Report on an unannounced inspection of

HMYOI Feltham A

by HM Chief Inspector of Prisons

4–14 March 2024

Contents

Introduction

At our 2022 inspection of HMYOI Feltham A, we awarded some of the best healthy establishment test scores achieved in recent years at this west London jail. It was disappointing to return to find there had been a deterioration in standards with levels of violence now the highest of any prison in the country.

In the summer of 2023, things had got particularly bad, with a dramatic increase in the number of assaults and a serious incident in the education block that led to its closure from 22 August until early September. It is to the credit of the governor and some impressive functional leaders that this decline has begun to be arrested.

Violence is at the root of almost all of the challenges that we found during this inspection. There has been an increase in extensive 'keep apart' lists that can become as much a cause of violence as they are a solution. There were 266 different instructions to prevent children from mixing, which inevitably affected the amount of time that boys could spend out of their cells with multiple regimes being run on the same unit. This limited access to education and meant that rather than being placed in classes with those who had similar abilities and interests, allocations were based on who could be put in the same room without fighting. Keep aparts also limited boys' access to visits and meant that medical appointments were being missed.

In the education block, the risk of fights breaking out meant that there were many staff patrolling the corridor and complicated arrangements to move groups of children in and out of the building. It was good to see some of the vocational courses such as barbering, cadets and horticulture operating well, but it was astonishing that the youth custody service and the education provider had allowed the introduction of a curriculum for English and maths that was not fit for the needs of the children at Feltham. There was also a shortage of level 3 courses on offer for the more able children.

A hallmark of this inspection was the generally good relationships that we observed. Staff knew the children in their care well and worked hard to engage the most challenging and needy.

Although parts of the buildings were looking tatty, particularly some of communal areas and the rooms used for small group work on the units, many cells had been refurbished and now contained showers.

Public protection arrangements were still not as good as they could have been, with the assessment and management of risk not taking place early enough. Although there had been some recent improvement, delays in release preparation meant that many of the boys still did not know where they were going to be living until just before release and this made it difficult for them to get into education, training or work.

In my introduction to the last Feltham YOI inspection in 2022, I ended by saying, 'even when things are going well, because of the nature of the children it serves, Feltham is a fragile place and close attention and support from the

Youth Custody Service (YCS) will be essential.' This inspection manifested that fragility: hardworking, dedicated staff and leaders continued to do their best, but the serious deterioration in the institution that took place last summer was taking a long time to put right. In the meantime, children were not safe enough; they were locked in their cells for far too long and the provision of education was inadequate.

Charlie Taylor
HM Chief Inspector of Prisons
March 2024

What needs to improve at HMYOI Feltham A

During this inspection we identified 10 key concerns, of which seven should be treated as priorities. Priority concerns are those that are most important to improving outcomes for children. They require immediate attention by leaders and managers.

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

Priority concerns

1. **Levels of violence and disorder were very high**. Conflict and keep aparts negatively affected many aspects of life at Feltham, including access to a meaningful regime, medical appointments and visits.

2. **There was a lack of support for the most vulnerable children.** The closure of Alpine unit had led to increasingly long periods of separation.

3. **Children spent too much time locked in their cells.**

4. **Leaders did not make sure that staff used children's starting points effectively to teach a well-structured curriculum in English and mathematics. Too few children achieved their qualifications.**

5. **Leaders did not make sure that children took part in sufficient education or that children attended, as expected, to make swift progress and gain substantial new knowledge and skills to help them in their next steps.**

6. **The provision to help children maintain family contact was poor.** There were insufficient opportunities for social visits and video calls were not promoted well enough to children.

7. **The identification and review of children's risk levels were weak.** Resettlement practitioners had not received adequate training in public protection risk management and children that were high risk of harm were not reviewed regularly.

Key concerns

8. **Levels of self-harm had increased and were too high.**

9. **Leaders did not provide a sufficient curriculum offer at level 3 to support children to progress and meet their educational needs and interests.**

10. **Leaders did not have sufficient oversight of the quality of the education provision and had not improved it significantly.**

About HMYOI Feltham A

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

Certified normal accommodation and operational capacity (see Glossary) as reported by the establishment during the inspection
Children held at the time of inspection: 84
Baseline certified normal capacity: 211
In-use certified normal capacity: 168
Operational capacity: 120

Population of the establishment
- 186 children received last year
- Five foreign national children
- 80% of prisoners from black and minority ethnic backgrounds
- 29% of children aged 18
- An average of 12 children released into the community each month

Establishment status (public or private) and key providers
Public

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

Prison group/Department
Youth Custody Service

Prison Group Director
Sonia Brooks OBE

Brief history
The original Feltham was built in 1854 as an industrial school and was taken over in 1910 by the Prison Commissioners as their second Borstal institution. The existing building opened as a remand centre in March 1988. The current HM Prison and Young Offender Institution Feltham was formed by the amalgamation of Ashford Remand Centre and Feltham Borstal in 1990–1991.

