Report on an unannounced inspection of

HMYOI Cookham Wood

by HM Chief Inspector of Prisons

4–20 April 2023

Contents

Introduction

HMYOI Cookham Wood is a young offender facility in Kent capable of holding 120 boys between the ages of 15 and 17, although some 18-year-olds are currently being retained due to population pressures in the adult estate. An institution dating from the 1970s, the accommodation blocks have been largely rebuilt in recent years, with new wings opened in 2014. At the time of this inspection the institution was only two-thirds full, with the 77 boys ranging from those on remand to some serving long, indeterminate sentences, including life. It follows that these boys are among the most vulnerable and challenging currently subject to the criminal justice system in England.

The findings of this inspection were extremely concerning, with evidence indicating outcomes for young people were poor in our tests of safety and purposeful activity, and not sufficiently good in care and resettlement. They were the latest in a pattern of deterioration dating back to 2016. These findings would be deeply troubling in any prison, but given that Cookham Wood holds children, they were unacceptable. As a result, I had no choice but to write to the Secretary of State immediately after the inspection and invoke the Urgent Notification process. That letter is published on our website and provides the detail behind my decision.

The most evident failing at Cookham Wood was the near total breakdown in behaviour management. Nearly a quarter of the boys told us they felt unsafe; this was perhaps unsurprising in view of the prevalence of delinquent behaviour and the number of weapons found – more than 200 in the months leading up to the inspection. The diffidence and lack of confidence we observed among staff in their dealings with young people suggested that some of them may also have felt unsafe. Inspectors witnessed repeated examples of intimidating and threatening behaviour by children towards staff, including insulting or pushing past them, which went unaddressed.

Staff had very low expectations of those in their care, and the ready acceptance of poor standards was widespread. Living units were dirty, important equipment was broken and graffiti was rife. Significantly, standards in staff facilities, such as offices, were also not good enough, and it was perhaps symbolic of the general malaise that several staff were not even wearing correct uniform. No one it seemed, had challenged any of this deterioration.

The only response to escalating poor behaviour appeared to be a readiness to lock down protagonists with a web of ‘keep apart’ orders which confined young people to their cells for extended periods of time. This overwhelmed any meaningful regime and dominated the experience of staff and children alike. During our visit 90% of boys were being kept apart from other prisoners, with nearly 600 keep apart instructions. There seemed to be no imagination, creativity, or plan for how to promote good behaviour with ineffective incentives on offer. Only on the small Cedar unit, with the possibility of temporary release for a few, were children being motivated to behave.

The separation of boys had led to a situation where solitary confinement had become normalised. Many were locked in their cells for 23.5 hours a day with hardly any meaningful human interaction. Some did not come out of their cells for days on end, a situation that amounted to solitary confinement. During the inspection, for example, we came across two boys requiring protection from their peers who had been subjected to these conditions for more than 100 days. The lock up and isolation meant the daily regime for all had become sclerotic, stifling any attempt at meaningful and sustainable access to education, work or activity. It was no surprise that our Ofsted colleagues judged education, learning and skills provision to be 'inadequate' in every regard.

The newly appointed governor had been in post for about six weeks and he indicated to us that he was aware of the problems in the establishment. The leadership team, however, lacked cohesion and had failed to drive up standards. In this context we were also surprised to be told that since the governor had been appointed, no senior leader from the Youth Custody Service had visited to make their own assessment of the establishment's evident failings. Many staff were open about how little confidence they had in leaders and managers. We were informed of some staffing shortfalls, but also that around 360 staff were currently employed at Cookham Wood. This included 24 senior leaders. In addition, there were several more working for partners in health care, education, and other areas. The fact that such rich a resource was delivering such an unacceptable service to just 77 children indicated that much of it was being wasted, underused or needed reorganising to improve outcomes at the site.

There will need to be urgent, concerted, long-term commitment from leaders at the YOI and from the Youth Custody Service to improve standards at Cookham Wood and make it an acceptable establishment to hold children.

Charlie Taylor
HM Chief Inspector of Prisons
May 2023

What needs to improve at HMYOI Cookham Wood

During this inspection we identified six priority concerns. Priority concerns are those that are most important to improving outcomes for children. They require immediate attention by leaders and managers.

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

Priority concerns

1. **Despite well-resourced local and national leadership teams, oversight of much of safety, living conditions and purposeful activity was poor. Staff did not have confidence in the leadership team and their morale was very low.**

2. **Evidence of the acceptance of low standards was widespread. Many staff were not wearing the right uniform, living units were dirty, important equipment was broken and graffiti remained a problem.**

3. **There was a complete breakdown of behaviour management. This had led to an escalation in poor behaviour to the point where there was widespread weapon making and nearly a quarter of children reporting that they felt unsafe**. Staff told us they were reluctant to search thoroughly or challenge threatening or intimidating behaviour because they were not always supported by colleagues or managers.

4. **Solitary confinement of children had become normalised at the establishment.** Over a quarter of the population was completely separated from the main population. Most were locked in their cells for 23.5 hours a day with no meaningful human interaction.

5. **Children were unable to access sufficient education. The range of education on offer was also insufficient and children had too few learning tasks to complete in their cells.**

6. **When children could attend, the quality of education was inadequate.**

7. **There were not enough teachers or prison officers to enable leaders to deliver the vocational curriculum.**

8. **Managers did not allocate children to vocational subjects based on their needs or aspirations.** Instead, children were allocated on the basis of which children could mix together. As a result, too many children were disengaged and lacked motivation to participate meaningfully in learning.

About HMYOI Cookham Wood

Task of the establishment
Young offender institution for boys aged 15 to 18 years.

Certified normal accommodation and operational capacity (see Glossary)
Children held at the time of inspection: 77
Baseline certified normal capacity: 193
In-use certified normal capacity: 188
Operational capacity: 120

Population of the establishment
- 57 new admissions in the last 12 months
- 17 foreign national children
- 61% of children from black and minority ethnic backgrounds
- 58% of children on remand
- 76 children released into the community in the last 12 months
- 21% of the current population are adults

Establishment status (public or private) and key providers
Public

Physical health provider: Central and North West London NHS Foundation Trust
Mental health provider: Central and North West London NHS Foundation Trust
Substance misuse treatment provider: CNWL
Dental health provider: Kent Community NHS Trust
Prison education framework provider: Novus
Escort contractor: Serco

Prison group/Department
Youth Custody Service

Prison Group Director
Heather Whitehead

Brief history
HMYOI Cookham Wood was built in the 1970s, originally for young men, but its use was changed to meet the growing need for secure female accommodation at the time. In 2007-8, it changed its function to accommodate 15- to 17-year-old boys to reduce capacity pressures in London and the south-east for this age group.

In January 2014, a new purpose-built residential unit was opened incorporating integrated facilities designed to meet the needs of the boys and to improve safety.

Short description of residential units
165 single cells with integral telephone and showers, spread over six self-contained landings. One cell to accommodate a boy with a disability.

The majority of children are housed in a single residential unit divided into six discrete landings, including a dedicated induction unit.

Cedar unit is a 17-bed resettlement unit separate from the main residential building.

Name of governor and date in post
Paul Crossey, 27 February 2023 –

Changes of governor since the last inspection
Darren Wilkinson, acting governor, July 2022 – February 2023
Simon Drysdale, governor, October 2020 – July 2022

Independent Monitoring Board chair
Keith Morrison

Date of last inspection
August 2021

Section 1 Summary of key findings

Outcomes for children

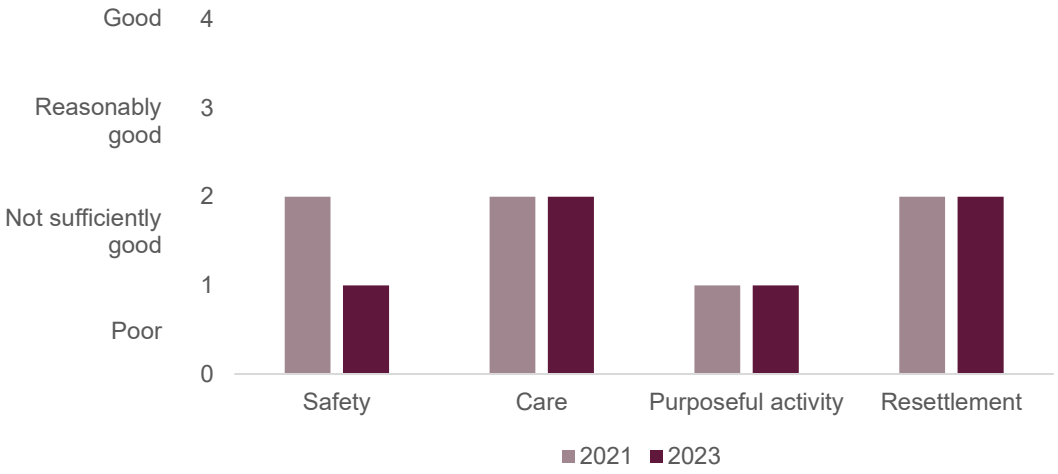
1.1 We assess outcomes for children against four healthy establishment tests: safety, care, purposeful activity and resettlement (see Appendix I for more information about the tests). We also include a commentary on leadership in the establishment (see Section 2).

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

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

1.3 We last inspected HMYOI Cookham Wood in 2021. Figure 1 shows how outcomes for children have changed since the last inspection.

Figure 1: HMYOI Cookham Wood healthy establishment outcomes 2021 and 2023



Progress on key concerns and recommendations from the full inspection

1.4 At our last inspection in 2021, we made 16 recommendations, 14 of which were about areas of key concern. The establishment fully accepted all of the recommendations.

1.5 At this inspection we found that one of our recommendations about areas of key concern had been achieved, one had been partially achieved and the remaining 12 had not been achieved. None of the recommendations made in the areas of safety or care had been achieved. Four out of the five key recommendations made in the area

of purposeful activity had not been achieved, with one recommendation partially achieved. In resettlement, one recommendation had been achieved and one had not been achieved. For a full list of the progress against the recommendations, please see Section 7.

Notable positive practice

1.6 We define notable positive practice as innovative work or practice that leads to particularly good outcomes from which other establishments may be able to learn. Inspectors look for evidence of good outcomes for children; original, creative or particularly effective approaches to problem-solving or achieving the desired goal; and how other establishments could learn from or replicate the practice.

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

1.8 The use of release on temporary licence (ROTL) was very good and the innovative use of special purpose ROTL had helped some children to reconnect with close family members. (See paragraph 6.27)

Section 2 Leadership

Leaders provide the direction, encouragement and resources to enable good outcomes for children in custody. (For definition of leaders, see Glossary.)

2.1 Good leadership helps to drive improvement and should result in better outcomes for children in custody. This narrative is based on our assessment of the quality of leadership with evidence drawn from sources including the self-assessment report, discussions with stakeholders, and observations made during the inspection. It does not result in a score.

