Report on an unannounced inspection of

HMYOI Parc

by HM Chief Inspector of Prisons

28 March – 8 April 2022

Contents

Introduction

HMYOI Parc is a facility for up to 60 young people located within Parc prison near Bridgend in South Wales, though managed as a separate entity. Operated under contract by the private company G4S, this inspection has again shown the facility to be arguably the best performing young offender institution in the country. Against all four of our healthy prison tests, we judged outcomes to be good, our highest assessment.

Underpinning Parc's success were the excellent relationships between young people and the staff who cared for them. The culture was one of engagement, high expectations and incentivisation of good behaviour. Staff modelled high standards of behaviour themselves and were prepared to tackle delinquency among young people when they saw it. In our survey, no children reported feeling unsafe and against almost every safety measure we look at, such as the amount of violence or the application of force, levels were lower than at comparable institutions.

Time out of cell was much better than we see elsewhere, with children unlocked for between eight and 11 hours a day during the week and for over four hours at weekends. Our colleagues from Estyn similarly reported very positively about both the quality of education on offer and crucially, the access young people had to this education. To the great credit of leaders and managers, this standard of regime had, following the application of sensible risk management arrangements, been sustained throughout most of the pandemic.

The institution had also prioritised the promotion of family ties, a factor of great importance to childrens' well-being and successful rehabilitation and resettlement. All but one young person held at Parc was more than 50 miles from home and yet there was a range of initiatives, including evening and weekend visits, that encouraged family contact and sat alongside other impressive work to support sentence management and resettlement planning.

Parc YOI was a very well led institution. Managers were visible, morale was high, and the overwhelming majority of staff supported the establishment's priorities, including its commitment to the young people held. The one caveat was that, in keeping with other YOIs, the number of children held at the time of our inspection was fairly low, and with a higher roll it is likely that the maintenance of these high standards will be tested. Notwithstanding, on its current performance Parc is setting a standard for the management of children and young people in custody. The director and her staff are to be congratulated on their achievements.

Charlie Taylor
HM Chief Inspector of Prisons
May 2022

About HMYOI Parc

Task of the establishment
To hold sentenced and remanded children aged 15 to 17 years.

Certified normal accommodation and operational capacity (see Glossary of terms)
Children held at the time of inspection: 20
Baseline certified normal capacity: 64
In-use certified normal capacity: 60
Operational capacity: 60

Population of the establishment
During the year March 2021 to February 2022:

- 59 children received, an average of five children a month
- One foreign national child at the time of the inspection
- Average of 53% of children from black and minority ethnic backgrounds
- An average of 17% of children on remand
- 46 children released into the community
- An average of 43% of children in the care of their local authority before custody

Establishment status (public or private) and key providers
Private G4S

Physical health provider: G4S Health Services UK
Mental health provider: Primary G4S Health Services UK
Substance misuse treatment provider: G4S
Prison education framework provider: G4S
Escort contractor: GeoAmey

Prison group/Department
Youth Custody Service

Brief history
The children's unit in HMP & YOI Parc opened in March 2002 as a 28-cell facility for remanded children aged 15 to 18. In October 2004, it expanded to house 36 children aged 15 to18, both remand and sentenced, with a further expansion in February 2007 to 64 children. Initially the unit housed Welsh children but since March 2013 the court catchment area has covered Wales and South-west England.

Short description of residential units
The children's unit consists of two accommodation units with single and double occupancy cells. Echo One is a 24-bed unit split over two levels and Golf One has a capacity of 36 on one level. Both units have showers and communal spaces.

Name of director and date in post
Janet Wallsgrove, June 2006 to present

Prison Group Director
Heather Whitehead

Independent Monitoring Board chair
Kelvin Hughes

Date of last inspection
November 2019

Section 1 Summary of key findings

1.1 We last inspected HMYOI Parc in 2019 and made 16 recommendations, four of which were about areas of key concern. The establishment fully accepted 11 of the recommendations and partially (or subject to resources) accepted three.

1.2 In April 2021, during the COVID-19 pandemic, we conducted a scrutiny visit at the establishment. We made two 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 Parc 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 one recommendation about key concerns in the area of safety. At this inspection we found that this recommendation had not been achieved.

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

1.7 We made one recommendation about key concerns in the area of resettlement. At this inspection we found that this recommendation had been achieved.

Progress on recommendations from the scrutiny visit

1.8 During the pandemic we made a scrutiny visit to HMYOI Parc. 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/.

1.9 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.

1.10 We made two recommendations about areas of key concern. At this inspection we found that one of the recommendations had been achieved and one had not been achieved**.**

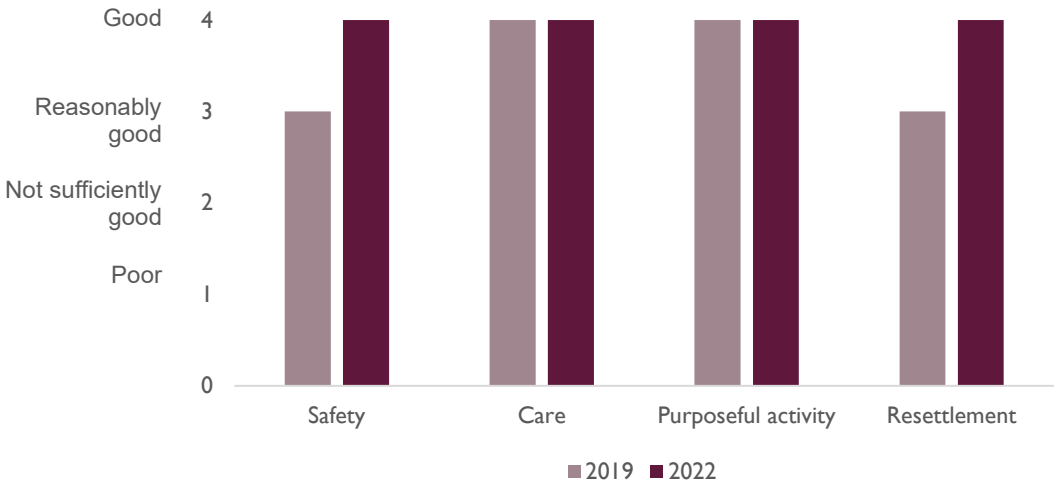
Outcomes for children

1.11 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).

1.12 At this inspection of HMYOI Parc, we found that outcomes for children had stayed the same in two healthy prison areas and improved in two.

1.13 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 Parc healthy establishment outcomes 2019 and 2022



Safety

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

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

1.14 Newly arrived children were met at reception by staff who carried out effective safety interviews. Ninety per cent of children told us they felt safe on their first night at Parc. The induction programme was good

and new admissions received four to five hours out of their cells each day.

1.15 In our survey, no children said that they felt unsafe at the time of the inspection and children confirmed this in private interviews with inspectors. The positive culture in the staff group, high expectations of children, very good relationships and effective multidisciplinary working supported the safeguarding of children. Child protection and safeguarding referrals were managed well and referred appropriately for external investigation, but there had been delays in final outcomes being notified to the prison and children.

1.16 Care for children at risk of self-harm was good and appropriately focused on providing education, engagement with staff and, where appropriate, support from family members and youth offending team workers.

1.17 Staff modelled high standards of behaviour and supported children to behave well. We observed only good behaviour in all areas of life at Parc. Levels of violence were lower than at the last inspection and good attempts were made to understand and resolve conflicts between children. Children described staff stepping in quickly when violence started and mediation taking place after fights. However, the ongoing conflict between children on the two residential units was detrimental to the overall ethos and children interviewed during the inspection could not explain why there were issues between the two units. Leaders made good use of data to inform their understanding of bullying and violence.

1.18 The incentives scheme was used well to encourage participation in educational and recreational activities and community living. Most low-level poor behaviour was challenged effectively by staff and formal adjudication processes were used for more serious rule breaches.

1.19 Levels of force had reduced since the last inspection and most of the force used was relatively low level. Oversight of use of force was generally good.

1.20 Few children were separated for reasons of good order or discipline and, where possible, the impact of separation was mitigated by a bespoke daily regime which mirrored that of other children at Parc. Children separated on the intensive support unit (ISU) experienced a far more limited regime, but this facility was rarely used. We were concerned that a child who was assessed as needing a tier four mental health bed had been placed at Parc and lived on the ISU for 14 days in 2021 before a move to hospital was arranged.

Care

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

At this inspection we found that outcomes for children remained good.

1.21 Relationships between staff and children were good. Children we spoke to were positive about their relationships with staff and responded very well to the nurturing and caring ethos of the unit. There had been significant investment in the custody support plan (CuSP) and both officers and children found the scheme beneficial.

1.22 Communal areas were clean, and equipment was in good condition and well maintained. Cells were in good order and with encouragement from staff, children kept them clean and tidy. However, the windows were in poor condition. Access to showers, laundry facilities and property was good. There had been 12 complaints in the last six months, all of which had been investigated well, and responses to the child were respectful. Consultation with children was not responsive.

1.23 The food had improved since the last inspection. The quantity of food was good, and a hot option was available at lunch and the evening meal. Children had plenty of opportunities to cook for themselves. Children were able to eat every meal in the communal areas and engage with peers and staff. Lunch and the evening meal were served by senior managers, giving them time to engage with the children.