Short description of residential units

Alpine:	Enhanced support unit (ESU) (currently closed for refurbishment)
Bittern:	Normal location
Curlew:	Platinum community
Dunlin:	Normal location
Eagle:	Closed for refurbishment

Falcon: Reintegration unit
Heron: Normal location
Jay: Induction unit
Grebe: Closed

Name of governor and date in post
Natasha Wilson, April 2022

Changes of governor since the last inspection
Emily Martin, 2018 – March 2022

Independent Monitoring Board chair
Jane Shalders

Date of last inspection
21 February – 4 April 2022

Section 1 Summary of key findings

Outcomes for children

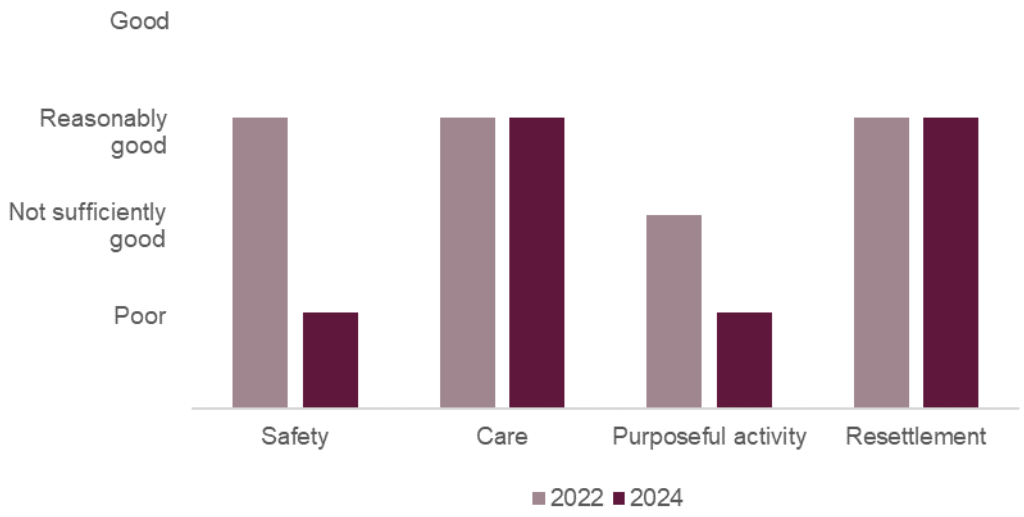
1.1 We assess outcomes for children against four healthy establishment tests: safety, care, purposeful activity and resettlement (see Appendix I for more information about the tests). We also include a commentary on leadership in the establishment (see Section 2).

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

- Poor for safety
- Reasonably good for care
- Poor for purposeful activity
- Reasonably good for resettlement.

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

Figure 1: HMYOI Feltham A healthy establishment outcomes 2022 and 2024



Progress on priority and key concerns from the last inspection

1.4 At our last inspection in 2022, we made 13 recommendations, nine of which were about areas of key concern. The establishment fully accepted 12 of the recommendations and partially (or subject to resources) accepted one.

1.5 At this inspection we found that one of our recommendations about areas of key concern had been achieved, one had been partially achieved and seven had not been achieved. For a full list of progress against the concerns, please see Section 7.

Notable positive practice

1.6 We define notable positive practice as:

> Evidence of our expectations being met to deliver particularly good outcomes for prisoners and/or detainees, and/or particularly original or creative approaches to problem solving.

1.7 Inspectors found five examples of notable positive practice during this inspection, which other institutions may be able to learn from or replicate. Unless otherwise specified, these examples are not formally evaluated, are a snapshot in time and may not be suitable for other establishments. They show some of the ways our expectations might be met but are by no means the only way.

Examples of notable positive practice		
a)	The safeguarding team checked cell bell response times each week. This had produced good results with one unit recording every response within five minutes for over a month.	See paragraph 3.13
b)	Every child, whether sentenced or on remand, was offered an annual health review and given the opportunity to explore health and well-being issues.	See paragraph 4.58
c)	The innovative weekly health care clinic for separated children had led to improved communication and outcomes. For example, one child who had been very resistant to receiving an MMR booster vaccination had had the opportunity to ask questions and had, after some time, changed his mind.	See paragraph 4.62
d)	The introduction of vocational training at weekends was an innovative approach to encouraging children to make productive use of their time.	See paragraph 5.6
e)	Support for children sentenced to life and long sentences was good. This included therapy, one-to-one support and group meetings for children to support each other.	See paragraph 6.18

Section 2 Leadership

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

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

2.2 Feltham had undergone several management changes since the previous inspection including the governor and deputy governor. This had been done in a planned way and we found a stable leadership team in place at the time of the inspection. There was also a new deputy director of operations at the Youth Custody Service (YCS) who visited the site frequently and her reports demonstrated an accurate understanding of the difficulties faced by leaders and staff and the outcomes for children.

2.3 Leaders had faced a very challenging summer in 2023. In the face of staff shortages on top of planned annual leave, managers were unable to deliver a consistent daily routine for children. This led to high levels of protesting behaviour which further reduced time out of cell. Combined with extremely high levels of violence, this meant that leaders had been unable to deliver basic entitlements to children, including education.

2.4 It was commendable that the governor, supported by the YCS and some very good managers in safeguarding, residence and reducing reoffending, had stabilised the prison, implemented an aspirational core day and made improvements from this time. Despite this progress, significant problems remained, principal among them being the high levels of violence, which continued to be the highest of all YOIs, the number of children kept apart from one another because of conflict and the limited time out of cell many children received.

2.5 In the face of these challenges, it was impressive that leaders had created a positive culture among front-line staff who were keen to do their best for children in their care. We saw many examples of staff working with children to address their needs.

2.6 Leaders were not providing all children with their statutory entitlement to education. Managers aimed to provide children with 15 hours of education each week but in practice many children received far less than this. Despite the education contract having been in place for over a year, leaders in the YCS and the education provider had failed to make sure there was a suitable English and mathematics curriculum at the time of the inspection.

2.7 The enhanced support unit (ESU) had been closed following damage by a child in autumn 2023. While some disruption was inevitable while the unit was refurbished, we were concerned to hear that there would be no provision at Feltham for children with particularly high levels of need until summer 2024. As a consequence, three children who would have benefited from this specialist support had been separated for extended periods on Falcon unit. This limited the ability of managers to offer a productive routine to all separated children.