2.2 A new governor had taken over the prison in February 2023, approximately eight months after the last incumbent had left. This gap had led to drift and the new incumbent had inherited an establishment facing acute challenges, including a demoralised staff, an atmosphere of fear and a culture of low expectations. These contributed to an inability to maintain decent standards in many areas, including behaviour management, cleanliness of residential units and the quality of teaching.

2.3 Leaders from the Youth Custody Service had not visited the site since the new governor had been appointed. The governor had set priorities to address these problems but at the time of our visit no progress was apparent.

2.4 Leaders had failed to address the now longstanding issue of shortages of operational staff. This, combined with high levels of sickness and a poor retention rate, meant that out of 148 operational posts, 65 staff were able to be deployed. It was concerning that rates of sickness and resignation had been increasing over the previous quarter and the proportion of staff who were unable to be deployed was among the highest in the prison estate. A key reason for this was low morale: in our staff survey 83% of respondents said their morale was low or very low. Many staff we spoke to said that they felt unsafe at work and were frustrated by inconsistent leadership and managers who undermined each other.

2.5 During the inspection we saw many staff not wearing the correct uniform, including epaulettes that would identify them to children. This was both emblematic and symptomatic of the drift in standards that pervaded the staff culture.

2.6 Although there was a shortfall of frontline officers, there were many examples of wasted resources. We were concerned that, despite around 360 staff in post, outcomes for the 77 children were so poor. There was a need for the Youth Custody Service (YCS) to make sure that the significant resources at Cookham Wood were effectively used.

2.7 There were 44 directly employed managers at Cookham Wood and several more working for partner agencies. Despite this, many aspects of governance and oversight were inadequate and, as a result, key processes had ceased to function effectively, including the deployment of operational and other staff, behaviour management, adjudications and systems for separating children. Given the size of the leadership team, it was disappointing that in our staff survey 71% of respondents said they met a manager just once a year or less to discuss how they were progressing in their role.

2.8 Leaders were not able to deliver a decent regime to children, most of whom could access an average of less than four hours a day out of their cells during the week and much less at the weekend. Many were subjected to what can only be described as solitary confinement during their time at Cookham Wood.

2.9 Partnership working between leaders and Gov Facility Services Limited was poor. The planned refurbishment of residential units was greatly delayed and a considerable backlog of simple repairs had not been completed. This affected key services, for example a door to the induction room had been broken for five months hindering children's access to key information during their first few days in custody.

2.10 The one area of strength at the establishment was Cedar unit (the resettlement/release on temporary licence unit). The unit had benefited from consistent leadership from a custodial manager with a clear vision who worked effectively with leaders in the resettlement team to implement an innovative approach to release on temporary licence for education, work and promoting family ties. Cedar unit was an oasis of calm and effective behaviour management in comparison to the rest of the establishment, and for the eight children living on the unit, it provided a potential opportunity to change their lives for the better.

Section 3 Safety

Children, particularly the most vulnerable, are held safely.

Early days in custody

Expected outcomes: Children transferring to and from custody are safe and treated decently. On arrival children are safe and treated with respect. Their individual needs are identified and addressed, and they feel supported on their first night. Induction is comprehensive.

3.1 Most children arrived at Cookham Wood Young Offender Institution (YOI) at a reasonable time, although records showed that 20 children had arrived after 8pm during the previous six months. This limited the ability of staff to assess risk and provide support for new arrivals, which was a particular concern for those who had not been held at Cookham Wood before.

3.2 The reception area had been refurbished since the last inspection. It now felt less institutional and provided a pleasant and comfortable area for children to complete arrival processes with staff.

Refurbished reception area

3.3 There were no new arrivals during our inspection. Staff described the arrival processes which included a health care screening with a nurse and an interview with a reception or first night officer to assess the child's vulnerability or risk. However, records of this assessment lacked

detail and were not shared with staff who would be involved in the child's care.

3.4 New arrivals were given a phone call, a small grocery pack and a battery-operated shaver to take to their cells. Those that arrived after the evening meal was served were offered hot food while they were in reception.

3.5 All new arrivals spent their first few days on B1, the induction unit. First night cells were adequately equipped and all cells had showers. Frequent first night checks were carried out and maintained until the required information about the child was received from community youth offending teams.

Prepared first night cell

3.6 In our survey, 69% of children, and only 50% of those with a disability, said they had felt safe on their first night. As with other units we found staff on B1 were managing significant levels on conflict between children. We observed, for example, a child being pressured by other children to perpetrate an assault on another new arrival.

3.7 In our survey, just 47% of children said they were told what they needed to know about Cookham Wood during their first days. We found the main induction room had been out of use for several months waiting for the door to be fixed. This hampered the delivery of private

induction sessions. A consistent theme raised with us by different agencies was the difficulty in finding private rooms to talk to children and make a timely assessment of their needs which had an impact on effective induction.

3.8 The organisation and oversight of induction were inadequate and did not make sure that all elements of induction were completed. There was no timetable for agencies to see children which increased the risk of some being missed. Some agencies used electronic case notes to record their meetings with children but this was not consistent and paper 'passports' that outlined the required elements of induction were also not being completed.

3.9 The use of induction unit staff to support other units further reduced the opportunity for children to be unlocked for induction sessions and to spend time out of their cells each day. This limited time unlocked was exacerbated by the occasional use of the unit to accommodate children who could not mix with other children and had to be unlocked individually (see paragraph 3.45).

Safeguarding of children

Expected outcomes: The establishment promotes the welfare of children, particularly those most at risk, and protects them from all kinds of harm and neglect.

3.10 External relationships with, and scrutiny by, the local authority remained well developed. In contrast, internal child protection arrangements had deteriorated during the second half of 2022 and concerns had been raised with the Youth Custody Service (YCS) by the local authority. This was being addressed by support from the local authority and the YCS safeguarding lead, but the challenge for leaders was to make sure that safeguarding was embedded in all areas of work at the establishment.

3.11 Leaders had recently implemented clear processes for the safeguarding team and designated social worker to follow. This included prompt triage of safeguarding concerns to determine which needed to be referred to the local authority. The on-site social work presence was shortly to be enhanced by the addition of a senior social worker to the team who would be a member of the senior leadership team.

3.12 The Medway local authority designated officer (DO) and safeguarding services manager (who also managed the on-site social workers) were regular visitors to the YOI, including for fortnightly DO clinics. These clinics also included representatives from Kent police and the health care provider and safeguarding incidents, many of which involved the use of force on children, were scrutinised well. Internal oversight meetings also took place regularly.

3.13 A sub-group of the Medway Safeguarding Children Partnership met quarterly to focus on the secure estate provision in Medway. Attendance included the local authority, Kent police, health care providers and commissioners, Barnardo's, the independent monitoring board and YOI leaders. Updates and data provided by and about Cookham Wood were discussed and a good level of external scrutiny was given to safeguarding areas. There was evidence to indicate that identified actions were followed up and progressed.

Suicide and self-harm prevention

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

3.14 The safety team was under-resourced. Only one of the four safety officer posts was filled, and this officer was often redeployed to work on residential units, seriously limiting the effectiveness of the department. Weekly safety meetings provided a forum to review individual cases of children involved in incidents of self-harm, assaults and illicit finds and those who were separated. A more recently introduced strategic monthly meeting focused on analysing incidents and responding to trends. The appointment of a safety analyst had led to early improvements in the data reviewed at these meetings and leaders were working to develop this further to aid their understanding of and response to the causes and patterns of self-harm.

3.15 There had been no deaths at the YOI since the last inspection. The self-harm rate had, however, increased and was now in the mid-range of YOIs holding children.

3.16 During the previous six months, there had been 34 instances of self-harm with two children each responsible for 10 of these incidents. There had been no serious self-harm requiring an investigation. One child had twice been to hospital after telling staff he had swallowed items, including batteries. The constant supervision cell had been used twice in the last six months for two different children, with the longest held for a period of three days. Anti-tear clothing had not been used.

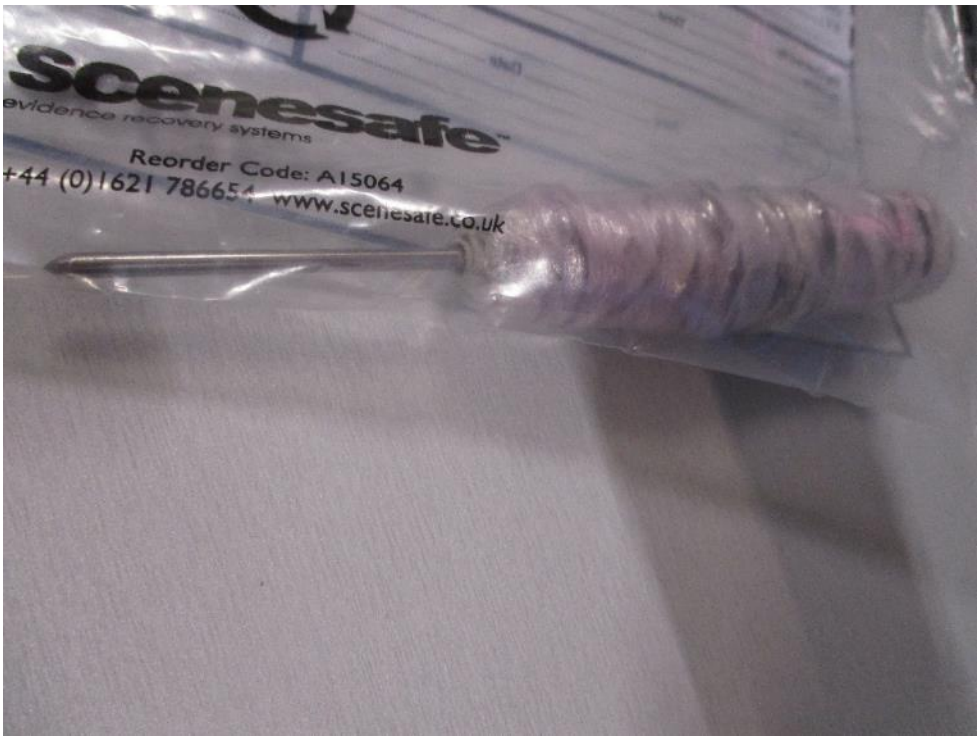
3.17 The number of children supported by ACCTs (assessment, care in custody and teamwork case management of children at risk of suicide and self-harm) was similar to the last inspection, with 39 opened during the previous six months. At the time of the inspection, three children were on ACCTs. Children who had experienced this support described staff checking on them and having someone to talk to as the main benefits.

3.18 Despite evidence of some good initial assessments and good case reviews, problems with the quality of ACCT documents still persisted. Reviews were not consistently conducted by the same case co-ordinator, observations and conversations were not all recorded and there was slow progress with many care plan actions. Quality assurance by the safety officer was identifying these deficiencies but this had yet to lead to improvements.

