Report on an unannounced inspection of

HMYOI Werrington

by HM Chief Inspector of Prisons

31 July – 11 August 2023

Contents

Introduction

Werrington is a young offender institution near Stoke-on-Trent, which at the time of this inspection held just 89 boys aged between 15 and 18 – slightly under its capacity. The risks associated with children's custody means that we inspect young offender institutions more frequently, and our last inspection of Werrington was only last year. Our findings at this visit were consistent with the disappointing outcomes we reported on then. Our healthy establishment tests remained poor in safety and purposeful activity. In care they had deteriorated and were now not sufficiently good. Only in resettlement did we consider outcomes to be reasonable.

Werrington's predicament was not helped by the instability and churn in its leadership. The current governor had been in post for only six months, and while we were assured that she understood the challenges to be addressed, she was the institution's fourth governor in three years.

Appropriate priorities were being set to address deficits and encourage improvement, but it was unclear how this would be achieved. One of the priorities we identified concerned how oversight of critical processes, such as child protection and behaviour management arrangements, had drifted and needed to be reinvigorated. Indeed, our report describes safeguarding and child protection processes as being in disarray. More positively, recorded violence, weapon finds, and use of force had all reduced, but the institution remained incredibly volatile, with individual acts of violence giving way to other forms of delinquency, notably repeated and increasing incidents of disorder and concerted indiscipline.

Over a quarter of the children we surveyed told us they felt unsafe, and 388 specific 'keep apart' instructions for just under 90 children dominated life in the institution, undermining everything from attendance at education to the quality of relationships they had with staff. Such arrangements, combined with staff shortages, meant that most children were out of their cells for no more than four hours each day and we found over a quarter locked in their cells during the school day. The library had been closed for over a year, too few children accessed the gymnasium and expectations for what could be achieved in education were very low. Our colleagues in Ofsted judged the overall effectiveness of education and work activities to be 'inadequate,' their lowest assessment. The failed nature of the regime, the lack of time out of cell, and the stifling effect of the overwhelming requirement to keep various children separated from one another, meant that various schemes supposedly aimed at incentivising children were totally lacking in credibility and effectiveness.

More positively, the institution did have an up-to-date reducing reoffending strategy supported by a good needs analysis, and reintegration planning was reasonably well organised. Work to support and maintain family contact was similarly encouraging.

Despite the near 340 staff of all grades and disciplines employed at Werrington, there was a significant shortfall in frontline supervisory staff, limiting access and negating the influence of much of this resource. Addressing this imbalance, as well as the need to reset what constitutes acceptable behaviour among children, seemed to be the critical next steps for this institution.

Charlie Taylor
HM Chief Inspector of Prisons
September 2023

What needs to improve at HMYOI Werrington

During this inspection we identified 15 key concerns, of which seven should be treated as priorities. Priority concerns are those that are most important to improving outcomes for children. They require immediate attention by leaders and managers.

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

Priority concerns

1. **Shortfalls of operational staff hindered the development of effective relationships with children and prevented children from accessing other services at Werrington.**

2. **Systems for the safeguarding of children had fallen into disarray.** Too many child protection referrals were outstanding and there were long delays in referring allegations of abuse to the local authority designated officer.

3. **Behaviour management systems were ineffective.** Leaders were consistently unable to deliver the incentives on offer and there were limited consequences for poor behaviour by children.

4. **Werrington accounted for 56% of all injuries during use of force in the YOI estate despite holding just 18% of the children.** Governance arrangements had not identified or addressed this issue.

5. **Children spent far too long locked up, particularly on weekends where many were in their cells for up to 22 hours a day.**

6. **Senior leaders had not given sufficient priority to delivering a high-quality education, skills and work curriculum.**

7. **The quality assurance and improvement arrangements for education were not effective in making sure that children received high-quality learning experiences.** Leaders and managers were unaware of the substantial weaknesses in the quality of education.

Key concerns

8. **Oversight of separated children was insufficient.** The regime for most separated children was poor, and some children were separated without authority.

9. **In our survey, just 37% of children said they felt cared for by staff.** The staff-children interactions we saw were mostly transactional and too few children received meaningful support from their allocated officer.

10. **Identified unfair treatment among different groups of children had not been investigated and addressed.** Leaders did not understand the perceptions of protected groups due to a lack of regular consultation.

11. **Regime pressures and the policy to keep children apart meant that they were often not taken to health care appointments.** This was a major waste of resources and had a negative impact on all services.

12. **Leaders did not promote reading and literacy.** There had been no library provision for over a year and there was an absence of an appropriate reading curriculum.

13. **Leaders and managers had not made sure that all children accessed their entitlement to education, and that allocations to education, skills and work activities were driven by children's needs and ambitions.**

14. **Leaders had not developed a wider curriculum that helped children to develop social, emotional and communication skills or prepare them sufficiently for life in modern Britain.**

15. **Children's risk management plans were weak and did not fully address the risks identified.**

About HMYOI Werrington

Task of the establishment
To hold sentenced and remanded children aged 15 to 18 years.

Certified normal accommodation and operational capacity (see Glossary)
Children held at the time of inspection: 89
Baseline certified normal capacity: 116
In-use certified normal capacity: 92
Operational capacity: 92

Population of the establishment
- 121 new children received in the last year.
- Seven foreign national children.
- Just under 60% of children were from ethnic minority backgrounds.
- 38% of children were on remand.
- 53% of children had previously been in the care of their local authority.
- 57% of children will become adults while in custody on their current sentence or remand.
- 35% of children had been excluded from mainstream education prior to custody.

Establishment status (public or private) and key providers
Public

Physical health provider: Practice Plus Group
Mental health provider: Midlands Partnership University NHS Foundation Trust
Substance misuse treatment provider: Midlands Partnership University NHS Foundation Trust
Dental health provider: Time for Teeth
Prison education framework provider: People Plus
Escort contractor: GEOAmey

Prison department
Youth Custody Service

Prison Group Director
Simon Drysdale

Brief history
HMYOI Werrington is in Staffordshire. It was originally opened in 1895 as an industrial school and was purchased by the Prison Commissioners in 1955. It was converted into a senior detention centre in 1957, and then became a youth custody centre in 1985 after the implementation of the Criminal Justice Act 1982. In 1988, it was converted into a juvenile prison, which is its current role.

Short description of residential units
Doulton unit
A wing and B wing – single occupancy cells, some with in-cell showers.

Denby unit
C1 – welfare and development enhancement unit: eight cells for children who require extra support.
C2 – 22 cells, all with showers: 12 are allocated to children on the highest level of the rewards scheme and 10 to children on induction.

Name of governor and date in post
Jasmin Steadman, from January 2023

Changes of governor since the last inspection
Keith Attwood, March 2021 – July 2022
Simon Drysdale, July 2022 – January 2023
Jasmin Steadman, from January 2023

Independent Monitoring Board chair
Sally Osbourne Town

Date of last inspection
24 January – 4 February 2022

Section 1 Summary of key findings

Outcomes for children

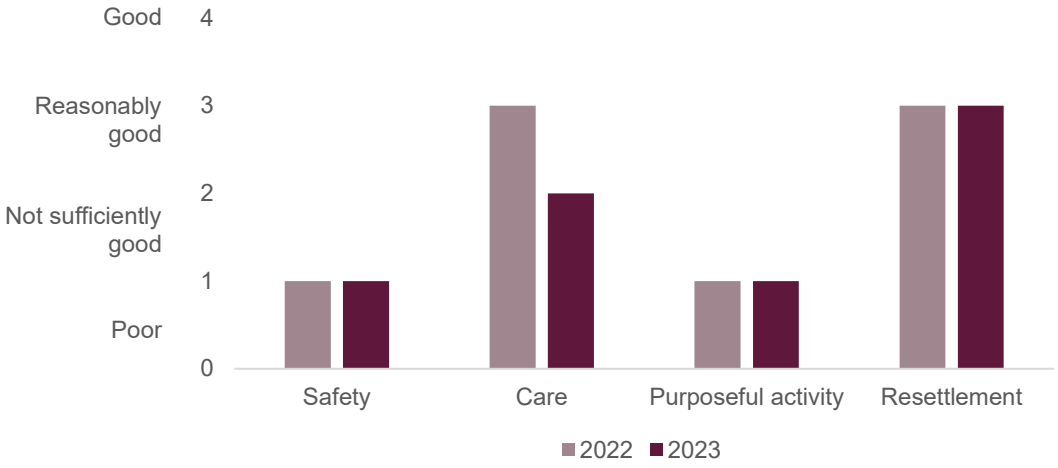
1.1 We assess outcomes for children against four healthy establishment tests: safety, care, purposeful activity and resettlement (see Appendix I for more information about the tests). We also include a commentary on leadership in the establishment (see Section 2).

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

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

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

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



Progress on key concerns and recommendations

1.4 At our last inspection in 2022, we made 16 recommendations, 13 of which were about areas of key concern. The establishment fully accepted 15 of the recommendations and partially (or subject to resources) accepted one.