2.8 Governance and oversight of health care were very good. The service was well led and children had very good access to a good range of health care services.

Section 3 Safety

Children, particularly the most vulnerable, are held safely.

Early days in custody

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

3.1 Most children arrived on vehicles that were clean and suitable. During the previous six months, 25 children had arrived after 8pm. This was not appropriate because it limited the support that staff could give to them before they were locked in their cell. The escort staff generally offered them snacks and a drink in transit and reception staff offered them a hot meal and drink on arrival. Children were able to make a phone call and have a shower if they wished.

3.2 The reception area was clean and tidy and holding rooms contained comfortable furniture and televisions displaying information relevant to children on arrival.

Reception holding room

3.3 Children had an initial safety interview followed by a private health screen conducted by a member of the health care team. Staff who worked in reception also worked on the first night unit, which meant that important information was shared effectively with staff who would be looking after them.

3.4 The induction unit had been moved to Jay unit which was due for refurbishment and did not have showers in the cells. Cells, while worn, were well equipped.

3.5 The induction programme covered most of the key areas of prison life including education, gym and conflict resolution. In our survey, just 57% of children said they were told everything they needed to know about life at Feltham. The initial stage of the induction, which included key procedures such as making an application or booking a visit, was sometimes rushed which limited children's ability to retain the information. New arrivals were moved from the induction unit after a week.

3.6 Children had very few opportunities to socialise with their peers during their induction. This was due to staff keeping them apart to minimise conflict (see paragraph 3.35) as well as the mix of different groups located on Jay unit. This included those from other prisons who were lodging during their trial and some vulnerable children were placed there for their own safety. As a consequence, staff were managing seven groups for 11 children.

3.7 Unit leaders and staff worked hard to get children out of their cells during the day. Despite their efforts, new arrivals spent most of their time locked in their cells in common with the other children at Feltham.

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 Despite very high levels of violence, children's perceptions of safety were reasonable and 8% said they felt unsafe in our survey. Children told us that they were reassured by the generally good relationship they had with staff.

3.9 Oversight of child safeguarding was good, with particularly strong links with the local authority. There were three local authority employed social workers in post who triaged every safeguarding concern and referred any that met the threshold to the local authority designated officer (DO) swiftly for investigation.

3.10 DO contact was good and they contributed well to safeguarding by regular attendance at several meetings at Feltham, including the

weekly risk management meeting. We saw evidence of collaborative working between the head of safeguarding and the DO.

3.11 During the previous 12 months, there had been 150 referrals, six of which had met the threshold and had been investigated by the DO. These referrals originated from a wide range of sources, including children and their families, and most were responded to quickly. Every referral was thoroughly investigated and a response sent to the person making the referral.

3.12 A team of three safeguarding officers conducted initial investigations into these concerns and saw most children who were victims or perpetrators of violence to make sure they were being supported.

3.13 This team also checked cell bell response times each week and asked staff and leaders to explain where it had taken more than five minutes to respond. This had led to improvement and one unit had recently recorded every response within five minutes for more than a month. This was reflected in our survey findings where 53% of children told us their emergency call bell was normally answered within five minutes compared to 32% at other young offender institutions (YOIs).

3.14 During our night visit, we observed staff with cell keys that were not held in a pouch with a tamperproof numbered seal (a safeguard used in most prisons to make sure that staff report when they enter a cell during the night), which was an unsafe practice.

Suicide and self-harm prevention

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

3.15 Levels of self-harm had risen substantially since our last inspection. During the previous 12 months, there had been 171 instances of self-harm compared to 40 during the same period before our last inspection. Levels of serious self-harm remained similar with nine children requiring treatment in hospital compared to seven at our last inspection.

3.16 Instances of self-harm had increased during the summer of 2023 due to prolific self-harm by a small number of children. Leaders had managed this well and the child with the most instances of self-harm had been moved to a secure hospital that offered better support for his mental health needs. Levels of self-harm had subsequently reduced but remained higher than previously.

3.17 We spoke to children who were being supported through the ACCT process (assessment, care in custody and teamwork case

management of children at risk of suicide and self-harm) who told us they felt well cared for.

3.18 Oversight of self-harm was largely good and regular quality assurance of ACCT documents had resulted in improvement. The quality of ACCT documents was better than we usually see. Safeguarding officers checked each one daily and provided feedback to staff. The feedback that we observed was child centred and focused on the quality of contact with staff.

3.19 Support plans for children in crisis were detailed and tailored to the needs of the child, who was invited to regular multi-agency reviews. The most complex cases were discussed at the weekly risk management meeting and progress against actions was also reviewed at this meeting.

3.20 Leaders did not routinely view data on self-harm and were unaware of the main causes or trends. There was no strategic plan to reduce the level of self-harm. Every incident of self-harm was reviewed but no learning or actions were generated following serious self-harm or near misses to try to prevent future occurrences.

3.21 An ambulance was now called as soon as a code blue was called and control room staff in the prison relayed information from the incident scene to the ambulance service. Once the ambulance had been called, only a health professional at the scene could cancel it.

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.

3.22 There had been a substantial rise in incidents of disorder over the past year to 320, an increase of more than 300% since the last inspection. The frequency of these incidents was higher than at any other establishment in England and Wales. They included children climbing and staying at height and acts of concerted indiscipline, many caused by conflict between children and frustration over the regime. The frequency of these incidents caused regular curtailments to the regime and demonstrated how fragile the stability was at the prison.

3.23 During the previous year, 343 weapons had been found which was a substantial rise from the 122 found before our previous inspection. Leaders had introduced a weapons strategy in recent months that sought to manage those found with a weapon and minimise the risks they posed. Other measures included, only allowing children to wear ankle socks to reduce the harm that could be caused by heavy objects in socks. This had already had an impact since its introduction at the end of 2023, with the average number of weapons found each month reducing by half.