Security

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

3.19 The widespread availability of weapons was a considerable concern. During the six months prior to the inspection, a concerning 228 weapons had been found, a number much higher than similar establishments. Security procedures that might deter weapons being carried around the prison, such as searching, were not effective: the searching that we observed was inadequate and missed key areas including children's socks and shoes. In addition, some searching took place without using available equipment, including metal detecting wands and poles. Accounting for tools and materials that could be used to make weapons was also poor. The tools for which residential staff were directly responsible, such as food probes, were not systematically accounted for (see paragraph 4.21).



Weapon made by a child

3.20 There was a reasonable flow of intelligence, with an average of 450 reports a month, an increase since the last inspection. At the time of the inspection the institution had a backlog of just over 100 intelligence reports, although all reports had been screened to make sure that they were appropriately prioritised. However, actions prompted by individual intelligence reports were not always carried out, for example only one-fifth of targeted searches were completed.

3.21 Most security measures were proportionate for the population, but in one instance we identified, leaders had prevented a child from receiving social visits because he was separated, which was completely inappropriate. In addition, most children subject to separation were placed on restricted visits, which were shorter and limited only to Monday. This made it impossible for many separated children to achieve their entitlement, particularly those who were on remand.

3.22 Mandatory drug testing (MDT) had been consistent during the previous six months. Fifty-two tests had been carried out, of which four had returned positive. This represented a positive rate of 7.69%, which was higher than we usually see in a children's prison. There was a one-page drug strategy, but many elements of the strategy were not being delivered, including the personal officer scheme and the rewarding positive behaviour policy.

Behaviour management

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

3.23 With the exception of Cedar unit, behaviour management in the institution was ineffective. Children lacked proper boundaries, and staff were not properly in control and were routinely inconsistent in their dealings with children. In responses to our staff survey and in discussions throughout the inspection, staff repeatedly expressed to us an anxiety about challenging children's behaviour or enforcing the rules in case they themselves became the target of an assault. Some, in addition, suggested that they could not always rely on colleagues or managers to support them (see paragraph 4.4). In the absence of an effective behaviour management plan, separation had become almost the only method of managing the most challenging boys and was, as a consequence, something that had come to dominate the daily experience of almost all in the institution.

3.24 An incentives scheme suggested two regime levels, silver and gold. On paper there were marked differences between these levels but stated incentives such as possession of a larger television or permission to dine in association out of cells were not delivered, which undermined the scheme.

3.25 In addition, green and yellow cards were meant to be used as a supplementary instant reward and sanctions scheme. Green cards could be traded for items such as chocolate bars or phone credit; yellow cards led to punishments, including loss association. Again, the scheme had no value because it was not delivered. During the first three months of 2023, only 46 yellow cards and 207 green cards had been issued, 70% of these by non-residential staff, such as education or Kinetic Youth workers. Despite the incentives and instant reward schemes, undesirable behaviour such as obstructing observation panels, graffiti and threats shouted through windows and doors frequently went unchallenged by staff.

3.26 Fundamentally, a child who had worked for the higher level was unlikely to receive the designated awards for their behaviour. Similarly, sanctions were often not implemented because activities like association were regularly cancelled for all children. This rendered both schemes ineffective.

3.27 The adjudication system for the most serious cases of bad behaviour, such as violence and weapon making, was also ineffective. Many charges were remanded for long periods before being dismissed. Management information systems showed that only half the adjudications were found proven, which was at odds with the general levels of disorder and delinquency. Punishments that were awarded were ineffective.

Bullying and violence reduction

Expected outcomes: Everyone feels safe from bullying and victimisation. Active and fair systems to prevent and respond to bullying behaviour are known to staff, children and visitors.

3.28 In our survey, nearly a quarter of all children (24%), said they felt unsafe. This compared with 5% at our previous inspection and 8% at similar establishments. Forty-two per cent of children told us they had felt unsafe at some point during their stay. The high number of weapons and the feeling that violence would arise if children mixed contributed to these very poor perceptions of safety.

3.29 The recorded rate of violence against children had decreased by 11% since the last inspection. During the previous six months, there had been 98 recorded assaults on children, the second highest number among similar prisons. Recorded rates of violence against staff had increased by 29% since the last inspection, with 75 assaults on staff reported over the previous six months. Twelve per cent of all incidents were classified as serious in nature and a third of incidents had involved a weapon.

3.30 One child told us:

> ‘I have been stabbed here and brutally assaulted and been punished for being the victim because Gov couldn’t prove who started it. The violence here is horrific, there are weapons everywhere.’

3.31 A significantly higher proportion of children in our survey reported verbal abuse (64%) and/or being the target of physical assault (35%) by other children compared to our previous inspection (34% and 11% respectively). We observed a lot of shouting and abuse among children.

3.32 At the time of our inspection, 90% of children were subject to ‘keep aparts’, with staff managing 583 individual conflicts in a population of 77 children. This meant that every movement for children had to be planned, delaying almost every activity, even opening a cell door. This had become the norm and dominated day-to-day life for all at Cookham Wood.

3.33 The work to address conflict was not effective. The conflict resolution team was understaffed and frequently cross-deployed to other tasks. During the previous six months, 86 referrals had been submitted, less than a quarter of which had led to anything approximating a positive outcome.

3.34 There was an inadequate response to violence and incidents were not investigated, which limited leaders’ understanding of the causes of violence and bullying. The recently reintroduced monthly safety meeting was a tentative start and leaders were planning a safety event to revise the safety strategy.

The use of force

Expected outcomes: Force is used only as a last resort and if applied is used legitimately by trained staff. The use of force is minimised through preventive strategies and alternative approaches which are monitored through robust governance arrangements.

3.35 The rate of force used was similar to the previous inspection. During the previous six months, there had been 307 recorded incidents of use of force. Use of pain-inducing techniques, a high-level intervention for children, was higher than at other establishments, being used four times in the last six months.

3.36 Most incidents of force occurred because of the risk of harm to others. The incidents that we viewed seemed justified and proportionate, but some lacked evidence of attempts to de-escalate. We were concerned that staff did not respond quickly to a child making a serious injury or warning sign (signs a child’s condition might be deteriorating, which include vomiting and breathing difficulties). During incidents that we

viewed, children had to make repeated communications to staff before action was taken to make sure they did not deteriorate further.

3.37 The quality of use of force reports varied greatly: some included a thorough account of the incident and what led up to it, while others did not contain any detail about the incident. Too many reports had not been completed which was concerning.

3.38 Oversight of use of force was reasonable, with all incidents screened for safeguarding concerns and to establish if full quality assurance was required. While this quality assurance had identified the issues, it had not yet addressed them. In addition, staff training was not at the required level and only 57% of staff had received up-to-date training.

3.39 Debriefs of children who had been restrained were not timely. Some took place more than a month after the incident and the child often did not engage.

3.40 Restraint management plans, which alerted staff to injuries or conditions such as asthma, were of adequate quality and readily available to staff.

Separation/removal from normal location

Expected outcomes: Children are only separated from their peers with the proper authorisation, safely, in line with their individual needs, for appropriate reasons and not as a punishment.

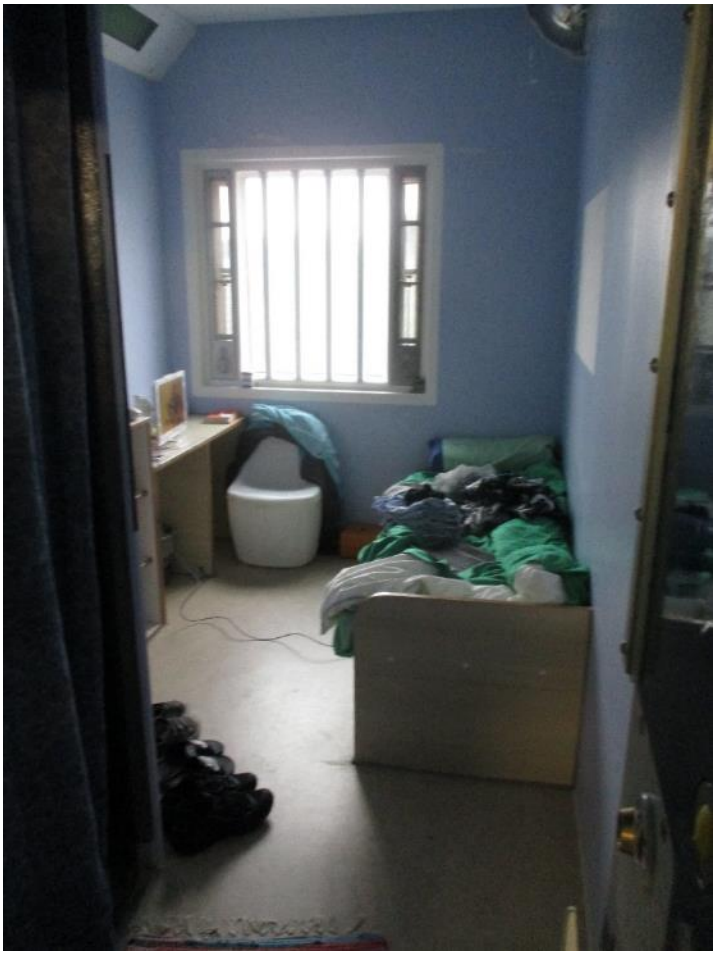
3.41 At the time of our inspection, more than a quarter of children were living in separated conditions under YOI rule 49 (see paragraph 3.23). This rule enables leaders to separated children from their peers to maintain good order or discipline (see Glossary). There was no designated separation unit and children were separated across the residential units. The very high levels of separation had overwhelmed the resources available to provide basic entitlements for these children, including education, exercise and visits.

3.42 The number of children separated had increased since our last inspection, with 184 children living in separated conditions during the previous six months. The average time that children spent separated had increased to 15 days. Two children had been separated for more than 100 days and a further four for more than 50 days.

3.43 Children could be separated for good order or their own protection on Rule 49 and could also isolate themselves if they were afraid of interacting with other children. At the time of the inspection, 21 children were separated, slightly more than half because they constituted a risk to others, a third for their own safety and the remainder were self-separating.

3.44 Separated children received an inadequate regime that amounted to solitary confinement for many children. The most consistent element of

a child's day was a 30-minute period of exercise but on many occasions even this was not delivered and children could spend days without leaving their cell.