1.5 At this inspection we found that three of our recommendations about areas of key concern had been achieved and 10 had not been achieved. One of the recommendations in the area of safety was achieved and the second was not. All four recommendations made in the area of care and all five on purposeful activity were not achieved.

Both recommendations on resettlement were 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 three examples of notable positive practice during this inspection.

1.8 In addition to the usual provision, the chaplaincy also provided a beneficial range of enrichment activities for the children, including current affairs discussion groups, arts and craft sessions, and film nights. (See paragraph 4.32)

1.9 The health care team had produced several films informing children about health issues such as vaccines and overdose awareness. Where possible, children were involved in the production of the films, which were available to view on their laptops. This work had a measurable and positive outcome for children's health care needs, for example, increased uptake in vaccinations. (See paragraph 4.44)

1.10 Children serving long or indeterminate sentences were supported by a 'Buddy' – an adult life-sentenced prisoner from HMP Warren Hill working towards their release – who discussed their experience of receiving lengthy custodial sentences with them in supervised video meetings. The information shared helped generate discussion and was intended to assist children to reflect and possibly motivate them to engage and progress their sentence. (See paragraph 6.23)

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 Werrington had experienced substantial recent leadership instability, with, for example, four governors in the past three years and personnel changes in other senior posts. This had made progress much more difficult to achieve or sustain and was indicative of challenges the Youth Custody Service (YCS) faced recruiting and retaining senior leaders at such risky and volatile establishments. Instability had clearly impacted oversight of key processes and safeguards, including child protection, the adjudication system, use of force and arrangements to manage complaints and legitimate redress. All of these policies and practices, as well as others, had deteriorated since the last inspection.

2.3 The new governor had been in post for six months. Her self-assessment report demonstrated some understanding of the strengths, weaknesses and challenges Werrington faced and had set appropriate priorities for the institution. These included improving safety and purposeful activity. Alongside the deputy governor, she was attempting to create a cohesive senior team and there was some evidence that problems were beginning to be addressed.

2.4 Improvement at Werrington had not been helped by the failure of national leaders to plan effectively for predicted rises in the adult prison population. The YCS was now, for example, retaining 18-year-olds in children's YOIs to free up spaces in adult prisons. This group now accounted for more than a third of Werrington's current population. The institution was unable to meet their needs in several key areas, and it was clearly a distraction from Werrington's core purpose to meet the needs of children.

2.5 Leaders were also dealing with significant shortages of prison officers. Absence because of sickness leave, injury and other reasons meant just 58 out of a target figure of 115 frontline staff were available to be deployed during our inspection. This committed group of staff simply did not have the time to build the effective relationships needed to support good outcomes at Werrington. In total, around 340 staff were employed to care for the children, but the combination of shortfalls of operational staff and difficulties mixing children meant that much of this rich resource was wasted, with specialist staff struggling to get access to the children.

2.6 The inability of managers to address ineffective behaviour management systems meant the site the site continued to be characterised by poor behaviour, limited time out of cell and the practice of keeping children apart to minimise conflict.

2.7 Managers had secured investment to improve residential units. However, many areas of the establishment, in particular the education facilities, remained unfit for purpose and in need of investment.

2.8 Partnership working, governance and oversight of health care were very good, and the service was well led.

2.9 Quality improvement arrangements in education were ineffective. While YOI leaders had identified that the quality of education was poor, improvement actions from the provider had taken too long to implement and had not been successful.

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 Werrington received about two new arrivals a week. Most arrived at a reasonable time, usually between 5pm and 7pm. The reception area was bright and welcoming.

Reception

3.2 Holding rooms had been refurbished and now provided a comfortable waiting space with access to a toilet. However, very limited information about life at Werrington was available, and the induction books given to children were disorganised and described as unhelpful by those who had received them.

Reception holding room

3.3 Reception staff were friendly and provided new arrivals with a hot meal and drink. They made efforts to make sure that children could make a phone call to families or guardians to let them know where they were. Strip searching of children in reception was only carried out if there was intelligence that it was necessary.

3.4 Staff used information on the youth justice application framework (YJAF) to prepare for the child's arrival. First night interviews were in private with officers and health care staff. Risks and needs were identified, and additional overnight checks were put in place for those who needed them; this was particularly necessary for children who arrived with limited information about them.

3.5 First night cells on the induction unit were not well prepared – some had graffiti on the walls and noticeboards, some clothing for children had holes and one pillow was very dirty.

3.6 Children spent their first night and induction on C2, the same unit as those on the highest level of the incentive scheme. New arrivals could meet with the induction peer mentor who provided some valuable information about what they could expect in custody. However, the atmosphere was at times chaotic and the association room on the unit often had loud music. Some new arrivals could mix with other children on the unit, but those who were unable to had few opportunities to leave their cell.

3.7 In our survey, only 54% of children said that in their first few days at Werrington they were told everything they needed to know about life at the prison. The daily routine was very limited during the first few weeks, and children had little access to fresh air. Those who arrived on a

Thursday or Friday experienced around 23 hours a day in their cells over the weekend (see paragraph 5.1). Children on the unit who we spoke to said they were bored and spent most of their time sleeping or watching TV.

3.8 The induction was disorganised and children said they found it confusing or overwhelming. Staff were supposed to assess children on the unit using a 'my story' document (an overview of the child's previous experiences, relationships and preferences), but these were not always completed and wing staff rarely used them to inform the care provided. A helpful induction presentation was available on the laptops given to children, but it was of limited use as children and staff were unaware of its existence and so unable to locate it.

Safeguarding of children

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

3.9 Safeguarding and child protection processes had fallen into disarray. There had been around 105 safeguarding referrals in the last year, around half of which were related to allegations of harm during a restraint.

3.10 There were long delays in referring allegations of abuse to the local authority designated officer (DO), and there was a backlog of 64 child protection investigations at the start of our inspection. Managers were taking steps, with support from the Youth Custody Service (YCS), to reduce this backlog; there were around 10 cases open, all with updated actions, when our inspection ended.

3.11 There were no regular safeguarding meetings to review themes arising from child protection referrals or discuss and allocate follow-up actions. Substantial gaps in social work provision over the last year had also affected the quality of some key elements of practice, such as prompt private discussions with children following concerns that had been raised.

3.12 The DO raised concerns with us that some staff had been recruited into roles in the safeguarding team even though several allegations had been made against them. The police were involved in investigating subsequent serious allegations at the time of the inspection.

3.13 These weaknesses were particularly concerning given some of the perceptions of children in our survey; 26% said they felt unsafe at the time of the inspection (compared with 11% in comparator establishments), only 27% would report victimisation by other children and 19% said they had been too scared to make a complaint.

3.14 Barnardo's provided onsite advocacy support and children could also contact Childline from their in-cell telephones if needed. This support was well used, with over 200 calls to both services in the last year.

Suicide and self-harm prevention

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

3.15 Recorded rates of self-harm were similar to the last inspection and remained low in comparison to other YOIs. There had been 31 recorded incidents of self-harm in the last six months involving 19 children, with an increase in January 2023 due to the arrival of a child who was in crisis. It was positive that staff had worked to support this child who, for the last two months, now no longer needed the additional support from assessment, care in custody and teamwork (ACCT) case management.

3.16 There had been 37 ACCTs opened in the last six months. Most were for children in the early days of custody if staff noticed that they were struggling to cope. The quality of ACCT documents was reasonable overall. There was a consistent case coordinator, good multidisciplinary attendance at reviews, and care plans were related to the individual needs of each child. In some cases, we found that officers had worked creatively to build a relationship with the child, for example carrying out reviews on the sports pitch followed by a game of football. Children who we spoke to felt supported by the additional involvement from staff that was part of the ACCT process.

3.17 Constant supervision had been used four times for three children in the last six months, which was more than at the last inspection. Most instances ended quickly and all involved reviews from health care staff to make sure the child's needs were properly assessed.

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.

3.18 Leaders had taken substantial action to reduce the number of weapons in Werrington. While the number remained high, with around 200 found in the last 12 months, it was fewer than the over 400 found before the last inspection. Leaders had developed a strategy to manage children found with a weapon to minimise the risks they posed, including escorted movements and additional routine searching. This was

combined with outside speakers, including victims who had been seriously affected by weapons use, a weapons amnesty and proactive searching carried out in partnership with the police.

3.19 Incidents of serious disorder had increased, which contributed to a volatile atmosphere. In the previous six months, there had been 60 incidents of disorder, which was a 76% increase since the last inspection and high compared with other YOIs. These incidents included children climbing and staying at height, acts of concerted indiscipline that included groups of children refusing to come off the exercise yards, and groups trying to smash through wooden doors to get to other children. This had resulted in multiple requests for national resources to help the establishment. These incidents were fuelled by conflict between different groups, copycat behaviour and frustrations that went unaddressed, such as the limited time out of their cell. The volatility this created affected children's perceptions of safety (see paragraph 3.30).