3.24 In the last year, 49 children had been strip-searched, including four under restraint. The authorisations that we reviewed did not always indicate why the search had taken place. We were not confident that there was an immediate threat to safety or security or that there were no other reasonable options available to resolve the situation.

3.25 At the time of the inspection, one restricted-status (children whose escape would present a serious risk to the public, the equivalent of category A prisoners in adult prisons) child was subject to additional security measures. New arrivals who were potentially of restricted status had limited contact with their families while they were assessed.

3.26 Security information was triaged and disseminated appropriately. During the previous six months, 1,391 intelligence reports had been submitted. Actions in response to intelligence were often limited. During the previous year, 167 targeted searches had been requested, mostly for contraband such as drugs, phones and weapons, but just under a third had been completed. Despite finds and intelligence of drugs, there had been no testing of children for substances due to a shortage of resources.

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.

3.27 Formal behaviour management systems had deteriorated. Leaders had completed a review and some systems were improving, but many depended on a reliable, motivational daily routine to be fully effective.

3.28 The three-tier incentives scheme was in place. Curlew unit was designed for children on the gold level who received far more time out of cell than their peers because they were all in one group. This afforded a good incentive to encourage positive behaviour. However, children on gold level who resided on other units had very limited incentives to behave. In principle those who behaved badly and were on the lowest level of the scheme (bronze), should have missed out on some of their activities. However, because these activities were regularly cancelled for all children, they saw very little impact. Similarly, children who had their television removed were left in possession of their DVD player, which children could use via their laptops to watch DVDs.

3.29 The instant reward scheme had limited effect. Green and yellow cards could be issued to children to recognise positive or negative behaviour. These should have provided an instant sanction or monetary reward but, because of the inconsistent regime, children could wait several days for their sanction and very few positive rewards were given out.

3.30 More serious charges were dealt with through the adjudication process. The rise in violence and disorder had increased the number of adjudications since the previous inspection, with 2,210 in the last 12 months. The timeliness of hearings had lapsed during the summer of 2023 but had improved in recent months. The most serious charges were referred to the police, but long delays often ensued. At the time of our inspection, 40 charges were outstanding but 27 of the children were no longer at the establishment, which was poor. There was not enough use of the independent adjudicator, with less than 2% of cases referred in the last year. Contact between prison leaders and the police had recently improved and a crime clinic had been introduced at the beginning of 2024.

3.31 In our last inspection report, we had been positive about Alpine unit where more vulnerable or challenging children had been supported. However, this had been closed towards the end of 2023 following damage, and we found that those who would have benefited from this environment as a way to manage their risk were separated in Falcon unit (see paragraph 3.44).

3.32 All children were discussed in rotation at the weekly core support meeting. These meetings had started to improve, with wider attendance by staff and more engagement by children. They provided a good opportunity for staff to discuss behaviour and other issues on each unit with a multidisciplinary team.

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.

3.33 Recorded rates of violence during the previous year had been higher than any other establishment in England and Wales. There had been 410 incidents of violence, a substantial increase on the 182 incidents in the 12 months before the last inspection.

3.34 The considerable increase in violence had started in the early summer and peaked in November 2023. A series of simultaneous events, including a rise in conflict and a subsequent reduction in time out of cell, had been compounded by an increasing population and staff shortages. Leaders had commendably arrested the serious decline through appropriate targeted action, including more time out of cell, improving delivery of the custody support plan (CuSP) and core support meetings, and the introduction of the weapons strategy. However, while overall levels of violence had been reducing in the previous three months, they were still much too high.

3.35 Conflict between children affected many aspects of life adversely, including access to time out of cell, education and health care. The number of keep aparts had increased from less than 200 in early 2023,

peaking at around 500 in September. The conflict resolution department was not fully staffed which was concerning given the impact of conflict in the establishment. At the time of the inspection, staff were managing 266 keep aparts in the population of 84 children, and many units were operating with three or more groups, which limited the time children spent out of their cells.

3.36 Investigations into violence lacked depth, which limited leaders' understanding of the causes. Weekly, monthly and quarterly safety meetings took place. The weekly and quarterly meetings were well attended and generated good actions, but the monthly meeting had inconsistent attendance, which limited its effectiveness. Data were not used well enough to improve understanding of the causes and types of violence.

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.

3.37 The rate of use of force had increased 68% since the previous inspection and was the highest of all YOIs. There had been 1,220 incidents in the last year.

3.38 Most incidents occurred to prevent assaults or fights. The incidents that we viewed were justified, principally as a response to violence and disorder, but some lacked evidence of attempts to de-escalate at the earliest opportunity. Nearly all incidents were ended once the child was back in his cell, and very few full relocations took place (full relocation involves a child being controlled in a specific position on the floor to allow staff to exit the room).

3.39 Scrutiny and oversight of incidents were reasonable, although in some incidents video footage did not cover the whole incident. Leaders did not routinely monitor data on the use of body-worn cameras or their use before an incident had started, which was a missed opportunity.

3.40 Important administrative processes, including the completion of paperwork required after a restraint, had been in disarray. Leaders had reduced the backlog from 900 outstanding reports to less than 100, but the quality of the paperwork was variable.

