Report on an unannounced inspection of

HMYOI Feltham A

by HM Chief Inspector of Prisons

21 February – 4 March 2022

Contents

Introduction

Our inspection of Feltham A in 2019 revealed “a dramatic and precipitous collapse in standards”. The prison had become so violent and chaotic that my predecessor decided to invoke the urgent notification (UN) process – the first time it had been used in a children’s prison.

At both of our scrutiny visits in July 2020 and February 2021 we saw signs of improvement, but the transformation we found at our most recent inspection was impressive. Much credit must go to the excellent work of the governor, who remained in post after the UN and had created a strong team around her with a renewed sense of purpose and vision. As a result, the prison was safer, happier and more productive, with a more confident staff team able to meet the often complex needs and address the behaviour of what was, at times, a challenging group of children.

We saw good functional leadership in a number of areas, including education, resettlement, and safety – where we saw some of the biggest improvements.

A notable success lay in the development of Alpine unit, which held children considered unable to mix with the general population due to their behaviour and level of need. A well-trained and motivated team created a supportive and inclusive culture that aimed to get the boys out of their cells and mixing with their peers in a therapeutic environment. As a result, children who in the past would have spent much of their time languishing in segregation were being given bespoke support and, where possible, helped to reintegrate back onto their wing or to make a successful transfer to adult prison.

Our reports frequently comment on the lack of motivation prisoners have toward the incentives and earned privileges (IEP) scheme, in which sanctions are harsh and desultory rewards are often not forthcoming. At Feltham, the IEP were some of the best I have seen; good behaviour was noted and rewarded while poor behaviour was usually addressed quickly. Every child I spoke to was aware of the opportunities offered in the Dunlin enhanced unit if they earned a place. Here, they got more time out of their cells and a chance to join activities such as the Duke of Edinburgh scheme, army cadets or the barbering workshop. The aim was to make this provision more widely available as the constraints from the pandemic were lifted.

The number of children on ‘keep apart’ lists – aimed to prevent particular children from mixing – had reduced and was lower than we had seen elsewhere. This was impressive, given that the population was largely London based and some were gang affiliated, thereby increasing the risk that conflict in the community would spill over into the prison.

Attendance in education stood at an impressive 96%, having improved noticeably since last time. It was disappointing, however, to see that children were put in lessons that did not differentiate them by ability, resulting in work being either too easy or too difficult.

The last day of our inspection coincided with the governor's last day in post, and she left for another prison having made very good progress. There remains, however, much to do at Feltham to complete the recovery from COVID-19, recruit and retain sufficient staff, improve the quality of education and continue to bear down on levels of violence which remain too high.

Even when things are going well, because of the nature of the children it serves, Feltham is a fragile place and close attention and support from the Youth Custody Service (YCS) will be essential to make sure that the transition from one leader to the next is a success.

Charlie Taylor
HM Chief Inspector of Prisons
April 2022

About HMYOI Feltham A

Task of the establishment
Feltham A manages children on remand and those who have been convicted by the courts.

Certified normal accommodation and operational capacity (see Glossary of terms)
Children held at the time of inspection: 75
Baseline certified normal capacity: 240
In-use certified normal capacity: 168
Operational capacity: 120

Population of the establishment
- 206 children received in a year
- 20% foreign national children
- 75% of prisoners from black and minority ethnic backgrounds
- Three children released into the community each month
- Seven children transferred to the adult estate each month

Establishment status and key providers
Public

Physical health provider: Central and North-west London NHS Foundation Trust (CNWL)
Mental health provider: CNWL
Substance misuse treatment provider: CNWL
Prison education framework provider: Prospects
Escort contractor: Serco

Prison group/Department
Youth Custody Service

Brief history
The original Feltham was built in 1854 as an industrial school and was taken over in 1910 by the Prison Commissioners as their second Borstal institution. The existing building opened as a remand centre in March 1988.

The current HM Prison and Young Offender Institution Feltham was formed by the amalgamation of Ashford Remand Centre and Feltham Borstal in 1990/1991.

Short description of residential units

Alpine:	Enhanced support unit (ESU)
Bittern:	Currently closed for installation of shower pods
Curlew:	Induction and reverse cohort unit (RCU)
Dunlin:	Platinum community
Eagle:	Normal location
Falcon:	Reintegration unit
Heron:	Normal location

Jay: Normal location
Grebe: Closed

Name of governor and date in post
Emily Martin, 2018-March 2022

Prison Group Director
Heather Whitehead

Independent Monitoring Board chair
Maggie Thurer

Date of last inspection
July 2019

Section 1 Summary of key findings

1.1 We last inspected HMYOI Feltham A in 2019 and made 28 recommendations, 14 of which were about areas of key concern. The establishment fully accepted 27 of the recommendations and partially (or subject to resources) accepted one.

1.2 In February 2021, during the COVID-19 pandemic, we conducted a scrutiny visit at the establishment. We made seven recommendations about areas of key concern.

1.3 Section 8 contains a full list of recommendations made at the last full inspection and scrutiny visit and the progress against them.

Progress on key concerns and recommendations from the full inspection

1.4 Our last inspection of HMYOI Feltham A took place before the COVID-19 pandemic and the recommendations in that report focused on areas of concern affecting outcomes for children at the time. Although we recognise that the challenges of keeping children safe during COVID-19 will have changed the focus for many prison leaders, we believe that it is important to report on progress in areas of key concern to help leaders to continue to drive improvement.

1.5 At our last full inspection, we made four recommendations about key concerns in the area of safety. At this inspection we found that four of those recommendations had been achieved.

1.6 We made three recommendations about key concerns in the area of respect. At this inspection we found that two of those recommendations had been achieved and one had not been achieved.

1.7 We made four recommendations about key concerns in the area of purposeful activity. At this inspection we found that three of those recommendations had been achieved and one had not been achieved.

1.8 We made three recommendations about key concerns in the area of resettlement. At this inspection we found that one of those recommendations had been achieved and two had not been achieved.

Progress on recommendations from the scrutiny visit

1.9 During the pandemic we made a scrutiny visit to HMYOI Feltham A. Scrutiny visits (SVs) focused on individual establishments and how they were recovering from the challenges of the COVID-19 pandemic. They were shorter than full inspections and looked at key areas based on our existing human rights-based *Expectations*. For more information on SVs, visit https://www.justiceinspectorates.gov.uk/hmiprisons/about-hmi-prisons/covid-19/scrutiny-visits/.]

1.10 At the SV we made some recommendations about areas of key concern. As part of this inspection we have followed up those recommendations to help assess the continued necessity and proportionality of measures taken in response to COVID-19, how well the establishment is returning to a constructive rehabilitative regime, and to provide transparency about the establishment's recovery from COVID-19.

1.11 We made seven recommendations about areas of key concern. At this inspection we found that four of the recommendations had been achieved and three had not been achieved**.**

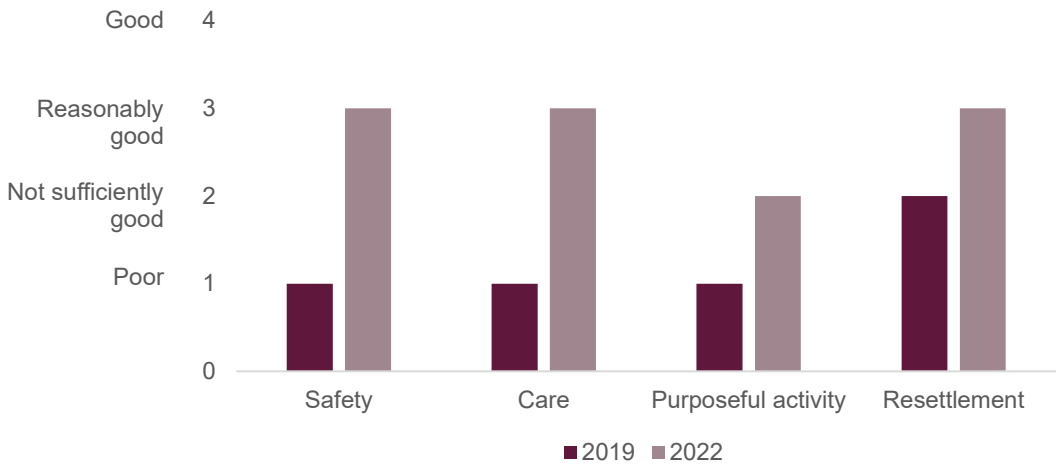
Outcomes for children

1.12 We assess outcomes for children against four healthy establishment tests (see Appendix I for more information about the tests). We also include a commentary on leadership in the establishment (see Section 2).

1.13 At this inspection of HMYOI Feltham A, we found that outcomes for children had improved in four healthy prison areas.

1.14 These judgements seek to make an objective assessment of the outcomes experienced by those detained and have taken into account the establishment's recovery from COVID-19 as well as the 'regime stage' at which the establishment was operating, as outlined in the HM Prison and Probation (HMPPS) National Framework for prison regimes and services.

Figure 1: HMYOI Feltham A healthy establishment outcomes 2019 and 2022



Safety

At the last inspection of HMYOI Feltham in 2019, we found that outcomes for children were poor against this healthy establishment test.

At this inspection we found that outcomes for children were now reasonably good.

1.15 The reception process was swift and children's perceptions of how they were searched and treated on arrival had improved. Reverse cohort arrangements were reasonably good but all children, including those who tested negative for COVID-19, had to isolate for 10 days. Cells on the induction unit were well prepared and welfare checks for newly arrived children were frequent and detailed.

1.16 There were strong links with the local authority, safeguarding referrals were completed in a timely manner and were well investigated by social workers who referred cases to the local authority designated officer (DO) where appropriate. During the night visit we observed evidence of poor practice that needed to be addressed.

1.17 Levels of self-harm had fallen by approximately 80% and there was good assurance of processes to keep children safe. Leaders discussed relevant data at the safety meetings and were aware of incidents and rates of self-harm. Children who had been at risk of self-harm felt well supported and cared for by staff.

1.18 Children’s perceptions of safety were similar to those at the previous inspection. Levels of violence, however, although still too high, had reduced considerably since our last inspection and were now similar to comparable establishments. Violence reduction and anti-bullying processes were effective and well embedded. These were underpinned by regular core support meetings which generated actions to help staff

manage children's behaviour. The enhanced support unit provided good care and support for children with the most complex needs, which was good practice. The conflict resolution team was proactive and had been effective in reducing the number of children who could not mix with their peers.

1.19 Most low-level poor behaviour and play fighting was challenged effectively by staff who used immediate rewards and sanctions appropriately. Children liked the benefits of both gold and platinum regimes which were motivational and promoted good behaviour.

1.20 Levels of force used by staff had also reduced greatly and were now comparable with similar prisons. In our survey, 52% of children said that they had been restrained compared with 74% at our previous inspection. Governance of use of force was generally good.

1.21 The number of children separated had reduced considerably since our last inspection and only one child was held on Falcon unit. Most children who needed to be separated received a tailored regime and were reintegrated within 72 hours. Children were no longer routinely separated on the wings.

Care

At the last inspection of HMYOI Feltham in 2019, we found that outcomes for children were poor against this healthy establishment test.

At this inspection we found that outcomes for children were now reasonably good.

1.22 Relationships between staff and children had improved considerably since our last inspection. Our observations of interactions between children and staff were positive. Case formulations and regular core support meetings helped residential staff to understand the needs of the children in their care. Most frontline staff were knowledgeable about children on their unit and we saw staff adapting their practice to meet their needs.