1.24 At the time of the inspection, there was no equality and diversity lead to take responsibility for this area, but some interesting initiatives had been developed to address this gap. Equality and diversity training for staff was well attended and the positive relationships that staff had with children mitigated the gap in provision. Good data were being gathered, but analysis and action planning were limited. There had been two complaints about discrimination in the last six months, both of which had been dealt with well.

1.25 There was very limited oversight and governance of the children's unit by senior health care managers. We raised this with managers during the inspection and they responded appropriately. The two highly motivated staff nurses provided skilled clinical care to the children, with whom they had good relationships. Access to primary and secondary care services was good. After a prolonged absence, Forensic Adolescent Consultation and Treatment Service (FACTS) had returned on site in February 2022 having delivered services virtually during much of the pandemic. FACTS staff did not have consistent access to SystmOne and clinical records were not completed in a timely manner. Access to pain relief at the weekend and overnight was sometimes subject to delay.

Purposeful activity

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

At this inspection we found that outcomes for children remained good.

1.26 Time out of cell was much better than at other YOIs. Most children were out of their cell for between eight and 11 hours a day during the week and four to six hours a day at the weekend. Children attended education together on weekday mornings and afternoons, ate together and participated in enrichment activities such as chess, pool and football tournaments.

1.27 Children had access to a well-stocked library, and the librarian visited once a week to speak to each child. Most children visited the gym every day and four PE officers provided access to a wide range of qualifications and activities.

1.28 Nearly all children developed skills and knowledge in classes which improved their employability and enabled them to gain a good range of qualifications. They made good progress in improving their literacy and numeracy skills, often from a very low start. Learners with additional learning needs and those from minority ethnic groups performed well when compared to the unit's learners as a whole. Attendance, punctuality and behaviour in class were excellent.

1.29 Teachers were respectful to children and acted as good role models in the way they spoke and engaged with them. Staff had high aspirations for the children and nearly all children behaved respectfully. The curriculum offered a broad range of subjects and activities on release.

1.30 Teachers understood learners' needs well and worked effectively as a team with additional learning needs specialists to provide strong, individualised support to children. Teachers used a good range of teaching skills to engage, support and assess learners.

1.31 All children were assessed promptly on arrival to determine literacy and numeracy levels and identify learning needs accurately. Teachers carried out further useful diagnostic reviews to make sure that the targeted support met learners' needs.

1.32 Communication within the education team and with senior managers was highly effective in developing tailored programmes to meet children's needs. A newly developed management information system had strengthened the monitoring of performance. Leaders took appropriate account of labour market information in reviewing and planning development of the provision.

Resettlement

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

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

1.33 All but one child at Parc was more than 50 miles from home. Managers had prioritised impressive access to phone calls, secure video calls and visits, especially at evenings and weekends. As a consequence, children at Parc were better able to maintain relationships with family and friends than those at other YOIs. There was good support for new fathers and a programme of regular family events was planned.

1.34 Strategic management of resettlement was improving. The recent needs analysis was useful but had not yet been used to inform the reducing reoffending strategy and action plan. Planning for the increasing number of children who required transition to adult prisons was reasonable. Home detention curfew, early release and release on temporary licence (ROTL) were managed effectively. Work to support the increasing number of children with long-term sentences remained underdeveloped.

1.35 Needs, engagement and well-being team caseworkers (NEWTs) had regular and meaningful contact with children. Evidence of their work on the Youth Justice Application Framework (YJAF) was very good. There was effective and frequent communication between NEWTs, youth offending teams, probation, social workers and parents. Sentence and remand plans were reviewed regularly. Review meetings were of a good quality and often included families. Children made good progress against their sentence plans, especially in education. Leaders had plans to increase the small number of interventions.

1.36 Information sharing for the increasing number of children who were subject to multi-agency public protection arrangements (MAPPA) was effective.

1.37 Most children had social services involvement in their care. The social worker post had been vacant for an extended period, during which NEWTs had done their best to challenge local authorities effectively to make sure that looked-after children received their entitlements.

1.38 Most children had their address confirmed before their release meeting, but a few late confirmations continued to affect negatively children's plans for education and health support. Outcomes in education, training and employment for children on release were reasonably good and better than we see at other YOIs.

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 concerns.

1.41 Key concern: The unit had not had a dedicated social worker for an extended period. This had reduced the support and advocacy available to the increasingly large proportion of children who were in the care of their local authority or who had some involvement with social services. Managers responsible for safeguarding and child protection did not have a source of expertise to refer to on site.

Key recommendation: The unit should have a dedicated, on-site social worker.
(To the Youth Custody Service)

1.42 Key concern: A very unwell child assessed as needing a tier four mental health bed had been placed at Parc and segregated for 14 days in 2021 before a move to hospital was arranged.

Key recommendation: Children who need a hospital placement should not be sent to prison as a place of safety.
(To the Ministry of Justice)

1.43 Key concern: There was no oversight or responsibility for equality and diversity work at Parc and analysis of data remained limited. Children we spoke to felt supported by staff and their needs were being met, but gaps in provision could cause risks.

Key recommendation: Leaders should provide effective oversight of equality and diversity work at all times and data should be scrutinised thoroughly to ensure unequal treatment is identified and addressed.
(To the director)

1.44 Key concern: Support for the increasing number of children with indeterminate or long-term sentences was underdeveloped and limited compared to other YOIs. More children than at the previous inspection were held on remand or were serving sentences for murder or attempted murder.

Key recommendation: There should be an appropriate range of support to meet the risks and needs of children serving indeterminate or long sentences.
(To the director)

Notable positive practice

1.45 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.

1.46 Inspectors found 12 examples of notable positive practice during this inspection.

1.47 Leaders and staff made sure that children spent most of their time out of their cells, engaged in education, physical exercise or other purposeful activity. The time out of cell and plentiful opportunities to engage with staff prevented boredom and frustration, leading to better outcomes for children in safety and care. (See paragraph 3.15)

1.48 Managers had created a positive culture which helped children to feel safe. They knew that staff expected high standards of behaviour from everyone and staff would intervene quickly in incidents and take steps to resolve conflicts. (See paragraph 3.23)

1.49 The effective delivery of the custody support plan scheme had already seen positive outcomes for children. Regular meaningful work was being done with the children to meet their individual needs. (See paragraph 4.2)

1.50 Positive staff encouragement made sure that children took responsibility for their cells and were able to live in a clean and tidy environment. (See paragraph 4.6)

1.51 Senior managers served lunch and evening meals which gave them time for effective interaction with the children. (See paragraph 4.11)

1.52 The offer of a ‘well man’ check to every child with a sentence of more than four years was a positive initiative to help children develop skills and care for their own health and well-being. (See paragraph 4.41)

1.53 Every child was referred to the optician for an assessment of their vision to determine the need for further treatment or glasses. (See paragraph 4.45)

1.54 All children were referred to the dentist following reception screening for a dental assessment. (See paragraph 4.73)

1.55 Most learners arrived with poor levels of literacy and numeracy. Their basic skills were assessed promptly and teachers undertook further assessments to clarify children’s needs. They used this information well to help children develop their skills. Nearly all children improved their literacy and numeracy skills by at least one level while in education and many by two levels. (See paragraph 5.7)

1.56 Nearly all staff had a very good understanding of learners' progress and emerging needs in education. They updated children's learning plans regularly and shared information to determine how best to meet each learner's needs. This resulted in well-tailored provision which enabled each child to make the best possible progress. (See paragraph 5.25)

1.57 Leaders had given priority to ensuring that children could successfully maintain relationships with family and friends. They had provided impressive access to phone calls and daily access to secure video calls and social visits. (See paragraph 6.2)

1.58 Outcomes in education, training and employment for children on release were reasonably good and better than we see at other YOIs. On release from custody, 19 children had had a placement in education, training or employment, including apprenticeships, college and, in some instances, a return to full-time education. (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 Leaders at Parc had worked well with Public Health Wales and the Welsh Government to put in place proportionate COVID-19 restrictions that also protected children's well-being. Local leaders had taken courageous decisions and had appropriately challenged HMPPS guidance where it would have led to poor outcomes for children. These decisions meant that, unlike their counterparts at other YOIs, children at Parc had received face-to-face education, PE and an effective library service throughout the pandemic. Because these services had restarted in April 2020 and expanded over the subsequent two years, children could access much more education and time out of cell than at other sites.

2.3 Leaders had created a positive culture among staff that supported impressive outcomes in all areas of our healthy prison tests. In our survey, 81% of staff, including 91% of frontline operational staff, said that their morale was high or very high. This high level of morale had been maintained despite the requirement for staff to run more services for children than at other sites. The overwhelming majority of staff spoke positively about leadership and 94% supported the establishment's priorities of enhancing further the services and support for children.

2.4 While the living units were not designed for use with children, managers had made the best of limited infrastructure by maintaining high standards of cleanliness and providing children with good access to the basics of everyday life. During our inspection, work was in progress to improve education and interventions facilities.

2.5 Leaders had implemented the custody support plan (CuSP) during the months before the inspection. All children were receiving regular support from their CuSP officer and CuSP sessions were recorded well.