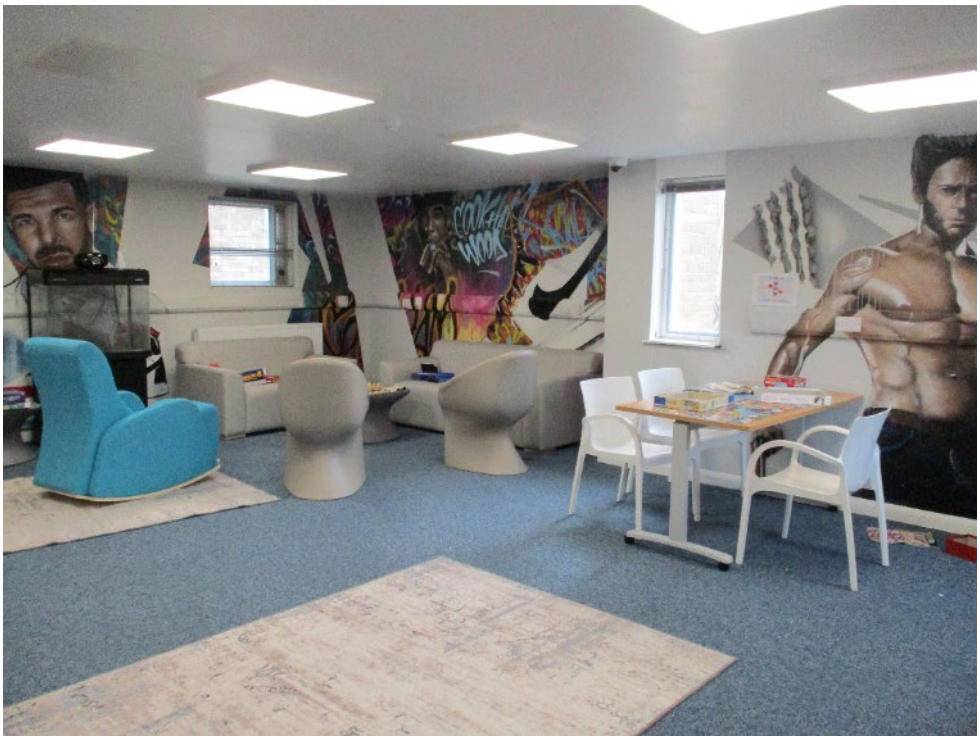
Separated child's cell

3.45 One child had been separated for nearly six weeks. The regime that he experienced was rarely recorded, although the evidence we saw suggested that he only had time in the open air on one-third of the days that he was separated. Records also indicated that this very limited time out of cell was sometimes cancelled because of the child's behaviour or because staff were unable to facilitate it. Records also showed that this child only left his cell on nine other occasions, for example court or social video calls.

3.46 Most separated children did not receive any education. In March 2023, for example, 37 children had been separated for a total of 453 days and yet the education provider had only delivered a total of 21 hours of education, a figure that equated to an average of less than three minutes per child each day.

3.47 The Phoenix Unit was a dedicated outreach facility for separated children. However, the high number of separated children, lack of staff and poor planning of access rendered the unit ineffective. This meant that children who were separated had hardly had any meaningful daily interactions with staff and even statutory visits were frequently

conducted without opening the cell door. Most records demonstrated that visitors only checked if the child wished to raise a concern rather than initiating a conversation or checking for signs of deteriorating mental health or well-being. We observed many missed opportunities to engage with children, for example when they were on the exercise yards. Professionals from other parts of the prison also told us that it was difficult to see separated children.



Phoenix unit

3.48 Reintegration planning was inadequate and initiatives such as interventions to reduce a child's risk rarely took place.

3.49 The oversight of separation was poor. Leaders were aware of the issues confronting separated children but did not address them adequately.

Section 4 Care

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

Relationships between staff and children

Expected outcomes: Children are treated with care by all staff, and are expected, encouraged and enabled to take responsibility for their own actions and decisions. Staff set clear and fair boundaries. Staff have high expectations of all children and help them to achieve their potential.

4.1 Children's perceptions of their relationships with staff had deteriorated since our last inspection. In our survey, only 60% said that most staff treated them with respect compared to 82% at the previous inspection.

4.2 Our survey also indicated that 56% of children had been verbally abused by staff, 37% had been threatened or intimidated and 29% said they had been physically assaulted, all of which were significantly worse than at our last inspection and at similar prisons. It was notable that only 32% of children compared to 68% at the previous inspection said that staff had not done any bullying or victimisation to them.

4.3 We observed a demoralised staff group, most of whom were also working long hours to cover for the high number of vacancies. These staff did not have time to form any kind of constructive relationship with the children in their care, their interactions were transactional at best and too many conversations took place through a locked cell door.

4.4 Most staff did not have the confidence to challenge poor behaviour because of concerns that other staff or leaders would not support them and they would be targeted subsequently by children (see paragraph 3.23).

4.5 Staff were very frustrated. Many said that they wanted to do more for the children in their care but the need to facilitate a high number of separate regimes for individual children meant that they had no time.

4.6 In contrast, there were much better relationships on Cedar unit where the regime was better and staff had the time and knew the children well. Children were not subject to keep-apart protocols and mixed freely with their peers and staff on the unit.

4.7 A personal officer scheme was designed to make sure that a named member of staff supported each child and developed a purposeful relationship with them. However, most children either did not know who their personal officer was or had not seen them for some time.

4.8 In the electronic records that we viewed, we found very few entries by staff recording personal officer contact with children. The inability of

leaders to deliver a personal officer scheme was inexplicable given the number of people working at the site and the comparatively small population of children they were looking after.

Daily life

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

Living conditions

4.9 There had been considerable delays in carrying out refurbishment work on the accommodation. B1 unit, for example, had been scheduled to take three months but had taken more than a year to complete. The cells on units that had been refurbished were in reasonable condition and most contained suitable furniture but they remained stark and we did not see many cells which children had been able to personalise.

4.10 Cells on the units that had not been refurbished were shabby and worn. Every cell had a shower and toilet, but the condition of some of the shower areas was poor with scale and graffiti. There was scale in the toilets and all units had some toilets with no seat.

Graffitied in-cell shower

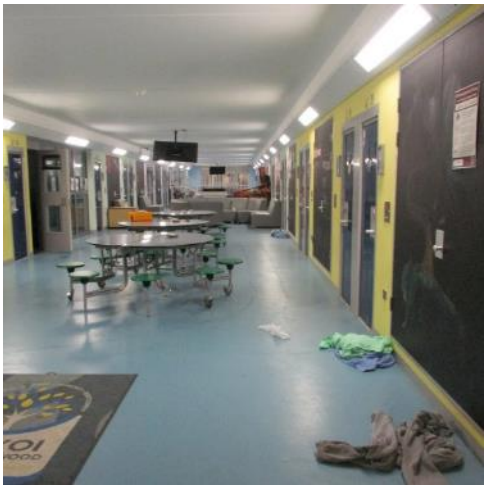
4.11 There was little encouragement for children to keep their cells clean and tidy. The keep-apart restrictions made it almost impossible to keep

a cell door open for long enough to complete tasks such as cleaning the cell floor.

4.12 The environment on Cedar unit, which was self-contained, was slightly better. The communal areas were well equipped, with a large television, comfortable seats, a fish tank and carpets.

4.13 There was less graffiti than at our last inspection, but it was still commonplace in cells and communal areas and remained a problem.

4.14 The landings and communal areas were dirty and we observed food and litter strewn across the floors. There was no cleaning routine on most units; cleaning was undertaken when staff could fit it in. Staff offices and facilities were hardly any better.



A2 unit (left) and Cedar unit (right)

4.15 Areas not immediately adjacent to the cells such as stairs and thoroughfares were the responsibility of a private contractor who attended once a day. This was not frequent enough and we regularly observed dirt and litter in these areas. On one afternoon, we saw food on the floor at the top of a flight of stairs that had been there the previous day.

4.16 Children received fresh bedding once a week but struggled to get their clothes laundered. There were six washing machines and four dryers, but only one washing machine and two dryers were working. Replacement washing machines had been in the prison for several months, but the maintenance contractor had not fitted them and they remained in storage. This was reflected in our survey where only 61% of children said that they normally had enough clean, suitable clothes for the week compared to 80% at similar establishments. In discussion, children confirmed that they simply could not get their clothes washed frequently enough.

4.17 Many other maintenance jobs were awaiting completion by the contractor and staff told us that they were unofficially doing some of this themselves as they were so frustrated with the delays. We made

several requests to the maintenance provider for information about the scale of the problem, but they did not respond.

4.18 There was some fixed exercise equipment and seating in the exercise areas which were fenced in. The surrounding fence had been extensively marked with graffiti and then painted over in patches with different coloured paint. This contributed to making the space feel shabby and austere.

Exercise areas (left) and all-weather sports area used for some exercise periods (right)

Residential services

4.19 Children's perceptions of the food were broadly similar to our last inspection. The meals that we observed were of reasonable quality and portion sizes were good. There were five options for children to choose from including cultural and healthy options.

4.20 The catering manager had recently conducted a survey of all children which had received a good response. He had used the responses to inform a review of the menu which had been received well by the children.

4.21 The kitchen needed refurbishment, but the staff kept it clean and food was stored appropriately. Children who helped to give out food on the serveries were not always appropriately dressed and did not have their heads covered. Food temperatures were not always taken and recorded before food was served as the food probes were missing during the inspection (see paragraph 3.19).

4.22 There were too few opportunities for children to eat together and they could expect to do this only on one day of the weekend. There were no cooking facilities available for children on the wings.

4.23 Children could order from the shop either on the kiosk or through their in-cell laptop. More than 400 items were available which included a good number of choices for children from different cultures.

4.24 No consultation on the range of goods available had taken place since 2021.

Consultation, applications and redress

4.25 There was little consultation with children except on Cedar unit. A scheme called 'junior leaders' had started in January 2023. A representative from each unit was to attend a monthly meeting to discuss topics suggested by their peers, but only one meeting had taken place. This had been attended by three children and leaders from the residential units, kitchen, offender management unit and diversity team, but the discussion had not been monitored or fed back to the children.

4.26 There were sporadic community meetings on the main wings but generally in response to an incident rather than discussing the children's concerns. There were no records of these meetings and no actions were generated.

4.27 Regular community meetings took place on Cedar unit and minutes indicated that appropriate actions were discussed. Information that the children needed was shared at these meetings which was particularly important for those who were frequently on release on temporary licence (ROTL).

4.28 Applications were submitted through the laptops in cells and most of the children we spoke to were positive about this procedure. Applications were dealt with reasonably well, although children told us it could take some time for the issue to be resolved. There was little oversight of this process and, despite available data, leaders did not know the number of applications submitted, the reasons for them and if they had been answered.

4.29 Oversight of complaints was good. During the previous 12 months, the number of complaints had increased which reflected the deterioration in the regime and staff relationships. The most common complaint concerned staff and there were very few complaints that should have been dealt with at a lower level. All complaints were answered, most within the timescales of five working days set by the Youth Custody Service.

4.30 Responses were generally polite and detailed and resolved the issues complained about. Responses that were not up to standard were rigorously challenged by the quality assurance system. All complaints were quality assured by the functional head and a further 10% by the deputy governor. We saw some examples of complaints being returned to leaders and staff to be re-written and an apology issued to the child, which was good.