1.23 Most communal areas and cells were clean and tidy, although some cells still had graffiti on furniture and badly stained toilets. Children benefited from improvements including in-cell telephones and laptops. In-cell showers had been installed on two units, but not all children could access a shower every day. Access to property required improvement. Children had justifiably poor perceptions of the complaints process.

1.24 The food was reasonably good and it was positive that children could sometimes eat together. Meals were served at the children's door when they were eating in their cell, which was poor practice.

1.25 Equality meetings did not identify or monitor disproportionality. Focus groups had not been taking place and leaders were not aware of the

needs of children with protected characteristics. Investigations into discrimination complaints were poor and responses to children required improvement. Children felt supported by chaplains but could only attend communal worship once every eight weeks, which was poor.

1.26 Governance arrangements were good, although prison representatives did not attend the local delivery board and, therefore, did not have effective oversight of services. CNWL had continued to monitor their own performance indicators and maintained their governance processes. The use of laptops had led to an increase in appointments for the sexual health clinic, which was positive. A rich skill mix of professionals worked collaboratively to provide good support to children with their mental health and substance misuse needs. The framework for integrated care was well embedded and provided a centre-wide approach in supporting children to feel safe and improve their emotional health and self-esteem. Pharmacy provision had improved, and medicines were administered safely. The carrying of medicines around the wings at 6pm was not good practice.

Purposeful activity

At the last inspection of HMYOI Feltham in 2019, we found that outcomes for children were poor against this healthy establishment test.

At this inspection we found that outcomes for children were now not sufficiently good.

1.27 Leaders were continually aiming to improve time out of cell for children, but progress had been hindered by the pandemic and staff shortages. The average time out of cell for during February 2022 was 5.5 hours, but this ranged from 1.5 hours for those who were in isolation to up to nine hours for some children. The introduction of evening activity was good and there were plans to extend this. Children had good access to the gym, but library provision was poor.

1.28 Leaders had put an education curriculum in place that enabled children to make progress in the skills they needed for employment and to overcome their barriers to learning. Most children received at least their statutory entitlement to face-to-face education. Attendance had improved and was high, but too few children attended education full time. Leaders did not ensure that there was enough learning in subjects other than English and mathematics at level 2 or higher. Education staff contributed to children's induction, but managers did not allocate children to education pathways that reflected their aspirations and career goals.

1.29 The quality of education had improved since the previous inspection, but the quality of teaching and assessment was still inconsistent. Most learners developed knowledge in GCSE English and mathematics courses and a good proportion of children achieved grade four or above. The ICT curriculum was very limited and vocational training options were available for only a small proportion of children.

1.30 Most children produced work of an acceptable standard. Children developed good practical skills in vocational programmes. Teachers' feedback varied in its usefulness and, too often, children did not act on it. Too many teachers did not check children's understanding fully in class.

1.31 Teachers identified children's learning support needs and special educational needs promptly. However, too many teachers did not adopt strategies in their teaching to support these children.

1.32 Children did not receive enough careers advice and guidance.

Resettlement

At the last inspection of HMYOI Feltham in 2019, we found that outcomes for children were not sufficiently good against this healthy establishment test.

At this inspection we found that outcomes for children were now reasonably good.

1.33 Children were much more positive about being helped to keep in touch with their families and friends than at the previous inspection. The introduction of in-cell telephones and laptops and the support from a family therapist and Spurgeons workers all contributed to improvements in enabling children to have regular contact with their families. Visits provision was too limited and underused.

1.34 Reducing reoffending work was informed by an up-to-date needs analysis and received reasonable oversight at regular meetings. Attention had been given to the increasing numbers of children with, or facing, long and indeterminate sentences and work to support them was developing well. Transitions to adult prisons were started in good time. Managers had been proactive in identifying how, subject to a risk assessment, restricted status children could be given information about the prison they would transition to. The monthly risk management meetings gave suitable oversight to public protection work.

1.35 Resettlement practitioners (RPs) had impressive knowledge of their own and colleagues' cases and children had good levels of contact with them. Most children we interviewed had a positive view of Feltham A and their RP. Regular reviews informed children's remand and sentence plans which were generally good and age appropriate. Restrictions imposed during the pandemic had reduced the number of face-to-face meetings children had with community agencies involved in their care which had been replaced by virtual meetings or conference calls. Release on temporary licence (ROTL) processes were thorough but fewer children were accessing ROTL than at the last inspection.

1.36 Over the previous year, 52 children had completed an accredited intervention and the first group intervention since the pandemic started had recently been completed. Children participated in other intervention

work delivered by several teams which addressed the factors that had led to their custody.

1.37 Social services were involved in the care of most children and had good support from the on-site social work team. This often involved making sure that children received statutory entitlements from their local authority.

1.38 During the previous six months, all children had had a confirmed accommodation placement more than 10 days before their release. However, only 19% had had a confirmed education or training place on release.

Key concerns and recommendations

1.39 Key concerns and recommendations identify the issues of most importance to improving outcomes for children and are designed to help establishments prioritise and address the most significant weaknesses in the treatment and conditions of children.

1.40 During this inspection we identified some areas of key concern and have made a small number of recommendations for the establishment to address those.

1.41 Key concern: Important safety procedures such as the protocol for entering a cell in an emergency overnight and calling an ambulance were not known by some staff who only worked nights. A cell door was left unsecured and was set up with a television and chair. This had occurred before the handover to night staff who did not have ready access to a cell key.

Key recommendation: Staff should adhere to policies which make sure that children are properly safeguarded during the night.
(To the governor)

1.42 Key concern: Equality work was underdeveloped. In particular, data was not used effectively to identify and address any unequal treatment.

Key recommendation. Leaders and managers should monitor data in order to identify and address any unequal treatment.
(To the governor)

1.43 Key concern: Children lacked confidence in prison procedures to redress perceived injustice. Discrimination incident report forms and complaints were not thoroughly investigated and responses were inadequate and often late. Quality assurance of DIRFs and complaints did not improve outcomes.

Key recommendation: Complaints and DIRFs should be thoroughly investigated and children should be routinely interviewed as part of the investigation.
(To the governor)

1.44 Key concern: Children did not spend enough time out of their cell and plans to increase it could not be realised with the current staffing shortfalls.

Key recommendation: Children should have 10 hours a day out of their cell.
(To the governor)

1.45 Key concern: Leaders and managers had not yet improved the quality of education sufficiently. Teaching and assessment practices were of inconsistent quality which adversely affected the progress children made in education. Too many teachers did not adapt their teaching to reflect known support strategies for children with special educational needs.

Key recommendation: Leaders and managers should continue to identify the weaknesses in teaching and assessment practices. They should ensure that staff development activities are targeted to improving the quality of individual teachers, and that they monitor closely the impact of these activities on improving teachers' skills so that more children, including those with special educational needs, make more rapid progress in developing their skills and knowledge.
(To the governor)

1.46 Key concern: Not all children had enough time scheduled during the core day in education activities and too few children could access vocational training.

Key recommendation: Leaders should increase the time children are timetabled to spend in education and should make sure that the timetable enables more children to access vocational training.
(To the governor)

1.47 Key concern: Poor ICT infrastructure was adversely affecting the experience of children in education. Children were not able to develop essential ICT skills or achieve appropriate qualifications in this subject.

Key recommendation: Leaders should urgently improve the technical resources available in education. They should ensure that the curriculum enables children to develop the essential ICT skills they need to succeed in their lives and careers, and that children are able to achieve appropriate qualifications in this subject.
(To the governor)

1.48 Key concern: Children did not receive ongoing careers advice and guidance. They were not aware of how to reach their career goals and did not have any opportunities to raise their aspirations through the curriculum offered or the activities to which they were allocated.

Key recommendation: Leaders and managers should make sure that children receive careers advice and guidance during their

custody at the prison. All children should be allocated to activities relevant to their career goals and should have more access to employers. Leaders should make sure that ROTL is used appropriately and that children explore the full extent of the careers available to them.
(To the governor)

1.49 Key concern: Too many children were leaving custody with no confirmed education or training placement.

Key recommendation: Leaders should implement robust systems to make sure that children are supported in securing recognised educational and training placements when transitioning from custody to the community.
(To the governor)

Notable positive practice

1.50 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.

1.51 Inspectors found eight examples of notable positive practice during this inspection.

1.52 Safeguarding procedures were very good. Complaints by children were referred to the on-site team of local authority social workers within 24 hours. Concerns were escalated appropriately to the local authority designated officer (DO), again within 24 hours. The social workers worked closely with prison staff and the DO attended the prison regularly. (See paragraph 3.11)

1.53 The four-tier rewards and sanctions scheme was well embedded and encouraged good behaviour in children. Staff and children liked the system of immediate rewards and sanctions. These incentive schemes were complemented by staff challenging low-level poor behaviour and setting appropriate standards and boundaries for children. (See paragraph 3.32– 3.33)

1.54 Weekly core support meetings enabled a wide range of departments, including resettlement, education, psychology and residential staff, to share information and understand children's needs. These meetings focused on the factors influencing a child's negative behaviour and underpinned all behaviour management processes.

1.55 Alpine unit (the enhanced support unit) provided excellent support for children with the most complex needs, and the levels of care shown by staff were impressive. This provision ensured children who would otherwise be separated received a full programme of activities from unit staff education, healthcare and psychology. The success of Alpine

meant other units were disrupted less often and staff had more time to meet the needs of the children in their care. (See paragraphs 3.38 – 3.41)

1.56 All children were referred to the dentist on arrival for a dental assessment. (See paragraph 4.78)

1.57 Leaders had developed a scheduling system which gave each child an individual weekly timetable and allowed departments to schedule time with a child that did not affect education or other key activities. (See paragraph 5.5)

1.58 A lifer and long-term sentences meeting attended by departments across the establishment was an innovative approach which focused on the needs of the increasing proportion of the population facing lengthy periods in custody. (See paragraph 6.24)

Section 2 Leadership

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

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 Feltham A was a well-led establishment. The governor and her team had made considerable improvements for children since our last inspection. We found that outcomes had improved in all four of our healthy prison tests and were now reasonably good in three. It was remarkable that this progress had taken place during a pandemic.

2.3 After our previous inspection and urgent notification, the Youth Custody Service (YCS) had improved oversight and created a dedicated leadership team for Feltham A. Leadership was now strong in most areas and particularly good in Alpine, safety, residential units and resettlement. Joint working between residence and safety was impressive. Partnership work was also good between the prison, education and health care which supported improvements in these areas.

2.4 YCS governance of education had been strengthened since the previous inspection. The appointment of a national manager with experience of education had helped local managers to understand their role and better oversee the education contract. Local prison managers now worked more successfully with the education provider to improve education at the site. YCS leaders had increased investment in the establishment. This had led to improvements in accommodation and facilities for children including in-cell telephones, laptops and showers. Several capital projects were in progress at the time of our inspection, including the refurbishment of Bittern unit and the building of a new reception and health care facility.

2.5 Leaders had implemented the framework for integrated care effectively; individual case formulations were good and regular core support meetings for every child supported improvements in safety, care and resettlement.

2.6 The establishment had experienced some staff shortfalls after a pause in recruitment during the pandemic. This was compounded by the recent outbreak of COVID-19, but at the time of the inspection the regime had been stabilised effectively by overtime payments. This meant that some members of staff were tired and, in our staff survey,

many respondents had poor perceptions of managers. Leaders needed to understand better and address these perceptions.