2.6 Leaders and managers understood the value of supporting children to maintain good family ties. They had prioritised secure video calls (see Glossary) and in person visits during evenings and weekends. Children were more likely to see family and friends regularly than at other sites.

2.7 There were some gaps in formal oversight in some areas, including safeguarding, equality and diversity and resettlement. These had not, however, adversely affected outcomes for children but needed to be addressed.

2.8 The achievements of leaders, managers and staff at Parc over the previous two years were impressive and children's experience of custody was more positive than at other YOIs. The contract for the establishment was being retendered at the time of our inspection and the challenge for managers was to maintain this success through this period of inevitable uncertainty.

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 An average of five children arrived at Parc each month. They were met at reception by an officer from the children's unit and taken straight to the unit. This ensured that they did not have contact with adult prisoners.

3.2 Initial safety interviews were held in a private office and focused appropriately on identifying potential risks to the children's safety and welfare. All new arrivals were also seen by one of the two unit nurses. Children were offered a hot meal on their first night and most were offered a shower. The few children that arrived outside the core day were offered a shower the following morning.

3.3 Most children were able to make a phone call home on their first night, but there were still delays in allowing children who were potentially restricted status (see Glossary) to make calls. In these cases staff made phone calls on their behalf.

3.4 Children were allocated a cell directly on the unit as there were no dedicated induction or first night cells. The cells were clean, free of graffiti and adequately equipped. Children were given bedding, clothing and an induction pack containing information about the prison, as well as toiletries, a puzzle book and writing materials.

3.5 Staff conducted half-hourly welfare observations on all new arrivals for their first three nights and, in our survey, 90% of children told us they felt safe on their first night. It was positive that children were encouraged to use their cell bells, usually reserved for emergencies, during their first few nights if they had any concerns or questions or wanted to talk to unit staff.

3.6 An induction programme was held over three days, overseen by a dedicated induction officer who worked closely with the children to make sure they understood how the unit operated, for example, how to use the electronic kiosks to choose meals, order phone credit or make appointments. During induction, children also met their custody support plan (CuSP) officers, had further appointments with the nurses and took a learning and skills assessment.

3.7 Cohort arrangements (see Glossary) allowed children on induction time out of cell only when other children were in education. This amounted to four or five hours a day, which was more than in similar establishments. Children could join the main regime after two negative COVID tests which enabled them to attend education and the gym the day after finishing induction.

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.

3.8 Safeguarding of children was underpinned by the positive staff culture of high expectations of children, very good relationships and effective multidisciplinary working. At the time of the inspection, no children said they felt unsafe, either in the survey or in private interviews with the inspection team.

3.9 The multidisciplinary meeting each morning remained an effective forum for staff to share information about, and safeguard, children. Unit staff had received safeguarding training in the previous six months and managers checked each morning that staff were wearing body-worn video cameras. Use of these cameras during incidents was becoming more routine which contributed to safeguarding as did the name badges worn by staff and the picture boards of staff around the unit.

3.10 The dedicated on-site social worker post had been vacant for an extended period which had reduced the advice available to managers responsible for child protection and safeguarding. Links with community safeguarding partners had been maintained throughout the pandemic. Unit managers attended local safeguarding board meetings and the local authority and police were usually represented at the unit quarterly safeguarding meeting.

3.11 Child protection and safeguarding referrals were managed well and were referred appropriately for external investigation. Eight referrals had been made during the previous six months and good records were kept of their progress. In some cases, there had been delays in providing the unit with final outcomes which had prolonged the period of uncertainty for children and staff involved with the referral.

3.12 Advocates from Barnardo’s were accessible to children. They helped children to raise concerns and provided another independent source of safeguarding support.

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.

3.13 There had been 17 recorded incidents of self-harm during the previous 12 months, about half of which had involved one child. Hospital treatment had not been required in any of the cases. The rate of recorded self-harm was similar to the last inspection and to other young offender institutions (YOIs). Nineteen ACCT documents (assessment, care in custody and teamwork case management of children at risk of suicide or self-harm) had been opened over the same period, most on arrival when risks had been identified by the courts or escorts. No children were on an open ACCT at the time of the inspection and only one child in the prison had ever been on an ACCT.

3.14 Children at the highest risk of self-harm were typically placed in a cell with CCTV so that staff could conduct welfare checks at night without disturbing them. However, observations were still made at predictable intervals which created unnecessary risk. In the ACCT documents that we reviewed, care plans were multidisciplinary, demonstrated attempts to keep children engaged in activities and education and, where appropriate, involved family members or community agencies, which was positive.

3.15 Unit staff demonstrated good knowledge of the children in their care and their circumstances and a busy regime reduced boredom and frustration (see paragraph 5.1). Staff made sure that children saw the mental health nurse whenever they might be particularly vulnerable, for example after a court appearance, medical appointment or legal visit.

3.16 At monthly safeguarding meetings only passing reference was made to self-harm. Useful data were not presented or analysed nor were actions taken to reduce self-harm. In contrast, individual cases were discussed in detail at daily multidisciplinary meetings.

3.17 There had been no self-inflicted deaths or near misses since the last inspection.

Recommendation

3.18 **Observational checks on children should not be carried out at predictable intervals**. (Repeated recommendation, 1.17)

Security

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

3.19 Physical security was generally proportionate for children at Parc.

3.20 The security department produced a local tactical assessment each month, which identified the key security threats for the whole prison. Conflict and violence were appropriately identified as the key threats on the children's unit, and the security department and unit staff worked well together to monitor and manage this.

3.21 During the previous six months, 189 intelligence reports relating to children had been received, a 65% reduction since the previous inspection, which security managers attributed to a reduction in the population on the children's unit. Intelligence reports were processed promptly and there was no backlog.

3.22 Unit staff responded quickly to intelligence and had completed all requested targeted searches during the previous year. Staff had conducted 32 intelligence-led searches between April 2021 and March 2022, recovering nine items including mobile phones and improvised weapons.

Behaviour management

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

3.23 We observed good behaviour by children across all settings. Children were kept busy with a full daily regime which reduced the likelihood of poor behaviour prompted by boredom. Staff modelled high standards of behaviour and expected, and supported, children to behave well. In our survey, 61% of children said that staff told them when their behaviour was good and 86% that when they got in trouble staff usually explained to them what they had done wrong. This was reinforced during our one-to-one interviews with children.

3.24 In our survey, only 47% of children said the incentives scheme encouraged them to behave well and 35% that they thought the scheme was fair. In conversations with individual children, they could describe how the scheme operated and said they felt fairly treated but some thought the differences between regime levels did not provide a sufficient incentive.

3.25 The scheme was used well to encourage children to take part in education and recreational activities and to mix with their peers, and low-level poor behaviour was challenged effectively by staff. Children could advance through the levels with no undue delays and, if they were demoted, they could quickly start to move up the levels again. Targets set for children to advance were clear and achievable. Reviews took place each week with some midweek reviews for children who needed more support to progress.

3.26 Use of data to identify disproportionality in the operation of the scheme had improved since the last inspection, but there was still scope to investigate the causes of differential outcomes more thoroughly.

3.27 There was no immediate rewards scheme, but this was being considered as a further means of promoting good behaviour.

3.28 More serious breaches in the rules were dealt with through the adjudication process which had been used 87 times in the previous six months, typically for incidents involving violence. Most adjudication hearings were conducted by one of the unit senior managers which helped to ensure consistency in the punishments awarded. Barnardo's advocates were now advised of children who were facing an adjudication hearing so that they could offer support. This had been identified as an omission at our last inspection.

Bullying and violence reduction

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

3.29 Levels of violence had reduced since the last inspection and 30 violent incidents had taken place between September 2021 and February 2022. Five injuries had been sustained over this period, one of which had required a child to attend hospital for assessment.

3.30 A conflict resolution team had been introduced since the last inspection. Members of the team were officers on the two residential units which gave them good insight into interactions between children and any developing tensions. Good efforts were made to understand and resolve conflicts between children during conflict resolution interviews and investigations and also by sharing information at the morning multidisciplinary meeting and in CuSP sessions with children (see paragraph 4.2). Leaders made good use of data to aid their understanding of bullying and violence.

3.31 Children described the staff as alert to tensions on the residential units and stepping in quickly if violence started. Mediation took place afterwards and immediate resolution was still used to prevent minor incidents from escalating.

3.32 Conflict among children on the two residential units had for some months prevented them from mixing as one large group for any activities. This unfortunately undermined the ethos on the unit and prevented managers from developing the culture further. Children whom we interviewed could not explain why there were issues between the two units.

3.33 Only one child in our survey said they would report being bullied or victimised by another child. This was concerning. Data showed that nine bullying incidents had been dealt with in the last six months and staff whom we spoke to were aware of the potential for bullying and victimisation. Challenge, support and intervention plans (CSIPs) were opened for children who were victims or perpetrators of victimisation and violence. During the previous six months, 21 CSIPs had been used and two were open at the time of the inspection. The children had a full regime and regular reviews were carried out.

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.

3.34 Use of force had reduced since the last inspection, with 99 incidents between September 2021 and February 2022. Records showed that on many occasions several children had been restrained during one incident: for example, in February 2022 16 restraints had been used during three assaults, each involving up to six children. Much of the force used had been relatively low level and care was taken to try to de-escalate incidents so that children walked back to their cells rather than being forcibly relocated. There were no instances of the use of pain-inducing techniques during this period.

