3.105)
	Faith and religious activity	**Page 66:** 34% of juvenile respondents to survey said that they saw a chaplain within their first 24 hours – significantly worse than 58% response in 2006 report. (5.45)
	Security and rules	**Page 69:** Not all authorised strip searches of juveniles were based on supporting intelligence. (6.1)
	Discipline	**Page 71:** The number of fractures and suspected fractures sustained by young people during use of force gave very serious cause for concern. Regime for segregation of young people included some association but access to showers and telephones was restricted inappropriately. (6.16) Advocacy services did not see young people routinely before an adjudication hearing and young people were not asked at the hearing if they required the assistance of an advocate. (6.20)

Details of YOI	Key issues	Comments
	Segregation	**Page 73:** 41 juveniles segregated, 36 under GOOD and 5 for own protection. Recommendation that care plans should be introduced for juveniles in the SACU. (6.48)
	Catering	**Page 77:** Juveniles able to dine out of their cell but only for breakfast and evening meal on Finian and Godric units. Limited number of seats – those without seats had to eat in cell. (7.7)
	Sentence planning and offender management	**Page 82:** No offender management policy to differentiate the methods of assessment and management for juveniles.(8.9)
	Reintegration.	**Page 85:** 2 juveniles had been discharged without an address to go to.
	Oswald Unit Arrival	**Page 93:** Strip searched unnecessarily as young people were strip searched before transfer in secure conditions.
	Environment	**Page 94:** Ratio of 11 staff to 40 prisoners during the day and 7: 40 at night. Cell ventilators didn't close properly and cold air blew into the cell. (9.10) Showers and laundry facilities could only be used twice a week. (9.11)
Name: Cookham Wood **Date of**	Courts, escorts and transfers	**Page 19:** Sometimes travelling to and from establishment with adults which was inappropriate. Young people regularly handcuffed when they moved between the vehicle and reception area regardless of risk. (1.1, 1.2, 1.4)

[2] Anticipated capacity by 9 March 2009

Details of YOI	Key issues	Comments
Inspection: 2-9 February 2009 **Gender/Age**: Male (15-17) **Operational Capacity/Actual Capacity:** 157[2]/120	First days in custody	**Page 20:** No peer support scheme in place to help new arrivals either in reception or in the first night centre. (1.13) **Page 21:** Quality of vulnerability assessments was mixed – some were formulaic, relied too much on self-reported information and were not being reviewed. There was no quality assurance system in place. (1.16) All young people were given a routine strip-search. The search took place in a crowded property store. There was a notice in reception warning young people that they would be strip-searched using force if they refused to cooperate that was removed by the governor during the inspection. (1.18) Information booklet provided to newly admitted young people was not in an age-appropriate style or suitable for young people with limited reading ability. (1.20) The information booklet was only available in English. (**Page 22,** 1.26) **Page 22:** Young people complained about being locked up too frequently. (1.24)
	Environment and relationships	**Page 25:** Living units were poorly designed, creating a claustrophobic environment unsuitable for boisterous young people. Long, narrow corridors between cells were hot spots for fights. As a result staff hurried young people into their cells, preventing them from having information interaction with each other and creating tension and occasional conflict between staff and young people. (2.2) Cell bells were not responded to with any sense of urgency and the risk of failure to respond to a genuine emergency was high. Young people were not located according to any specific criteria. Complains by young people about excessively hot room temperature. (2.3) Single cells fitted with bunk beds to be used as double cells and a door that had screened the toilet had been removed. Too cramped for 2 young people to share a cell. Initial cell sharing risk assessments not regularly reviewed. (2.4) **Page 26:** Lack of basic information on daily routine and unit life. No information in languages other than English. (2.8)

Details of YOI	Key issues	Comments
	Relationships between staff and young people	**Page 27:** Relationships were frequently tense between staff and young people on the residential units. The development of good relationships was impeded generally by poor communication and specifically by weaknesses in procedures that were dependant on good communication. (2.22) **Page 28:** Varying levels of engagement between staff and young people – apparent that staff who would not have chosen to work with juveniles but had been required to do so lacked confidence in their ability to engage effectively. (2.25) Systemic weaknesses which made it difficult for young people to gain staff attention through formal procedures such as the complaints system, anti-bullying work, personal officers and unit-based consultation groups. Noted that young people resorted to extreme behaviour to gain attention. (2.26)
	Personal officer	**Page 28:** Personal officer scheme was not effective. No purposeful contact between personal officers and young people. Written records by personal officers were infrequent and lacked insight. Personal officers rarely attended important meetings relating to the care of young people they were responsible for. (2.28, 2.29-2.31) **Page 29:** Lack of effective personal officer work contributed towards poor coordination of individual care and inconsistency of support for young people. (2.32)

Details of YOI	Key issues	Comments
	Safeguarding	**Page 31:** Safeguarding children policy was not being fully implemented and much of the content was aspirational and unlikely to be achievable in the foreseeable future. (3.2) A considerable number of staff demonstrated little aptitude or willingness to make a successful transition from working with adult women to working with children and young people. Young people described discussion with staff who had expressed a preference to work with women. (3.3) Poor attendance at the safeguarding committee meeting. (3.4) Data collection and analysis were inadequate in all safeguarding areas. Some essential components of safeguarding were not routinely monitored by the safeguarding committee including injuries sustained by young people, the use of force and public protection. (3.5) Poor follow up action – e.g. staff whose Criminal Records Bureau checks had raised concerns had been discussed but it was unclear if these concerns had been address. (3.6) **Page 32:** Data collection and analysis of injuries sustained during restraint were inaccurate. Surprising that the inaccuracy of the data had not been identified by monitors from the YJB and the Women's and Young People's Group. Failure to analyse or monitor records of injuries sustained by young people. (3.7) Examples of punitive action against young people who had complained about bullying and were not taking part in the regime. Quality of care plans generally low. (3.8)

Details of YOI	Key issues	Comments
	Bullying	**Page 33:** The Cookham Wood anti-social behaviour strategy (CABS) had been updated in January 2008 but was not informed by relevant information about the extent and nature of bullying within the establishment and did not reflect some recent procedural changes. (3.18) Poor attendance at the monthly multidisciplinary violence reduction committee (3.20) and minutes from the meeting showed no reporting of data collection and analysis in relation to bullying prior to December 2008 (3.23). Staff and young people felt bullying was a significant problem – during the last quarter of 2008, 42 support plans and 70 action plans had been opened at a time when the population had not exceeded 99 young people. (3.23) **Page 34:** 26% of young people stated that they felt unsafe within the establishment (this was the same as the comparator). Records of investigations into bullying were frequently inconclusive and subsequent action plans were lacking. (3.28) CABS documents were often raised following investigations but were rarely implemented effectively. (3.29) **Page 35:** Many staff said they felt unable to tackle bullying as they have wished because they lacked clear guidance and direction. No officers spoken to were aware of the anti-social behaviour strategy. (3.32) All young people spoken to expressed a lack of confidence in the establishment's ability to support them or other young people who were being bullied. (3.33) A number of young people remained in their cells, refusing to go to education, dine out or associate because they were being bullied or feared being assaulted or getting into a fight. They did not have support plans and written records were poor. (3.36)

Details of YOI	Key issues	Comments
	Self-harm and suicide	**Page 36:** Suicide and self-harm policy did not reflect the needs of young people (3.48). There were no references to specific concerns regarding young people and no development objectives (3.49). **Page 37:** Poor attendance at the suicide prevention committee meetings. Data collected was not analysed by the coordinator or committee. (3.50) The suicide and self-harm prevention coordinator had not been able to attend the specific training course for the role. (3.51) Care maps were inadequate – the majority did not address the young person's individual needs and did not show that all appropriate sources of support had been explored. Action points were not always appropriate and were not allocated to accountable members of staff. Example – one goal listed was "To think about things." (3.52) Some ACCT documents had infrequent monitoring entries noted but there was no evidence of follow up action to address this. (3.53) Limited coordination between the suicide and self-harm coordinator and the violence reduction coordinator to establish whether the self-harming behaviour or concerns were related to bullying. (3.54) Poor contact with families of young people – never been invited to an ACCT review. (3.55) Not all night staff carried ligature shears (3.57).