4.31 During the previous 12 months, 59% of complaints had been upheld or partially upheld. Leaders gathered a good amount of data on complaints but did not use the data to carry out further analysis into trends or to address the reasons for complaints.

4.32 Children had good access to advocates when submitting complaints and we saw a considerable proportion where Barnardo's advocates had helped them to complete their complaints.

4.33 This was also the case with children's legal rights. Two independent social workers and Barnardo's representatives were available to provide independent guidance or to steer children to the appropriate assistance. Leaders had also arranged for four staff to be trained in the near future to help foreign national children (see paragraph 4.41).

4.34 Legal visits took place on three weekday mornings and children also had access to remote video link visits with their legal representatives. Leaders tried to maintain these video links as a priority but visits were occasionally cancelled because of staff shortages.

Equality and diversity

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

Strategic management

4.35 Equality and diversity work was not given a high priority and its promotion was not sufficiently embedded across the YOI. The identification of members of the senior leadership team as protected characteristic leads had not resulted in any tangible outcomes and managers acknowledged that this needed to be addressed. Similarly, children were not sufficiently involved in the development of equality and diversity work. There were no peer representatives, no forums for children from different groups, limited consultation and no child presence at meetings where equality and diversity were discussed. The keep-apart regime which pervaded all areas of work prevented progress with some of these initiatives.

4.36 The small, committed diversity and inclusion team had experienced several management changes since the last inspection. It consisted of three people, one of whom was part time, and the team had until recently experienced frequent redeployment of its operational resource. There was one vacancy on the team which was filled when possible by staff on restricted duties. Work in progress included planning to mark specific events, for example Gypsy, Roma and Traveller (GRT) month (10% of children identified as GRT in our survey), Deaf Awareness Week and Black History Month. A newsletter had been introduced which was intended to be a regular publication.

4.37 Policy and strategy documents had been reviewed in 2022 and an equality action plan developed. An equality action team had met three times since November 2022 to oversee the equality and diversity work.

Minutes recorded discussion of a reasonable range of topics but did not indicate that the forum was driving improvement in outcomes. The need to identify and address disproportionate outcomes was recognised, but data were not interrogated at this or other meetings to identify areas that required attention and how this would be done. Managers were realistic in their assessment that they needed to make sure that protected characteristic information was collected consistently during induction to aid reliable identification of disproportionality.

4.38 Twenty-eight discrimination incident report forms (DIRFs) had been submitted during the previous six months, most by staff. Despite reminders from the diversity and inclusion team, 11 had been responded to late which illustrated the lower priority given to equality and diversity work. The level of enquiry into incidents was variable despite a useful checklist for investigators to use. Internal quality assurance had started to identify where more robust enquiry was needed and the recent involvement of the Zahid Mubarek Trust to aid this process was a positive step.

Protected characteristics

4.39 In our survey, children from most protected characteristic groups had similar perceptions to their peers. Sixty-four per cent of children were from black and minority ethnic backgrounds. They raised with us similar concerns to white children, including safety, the poor regime and too few staff. In private interviews, children expressed the view that their treatment was not based on protected characteristics but on their individual behaviour and the relationships they had with staff.

4.40 In our survey, 37% of children said they had a disability and they were the only protected characteristic group to report different perceptions of the establishment. Only 17% compared with 55% of other children said it was normally quiet enough to relax or sleep at night and just 22% compared with 66% that they usually spent more than two hours out of their cells on weekdays. These children would have had a range of learning disabilities or neurodiverse conditions and their poorer perceptions needed to be understood and addressed.

4.41 There were 15 foreign national children at the time of the inspection. Services for these children had deteriorated since the previous inspection. Home Office immigration enforcement staff no longer visited for immigration surgeries, though this was mitigated in part by quarterly visits from the immigration prison team. Some staff were shortly to go to HMP Maidstone for training (see paragraph 4.33). Children with no family in the UK could have a free five-minute phone call each month and one child was using this opportunity. Staff were aware of the telephone interpreting service but said that it was rarely needed.

4.42 Several of the DIRFs submitted by staff mentioned discriminatory remarks made to them by children. Staff had been able to attend transgender awareness sessions. Lack of support for LGBT staff was mentioned in the staff survey conducted for this inspection. No children had disclosed that they were LGBT.

4.43 The chaplaincy was now based away from the main house block but chaplains were still active and visible around the site. Their new base included improved ablution facilities but their removal from the residential units made it more difficult to see children spontaneously. Chaplains found it difficult to find private spaces to speak to children, but in our survey 77% of children said they were able to see a chaplain of their faith in private which was similar to the previous inspection.

Multi-faith room

4.44 The team had one vacancy for a Church of England chaplain. Pending recruitment, the sessional Sikh minister was filling the slot in the team to make sure that statutory duties such as meeting new arrivals and seeing separated children each day could be completed. The Free Church chaplain was conducting Sunday worship with contributions from community faith groups.

4.45 Chaplains offered weekly group worship sessions and classes for their faiths, but problems with children mixing restricted access to communal worship by unit location. This meant, for example, that Muslim children could only attend Friday prayers once every five weeks. Faith materials were available on children's laptops for them to use when they were not able to attend in person. Between October 2022 and the start of this inspection in April 2023, 15 of 76 planned weekend group worship sessions had been cancelled because of operational staffing problems, which was poor.

4.46 Chaplains described collaborative relationships with other parts of the YOI as they carried out their spiritual and pastoral roles, including the celebration of religious festivals. Ramadan was progressing well during the inspection with only two children who started deciding not to

continue with their fast. Children were being consulted about preparations for Eid food, which was available to all children.

Health services

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

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

Strategy, clinical governance and partnerships

4.48 Central and North-West London NHS Foundation Trust (CNWL) delivered mental health and primary care services. Dental services were provided by Kent Community NHS Trust. Despite references in our previous reports and in partnership and local quality board meetings, the longstanding concerns about the lack of access to the children remained unresolved. Officer availability and delayed movement and the lack of confidential therapeutic space for delivering planned mental health interventions all contributed to the problem. The Framework for Integrated Care (Secure Stairs) model (see Glossary) had been introduced in 2018, but it was an underused resource.

4.49 Following a recent procurement process, CNWL had been awarded the contract in April 2022. There was no up-to-date health needs assessment to identify the particular service requirements for children at Cookham Wood, which was an omission.

4.50 The head of health care, deputy head of health care and clinical leaders provided clear leadership and accountability to an enthusiastic and caring team who were committed to the delivery of a service focused on the needs of the child.

4.51 CNWL monitored their performance indicators and maintained the governance processes, but the lack of a robust, embedded prison-led local delivery board prevented prison leaders from having effective oversight of services.

4.52 Complaints were well managed. A member of staff visited the child and a follow-up letter addressed all the key concerns. Letters were polite but not always written in plain English.

4.53 Incident reporting and investigations were prompt and lessons learned were effectively disseminated through daily staff briefings, emails and care quality meetings.

4.54 Staff were on site from 7.30am until 9pm, with a reduced service at weekends. The health care service was well staffed and staff felt supported by effective clinical and safeguarding supervision. Health care staff used electronic health records for the children and those that we sampled were of a good standard.

4.55 Information-sharing agreements supported the sharing of patient information and risks. However, we saw examples where joint working would have been expected within the Secure Stairs framework but remained separate, for example physical and mental health teams delivered separate discharge plans which were not integrated with the prison discharge plan.

4.56 Children were asked to provide feedback on services through surveys. There were no forums for children to express their views, which was an omission.

4.57 Emergency resuscitation equipment was in good condition and daily equipment checks were completed. The emergency bags weighed 15.4kg, which presented a health and safety risk to staff. We raised this with the head of health care and were assured that this would be reviewed. We were told that staff were quick to respond to emergencies and an ambulance was automatically called when an emergency call was made over the radio.

Promoting health and well-being

4.58 CNWL had an overall health and well-being strategy but there was no joint local policy with the prison to deliver planned health education throughout the year.

4.59 There were some clinics for age-appropriate health interventions, for example smoking cessation and childhood vaccinations. A considerable number of children had not received their secondary school level boosters. Clinical records demonstrated that staff promoted vaccinations, but there was a general reluctance by children to take this up. The absence of a strategy to address vaccine hesitancy and improve uptake was a personal as well as a public health risk.

4.60 Children received a health information leaflet and sexual health urine screening on arrival. Condoms were made available to children on release.

Primary care and inpatient services

4.61 Primary care services were well led and well resourced. GP and nurse appointments were available every day and, if a child did not attend, they were rebooked to the next available slot. The primary care clinic rooms were close to the wings which made access easier than for other services.

4.62 All children were screened on arrival using a national child health assessment tool, which included a neuro-disability assessment to identify possible dysfunction. Health care assistants carried out a sight

and hearing screening and children were promptly referred to the GP or optician if required, which was good practice.

4.63 Health care applications were made electronically on laptops. The applications were reviewed twice a day by the primary care nurse who visited the child to discuss their needs.

4.64 There was a good range of primary care, appropriate to the needs of children, which included optometry, GP consultations, nurse-led clinics and physiotherapy. The optometry provider had recently changed to Prison Optometry and, although efforts had been made to reduce the waiting list, the longest wait remained 15 weeks which was too long.

4.65 Following previous incidents when a child had become unwell during Ramadan, all children who were fasting received a daily welfare check by the nurse, which was good practice.

4.66 A sub-contracted GP practice delivered four sessions a week, including Saturday mornings for emergencies, which was sufficient to meet the need. Routine GP appointments were available within one to seven days and the NHS 111 service was used out of hours. GPs managed children with long-term conditions and, if necessary, referred the child to specialists. Care plans were generic and lacked evidence that the child had contributed to compiling the plan, which was unsatisfactory.

4.67 Hospital appointments were effectively monitored and, although few in number, some had been cancelled and rearranged because of operational pressures.

4.68 Social care provision had not changed since the last inspection. There was no partnership agreement with the local authority, no identified domiciliary care provider for children who arrived with additional care needs and no trained peer support. We saw no evidence of unmet needs at the time of the inspection, but this situation carried potential risks.

Mental health

4.69 The health and well-being team (HWBT) delivered all mental health care within the Secure Stairs framework. The richly multidisciplinary staff group worked from 8am to 5pm Monday to Friday and were highly skilled and motivated. At the time of the inspection, the HWBT were supporting 63 children, 82% of the population.

4.70 All children were seen in reception and assessed by the primary care nurses. Children with mental health needs were then referred to the HWBT who saw urgent referrals on the same day and routine referrals within three days, which was appropriate.

4.71 All new referrals were discussed at the weekly triage meeting. Following triage, the mental health and neurodiversity components of the assessment were undertaken, information was obtained from other sources and the initial outline of integrated care needs ‘formulation’ was completed with the child (a joint effort between a child and their

psychologist to summarise difficulties, explain why they may be happening and make sense of them). This was further discussed at the clinical team meeting and allocated to the appropriate professionals. A handover took place twice a day for all staff, which ensured that risks were managed in a timely manner.