Damaged education area after recent incident of disorder

3.20 Security seemed proportionate to the risks posed; for example, children were only strip searched when there was intelligence to support it. Movement of children to education and activity areas was, however, slow due to the amount of conflict and the number of 'keep aparts' (see paragraph 3.31), which meant movement was restricted to small class groups.

3.21 Intelligence reports submitted to the security department had decreased slightly since the previous inspection, with around 280 a month received. Reports were processed efficiently, which enabled good information-sharing at the daily manager meeting. However, some actions from intelligence were not taken; for example, only 70%

of the targeted searches requested were completed and, while these were timely, had resulted in finds in only 42% of the searches conducted.

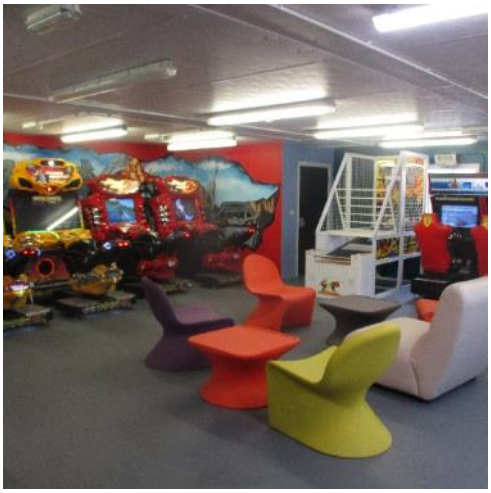
3.22 Leaders were focusing resources on intelligence-led drug testing; only six tests had been completed in the last six months, with only one found positive. We found little other evidence that substance misuse was a concern at Werrington.

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 Behaviour management systems were ineffective, incentives for good behaviour were not delivered, and there were very few consequences for poor behaviour, even when it was serious in nature. As a result, we saw poor behaviour going unchallenged.

3.24 The incentive scheme indicated three regime tiers – bronze, silver and gold – with some children who had achieved gold living on C wing, the 'diamond community' (see paragraph 4.6). While in principle there were key differences between the incentive levels, in practice, due to the limited daily routine and inconsistent application of the scheme, children and staff we spoke too had, with some justification, little confidence in the scheme. For example, although children on the bronze level were not allowed on evening and weekend structured activities, due to staffing shortfalls, these rarely took place anyway, so no one had access. Equally, while leaders had developed some good association rooms for those on gold level, children were not allowed enough access to this privilege even if they had earned it. Other benefits, such as games consoles, were not readily available for children entitled to them.




Association rooms for those on the gold level of the incentives scheme.

3.25 Under the parallel instant reward scheme, children's positive behaviour was awarded a merit, equivalent to 50 pence, to provide regular and frequent reinforcement of positive behaviour. However, the scheme had weaknesses; it was unclear how effectively it was operating and there was no oversight, which meant leaders were not aware of how many rewards were given and by whom – for example, we found evidence of children receiving multiple merits for the same task on the same day by the same staff member.

3.26 The adjudication system was used for the most serious cases of bad behaviour, including violence, damage and incidents of disorder. In the last six months, 896 adjudications had been held, of which 65% had been found proven; the remainder were either dismissed, not proceeded with or referred to the police for criminal charges. However, punishments issued through this process were not effective due to limited delivery of the daily routine; for example, while children were given loss of association in 60% of adjudications found proven, association rarely took place, so it was meaningless.

3.27 During the inspection, we discovered that 180 adjudications forwarded to the police were outstanding. Leaders were unaware of this backlog, despite a weekly crime clinic meeting between the police and prison staff. Delays in this system meant many children would receive no consequence for serious acts of violence and disorder.

3.28 The welfare development and enhancement (Wade) unit was used to manage children with high levels of complexity, due to challenging behaviour or vulnerabilities. It held up to eight children. Due to conflicts between the children living on the unit, they were unlocked for activities in smaller groups. Education and other activities were often held on the unit. Most children were managed by a multidisciplinary team, which met the child regularly to set goals and assess progress. However, staff on the unit often did not attend these meetings, which was a missed opportunity.

The Wade unit

Bullying and violence reduction

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

3.29 While conflict and violence remained a concern, the overall rate of violence had reduced. Assaults on children had gone down by 37% and those on staff by 25%. In addition, the severity of violence had also reduced.

3.30 Despite this, children's perception of safety had deteriorated; in our survey, 26% of children said they felt unsafe, which was higher than similar prisons. This perception was fuelled by the volatile and unpredictable environment in which they lived (see paragraph 3.19). Children we spoke to described being hypervigilant when out of their cell, particularly fearful when moving around the prison, and worried about staff making mistakes resulting in them coming into contact with children with whom they had disagreements.

3.31 The number of children being kept apart from their peers to reduce conflict and violence remained high and continued to negatively impact on daily life at Werrington, including access to education, health care and time out of cell. Staff were managing 388 non-associations or 'keep-aparts' in a population of 89 children, a slight increase since the last inspection.

3.32 The conflict resolution team was working hard to deal with the issues at Werrington and had some success. The team encouraged and motivated children to participate actively in resolving their conflicts. Conflict resolution was voluntary and relied on children's willingness to engage in the process. During the inspection, we observed children actively seeking the conflict resolution staff to deal with their issues, which we do not usually see in similar prisons. Each member of the conflict resolution team was responsible for a designated area of the prison, so they built relationships and rapport with children. Two children were included as conflict representatives to support the work. Achievements so far meant that A wing was close to being able to mix fully, and the number of groups on the wing had reduced from four to two.

3.33 Instances of violence and bullying were not investigated, which limited leaders' understanding of the causes. They were due to implement a new system to address this lack of investigation and develop understanding.

3.34 A well-attended weekly safety intervention meeting (SIM) discussed children of concern. The minutes showed good sharing of knowledge about children, but not always a clear focus on agreeing actions to be taken. The strategic safety meeting had only recently resumed, and it was too soon to assess its effectiveness.

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 There had been 383 incidents of force used on children in the last six months, a reduction of just under a fifth since the last inspection. We were concerned that there was insufficient oversight of these incidents, and subsequently we found significant concerns that managers had not identified or addressed. These concerns included the fact that Werrington accounted for 56% of all use of force injuries in the YOI estate, despite holding just 18% of the total population. The duration of restraint had increased to an average of four-and-a-half minutes, which was the longest for all YOI sites. In addition, use of force reports persisted in being overdue; at the time of the inspection, 69 reports from staff were overdue, as well as 60 injuries to children forms completed post-restraint.

3.36 Individual scrutiny of incidents remained good, with a daily triage of all incidents with health care staff in attendance. Issues were noted and referred as child protection concerns where necessary (see paragraph 3.10). There was a weekly meeting to discuss incidents with the deputy governor, and an additional quarterly meeting, with independent

scrutiny, for restraints where pain-inducing techniques had been deployed – there had been three in the last six months.

3.37 An incident of disorder and the subsequent request for national resources (see paragraph 3.19) had resulted in the use of very high-level interventions, including advanced trained dogs as well as pyrotechnics – explosive devices that produce a flash of light and loud noise intended to distract temporarily and are used only in the most serious of incidents.

3.38 While most of the samples of force that we viewed were proportionate, in several incidents it was not justified or we had had more general concerns; these had already been referred as child protection referrals. In some incidents, opportunities to de-escalate were missed.

3.39 There had been one incident of the use of unfurnished accommodation where items, including the child's mattress, were taken out of their cell. This was for a very short period due to a high risk of self-harm.

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.

3.40 The number of children separated had doubled since our last inspection, with 116 episodes in the last six months. However, there was a reduction in the average duration, which was now just under eight days; it was rare for children to be separated beyond 21 days. Werrington had no designated separation unit, with children mostly separated on their residential unit.

3.41 Time out of cell for separated children was poor; for children separated on the main residential areas, the minimum they could expect was less than an hour a day for time in the open air and to shower. One child who had been separated for 10 days had been offered no education and only one gym session and a single period of activity with Kinetic Youth (see Glossary). One record for him said:

'… hasn't been offered a regime this morning due to things needing to be done on the wing, he says he is okay though.'

3.42 Reviews of separated children had improved since the last inspection. They were well attended. Goals set for the child were relevant to the risks posed and reasons for their separation, and were achievable, for example, not to make weapons.

3.43 We were concerned to find children separated without the appropriate authority and therefore the subsequent safeguarding measures, such as health care screenings and statutory visits. This included a child

who had recently arrived and had been unofficially separated for several days. In addition, some children had been separated post-incident. Leaders said that these children were separated for an education session as a period of reflection and to assess the risk; however, there was no oversight to make sure that each child was reintegrated swiftly after this session.

3.44 Oversight of separation was insufficient, with only one very recent meeting that was poorly attended. Statutory daily visits by leaders, health care staff and chaplains did not always take place. Separation files were poorly organised; we found two files where the most recent review was absent, and in one case, the child had been taken off separation but unit staff were not aware of this.

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 Although there were many committed staff, children's limited time out of cell and the pervasive focus on keeping them apart from one another impeded the development of good staff-children relationships.