Separation/removal from normal location

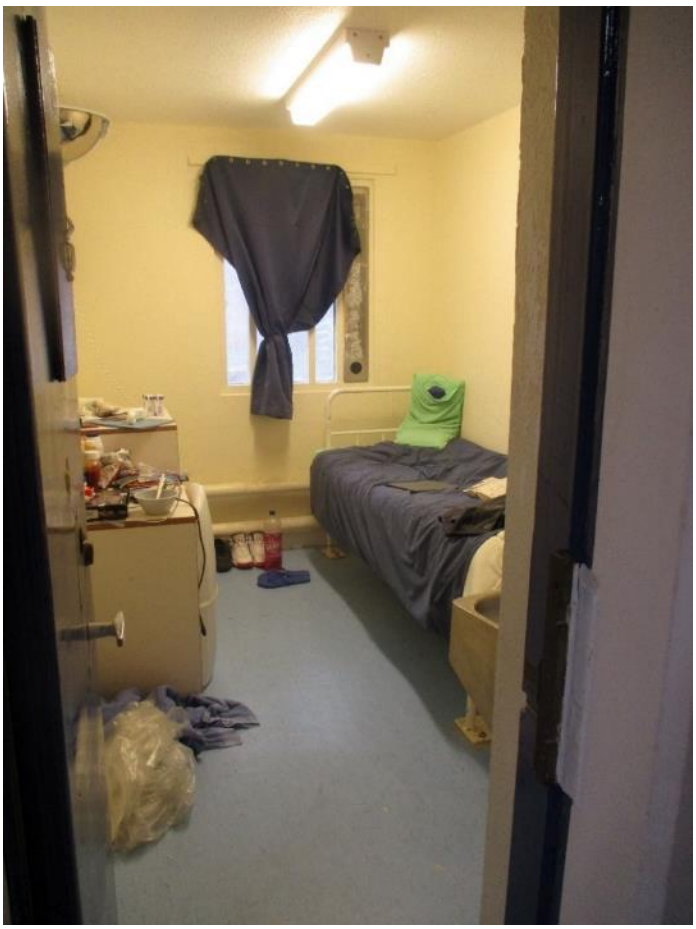
Expected outcomes: Children are only separated from their peers with the proper authorisation, safely, in line with their individual needs, for appropriate reasons and not as a punishment.

3.41 Segregation had increased sharply since the last inspection and was at a high level. During the last year, there had been 289 episodes, compared to 109 in the 12 months before the last inspection.

3.42 Reintegration planning started on the day a child was separated, which was positive. However, the average length of separation had increased from 7.5 to 10.5 days following the closure of the Alpine unit and the introduction of the weapons strategy. Some very prolonged separations were concerning, including seven children who had been separated for more than 50 days, two of them for more than 100.

3.43 Unfurnished accommodation had been used on four occasions in the last year. Stays had been short, with most lasting for less than an hour. On three of these occasions, we found its use to have been unnecessary.

3.44 Most children who were separated lived on the Falcon unit where the overall conditions were reasonable. Cells were being painted but the shower areas had mouldy ceilings and there was some graffiti. Children we spoke to were positive about the staff on the unit. The closure of Alpine resulted in more children than previously living on Falcon unit which made it more difficult for staff to make sure that each separated child received a productive routine including meaningful human interaction each day.



Occupied segregation cell

3.45 Leaders had recently implemented a routine for separated children that allowed more access to education and other activities. This was still not equal to other children because the increasing use of separation limited the ability of staff to deliver a productive routine for each child. Leaders had introduced a range of creative activities in the weeks before the inspection, including yoga and a well-being session, which was good (see paragraph 4.63). Leaders had worked hard to make sure there was oversight, which included quality assurance of paperwork and meetings.

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 It was a credit to staff and managers that they had maintained positive relationships with children despite the challenges of the previous six months. We saw many friendly and helpful interactions during the inspection. In our survey, 84% of children said they felt staff treated them with respect. In interviews they described staff as mostly fair but not always reliable when it came to delivering activities.

4.2 The number of custody support plan (CuSP) sessions was steadily improving after a decline in summer 2023 and was better than at similar YOIs. This reflected careful planning by leaders to allow time for sessions to take place. We saw instances of staff taking advantage of opportunities to offer CuSP sessions whenever they could. Management checks were carried out to make sure that sessions took place regularly and staff spoke positively about their CuSP work. Some linked these sessions with daily activities such as helping children to keep their cells in decent condition (see paragraph 4.6). Most children found these sessions helpful and electronic case notes reflected detailed conversations and staff developing a greater understanding of the children.

4.3 The positive picture was not reinforced by staff from other departments who too often talked to children through their doors. This compromised confidentiality and did not encourage meaningful discussion.

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 mostly clean and tidy and efforts had been made to equip them with recreational activities. ‘Corner rooms’ were

used for various purposes including one-to-one meetings, outreach education, association, Kinetic Youth sessions and communal eating. These rooms were often uninspiring and leaders had started to remedy this with wall art, but not enough had been done to make them age appropriate. Similarly, outdoor exercise areas were drab for children using the exercise equipment.

Exercise area

4.5 Each child had their own cell which was adequately equipped. Some were more personalised than others with photos, cards or certificates. There was some graffiti despite efforts to eradicate it. Most cells now had integral shower units and toilets. Our survey reflected an improvement with 91% of children saying they could shower every day compared to 64% at the inspection in 2022. Children on two units, Jay and Falcon, still shared communal showers which were in reasonable condition but with poor ventilation and peeling ceiling paint.

Communal showers on J unit (top) and in-cell shower unit

4.6 Staff carried out daily cell checks, awarding marks out of 10 for cleanliness and tidiness. We saw examples of staff helping children to understand what was expected of them and showing them how to

clean their cells properly. Access to clean bedding, towels, clothing and cleaning materials was generally good and children now had adequate access to laundry facilities.