2.7 Leadership of equality, diversity and faith continued to require improvement. Managers were enthusiastic but needed to focus more on identifying and addressing unequal treatment.

2.8 The governor left her role at the end of this inspection. Feltham is a high-risk and complex establishment where outcomes have varied over the past 10 years. The challenge for her successor is to consolidate the improvements outlined in this report and build on them.

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 Arrangements for children's early days at Feltham A had much improved since our last inspection. About five children a week arrived in modern clean vehicles that were appropriate for transporting them. Contracted staff who accompanied children from court gave them food, snacks and drinks during the journey and prison staff made the same offer when they arrived at reception.

3.2 A nurse gave all children a COVID-19 clinical assessment on the vehicle before the child alighted (see paragraph 4.36). If the child was assessed as symptomatic, they went directly to the induction and first night centre (Curlew) which minimised the risk of contact with others.

3.3 All other children came into reception where an assessment of risk and vulnerability was conducted in private by staff, including medical staff. In our survey, 79% of children said they were treated well in reception and searched in a respectful way. The reception process lasted a little over an hour. The few children who arrived after 7pm were fast tracked to Curlew within 20 minutes of arrival.

Reception interview room

3.4 In our survey, 59% of children said they had problems when they first arrived and, of these, 52% said that staff helped them to resolve them compared with 23% at the previous inspection.

3.5 The reverse cohort unit (RCU) (see Glossary) was also situated on Curlew and all children were required to isolate for 10 days on arrival. This period was rigidly applied regardless of a negative COVID test during that time and left children unnecessarily isolated.

3.6 Curlew was tidy, clean, and well furnished. First night cells were freshly painted, free of graffiti and well prepared. Showers had been fitted to all cells. Children we spoke to said they knew staff well, felt cared for and had been provided with adequate toiletries and bedding. Time out of cell was more limited than other units at two hours a day, although children were encouraged to use their time with a wider range of activities than we have observed in other young offender institutions (YOIs). Activities such as wing-based education, the exercise room or interactions with staff were actively encouraged. Record keeping of children's regimes was very good.

Well-prepared first night cell

3.7 Comprehensive welfare checks were in place for those on the induction unit. These were recorded in each child's record which contained information that helped staff to get to know them better. We looked at entries in the books which were frequent, focused and comprehensive, and explained how each child was coping, feeling and being supported.

3.8 The introduction of an exercise room with equipment on Curlew was a good initiative and we observed children using it while supported by staff, which was positive.

3.9 In our survey, 59% of children said they were told everything they needed to know in the first few days compared with 36% at the previous inspection. Information provided during induction was up to date and relevant and told children whom they would meet and when as they moved through the induction programme.

Safeguarding of children

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

3.10 In our survey, 9% of children told us they felt unsafe at the time of the inspection and 33% said they had felt unsafe at some point at Feltham. This was similar to the previous inspection and other YOIs.

3.11 Safeguarding referrals were completed swiftly and forwarded to a team of local authority social workers who were based on site. A brief investigation of every referral was conducted and any that met the appropriate criteria were sent to the local authority designated officer (DO). Any referrals or complaints that could not be investigated thoroughly or lacked information were automatically referred to the DO. This prevented delays and provided the appropriate level of scrutiny.

3.12 Eight safeguarding referrals during the previous six months had been referred to the DO, which was much lower than the 53 at the previous inspection.

3.13 During the night visit, we found that dedicated night staff were unsure of the correct procedures to enter a cell when a child was at risk of serious harm to themselves or needed immediate aid. Cell bells were not always responded to quickly, staff were unaware of the location of defibrillators and procedures for calling an ambulance were confused (see paragraph 3.24). All these factors had the potential for unacceptable delays in a life-threatening situation.

3.14 On one unit we found an unoccupied cell with the door open and a television and chair set up ready for night staff to use during their shift. This contravened prison rules and was very concerning.

3.15 Safeguarding was discussed at the weekly safety meeting and in more depth at the monthly and quarterly meetings which were also attended by the DO and the social work team. An impressive amount of data was reviewed at the quarterly meeting to identify trends or patterns in safeguarding referrals.

3.16 We saw evidence of good inter-agency working between the prison and the local authority and the governor sat on the Hounslow Children's Safeguarding Board.

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.

3.17 Strategic oversight of the management of self-harm had considerably improved since the last inspection. Rates had reduced by approximately 80% and were now similar to other YOIs.

3.18 There had been 40 self-harm incidents in the last 12 months, and seven children had required hospital treatment. Most had harmed themselves by banging their heads or making cuts to their bodies. We observed high levels of support and care for those children.

3.19 In our survey, 62% of children said they felt cared for by staff compared with 19% at the previous inspection. During the previous year, 50 ACCT documents (assessment, care in custody and teamwork used to direct the care of children at risk of suicide or self-harm) had been opened. At the time of our inspection three children were being supported and monitored on ACCTs.

3.20 We spoke to children who were on open ACCTs and each said they felt well supported and cared for by staff. Children now had consistent case managers and reviews had been conducted with a nurse in attendance who knew the child well. There was a good focus on ensuring children at risk of self-harm were kept occupied and had multiple opportunities to speak to staff about their concerns.

3.21 Training for staff to support children at risk of self-harm had been suitably prioritised. Ninety-three per cent of staff had been trained in the new ACCT version 6, and 25 newly trained ACCT case managers were in post. It was evident that enhanced staff training had improved the support provided to children.

3.22 Our concern at the last inspection about the inaccuracy of self-harm data had been addressed and strategic oversight had markedly improved. Leaders were now familiar with these data which were monitored vigilantly at safeguarding meetings. Stringent assurance processes ensured that case reviews took place on time and were well attended. ACCT documents were checked each day and any concerns were addressed with swift remedial action. Families were not routinely involved in reviews which was a gap.

3.23 In our survey, 48% of children said that their emergency cell bells were answered within five minutes compared with 25% at the previous inspection. Cell bell response times were generally better during the day than at night, when there were too many delays. (see paragraphs 3.13 and 3.14).

3.24 In the event of a medical emergency, ambulances were not routinely called by wing staff who waited for a nurse or paramedic to arrive and decide if the ambulance was warranted. This delay represented a risk to children's safety (see paragraph 3.13).

3.25 Defensible decision logs for children at risk of harm but also subject to separation (Rule 49) from other children were reasonably well completed. Documents that we examined indicated clear decision making and that separation was used as a last resort.

Recommendation

3.26 **Ambulances should be requested without delay by staff who identify a medical emergency.**

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.

3.27 Security procedures were proportionate to the risks presented by the population. At the time of the inspection, two restricted status (equivalent to category A adult prisoners) children were subject to additional security measures.

3.28 There was a joint security department for the children's and adults' sites at Feltham, and security information for both was discussed at a monthly meeting. A detailed local tactical assessment was completed for each site which reflected the specific concerns faced by the two parts of the prison. The assessment for the children's site was discussed at key safety meetings attended by staff from the security department.

3.29 Security information was well managed and disseminated appropriately. During the previous six months, there had been 1,972 information reports for Feltham A compared with 3,432 at our previous inspection which reflected the much more stable atmosphere in the prison.

3.30 Information reports that were potentially serious were dealt with quickly, but more routine reports were not always actioned in a timely manner because of staffing constraints. Random drug testing was carried out and no children had tested positive over the last six months.

3.31 There was no backlog of telephone or mail monitoring, although very few children were subject to these restrictions. Telephone calls for restricted status children were limited to 35 minutes a day which was too restrictive.

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.

3.32 Behaviour management processes consisted of immediate rewards and sanctions, weekly reviews and longer-term incentives including the platinum unit, ROTL and early release. This was underpinned by good relationships between children and staff.

3.33 Immediate rewards and sanctions took the form of green and yellow cards. Green cards for good behaviour allowed children to spend additional money in the shop and yellow cards gave an immediate sanction proportionate to the behaviour, such as loss of eating out of cell. These immediate rewards and sanctions aimed to support children to progress through the four incentive levels as their behaviour was reviewed.

3.34 Children could spend more time out of cell and get additional access to spending money and games consoles as they progressed through the levels of the incentives scheme. Dunlin unit was the platinum wing where children had a game console in their cell. Children living there also had access to vocational training including the Army Cadets, barbering and multi-skills which were popular with children and encouraged them to behave well.

3.35 We observed staff challenging most low-level poor behaviour which helped to set suitable boundaries for children and clarify the reason for any sanctions being imposed.

3.36 All children are discussed at the weekly core support meeting on a rotational basis, where their needs formulation is reviewed. However, when staff become concerned about a child's behaviour or change in behaviour, they will be discussed in addition to those on the rotational agenda. Children were frequently invited to these meetings to take part in the discussion, which was positive.

3.37 Behaviour management meetings took place each week. Children's needs are discussed and how they can best be met or addressed , which was good practice. Those with the most complex needs were placed on an enhanced support team (EST), and a treatment plan was introduced with increased input from psychology and mental health and other relevant departments.

3.38 Some children who were on an enhanced plan were moved to the Alpine unit, which provided more support for those who needed it. The facilities on Alpine were excellent and the top floor had been converted into a gym, music room and activity area together with offices and meeting rooms.

3.39 Staff interactions with, and knowledge of, the children on Alpine were very good. These sometimes very vulnerable children mixed together well and staff could maximise the time out of cell and activity available to each child.

Alpine communal area

3.40 Enhanced support meetings took place weekly and the child and their family were invited to attend. There was good transitional support provided for those children who returned to the other units. These children benefited from the continuing input of an enhanced support meeting for as long as necessary.

3.41 Strategic monthly and quarterly safeguarding meetings also took place. Attendance was good and resulted in effective actions that supported the reduction in violence and improvement in behaviour across the site.

3.42 There was a considerable reduction in the number of adjudications. During the previous six months, 539 had taken place compared with 1,759 at the previous inspection.

3.43 Most charges were at an appropriate level for and the awards in the sample that we viewed were proportionate to the offence. Levels of enquiry were inconsistent, and we saw examples where there was little enquiry before the charge was proved.

Adjudications room

3.44 Leaders had recently introduced a restorative justice approach to adjudication awards where children had the opportunity to make amends to a victim, which was commendable. This was not yet embedded, and it was too early to identify results.

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.

3.45 Violence had reduced considerably since our last inspection and was now similar to other YOIs. During the previous six months, there had been 81 incidents of violence compared to 325 at the last inspection. Assaults on staff had reduced from 152 to 32 at this inspection.

3.46 The violence reduction strategy was focused on the core support meetings for each child (see paragraph 3.36). All children involved in acts of violence were seen by the conflict resolution team. Referrals could be made to the team from anywhere in the prison, and children could refer incidents themselves in confidence using the laptops in their cells.

3.47 The conflict resolution team was very active and had managed to reduce the number of groups of children who could not mix for fear of violence. At the time of the inspection, more than half the units had only one group; as a result, children could access more time out of cell. The number of children who needed to be kept apart from each other had reduced but there remained more than 100 'keep aparts' in a population of 76. The team had credible plans to reduce this number further.

3.48 The keep apart list was managed well and no longer affected children's ability to attend education or other activities. However, it did impact on corporate worship, the unit the child lived on, and the education session they attended.