3.35 In our survey, 89% of children said that they had experienced staff using force, all of whom said that someone had talked to them about the restraint afterwards. During our interviews, children expressed mixed views on the usefulness of this discussion and on whether sufficient attempts had been made to de-escalate the situation.

3.36 Oversight of use of force was good. Incidents were reviewed promptly by one of the managing and minimising physical restraint (MMPR) coordinators using CCTV and body-worn camera footage, and child protection concerns were identified and reported. All incidents of force were reviewed at a weekly MMPR meeting to identify and address shortcomings. Staff involved in restraints completed their documentation promptly and MMPR coordinators and a senior operational manager carried out quality assurance.

3.37 Regular staff training took place, with priority given to de-escalation. Quality assurance and oversight were used well to identify themes to

be incorporated into training and to identify members of staff who would benefit from additional advice or guidance. One-to-one drop-in sessions were used for these staff and for those who wanted clarification on MMPR techniques or processes.

3.38 MMPR handling plans were in place for children with a medical condition who would have been at risk during use of force and a discrete identifier showed which cells these children occupied (see paragraph 4.23). Most of the staff we spoke to knew where to find the plans and which children had one.

Recommendation

3.39 **Managers should make sure that debriefs following restraint are comprehensible and useful to children.**

Separation/removal from normal location

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

3.40 During the previous six months, five children had been separated from their peers for reasons of good order or discipline, three of whom had remained in their allocated cell while separated. Records showed that their regime was kept as similar as possible to that of other children. At the time of the inspection, a child who was separated attended education in the morning and afternoon with a peer and had evening and weekend activities with staff that mirrored those of his peers. Reintegration was considered as soon as separation started.

3.41 The intensive support unit (ISU), which had two cells, was sometimes used to separate children. It was physically apart from the rest of the unit and children separated there had a far more limited regime. The ISU was not used often but two new arrivals had been separated there during the previous six months, the first use of the unit since September 2020. The use of the ISU was justifiable in both cases. One child spent four days there before joining his peers and the other 14 days while a move to hospital was arranged. This was the longest period of separation at Parc over the previous six months and it was concerning that the child had been placed at Parc despite his medical needs being known prior to custody.

3.42 More use had been made of separation than at other YOIs while a child was awaiting an adjudication. This happened when there were concerns about risks to or from the child following the incident they had been involved in. Separation was used for the minimum time, usually a day, while issues were resolved.

3.43 Separation records were appropriate and indicated that separation was justified and reviews were taking place. Daily statutory visits by chaplains, health care staff and unit managers were recorded and

some entries described the interaction that had taken place with the child.

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 were good. Children we spoke to were positive about their relationships with staff and responded well to the nurturing and caring ethos of the unit. In our survey, 82% of children said there was a member of staff they could turn to if they needed help. Photographs of staff and their roles were clearly displayed on the units to make it easier for children to identify them. Children were positive about the support they received from Barnardo's advocates and the needs, engagement and well-being team (NEWT).

4.2 There had been significant investment in the use of custody support plan (CuSP) which had been in operation for five months and both officers and children found the CuSP beneficial. All staff had completed the training and most weekly meetings between CuSP officers and children were taking place. A mapping exercise had determined the allocation of staff to children based on mutual interests, which was good. The on-site psychology team completed quality assurance and held monthly local management team meetings to review the work and to offer support and guidance to staff.

4.3 At the time of the inspection, no children had been identified as representatives on the units. There were plans to appoint a child as an equality and diversity representative in the near future. Two prisoners from the adult estate, who had previously been on the children's unit, visited the children to speak about their experiences of transition and to offer advice. Their visits had been infrequent during COVID restrictions and more time was being allocated for this.

Daily life

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

Living conditions

4.4 Communal areas were clean and equipment was in good condition and well maintained. Notice boards were kept up to date with relevant information on support agencies and events calendars, which was positive.

G1 unit

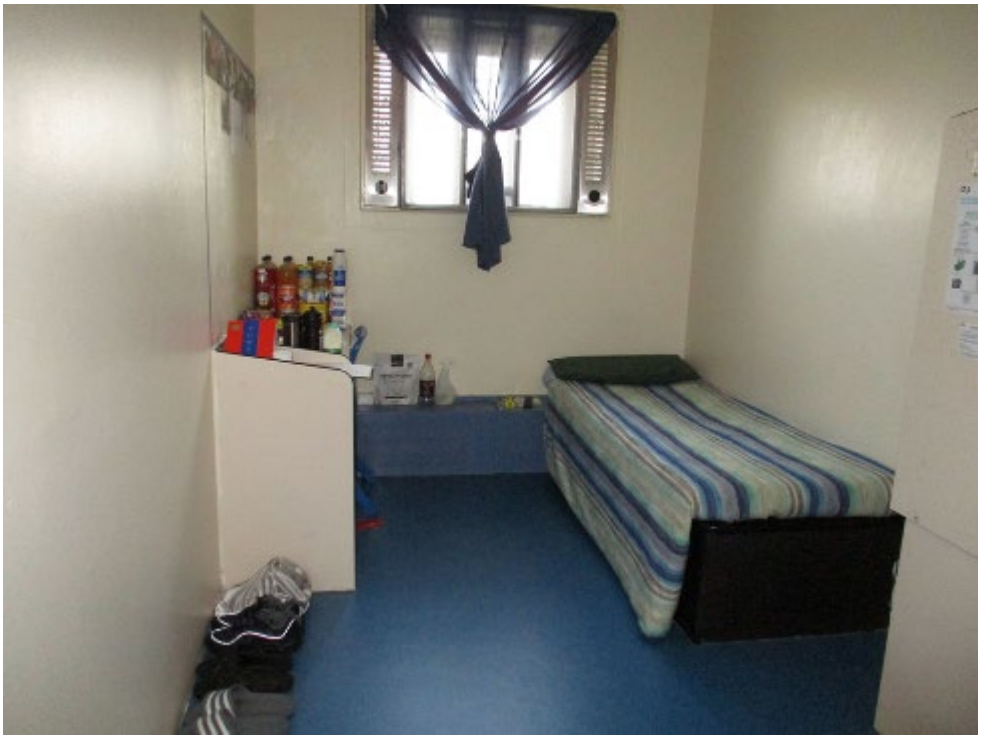
4.5 The exercise yards were small but were kept tidy. We saw children using the outdoor spaces during breaks from education.

E1 exercise area

G1 exercise area

4.6 Cells were well equipped and children took responsibility for keeping them clean and tidy, with encouragement from staff. Cell competitions were held each week with prizes awarded to the winner, often extra snacks. However, the windows were in poor condition with graffiti and ingrained dirt. In some cells, broken air vents affected the ventilation

and, in our survey, only 44% of children said the temperature of their cell was about right. Children had not been sharing cells since the start of the pandemic, which was positive.



Occupied cell on G1 unit

4.7 Access to showers was good and 95% of children in our survey said they could shower every day. The showers were clean but in need of refurbishment. Shower facilities in the cells were planned for the following year. The laundry facilities remained good and were accessible on both units. Children's property was kept in the adult prison and staff had collected property for the children during COVID restrictions. Children were able to receive parcels from family and friends each month.

Recommendation

4.8 **Windows should be free of graffiti and dirt, and maintenance should be carried out on broken air vents.**

Residential services

4.9 The food had improved since the last inspection. In our survey, 50% of children said the food was very or quite good. Food was now being prepared in the staff canteen during the week and, as a result, the quality had improved. The quantity of food was reasonably good and a hot option was available at lunch and for the evening meal.

4.10 The children received extra snacks throughout the day, including noodles and cereal which they were happy with. There were frequent opportunities for children to cook for themselves in the evenings and at weekends.

4.11 Children were able to eat in the communal areas for every meal. We observed good interactions among children and staff at mealtimes. Lunch and evening meals were served by senior managers, giving them time to engage effectively with the children. We observed staff preparing meals during the evening and early morning for children on Ramadan, which was good.

4.12 Children we spoke to were happy with the canteen service but would have liked a wider range of products to be made available. This had been raised in consultation meetings and staff were trying to address this by purchasing additional goods for the children to buy.

Consultation, applications and redress

4.13 During the previous six months, there had been 12 complaints which had been investigated well with communication with children throughout. Responses were timely and respectful and quality assurance continued to make sure that processes were effective. In our survey, 88% of children said they knew how to make a complaint and no child said they ever felt too scared to do so. The units were well stocked with complaint forms and there was evidence of Barnardo's advocates helping children to complete the forms.

4.14 The monthly young people's forum was not always well attended by staff and children. Discussions were repetitive and actions were not always addressed but were rolled over to the following month. We were told that the forums were open to all children to attend, but this was not possible while children from the two units were unable to mix. Managers needed to think of new ideas to reinvigorate consultation with lower numbers of children on the units.

4.15 The needs, engagement and welfare team continued to give good support to children and their families with legal rights. The team had a good working relationship with the Howard League for Penal Reform and Barnardo's, who provided additional support to the children if needed.