Occupied cell

4.7 Children had in-cell telephones and a laptop. The laptops provided useful information about the YOI and were used by leaders to communicate with children and seek their views (see paragraph 4.14). Children used the laptops to contact departments and to make food and shop orders.

Residential services

4.8 In our survey, 44% of children said the food was good or quite good and 46% that they usually got enough to eat, similar to comparable YOIs and the 2022 inspection.

4.9 Children ordered meals on their laptops from the standard menu for the children's estate which offered a four-week cycle of choices for the evening meal. The options catered for religious and other dietary requirements and Ramadan had been prepared for appropriately.

4.10 With the exception of Curlew unit where children ate all their meals together, children often ate their meals alone while locked in their cells. Too often, staff took children's meals to their cells rather than allowing

them to collect them from the unit servery. Evening meals were divided into portions in the main kitchen to maintain consistency and fairness. We observed unit staff using cups rather than the utensils available in serveries when serving food.

4.11 Unit serveries were clean but some food was left in ovens in the main kitchen overnight.

4.12 Children could order weekly from the shop using their laptop but could wait up to 10 days to make and receive their first order depending on when they arrived at Feltham. Additional phone credit could be ordered and children could buy items from a small choice of catalogues available on their laptops. Some hair and skin products were available for children from ethnic minorities to buy.

Consultation, applications and redress

4.13 Many children were unaware of formal consultation arrangements through the youth council. The council had not met for several months in the second half of 2023. Notes of the more recent monthly meetings did not show what changes had taken place as a result of the consultation or what actions had been taken.

4.14 Keep aparts limited the number of children who could take part in discussion forums. Leaders had used laptop surveys to seek children's views on specific topics, for example, their experience of the custody support plans (CuSPs, a plan developed through weekly meeting with an officer), and the governor invited children to submit questions and had used video messages on their laptops to respond and to share information about events. Most recently an informative video message had explained what to expect during our inspection and how children could contribute to it.

4.15 Laptops were used to make applications. Over the previous 12 months, an average of about 1,400 applications had been made each month, nearly all of which had been responded to on time. Leaders were given monthly reports of applications in their area of responsibility.

4.16 Children had made 152 complaints in the last year. These were made on paper to maintain confidentiality and blank forms were available on the residential units. Advocates from Barnardo's had helped some children to write complaints. In our survey, 22% of children said they had felt too scared to make a complaint, and this had not been adequately investigated by leaders.

4.17 The responses to complaints that we sampled were generally polite and addressed the issues raised. Most responses demonstrated discussion with the child as part of the investigation. Quality assurance was completed by leaders for their own areas of responsibility. They received monthly data and were aware of the more common reasons for complaints, such as clothing being misplaced or damaged in the unit laundry facilities. During the previous year, about one-third of

responses to complaints had been late but the absence of monitoring data over longer periods meant that leaders were not aware of this.

4.18 Children could access information on their legal rights and sentencing on their laptops. Other legal information could be requested from the library and, since January 2024, children had had pin phone numbers to make free calls to their legal advisers. Legal visits took place on weekday mornings and one afternoon in private rooms and children also had access to remote video link visits with their solicitors and other professional visitors. Advocates from Barnardo's and social workers seconded to the YOI (see paragraph 6.19) were now on site to offer independent advice.

Equality and diversity

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

Strategic management

4.19 Oversight of equality and diversity had improved since our last inspection. The monthly diversity and inclusion management meeting (DIMM) was well attended and generally chaired by the governor. Children were invited to this meeting and engaged actively with a discussion on, for example, mental health or provided feedback on life on one of the units.

4.20 A wide range of data specific to Feltham A were considered at the DIMM meetings which enabled leaders to identify potential discrimination. We saw good evidence of investigation into procedures, including separation from normal location and complaints.

4.21 The actions generated from the DIMM were suitable and most were completed swiftly, but the overarching equality action plan did not include analysis or actions from any consultation with children or complaints about discrimination.

4.22 During the previous 12 months, 54 discrimination incident report forms (DIRFs) had been submitted. The responses we looked at were respectful and answered the subject of the DIRF, but children waited too long for a response. There was a quality assurance process which was supported by external scrutiny from the Zahid Mubarek Trust who viewed all the DIRFs submitted.

4.23 Peer mentors had recently been re-introduced, but their role was limited to supporting a small number of their peers as they could only mix with children from their own group.

Protected characteristics

4.24 A full-time diversity and inclusion officer held forums with children each month. Each of the protected characteristics was covered and issues raised at the DIMM or by children in other forums were discussed. Most of these forums were limited in their effectiveness because they only involved one or two children due to the complex 'keep apart' system.

4.25 There had been a focus on cultural and religious celebrations as well as events to celebrate diversity and an extensive calendar of events was planned throughout the year. There had recently been a well-attended event to celebrate International Women's Day and the forthcoming celebration of Eid was accessible to all children, which was good.

4.26 There was a lead for children with neurodiversity and Feltham had retained its health services autism accreditation. Work was also under way to make sure that children with more severe neurodiverse needs had a personal emergency evacuation plan (PEEP), which was a positive step forward.

4.27 In our survey, 28% of children identified as having a learning need or disability that affected their daily life. Although few had physical disabilities but there had been several over the preceding year with hearing and sight difficulties and some with injuries such as broken limbs. All these children had a PEEP which was reviewed regularly, and staff knew about them and where to find them.

4.28 It was positive that some children with learning difficulties also had PEEPs so that staff were aware they may need additional support during an emergency.

4.29 Very few children declared that they were gay, bisexual or transgender. Leaders were aware of the reasons why children did not feel comfortable disclosing this information and had organised events to celebrate and inform children about the LGBT+ community. These had also taken place for staff and it was positive to see role models from this community in the staff group making themselves available to answer questions from children and offer support when needed.