3.49 There was an appropriate anti-bullying policy in place (PEACE) with two levels. When an incident of bullying occurred, the bully was challenged and the victim offered support. At level one the bully was given a warning and his behaviour monitored to see if it continued. At level two further interventions such as conflict resolution were considered, and sanctions were used to challenge bullying behaviour.

3.50 Anti-bullying information was shared at the core support meeting and children suspected of bullying were discussed and further appropriate actions decided to challenge antisocial behaviour.

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.

3.51 Levels of use of force had reduced considerably since our last inspection. During the previous six months, force had been used 270 times compared with 727 at the previous inspection. In our survey, 52% of children told us they had been physically restrained at Feltham against 74% last time.

3.52 Pain-inducing techniques had been used once in the last six months and the incident had not met the criterion of a serious risk of harm to the child or a member of staff. Leaders had identified this and taken appropriate steps to address these concerns.

3.53 Oversight had improved and the restraint minimisation policy was clear and comprehensive. Each child was debriefed following a restraint and every use of force was scrutinised by the managing and minimising physical restraint (MMPR) team within 24 hours. Safeguarding concerns that were identified or any complaint made by a child were immediately referred to a team of dedicated social workers from the local authority who were based on site. Any referral to this team that needed to be seen by the DO was submitted immediately. Any restraint

with no CCTV or body-worn video camera footage was also referred straight to the DO for further investigation.

3.54 There had been a considerable backlog of uncompleted use of force reports at the last inspection. This had markedly reduced and now only 38 reports were outstanding.

3.55 Use of force was considered at a series of meetings. The DO attended each month to view any restraints of concern and an additional random sample. The MMPR team had received appropriate training and had reduced the number of times children were placed back in their cells face down under restraint by 88%, which was very good.

3.56 A wide range of data was examined at the quarterly strategic safety meeting. This helped leaders to identify trends in use of force and generate suitable actions to try to reduce it.

3.57 The use of body-worn video cameras by staff to record incidents was inconsistent. We saw very few instances in the footage that we viewed of staff capturing the start of incidents on film. This affected leaders' ability to make sure that all use of force was justified.

Recommendation

3.58 **Pain-inducing techniques should only be used when there is a risk of serious harm to a child or member of staff.**

Separation/removal from normal location

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

3.59 Children were now separated from the main population on Falcon unit only, and the number of children and their average length of stay had reduced. Over the previous six months, children had been separated from their peers for a total of 402 days compared to 1,148 at the previous inspection.

3.60 In our survey, 43% of children said they had been kept locked up and stopped from mixing as a punishment compared to 75% at the previous inspection.

3.61 Fewer children were separated for long periods than at our last inspection. Separation of more than 21 days (and every 21 days thereafter) had to be approved by a deputy director from the Youth Custody Service. During the previous six months, this had occurred twice and neither occasion had exceeded 42 days, compared with 89 days at our previous inspection.

Segregation cell

3.62 A reintegration plan was devised for each child as part of their core support (see paragraph 4.3). The reasons for separation were addressed effectively and children were able to return to normal location swiftly. Children with the most complex needs were moved to the enhanced support unit (see paragraph 3.38).

3.63 Governance had improved. In the records that we reviewed there was a justifiable reason for separation in every case and the correct level of authority had been acquired. A health care professional had approved each use of separation and they visited the unit each day to check on children's welfare. Management checks also took place daily.

3.64 Children spent more time locked in their cells while separated but every effort was made to make sure they attended education classes in the morning. Other activities and interventions were also planned into the core day such as meetings with the conflict resolution team and core support. We observed staff interacting well with children on the unit and getting them out of their cells to take part in activities, even if that was limited to cleaning or performing basic chores.

3.65 Thought had been put into the separation process. Staff carried out an outreach service which provided additional support to children at risk of being separated to try to prevent it. The service also enabled children who were struggling to cope on the main wings being allowed to return

to the separation unit during the day to take part in activities with the staff. This helped to reduce tension and pressure from their peers and children responded well to this.

3.66 Unfurnished accommodation, a spartan cell used only in a case of clearly defined risk if a child was held in a normal cell, had only been used twice since early 2020. Both occurrences had been justified and for the minimum time necessary. This presented a stark comparison with our last inspection when this accommodation had been used 69 times in six months.

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 Relationships between staff and children had improved greatly since our last inspection. In our survey, 62% of children said they felt cared for by most staff compared to 19% at the last inspection. We observed positive interactions between children and staff.

4.2 In our survey, 77% of children said that if they had a problem, they had a staff member they could turn to for help. However, only a few children had a designated personal officer who reviewed their progress with them regularly, using the custody support plan (CuSP) framework.

4.3 Each residential unit held a weekly core support meeting which involved a wide range of departments including resettlement, education, psychology and residential staff. All children were discussed every few weeks and any child of concern was discussed at that week's meeting. These meetings helped residential and other staff to understand the needs of the children in their care. Most front-line staff were knowledgeable about the children on their unit, and we saw them adapting their practice to meet children's needs.

Heron wing communal area

4.4 Leaders were visible on residential units supporting officers, many of whom had less than two years' experience. Leaders had recently introduced guided reflective practice to support staff in caring for children. This was a positive initiative.

Recommendation

4.5 **All children should have a designated personal officer.**

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

4.6 Feltham A consisted of eight residential units. The communal areas were clean and tidy, but the exercise yards were uninspiring.

Heron exercise yard

4.7 Refurbishment had been undertaken in some areas since our last inspection and two units were closed. Communal showers had been refurbished and were of a reasonable standard, and shower pods were being installed in cells. Access to showers during the pandemic had varied for those children who did not have showers in their cells.

D wing shower pod

4.8 All children lived in single cell accommodation. The cleanliness of cells had improved and there was a rolling painting programme to make sure that they were of a reasonable standard. In areas that had not been refurbished some toilets were badly stained, and there was graffiti on furniture in the cells. A project had recently started using a blackboard on the back of cell doors.

4.9 Staff encouraged children to keep their cells clean by giving a daily score on the outside of the cell door. This was a positive initiative which enabled children to access incentives if they kept their room tidy for more than three days.

4.10 Since our last inspection the cells had had telephones installed, and each child had a laptop in their cell to access information about prison life, for example to order canteen.

Empty room ready for occupation – Heron wing

4.11 Children could wear their own clothes and had access to cleaning materials, laundry facilities and clean bedding each week. Access to property was slow: a parcel remained in quarantine for 72 hours, which was disproportionate, and passed through several departments before being issued. In our survey, only 46% of children said they could access their stored property easily.

Residential services

4.12 In our survey, 42% of children said that the food was good. The food and portion size that we observed were reasonable. A four-week menu cycle was in operation and children could order their choice of meals on their laptops. The kitchen staff worked well with children who had special dietary needs.

4.13 Children on the highest regime level were able to eat out for all meals, while other children ate of their cell out at lunchtime on rotation while eating the rest of their meals in their cells.

4.14 Children could order clothes and other personal items from a reasonable choice of suppliers.

Consultation, applications and redress

4.15 Prison leaders consulted children regularly about their views and experience. Open forums were held on the units each week for children to discuss prison life. Formal consultation took place monthly at the prison council, although this had been intermittent during the pandemic. Leaders had recently started to share outcomes from meetings with children, but this was not yet embedded.

4.16 Children had a poor perception of complaints. In our survey, only 15% of children said they were dealt with fairly against the comparator of 46%. Forms were freely available on all units and 80% of children in our survey said they knew how to make a complaint. During the previous six months, one-third had been responded to late and, in the responses that we reviewed, some lacked investigation and did not focus on the issues raised. There was a quality assurance procedure, but this had been ineffective.

4.17 Some applications were now made on the children's laptops. The rest were made on paper forms, but there was no tracking system and sometimes processes such as visits applications took too long. Leaders were planning to move all applications to the digital system.

4.18 Legal provision was adequate. There was enough capacity for children to meet their legal advisers face to face, as well as a video link facility. Children could contact Barnardo's advocates based in the prison and each child met an advocate on induction. In our survey 78% of children said they could speak to a Barnardo's advocate when they needed to compared with 52% at the previous inspection.

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

4.19 An equality manager was in post who was enthusiastic about his role. However, strategic oversight of equality remained weak. Monthly equality meetings were chaired by the governor but most of the data discussed related to a combination of Feltham A and B and there was limited monitoring of equality data specifically for the children's site. The absence of suitable data prevented identification of unequal treatment.

4.20 The equality action plan had not been reviewed or updated recently and the committee had not been actively tracking or monitoring concerns about equality.

4.21 There were no peer equality representatives and leaders relied heavily on the youth council to raise concerns over equality. This was not an appropriate forum for children to raise sensitive matter.

4.22 During the previous 12 months, 54 discrimination incident report forms (DIRFs) had been submitted, most were by staff about children. The quality of most investigations was poor, with no evidence that the child had been spoken to in some cases. Quality assurance processes for DIRF investigations were inadequate and did not always identify weaknesses in investigations and responses.

Protected characteristics

4.23 Support for children with protected characteristics had deteriorated. Forums for these children to air their concerns had not been taking place and prison leaders were not aware of the specific needs of children, which was very disappointing.

4.24 Some literature and posters about protected characteristics had been handed out to children or placed prominently on walls, although many children we spoke to were not sure how to raise concerns about equality.

4.25 Celebratory events to mark cultural celebrations were very limited. There was a heavy reliance on the education department leading on Black History Month and Chinese New Year. Children had not been involved in cooking celebratory meals in the main kitchen nor were they given the opportunity to contribute to the planning of celebrations.

4.26 At the time of our inspection, there were no children with physical disabilities. Leaders were aware of the assessments required to make sure that individual needs were met and which documentation to complete such as personal emergency evacuation plans (PEEPs).

4.27 Leaders were unaware of any children who identified as gay, bisexual or transgender and there was little in place to support these children. There were no forums to encourage talking openly and no free helpline for these children to call from their in-cell telephones.

4.28 Seventy-five per cent of children identified as black and minority ethnic, although little had been done to identify the specific needs of these children or to address disproportionality. The equality manager had contacted community organisations to provide support to this group but had not yet received a response.

4.29 In our survey black and minority ethnic children had worse perceptions of the incentives scheme and more reported being separated than their white counterparts. The poor understanding of equalities data left managers unable to explain these differences.

4.30 At the time of the inspection, two children had identified as foreign nationals. The UK Border Agency attended the prison once a month to see foreign national children and professional interpreting services were used when needed.

4.31 The constraints of the keep apart groups meant that children could only access the mosque or chapel once every eight weeks, which was poor. It was concerning that leaders had not found ways to address this.

4.32 In our survey, 93% of children said their religious beliefs were respected compared with 67% at the previous inspection. The managing chaplain had taken up post just after our last inspection and there was very good one-to-one faith support for most children. In our survey, 91% said they could speak to a chaplain of their faith against 66% at the last inspection.

4.33 Chaplains were active in day-to-day life at the prison and met all children within 24 hours of arrival. They attended the wings promptly when requested, but still sometimes spoke to children through their doors which was unacceptable.

4.34 At the time of the inspection, 41% of children identified as Muslim. Signage indicating the direction to face for Islamic worship had been painted over on most units and chaplains showed children how to do this. Children had access to a good supply of religious books, prayer mats and religious clothing. There were no faith groups or courses and no plans to introduce them.

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.