Details of YOI	Key issues	Comments
	Child protection	**Page 39:** Comprehensive child protection policy but it had not been reviewed since December 2007 when it had been developed to cater for the small population of 17 year old girls held at Cookham Wood. (3.71) Poor attendance at child protection committee meetings. Poor follow-up after meetings. (3.73) Not all staff were CRB cleared. The cohort of detached duty staff which had arrived on the first day of the inspection were neither CRB cleared nor trained in child protection or working with children. Other groups of staff including healthcare staff, chaplains, operational support grades and visiting Samaritans had not been CRB cleared. 89% of staff had been trained in juvenile staff awareness programme (JASP) level one and only 68% had been trained to level two. There was no social worker with specific responsibility for looked-after children. (3.76)
	Diversity	**Page 41:** Action points from the diversity and race equality action management (DREAM) team meetings were not always followed up on. (3.84) Insufficient representation from young people. No support or training provided. (3.85, 3.86) **Page 42:** Black and ethnic minority young people said that they were discriminated against by staff and treated differently from white young people. (3.88) Apart from DREAM team meetings, there was no other formal consultation with black and ethnic minority young people. Only 40% of staff had received diversity training. (3.92) **Page 43:** The disability liaison officer rarely attended the DREAM team meetings or provided a report. (3.94)

Details of YOI	Key issues	Comments
	Foreign nationals	**Page 44:** The foreign nationals policy had not been updated following the re-role and did not reflect the circumstances of foreign nationals under the age of 18. (3.111) No external immigration advice and support agencies visited young people in the establishment. (3.112) No arrangements to meet young people regularly who were foreign nationals as a group to consult them. (3.114)
	Contact	**Page 45:** 46% of young people said they experienced difficulty sending or receiving mail, significantly worse than the comparator of 30%. (3.122) **Page 46:** Young people did not have daily access to telephones. Survey results showed that 48% of young people experience difficulty using the telephones, significantly worse than the comparator of 31%. (3.124) Inadequate visit entitlements (3.126). Inadequate visiting facilities (3.130).
	Applications and complaints	**Page 47:** Complaints were not dealt with well and young people had no confidence in the complaints system. Replies to complaints were not always concluded satisfactorily. No management quality assurance checks or analysis of patterns and trends. (3.141) **Page 48:** Young people told us that they did not appeal against decisions because managers always supported staff (3.145). Poor responses to many of the complaints examined (3.146).
	Legal rights	**Page 49:** No legal rights officers. Young people were obliged to rely on their solicitors for all aspects of their legal rights as there were no trained legal rights officers in the establishment. This was not satisfactory as the visits room was not suitable for legal visits and access to telephones was limited. (3.152)

Details of YOI	Key issues	Comments
	Health services	**Page 51:** The prison clinical governance group was scheduled to meet bi-monthly but had not met since October 2008 and attendance was poor (4.3). The medicines and therapeutics committee met quarterly – while Cookham Wood was represented at the meetings, there was no attendance by a GP and nurse representation was infrequent. (4.4) Healthcare staff did not routinely attend training planning meetings and reviews unless asked. While they did provide written information, this was often brief with similar entries for a number of young people. (4.5) **Page 52:** There did not appear to be a system for healthcare staff to communicate to wing staff. Some staff used the wing observation book while others spoke to officers but did not record the information.
		Page 53: No children's nurses. (4.13) Entries in clinical records were sometimes difficult to read and it was not always clear who had made an entry. (4.19, 4.20) **Page 55:** No provision for young people to obtain simple pain relief once nursing staff had left the establishment. (4.29) **Page 56:** Consultant psychiatrist had problems seeing all patients booked for his weekly clinic because of delays in escorting the young people to their appointments. (4.37)
	Activities	**Page 59:** Delays in joining the education induction programme because it was not a rolling programme. (5.2) Too few vocational places to meet the needs and preferences of young people. (5.3) **Page 60:** Inconsistency in the use of individual learning plans that were very basic and too vague to be useful. (5.11) **Page 61:** Inadequate support provided by Connexions – young people did not get enough careers advice. (5.12)
	Faith and religious activity	**Page 63:** Constraints on availability of chaplaincy as they were all part-time workers. (5.36) **Page 64:** Chaplaincy rarely represented at training planning meetings or ACCT reviews. (5.39)

Details of YOI	Key issues	Comments
	Time out of cell	**Page 64:** Time out of cell for those who could access all possible activities amounted to almost 10 hours a day but that was only possible 3 or 4 times per week. Time out of cell at weekends was greatly reduced. (5.43) **Page 65:** Records did not always accurately reflect when exercise was cancelled. (5.46) Time out of cell was reduced because staff did not adhere to scheduled unlock times (5.47)
	Security and rules	**Page 67:** All young people were routinely strip searched on reception, discharge and when taking a mandatory drug test. The log of non-routine strip searches did not record who had authorises the search. (6.4) The local searching policy stated that the use of force would be employed as a last resort if a young person refused to comply with a strip search. (6.5) Young people felt that there was inconsistency in how rules were applied by staff. (6.8)

Details of YOI	Key issues	Comments
	Discipline	**Page 68:** The minor report system was rarely used and a number of adjudications were found which might have been more appropriately dealt with through this system. (6.14) Paperwork given to young people on the day of adjudication was in a standard format used throughout the Prison Service and was not age appropriate. (6.16) **Page 69:** Levels of use of force were high. Data submitted to the YJB showed that levels of restrictive physical interventions per individual were amongst the highest in the juvenile estate. 35% of young people said they had been physically restrained compared with the comparator of 27%. (6.18) Very little analysis of use of force data by the establishment – no detailed trend analysis, no evaluation. (6.19) 16 occasions in the last 6 months of 2008 when the use of force had been planned but none of these had been video recorded. (6.21) **Page 70:** The restrictive nature of the layout of the separation and care unit made it difficult to ensure daily access to telephones and sufficient time out of cell. (6.24, 6.25) Young people complained of the cold in the separation and care unit. (6.24) The majority of young people did not attend education but instead completed work in their cell. (6.27)
	Rewards and sanctions	**Page 72:** The rewards and recognition scheme was not motivational. Targets set were not specific. (6.42) The scheme had a comprehensive and clear policy but there was no evidence of any governance of the scheme and a number of staff said they had never read the policy. (6.46) Review boards were triggered in an inconsistent way and were often carried out without the involvement of the young person. (6.47) **Page 73:** Monitoring of young people on basic regime was poor. Wing files had inadequate entries to inform weekly reviews. (6.48)

Details of YOI	Key issues	Comments
	Services	**Page 75:** Breakfast eaten in cells. Inadequate portions for adolescent boys. (7.3) Some young people lost their entitlement to dine out as a punishment while others were unwilling to eat communally because they feared being bullied or getting into a fight. Young people who refused to dine out were punished by having their electricity turned off or being given a demerit. This resulted in them ending up on basic level of the rewards and sanctions scheme eventually which exacerbated their difficulties.
	Resettlement	**Page 79:** There was a comprehensive resettlement policy but it had not been updated since the re-role. (8.2) A resettlement policy committee had not get been properly convened. (8.3)
	Training planning and remand management	**Page 80:** Reviews lacked multidisciplinary input and lack of privacy was an issue. (8.7-8.9)
	Reintegration planning	**Page 81:** Staffing shortages in the resident areas diverted the resettlement team from carrying out their designated function of individual casework. (8.14) **Page 82:** The use of ROTL was underdeveloped (8.19) There were no trained lifer officers for young people who had been sentences to an indeterminate sentence for public protection. There was no psychology support for young people serving long sentences for serious offences. No specialist input for young people convicted of sex offences. (8.20)

Details of YOI	Key issues	Comments
	Substance use	**Page 83:** The drug and alcohol strategy was out of date and under review. A population needs analysis had not been conducted (8.29) There was an agreement with the JYB that young people requiring stabilisation and detoxification would not be sent to Cookham Wood as there was no 24-hour nursing care. However this has happened on two occasions. (8.32) The YPSMS provided a limited range of services due to staff shortage and vacancies. (8.34) **Page 84:** One-to-one work was limited, there was no group work and the range of interventions on offer was inadequate. (8.37) The YPSMS did not provide information or support services to young people's families and carers. (8.39) Mandatory drug testing always involved strip searching without prior risk assessment (8.41)
Name: Downview (Josephine Butler Unit) **Date of Inspection:** 12-14 May 2008 **Gender/Age**: Women/17-18 **Operational Capacity/Actual Capacity:** 16/16	Psychology service	**Page 15:** No dedicated psychology provision for the Unit. Arrangement that a psychologist from a neighbouring prison attends was inadequate to fully meet the needs of the girls.
	Mandatory drugs testing	**Page 16:** Mandatory drug testing continued despite recommendations that adult-orientated practices and procedures of mandatory drug testing are not appropriate for young people. The girls reported feeling embarrassed by the process.(2.8)
	Personal officers	**Page 17:** Style and quality of the written contributions varied. Focus almost entirely on discipline and was overly punitive. Nearly half of the girls taking part in the survey said that they did not feel supported by their personal officer. (2.14)
	Child protection	**Page 18:** No joint training with Children's Services. (2.15) Child protection log not up to date – lack of scrutiny by local authority (2.16) The girls no longer attending safeguarding meetings (2.21)
	Self harm and suicide	**Page 21:** Key workers did not always attend ACCT reviews (2.29) Concerns about one young person who had self harmed and was put in strip clothing rather than being the subject of constant staff interaction and monitoring. (2.33) – strip clothing use not monitored.