4.72 Each wing had a landing support worker and prison staff knew who these were. The HWBT facilitated a weekly reflective practice session and core support team meeting for each wing, although following changes in the prison regime these meetings were now less well attended by officers and other members of the multidisciplinary team. Most officers we spoke to on the wings were not aware of the location or contents of the formulation documents and did not relate formulations to the Secure Stairs framework, which was poor.

4.73 The HWBT were able to offer a wide range of interventions, but most appointments were repeatedly cancelled because of poor access to the children in confidential and therapeutic rooms and the lack of escort staff. Too often clinicians visited children and talked to them through the cell door which was an inadequate replacement for structured therapy.

4.74 The clinical record entries that we reviewed were frequent but often sparse because no therapy had been offered. Children we spoke to knew who their HWBT clinician was.

4.75 Risk assessments were completed on the electronic clinical record and those that we inspected had been updated appropriately. The clinical records contained a number of care plans, but it was not always clear who the main key worker was. As a result, care was not coordinated or delivered in the most effective way to give the best outcome for the child.

Substance misuse

4.76 There was a drug strategy, but no multidisciplinary meetings or action plan to inform and review delivery. A comprehensive needs assessment to inform the needs of the service had not been carried out.

4.77 No children were receiving clinical treatment at the time of the inspection. Two nurses in the HWBT were able to complete clinical assessments and were Royal College of General Practitioners level 1 trained (RCGP Certificate in the Management of Drug Misuse), which was appropriate. The GP or psychiatrist continued to prescribe where necessary.

4.78 Three psychosocial workers were co-located with other members of the HWBT and some joint assessments were carried out when a dual diagnosis (co-existing mental health and substance misuse conditions) was identified. They also participated in the formulation meetings, which was good.

4.79 The children were assessed on arrival and any substance misuse concerns were referred to the HWBT psychosocial workers who assessed the children within five days of arrival. A child with urgent concerns was seen on the same day, which was good.

4.80 The staff completed risk assessments and care plans with children and these were reviewed by their manager during supervision to support safe care. A good range of interventions were offered, including harm reduction using trauma-informed practice. As access to the children was very difficult, the use of telephone appointments was sometimes the only option, but this was not conducive to effective confidential therapy.

4.81 No training on substance misuse had been completed for prison staff. The team offered bespoke sessions on the wings to share information on specific substances, which was good.

4.82 There were no drug champions or peer support workers, which was a gap.

Medicines optimisation and pharmacy services

4.83 Medicines management and oversight were good. Services were well organised and medicines were supplied by the pharmacy at HMP Rochester when required.

4.84 Medicines were stored appropriately and stock was checked and ordered each week. Incident reports about delayed arrivals of medicines had been addressed at the most recent medicines management meeting, which was appropriate.

4.85 The pharmacy team, which included a specialist paediatric pharmacist, visited once a month and carried out essential audits. The locality medicines management meeting met regularly to review local policies and procedures and prescribing trends.

4.86 The pharmacist met the children who were on long-term medication to support the child's understanding of the medicine, which was good practice.

4.87 Prescribing was age appropriate. Most medicines were administered twice a day, which was not always in accordance with therapeutic dosing. As at our last inspection, managers were aware of this and there were continuing discussions about increasing the number of medicines held in possession and how to make sure that these were stored safely.

4.88 We observed that none of the children who attended the hatch for medication had an identity (ID) card. Officers did not routinely check that the child had ID before escorting them. We raised this during the inspection but with no immediate improvement. Staff administering medicines asked the children for their date of birth and we noted that the nurses knew all the children by name. The administration of

medicines took a long time to complete because of the restricted flow of attendance caused by the limitations on mixing children together.

4.89 Nurses used patient group directions (which enable them to supply and administer prescription-only medicine) on a limited basis. Over-the-counter medicines administered by nurses were recorded appropriately on the electronic clinical record.

4.90 Officers provided pain relief at night for children experiencing dental pain.

Dental services and oral health

4.91 Kent Community NHS Trust delivered an appropriate range of NHS dental treatments, including oral health advice and disease prevention. They operated one session a week, supported by a dental nurse, and in an emergency the child would be transferred to a community dentist. The dental nurse followed up children who were anxious about seeing the dentist which had encouraged those in receipt of treatment to complete the course. This was good practice.

4.92 The dental nurse reviewed all applications and allocated appointments based on clinical need. There was no waiting list for new assessments at the time of the inspection. The dentist made comprehensive notes of interventions on the electronic clinical record.

4.93 The dental suite was fit for purpose and, although there was no separate decontamination area, the facilities met infection control standards. The dental suite was cleaned and tools were audited during each session, with comprehensive records.

4.94 Emergency drugs and oxygen stored in the dental suite were also audited weekly by dental staff. Dental equipment was maintained and certified appropriately.

Section 5 Purposeful activity

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

Time out of cell

Expected outcomes: Children spend most of their time out of their cell, engaged in activities such as education, leisure and cultural pursuits, seven days a week.

5.1 During the roll checks that we conducted we found 41% of children locked in their cells during the school day. Most of these children only ever left their cells for 30 minutes to go outside on the exercise yards and to collect their meals, which was poor (see paragraphs 3.44 and 3.46).

5.2 In our survey, only 49% of children said that they usually spent more than two hours out of their cell on a weekday compared with 77% in similar establishments. Staff shortages and complicated unlock arrangement prevented the delivery of association on weekdays.

5.3 Children who attended education fared slightly better and could expect an average of three hours 45 minutes each weekday out of their cell. This was still considerably lower than our expectation of 10 hours a day.

5.4 Weekends were equally bleak. Children who could mix together had an average of about three hours out of their cells, with one hour outside for exercise, one hour of association with their peers on the unit and some time in the gym on one of the days. Children were also likely to be able to eat out of their cells for one meal over a weekend but this was not consistently delivered.

5.5 Cedar unit, which held a small number of children, provided much more time out of cell with an average of about six hours each day. Each child was either in education or on release on temporary licence (see paragraph 6.26) during the week and was out of their cells for most of the day. They had association time together in the evenings and took part in additional activity (see paragraph 5.11) at the weekends.

5.6 In our survey, only 12% of children said that they went to the gym or played sports more than once a week compared with 71% at our previous inspection and 61% at other YOIs.

5.7 Children could attend the gym for a three-hour session once during the week as part of their education pathway and once at weekends for 90 minutes if they mixed with other children on their unit. However, this was affected by the multiple keep-apart protocols (see paragraph 3.32). Children who did not attend education missed their weekday sessions

and both the gym and two all-weather pitches were rarely used to their capacity.

5.8 Children's time in the gym was further affected because there were only six gym staff out of a complement of nine. There was also frequent cross-deployment of staff to support the residential units which further reduced the number of sessions available.

5.9 Leaders had realised that one three-hour session was too long for most children and had recently altered this to two 90-minute sessions during the week. This had created additional problems with the high number of keep-aparts further reducing the number of children who were attending. We observed the gym staff working to a complicated attendance system in an attempt to maximise gym attendance.

5.10 The same situation applied at weekends when children who mixed had the opportunity to go to the gym, while those who were separated or could not mix attended the gym on their own. This happened infrequently and only when staff could fit them in.

5.11 Children on Cedar unit took part in the Park Run scheme outside the prison at weekends if they wished (see paragraph 5.5), but other activities such as the twinning project with a local professional football team had recently stopped. Gym staff had advanced plans to reintroduce the Duke of Edinburgh Award scheme for children during the summer, which was positive.

5.12 The library was only open during the week and there was a rota for children to attend which reflected each of the education pathways. Records showed that, during the previous 12 months, about 29 children had visited the library each week, which was too few.

5.13 The library was a pleasant environment and held a good range of books. Some children completed quizzes or played games such as chess with the librarians. Children could also learn about the rules of the road using laptops in preparation for learning to drive on release.

5.14 There was some promotion of literacy. The Six Book challenge had taken place recently when children had to read six different books and write a brief precis of each, with prizes for all who took part. The librarian also made sure that learning in the various pathways was supported by ordering books that linked with the pathways, for example there were books about coffee and tea in preparation for the barista course.

Education, skills and work activities

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

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

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

Overall effectiveness:	Inadequate
Quality of education:	Inadequate
Behaviour and attitudes:	Inadequate
Personal development:	Inadequate
Leadership and management:	Inadequate

5.16 Prison leaders had presided over a largely impoverished regime that did not offer children the education, skills and work opportunities to which they were entitled. Chronic staff shortages of both prison officers and college teachers had resulted in children too often being confined to their cells because there were not enough officers to escort them to activities or a lack of qualified teachers to teach them, especially in English and mathematics.

5.17 Leaders and managers, including those responsible for governance, had worked together to identify many of the key concerns also identified by inspectors. However, they had made very limited progress towards improving the provision since the inspection in 2021 and the independent review of progress in 2022. Consequently, the overall quality of provision had deteriorated further and none of our concerns had been fully rectified.

5.18 Prison managers had carried out an appropriate curriculum needs analysis. This had resulted in a suitable rationale to offer a broad

vocational curriculum, supported by a core day covering English, mathematics and personal, social and health education (PSHE). Managers planned to offer core provision alongside vocational pathways in horticulture, painting and decorating, barbering, catering, music, radio and fitness. However, largely owing to difficulties in recruiting staff, the only vocational courses offered were in music, radio and fitness. Catering was only reintroduced during the week of the inspection, following a six-month period of suspension.

5.19 Furthermore, managers did not provide any opportunities for children to learn about how to set up their own business, despite an identified demand for self-employed barbers, cleaners and gardeners. No provision was offered at level 3 or above. In our survey, only 32% of children said that they had learned anything at Cookham Wood that would help them on release.

5.20 Prison leaders provided enough activity places for all children. Following induction, prison and college managers attended a weekly allocations board meeting to determine vocational pathways for each child. However, this process was largely driven by the logistics of ensuring that children were selected for courses based on whom they could or could not mix with, rather than on children's chosen curriculum pathway. As a result, most children were not taking their preferred course and many became demotivated and disengaged.

5.21 Too many children, particularly those identified during induction as having additional needs, had not had a review of their progress to measure the effectiveness of the support they were receiving. Many additional support plans recommended that children should be in receipt of one-to-one support in classes from a learning support practitioner. Where this happened, support was often effective. However, too many children did not receive the extra help they needed in class because of a shortage of learning support practitioners. As a result, these children did not make the progress of which they were capable.