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

4.35 Central and North-west London NHS Foundation Trust (CNWL) were the prime providers of health care, including mental health and substance misuse services. Dr Khan provided the oral health service which was directly contracted by NHS England and NHS Improvement. Strategic meetings and contact with NHS England and NHS Improvement had continued throughout the pandemic. The local delivery board had not met since November 2021 and prison leaders did not, therefore, have oversight of the governance of health care services. CNWL had continued to adhere to its internal governance and audit procedures.

4.36 COVID-19 outbreaks had been well-managed and prison and health care staff had worked well together to implement COVID-19

vaccination programmes. New admissions were tested on day one and day six but remained in isolation for 10 days whatever the result.

4.37 The head of health care and the primary care lead were both very recent appointments. The primary care lead had given strong leadership to the team and had started to deliver clinical supervision which had previously been inconsistent. Staff told us that they felt supported by managers. We observed staff who provided a kind and caring service and were very knowledgeable about the children.

4.38 Compliance with mandatory training was reasonable. Supervision of health and well-being was well structured and embedded.

4.39 The health care unit needed refurbishment and it was difficult to maintain high standards of infection prevention and control. This had been raised at the Partnership Board but had yet to be resolved.

4.40 All staff maintained the electronic clinical record, SystmOne, and the standard of entries was reasonable. Care plans ranged in quality from reasonable to very good.

4.41 All the health defibrillators had been replaced to standardise training and use. The emergency bag in Bittern unit was well equipped but was too heavy to be carried about. If there was a medical emergency on the wings, an ambulance was not called until health care staff had decided that it was necessary. This presented a risk of delays in treatment (see paragraph 3.24).

4.42 Children could submit confidential complaints which were responded to promptly. Replies were respectful and focused on the concern, but they were not written in age-appropriate language. We raised this with the primary care lead who immediately identified training needs.

4.43 Staff were confident to make safeguarding referrals and health care was represented at safeguarding meetings. During the inspection, a safeguarding incident was reported to health care managers who took appropriate action promptly.

Recommendation

4.44 **The local delivery board should meet regularly so that all partners have oversight of the governance of health services to make sure that health outcomes for children are optimised**.

Promoting health and well-being

4.45 CNWL did not have a local health promotion strategy or a health promotion lead and there was a limited range of health promotion material across the prison.

4.46 Children were offered screening for hepatitis B and sexually transmitted infections. They had prompt access to the weekly smoking cessation clinic, which was good.

4.47 The use of laptops for appointments had led to a considerable increase in attendance at the sexual health clinic, which was positive. There had been a waiting list of five children, and within one week of the implementation of the laptops that figure had risen to 19. Appointments had been scheduled for all these children within the appropriate timeframe.

4.48 Children were offered a range of vaccinations including MMR. The longest wait for vaccinations was 25 weeks, which was too long.

4.49 An external NHS provider had attended to deliver COVID-19 vaccinations. Children who declined the vaccination were told that the opportunity to be immunised remained open and health care staff raised this at all their contacts with children.

Primary care and inpatient services

4.50 A well-led primary care team delivered a wide range of services, including for long-term conditions, although we found three children with no asthma care plan. The GP was available six days a week and out of hours. Urgent GP appointments were available on the day and routine appointments were booked within a few days.

4.51 At the time of the inspection, 20 children were waiting for up to four weeks for optometry services. Physiotherapy services had the longest waiting list at 10 weeks, with 21 children on the list.

4.52 Health screening was undertaken by a competent health professional using the national children's health assessment tool (CHAT). All new arrivals were seen by a nurse before they left the transport for their temperature to be taken. If a nurse was not immediately available, this caused delays in children alighting from the vehicle. Secondary screening was now carried out on the following day on Bittern unit. Further CHAT assessments for substance misuse, neurodiversity and mental health and well-being were undertaken by the health and well-being team during the child's first week in custody.

4.53 In our survey, more children said it was easy to access the dentist and mental health workers than at the time of our previous inspection. 86% of children who had a health problem told us they had been helped compared with 43% in 2019.

4.54 At the time of the inspection, 20 children with additional health risks had an enhanced MMPR handling plan (managing and minimising physical restraint). These were overseen by the primary care team leader and shared appropriately. Every child had a cell-sharing risk assessment on arrival.

4.55 The small number of secondary care appointments were managed well. Many of the children refused to attend their appointments and there was a higher percentage of did-not-attend than we usually see.

4.56 At the time of the inspection, no child was receiving social care and staff could not recall the last time that social care services were

required. The health care provider had identified contacts in the prison and the local authority to initiate a referral and assessment if needed.

Mental health

4.57 CNWL delivered an integrated health and well-being service which identified and supported children's primary and secondary mental health needs. The team was well led with a shared vision to support children to a high standard.

4.58 Referrals to the team were triaged at daily allocation meetings to decide which professional expertise was needed to offer care and support.

4.59 There was no waiting list and children were seen and assessed in a timely manner. The team provided 24-hour nursing care, psychologists, psychiatrists and drama and music therapy. Speech and language and occupational therapy were also available to support children with their communication and daily living activities. The team had remained on site during the pandemic and, although group work was not taking place, children still received regular face-to-face support.

4.60 Approximately 90% of prison staff had received mental health awareness and trauma-informed training to help them achieve a better understanding of children's needs. Regular core support group meetings made sure of a collaborative approach to care.

4.61 The framework for integrated care (see Glossary) was firmly embedded into practice and all staff received supervision and reflective practice. Children received a range of tailored interventions from a trauma, sensory and attachment perspective and those with severe mental illness were supported by specialist child and adolescent mental health service (CAMHS) professionals. Any children who required physical health checks were referred to the primary care team for follow up.

4.62 Each child had a comprehensive formulation (specific assessment tool used in children's mental health care) and was given opportunities to express what was important to them and why. This information was shared with the prison to ensure a uniform approach to care. Joint working took place with the substance misuse team where appropriate and effective discharge and transfer arrangements provided continuity of care.

4.63 Innovative multi-agency working supported children on remand and awaiting trial. The aim was to reduce anxiety and help individuals understand the court process and support them through the early stages of a life or long-term sentence.

4.64 In the last two years no child had required assessment or transfer under the Mental Health Act.

Substance misuse treatment

Expected outcomes: Children with drug and/or alcohol problems are identified at reception and receive effective treatment and support throughout their stay in custody.

4.65 CNWL delivered clinical and psychosocial substance misuse services which met the needs of the population. There was an up-to-date drug and alcohol strategy and the service leads attended prison drug strategy meetings. Both teams met regularly to discuss children with complex needs.

4.66 A nurse was available each day for clinical assessments and flexible prescribing was available seven days a week from the clinical lead, GPs and out-of-hours service. During the previous 12 months, only two children had required clinical treatment for substance misuse.

4.67 About 30 children were receiving tailored interventions from the psychosocial team. Referrals came from a variety of sources and were prioritised according to need. Any child who declined support was followed up by the team within a month.

4.68 The team had experienced a considerable reduction in staff numbers, although children's needs were met and recruitment was under way to fill staff vacancies. No children were waiting to be seen at the time of inspection.

4.69 The team were in a separate room from the main health and well-being office but there was effective communication among professionals. Weekly multidisciplinary meetings were held to discuss children's needs, and joint support was given to any children with a dual diagnosis of mental health and substance misuse.

4.70 The team had remained on site during the pandemic. Children received age-appropriate support and staff had maintained regular contact with children. The recent introduction of laptops was viewed positively by staff as an opportunity for further contact. The team delivered short- and long-term interventions depending on children's individual needs. Harm reduction advice was provided to all children and feedback was gathered at the end of their treatment to help inform service delivery.

4.71 Support was provided before release or transfer, and the team liaised with relevant agencies and prison teams to deliver continuity of care. The team also supported children on the day of release and one month later to signpost them to relevant services if required.

Medicines optimisation and pharmacy services

4.72 Pharmacy services were now provided by St. Charles' Hospital. The service was managed locally by a full-time technician and a full-time locum pharmacist. These posts were shared across the whole Feltham site. The nurses and paramedics administered medicines between

three and four times each day with most medicines issued as single supervised doses. Medicines arriving with children were passed over to the pharmacy team to reconcile and request additional information from the child's GP if required. These were then prescribed and reissued for ongoing care.

4.73 In response to a key concern at our previous inspection, morning medicines were now administered at 8am from a purpose-built medicine administration area on Bittern unit. Medicines administration was good and included controlled drugs administration. The process was supervised well by officers.

4.74 Storage was managed well but not all medicines were issued from named boxes. Some pain prescribed medicines were issued from stock to reduce the number of boxes carried around the establishment. These medicines were administered at cell doors which was not good practice and carried risks when children were all unlocked on the wings.

4.75 There had been no face-to-face pharmacy clinics during COVID restrictions, but complex cases could be referred if required. There had been no examples of this in the previous six months.

4.76 Out-of-hours medicines could be acquired through the local hospital pharmacy, but this had not been needed in recent months as staff had access to out-of-hours medicines stocked at Feltham B. The regional pharmacy lead had good oversight of the provision and chaired regular medicines management meetings. The meetings were well attended and formulary and prescribing trends were discussed. Several audits had been undertaken in recent months, including a controlled drugs audit which had scored well.

Dental services and oral health

4.77 At the start of the pandemic, the dental surgery at Feltham had been registered as an urgent care hub which had enabled appointments to continue. There was a dentist on site every Tuesday and Thursday. In addition to routine dentistry, orthodontics and oral surgery were available. The surgery had an air purifier and had been able to carry out aerosol generating procedures.

4.78 All children were referred to the dentist on arrival, which was good practice, and there was no waiting list for routine appointments. At the time of inspection, one child had been on the waiting list for treatment for five weeks, which was reasonable.

4.79 During COVID-19 outbreaks the dentist had visited children on the wings for a preliminary assessment and offered dental hygiene advice at every contact.

4.80 Children who experienced dental pain were provided with over-the-counter analgesia and the dentist attended out of hours as required.

4.81 The dental surgery was worn and shabby but there was evidence of a regular cleaning schedule. The surgery did not have a separate decontamination room, but the cleaning area was clearly labelled and easily identified. Finance had been secured and building work was due to start during 2022 to provide a separate room which, once complete, would meet best practice standards. Equipment, waste management and servicing were in line with expected national standards.

4.82 Children who were due for release but required ongoing treatment were advised of the procedure for registering with a dentist and information on the outstanding treatment.

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 Leaders were striving to improve time out of cell for children, but progress had been hindered by the pandemic and staff shortages.