4.2 In our survey, only 37% of children said they felt cared for by staff. We observed mostly transactional interactions. Staff were limited to carrying out functional tasks, in particular, enabling movements and making sure that children were locked up and unlocked accordingly. Children told us some staff were more helpful than others and we did see examples of them taking time to speak to children in the few instances where they were able to, for example on the exercise yard.

4.3 In our survey, just 61% of children said they had a member of staff they could turn to if they had a problem, and although all children were allocated a specific officer, many did not know who this was. There was limited delivery of the child's custody support plan (CuSP, created through weekly meetings with a member of staff they knew well), with only 19 children having a plan. The remaining children received checks that were mostly brief welfare checks. CuSP sessions were delivered inconsistently and variable in quality. The sample we reviewed had some excellent examples of reflective discussions, but these were few and far between. Quality assurance had not been effective in standardising delivery.

Daily life

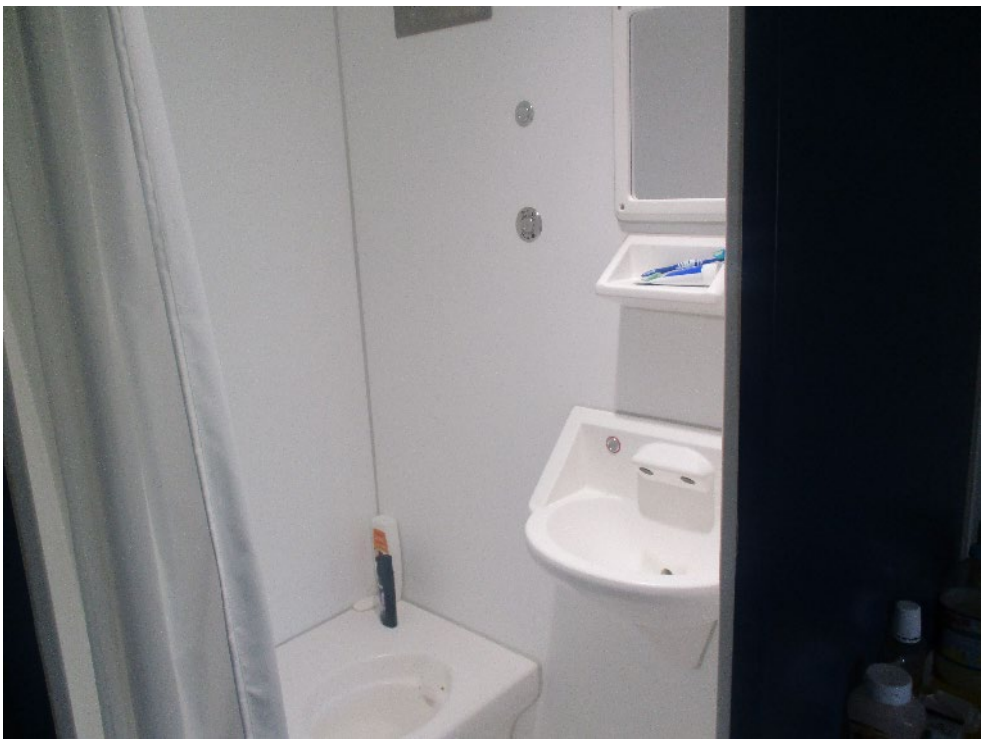
Expected outcomes: Children live in a clean and decent environment and are aware of the rules and routines of the establishment. They are provided with essential basic services, are consulted regularly and can apply for additional services and assistance. The complaints and redress processes are efficient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

Living conditions

4.4 The environment at Werrington remained institutional. Some investment had been secured to improve the cells and install in-cell

showers in the main residential units, but this project was in progress and meanwhile children continued to live in wings similar to many of those in the adult estate. The education unit where children spent most of their time when out of their cell was in a very poor condition. For most children, their cells were basic with generally adequate furniture. Blackboard walls in some cells were a welcome initiative for children to use constructively. Many toilets remained stained, and none had lids. The communal showers for those without in-cell facilities were adequate.

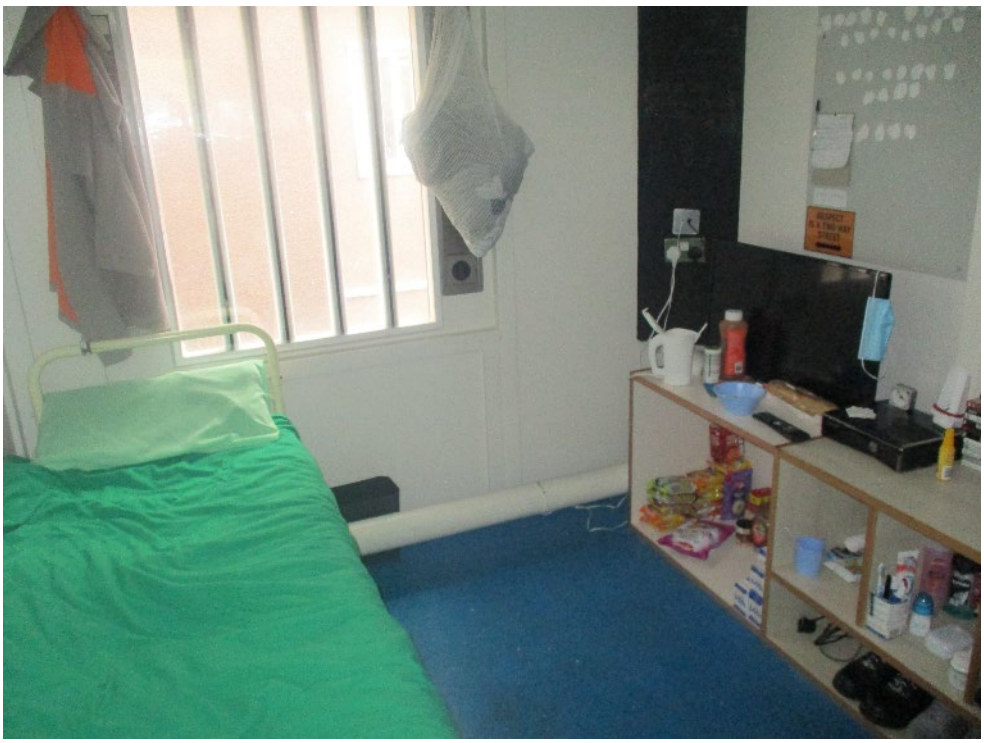
Refurbished cell



In cell showers

4.5 Leaders had created some age-appropriate recreational rooms that were better than those at the previous inspection, but others remained dreary. The gold 'arcade room' was a welcome space but undermined by its limited use (see paragraph 3.24).

4.6 The main residential units (A and B) were too large, which hindered behaviour management and, in turn, positive outcomes for children. For the 17 children on the Diamond and induction unit, the smaller space and softer furnishings created a better environment (see paragraph 3.24).



Cell on Diamond and induction unit

4.7 Access to cleaning equipment was sufficient and we saw evidence of staff encouraging children to keep their cells clean. Children had reasonable access to clean clothing and bedding.

4.8 Each child was allocated a laptop which they used to communicate with various departments and staff, as well as fill out menus, order items or watch content uploaded by leaders.

4.9 Children waited far too long for staff to respond to emergency cell bells. On one wing we found that staff took longer than five minutes to answer 106 bells during one week.

Residential services

4.10 Most children had all their meals given to them at their cell door and ate them alone while locked up in their cells. The few children on the Diamond and induction unit were able to eat together for their evening meal.

4.11 The food was of reasonable quality, although in our survey only 37% of children said it was good and 38% that they got enough to eat. Main meals were supplemented by a snack and juice during the school day in education.

Some of the food provided

4.12 Only 10% of Muslim children compared with 52% of non-Muslims said the food was good. We found insufficient oversight of the serving of halal food; this was addressed during our inspection. Leaders needed to explore these issues further (See paragraph 4.25).

4.13 In our survey, 59% of children said the shop provision catered for them. They could also shop from a range of catalogues, and browse through a list of items available on their laptops. There was also a list of specialised hair products that ethnic minority prisoners could buy. There had been some efforts to consult with children, but it was not clear how changes were made or how other protected groups' needs had been addressed (see paragraphs 4.14 and 4.21). In our survey, Muslim children were also more negative about the shop provision than non-Muslims with only 33%, against 72%, saying that it sold the things they needed.

Consultation, applications and redress

4.14 There had been some recent efforts to consult with children, but these was piecemeal and not yet effective, and it was unclear what changes were made as a result. For example, there had been surveys on the shop provision through the children's laptops, but the findings had not been used to inform decisions.

4.15 The student council was in its infancy, not well attended and not yet embedded. Children who sat on it were not sufficiently representative of the population, mostly due to issues with conflict and 'keep aparts'. Leaders told us they were exploring this further to enable a wider group of children to participate.

4.16 Children used their laptops to make applications, and oversight of this was reasonably good. Data were used to monitor the promptness of responses. There was a robust quality assurance process that provided feedback where improvement was required.