4.30 There was no policy for transgender children, although the diversity manager understood their needs and how they should be treated. The diversity team were awaiting national guidance to be published by the Youth Custody Service (YCS).

4.31 In our survey, 78% of the population identified as from an ethnic group other than white. Leaders had responded well to consultation with black and minority ethnic children and a range of products designed for black hair and skin were available. An additional first night pack was provided for black and minority ethnic children containing skin creams and other items that they may need on arrival.

4.32 In our survey, the perceptions of children from a black and minority ethnic background about their treatment were broadly similar to those of white children except that significantly more said they had been restrained than white children. This had been identified by leaders as use of force was a standing agenda item at the DIMM. The managing and minimising physical restraint (MMPR) coordinators had begun interviewing children following restraint and speaking to staff during minimising and managing physical restraint refreshers to find out the reasons for this.

4.33 At the time of the inspection, just over 6% of children identified as foreign nationals. They could meet Home Office staff each month if they wished. Professional interpreting services were available and records showed they were used regularly. We met a child who had had the induction programme explained to him in his first language via this service.

4.34 At our last inspection, we highlighted that children could only access the mosque or chapel for corporate worship about once every eight weeks because of the constraints of the keep apart system. This had not improved, which was poor.

4.35 In our survey, 93% of children who had a religion told us their religious beliefs were respected and 95% said they could speak to a chaplain of their faith in private, both of which were similar to the last inspection.

4.36 The chaplaincy was active and one-to-one pastoral support was available for most children. The chaplains were visible on the units and tried to speak to children face to face when they went to see them, although keep apart protocols could make this time consuming. The chaplain had recently produced videos on reducing conflict that were available to children on their laptops.

4.37 In our survey, 38% of children said they were Muslim. Ramadan was taking place during the week of the inspection and children told us that it was well organised, which they appreciated. Qibla signage had been reintroduced on the units, which was good.

Health services

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

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

Strategy, clinical governance and partnerships

4.39 The partnership working between health services providers and the prison team was good. A regular local delivery board enabled accountability and governance issues to be explored. However, this was undermined by continuing concerns about the ability of leaders to get children to their health care appointments. Some children did not have access to continuity of care and clinical time and resources were wasted.

4.40 An effective clinical governance framework focused on delivering and improving patient care and included regular audit and learning from incidents.

4.41 Clinical leaders provided effective oversight of services and front-line staff said they felt well supported. There were staff vacancies in primary care and mental health, but regular bank and agency staff provided effective cover and the impact on patient care was negligible.

4.42 Mandatory training was up to date and staff had the opportunity to access further professional development to meet the needs of this age group.

4.43 We reviewed a sample of patient clinical records which described patient need well and captured interventions appropriately. We found documented discussions with children that had taken place through the observation panels in the cell door. This had included conversations about clinical concerns which was neither appropriate nor confidential.

4.44 From our observations, health care practitioners clearly knew their patients and treated them with dignity and respect.

4.45 There were insufficient treatment rooms and a lack of confidential therapy rooms which meant that children were not always seen in appropriate facilities. Too many clinical spaces did not comply with infection prevention standards and some needed refurbishment.

4.46 Health care practitioners trained to immediate life support level provided a rapid response in the event of a health emergency, making use of strategically placed resuscitation equipment which was checked and maintained regularly.

4.47 All health care staff we spoke to understood how to deal with hypothetical safeguarding concerns that we described and had received appropriate training. Safeguarding supervision regularly took place and provided useful support to staff who had concerns for the welfare of children.

4.48 Health care complaints were rare and most were addressed by meeting the child face to face and then confirmed in writing. One complaint, which had several elements, had not been resolved to the child's satisfaction and had required a full written response. The response letter explored each of his concerns and was written in child-friendly language.

Promoting health and well-being

4.49 There was no whole-prison health promotion strategy to drive an integrated approach between key services. A wealth of health and well-being information was available on the children's laptops but limited child-focused information was displayed across the establishment. Central and North-west London NHS Foundation Trust (CNWL) had recently appointed a health promotion practitioner who was working with all the health teams and the diversity and inclusion prison lead to encourage a more coordinated and child-focused approach, which was promising.

4.50 The uptake of the MMR vaccination was very good following a recent proactive approach to provide clinics on the units. This was positive in the context of the increase in measles in the London area. The team were now adopting the same approach to other child health immunisations and vaccinations to try to increase the uptake.

4.51 Blood-borne virus testing and sexual health screening were offered and there was access to sexual health services. Barrier protection and related health advice were available, including on release.

4.52 Smoking cessation support was available and nicotine replacement patches were offered.

Primary care and inpatient services

4.53 The primary care service was well led, with good managerial oversight and a team committed to the children's well-being. It operated a seven-day, 24-hour nursing service, with GP clinics delivered five times a week and a routine/urgent clinic on Sundays. In addition, an out-of-hours service was available to support patients and practitioners.

4.54 The primary care team was passionate and highly motivated. There was a good range of age-appropriate primary care services, and all health care applications were made through an app on the child's laptop.

4.55 At the time of the inspection, there was no waiting list to see the GP and children with an urgent need could be seen quickly.

4.56 Children were screened at reception using the comprehensive health assessment tool (CHAT) and a prompt secondary health screening nearly always took place the next day. The assessments were thorough and children were promptly referred to other services as required.

4.57 Children with long-term conditions were well managed, with annual reviews and care plans in place which were discussed with the children to encourage them to manage their own condition.

4.58 It was notable that every child, regardless of whether they were sentenced or on remand, was offered an annual health review and

given the opportunity to explore any concerns or identify any health and well-being issues.