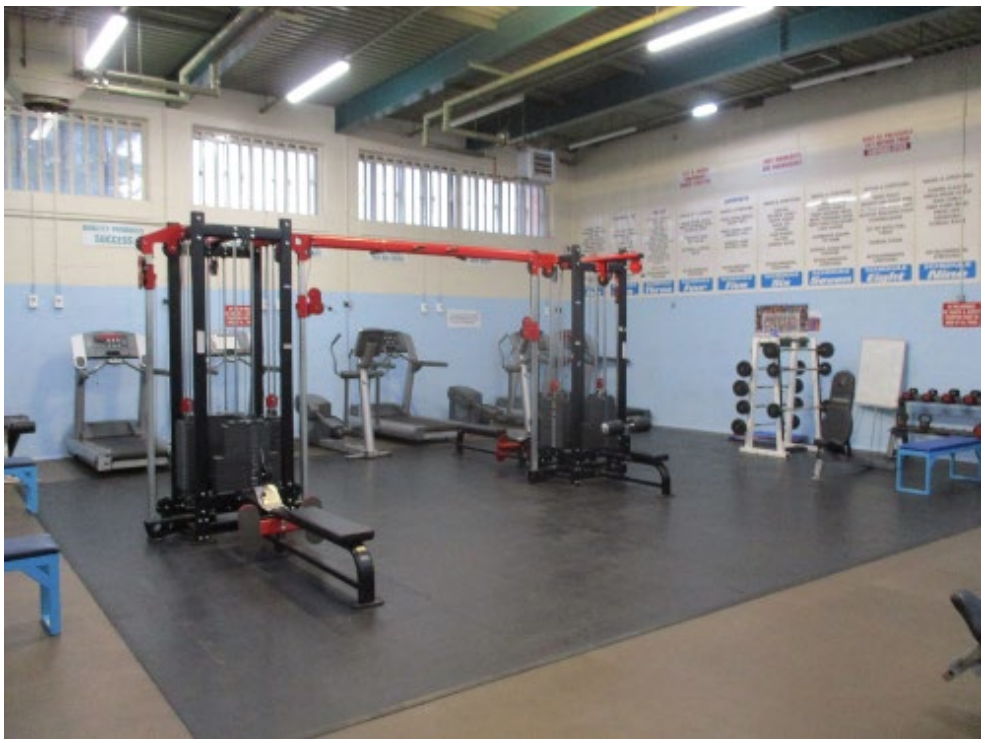
5.2 Time out of cell varied across units. Some were divided into two or three groups to reduce violence and these children had less time out of cell than those on units with only one group. At the end of January 2022, leaders had improved time out of cell by introducing evening activities on weekdays, including additional gym, room cleaning and Kinetic Youth activities (a not-for-profit social enterprise that supports young people to improve their lives). At the time of our inspection, children received an average of 5.5 hours out of their cell each day during the week. This was better than similar establishments but did not meet our expectations of 10 hours a day.

5.3 Children who were on the reverse cohort unit (see Glossary) or isolating with COVID-19 had a poor regime, with 1.5 hours out of their cells each day. The prison had been experiencing COVID outbreaks since November 2021 and many wings had been affected by this regime.

5.4 Records showed that time out of cell at weekends ranged from 2.5 to 4.5 hours although, in our survey, only 32% of children said they were out of their cells for more than two hours on a Saturday and Sunday.

5.5 Leaders had developed an impressive scheduling system since the last inspection. Each child was given an individual weekly timetable which enabled departments to schedule time with a child that did not affect education or other key activities.

5.6 Children had good access to the gym and were allocated four sessions a week, with an additional evening session every fortnight. Physical education facilities were good and included a large sports hall, a well-equipped gym, and a large outdoor activity area.



Gym

PE staff had good links with community sports clubs, including Chelsea Football Club, Richmond Rugby Club and Fulham Reach Boat Club.

Fields

5.7 At the time of our inspection the gym was not delivering courses for qualifications.

5.8 Library provision was poor and children only had remote access to the library facilities shared with Feltham B. Library staff visited children on their residential unit to take requests. This service was well used with more than 250 books or DVDs issued each month. Leaders had secured funding for a dedicated library for Feltham A.

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 key concerns and recommendations, 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:	Requires improvement
Quality of education:	Requires improvement
Behaviour and attitudes:	Requires improvement
Personal development:	Requires improvement
Leadership and management:	Requires improvement

5.10 Leaders and managers had focused on improving the quality of education since the previous inspection, but the quality of teaching and assessment required improvement. Managers had accurately identified the strengths and areas for development in the provision. They set sensible actions to improve quality and had achieved most of the recommendations from the previous inspection. However, staff vacancies over recent months and COVID restrictions had affected their ability to improve the quality of education quickly enough.

5.11 Governance arrangements had been improved since the previous inspection. Those responsible for governance from the Youth Custody Service and the prison had a good understanding of their role and

responsibilities, and of the quality of education. They offered effective support and held leaders to account for any underperformance. They closely monitored leaders' progress in making improvements to, for example, attendance, behaviour and hours of curriculum taught. Education and prison leaders worked effectively in partnership to open well-resourced new workshops for children in vocational areas which included painting and decorating, barbering and Army Cadets.

5.12 Managers worked well with other community agencies to support children with their development. For example, they worked with Chelsea Football Club to provide leadership qualifications and Hackney Music Trust for the music production course, to provide mentoring for children. Children who benefited from these partnerships were helped to secure work or training on release.

5.13 Managers had recently started to provide teachers with a broad range of useful professional development each week. These activities were informed by quality assurance findings and contained an appropriate mix of administrative processes and pedagogical topics. However, the improved teaching and assessment practices were too recent to have had sufficient or sustained impact on improving the overall quality of teaching.

5.14 Leaders enabled most children to receive at least their statutory entitlement to face-to-face education. The small proportion of children who did not receive their entitlement to education hours were those with the most complex needs. These children each had an individual timetable which included important time with community agencies to help them address their specific behavioural and learning needs. However, there were not enough timetabled hours for education for these children.

5.15 Less than a quarter of children could access vocational training which was only available to children in one of the residential units. Leaders did not include enough learning at level 2 or above within the curriculum. Leaders enabled a small proportion of children to follow a bespoke curriculum, such as completing A-levels or distance learning at level 3 if they already had the required qualifications at level 2.

5.16 The proportion of children being taught GCSEs in English and mathematics had increased since the previous inspection. Leaders had extensive plans for the imminent further expansion of the curriculum to introduce business, media and horticulture. Their recovery plan (see Glossary), which was not yet in place, included a revised timetable to make sure that all children received more hours in education and to provide a greater breadth of qualification types.

5.17 Children achieved useful additional qualifications alongside their main subjects. For example, in barbering they completed a level 2 dermatitis certificate, and in the Army Cadet programme they gained qualifications in first aid and the bronze Duke of Edinburgh award. In catering, children achieved food safety and food hygiene qualifications in addition to their main qualification.

Barber shop

5.18 Children received their induction to education early in their custody at Feltham and quickly spent their time productively. However, at induction staff did not adequately identify children's aspirations and career goals. In addition, staff set targets for children during induction and while in learning that were pertinent to their individual needs, but they did not help children understand how to achieve them.

5.19 Leaders and managers did not reflect children's aspirations and career goals when allocating them to activities, although they made sure that education levels, learning needs and intervention requirements were considered alongside the process of allocation. Children accessed an appropriate mix of subjects that met their education needs well, including English, mathematics, music, catering and personal and social development.

5.20 Prison and education staff did not provide enough advice and guidance to help children form clear career plans during their time in custody. Children did not have sufficient access to employers to explore their career options or raise their ambitions. Leaders ensured that the support for children nearing release was more effective, although they

had not yet fully re-introduced release on temporary licence (RoTL, see Glossary).

5.21 The pay that children received was fair. Rewards and incentives policies had been very effective in fostering improved behaviour in education. Far fewer incidents of extreme poor behaviour occurred, and only one child had been excluded from education for a short period in the last four months. There were still, however, too many instances of low-level disruption in lessons.

5.22 Staff identified children's learning support needs and special educational needs promptly. When needs were identified on arrival, a more in-depth screening was conducted by appropriately qualified education staff or health care professionals. Teachers had recently started to share useful information about support strategies, but too many teachers did not routinely adopt these strategies in their teaching and many learners lost interest in their lessons as they struggled to understand the content.

5.23 Most teachers checked children's previous experience and knowledge of their subjects but did not use this information to plan learning. As a result, in most subjects children followed the same learning plan regardless of their abilities. Teachers enabled children to build underpinning knowledge and skills gradually. For example, in music children first developed their understanding of familiar, and then more unfamiliar, musical instruments. In painting and decorating, children built on skills in painting simple areas such as doors before moving on to cornices and skirting boards, then manually applying straight lines of paint.

5.24 Most children produced work in education to an acceptable standard for their level of learning. The children in vocational programmes developed particularly good skills which would help them on release. Their practical work was of a high standard. For example, in barbering they developed technical skills such as plaiting hair, and important employability skills such as undertaking useful client consultations.

5.25 Too often, children did not act on the feedback they were given by teachers to improve their written work. The feedback was often not useful enough and teachers rarely used it to help children improve their spelling, punctuation and grammar. Too much work submitted by children was not assessed. As a result, children did not know what the quality of their work was like and teachers did not use assessments to inform future learning.

5.26 Children developed secure knowledge in GCSE English and mathematics. For example, in mathematics they worked accurately with decimal places and significant figures and in English they applied their knowledge of homophones (a word that is pronounced the same as another word but differs in meaning) to correct their work. The proportion of children who achieved their GCSE English and mathematics qualifications was high and a high proportion achieved high grades.

5.27 Teachers did not help children to improve their mathematics skills in subjects such as catering and music. They did not grasp the opportunities provided by the curriculum to help children apply these skills in different contexts. However, most teachers helped children to acquire and use the technical vocabulary related to their subjects.

5.28 Children did not develop their practical information and communication technology (ICT) skills well enough. Their development of these essential employability and life skills was severely affected by the lack of a suitable computer infrastructure. The ICT curriculum was too limited as a result and did not support children to develop careers in this field or to gain more advanced skills. ICT teachers produced a range of effective theory-based materials to help lessen the impact of the poor-quality hardware. For example, children developed knowledge of the subtle approaches bullies often take when targeting victims online.

5.29 Too often teachers did not check children's understanding fully in class. They did not explore the depths of children's knowledge and were too quick to answer questions for them. As a result, children were not fully engaged and lost focus too quickly in lessons. Children's progress was further affected by staff absences and poor cover arrangements.

5.30 Children on vocational courses benefited from good resources. The newly opened workshop areas were clean, tidy and well equipped, reflecting industry standards. Children valued and respected these resources. Children aspired to get into vocational training and these courses provided an effective incentive to improve their behaviour.

Vocational training

5.31 Leaders and staff had successfully improved attendance and punctuality to education since the previous inspection. Attendance rates were high and instances of children arriving late to lessons were rare. Children felt safe in classrooms and workshops, but they felt less safe when moving between lessons and around the prison.

5.32 Most children had a positive attitude towards education and valued the opportunity to participate. They recognised the importance of education and gaining qualifications and particularly valued the opportunity to gain their GCSE qualifications or to improve their existing grades.

5.33 Most teachers made sure that the curriculum enabled children to improve their understanding of living in modern Britain. Children demonstrated respectful behaviour most of the time and understood the importance of practising fundamental British values. For example, in catering children developed a good understanding of democracy through the selection of the head chef. They were able to link learning on healthy relationships to mutual respect and how this extended beyond romantic relationships.

5.34 Most teachers helped children to develop their character and confidence. Through the music curriculum children learned to broaden their horizons by developing an appreciation of wider genres, from a narrow interest in music associated with violence and misogyny, such as Drill (a sub-genre of rap popular with younger generations). In art therapy sessions, children explored personal issues that prevented them from participating more fully in education. In lessons with a community charitable organisation, children developed communication skills through well-planned activities with a focus on teamwork and well-being.

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 In our survey, 67% of children said that they were helped to keep in touch with their families and friends compared with 28% at the previous inspection. Despite this, they and their families were not given enough support to maintain face-to-face contact. The proportion of children who said they had visits from family or friends had reduced from 87% in 2019 to 59% at this inspection.