Recommendation

4.16 **Consultation should include the views of all children and actions should be addressed in a timely manner.**

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

4.17 At the time of the inspection, there was no equality and diversity lead. Some work on equality and diversity had continued and there was an action plan, although it was unclear where responsibility for this lay and it was not discussed at management meetings.

4.18 There were interesting and developed ideas to fill this gap. Ethnic Minorities and Youth Support Team (EYST), a voluntary community service, had been commissioned to deliver equality and diversity work in the near future. They had already completed training with nearly all staff in the children's unit, which was positive.

4.19 Useful data on the protected characteristics (see Glossary) of the children were being collected on a 'strengths and culture' database. It was evident that staff knew the children in their care, but it was unclear if information on the database was being considered. The monthly monitoring and review group reviewed ethnicity data from areas such as violence and behaviour management, but analysis of this information remained limited.

4.20 Consultation forums had continued throughout the pandemic and had more recently been supported by other staff members in the absence of a dedicated lead. However, the forums were not always well attended by staff or children nor focused on diversity and inclusion.

4.21 There had been two complaints about discrimination in the last six months, both of which had been dealt with well, including interviews with children which were conducted in a timely and fair manner. Plans were in place under the new contract for EYST to scrutinise and support this process.

Protected characteristics

4.22 At the time of our inspection, 58% of children were from black and minority ethnic backgrounds. These children said they felt supported by staff and that their needs were being met.

4.23 In our survey, 16% of children said they had a disability, all of whom said they were getting the support they needed. No children were on an assisted living plan, which was appropriate. Coloured stickers were used outside the cell doors for staff to identify children who needed adaptations with minimising and managing physical restraint (MMPR), which was good (see paragraph 3.38).

4.24 At the time of the inspection, one foreign national child had been identified. Support was being arranged for him.

4.25 Special events had continued to take place on the units and were well advertised to the children. We saw examples of children engaging in LGBTQ+ awareness month and cultural cooking classes and the feedback from children was good.

4.26 Support from the chaplaincy had been maintained throughout the pandemic and they visited the children each day. In our survey, 50% of the children said they had a religion, all of whom said that their religious beliefs were respected. Three children were participating in Ramadan at the time of our inspection and support was being offered by the Muslim chaplain and staff on the unit.

4.27 Children had not had access to corporate worship during the pandemic and this was due to restart soon. The Message Trust, a Christian charity, visited the unit once a week to offer support, including Bible study groups, and to engage the children in music classes, which was positive.

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.

Strategy, clinical governance and partnerships

4.28 G4S Healthcare delivered primary care including mental health. Dental services were provided by Time for Teeth. Child and adolescent mental health services were commissioned through the All Wales Forensic Adolescent Consultation and Treatment Service (FACTS) within Cwm Taf Local Health Board. A suitable health needs assessment had been published in 2021 and there was an action plan to address identified needs.

4.29 Partnership boards and local governance meetings had continued throughout the pandemic, but neither agenda included governance of the children's service and there was no oversight or scrutiny of the care provided. Internal audits and incident reports had been conducted and submitted to managers for local review. Health care managers had not visited the children's unit since the start of the pandemic and there was a lack of management oversight. We raised this with the senior manager of health care who promptly drew up a schedule of planned visits to the children's unit.

4.30 Prison and health care staff had worked well together to manage the impact of the pandemic and deliver the COVID-19 vaccination programme. Children were PCR tested on day one and day five and, if both tests were negative, were allowed to mix with other children.

4.31 Primary care was delivered by two highly committed nurses who provided a kind and caring service and were very knowledgeable about the children. Children told us that they knew the nurses and could talk to them.

4.32 Compliance with mandatory training was up to date with appropriate training and documented clinical supervision.

4.33 The treatment room was in good condition and also served as the medicines administration room. Medications were stored correctly and stock levels were monitored.

4.34 The standard of entries on SystmOne, electronic clinical records, was reasonable. Care plans were good but lacked evidence that children had been involved. An automated external defibrillator was strategically sited and subject to regular checks. At the last inspection ambulances had not routinely been called in an emergency, with potential delay to treatment. An ambulance was now automatically called in emergencies, which was good.

4.35 The poster advertising the complaints process was being reviewed at the time of the inspection to make it easier for children to understand. There had been one written complaint during the previous year which had been responded to promptly but had not been written in age-appropriate language.

4.36 Staff were confident to make safeguarding referrals and health care was represented at safeguarding meetings.

Promoting health and well-being

4.37 There was no local health promotion strategy but both nurses took initiatives to promote health. There was a wide range of health promotion material across the unit.

4.38 Children were screened promptly for hepatitis B and sexually transmitted infection. Children who smoked were assessed on arrival and provided with nicotine replacement lozenges at reception, which was good.

4.39 Children were offered a range of childhood vaccinations including MMR and all children who had been due those immunisations were up to date.

4.40 We were advised that the changing public guidance on COVID-19 immunisation for children had been one of the reasons cited by those who declined the immunisation. Children who declined the vaccination were advised that the invitation to be immunised remained open and health care staff raised it at every contact.

4.41 Every child serving a long sentence was offered an annual ‘well man’ health check.

4.42 Health care and gym staff had worked with a local training company to deliver a first aid course after education finished. The children had given very positive feedback.

Primary care and inpatient services

4.43 Health screening was undertaken by a nurse using the national comprehensive health assessment tool (CHAT). All new arrivals were seen by a nurse who took their temperature before screening was undertaken. Subsequent CHAT assessments, including substance misuse, neurodiversity, mental health and well-being, were carried out during the first week in custody and completed to a high standard.

4.44 The nurse-led primary care service offered a good range of services, including long-term conditions. The health care team from the adult prison provided nursing cover out of hours. During the pandemic the GP had started to visit the unit once a week to see patients which had been appreciated by the children. This had improved efficiency, reducing the need to transfer a child to the main health care unit and lessening the impact on the main prison regime. The GP service was delivered six days a week and included out-of-hours provision. Urgent GP appointments were available on the day and routine appointments took place on the unit.

4.45 All children were referred to the optometry service which attended once a month. There was a maximum wait of four weeks. The physiotherapist had one child on the caseload at the time of our inspection and routine appointments were offered promptly.

4.46 The nurses contributed to enhanced MMPR plans to make sure that additional health risks were shared appropriately (see paragraph 4.23). This was good practice.

4.47 There were infrequent secondary care appointments and these were managed well.

4.48 At the time of the inspection, no child was receiving social care. Staff could not recall the last time that such services had been required, but they understood how to make a referral if it became necessary.

Mental health

4.49 Every child was assessed on arrival by the primary care mental health nurse who made prompt referrals to FACTS or the GP. Support was offered with sleep hygiene, relaxation and mindfulness practice, which was good.

4.50 Referrals to the FACTS team could be made by health care and prison staff. All referrals were reviewed at a weekly meeting, but any child requiring an urgent referral was seen within a week. FACTS attended the prison once or twice a week but did not have an established base there. Information was, therefore, shared by email which was not conducive to team building or efficient communication.

4.51 There was no waiting list and children were seen and assessed in a timely manner. Children had been seen on video calls during the pandemic and the team had returned to face-to-face appointments in February 2022.

4.52 Children on the FACTS caseload had access to structured interventions which included development of coping skills and managing emotions. There was still a lack of access to therapists usually associated with children's mental health services, such as art, drama, music and speech and language. The health needs assessment had identified gaps in psychological interventions and programmes for children which remained outstanding.

4.53 FACTS had had difficulty with access to the prison clinical record and this was in the process of being remedied. FACTS practitioners did not make full entries on SystmOne and their summaries stated that a fuller account was kept on the Cwm Taf Local Health Board clinical record system. Dual record keeping presented inherent risks, including the potential failure to impart critical information.

4.54 During the previous two years, two children had required assessment or transfer under the Mental Health Act which had taken place in a timely manner.

4.55 Preparation for release or transition planning was undertaken by primary care or FACTS if the child was on their caseload, which was appropriate.

Recommendations

4.56 **Children should have access to a wider range of therapeutic interventions, including speech and language therapy.**

4.57 **FACTS should contribute to the prison-based clinical record system to ensure that there is a single, comprehensive record of assessment, care and treatment for children in their care.**

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.

4.58 There was no up-to-date drug and alcohol strategy to meet the needs of the population. Primary care and the substance misuse teams met the needs of the children. A dedicated psychosocial worker based on the children's unit had up-to-date training and regular supervision.

4.59 Children were assessed using the CHAT 3 substance misuse assessment tool. The GP saw children who needed clinical assessment and treatment for substance misuse. This had happened once in the previous year.

4.60 Children were assessed on arrival by primary care. They referred children to the psychosocial worker who saw them within 24 to 48 hours of admission. Every child received an intervention on illegal substances to raise awareness of the risks.

4.61 Children received age-appropriate support and 11 children were undertaking tailored interventions at the time of the inspection. Each child had a detailed history and care plan with agreed actions and goals, which was good.

4.62 Any child with a mental health condition and a history of substance misuse was referred to FACTS. This occurred infrequently and any referral was seen promptly.

4.63 Harm reduction advice was given to all children and feedback was gathered at the end of treatment to inform service delivery.

Medicines optimisation and pharmacy services

4.64 Pharmacy services were provided by a pharmacy based in the adult prison. The service for children was managed locally by a full-time technician supervised by a full-time pharmacist.