Details of YOI	Key issues	Comments
	Substance use	**Page 25:** Shortage of support services – no respondents said they had received help with alcohol problems (compared with 41% comparator) and 13% that they had help with drug problems (compared with 42% comparator) (2.53)
	Counselling	**Page 25:** Counselling service only available to sentenced girls. (2.59) **Page 26:** Psychology provision lacked specialisms in the field of sexual and physical abused of ADHD.
	Adjudications	**Page 31:** Records of adjudications limited (2.100)
	Use of force	**Page 32:** No analysis of use of force to identify patterns and trends. Force used mainly in order to prevent self-harm. Came across one girl who had had her clothing forcibly removed. (2.104) Separation used (young person put behind door for 5 minutes) – not monitored and discretionary (2.107)
	Resettlement	**Page 34:** Policy committee should meet more regularly and should be linked to relevant area and regional strategies. (2.116)
Name: Eastwood Park (Mary Carpenter Unit) **Date of Inspection:** 14-18 May 2007 **Gender/Age**: Women/17 **Operational Capacity/Actual Capacity:** 16/16	Strip-searching	**Page 9:** All strip searched regardless of risk upon arrival (HP3) **Page 10:** Use of strip cell albeit rarely (HP3) Only 37% of survey respondents reported feeling safe on their first night (HP5) (1.14)
	Admission	**Page 18:** Initial vulnerability assessments not developed or reviewed. Inappropriate strip searching in unsuitable room (1.6) **Page 19:** Observation process not properly adhered to - pro forma not filled in at the end of observation period and review process not adhered to (1.14) **Page 20:** No peer support scheme (1.24)
	Care plans	**Page 25:** Young people did not have individual care plans (3.1)
	Safeguarding committee	**Page 26:** Poor attendance by members (3.3)

Details of YOI	Key issues	Comments
	Self-harm and suicide	**Page 27:** Quality of documentation varied. Guidance in suicide and self-harm prevention policy was not always followed. Reviews were not carried out on time and were rarely multidisciplinary. (3.18) **Page 28:** Some care maps lacked details and accountability for some action points was sometimes unclear. No family involvement. (3.23)
	Child protection	**Page 29:** Not all duty governors trained in basic child protection. (3.31) Child protection log not checked by the YJB or area manager (3.35)
	Race equality	**Page 30:** Not all staff had undertaken diversity training. The impact assessments and race equality action plan did not consider the specific issues and needs of young women on the unit. (3.42) Bi-monthly race equality action team meetings were held in main prison but issues specifics to the unit were not routinely discussed and unit staff attended inconsistently. The prison diversity officer did not regularly attended the prisoner's safer custody meetings which would have increased links between the work in these two key areas. (3.43)
	Applications and complaints	**Page 35:** Written replies to some complaints were inadequate. (3.74). Some were terse and lacked details (3.77)
	Healthcare	**Page 37:** No special sexual abuse counsellors. No health development plan and no up to date health needs assessment. (4.1) **Page 41:** No formal mental health awareness training for unit staff. (4.39)
	Security and rules	**Page 51:** Routine strip-searching on arrival and before discharge to court without a risk assessment indicating that it was necessary for their own protection or the protection of others. (6.1)
	Discipline	**Page 52:** Women subjected to single separation were inappropriately prevented from attending daytime activities. Use of force documentation not always completed properly. Use of special cell – regarded as inappropriate by report, even for short periods of time. (6.6, 6.13)

Details of YOI	Key issues	Comments
	Resettlement	**Page 57:** Inadequate unit resettlement policy. Not based on a needs analysis and there were no local partnership to develop resettlement services. Problems finding suitable post-release accommodation – not measure or addressed in the policy – and a lack of support from Connexions. No use of release on temporary licence. Unit specific issues not adequately covered. (8.1)
	Training planning and remand management	**Page 59:** Lack of involvement of young people in their planning process – 22% said that had a say in what would happen to them on release (significantly worse than the comparator of 39%) and 76% said there were still things they would like help with before release (significantly worse than the comparator of 38%). (8.15) Absence of specialist social worker. (8.16) **Page 60:** Mandatory drug testing took place in the main prison where officers had not received child protection training. (8.19) Joint care planning not formalised. (8.21)
	Public protection	**Page 63:** Public protection did not form part of the agenda of the safeguarding committee.
Name: Feltham **Date of Inspection:** 4-8 June 2007 **Gender/Age**: Male/15-18 **Operational Capacity/Actual Capacity:** [●]/193	First days in custody	**Page 22:** Juveniles routinely strip searched on arrival (1.11) No peer support system (1.12)
	Residential units	**Page 27:** Concerns about the cleanliness and state of cells. (2.2)
	Relationship between staff and young people	**Page 28:** 60% of black and ethnic minority young people said that staff treated them with respect (significantly below the 82% comparator for white young people) (2.15)
	Personal officers	**Page 29:** No formal links between personal officers and offender supervisors. Rare for personal officers to attend remand/training planning or sentence planning meetings. (2.19) Rare for personal officers to attend ACCT reviews. (2.20)

Details of YOI	Key issues	Comments
	Safeguarding	**Page 31:** Key members of the safeguarding committee did not always attend or submit reports in their absence. (3.2) Significant gaps in data in some key safeguarding areas – notably bullying and child protection (3.)
	Bullying and violence reduction	**Page 32:** Young people not represented at the violence reduction forum. (3.10) No specific guidance on ways of enabling visitors and families to alert staff to bullying. (3.12)
	Self-harm and suicide	**Page 34:** No monitoring of the use of anti-ligature clothing or of young people at risk of self-harm placed in the segregation unit. Night staff not carrying ligature cutters. Only 5% of night staff trained in first aid. (3.25) **Page 35:**Personal officers rarely attend ACCT reviews (3.27) No Listener equivalent service for juveniles e.g. peer support (3.29) Suicide and self-harm prevention policy makes no reference to the suicide prevention team. (3.34) **Page 37:** ACCT documentation poor in equality – assessments not sufficiently detailed and care maps not tailored to individual need. (3.38) **Page 38:** Staff did not follow the suicide and self-harm prevention policy and were generally not familiar with it. Many aspects of the policy were aspirational and not complied with. Insufficient follow up action on identified patterns and trends. (3.41)
	Child protection	**Page 38:** Significant number of staff has still not received training. Lack of training was a particular concern in key areas where staff were involved in full searches such as juvenile reception and the mandatory drug testing unit. **Page 40:** Mixed staff awareness about child protection issues. Insufficient funding to ensure that all new staff received the juvenile awareness staff programme training. Significant number of staff untrained. (3.56) Accurate records of staff who had undergone enhance Criminal Record Bureau checks were not available (3.59)