5.22 The overall quality of education provided by the education contractor was inadequate. Teachers struggled to maintain discipline and there was widespread tolerance and acceptance of low-level and occasionally serious disruptive behaviour. As a result, teachers' attempts to sequence and organise learning in a logical and coherent way were largely unsuccessful. In too many instances, children were disengaged, lacked focus and failed to participate actively in the learning activities set by the teacher. Poor attendance often limited the range of teaching methods that the teacher could usefully deploy. In the majority of sessions visited during the inspection, there was little evidence that children had developed any significant new knowledge, skills or behaviours in any of the core subjects or in the vocational pathways.

5.23 Provision for children on vocational training pathways in music and radio production was good. Children produced work of reasonable quality and teachers provided useful and helpful feedback. Attendance

was generally good and children were better behaved and learned useful new knowledge and skills to support their next steps.

5.24 In most subjects, children's written work was often of low quality and contained many uncorrected spelling and punctuation mistakes. Written work often contained inappropriate references to drugs and violence. Teachers often marked this work as correct, without challenging children to produce more acceptable or accurate answers. There was little written work of high quality or that showed children striving to reach high standards. Teacher feedback on children's work in English and mathematics was poor, with insufficient detail to help them correct mistakes and improve their work.

5.25 Children who did not participate in classroom-based education were allocated to individual sessions with a teacher on their accommodation wings. However, children rarely received the number of visits required to provide them with a full timetable of learning activities.

5.26 For the 17 children held in separate accommodation for their own safety, leaders offered very few opportunities to participate in education, skills and work activities, including enrichment activities. College staff provided some learning resources to support in-cell work and some one-to-one learning sessions with a teacher, but this was inconsistent and poorly planned.

5.27 Prison managers did not provide any opportunities for children who were 18 years old (and over) to participate in prison work. As a result, these children received little training or work experience to help them prepare for their release into the community or transition to the adult estate.

5.28 The education contractor's literacy specialists had devised a suitable reading strategy which was relevant to the children's estate. Working with other YOIs, staff had developed suitable initial assessment tools for reading and advanced plans were in place to implement regular library sessions to promote reading and to offer vocationally related reading activities. However, it was too soon to judge the impact of these initiatives.

5.29 Too many children's attendance was poor, particularly in English, mathematics and PSHE, and more often so in the first period each morning. Many children chose not to attend sessions because they lacked the motivation to do so. The lack of sufficient officers resulted in activities being regularly cancelled because of the logistics involved in moving children to education while also ensuring their safety during movement. As a result of this, children rarely received a full week of learning activities: instead, education activities often took place on only two or three days each week instead of five.

5.30 The proportion of children studying English and mathematics or a vocational pathway who did not complete the qualification was too high. Although some of these children had been transferred to other establishments or released on bail, many others had simply not

attended the examinations. However, those who did sit the examinations tended to achieve well.

5.31 Children were often badly behaved and occasionally extremely disruptive. The establishment's rewards and incentives policies had been ineffective in fostering improved behaviour (see paragraph 3.26). Teachers frequently issued informal and formal warnings during sessions. Five classrooms were no longer in use because children had damaged the doors, rendering them incapable of being properly locked. Discriminatory and offensive language was regularly observed during learning sessions, with little or ineffective challenge from the teacher. In one incident a boy directed deeply offensive and racist language towards a college manager which the teacher failed to challenge.

5.32 Children had some understanding and awareness of issues related to healthy relationships, consent and respect for others. They could articulate the basic tenets of British values and understood the importance of tolerating the beliefs of others and respecting diversity. However, this rarely translated into appropriate conduct during learning sessions. Few children showed any of the necessary personal and social skills likely to help them upon release or transfer to another establishment.

5.33 Leaders and managers had a broad understanding of the education and employment opportunities available for children whose release date was imminent. The college's education and resettlement team interviewed children approaching their release date to help them with job search, further education and training and writing a CV. However, the establishment did not have access to the virtual campus (prisoner online access to community education, training and employment opportunities) to enable children to carry out job search activity.

5.34 The college's education and resettlement team had developed productive links with several employers in construction and music production, which had resulted in a few children being offered a job, work experience or an apprenticeship. In addition, a small number of children had benefited from opportunities to participate in education, work and training activities through release on temporary licence and a few had secured work experience opportunities as a result.

Section 6 Resettlement

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

Children, families and contact with the outside world

Expected outcomes: Managers support children in establishing and maintaining contact with families, including corporate parents, and other sources of support in the community. Community partners drive training and remand planning and families are involved in all major decisions about detained children.

6.1 Maintaining contact with families and the wider community remained deficient. In our survey, only 46% of children said they had been helped to keep in touch with family and friends compared with 68% at other YOIs.

6.2 Social visits took place three times a week. In our survey, just 40% of respondents said it was quite easy for friends and family to visit them and only 26% of the children who received visits said they had visits from family or friends once a week or more. The visits hall remained an uninspiring space.

Visits hall

6.3 More visit slots were now available, but 24% of all social visit sessions in the last 12 months had been cancelled, which was unacceptable.

While some cancellations occurred because of a lack of prison staff to supervise the visits hall, leaders had not monitored the reasons and were unaware of the scale of the problem. Some children we spoke to, said, quite rightly, they had felt upset and confused at their visits being cancelled at short notice with little explanation.

6.4 Secure video calling (see Glossary) for children to keep in touch with friends and family was a wasted resource. Only 9% of children in our survey said they had used the service and only 94 video calls had been made in the previous six months. The two laptops designated for this purpose were not readily available and the opportunity for children to use video calls to maintain contact had not been promoted or encouraged.

6.5 The four family days that had been delivered in the last six months had been well coordinated and appreciated, although only 19 children had been able to attend because of keep-apart protocols (see paragraph 3.32). Support services for children and their families and friends were too limited.

Pre-release and resettlement

Expected outcomes: Planning for a child's release or transfer starts on their arrival at the establishment. Resettlement underpins the work of the whole establishment, supported by strategic partnerships in the community and informed by assessment of a child's risk and need. Ongoing planning ensures a seamless transition into the community.

6.6 Resettlement practitioners (RPs) were enthusiastic about their work and knew the children well. The team had reduced from 10 to eight caseworkers over the past six months. At the time of the inspection, there were vacancies and sickness absences in the team which was effectively operating with just 4.5 staff. As a result, they focused primarily on initial and final reviews and looked-after children.

6.7 Two social workers had been allocated full time to the prison by the local authority. They attended review and sentence planning meetings and provided a useful conduit to their colleagues in the community teams.

6.8 The age of transition to the adult estate had been increased from 18 to 19 as a mitigation to help reduce pressure on places in the adult prison estate. Local leaders had worked to limit the consequences and impact with resettlement practitioners ensuring contact with adult services, including the probation service, when the child turned 18.

6.9 Early release was managed well. Assessments were thorough and timely, allowing sufficient work to be undertaken for effective release planning. Children whom we interviewed who were eligible for early release saw it as an opportunity and it was used effectively by RPs to promote good behaviour.

6.10 The Cedar unit provided an enhanced resettlement environment for a small number of children who attended training or education and were approved for ROTL. The unit was calmer and cleaner (see paragraph 4.12) and children on Cedar spoke of their preference for living there.

6.11 Preparation for release was progressed through the sentence planning process. Every attempt was made to make sure that each child had a confirmed address within two weeks of their release date. Accommodation issues were discussed during sentence planning, usually within 12 weeks of the child's release. If problems arose, the prison social worker accelerated the issue to the supervising youth offending team.

Training planning and remand management

Expected outcomes: All children have a training or remand management plan which is based on an individual assessment of risk and need. Relevant staff work collaboratively with children and their parents or carers in drawing up and reviewing their plans. The plans are reviewed regularly and implemented throughout and after a child's time in custody to ensure a smooth transition to the community.

6.12 The resettlement team made early contact with sentenced and remanded children, usually within one or two days of their arrival. Contact was then maintained by the same RP.

6.13 Most RPs aimed to have some form of meeting, either face to face or by phone, with each child at least fortnightly. The frequency of formal contact between RPs and children allocated to them varied, reflecting the staffing levels within the team. Most children spoke highly of their RP and valued their relationship with them.

6.14 In our survey, just 46% of children knew they had a sentence plan. Plans that we reviewed contained achievable targets but actions to realise the intended outcome were often written in unspecific terms.

6.15 Staff shortages in the resettlement team affected their work, particularly the timing and frequency of remand and sentence planning meetings. Some initial and subsequent planning reviews were late. In some cases, planning meetings continued to be held regularly, whereas others were held intermittently or with delays, sometimes of several months.

6.16 Meetings that were held were well attended and included representatives from the interventions team and/or the prison social workers. The child's YOT and social workers attended planning meetings or contributed a written report. Parents were also invited to attend where appropriate and often did so.

Public protection

6.17 Management of risk of harm had improved since the last inspection. The introduction of a screening assessment to identify public protection concerns, contact restrictions and risk levels ensured that information about the child was shared with appropriate staff. These measures were reviewed at the monthly interdepartmental risk management meeting that had been restructured and was now operating well. Meetings were frequent, well attended and reviewed relevant children.

6.18 At the time of our inspection, three children were on PIN phone and mail monitoring. Assessments that we reviewed were not always proportionate and decisions to continue monitoring were not always recorded.

6.19 Children who were approaching their release date and required management under multi-agency public protection arrangements (MAPPA) were reviewed to make sure that their management level was confirmed in good time for their release. Leaders had addressed previous weaknesses with MAPPA that we saw at the previous inspection. These were now robust with an established escalation procedure to confirm MAPPA levels in cases subject to delays.

Indeterminate- and long-sentenced children

6.20 Support for indeterminate and long-sentenced children was limited. At the time of our inspection there were four children with indeterminate sentences and 16 were on remand or awaiting the outcome of cases that could attract such sentences. There was currently no plan in place to meet their needs.

Looked-after children

6.21 In our survey, 65% of children said they had been in the care of their local authority. Support for these children was mainly provided by the two social workers based at the prison but was limited to statutory entitlements such as pocket money and clothes.

6.22 The social workers contacted appropriate local authorities and looked-after children case reviews were taking place at a frequency based on the specific needs of the child.

6.23 The social workers played a substantial role in supporting the resettlement team and worked closely with resettlement practitioners. They also acted as appropriate adults for children being interviewed by police. Plans to enhance the support for looked-after children were being considered, such as the delivery of specialised courses.

Reintegration planning

Expected outcomes: Children's resettlement needs are addressed prior to release. An effective multi-agency response is used to meet the specific needs of each individual child to maximise the likelihood of successful reintegration into the community.

6.24 Planning for reintegration was reasonable but outcomes for education and training on release were poor.

6.25 No children had been released without accommodation, but 77% of children released during the previous 12 months did not have an education or training place, which was poor. There was no initiative to help children learn about finance and debt management and no plans to address this.