6.2 In-cell telephones had been introduced since the previous inspection and children had received additional phone credit throughout the pandemic. More recently, each child had been given a laptop to use in their cells and could communicate with their approved contacts using 'email a prisoner'. Both these improvements were appreciated by children.

6.3 Family workers from Spurgeons (a charity contracted to provide family support services for children and their family and friends who visit them) were available in the visitors' centre and worked with children individually. They ran a course for children who were parents themselves, a locally developed course, 'boys to men', for children with longer sentences and family visits. Family visits had recently restarted following the most recent COVID-19 outbreak at Feltham and included a small number of families to mark events such as GCSE success or completion of an accredited intervention (see paragraph 6.34). A family therapist worked with children and families with more complex needs for which there was a suitably furnished room.

Family workroom

6.4 Use of visits and secure video calls (see Glossary) was low. The family therapist and a Spurgeons worker had recently consulted children about this and managers now needed to address this and make sure that booking visits was made as easy as possible for children and their families.

6.5 The visits room was a decent environment. Visits were available two afternoons a week but there were no evening or weekend visits which gave limited options to parents/carers with fixed work schedules or other children to look after.

Visits room

Pre-release and resettlement

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

6.6 Work to reduce reoffending was informed by an up-to-date needs analysis. Regular oversight of progress against the action plan took place at a monthly meeting which was reasonably well attended by managers.

6.7 There were some staff vacancies amongst the team of resettlement practitioners (RPs), but to a large extent these were mitigated by a smaller number of children at Feltham than previously. Caseloads were manageable with the largest group of 14 children managed by one RP. RPs aimed for and generally achieved weekly contact with each child they were responsible for.

6.8 Children interviewed about their experience of resettlement support all said that they had regular contact with their RP and described good relationships. When children initiated a request to see their RP, they told us that RPs were responsive.

6.9 The RPs had impressive knowledge of their cases. They also had a good awareness of colleagues' cases so that enquiries could be dealt with in the absence of the named RP. We saw many examples of calls

from parents, youth offending teams (YOTs) and other practitioners being handled effectively and respectfully in these circumstances.

6.10 Resettlement managers provided good oversight of RP work. They met each RP to discuss activity and the standard of their work, providing clear written feedback which included strengths and areas for improvement. RPs were able to reflect on these reviews to us and identify that improvements in their practice had been supported. Managers had yet to achieve their aim of a monthly meeting with each RP.

6.11 The use of release on temporary licence (ROTL, see Glossary) was lower than previously and only two children had had ROTL in the previous six months. Notwithstanding the impact of the pandemic and the number of children who were eligible for ROTL, there was scope to make more use of it to support resettlement (see paragraph 6.29). Managers were trying to improve use by reviewing children as soon as they were eligible for ROTL and setting targets when needed to help them reach the required standard. ROTL documents were of a good quality with clear, well-reasoned decisions. Risk issues were anticipated and managed and ROTL activity that had taken place supported sentence plan objectives.

6.12 Oversight of planning for release, transition and ROTL had been improved. Early release and home detention curfew (HDC) processes were managed well but, at the time of the inspection, an 18-year old was waiting for suitable accommodation to be found for his HDC release. He had already been detained for a month beyond his earliest release date.

6.13 Transition to the adult estate was well supported through active case management by the RPs. Planning for transitions was started in good time and our case sample showed evidence of good work to facilitate moves to Feltham B, Aylesbury, Swinfen Hall and Portland. A prison offender manager from Swinfen Hall had visited a 17-year old facing an indeterminate sentence and was able to tell him about his transition and how he could pursue degree level studies through the Open University. Another child with a four-year sentence had plans for ROTL and construction work after moving to Feltham B, the young adults' site. Managers had sought a way with the HMPPS central team for children with restricted status to have information about where they would transition to, subject to risk assessment.

6.14 Managers had recently started to request follow-up data from community partners after children were released, but it was too early to carry out analysis of resettlement outcomes.

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 We reviewed 20 cases, all of which had an up-to-date resettlement plan which had been shared with community partners on the Youth Justice Assessment Framework. These were of a good standard and had been subject to appropriate reviews.

6.16 Children had regular review meetings which included community services, for example their YOT workers and social workers. During the COVID-19 restrictions, many reviews had taken place with virtual or telephone attendance by key community partners. In most cases, residential staff were not involved in these reviews. This was a missed opportunity given their understanding of the children they worked with and their increasing involvement in core support team meetings.

6.17 Resettlement plans included targets for children to work towards and it was clear that every target was relevant to offending behaviour, progression or resettlement. Individual targets were broken down into clear steps which were expressed in an age-appropriate way. This approach helped to motivate progress reinforced by frequent contact with RPs.

6.18 In our survey, 57% of respondents said they had a plan they were working towards which contained their objectives. All the cases in our sample contained a plan and this relatively low level of awareness amongst children needed to be investigated.

6.19 Progress against resettlement plan targets was adequate in most of the cases in our sample. Most plans included multiple targets, the most common of which specified engagement with a department, for example psychology or well-being. Other targets specified a particular goal and a timescale. These were linked to the green card scheme for rewarding positive behaviour and children could be reminded of them to good effect at weekly meetings (see paragraph 3.33). However, in some cases targets which challenged offending behaviour could have been given higher priority.

Public protection

6.20 All children received an initial screening to identify public protection issues and contact restrictions, and mail and phone monitoring were put in place when necessary. These measures were reviewed at the monthly interdepartmental risk management meeting (IDRM) which provided oversight of risks to and from children. At the time of the

inspection, the only children on monitoring were of restricted status (see paragraph 3.31) and monitoring was up to date.

6.21 Children who were approaching their release date and who required management under multi-agency public protection agency measures (MAPPA) were reviewed to make sure that their management level was confirmed in good time for their release. Managers used established escalation processes to confirm these levels in cases subject to delays.

Indeterminate and long-sentenced children

6.22 A lifer and long-term sentences meeting attended by departments across the establishment focused on the needs of the increasing proportion of the population facing lengthy periods in custody.

6.23 At the time of the inspection, five children were serving indeterminate sentences and another 14 were on remand or awaiting sentencing for offences of murder or attempted murder. An RP in the resettlement team had taken the lead in developing support for these children. This had included joint work with the well-being team to arrange for a Central Criminal Court youth justice mental health liaison officer to meet groups of children facing trial for the most serious offences and explain court proceedings to them. This had been reinforced by clear, informative leaflets which were available on the children's laptops. The RP lead explained to children with indeterminate sentences how they would progress through their sentence and key milestones for them to achieve. A forum was being planned by the well-being team and support work for families/carers of children with indeterminate sentences was being developed by the family therapist in response to concerns children raised during consultation about the impact of their sentences on their families.

6.24 Children with long or indeterminate sentences had the same sentence planning and review process as other children. This continued to be supplemented by assessments carried out by the psychology team to inform long-term sentence planning, multi-agency lifer risk assessment panels and annual life sentence reviews.

Looked after children

6.25 In our survey, 53% of children said they had been in the care of their local authority. Records showed that most children had had some social services involvement in their lives while some were looked after before they came into custody many had become looked after on being remanded into custody. During February 2022, 48 children had been looked after for this reason.

6.26 The small team of on-site social workers met all new arrivals and completed a detailed screening to identify those who were entitled to support from their local authority. The social workers contacted the appropriate local authority to outline their obligations while the child was in custody. They made sure that children received their statutory entitlements and that reviews took place with the local authority.

6.27 The social workers played an active role in core support team meetings (see paragraph 3.36) and worked closely with resettlement practitioners. They also acted as appropriate adults for police interviews when needed.

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.

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

6.29 During the previous six months, all children had had accommodation confirmed at least 10 days before their release, although only 19% had had education or training identified when they were released. This was particularly disappointing given the regular attendance at education by most children at Feltham A. Not enough use was made of ROTL in this area (see paragraph 6.11).

6.30 The in-house social work team had developed a pre-release course for children which had been delivered once during the pandemic and was due to restart in April 2022. Workers from Kinetic Youth offered useful advice and support on money management.

6.31 Resettlement practitioners made sure that children were met by a suitable adult when they were released and that they understood their licence conditions. Reception staff went through release conditions again immediately before release and made sure that children had all their belongings. Suitable holdalls and clothes were available for any child who needed them.

Interventions

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

6.32 Children had access to accredited interventions from both the programmes team and from other providers such as the well-being and psychology teams. The increased use of formulations (see paragraph 4.62) and core support team meetings helped to identify need and the sequencing of interventions work.

6.33 During the previous year, 52 children had completed an HMPPS accredited intervention approved for use in the youth custody estate. The first group intervention since the pandemic started had recently been completed, which was a positive step forward. Children's success

in completing the programme had been marked by a celebration event attended by families.

6.34 Children could take part in other intervention work which addressed factors that had led to their custody. At the time of the inspection, for example, six children were working with the family therapist, six with the counselling psychologist and five were completing one-to-one work with a forensic psychologist. Other children were addressing substance misuse or sexually harmful behaviour with the well-being team.

6.35 Forensic psychologists worked individually with children on behaviour management, assessment of risk and progression, and approved interventions for children with more complex needs. They also supported initiatives such as conflict resolution, enhanced support services, custody support planning and integrated care.

Health, social care and substance misuse

6.36 Children's mental health and substance misuse services made sure that, wherever possible, the child had met the community health professional before release.

6.37 Children were seen by a primary care nurse before release. They were given a summary of treatment and medication to take home where necessary. However, this was not integrated into resettlement work which meant that children might lack support, for example in registering with a GP or dentist. We were told that work had started to make sure that primary care became part of resettlement planning.

Section 7 Summary of key concerns and recommendations

The following is a list of repeated and new concerns and recommendations in this report.

Key concerns and recommendations

7.1 Key concern (1.41): Important safety procedures such as the protocol for entering a cell in an emergency overnight and calling an ambulance were not known by some staff who only worked nights. A cell door was left unsecured and was set up with a television and chair. This had occurred before the handover to night staff who did not have ready access to a cell key.

Key recommendation: Staff should adhere to policies which make sure that children are properly safeguarded during the night.
(To the governor)

7.2 Key concern (1.42): Equality work was underdeveloped. In particular, data were not used effectively to identify and address any unequal treatment.

Key recommendation: Leaders and managers should monitor data in order to identify and address any unequal treatment.
(To the governor)

7.3 Key concern (1.43): Children lacked confidence in prison procedures to redress perceived injustice. Discrimination incident report forms and complaints were not thoroughly investigated and responses were inadequate and often late. Quality assurance of DIRFs and complaints did not improve outcomes.

Key recommendation: Complaints and DIRFs should be thoroughly investigated and children should be routinely interviewed as part of the investigation.
(To the governor)

7.4 Key concern (1.44): Children did not spend enough time out of their cell and plans to increase it could not be realised with the current staffing shortfalls.

Key recommendation: Children should have 10 hours a day out of their cell.
(To the governor)

7.5 Key concern (1.45): Leaders and managers had not yet improved the quality of education sufficiently. Teaching and assessment practices were of inconsistent quality which adversely affected the progress children made in education. Too many teachers did not adapt their

teaching to reflect known support strategies for children with special educational needs.