Details of YOI	Key issues	Comments
	Race equality	**Page 42:** None of the wing officer race relation representatives had received training. They did not attended the focus group meetings and lacked clarity about their roles. (3.69)
	Contact	**Page 47:** One telephone for up to 30 young people. 40% of respondents said they had problems getting to the phone (significantly worse than the comparator of 33%). (3.102) No daily access to telephones (3.103) No daily visits or evening visits (3.104) and visits less than 1 hour in length (3.106) **Page 48:** Legal visits not conducted in private. (3.138) **Page 50:** Strip searching at the end of visits.
	Legal rights	**Page 52:** Shortage of private space in legal visits area.
	Health services	**Page 53:** No separate area to care for patients requiring a greater level of therapeutic interaction. Recommended in a previous inspection that a mental health 'high intensity' nursing area should be established in the inpatient unit. (4.3) **Page 54:** Only 2 of the nursing staff on the inpatient unit had up to date juvenile awareness staff programme. Many staff had not received child protection training (4.10) **Page 60:** No log of anti-ligature clothing used. (4.43) Mental health needs assessment not carried out. Primary mental healthcare still not formally available (4.44) Young people waiting for months for mental health assessments for transfers to secure NHS beds. (4.65)
	Education	**Page 68:** Lack of formal education provision for many juveniles. (5.16)
	Time out of cell	**Page 73:** Exercise in the open air was not offered to juveniles although yards were almost complete and were due to be commissioned for use. (5.53)
	Offender management and planning	**Page 93:** 14% of respondents felt that they had done anything, or that anything had happened to them at Feltham that would make them less likely to offend (significantly lower than the comparator of 43%.) (8.38)

Details of YOI	Key issues	Comments
Name: Foston Hall (Toscana Unit) **Date of Inspection:** 31 March – 4 April 2008 **Gender/Age**: Female/ 17-18 **Operational Capacity/Actual Capacity:** 14/16	Courts, escorts and transfers	**Page 17:** Serious problems with late arrivals. Lack of information before the girls arrived at the Toscana Unit. (1.1)
	Strip searching	**Page 18:** Routine strip searching (1.9, 1.13) **Page 19:** No formal peer support system (1.17) Long periods of time unoccupied in the first week – not integrated into the regime quickly enough. (1.20)
	Residential units	**Page 21:** Poor ventilation. Girls insufficiently involved in unit meetings. (2.1)
	Personal officers	**Page 23:** Personal Officers not involved in ACCT procedures. Their role did not cover contact with families or pre-release work. (2.17)
	Safeguarding	**Page 25:** No trend analysis of safeguarding data. (3.1) **Page 26:** Lack of co-ordination between care planning systems. (3.7)
	Bullying	**Page 27:** Weaknesses in record keeping and investigations into bullying sometimes inadequate. (3.13) **Page 28:** Confusion around which staff had anti-bullying training. Aspirational ideas as not all staff had anti-bullying training. (3.24)
	Self-harm and suicide	**Page 29:** No peer support. (3.28) The unit did not have its own self-harm and suicide prevention policy but instead worked to the prison's wider policy document. (3.29) **Page 30:** Consideration not routinely given as part of the ACCT process to notifying parents or carers about self-harm incidents. (3.32) Reviews were rarely multidisciplinary, records varied in quality and some indicated a lack of focus on the specific issues. (3.33) Inadequate suicide and self-harm prevention training. Only 18 out of 45 staff had completed the ACCT awareness training. (3.36) Only 7 staff had completed first aid training, only 2 of whom could work at night. No emergency radio codes to alert healthcare staff to an emergency on the unit. (3.37)

Details of YOI	Key issues	Comments
	Child protection	**Page 31:** Not all staff had been training in child protection and some had not been Criminal Records Bureau cleared. (3.44, 3.49) 11 members of staff had not completed the juvenile awareness staff programme covering basic child protection awareness. (3.49)
	Diversity	**Page 33:** Less than half the staff had been trained in diversity. (3.56)
	Contact	**Page 35:** All letters were routinely read which was inappropriate. (3.69)
	Applications and complaints	**Page 37:** No audit trail for applications and no analysis of complaints to identify patterns or trends. (3.77)
	Healthcare	**Page 42:** Staff shortages affected mental health provision – counselling only provided occasionally. (4.28)
	Education	**Page 45:** Lack of opportunity for accreditation in some areas. (5.3) Lack of support for girls whose first language was not English. (5.4) **Page 46:** Limited provision for more able girls and those interested in vocation courses. (5.6)
	Physical education	**Page 47:** Few girls were studying for accredited activities and the range of activities on offer was narrow. (5.20)
	Faith and religious activity	**Page 48:** Only 17% of girls, significantly worse than the comparator of 50%, said they had access to a chaplain within their first 24 hours and 36%, significantly worse than the comparator of 80%, said it was easy to attend religious service, (5.28)
	Time out of cell	**Page 49:** Less time out of cell at weekends, particularly girls on the lowest level of the rewards and sanctions scheme. (5.33) Only girls on gold level received 10 hours out of their cells at weeks. Girls on bronze only got 9 ½ hours on weekdays and 6 hours at weekends. (5.34)
	Security and rules	**Page 52:** Poor attendance by security at safeguarding meetings. (6.7)

Details of YOI	Key issues	Comments
	Discipline	**Page 52:** Disciplinary systems not well monitored to identify trends or assess fairness. Advocates did not play a prominent role in disciplinary procedures. (6.13) **Page 53:** Over use of adjudications - the process was not effective in changing behaviour or empowering staff. (6.14) Poor management checks on the fairness of the system. Minor behaviour incidents could have been dealt with through the rewards and sanctions scheme. (6.18) 36% of girls, against a comparator of just 10%, said that they had been physically restrained. (6.19) **Page 54:** The girls were not always debriefed after incidents. No routine monitoring of the use of force. (6.21)
	Rewards and sanctions	**Page 55:** Poor communication between staff and young people about the process, particularly those being considered for downgrading. (6.35)
	Resettlement	**Page 59:** Insufficient use of release on temporary licence. (8.1)
	Training planning and remand management	**Page 60:** Individual targets not always sufficient specific. (8.10) Personal officers did not always attend planning meetings. (8.12)
	Substance use	**Page 62:** The girls had to undertake mandatory drug testing on the adult site. (8.22)
Name: Huntercombe **Inspection:** 9-12 December 2008 **Gender/Age**: Male/Under 18 **Operational Capacity/Actual Capacity:** 365/311	Safeguarding	**Page 15:** Use of force and public protection not included in the remit of the safeguarding committee. (2.1)
	Size of units	**Page 16:** Up to 60 young people being held on each residential unit – no daily association or shower. Communal areas too small for all young people to be out of their cells at the same time. Normally 1 senior officer and 3 officers per unit – all units except for one were full. (2.6)

Details of YOI	Key issues	Comments
	Late arrivals	**Page 16:** Elements of safety compromised when young people arrived late at night. Lack of input from the JYB was a significant weakness in resolving this. (2.8)
	Strip searching	**Page 17:** Still routinely carried out on admission, release and randomly in 10% of cases following a visit. Strip searching under restrained had happened once (although was the subject of an internal investigation). (2.10)
	Visits	**Page 17:** Entitlement to visits was limited to 1 visit every 2 weeks and accumulated visits were rare. Survey carried out into the needs of visits but the views of young people were not taken into account. (2.12)
	Training planning meetings	**Page 17:** Held in public in the visits area despite recommendations for improvements in 3 previous inspections – seriously detrimental to effective care planning for young people.
	Information about Huntercombe	**Page 18:** Only 25% of young people received information about Huntercombe before arriving there. (2.20) **Page 19:** Problems with late arrivals, basic information being provided and opportunity to shower on night of arrival. (2.23-2.25)
	Showers	**Page 20-21:** Cameras in shower areas in all residential units apart from one. Intrusive, did not enhance supervision of the showers, only provided a potential source of evidence if an incident occurred. Previously recommended for removal. **Page 22:** No daily access to showers – only 23% of young people said they could shower every day (significantly worse than the comparator of 64%). Poor access to showers after PE. (2.40) (2.169)
	Disability	**Pages 20-21:** No formal policy or procedures. No cell in the establishment adapted for a young person with a physical disability. (2.36)
	Interaction between young people and staff	**Pages 22-23:** 58% of young people said that staff treated them with respect (worse than the comparator of 75% and 77% in 2006). Only 22% of young people said staff had checked on them personally in the previous week to see how they were getting on – significantly worse than the comparator, no better than previous inspections. (2.44)
	Personal officer	**Page 23:** Poor contact with personal officers. (2.47)