4.17 Werrington had the highest rate of complaints submitted for the type of prison and it was rising. There were no meetings or forums for leaders to review complaints data routinely. Despite some analysis, leaders had failed to explore trends or generate targeted action. The quality of responses to complaints was too variable and quality assurance had not yet been effective in making sure there was at least a minimum standard. Leaders had recently refreshed the process, but too many responses that we sampled were not helpful or did not always address the child's underlying issues. Some had been well formulated and typed, and others brief or handwritten. Responses were generally prompt.

4.18 Children were able to speak to legal advisers for free and we saw examples of resettlement practitioners enabling this support for them. Barnardo's supported children across a variety of aspects of prison life, including in legal matters such as appealing sentences or support with adjudications.

4.19 The facilities for legal visits and video link for children to meet their legal representatives were sufficient, with two booths that could be requested for privacy. Due to the absence of library provision (see paragraph 5.6), there were no up-to-date legal texts for children to borrow, and those we asked did not know that legal books should be available to them or how to access them.

Equality and diversity

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

Strategic management

4.20 Work to promote equality and ensure fair treatment of children continued to be a weakness. There had been an establishment lead for this area until May 2023, but in their absence, work had now stalled. Werrington had no strategy or action plan.

4.21 Leaders produced a useful range of data to identify potential areas of disproportionate treatment. This was reviewed each month by the protected characteristic leads, recently appointed members of the senior leadership team. Despite the identification of areas of potential unfair treatment - for example, children with disabilities were more likely to experience separation and black children were more likely to be

involved in use of force – there was limited investigation and no coordinated action taken. Protected characteristic leads did not consult children from protected groups regularly to understand more about their perceptions of unfair treatment.

4.22 Children and staff could access discrimination incident reporting forms (DIRFs) which were available on each wing. There had been 32 DIRFs submitted in last six months; most were about race and two-thirds were submitted by staff about behaviours they had observed between children. Some complaints had not been investigated at all and others were significantly delayed. In one example, a member of staff had submitted a DIRF following observation of a child behaving in such a way to another child, but over three months later, the complaint had not been investigated and the behaviour had not been challenged. In the absence of an effective behaviour management system (see paragraph 3.23), there were very few consequences for children who were often observed using abusive racist language towards other children or staff.

4.23 Managers were not discussing the repeated issues arising from DIRFs and, as a result, there was no plan for how staff could deal with these issues. There was no longer any regular external scrutiny of DIRFs and internal quality assurance was ineffective.

Protected characteristics

4.24 Around 60% of the population were from black or minority ethnic backgrounds, 24% of children in our survey said they had a disability, 30% of the population were Muslim and seven were foreign nationals. In addition to this, 35% of the population were now over 18. The chaplaincy provided some useful individual help to the very small number of children who identified as being from a Gypsy, Roma or Traveller community.

4.25 While our survey found that children's perceptions of their treatment was generally similar whatever their protected characteristic, Muslim children had some more negative views about the quality of food and items available in the prison shop (see paragraphs 4.12 and 4.13).

4.26 There had been no consultation with children from black and minority ethnic backgrounds which was a gap, especially when there was evidence of some poorer perceptions. Some informal discussions following use of force debriefs had noted that black children felt they were unfairly treated in some sanctions, and that racism was not challenged effectively by staff.

4.27 Support for the seven foreign national children remained good. A dedicated resettlement practitioner was the point of contact for families and the Home Office casework team, who visited the prison monthly to meet new arrivals, discuss their status and agree next steps. At the time of our inspection, all foreign national children spoke English as their first language; translation services were available for family members or children when they were needed.

4.28 At the time of our inspection, no children with disabilities or additional needs required personal emergency evacuation plans (PEEPs). Previous plans that we saw were thorough, and staff were well informed about how children should be managed if they needed help.

4.29 There were no children who identified as gay, lesbian or bisexual at the time of our inspection, and no trans children. Individual support was available for these children if needed.

4.30 The chapel had been refurbished in August 2022 and the facilities were good. The refurbishment included a private room that could be used to support children after a bereavement.

The chapel

4.31 Children had good access to corporate worship, faith-based classes and groups, and almost 90% of the population received some form of supported from the chaplaincy care team. Two separate groups were facilitated to run Friday prayers, and there was also Sunday worship, one-to-one pastoral support, as well as a recently introduced group for children serving life sentences, 'the Big Stretch' (see paragraph 6.23). The chaplaincy was active around the prison, and in our survey, 85% of children who had a religion said they could speak to a chaplain of their faith in private if they wanted to.

4.32 The chaplaincy also provided a beneficial range of activities targeted at children who had limited time out of their cells. These included current affairs discussion groups, arts and craft sessions, and film nights. In the previous month, the chaplaincy had facilitated over 230 visits to these activities from children, including at weekends.

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.

4.33 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

4.34 Practice Plus Group (PPG) were the prime providers of health care services and subcontracted mental health and substance misuse services to Inclusion (Midlands Partnership University NHS Foundation Trust) and dental services to Time for Teeth.

4.35 The longstanding issue of children not attending health appointments due to regime pressures and the prison's 'keep-apart' policy had persisted and was permeating through all health services. This was resulting in the loss of valuable clinical resources.

4.36 The leadership team of an operational head of health, a clinical deputy head of health and a business manager had very good oversight of the service, and data were used effectively to improve health outcomes. There was clear leadership and accountability, and we observed staff who were caring and professional, delivering care creatively to make sure children's health care needs were met.

4.37 PPG had good governance structures, with an appropriate suite of local and regional meetings. We saw a regular schedule of clinical audit and the results of these informing clinical practice. A well-attended local delivery board took place regularly with actions monitored. The minutes confirmed the provider was working collaboratively with prison leaders to reduce the number of non-attended appointments, but this had yet to yield an improvement.

4.38 Clinical staff's mandatory training compliance was good, and all staff had received an annual appraisal. Clinical and managerial supervision arrangements were embedded, and all staff we spoke to felt supported and valued by the leadership team. The business manager was leading on a staff well-being committee, which was positive.

4.39 Incidents were reported and investigations took place promptly. Lessons learned were disseminated effectively via email, daily handovers, staff meetings and a monthly *Health care highlights* newsletter produced by the deputy head of health care.

4.40 Health care complaints, although infrequent, were well managed with an emphasis on face-to-face resolution. Providers sought patient feedback following clinics.

4.41 Information governance structures were robust and information-sharing agreements supported the sharing of patient information and risks. All health staff maintained the electronic medical record, SystmOne, and the standard of entries was very good.

4.42 Clinical rooms were clean and well ordered and met infection prevention standards.

4.43 Emergency resuscitation equipment was in good condition and subject to regular, documented checking.

Promoting health and well-being

4.44 Health promotion was very good, due in part to a prison-wide approach and the use of targeted work. The health care team had produced several films informing children of health issues such as vaccines and overdose awareness. Where possible, children were involved in the production of the films, which were available to view on their laptops. We saw evidence of much improved outcomes for children because of this work; for example, there had been a 50% increase in the uptake of vaccines following one piece of work.

4.45 Information was available to children about national campaigns in a way they could understand, including in foreign languages and a variety of formats, such as notice boards, newsletters and electronic messaging.

4.46 All children were offered and able to access age-appropriate health checks, disease prevention and screening programmes. Where they declined such offers, they were asked again throughout their time in the prison should they change their decision.

4.47 Sexual health services were embedded and easily accessible to children. Relevant and appropriate sexual health advice was provided through their care and before release. Smoking cessation services were available to children who smoked.

4.48 The service was unable to deliver peer support due to 'keep-aparts' and regime issues. This was a missed opportunity to improve outcomes for children.

Primary care and inpatient services

4.49 Too much clinical time was wasted due to the prison's keep apart rules and regime pressures. This meant clinicians often spent more time waiting for children to be brought to appointments or that appointments were cancelled. Despite this challenge, primary health care was good.

4.50 On their day of arrival, all children's health care needs were assessed promptly by a competent health professional. Assessments identified

children's immediate needs, covering all relevant information to inform care staff of children's needs and including, but not limited to, past medical history, current treatment needs and risk information, and appropriate plans were implemented to make sure they were met. When required, children's health care information was shared with the prison throughout their time there.

4.51 Assessments identified children who required secondary care at the earliest opportunity, and care staff made sure that their needs were met. There were systems to make appropriate referrals and for care to be delivered. Waiting times were monitored and were equivalent to those in the community. Appointments in the community were facilitated with few cancellations.

4.52 Children had good access to all primary care services with community-equivalent waiting times. Health care provision was available to children 24 hours, including out-of-hours GP services. Appointments were well managed with children able to request an appointment with a health care professional easily.

4.53 All children received an annual health review, based on looked after children community reviews; this was positive and had attracted national commendation.

4.54 Children with long-term conditions were cared for well. Competent staff understood each condition and made sure that children received appropriate care. Records were to a high standard and demonstrated children's involvement in their creation.

4.55 Health care staff were flexible in their approach to providing care. Where able and appropriate, they delivered care on the wings to make sure that health care needs were met.