4.65 Medicines arriving with children were passed to the pharmacy team to reconcile and request additional information from the child's GP if required. These were then prescribed and reissued.

4.66 At the time of the inspection, two children were in receipt of medication. Children were unlocked in time to receive medication from the nurse before going to education and subsequent doses were delivered at 11.45am and 5pm. Medicines administration was good.

4.67 In-possession risk assessments were undertaken on a needs-led basis and updated or reviewed with each prescription. One child held in-possession medication at the time of the inspection. He was visited by the nurse each day to reinforce adherence to the prescription, which was good.

4.68 Medication was routinely administered from the treatment room with competent supervision by officers.

4.69 Storage of medicines was well managed and prescribed medication was issued from named boxes.

4.70 Out-of-hours prescribed medicines could be acquired through the on-site pharmacy, but this had not been necessary in recent months. A supply of over-the-counter medicines was held in the medicines cabinet on the unit and could be administered under the patient group directive policy. Access to pain relief at weekends and overnight was sometimes subject to delay: delays were reviewed through incident reporting and any concerns addressed.

4.71 Discussions at monthly medicines management meetings included formulary and prescribing, trends in incident reporting and the outcome of audits.

Recommendation

4.72 **Children should have prompt access to pain relief at the weekend and overnight**.

Dental services and oral health

4.73 All children were referred to the dentist on arrival, which was good practice. The dental service was based in the adult prison and delivered a daily service from Monday to Friday. There were ring-fenced slots for the children and no waiting list for routine appointments.

4.74 Children who required treatment had scheduled appointments and the surgery had been able to carry out aerosol generating procedures which ensured that waiting times were short.

4.75 Dental hygiene advice and oral health promotion were offered at every contact.

4.76 Children who experienced dental pain were provided with over-the-counter analgesia and were seen within 48 hours during the week.

4.77 Infection prevention and control measures were followed and there were regular audits to monitor standards. The surgery had a separate decontamination room with clean and dirty areas that were clearly labelled.

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 Time out of cell remained very good, and much better than at other young offender institutions (YOIs). Most children were out of their cells for between eight and 11 hours a day during the week and between four and six hours a day at weekends. In our survey, 95% of children said they spent more than two hours out of their cell on weekdays and 90% at weekends compared with 42% in other YOIs. A regime consisting of at least four hours out of cell was organised for children on induction and those under reverse cohort conditions (see Glossary).

5.2 Despite a number of children who were in conflict being unable to associate together, staff remained committed to delivering a full regime and giving children access to a range of activities and classes. We observed a child subject to separation engaging in education, carpentry and outdoor physical exercise. Children attended education together on weekday mornings and afternoons, ate together and participated in enrichment activities such as chess, pool and football tournaments.

5.3 Children had access to a well-appointed gym and small all-weather pitch. Most children visited the gym every day, and four PE officers delivered a wide range of qualifications and activities.

Children's unit gym

All weather sports area

5.4 The children's unit had a well-stocked library, which contained age-appropriate books, Welsh language materials, easy read and quick-read books, and a range of graphic novels. The librarian attended once a week to speak to each child and children could borrow books at any time, facilitated by an officer or a teacher.

Children's unit library

Education, skills and work activities

Arolygiaeth Ei Mawrhydi dros Addysg a Hyfforddiant yng Nghymru
Her Majesty's Inspectorate for Education and Training in Wales

Inspection of the provision of education and educational standards, as well as vocational training in YOIs for young people, is undertaken by Estyn, the office of Her Majesty's Inspectorate for Education and Training in Wales, working under the general direction of HM Inspectorate of Prisons. Estyn is independent of, but funded by, the National Assembly for Wales. The purpose of Estyn is to inspect quality and standards in education and training in Wales.

Expected outcomes: All children are expected and enabled to engage in education, skills or work activities that promote personal development and employability. There are sufficient, suitable education, skills and work places to meet the needs of the population and provision is of a good standard.

5.5 Estyn made the following assessments about the learning and skills and work provision:

- Standards: Excellent
- Well-being and attitudes to learning: Excellent
- Teaching and learning experiences: Excellent
- Care, support and guidance: Excellent
- Leadership and management: Excellent

5.6 The high standards that children achieved had been maintained since the previous inspection, despite the challenges presented by the recent pandemic.

5.7 Nearly all learners made good progress in improving their literacy and numeracy skills, often from a very low start. Many improved these skills by two levels and nearly all improved by one. Learners used literacy and numeracy in class sessions. In music a few children developed their vocabulary when writing songs. In English, learners explored the meaning of phrases they had not encountered before. In several classes, children read work aloud in front of their peers.

5.8 Children had good access to IT in classes which helped them to gain skills to improve their employment prospects. In music lessons, most learners developed useful IT skills while using digital editing and sequencing applications. In a class leading to a cleaning qualification, learners used IT to learn how to minimise hazards in the workplace.

5.9 Most learners were able to improve their skills and knowledge in subjects that particularly interested them, often progressing to higher levels of qualifications. The breadth of the curriculum allowed nearly all children to become engaged in an area of learning that they identified as relevant to their interest, abilities or experience. For example, in music lessons, they made strong progress in a short time to develop an understanding of musical timing, rhythm and expression. A few learned to play musical instruments to a competent level. In PE, children developed fitness and sport skills, benefiting from the prison's partnership with organisations such as Dallaglio Rugby Works, which had offered one child paid employment on leaving Parc.

5.10 Most learners understood broadly what they needed to do to complete their qualifications. Nearly all had clearly defined targets in their learning plans and had achieved several qualifications in the broad range of short courses that they were pursuing. A majority progressed into higher levels of qualifications during their time in the children's unit.

5.11 Children with additional learning needs and from different ethnic backgrounds performed slightly better than learners as a whole.

Well-being and attitudes to learning

5.12 Children responded very well to the nurturing, caring ethos of the unit. Nearly all the children knew how to raise concerns with staff and every child that inspectors spoke to felt safe in class.

5.13 Nearly all children were encouraged to engage well in education and to contribute fully in class. Many became fully immersed in sessions. One

learner observed that ‘sometimes when I’m in this lesson, I forget that I’m in prison’.

5.14 Children consistently arrived punctually to lessons and settled quickly into tasks.

5.15 Children’s attendance in classes was excellent and their behaviour was exemplary. We did not observe any instances of children being returned to their cells because of poor behaviour in class.

5.16 All children showed respect to each other, to staff and to visitors. They took turns to contribute and supported each other effectively to complete tasks. In citizenship lessons, nearly all children developed important skills in tolerance, resilience and respect.

5.17 Children were very proud of their work and were keen to share their successes and achievements with visitors. For example, children in cooking wanted staff and visitors to taste their food and in carpentry, they wanted to show what they had made and to explain whom it was for.

5.18 Children improved their understanding of how to avoid reoffending in several classes. In one session, they discussed how the skills they were learning could help them find employment and break a cycle of offending behaviour.

5.19 Many learners developed confidence in sessions, for example in music they took pride and care in writing and recording songs, which encouraged them to build on their achievements. A few identified that music had helped them to reduce anxiety and develop resilience since they arrived.

5.20 Children learned about healthy lifestyles across the curriculum, for example in a cooking session they discussed healthy food choices and food safety. In a British Institute of Cleaning Science lesson children learned about safety in the workplace and their responsibility to keep themselves and others safe.

5.21 There were many stimulating displays in the education area to promote awareness of healthy development and lifestyles.

Teaching and learning experiences

5.22 The curriculum offered a broad range of subjects and activities to give children the skills they needed to progress into education, training and employment on release.

5.23 Teachers were well qualified and highly skilled, working effectively as a team with specialists to support children with additional learning needs. Together, they provided strong, individualised support to children.

5.24 Classrooms were well equipped, with appropriate access to IT and a wide range of learning resources. Teachers displayed children’s work to celebrate their success and to motivate other learners. Many

teachers used IT well to enhance their teaching, using interactive whiteboards to engage learners at the beginning of sessions. Teachers' whiteboard presentations were invariably stimulating and catered well for learners with a wide range of learning styles and reading abilities.

5.25 Most teachers understood learners' needs very well and they were well informed about children's progress and development. Nearly all staff shared information about learners' progress at weekly meetings and teachers used this information effectively when planning sessions, so that they catered for each learner's individual needs.

5.26 Most teachers used a good range of teaching skills to engage, support and assess learners. They used questioning skills effectively to assess children's understanding of work and gave children positive feedback to reinforce their progress.

5.27 Most teachers used differentiation effectively in class, ensuring that learners of different ability levels made the best possible progress.

5.28 Teachers were very respectful to children and acted as good role models. Nearly all children behaved respectfully in return.

5.29 Staff had high aspirations, encouraging children to progress and achieve beyond the standard that the child had believed possible.

Care, support and guidance

5.30 Staff made sure that children understood and observed social distancing arrangements and the need to take lateral flow tests promptly if they felt ill.

5.31 All children were assessed promptly on arrival to determine literacy and numeracy levels and identify their learning needs.

5.32 Teachers carried out further useful diagnostic reviews to ensure that the targeted support provided met all learners' needs. Education staff explained clearly to children the range of educational options available which helped them to plan how they could best spend their time at Parc.