Details of YOI	Key issues	Comments
	Safeguarding children committee	**Page 24:** Did not oversee multi-agency public protection arrangements or other public protection issues. Important components of safeguarding children. (2.54)
	Bullying	**Page 25:** Shortfalls in the investigative process. (2.56) Quality of entries in monitoring documentation varied greatly – the majority remained inadequate. Management checks carried out at least once a day, they did nothing to challenge the poor entries and managers simply used a rubber stamp to indicate the document had been seen. (2.59)
	Self-harm and suicide	**Page 27:** Poor entries in the self-harm monitoring forms. Inadequate management checks. (2.68) **Page 28:** Increase in incidents of suicide and self-harm, particularly the use of ligatures. (2.75) Rubber stamps commonly used by managers to indicate that the self-harm monitoring forms had been checked. With the exception of the head of safeguarding, managers had failed to make any additional comment on the quality of the entries. (2.76)
	Child protection	**Page 29:** 103 members did not require children protection awareness training due to their rank and/or role within the establishment. The result is that education and healthcare staff were not required to undertake child protection training. Not all duty managers had been trained and there were 8 senior offices awaiting training. (2.78) No specialist counselling available – significant gaps in the range of counselling services provided. (2.80)
	Foreign national young people	**Page 31:** No foreign nationals policy (2.89) Delays with deportation notices. (2.93)

Details of YOI	Key issues	Comments
	Access to telephones	**Page 32:** In the survey only 19% of young people said they were able to use the telephone every day (significantly worse than the comparator of 59% and the 32% reported in 2006). (2.95) Difficulties accessing the telephone (25% of young people) (2.96) No practical support available to family or friends to assist with visiting the prison (2.97). Young people not getting visits within 2 days of arrival e.g. if admitted on Monday will have to wait until the following weekend before getting the first visit (2.98). Not all visits lasted two hours – unsatisfactory in light of the fact that 63% of young people lived over 50 miles away compared with 38% in 2006 (2.99). Problems with visitors centre (2.100) and searching visitors (2.104).
	Access to legal rights	**Page 34:** No legal rights service available to young people. (2.114) **Page 35:** No area for private legal interviews. (2.115)
	Health services	**Page 35:** No robust system in place to prevent young people with severe mental health needs from moving between prisons without consultation with the mental health team. (2.117) **Page 37:** Weekly mental health referral meetings not attended by all caseworkers with responsibility for the young people discussed. **Page 38:** A number of staff vacancies including nurses (2.136), children's nurse (2.137) and graduate mental health posts. (2.140)
	Education	**Page 39:** Provision of literacy and numeracy underdeveloped. (2.148) **Page 40:** Improvement needed to ensure that all young people had clear and measurable targets. (2.153)
	Faith and religious activity	**Page 42:** 49% of young people said it was easy or very easy to attend religious services (significantly worse than the comparator of 55% and no significant improvement on the previous inspection). (2.170)

Details of YOI	Key issues	Comments
	Time out of cell	**Page 43:** Deemed unsafe to unlock all 60 young people in each unit at the same time. As a consequence only 30 young people were unlocked together which meant that they had association every other evening during the week. When staffing levels dropped, association was reduced further to two sessions of 1 hour for 15 young people. 6 ½ hours unlock at the weekend. (2.174) In the survey, only 4% of young people said they could go outside for exercise every day (significantly worse than the comparator of 34% and 35% at the last inspection in 2006). (2.177)
	Security	**Page 45:** No monitoring or analysis of strip searches. Safeguarding committee had no role in the governance of these procedures. (2.183)
	Adjudications	**Page 45:** Young people not routinely asked if they wished to have advice from an advocate. Difficulty of young people in understanding the written information about adjudications or did not bother to read it as it appears too complicated.
	Use of force	**Page 45:** No discernible quality assurance of the use of force. Limited monitoring and analysis. (2.187) **Page 46:** No opportunity for young person subjected to use of force to discuss it. Informal arrangement that orderly officer talks to young person – inappropriate as officer may have been directly involved in overseeing the use of force. (2.188) Use of unfurnished cell – poor records showing use and no governance. (2.191) No policy setting out the role and function of the intensive support unit. (2.192) Needs refurbishment – resembles a traditional adult segregation unit. (2.194) Deficiency in area of action plans for young people on the intensive support unit – no formal action plan or care plan process. Personal officers rarely visited young people located there. (2.196)
	Rewards and sanctions	**Page 47:** Extremely punitive regime. (2.197) No discussion with young person on basic regime about how his behaviour could improve and how he could be helped to achieve targets.
	Dining	**Page 48:** Limited opportunities to dine out of cell. No encouragement for staff to dine with young people. (2.200) Problems with breakfast (2.201) and time of meals. (2.202)

Details of YOI	Key issues	Comments
	Publication protection policy	**Page 53:** No local public protection policy. (2.234)
Name: New Hall (Rivendell Unit) **Date of Inspection:** 30 July – 3 August 2007 **Gender/Age**: Female/17-18 **Operational Capacity/Actual Capacity:** 26/26	Court, escorts and transfers	**Page 17:** Frequent late arrivals and problems with shared transport (1.1).
	First days in custody	**Page 18:** Routine strip-searching. (1.9) **Page 19:** Not risk assessed, intrusive and degrading, particularly given that many girls were likely to be victims of sexual abuse. (1.15) Absence of female members of staff on duty at times. (1.18) **Page 20:** No peer support scheme. (1.25)
	Safeguarding	**Page 25:** Monitoring of safeguarding arrangements was not sufficiently robust. Data on the main safeguarding areas, with the notable exception of child protection, but it was not analysed and used to inform the safeguarding strategy. No individual care plans. (3.1) **Page 25:** Safeguarding committee had not met between July 2006 and March 2007 – this meant no external scrutiny of safeguarding arrangements by the local authority in that period.
	Bullying	**Page 26:** No staff had taken anti-bullying training in the previous year. (3.13)
	Self-harm and suicide	**Page 27:** High number of instances of self-harm, the majority of which were said to be minor but there was an absence of analysis to verify this. ACCT documentation was not always completed to a good standard. Reviews usually multidisciplinary but unit staff were not always sufficiently conversant to add support to the care plan. 1/3 of staff had not undertaken the foundation suicide and self-harm course. (3.20) Unit did not have its own self-harm and suicide policy – used wider prison document. (3.21)

Details of YOI	Key issues	Comments
	Child protection	**Page 29:** Child protection procedures not managed well. No external scrutiny or proper management oversight of child protection procedures. Record keeping, data collection and monitoring of child protection were inadequate. (3.30) Child protection policy presented to Wakefield District Safeguarding Children Board but had not yet been agreed. Policy was not being fully implemented, particularly with regard to the monitoring and review arrangements. (3.31) Most unit staff had been trained in child protection awareness but staff cross deployed from the main prison when there were staff shortages had not. (3.32) Serious deficiencies in the child protection document. Log of child protection referrals was not maintained, records of referrals were incomplete and lacked detail. Safeguarding committee had not met for a year and there was no separate child protection committee. (3.34) No social worker in post although replacement was due to join shortly. (3.35)
	Race equality	**Page 30:** Unit specific race and diversity issues not explicitly covered. Complaint forms not widely available. Little promotion of diversity. (3.40)
	Foreign nationals policy	**Page 32:** Not unit-specific, guidance for staff and formal support for young women was lacking. Translation/interpreting services were little used. (3.55) Free monthly 5-minute telephone call offered in lieu of a visit. (3.58)
	Contact	**Page33:** Little done to encourage family contact. (3.67) No dedicated family liaison officer. (3.71)
	Applications and complaints	**Pages 34 and 35:** Role of advocates and the participation meetings was unclear. (3.77) Responses to complaints were prompt but most lacked detail and courtesy. (3.80)