6.26 Release on temporary licence (ROTL) presented a much improved picture. During the previous 12 months, 19 children had attended 450 ROTL placements, far more than at other YOIs. ROTL risk assessments that we reviewed reflected well-balanced risk management appropriate to the child's needs and to help them reduce their risk of reoffending. The ROTL process was overseen by an enthusiastic manager who involved the child and routinely kept them informed which they appreciated. The use of special purpose licences to facilitate some ROTLs had helped several children to reconnect with close family members, which was innovative.

6.27 ROTL was used to incentivise positive behaviour, maintain family contact and prepare for employment. Examples included working in a bakery and family therapy delivered in the community which was very impressive.

6.28 During the previous 12 months, 35 children had been transferred to the adult estate. Resettlement practitioners prepared for transitions and had forged positive links with a number of adult prisons to provide a handover. Several managers had visited to meet the child and conduct a handover face to face. One child had transferred to a category D open prison which was positive and a rare occurrence among YOIs.

Interventions

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

6.29 The needs analysis to identify suitable interventions was two years out of date. Leaders had not given this sufficient priority and were not aware of the children's requirements.

6.30 The interventions facility was very good with several rooms in a suitable environment to deliver courses. However, it had been closed

for more than six months because of a lack of prison staff to supervise it.

6.31 The interventions team was staffed and funded to deliver a small number of interventions, juvenile enhanced thinking skills (JETS), Feeling It and A>Z (see Glossary), but was failing to meet delivery targets. Facilitators found contact with children challenging because of the keep-apart procedure and cancellations of interventions were a frequent occurrence (see paragraph 3.32). Unsurprisingly, the number of children who had completed interventions was low, at just 31 completions in the last 12 months.

6.32 Family therapists, psychologists and forensic psychologists attempted to deliver one-to-one treatment but were impeded by a lack of suitable space with the intervention department closed and they struggled to gain access to see children. The two on-site family therapists had high caseloads and similarly struggled to see children.

6.33 We spoke to treatment and programme facilitators who felt very frustrated by the lack of programme delivery and were worried about the impact it had on children. Leaders had lost sight of this problem. They were not monitoring the limited delivery of interventions and did not have a plan to address it.

Health, social care and substance misuse

6.34 Pre-planning for discharge was good and all children were seen by a nurse a week before discharge. Where necessary, liaison with a community GP or other providers was undertaken.

6.35 Discharge planning to meet mental health needs was effective. Discharge summaries and thorough handovers to community teams were completed. Where appropriate, follow-up telephone calls or visits to the child were carried out, which was positive.

6.36 Substance misuse support was also provided before release or transfer. The team liaised with relevant agencies and prison teams to deliver continuity of care, which was good. Some staff carried out visits to accommodation before release.

Section 7 Progress on recommendations from the last full inspection report

Recommendations from the last full inspection

The following is a summary of the main findings from the last full inspection report and a list of all the recommendations made, organised under the four tests of a healthy establishment.

Safety

Children, particularly the most vulnerable, are held safely.

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

Key recommendations

An effective violence reduction strategy, with a robust action plan, should be implemented to reduce the incidence of violence. (1.36)
Not achieved

Consistent expectations of behaviour should be set and communicated to children. (1.37)
Not achieved

There should be clear pathways for children that properly incentivise education, rehabilitation work and prosocial behaviour. (1.37)
Not achieved

Leaders and managers should make sure that children subject to separation can access a regime that is equivalent to that of their non-separated peers. (1.38)
Not achieved

Care

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

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

Key recommendations

The establishment should be well maintained, clean and free of graffiti. (1.39)
Not achieved

Leaders should make sure that all incidences of discrimination are identified, investigated and addressed. (1.40)
Not achieved

Children should be able to access planned mental health care appointments in clinically appropriate and therapeutic environments. (1.41)
Not achieved

Recommendations

A memorandum of understanding should be developed with the local authority and social care provider, to make sure that arrangements are in place if a child needs social care. (4.52)
Not achieved

Medicines should be administered in line with national standards and at times which facilitate optimum therapeutic effect. (4.72)
Not achieved

Purposeful activity

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

At the last inspection in 2021, outcomes for children were poor against this healthy establishment test.

Key recommendations

Opportunities for children to spend time out of their cell in education or other constructive activities, including social time together, should be increased, particularly at the weekend. (1.42)
Not achieved

Leaders should make sure that they maximise opportunities for children to study, including in-cell study. (1.43)
Not achieved

Leaders should make sure that the curriculum includes sufficient opportunities for children to develop vocational, mathematics, English and ICT skills. (1.44)
Not achieved

Leaders across the prison should make sure that they work collaboratively to prioritise education and increase children's attendance at classes. (1.45)
Partially achieved

Leaders should make sure that teachers provide children with constructive feedback that helps them to improve their work. (1.46)
Not achieved

Resettlement

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

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

Key recommendations

Children should receive support to enable them to maintain contact with their family and friends in the community. (1.47)
Not achieved

Risk management processes, including ROTL and public protection, should identify and action risks adequately. (1.48)
Achieved

Appendix I About our inspections and reports

HM Inspectorate of Prisons is an independent, statutory organisation which reports on the treatment and conditions of those detained in prisons, young offender institutions, secure training centres, immigration detention facilities, court custody and military detention.

All inspections carried out by HM Inspectorate of Prisons contribute to the UK's response to its international obligations under the Optional Protocol to the UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). OPCAT requires that all places of detention are visited regularly by independent bodies – known as the National Preventive Mechanism (NPM) – which monitor the treatment of and conditions for detainees. HM Inspectorate of Prisons is one of several bodies making up the NPM in the UK.

All Inspectorate of Prisons reports carry a summary of the conditions and treatment of prisoners, based on the four tests of a healthy prison that were first introduced in this Inspectorate's thematic review *Suicide is everyone's concern*, published in 1999. For children's establishments the tests are:

Safety
Children, particularly the most vulnerable, are held safely.

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

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

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

Under each test, we make an assessment of outcomes for children and therefore of the establishment's overall performance against the test. There are four possible judgements: in some cases, this performance will be affected by matters outside the establishment's direct control, which need to be addressed by HM Prison and Probation Service (HMPPS).

Outcomes for children are good.
There is no evidence that outcomes for children are being adversely affected in any significant areas.

Outcomes for children are reasonably good.
There is evidence of adverse outcomes for prisoners in only a small number of areas. For the majority, there are no significant concerns. Procedures to safeguard outcomes are in place.

Outcomes for children are not sufficiently good.
There is evidence that outcomes for children are being adversely affected in many areas or particularly in those areas of greatest importance to their well-being. Problems/concerns, if left unattended, are likely to become areas of serious concern.

Outcomes for children are poor.
There is evidence that the outcomes for children are seriously affected by current practice. There is a failure to ensure even adequate treatment of and/or conditions for children. Immediate remedial action is required.

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

We also provide examples of **notable positive practice** in our reports. These list innovative work or practice that leads to particularly good outcomes from which other establishments may be able to learn. Inspectors look for evidence of good outcomes for children; original, creative or particularly effective approaches to problem-solving or achieving the desired goal; and how other establishments could learn from or replicate the practice.

Five key sources of evidence are used by inspectors: observation; children and staff surveys; discussions with children; discussions with staff and relevant third parties; and documentation. During inspections we use a mixed-method approach to data gathering and analysis, applying both qualitative and quantitative methodologies. Evidence from different sources is triangulated to strengthen the validity of our assessments.

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

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

This report

This report outlines the priority and key concerns from the inspection and our judgements against the four healthy prison tests. There then follow four sections each containing a detailed account of our findings against our *Expectations. Criteria for assessing the treatment of children and conditions in prisons* (Version 4, 2018) (available on our website at https://www.justiceinspectorates.gov.uk/hmiprisons/our-expectations/children-and-young-people-expectations/). Section 7 lists the recommendations from the previous full inspection (and scrutiny visit where relevant), and our assessment of whether they have been achieved.

Findings from the survey of children and a detailed description of the survey methodology can be found on our website (see Further resources). Please note that we only refer to comparisons with other comparable establishments or previous inspections when these are statistically significant. The significance level is set at 0.01, which means that there is only a 1% chance that the difference in results is due to chance.

Inspection team

This inspection was carried out by:

Martin Lomas	Deputy Chief Inspector
Angus Jones	Team leader
Liz Calderbank	Inspector
David Foot	Inspector
Angela Johnson	Inspector
Esra Sari	Inspector
Donna Ward	Inspector
Helen Downham	Researcher
Grace Edwards	Researcher
Emma King	Researcher
Helen Ranns	Researcher
Joe Simmonds	Researcher
Sarah Goodwin	Lead health and social care inspector
Lynn Glassup	Health and social care inspector
Bev Gray	Care Quality Commission inspector
Jai Sharda	Ofsted inspector
Dave Baber	Ofsted inspector
Shane Langthorne	Ofsted inspector
Elizabeth Barker	HMI Prisons observer

Appendix II Glossary

We try to make our reports as clear as possible, and this short glossary should help to explain some of the specialist terms you may find. If you need an explanation of any other terms, please see the longer glossary, available on our website at: http://www.justiceinspectorates.gov.uk/hmiprisons/about-our-inspections/

A>Z
A six-session motivational and enabling intervention which aims to increase a child's motivation to change and to engage in purposeful activity.

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

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

Feeling it
A programme for children convicted of violent offences or who often become angry with others or situations. Feeling it applies cognitive behavioural theory to support children in raising awareness of emotions and managing these in a helpful way. The intervention consists of 12 sessions over four weeks with three sessions a week.

Juvenile enhanced thinking skills (JETS)
The JETS programme addresses thinking and behaviour associated with offending through a series of structured exercises designed to teach a child interpersonal problem-solving skills.

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

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

Rule 49
Young Offender Rule 49 enables managers to segregate any child who, by their behaviour, presents a risk to the maintenance of good order or discipline or who is themselves at risk of harm from other children.

Secure Stairs
Addresses the needs of children in secure children's homes, secure training centres and young offender institutions. This framework allows for a coordinated approach to assessment, sentence/intervention planning and care, including input from mental health staff regardless of previous diagnosis, as well as from social care professionals, education professionals and the operational staff working on a day-to-day basis at the setting.

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

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

Appendix III Further resources

Some further resources that should be read alongside this report are published on the HMI Prisons website (they also appear in the printed reports distributed to the establishment). For this report, these are:

Establishment population profile

We request a population profile from each establishment as part of the information we gather during our inspection. We have published this breakdown on our website.

Survey of children – methodology and results

A representative survey of children in the establishment is carried out at the start of every inspection, the results of which contribute to the evidence base for the inspection. A document with information about the methodology and the survey, and comparator documents showing the results of the survey, are published alongside the report on our website.

Establishment staff survey

Establishment staff are invited to complete a staff survey. The results are published alongside the report on our website.

Any enquiries regarding this publication should be sent to us at the address below or: hmiprisons.enquiries@hmiprisons.gsi.gov.uk

This publication is available for download at: http://www.justiceinspectorates.gov.uk/hmiprisons/

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