4.56 Although no children required social care, we were assured that necessary systems were in place if this were needed.

Mental health

4.57 Inclusion provided an integrated mental health and substance misuse team, which identified and supported children's primary and secondary mental health needs. The team supported 59 children at the time of the inspection, and we found a child-focused service delivered by skilled and knowledgeable clinicians.

4.58 Every child received an assessment of their mental health during their induction, and referrals to the team were triaged effectively and discussed at the weekly multidisciplinary meeting. There were good arrangements for children requiring urgent care, and access to a psychiatrist was prompt.

4.59 The service had a designated officer to escort patients, but we were told they were regularly cross-deployed to other duties due to staff shortfalls. As a result, clinicians saw patients on the wings in rooms

that were not confidential. A suitable room had been found near to education, with funding agreed to make it functional.

4.60 The team was rich in skill mix and experience, and operated a duty professional service that allowed clinicians to attend all initial ACCT reviews, urgent assessments and Rule 49 (segregation) reviews. The prison's keep-apart policy meant valuable mental health groupwork, which included drama therapy, could not be facilitated.

4.61 The Secure Stairs (integrated care model) was not yet fully embedded into practice. Although at the time of the inspection, 65 young people (75%) of the population had a comprehensive formulation, and there was a weekly group reflective practice on the wings, the delivery of core support teams needed to improve. This was acknowledged by the service, and we were advised that a clinical lead for Secure Stairs delivery had recently been appointed.

4.62 We were concerned that children could not access a timely autism assessment and waited longer than children in the community. Inclusion was not commissioned to undertake these assessments, which meant requests went to the community provider.

4.63 The records we sampled showed that children were supported by the mental health team with care plans and risk assessments, which were regularly reviewed, and children we spoke to were complimentary about the care they received.

Substance misuse

4.64 Strong links between the Inclusion team, the prison and stakeholders contributed to an effective drug strategy. Regular meetings attended by key departments further embedded effective joint working.

4.65 A trained and competent member of the Inclusion service assessed the drug and alcohol needs of all children arriving to the prison, in line with national guidance. Assessments were thorough and completed in good time. Although clinical need was low, systems were in place if needed.

4.66 Sufficient trained and experienced staff were deployed. Staff made sure that children's needs were met through effective, evidence-based psychosocial and clinical (when required) interventions. Harm reduction advice was evident throughout children's treatment.

4.67 Children with dual-diagnoses needs (covering both mental health and substance misuse) received coordinated comprehensive support from both substance misuse and mental health practitioners.

4.68 Children working with the service had personalised care plans outlining their treatment needs. Care plans were regularly reviewed.

4.69 Due to regime pressures and keep apart rules, the service was unable to deliver valuable groupwork or peer support. This was a missed opportunity to improve outcomes for children.

Medicines optimisation and pharmacy services

4.70 Medicines were generally managed safely and effectively, led by senior nurses. Patient-named medicines were dispensed from HMP Oakwood, and were received into Werrington safely and transported to the pharmacy securely.

4.71 Medicines reconciliation for new arrivals was prompt and health care administrators checked adherence to the process. In-possession risk assessments were completed and reviewed during children's annual health check or sooner if necessary.

4.72 All medicines were administered from the pharmacy, apart from night-time doses which were delivered to cell doors. Administration was hampered significantly by regime pressures which resulted in the morning administration often taking longer than three hours, wasting valuable clinical time. Leaders were sighted on nurses' concerns that medicines compliance at night could not be easily observed due to the prison's policy of deploying a metal bar across the cell door, which allowed it to open only slightly. PPG were discussing this through regional governance.

4.73 There was a range of stock medicines which was subject to oversight, and the management of controlled drugs was excellent. Health care staff undertook spot-checks of cells to make sure there was compliance with in-possession medicines.

4.74 Nurses used patient group directions (enabling them to supply and administer prescription-only medicine), and they recorded the administration of over-the-counter medicines appropriately on the electronic clinical record.

4.75 The local medicines management meeting met regularly to review local policies and procedures, and prescribing trends. Leaders also attended regional medicines management meetings.

Dental services and oral health

4.76 Children received dental treatment from a skilled and competent team. Dental staff held the required qualifications and had regular additional training. Treatment delivered was appropriate and met professional standards.

4.77 Children were able to access all community-equivalent dental treatment with waiting times similar to those in the community. There were arrangements to make sure that children requiring emergency dental treatment were able to access it. When required, there were prescribing arrangements for children who required medicines following dental treatment.

4.78 Regime pressures and keep-aparts had resulted in clinical inefficiencies that needed to be addressed. On one day during the inspection, the dentist saw only seven of the 13 children booked as the

prison was unable to facilitate getting the remaining six to the dental suite.

Section 5 Purposeful activity

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

Time out of cell

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

5.1 The prison's data showed that each child received on average just four hours a day out of cell on weekdays and three hours at the weekend; many children received less than this. We found 27% of children locked up during the school day, more than at our last inspection.

5.2 The daily routine was undermined by staff shortfalls, 'keep aparts' and violent incidents; these meant that children did not have a clear expectation of what their day would look like. The highly controlled escorted movements to activity had a knock-on effect on time unlocked and punctuality (see paragraph 3.18). It was concerning that only 51% of children in our survey said they could spend time in fresh air on most days, compared with 71% at other YOIs.

5.3 Around three-quarters of children could benefit from four to six hours a day out of their cell on weekdays; most children rarely received any association. However, some children were forced to choose between spending time on the basics, such as education, or on exercise.

5.4 A fifth of children attended education part-time only, which further reduced their time out of cell; this was even worse for some other smaller cohorts such as those subject to separation or in their first few days at Werrington (see paragraph 3.7).

5.5 Children were generally locked up on Friday afternoons to facilitate the delivery of guided reflective practice for staff. The weekend regime was poor with many children spending 22 hours a day locked up; in our survey, only 23% of children said they were unlocked for more than two hours a day at the weekend. A selection of enrichment activities and competitions had been offered during weekends and evenings, but delivery was sporadic.

5.6 The library had not operated for over a year. Leaders told us there were some librarians due to start imminently, and the library itself had moved to a new location in the prison. Children had access to a very limited range of books, available from on-wing bookshelves. The gap in provision was unacceptable.

Small wing bookshelf

5.7 Despite the children's enthusiasm for the gym, in our survey only 21% said they could go to it once a week or more, compared with 48% at other YOIs. Children were timetabled to have at least one session of gym a week as part of their core education hours. The offer for recreational gym was much more fragile and worked on a rota; it relied on gym staff, including some from other establishments, working overtime to facilitate evening and weekend sessions.

5.8 Gym facilities were good, including a brand-new rock-climbing wall, a sports hall and all-weather pitch, as well as cardiovascular and weights area. The atmosphere we observed when children were participating was positive and relaxed. Leaders were liaising with external organisations, for example the twinning project with Birmingham City football club, and the Duke of Edinburgh's Award scheme, but no children were actively participating in these initiatives during our inspection.

Sports hall

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.

5.9 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.

5.10 Education, skills and work activities were not a high enough priority for senior leaders at this young offenders' institution. They had not implemented sufficiently robust governance to make sure that children received high-quality education. Senior YOI leaders did not challenge education leaders and managers sufficiently or knowledgeably to ensure continuous and sustainable improvement.

5.11 YOI and education, skills and work leaders and managers had failed to provide children with a positive learning environment. The standard of the learning environment was extremely poor, particularly in classrooms, and was not conducive to learning. Many classrooms were dirty and in a poor state of repair. Likewise, educational resources did not promote a positive attitude to learning. While leaders had invested recently in new information and communication technology (ICT) equipment, none of it, including the virtual campus (see Glossary), was functioning at the time of the inspection nor had been for over six months. The lack of functioning ICT equipment prohibited children from developing essential digital skills.

5.12 Leaders and managers lacked a sufficiently ambitious strategy for the education, skills and work curriculum. They focused too much on keeping children apart from each other to avoid behavioural and violent incidents, rather than on managing behaviour.

5.13 The education provider's quality assurance and improvement arrangements were not effective. They did not ensure that children received high-quality learning and training experiences that prepared them successfully for their next steps on transfer or release. For example, education managers' feedback on their observations of teaching and learning was overly positive and did not identify accurately the poor standard of tutors' teaching practices. Education managers focused too much on audit processes rather than on improving the quality of the education and training that children received.

5.14 Leaders and managers had identified accurately the poor quality of education. They had raised concerns with the education provider. However, these had not been acted upon and so leaders and managers allowed poor education to continue. This lack of effective collaboration between the education provider and YOI leaders and managers meant that the weaknesses identified at the previous inspection remained and, in too many instances, had worsened.

5.15 Although there were sufficient places for all children to attend education and vocational training activities, only a handful attended them regularly. This severely deprived children at Werrington from accessing the statutory hours of education to which all children are entitled.