5.33 A robust and effective tracking system enabled staff to demonstrate that support was helping learners to progress. Nearly all teachers used the system consistently and shared with each other information about learners' outcomes.

5.34 Staff worked together effectively to support individual learners. They closely monitored and briefed each other on learners' behaviour, academic progress and attendance. They updated children's individual educational plans regularly. Staff monitored vulnerable children's progress, behaviour and emerging needs very effectively, sharing information within the team to enable a joint, consistent response to learners' needs.

5.35 Some children were given the chance in cooking sessions to reflect their own culture by making traditional meals.

Leadership and management

5.36 Successful arrangements had been made throughout the pandemic to enable children to continue to progress with their learning. Careful planning enabled children to access workshops or class-based sessions, while minimising their risks of exposure to infection. This enabled children to continue to engage in learning, to gain qualifications and to occupy themselves in a purposeful manner.

5.37 Communication within the education team and with senior managers was highly effective in developing tailored programmes to meet learners' needs.

5.38 Prison staff and managers met regularly to review children's progress and to share information on emerging issues that learners may have been experiencing. This helped the team to understand the children's changing needs and to adapt their teaching to deliver a dynamic and appropriate service to each learner. The very good cooperation and respect between education and wing staff enabled the education team to plan children's education well.

5.39 A newly developed management information system had strengthened the education unit's monitoring of children's performance. The system had improved managers' ability to monitor the performance and quality of education provision and delivery, and to ensure that all staff were making an effective contribution to children's progress in learning.

5.40 The head of the children's unit worked effectively with the prison's head of learning to monitor performance against targets. Managers used data effectively to plan and evaluate provision. All staff understood their individual targets for the achievement of learners' goals.

5.41 Managers undertook comprehensive and honest self-evaluation. They used their findings to inform a process of quality development planning, which analysed evidence and set out appropriate plans for improvement. They allocated resources effectively to reflect their operational planning. Leaders and managers had started to implement a plan to increase the space available to the children's unit in order to develop provision further.

5.42 Leaders took appropriate account of labour market information in reviewing and planning the development of services. They used this information well to evaluate regularly the appropriateness of the provision to meet the needs of the economy.

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 Distance from home continued to present a challenge for children at Parc and, at the time of the inspection, all but one child was more than 50 miles from home. Leaders had recognised the potential difficulty with family contact and had given priority to making sure that children could successfully maintain relationships with family and friends while in custody.

6.2 This good outcome had been achieved by providing impressive access to phone calls and daily access to secure video calls (see Glossary) and social visits, which were available during the evenings, Saturdays and two hours on Sundays. In our survey, 100% of children said they were able to use the phone each day. During the previous six months, 579 video calls had been made. In one example, a child had been able to use a video call to his mother or grandmother every weekday after finishing education.

Video calls room

Children's unit visits area

6.3 Children were positive about the encouragement they received from staff to maintain relationships and, in our survey, 83% of children said that they were helped to keep in touch with their family and friends. The proactive family engagement worker identified children who had not recently booked a video call or social visit and spoke to them to make

sure they were familiar with the booking system and to encourage them to use it.

6.4 A Sunday cooking day had recently been organised for children and their families which lasted three hours. Children could cook homemade food such as curry and chicken and egg fried rice and eat it with their families. Positive feedback had been received from children and their families, particularly those who had travelled long distances. A programme of similar family events was planned for the future.

6.5 At the time of the inspection, two children at Parc were fathers. They received good support and, in one case, staff had helped a child to build a relationship with his baby daughter whom he had never met before entering custody. These fathers had visits with their children in a quiet room separate from the main visits hall which was a thoughtful initiative.

6.6 The range of support available to children and families and the encouragement of staff enabled children at Parc to maintain relationships with family and friends more successfully than at other YOIs. We found evidence of routine involvement by families in sentence planning reviews and handover meetings before children transitioned to the adult estate, which was good practice.

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.

6.7 Strategic management of resettlement was improving. A needs analysis had very recently been completed by the new Youth Custody Service psychology team which showed that a high proportion of children had witnessed or experienced abuse and most were in custody for violent offences. Leaders had not yet used the recommendations from the needs analysis to inform the reducing reoffending strategy and action plan.

6.8 The team of needs, engagement and well-being caseworkers (NEWTs) had regular and meaningful contact with children and their knowledge of individual cases was impressive. Supervision of the NEWTs by managers was now good. The team had one-to-one and group supervision with the effective practice manager which helped to develop consistency, promote good practice and identify training needs. Evidence of the work undertaken by NEWTs on the Youth Justice Application Framework (YJAF) was very good.

6.9 The NEWTs made considerable efforts in all cases to identify and contact relevant workers from community agencies, such as the child's youth offending team (YOT) or social worker, and encourage them to

make direct contact with the child. This approach was particularly successful and helped children to maintain relationships with support services in the community to prepare for release.

6.10 Planning was reasonable for the increasing number of children who required transition to adult prisons. At the time of our inspection, seven sentenced children would need to transition to adult prisons when they reached 18 years of age. Transitions were discussed at sentence planning reviews, and handover meetings with the receiving establishment were held about a month before the transfer. These meetings involved a member of staff, usually a prison offender manager, from the receiving establishment and other agencies such as YOT, probation and the child's family where possible. Good links had been established with young adult prisons to improve the information that children and their families received before the transfer.

6.11 Children who were eligible were helped to access home detention curfew (HDC), early release and release on temporary license (ROTL, see Glossary). Two children had used ROTL in the previous six months: one had met a personal adviser in the community and the other had attended a bank appointment. The targets that children needed to work towards to achieve ROTL were discussed at sentence planning meetings.

Training planning and remand management

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

6.12 We reviewed 10 cases, all of which had an up-to-date plan which was appropriately shared with community agencies using YJAF. In all cases, there was evidence of effective and frequent communication between NEWTs, YOTs, probation, social workers and parents to inform realistic targets for children.

6.13 Sentence planning in the cases that we reviewed was good. In our survey, 67% of children said they had a plan and 100% of these children said that they understood what they needed to do to achieve their objectives and targets. This was reflected in our interviews at which children could recognise and describe their targets.

6.14 Children's sentence and remand plans were reviewed regularly and activities in the prison were generated from the reviews. The two sentence and remand planning meetings that we observed were of a particularly high quality and attended by a range of participants, including community agencies and families. Comprehensive records

were made at these meetings of the work undertaken in each area and the progress made.

6.15 Children made good progress against their sentence plans, particularly in education. In our interviews, children said that the education at Parc was particularly good, commenting positively on the breadth of the curriculum and the opportunity to study new subjects such as cookery and music.

Public protection

6.16 Procedures to identify children who posed a potential risk to the public were sound. At the time of the inspection, seven children were subject to multi-agency public protection arrangements (MAPPA), an increase since the previous inspection. Five of these required management at level 2 or 3, which required active involvement by agencies such as the YOT, police and/or probation to manage the risk of serious harm. NEWTs had regular communication with these agencies and shared information effectively through virtual attendance at MAPPA meetings and written contributions describing the child's behaviour in custody (MAPPA-F).

6.17 Children subject to MAPPA who were due to be released were reviewed by leaders and NEWTs at quarterly resettlement meetings and during regular case supervision. Children who were due to transition to adult prisons were reviewed at handover meetings. Risk management plans that we reviewed were of a reasonable quality and were informed by discussions with YOTs about the risk of harm on release.

6.18 Other public protection procedures to inform risk management were robust. No children were on mail or telephone monitoring at the time of the inspection, but we reviewed previous monitoring logs which were up to date and accessible to NEWTs.

Indeterminate and long-sentenced children

6.19 Support for the increasing number of children held on indeterminate or long-term sentences was underdeveloped and too limited compared to other YOIs. At the time of our inspection, eight children were held on remand or were serving sentences for murder or attempted murder, an increase since the previous inspection.

6.20 Children who had received indeterminate or long sentences received regular contact with their NEWT and had the same sentence planning review meetings as other children at Parc. Multi-agency lifer risk assessment panels were conducted for appropriate children and the recently introduced YCS psychology service contributed to sentence planning and parole reports. Plans were under way for the team to start delivering the 'Life Minus Violence - Enhanced' (LMV-E) intervention, which aimed to work one to one with children with the highest level of risk for violence.

Looked-after children

6.21 In our survey, 47% of children said that they had been in the care of the local authority. Data showed that of the 19 children at Parc at the time of the inspection, 17 had involvement with children's services. In March 2022 alone, eight children had become looked after on being remanded into custody.

6.22 The social worker post had been vacant for an extended period and there was a lack of independent advocacy for looked-after children. NEWTs were doing their best to fill the gap by challenging local authorities to make sure that looked-after children received their entitlements and that review meetings took place when required. NEWTs also challenged YOTs when children who had experienced exploitation had not been referred to the national referral mechanism.

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.

6.23 Reintegration planning and outcomes for children on release had improved. Over the last 12 months, 25 children had been released, most of whom had their address confirmed before their final release meeting. Three children had late confirmations and in one case a child did not know where they would be living until the day before their release date. This had a negative impact on the child's plans for education and health. Leaders had ensured that escalation processes for issues with accommodation were used and NEWTs routinely referred to Barnardo's and the Howard League for advice when needed.