Key recommendation: Leaders and managers should continue to identify the weaknesses in teaching and assessment practices. They should ensure that staff development activities are targeted to the needs of individual teachers, and that they monitor closely the impact of these activities on improving teachers' skills so that more children, including those with special educational needs, make more rapid progress in developing their skills and knowledge.
(To the governor)

7.6 Key concern (1.46): Not all children had enough time scheduled during the core day in education activities and too few children could access vocational training.

Key recommendation: Leaders should increase the time children are timetabled to spend in education and should make sure that the timetable enables more children to access vocational training.
(To the governor)

7.7 Key concern (1.47): Poor ICT infrastructure was adversely affecting the experience of children in education. Children were not able to develop essential ICT skills or achieve appropriate qualifications in this subject.

Key recommendation: Leaders should urgently improve the technical resources available in education. They should ensure that the curriculum enables children to develop the essential ICT skills they need to succeed in their lives and careers, and that children are able to achieve appropriate qualifications in this subject.
(To the governor)

7.8 Key concern (1.48): Children did not receive ongoing careers advice and guidance. They were not aware of how to reach their career goals and did not have any opportunities to raise their aspirations through the curriculum offered or the activities to which they were allocated.

Key recommendation: Leaders and managers should make sure that children receive impartial careers advice and guidance during their custody at the prison. All children should be allocated to activities relevant to their career goals and should have more access to employers. Leaders should make sure that ROTL is used appropriately and that children explore the full extent of the careers available to them.

(To the governor)

7.9 Key concern (1.49): Too many children were leaving custody with no confirmed education or training placement.

Key recommendation: Leaders should implement robust systems to make sure that children are supported in securing recognised

educational and training placements when transitioning from custody to the community.
(To the governor)

Recommendations

7.10 **Recommendation (3.26): Ambulances should be requested without delay by staff who identify a medical emergency.**
(To the governor)

7.11 **Recommendation (3.58): Pain-inducing techniques should only be used when there is a risk of serious harm to a child or member of staff.**
(To the governor)

7.12 **Recommendation (4.5): All children should have a designated personal officer.**
(To the governor)

7.13 **Recommendation (4.44): The local delivery board should meet regularly so that all partners have oversight of the governance of health services to make sure that health outcomes for children are optimised.**
(To the governor)

Section 8 Progress on recommendations from the last full inspection and scrutiny visit reports

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. If a recommendation has been repeated in the main report, its new paragraph number is also provided.

Safety

Children, particularly the most vulnerable, are held safely.

At the last inspection in 2019, outcomes had deteriorated in all aspects of safety. The safeguarding team was overwhelmed, and we could not be confident that action was always taken to safeguard children from harm. Violence, self-harm and use of force had all risen significantly since the previous inspection just six months ago. Management of these areas was weak, data on self-harm were poor, oversight of use of force was inadequate and behaviour management processes were not implemented effectively. The regime for separated children was poor. Security procedures to keep children apart affected the delivery of key work in every area of the prison. Significant action was required over a sustained period to halt the decline, stabilise the establishment and improve outcomes for children. Outcomes for children were poor against this healthy establishment test.

Key recommendations

Comprehensive safeguarding arrangements should be put in place and managed robustly to ensure children are kept safe.
Achieved

The governor should implement an effective behaviour management strategy to reduce the incidence of poor behaviour and violence.
Achieved

Managers should ensure that all children subject to separation receive a decent regime including meaningful human interaction and their education entitlement.
Achieved

The approach to security should be reviewed to ensure that security measures and restrictions are proportionate for children and based on individual risk assessments.
Achieved

Recommendation

The regime for children being managed on ACCT documents should meet their needs for activity, support and interaction with others
Achieved

Care

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

At the last inspection in 2019, relationships between staff and children were poor. Staff simply did not have the time to form effective relationships with children and we observed a minority of staff using inappropriate language in the presence of children. Living conditions were adequate but children could not have a shower each day. The complaints system worked well. Consultation was reasonably good. The strategic management of equality work was reasonable, but managers no longer had any tools to identify and address disproportionate treatment. Good health services were undermined by the inability to get children to appointments and significant weaknesses in the administration of medicines. Outcomes for children were poor against this healthy establishment test.

Key recommendations

Leaders and managers should be visible and support frontline staff to develop respectful, caring and effective relationships with the children in their care.
Achieved

Data should be provided each month which enable managers to identify any disproportionality in treatment or access to the regime and to take action.
Not achieved

The prison partnership board should ensure that patients access health and substance misuse services at the required times and receive their medicines in a safe manner at the prescribed times. These arrangements should be monitored to ensure that the health of patients is not compromised.
Achieved

Recommendations

Accommodation should be suitable for children. It should be clean, free of graffiti and well furnished.
Achieved

Children should be able to use showers and telephones every day.
Not achieved

Children should be able to eat their meals together.
Partially achieved

Consultation arrangements for children with protected characteristics should be formalised and consistent so that children can express their distinctive views and their specific concerns can be addressed
Not achieved

The inpatient unit should only be used for health and therapeutic purposes. Children should not be located on the inpatient unit to address operational issues
No longer relevant

Purposeful activity

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

At the last inspection in 2019, the regime for many children was poor and recent improvements needed to be sustained and developed. The library and gym facilities were good, but most children were unable to use them regularly. Leaders and managers at all levels had failed to provide an acceptable standard of education for the children. Only 37% attended education in many sessions and the punctuality of children and teachers was unacceptable. Teaching and learning were inadequate, and many teachers lacked the knowledge to meet the additional learning needs of children. Behaviour had declined significantly, disrupting the little education that was delivered. Consequently, success rates had declined across most subjects. Outcomes for children were poor against this healthy establishment test.

Key recommendations

The extension of the regime should be prioritised to allow children to attend education and activities and realise their entitlement to a full education timetable. Education should receive the necessary priority from across the prison and children should be well prepared for a positive education, training and employment outcome.
Not achieved

Prison leaders and managers should improve the quality of teaching, training and assessment through rigorous training and monitoring, ensuring that all teachers are equipped to support all children effectively, including those with additional learning needs.
Achieved

Leaders and managers should ensure that all staff behave as good role models for children, that teachers help children to improve their behaviour, and that vocational areas are developed so that they are used well and the development of essential work-related skills is promoted.
Achieved

Leaders and managers should ensure that all staff behave as good role models for children, that teachers help children to improve their behaviour, and that

vocational areas are developed so that they are used well and the development of essential work-related skills is promoted.
Achieved

Recommendations

Children should spend at least 10 hours out of their cells each day
Not achieved

Access to the gym should be improved to ensure that all children have access to two sessions of gym a week.
Achieved

Managers should monitor the time that children wait to be allocated to education and activities, ensuring that this is minimised and that they join education as soon as possible after arriving at the establishment.
Achieved

Leaders and managers should ensure that children access and benefit from adequate learning resources in learning environments that are clean, free of graffiti and fit for purpose.
Partially 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 2019, children and families work had deteriorated since the previous inspection. The reducing reoffending strategy was up to date but key actions needed implementation. Despite some improvement, planning was too focused on behaviour in custody and was not supported by residential staff. The work of case workers and other professionals was undermined by difficulties in accessing children, many of whom were released or transferred from Feltham without undertaking any offending behaviour programmes. Public protection work was reasonable. Home detention curfew and early release processes were managed well. Preparation for health and substance misuse care after release was good. However, many children did not receive enough support to find accommodation or education on release. Outcomes for children were not sufficiently good against this healthy establishment test.

Key recommendations

The regime and the staff should encourage and support children to establish and maintain contact with their family and friends.
Not achieved

Resettlement meetings and plans should prioritise resettlement needs which children understand to ensure a smooth transition into the community.
Achieved

Staff should ensure that children are able to access the appropriate interventions before release.
Not achieved

Recommendations

More use should be made of release on temporary licence for resettlement purposes.
Not achieved

Caseworkers should be appropriately trained and supervised to assess needs and risk of harm, and to formulate plans which reflect both the custodial and community elements of the sentence.
Achieved

Children who are remanded or sentenced and facing a long period in custody should have access to formal staff and peer support to help them progress through their sentence.
Achieved

All children assessed as requiring a programme relating to sexually harmful behaviour should undertake the most suitable interventions to meet their needs.
Achieved

Recommendations from the scrutiny visit

The following is a list of the recommendations made in the scrutiny visit report from 2021. If a recommendation has been repeated in the main report, its new paragraph number is also provided.

Leaders and managers should ensure that welfare checks are conducted and recorded each day for every child and that staff are aware of their responsibility to do so.
Not achieved

Leaders and managers should ensure that all child protection concerns are promptly referred to the local authority designated officer.
Achieved

Leaders should investigate the rise in group assaults and put measures in place to prevent them.
Achieved

Resources had been allocated to improve equality work but there was no clear plan for improvement. Some monitoring of treatment and access to services by protected characteristic groups took place but there was no evidence of action taken to investigate or address discrepancies.
Not achieved

Children should arrive at education classes on time.
Achieved

Children and their families should be actively supported to make full use of the options available for video calls and visits.
Not achieved

The reasons for children not attending their review meetings should be identified and addressed so that children are familiar with their targets and contribute to their future plans.
Achieved

Appendix I About our inspections and reports

Her Majesty's 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, police and 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 Her Majesty's 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 one of the following:

Key concerns and recommendations: identify the issues of most importance to improving outcomes for children and are designed to help establishments prioritise and address the most significant weaknesses in the treatment and conditions of children.

Recommendations: will require significant change and/or new or redirected resources, so are not immediately achievable, and will be reviewed for implementation at future inspections.

Examples of notable positive practice: 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; surveys of children and staff; 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 prisons 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 provides a summary of our inspection findings against the four healthy establishment 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/). The reference numbers at the end of some recommendations indicate that they are repeated and provide the paragraph location of the previous recommendation in the last report. Section 7 lists all recommendations made in the report. Section 8 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 Appendix II: Further resources). Please note that we only refer to comparisons with other comparable establishments or previous inspections when these are statistically significant. The significance level is set at 0.01, which means that there is only a 1% chance that the difference in results is due to chance.

Inspection team

This inspection was carried out by:

Charlie Taylor	Chief inspector
Angus Jones	Team leader
David Foot	Inspector
Angela Johnson	Inspector
Esra Sari	Inspector
Donna Ward	Inspector
Martyn Griffiths	Inspector
Joe Simmonds	Researcher
Helen Ranns	Researcher
Alec Martin	Researcher
Emma King	Researcher
Sarah Goodwin	Lead health and social care inspector
Tania Kennedy	Health and social care inspector
Dee Angwin	Care Quality Commission inspector
Gary Turney	Care Quality Commission inspector
Rebecca Perry	Ofsted inspector
Cath Jackson	Ofsted inspector
Saul Pope	Ofsted inspector

Appendix II Glossary of terms

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.

Framework for integrated care (also known as "SECURE STAIRS")
A framework for integrated care commissioned by NHS England and Improvement for children in secure children's homes, STCs and YOIs.

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.

Personal protective equipment (PPE)
Safety equipment including masks, aprons and gloves, worn by frontline workers during the COVID-19 pandemic.

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

Recovery plan
Recovery plans are published by HMPPS and aim to ensure consistency in decision-making by governors, by setting out the requirements that must be met for prisons to move from the most restricted regime (4) to the least (1) as they ease COVID-19 restrictions.

Reverse cohort unit (RCU)
Unit where newly arrived prisoners are held in quarantine for between seven and 10 days.

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

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

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

Appendix III Further resources

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

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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