Leaders and managers had created limited work activities in the laundry for the personal safety of a few children who were vulnerable to bullying and violence in other education settings. There were occasional cleaning roles on the residential units for children who did not want to attend education or training and for those who were aged over 18. Local pay rates for children attending activities were broadly fair and equitable.

5.16 Allocations to education, skills and work activities were not always fair or equitable. Too many children were not allocated to their preferred vocational pathway, or they attended education because of who they could or could not have contact with. The few children who were allocated to prison work did not develop new knowledge and skills that would be helpful for them in future employment opportunities on transfer or release. The work was mundane and lacked structure.

5.17 Engagement and resettlement workers provided helpful and detailed information, advice and guidance to children at induction sessions and when they were nearing the end of their sentences. This included adequate careers information, advice and guidance where appropriate. However, leaders and managers failed to gather sufficient knowledge of children's destinations when they were released into the community. Where they were aware that children had secured education, training or work opportunities, they did not know whether they sustained these destinations over a reasonable period.

5.18 Leaders and managers had allowed an education staff shortfall to impact on the education available to children. Furthermore, a shortage of prison officers meant that children did not arrive on time to their lessons and missed out on valuable learning. Too often, managers split educational gym sessions in half to avoid two rival groups of children being in the gym areas at the same time. This further reduced the learning opportunities available to children.

5.19 In December 2022, the education provider changed from Novus to PeoplePlus. Despite an extensive review of the curriculum by PeoplePlus in January 2023, the quality of education had continued to decline since the previous inspection. Leaders, managers and tutors had failed to develop a suitable, ambitious and rehabilitative curriculum to meet children's needs, including for those who were serving longer sentences or aged over 18.

5.20 Tutors did not take sufficient account of what children already knew and could do so that they could tailor learning and work activities to their prior knowledge, experience and future goals. Children's learning targets in vocational courses and functional skills lessons related primarily to the achievement of unit criteria of qualifications. Tutors taught children with very mixed abilities from entry level 1 to level 2 in the same lessons. Despite this, almost all children undertook the same activities, which curtailed the amount of new knowledge that many gained. The quality of teaching in most functional skills lessons and in vocational workshops was poor. English and mathematics functional skills lessons were too often taught by unqualified staff. Although tutors

benefited from a range of training and development activities, managers had not identified that these were not leading to an improvement in their performance.

5.21 The curriculum for the very few children who learned on the residential units was too narrow. It consisted of functional skills English and mathematics. Children here received face-to-face visits from tutors, which they enjoyed. However, visits were sporadic and not supported by a structured and coherent learning plan, and children did not know when they would receive them. They completed the same unhelpful worksheets that tutors provided in English and mathematics lessons in the education centre. This approach did not provide an individualised learning programme that helped children to understand the specific concepts that they found difficult or to reinforce that learning to support their success in these subjects.

5.22 The inclusion team conducted thorough assessments of children's needs, particularly those with special educational needs and disabilities. They produced comprehensive individual learning plans that included engagement strategies for each child, which they shared with teaching staff. The inclusion team supported these children individually in specific areas of learning that they found difficult, such as spelling and grammar. This support was effective. However, tutors did not use the shared information or deploy appropriate strategies routinely in lessons to support these children to learn or to plan activities to accommodate their needs.

5.23 Leaders, managers and tutors had been particularly slow in developing an appropriate reading strategy that supported children across the institution to develop their reading skills. They had not implemented an effective process to assess the gaps in all children's reading skills upon arrival. Only children who were assessed at English entry level 3 or below undertook reading tests to determine their reading ages. The few whose reading age was identified as being under 12 years were supported by the Shannon Trust literacy programme to improve their reading skills, but this was having a positive impact on only a very small proportion of children. The library had been closed since the start of the COVID-19 pandemic (see paragraph 5.6) and managers told us that this had impacted on the implementation of their reading strategy. Leaders and managers had not introduced the use of phonics to help children to learn to read or develop their reading skills.

5.24 Teaching staff did not challenge poor behaviour and highly inappropriate language sufficiently in lessons. They often struggled to maintain discipline. In too many instances, lessons were chaotic and children displayed intolerance and misogynistic attitudes towards tutors, visitors and society in general. Children's relationships with and attitudes towards tutors and staff were not consistently respectful. While children worked successfully with their peers and tutors in a minority of vocational lessons, this was not replicated across the whole of the education and vocational training provision. Staff's engagement with children was often too informal and did not provide role models of how they should behave.

5.25 Leaders, managers and tutors did not have high enough expectations of what children could achieve. Their approach to learning did not encourage children to take pride in what they did. Too many children were pessimistic about their futures and lacked self-esteem. They were not committed to their own learning and personal development and did not understand how education could help them to improve their prospects. The 'keep apart' policy had an adverse impact on children's personal development because they could not mix naturally with each other to practise appropriate life skills, such as social interaction and communication skills.

5.26 Most children enjoyed the few enrichment days and themed events provided. However, managers did not monitor the impact of these activities to understand how they benefited children's development of skills such as teamworking and problem-solving that would help them in their next stages of education, employment or independence.

5.27 Leaders and managers provided very few learning opportunities at level 3 or above for the more-able children and for those who had already achieved grade 4 and above in their GCSE examinations. At the time of the inspection, the only available option was AS level mathematics.

5.28 Tutors and managers failed to prepare children effectively for life in modern Britain. References to fundamental democratic values in lessons were, at best, cursory. While the student council was effective in bringing about positive change on matters relating to children's personal needs, most requests for changes to the education, skills and work provision, and a suitable curriculum for the third of the population aged over 18 took too long to implement.

5.29 Tutors did not incorporate industry-standard expectations routinely into vocational learning. For example, they did not prepare children effectively for work environments by providing the correct personal protective equipment. Leaders had permitted contractors to take far too long to install the industry-standard ovens and hobs bought to replace the unsuitable domestic cookers in the hospitality and catering area. This disadvantaged children who could not develop their cooking skills in realistic working environments.

5.30 Managers had started to re-engage with employers through activities such as employment fairs (see paragraph 6.27). Children responded well to these, but it was too soon to judge how these initiatives supported their next steps. Curriculum managers did not draw sufficiently on employers' expertise to inform the design of the curriculums.

5.31 Children's opportunities for release on temporary licence (ROTL) were extremely restricted. Of the 14 children identified as eligible for ROTL, fewer than five had placements in the community, due to managers' assessment of the risk that they could pose. This meant they could not access valuable study or work opportunities, despite being entitled to do so.

5.32 Children did not always feel safe in their education and vocational training activities. They felt that their concerns would not be taken seriously and, in a few instances, were afraid to share their worries. Children often returned to their residential units because they were afraid of peers' attitudes towards them in lessons and the consequences of not seeming to fit in.

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 According to local statistics the families and friends of 64% of children had to travel more than 50 miles to visit them.

6.2 Leaders told us that there were long delays for families using the visits booking line, which sometimes took several hours. Access to visits was further frustrated by keep apart issues. Staff checked for potential conflict and would cancel visits for any children they knew might fight in order to reduce risk. Staff had cancelled visits on 14 occasions in the previous month for this reason. Children also booked visits on several different days in close succession and then cancelled some at the last minute to avoid conflict; this further reduced the availability of visits sessions.

6.3 The visitors' centre had been closed for some time, which was disappointing given the distance that visitors had to travel. However, when they arrived, visitors did not have long waits for visits to start. The visits hall was pleasant, with space for families to hold reasonably private conversations. Refreshments were available. The visitors we spoke to said they were treated respectfully by staff.

The visits hall

6.4 Children could also use secure video calls (see Glossary) every day except Saturdays, including some weekday evenings which were popular with them. Only one laptop, however, was available for this purpose and, although video calls were always fully booked a month in advance, there were no plans to increase the number of machines.

6.5 The 'emailaprisoner' service (allowing families and friends to send emails to prisoners) was available for children and their families to use through the in-cell laptops issued to children; it was well used.

6.6 A family engagement officer provided a very good service to children and their families. They contacted both the family and local authority responsible for each child on arrival and sent a very informative welcome pack about Werrington and what would happen during the first few weeks of custody. The engagement officer tracked visits and contacted the local authority about children not receiving any.

6.7 The prison promoted family contact through sharing a steady flow of information with the family, both positive and negative. This helped understanding about what was happening and why certain decisions were being made. Children could send out photographs of themselves and make cards for birthdays or other events. Monthly newsletters for families detailed what was happening at Werrington, and some celebrated cultural events such as the festival of Eid. There was regular consultation with families, an annual survey, and the governor held quarterly online video calls that families could join and ask questions or make suggestions.

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.

6.8 A new reducing reoffending strategy was in place, supported by a good needs analysis that had taken into consideration the views of children as well as the opinions of staff involved in their care. This had created 52 recommendations that leaders were committed to achieving.

6.9 While a regular reducing reoffending meeting took place, attendance was often poor and key partners failed to contribute, which hampered progress. In addition, actions from the strategy and the meetings were not systematically tracked or monitored.