6.24 Outcomes in education, training and employment for children on release were reasonably good and better than we see at other YOIs. Most children were not in education, employment or training on arrival at Parc, but during the last 12 months 19 had a placement in education, training or employment planned for release. This included apprenticeships, college and, in some cases, a return to full-time education. Four children had left with referrals to career advisers, but two children had left with no arrangements in place at all.

6.25 NEWTs attended throughcare meetings in the community after children had been released, but these meetings were not yet establishing sustainable resettlement outcomes for children.

Interventions

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

6.26 Before interventions work started, NEWTs completed a readiness assessment with children to identify individual factors that needed to be reflected in the delivery of the intervention. This also helped to establish a child's motivation to engage successfully in the intervention. Two interventions were delivered: motivate to achieve (M2A) focused on goal setting which had been completed by five children; and 'timewise' aimed at children involved in violence while in custody. Two children had recently started this programme.

6.27 Leaders had plans to increase the number of interventions. LMV-E was due to be delivered by the psychology team (see paragraph 6.20) and NEWTs were working on a programme of psychoeducational work, such as knife crime awareness, which focused on offence-related behaviours.

Health, social care and substance misuse

6.28 Nurses met children to plan for transition to the adult estate or for release four weeks beforehand. Every child was seen on the day of release or transition and given medication to take home where appropriate.

6.29 Support for substance misuse was provided before release or transfer, and the psychosocial worker liaised with relevant agencies and prison teams to deliver continuity of care. The psychosocial worker saw children on the day of release and one month later to signpost them to relevant services if required.

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): The unit had not had a dedicated social worker for an extended period. This had reduced the support and advocacy available to the increasingly large proportion of children who were in the care of their local authority or who had some involvement with social services. Managers responsible for safeguarding and child protection did not have a source of expertise to refer to on site.

Key recommendation: The unit should have a dedicated, on-site social worker.
(To the Youth Custody Service)

7.2 Key concern (1.42): A very sick child who needed to be in hospital had been placed at Parc and segregated for 14 days in 2021 before a move to hospital was arranged.

Key recommendation: Children who need a hospital placement should not be sent to prison as a place of safety.
(To the Ministry of Justice)

7.3 Key concern (1.43): There was no oversight or responsibility for equality and diversity work at Parc and analysis of data remained limited. Children we spoke to felt supported by staff and their needs were being met, but gaps in provision could cause risks.

Key recommendation: Leaders should provide effective oversight of equality and diversity work at all times and data should be scrutinised thoroughly, considering all protected characteristics.
(To the director)

7.4 Key concern (1.44): Support for the increasing number of children with indeterminate or long-term sentences was underdeveloped and limited compared to other YOIs. More children than at the previous inspection were held on remand or were serving sentences for murder or attempted murder.

Key recommendation: There should be an appropriate range of support to meet the risks and needs of children serving indeterminate or long sentences.
(To the director)

Recommendations

7.5 Recommendation (3.18): Observational checks on children should not be carried out at predictable intervals.
(To the director)

7.6 Recommendation (3.39): Managers should make sure that debriefs following restraint are comprehensible and useful to children.
(To the director)

7.7 Recommendation (4.8): Windows should be free of graffiti and dirt, and maintenance should be carried out on broken air vents.
(To the director)

7.8 Recommendation (4.16): Consultation should include the views of all children and actions should be addressed in a timely manner.
(To the director)

7.9 Recommendation (4.56): Children should have access to a wider range of therapeutic interventions, including speech and language therapy.
(To HMPPS/YCS and the health care provider)

7.10 Recommendation (4.57): FACTS should contribute to the prison-based clinical record system to ensure that there is a single, comprehensive record of assessment, care and treatment for children in their care.
(To the director and the health care provider)

7.11 Recommendation (4.72): Children should have prompt access to pain relief at the weekend and overnight.
(To the director and the health care provider)

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, reception processes were swift and the induction had improved since the previous inspection. Child protection arrangements were well embedded. Care for children at risk of self-harm was good but monitoring was too predictable. Levels of violence had reduced but were still high. Challenge, support and intervention plans were used effectively to address bullying and violence and support victims. The incentives scheme was motivational and good relationships between staff and children supported effective behaviour management. Use of force remained high and governance was good. Separation was only used for very short periods and oversight had improved. Outcomes for children were reasonably good against this healthy establishment test.

Key recommendation

HMPPS should ensure that all children at Parc can make direct phone calls on their first day in custody. (S43)
Not achieved

Recommendations

Observational checks on children should not be carried out at predictable intervals. (1.17)
Not achieved (recommendation repeated, 3.18)

CCTV monitoring should not be used in place of meaningful human interaction and personal observation. (1.18)
Achieved

All children should have the opportunity to seek advocacy in good time before an adjudication. (1.36)
Achieved

Care

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

At the last inspection in 2019, children were positive about staff and we observed good, caring interactions throughout the inspection. These good relationships supported outcomes in all areas of life at Parc. The standard of accommodation was generally good and the complaints and application systems worked well. Children were able to eat all their meals together, but the quality of food required improvement. Equality and diversity work generally met individual needs. Faith provision remained good. Health care services remained generally good but there were deficiencies in the CAMHS service. Outcomes for children were good against this healthy establishment test.

Key recommendations

Data should be scrutinised thoroughly to ensure that behaviour management processes are not discriminatory. (S44)
Not achieved

Child and adolescent mental health services should deliver a suitable range of assessments, treatment and interventions for children in line with national standards. (S45)
Not achieved

Recommendations

Child and adolescent mental health services should contribute good quality clinical records to a single contemporaneous health record for the children in their care. (2.54)
Not achieved

Information governance practices should accord with professional standards. (2.55)
Not achieved

Integrated substance misuse services should provide adequate assessments, interventions and discharge plans to improve outcomes for children. (2.62)
Achieved

Purposeful activity

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

At the last inspection in 2019, time out of cell remained far better than at other YOIs and during our roll checks all children were out of their cells. The library facilities and access were reasonably good and PE provision was excellent. Achievement rates had improved from the high levels seen at our last inspection. Children with additional needs and those from a black and minority ethnic background progressed at the same rate as other learners. Nearly all children attended education regularly and developed good attitudes to learning. Teaching was very good; teachers had high expectations of children, differentiated well to meet need and planned lessons effectively. Managers delivered an appropriate curriculum and provided children with the support they needed to progress. Outcomes for children were good against this healthy establishment test.

Recommendations

The vocational skills curriculum should be broadened so that children have more opportunity to join a vocational course or employment on release. (3.12)
Partially achieved

Provision should be made for children who are speakers of other languages so that they can develop their oral English to a functional level. (3.13)
Partially achieved

Managers should ensure that children can access reliable virtual learning resources. (3.17)
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, support for children to maintain contact with their family and friends was very good. There had been gaps in the management of resettlement over the previous year which had led to drift in some provision. The needs engagement and wellbeing team held low caseloads and had frequent meaningful contact with children. Planning meetings were well attended and supported by residential staff. Prison staff were beginning to challenge community partners to improve resettlement outcomes for children. Public protection arrangements were reasonable. Despite the best efforts of staff, there were cases where accommodation was not confirmed early enough to enable education and health care needs to be met. Outcomes for children were reasonably good against this healthy establishment test.

Key recommendation

Leaders and managers should provide effective oversight of the delivery of resettlement work to ensure that assessments are robust, children's needs are met and there are clear escalation routes for concerns. (S46)
Achieved

Recommendations

Children on remand who are transferring to adult prisons should be given full information about the establishment they are going to. (4.15)
Achieved

There should be management oversight of all high risk of harm cases to ensure that actions to mitigate the risk that children might pose have been completed before release. (4.27)
Achieved

The prison should ensure that children are allocated to interventions based on their offence related behaviour and release date. (4.41)
Not achieved

Recommendations from the scrutiny visit

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

Eighteen-year olds held in children's establishments should be properly supported during their transition to the most suitable prison in the adult estate. (S3)
Achieved

Children should be found suitable accommodation early enough before their release to allow for resettlement plans to be fully achieved. (S4)
Not 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 Estyn or Ofsted (England), the General Pharmaceutical Council (GPhC) and occasionally 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:

Martin Lomas	Deputy chief inspector
Angus Jones	Team leader
Liz Calderbank	Inspector
Angela Johnson	Inspector
Lindsay Jones	Inspector
Chelsey Pattison	Inspector
Rebecca Stanbury	Inspector
Donna Ward	Inspector
Rachel Duncan	Researcher
Amilcar Johnson	Researcher
Joe Simmonds	Researcher
Sarah Goodwin	Lead health and social care inspector
Claire Price	Health Inspectorate Wales inspector
Alun Connick	Estyn lead inspector
David Tiddy	Estyn 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/

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.

Custody support plan (CuSP)
A care planning approach that provides each young person with a personalised officer to work with on a weekly basis in order to build trust and consistency.

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

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

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.

Restricted status
Restricted status is the equivalent of category A in the adult male estate. It is applied to any child convicted or on remand, whose escape would present a serious risk to the public.

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) which 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 reports distributed to the establishment). For this report, these are:

Establishment population profile

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

Survey of children – methodology and results

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

Establishment staff survey

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

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

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

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