Details of YOI	Key issues	Comments
	Health services	**Page 37:** No complete health needs assessment. Primary care services were not specific to young women and there was no dedicated nurse for the unit during the core day. Primary care nurses did not attend DTO or other care planning meetings. No formal information-sharing policy. Lack of integration of primary staff into the unit. Some girls were not given a secondary health screen and some referrals to other health professionals were not actioned. Poor clinical record-keeping. Inadequate health promotion. Mental health services good but not child and adolescent mental health services-led. (4.1) **Page 38:** No full-time dedicated primary care nurse for the unit. (4.7) Named nurse had not received child protection training. Documentary evidence of enhanced Criminal Record Bureau checks for all nurses was not available. (4.8)
	Education	**Page 43:** Lack of careers education or information. Poor access to the library. (5.1)
	Physical education and health promotion	**Page 46:** No access to the gym on the main site. Poor outdoor facilities. (5.24)
	Faith and religious activity	**Page 47:** Liaison chaplain for the unit saw all new arrivals but did not have adequate facility time to carry out a full pastoral role on the unit. (5.31)
	Time out of cell	**Page 48:** Young people sometimes locked up when there were staff shortages. Often bored in evenings and at weekends. Girls on the basic level of the rewards and sanctions schemes spent too long locked up at weekends. (5.36)
	Security and rules	**Page 51:** Some security measures were too extreme. Overuse of routine strip searching. Unit-specific security information reports were not collated or analysed separately. Intensive supervision room was used inappropriately as a special cell and first night cell. (6.1) Young women strip searched without risk assessments on reception and discharge, during cell searches, in visits and for mandatory drug testing. (6.3)

Details of YOI	Key issues	Comments
	Adjudications	**Page 52:** Adjudications used excessively. High use of force and monitoring and analysis not sufficiently robust. Injuries sustained during the use of force were not monitored. (6.9) Adjudication process was used inappropriately for behaviour that should have been dealt with by other means. (6.12)
	Substance use	**Page 62:** Not all staff at the substance misuse unit had child protection training. (8.24)
Name: Parc **Date of Inspection:** 1-5 October 2007 **Gender/Age**: Male/15-18 **Operational Capacity/Actual Capacity:** 56/64	Safeguarding	**Page 15:** Young people routinely strip searched on arrival and departure (2.13). Section in strip search documentation allowing for forcible strip searching giving the process undue legitimacy. (2.14) **Page 16:** Log of strip searches carried out in the main admission area did not distinguish juveniles from adults, did not specify the occasions when juveniles were searched or provide any background explanation. (2.15)
	Child protection	**Page 16:** 4 recently appointed staff started post before they received child protection training. (2.18)
	Healthcare	**Page 20:** Beds in healthcare used for separation of young people who were disruptive. **Page 21:** Poor mental health services. No specific child and adolescent mental health services in place. Lack of structure service to care for all young people with mental health needs – concerns by staff. (2.41)
	Education	**Page 23:** Staff sickness had an impact on attainments of young people. (2.63) Curriculum too narrow – few opportunities for young people to prepare for working life. No programme of personal, social and health education. (2.65)
Name: Stoke Heath **Date of**	Court, escorts and transfers	**P17:** One young person reported being given bag to urinate in instead of comfort break. (1.2) Late arrival but extent to which this happened not clear as not monitored. (1.3)

Details of YOI	Key issues	Comments
Inspection:13-17 October 2008 **Gender/Age**: Males/Under 18 **Operational Capacity/Actual Capacity:** [•]/ 163	First days in custody	**Page 19:** Strip searched upon arrival. Made to stand on a slatted wooden platform – appeared unnecessarily uncomfortable. (1.13) **Page 20:** Quality of initial vulnerability assessments ranged from poor to satisfactory. Superficial and showed no evidence that the member of staff completing the form had read the relevant documents, including the ASSET. Risk management plans were inadequate. (1.20) Cells supposedly ready for occupation were dirty, contained rubbish, were graffitied and missing furniture. (1.24)
	Safeguarding	**Page 27:** Lack of coordination between the work carried out by the safeguarding committee and the violence reduction committee. Gaps in the strategic management of some important areas of safeguarding as a consequence. (3.1) Lack of monitoring and analysis of some important safeguarding areas. Lack of data relating to self-harm incidents and no strategic management of self-harm prevention. (3.3) Care plans limited in scope and inadequate for addressing the individual needs of vulnerable young people. Vulnerable care unit renamed the independent support and care regime (ISCR) but the environment remained austere and uncomfortably confined – inappropriate location. (3.4)
	Bullying	**Page 28:** Remained a significant problem. Not all incidents were referred through the correct system or investigated property and recording of bullying was inconsistent. Staff entries in monitoring documents lacked evidence of engagement between staff and young people. (3.10)
	Self-harm and suicide	**Page 30:** Strategic management of suicide and self-harm was hindered by limited analysis of the available data. Attendance at reviews was not always consistent. No peer support scheme. (3.26)
	Child protection	**Page 33:** Monitoring and analysis of child protection referrals were limited. The majority of staff were trained and Criminal Records Bureau cleared. Not all staff who were cross-deployed from the adult side when there were staff shortages were trained to work with children or CRB cleared (2/3 of staff). (3.42, 3.45) **Page 34:** No ongoing analysis of patterns or trends of child protection referrals.

Details of YOI	Key issues	Comments
	Diversity	**Page 35:** Only 40% of staff had received diversity training. (3.60) **Page 37:** No general diversity policy. (3.65)
	Contact	**Page 39:** Young people not always taken to their visit on time. Subject to random strip searches after visits. Security policy placed an over-reliance on a drug dog indication to support a closed visit.
	Health services	**Page 45:** Applications for appointments could not be made confidentiality. The record keeping system was unsound. Not all inpatients had clear care plans and not all had a clinical need. (4.1) Young people spending a long time locked up in healthcare. (4.35) Primary care mental health nurses were often allocated to generic nursing duties, which affected their ability to carry out their mental health work. (4.37)
	Education	**Page 53:** No library provision at the weekend. (5.1)
	Time out of cell	**Page 58:** Not enough time out of cells – maximum time was 9 hours and 25 minutes on week days and 6 hours and 5 minutes at weekends averaging 8 ½ hours per day (in comparison with the expected 10 hours). (5.38) Young people were only offered exercise in the open air for an hour at weekends and timings clashed with other activities. (5.43)
	Security and rules	**Page 61:** Routine strip searches – inappropriate for this age group without a completed risk assessment submitted to the governor for approval (6.8).
	Adjudications	**Page 62:** Excessive punishment at times following adjudication e.g. 100% loss of earnings for long periods. Long periods of time (up to 30 days) in the separation and reintegration unit but did not have individual care plans. (6.13)
	Rewards and sanctions	**Page 68:** Young people on basic regime only received association at the weekends and were unlocked to use the telephone once a week. (6.58)
	Catering	**Page 69:** Young people ate breakfast in their cells – inappropriate as toilets were only partially screened. (7.6)
	Resettlement	**Page 73:** Needs analysis not carried out to inform the draft resettlement strategy (8.1).

Details of YOI	Key issues	Comments
	Training planning and remand management	**Page 75:** Attendance at planning reviews varied. Low attendance for families. Irregular attendance by education and the young people's substance misuse team. Rare representation by healthcare. (8.19)
	Substance use	**Page 77**: Use of strip searching before random drug testing without prior risk assessment. (8.34)
Name: Warren Hill **Date of Inspection:** 16-18 July 2007 **Gender/Age**: Male/Under 18 **Operational Capacity/Actual Capacity:** 222/217	Arrival in custody	**Page 15:** Late arrivals. Only 17% of young people said that they had received enough comfort breaks. (2.1)
	Outdoor exercise	**Page 16:** No outside exercise scheduled for the weekend. Only 19% of young people surveyed said they could go outside for exercise every day – significantly worse than the comparator of 29%. (2.5)
	Strip searching	**Page 17:** Young people continue to be routinely strip searched on arrival or when leaving for or returning from court. (2.12)
	Residential units	**Page 20:** Ligature points remain in the shower areas. Only 27% of respondents, compared with 33% comparator, said that staff checked on them personally in the last week to see how they were getting on. (2.31) Only 32% of respondents (significantly worse than the comparator of 43%) said they had met their personal officer in the first week. (2.32)