6.10 A team of eight resettlement practitioners (RP) and one family liaison manager, who each had responsibility for a caseload of children, were pivotal to supporting children's progression, risk management, and linking into the community. While caseloads were reasonable, due to staffing pressures in the prison, many were often taken out of their roles to do other duties.

6.11 Leaders had worked hard to develop strong links with youth offending teams in the community (YOT), who had responsibility for children on release, and there were plans to enhance this further by having a member of staff from the YOT permanently on site. It was positive that RP's co-ordinated agency's effectively to ensure children were not attending multiple meetings.

6.12 Home detention curfew (HDC) was well managed. Although relatively few children were eligible, there had been one HDC release in the previous six months and this was on time.

6.13 Release on temporary licence (ROTL) was underused and used for only one child at the time of the inspection, who worked at a local barber. Only one other child had been granted ROTL in the last six months.

6.14 The number of young adults transitioning to the adult estate after turning 18 had reduced considerably due to the recent change in national policy to keep children in YOIs until they were 18 and 10 months old. As a result, more than a third of the population now held at Werrington had turned 18, many of whom would normally have been moved to the adult estate.

Training planning and remand management

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

6.15 All children had had an up-to-date Asset-plus (the electronically recorded assessment of risk and sentence plan targets for children in custody) completed within the past 12 months. However, some technical issues with this system at Werrington resulted in missing information and disjointed assessments that were difficult to read. The assessments that were not affected by these issues were completed to a reasonable standard and reviewed regularly.

6.16 Each child had a plan in place, named 'one plan', where targets were set for each child to support them and help them to progress in custody. The plan also included arrangements for potential release, such as accommodation and education, training and employment. These were completed in an easy read format, which was helpful when sharing them with the children. However, plans to manage children's risk, particularly on release, were weak and did not always fully address the risks that had been identified.

6.17 The provision for children convicted of sexual offences was insufficient. At the time of the inspection, there had been significant delays in carrying out required assessments, which was likely to result in some children being released without an intervention taking place.

6.18 There were consistently good levels of contact between RPs and children both in meetings and additional contact outside this, which included any pre- and post-court appearances. We saw examples of thoughtful interactions, including getting a child to try on his suit before attending court.

Public protection

6.19 A monthly risk management team (RMT) meeting looked at all children identified as a potential risk to the public or who fell under multi agency public protection arrangements (MAPPA) guidelines. This meeting received a comprehensive report from each child's RP, and on some occasions the YOT. The risk identification in the cases we sampled was generally thorough and well considered with good focus on all aspects of risks in the community and custody, including child exploitation, neglect, and emotional and physical harm.

6.20 Children subject to MAPPA were identified and their YOTs contacted promptly to ascertain their management level on release. When this information was not provided, RPs followed up to make sure that it was.

6.21 Written reports submitted to MAPPA meetings were too variable; some lacked analysis of the child's behaviour and how that contributed towards their level of risk. Where possible, practitioners attended the meetings in person.

Indeterminate and long-sentenced children

6.22 There was some good provision for children servicing indeterminate sentences, which accounted for around 5% of the population.

6.23 There were two schemes in place that linked these children to adult prisons to provide support, information and advice, given they were at the beginning of a long sentence and would be transitioning to an adult prison. A scheme called the 'Big stretch', run by the chaplaincy, held events in which key speakers such as ex-offenders spoke with the children. A separate scheme pairing children with a life-sentenced adult nearing the end of their sentence, and they communicated through supervised video link or correspondence. Letters we viewed were thoughtful, with the potential to generate discussion, assist with reflection and promote motivation for the child to engage and progress their sentence.

Looked after children

6.24 In our survey, 53% of children said they had been in the care of the local authority (LA) at some point before custody. A social worker saw all children on arrival and contacted their local authority. Requests to LAs for financial support were usually made but follow up was lacking.

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.

6.25 The education provider allocated an engagement and resettlement (ER) worker to each child on arrival, and release plans were started straight away. These plans were mostly good, and children's needs on release were well identified by their RP and ER. Children on remand also had plans that included their education, training and employment (ETE).

6.26 Children's educational and vocational needs were assessed. They should have been allocated to a pathway based on these needs, but this was not always possible due to demand and limited spaces on some courses.

6.27 Department for Work and Pensions staff attended regularly and linked well with RPs and ERs, assisting in providing children with careers advice, finding work opportunities or making appointments for benefits claims on release. Children with no ID could apply for a Citizen Card

(proof of age identity card) or their birth certificate. There had been some recent employability events, such as an employment fair attended by local employers. Children were also given support to write a CV.

6.28 In the available records for the last six months that we viewed, 62% of children released had some type of ETE outcome on release, such as a place in education, an apprenticeship or a job. However, these records were incomplete and leaders did not know how many of these placements were sustained over time. In the same period, 22 of the 24 releases went into sustained housing on release, although 18 of these were only confirmed within their last seven days in custody, which affected planning for other areas, including health care and education.

6.29 Children being released were given a helpful diary that contained all their appointments and contact details, such as where and when to meet the YOT, social worker or probation officer.

Interventions

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

6.30 Several accredited behaviour programmes were available at Werrington on both a one-to-one basis and in groups. All children were assessed on arrival by the interventions team, which was now fully staffed, and any need identified. At the time of our inspection, 12 children had been highlighted as needing to access a programme, all of which were planned to be completed within a reasonable timescale.

6.31 Accredited courses aimed to tackle issues of risk for children in areas such as anger, through aggression replacement training (ART), emotional support in the 'Feeling It' course, support to make positive change in the A-Z programme (motivational group work aimed at setting goals and developing plans to achieve them), and the Juvenile Estate Thinking Skills (JETS) programme. Some high-intensity courses available included 'Life Minus Violence', delivered by psychology staff, which targeted violence and aggression.

6.32 Resettlement practitioners helped children prepare for release with a life skills course, showing them how to cook, iron and clean before they went on to live on their own, and Kinetic Youth (see Glossary) offered some groups to all children about knife crime, decision-making and parenting. These courses were well attended and popular with more than 20 children attending each course in the last six months.

Health, social care and substance misuse

6.33 Health care staff completed pre-release assessments and interventions for children approaching release. Assessments were thorough and appropriate to children's needs. They shared relevant health care information with community providers and made appropriate referrals.

6.34 Inclusion staff ensured person-centred plans were in place for children approaching release and provided harm-reduction advice when appropriate.

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 2022, we found that outcomes for children were poor against this healthy establishment test.

Key recommendations

An informed and establishment-wide strategy should be implemented to reduce levels of violence.
Achieved

Behaviour management processes should be developed that give all staff the confidence to challenge poor behaviour and promote prosocial behaviour.
Not achieved

Care

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

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

Key recommendations

Relationships between staff and children should be meaningful and support children's progression.
Not achieved

Children should live on age-appropriate wings that are configured and resourced so that children can engage in a full regime of activities that support their rehabilitation.
Not achieved

Unequal outcomes should be investigated and addressed.
Not achieved

Sustained action should be taken to make sure that health resources are fully used to optimise the health care of patients.
Not achieved

Purposeful activity

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

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

Key recommendations

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

Leaders should support staff to deliver a curriculum that develops children's skills in their subject.
Not achieved

Staff working on functional skills courses should ensure that the curriculum is ambitious and develops children's knowledge.
Not achieved

Leaders and managers should ensure that children have the opportunity to study their chosen subject.
Not achieved

Staff should set high expectations for children. Children should be encouraged and supported to identify and develop the skills that will support them during their time in custody and on release.
Not achieved

Recommendations

Prison staff should make sure that children arrive promptly to lessons.
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 2022, we found that outcomes for children were reasonably good against this healthy establishment test.

Key recommendations

The range of interventions should be broadened to include those aimed at children serving life or indeterminate sentences. Interventions should be sequenced to make sure that all children requiring interventions receive them.
Achieved

Leaders should implement robust systems that ensure recognised educational and training placements are secured when transitioning from custody to the community.
Achieved

Recommendations

The needs analysis should be fully reviewed to enable leaders to plan appropriately to reflect the needs of the current population.
Achieved

The remit of the reducing reoffending meeting should be broadened to make sure that monitoring of data is comprehensive and to provide strategic oversight to leaders.
Not 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
David Foot	Inspector
Sumayyah Hassam	Inspector
Rebecca Stanbury	Inspector
Dionne Walker	Inspector
Donna Ward	Inspector
Helen Downham	Researcher
Emma King	Researcher
Helen Ranns	Researcher
Samantha Rasor	Researcher
Joe Simmonds	Researcher
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Jacob Foster	Care Quality Commission inspector
Maria Compton	Ofsted inspector
Tony Gallagher	Ofsted inspector
Maria Navarro	Ofsted inspector
Jai Sharda	Ofsted inspector
Suzanne Wainwright	Ofsted inspector

Appendix II Glossary

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

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.

Kinetic Youth
A not-for-profit social enterprise that primarily works with young people in custody to provide enrichment activity and help them gain new skills and understand their world better.

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

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

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

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.

Virtual campus
Internet access to community education, training and employment opportunities for prisoners.

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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