Details of YOI	Key issues	Comments
	Bullying	**Page 21:** Restrictions for bullying included less access to visits and showers. (2.33) Young people identified as bullies did not have individual plans aimed at tackling their bullying behaviour. No mediation or restorative justice work done. (2.39) No information on bullying collated or analysed for some time. (2.41) Only 14% of staff had been trained in anti-bullying procedures. (2.43)
	Suicide and self-harm	**Page 23:** 92% of staff had been trained in ACCT foundation procedures. (2.49) Documentation surrounding use of anti-ligature clothing was not always completed and incidents were not always logged appropriately. (2.51) **Page 24:** No peer support scheme. (2.54) Initial assessments for ACCT were usual good but care maps did not always address the needs identified or specify who was responsible for actions agreed. They were not updated. Reviews were rarely multidisciplinary. Disciplines represented at the safeguarding case review team meetings were not represented at ACCT case reviews which generally involved only residential staff and the young person. (2.56)
	Safeguarding	**Page 24:** Less than half of the designated membership of the safeguarding case review team had attended the last three meetings (2.59). **Page 25:** Data on the level and nature on self-harm and bullying was not collected. Injuries sustained during the use of force were monitored by the security committee but this information was not passed to the safeguarding strategy committee. Child protection referrals were not considered by the safeguarding strategy committee. (2.560) The child protection register was not up to date and a number of individual logs contained insufficient details. (2.64) No separate child protection committee. (2.66) **Page 26:** Only 57% of discipline staff and 36% of education staff had received child protection training.
	Diversity	**Page 27:** Only 30% of staff had completed diversity training. (2.76)
	Foreign nationals	**Page 28:** Inadequate foreign nationals policy. (2.82)

Details of YOI	Key issues	Comments
	Contact	**Page 29:** Young people on silver and bronze level of the sanctions scheme could not have visits during the week. (2.86)
	Strip searching	**Page 29:** Routine strip searching carried out randomly on 10% of young people receiving visits. (2.87)
	Applications and complaints	**Page 29:** Consultation meetings held irregularly, often without representation from every wing. (2.90) **Page 30:** Only 18% of young people said that complaints were sorted out fairly.
	Health care	**Page 33:** Nurses had no access to clinical supervision. (2.113) No triage training for nursing staff. (2.114) **Page 34:** Unsatisfactory healthcare application system – not confidential, high risk of forms being lost or mixed up with other mail. (2.123)
	Education	**Page 36:** Learning needs of young people under school leaving age were not being met by the curriculum which was insufficiently related to the national curriculum. (2.141) **Page 38:** Staff absences and vacancies causing classes to be cancelled. (2.152) **Page 39:** Poor Connexions service provisions.
	Time out of cell	**Page 43:** Young people on the main site were unlocked for less than 6 hours a day at weekends and those on Carlford unit for 8 hours. (2.179) Poor recreation facilities. (2.181)
	Security and rules	**Page 43:** Young people continued to be strip searched without a risk assessment (2.184). **Page 44:** No separate records kept for strip searching that involved the use of force. 31 such instances. (2.185)

Details of YOI	Key issues	Comments
	Discipline	**Page 45:** No overarching behaviour management strategy. Records did not indicate that adjudication process was age-appropriate. Some examples of inappropriate adjudication. (2.191) Nearly 10% of staff were out of date in basic control and restraint training. (2.193) **Page 46:** Use of force documentation not quality checked – rubber stamping. No proper system of quality assurance to identify procedure or practice short-comings. (2.199) No central log for use of strip clothing. (2.200)
	Rewards and sanctions	**Page 47:** Specialist forum where young people could comment on rewards and sanctions was no longer held. (2.202)
	Catering	**Page 48:** Young people continued to eat in their cells on the main units.
	Resettlement strategy	**Page 49:** Needs analysis information available through the ASSET forms completed but data not aggregated. No other effort made to carry out a resettlement needs analysis. (2.218) Reduction in use of release on temporary licence. (2.220)
	Training planning and remand management	**Page 50:** Representatives from education attended all initial training planning meetings but seldom any of the subsequent reviews. (2.223) All young people convicted of a sexual offence should have an assessment of their need for specialist services. (2.229)
	Public protection	**Page 50:** No representation at multi-agency public protection arrangement reviews in the community. (2.226)
Name: Werrington **Date of Inspection:** 16-20 April 2007 **Gender/Age**: Males/Under 18	Strip-searching	**Page 17:** Strip searching using force still permitted. No evidence of authorisation by a governor. 2 incidences of strip searching under restraint – no evidence that the search had been properly authorised or that every effort had been made to secure the young person's compliance to avoid a forcible strip-search. In both cases of forcible strip searching the young people had had their clothes cut off. (2.1)
	Education	**Page 17:** Shortfall in vocational provision. (2.3)

Details of YOI	Key issues	Comments
Operational Capacity/Actual Capacity: 153/162	Time out of cell	**Page 17:** Most young people out of cells for at least 10 hours a day during weekdays, but for only an average of 7.4 hours at the weekend. (2.4)
	Regular access to fresh air	**Page 18:** No scheduled access to daily fresh air. Some young people who were unemployed had no access to fresh air. Only 6% of young people responding to the survey said that they could go outside for exercise every day. (2.5)
	Court, escorts and transfers	**Page 18:** Late arrivals common. (2.7)
	Training plan and remand management	**Page 19:** No clear guidance about the procedures for chairing training plan reviews. No new guidance received from the YJB. Visiting YOT workers to chair reviews but in practice this only occurred when YOT workers were willing – if not, prison staff frequently took on the role. Confusion which led to badly run meetings. (2.10)
	Resettlement and aftercare provisions	**Page 19:** RAP support packages not available to all young people who required structure support. (2.11) Mandatory drug testing policies and procedures still haven't changed. (2.12)
	Strip searching	**Page 20:** Routine strip searching on arrival to and discharge from the establishment without any form of risk assessment. Information in accompanying documentation such as history of abuse was not taken into account to balance the security requirements of the establishment with the welfare of the young person.
	Inductions	**Page 22:** Inadequate number of trained staff to induct new arrivals e.g. if arrival occurred on a Friday. No use of peer workers. (2.27) No recognised first night accommodation. (2.29) Inadequate ventilation – frequently too hot, sometimes too cold. (2.33)
	Showering	**Page 23:** Only 32 of survey respondents said that they had the opportunity to take a shower every day (significantly worse than the comparator of 53%). (2.39)
	Personal officers	**Page 25:** No training on the role of personal officer. Little interest or enthusiasm for the scheme among staff or young people. (2.50) Wing records showed little evidence of any planned, welfare-type work with young people. Timing of entries was erratic. (2.51)

Details of YOI	Key issues	Comments
	Safeguarding	**Page 26:** Strategic management of safeguarding was still embryonic. (2.54) Void in important management aspects of safeguarding such as a data analysis and proper quality assurance of suicide and self-harm prevention and anti-bullying procedures. No monitoring of injuries sustained during the use of force. (2.55)
	Bullying	**Page 27:** Inadequate investigations into the allegation of bullying. Bullying information not always passed on to the anti-bullying coordinator (2.60). Little work done with identified bullies. Little support done to support the victim other than to move him, rather than the bully, to a different location. (2.66)
	Suicide and self-harm prevention	**Page 28:** Self-harm monitoring reviews rarely attended by more than the young person and unit manager. Limited in scope and used to monitor rather than engage with the young person. Insufficiently precise care plans and not always updated following a review. Quality of monitoring entries varied but generally did not demonstrate adequate engagement with the young person. (2.70) No formal arrangement to offer peer support to young people at risk of self-harm. (2.71) **Page 29:** Most staff trained in ACCT procedures. Weaknesses in the procedural aspects of the ACCT process. Most staff had receive child protection training and also enhance Criminal Records Bureau clearance. (2.76) Departure of social worker because of long-term uncertainty about the funding of her post – gap for the safeguarding team and in services for young people. (2.77)
	Contact	**Page 31:** Problems with visits e.g. a young person admitted on a Wednesday could not always be guaranteed their first visit until the following week. (2.88) **Page 32:** Only 28% of survey respondents said they could use the telephone to speak to someone in their family every day. Significantly below the comparator of 50%. (2.95)

Details of YOI	Key issues	Comments
	Substance use	**Page 33:** Failure by senior managers to regularly attend the substance misuse strategy meetings. (2.101) Reception testing not carried out. (2.102) Healthcare staff had not undertaken substance misuse training and it was not included in the planned training. (2.103)
	Education, training and library provision	**Page 37:** Young people were not always clear about their personal learning goals or formal progression. Need for individual learning plans to be more precise and progress towards them monitored more frequently. (2.126) No support scheme by the library to help young people with their literacy. (2.136)
	Physical education	**Page 40:** Insufficient PE offered. 1.5 hours per week available to young people deemed insufficient. (2.143)
	Time out of cell	**Page 41:** Lack of evening association at weekends. 36% of respondents said that they went on association more than 5 times a week – significantly worse than the comparator of 46%. (2.151) No system to monitor young people who did not participate in association. (2.153)
	Discipline	**Page 42:** Inappropriate punishments sometimes given – in one instance the punishment was 100% stoppage of earnings. (2.157) **Page 43:** Adjudication room and process is age inappropriate. (2.162) Recommendation that the prison develop methods other than forcible strip searching to manage individuals who refuse to comply with a search such as temporary separation and direct supervision – failure to achieve this. (2.165) No proper register kept of the use of the safer cells on C1 landing. (2.166) **Page 44:** Young people in the calm down rooms not kept under constant supervision – staff made infrequent checks and a lack of staff engagement to help young people regain control of themselves. (2.169) Use of force documentation not certified by the deputy governor who told the inspectors that he quality assured all use of force documentation. (2.173) No log of strip search under restraint that had taken place, therefore not possible to confirm how often strip searching under restraint had been carried out (2.174) (see page 45, para 2.176).

Details of YOI	Key issues	Comments
	Strategic management of resettlement	**Page 47:** Release on temporary license should be extended to include greater use of working out throughout the year – not achieved, ROTL scheme had become dormant. (2.188) **Page 48:** No specialist input available to young people who required assistance with housing and employment on their release. (2.191)
Name: Wetherby **Date of Inspection:** 30 June – 4 July 2008 **Gender/Age**: Males/15-18 **Operational Capacity/Actual Capacity:** 153/162	Courts, escorts and transfers	**Page 19:** Problems with late arrivals. (1.1)
	First days in custody	**Page 20:** Lack of information on arrival. Not all staff had the skills to complete vulnerability assessments or behaviour plans. (1.9) Routine strip searching on arrival and each time the young person left the establishment. (1.14) **Page 21:**Staff not trained to carry out the vulnerability assessments. Assessments at the time of the inspection were of a high standard but less recent assessments contained many omissions and were generally poor. (1.19)
	Residential units	**Page 25:** Residential units were too large. Some used inappropriately for double occupancy. (2.1) Young people had associated every other day because of the size of the units – therefore only able to take a shower and make telephone calls to family every other day. (2.2) Cell sharing risk assessments only reviewed monthly or as a result of a significant event involving cell sharers. (2.4) Only 17% of young people participating in survey said that their cell bell was responded to within 5 minutes (significantly worse than the comparator of 34%). (2.5)
	Hygiene	**Page 26:** In double occupancy cells the only screening from the other occupant for the in-cell toilet was a plastic shower curtain. Only 18% of respondents to survey said that they could shower every day, significantly worse that the 57% comparator. (2.10)

Details of YOI	Key issues	Comments
	Personal officers	**Page 28:** Not all young people met their personal officer. Personal officers did not routinely attend important meetings relating to the young people they were responsible for. (2.28) Lack of continuity of personal officers. (2.29)
	Safeguarding	**Page 31:** Safeguard children policy had been recently revised but was still in draft form and had not been formally agreed with Leeds Social Care. Many aspects of the policy were aspirational. (3.2) Lack of clarity about role of committees overseeing safeguarding functions. (3.3) **Page 32:** Confusion amongst staff over the role of the behaviour support plan. 90% of staff check to enhanced level by the Criminal Records Bureau – the remaining staff were awaiting clearance. (3.8)
	Bullying	**Page 33:** Recommendations from the most recent anti-bullying survey had not been incorporated into the current policy. (3.19) **Page 34:** Other than monitoring and demotion in the rewards and sanctions scheme, no specific programme work was undertaken with identified bullies or their victims. (3.24) No anti-bullying training for staff had been delivered in the previous 12 months. (3.26)
	Self-harm and suicide	**Page 35:** Suicide and self-harm policy did not sufficiently reflect the needs of children and young people at the establishment. Frailties in case management and in some aspects of the ACCT process including insufficient multidisciplinary engagement in reviews. Lack of coordination of care across disciplines. (3.36) **Page 36:** Care maps were often vague and non-specific as to the assignment of responsibility. (3.39) Reviews were chaired by whichever staff were available on the day. (3.40) **Page 37:** No staff training in suicide and self-harm prevention for over two years. (3.43)

Details of YOI	Key issues	Comments
	Child protection	**Page 38:** Child protection referrals were inappropriately filtered by untrained staff. Not all allegations against staff were passed on to the local children's services child protection agency. Investigations were carried out with a focus on criminal prosecution rather than child protection. Too few internal investigations when allegations against staff were not proceeded with. (3.54) 76% of target staff had been trained in basic child protection. Some staff in key posts had not been trained in child protection including some posted in reception and the SCU, who would have been required to undertake strip searching procedures. (3.56) Only 1 social worker in post. (3.57)
	Diversity	**Page 39:** Diversity arrangements relatively underdeveloped (3.68)
	Race equality	**Page 41:** Two areas where black and minority ethnic young people responded significantly more negatively regarded being restrained and being victimised by staff. (3.80)
	Foreign nationals	**Page 43:** No forums offering support for young people who were foreign nationals. Few had contact with the foreign nationals coordinator. Interpreting services not used regularly. (3.98)
	Contact	**Page 45:** 38% of survey respondents said that they had problems sending or receiving mail (significantly worse than 30% comparator). **Page 46:** Young people did not have daily access to telephones because they did not have association every night. (3.112) Inadequate visiting rights – unsentenced young people only entitled to one 2 hour visit per week. (3.114)
	Applications and complains	**Page 48:** A significant number of young people said that they did not know how to make a complaint. Only 1/3 said that it was easy to make a complaint. No training given to staff on how to deal with a complaint. (3.131)

Details of YOI	Key issues	Comments
	Healthcare	**Page 51:** Healthcare department in a poor state of repair and not decorated in an age appropriate manner. Primary care underdeveloped. (4.1) **Page 52:**Lack of specialist expertise to support fully young people in areas such as physical disabilities and those with dual diagnosis (mental illness and substance misuse) needs. (4.12) **Page 57:** Poor attendance at mental health awareness training – no compulsory mental health training. (4.44)
	Education	**Page 59:** Too few activity places to provide full-time purposeful activity for all young people. Specific needs of children under school leaving age were not being met. (5.1) Delays in carrying out risk assessments which meant that too many young people were unemployed for either the morning or the afternoon and therefore spent too much time not purposefully engaged and often locked in their cells. **Page 61:** Not all staff were trained in child protection and attendance by education staff at training planning meetings was low. (5.15)
	Time out of cell	**Page 66:** Only 16% of young people said that they had association 5 or more times a week (significantly worse than the comparator of 50%). (5.49) Some young people could spend up to 21 hours a day locked up on some days. (5.52) 10% of respondents said that they could go outside for exercise every day (significantly worse than the comparator of 31%). (5.54)
	Security	**Page 69:** Routine strip searches - told that even if it was known that a young person had been the victim of abuse previously, the requirements of security took precedence. (6.3)

Details of YOI	Key issues	Comments
	Adjudications	**Page 70:** Adjudications were overly used and little was done to engage young people in the process. (6.7) **Page 72:** Use of force was high. No detailed trend analysis. (6.17) **Page 73:** Access to exercise, telephone calls and showers in the separation and care unit was based on good behaviour. (6.25) Documentation relating to the use of the special cell and good order and discipline was incomplete. No care plans for young people who had been held on the unit. (6.26)
	Rewards and sanctions	**Page 75:** Young people on basic level were required to eat their meals in cell, were deprived of the opportunity to take part in family days and were not permitted to have association or a television. Initially reviewed after 3 days and thereafter 7 days. (6.48)
	Catering	**Page 77:** Some young people were required to eat in their cell as part of a punishment which meant that young people ate in a small space alongside a toilet without a lid (7.3).
	Resettlement	**Page 81:** Limited amount of needs analysis work carried out in relation to resettlement. (8.1)
	Training planning and remand management	**Page 83:** Limited input to the planning process from departments within the establishment. Little participation of families. (8.17)
	Substance use	**Page 84:** No comprehensive clinical management protocols. No substance misuse lead nurse. (8.25) **Page 86:** Mandatory drug testing still used, included strip-searching without risk assessments being carried out in advance. (8.46)