4.59 The team had a good mix of skills and there were daily handover meetings for staff to share important information about patients. Information from the daily handover was not automatically recorded in the child's clinical record, which was a gap. When we raised this with managers, it was promptly addressed. Multidisciplinary meetings were held weekly to discuss patients presenting with complex needs.

4.60 There was effective administrative and clinical oversight of external hospital appointments, which were few in number. Children who needed to go to the local emergency department did so promptly with health care and prison staff working together effectively to minimise any potential delay.

4.61 Health care staff contributed to the risk assessment of children who might have to be restrained. When an incident took place, health care staff were called but it became apparent that not all primary care staff had been trained in when to intervene during a restraint, which was a concern. This was raised with senior managers who assured us that this would be addressed.

4.62 Health care staff visited segregated children on Falcon unit every day and had worked with prison staff to set up a regular Monday afternoon drop-in clinic. This innovative clinic enabled children to choose to have their vital signs taken, such as weight or blood pressure. Staff reported that this had also improved communication and outcomes. For example, one child who had been very resistant to receiving an MMR booster had had the opportunity to ask questions and had changed his mind.

Mental health

4.63 A highly skilled multidisciplinary health and well-being team delivered child-focused, trauma-informed care to a complex cohort of children. Access to the service was hampered by limited space and constraints in the regime. The team was diligent in following up children who did not attend and rebooking treatment.

4.64 A well-led team comprised psychology staff, speech and language therapists, creative psychotherapists, mental health nurses and a psychiatrist. There were a few vacancies, but recruitment was in progress.

4.65 Children's mental health needs were assessed during their reception health screening, with specialist follow-up within 72 hours. Following comprehensive assessments of mental health and neurodisability needs, allocation and interventions were agreed at daily triage meetings or at the weekly multidisciplinary meeting.

4.66 Children received a range of tailored interventions including compassion focused therapy and coping and communication skills.

Children with neurodevelopmental needs were supported, including those who had diagnoses of attention deficit hyperactivity disorder (ADHD) and autism spectrum disorders (ASDs). Assessments for children with potential neurodiverse conditions were undertaken.

4.67 The psychology-led sexual behaviour service provided assessment, risk evaluation and interventions for children who displayed harmful sexual behaviour. Two children were receiving this service at the time of the inspection.

4.68 The team delivered therapeutic interventions to around 65 children based on their individual needs. There was a small waiting list for psychological therapies but children waiting were seen each week for check in-sessions by other team members.

4.69 Clinical records that we reviewed were of a high standard and indicated excellent levels of support. Each child had a comprehensive formulation (an assessment tool used in children's mental health care) and the child was given opportunities to express what was important to them. Information was shared with key stakeholders to promote an integrated approach to care, and they liaised with relevant services on release or transfer.

4.70 Regular group reflective practice sessions for operational staff were facilitated by the team. Each unit held a weekly core support group meeting. Changes to the time of these meetings had helped to improve multi-agency attendance and support integrated care.

4.71 Team members worked between 7.30am to 6.30 pm each weekday and at weekends two mental health nurses were available to respond to any urgent need. The team actively contributed to all ACCT reviews.

4.72 Officers received trauma-informed training including sessions about autism and communication delivered by the speech and language therapists to enable a better understanding of children's needs.

4.73 Two children had been transferred to a specialist secure unit under the Mental Health Act in the last 12 months. One was just within the national timeframe of 28 days and one just over at 30 days because of pressure on beds.

Substance misuse

4.74 CNWL integrated clinical and psychosocial substance use treatment services met the needs of the population. The team worked seamlessly in prison drug strategy, safety and resettlement meetings to encourage recovery and rehabilitation.

4.75 Staff provided children with in-cell packs to help them get to know staff and identify support needs.

4.76 No children had required clinical substance misuse treatments during the past 12 months and a very low number of children had been identified as likely to benefit from psychosocial support.

4.77 The team had recently recruited two new team members and were now fully staffed. There had been delays in seeing patients who required psychosocial support, but this had now been resolved.

4.78 It was difficult to run group sessions for children needing psychosocial support because of the restrictions on who could mix together. There were no peer workers at the time of the inspection, but this was being considered now that there was a full complement of staff.

4.79 There was an efficient open referral system in the prison and, once fully embedded, new staff would provide training for officers.

4.80 Limited space was available for staff to see children and to write notes and care plans.

4.81 Mutual aid groups such as Alcoholics Anonymous came to the prison on occasion to provide additional support.

4.82 When children were released, staff provided harm minimisation advice. Naloxone (an opiate reversal agent) was available but rarely used. Local drug teams also provided support for children on release.

4.83 Weekly multidisciplinary meetings were held to discuss children's needs and joint support was given to any children with a dual diagnosis of mental health and substance misuse.

4.84 Children received age-appropriate support and staff had maintained regular contact with children as well as they could within the restrictions of the regime. The team delivered short- and medium-term interventions depending on children's individual needs. Harm reduction advice was provided to all children and feedback was gathered at the end of their treatment to help inform service delivery.

Medicines optimisation and pharmacy services

4.85 Overall, medicines were delivered to children safely and in a timely manner.

4.86 Medicines came from a pharmacy in St Charles Hospital which was part of the same NHS Trust. It was possible for prescriptions to be written out of hours and a good range of medicines on site meant there was minimal delay for children receiving treatment.

4.87 The prescribing of medicines that were open to abuse was well controlled.

4.88 A regular medicines management group was attended by pharmacy staff. Near misses and incidents were recorded on Datix and investigated for lessons to be learned and to address concerns about patient safety. A final accuracy check was carried out by pharmacy staff on medicines dispensed by the hospital. Some errors had been identified before the medicines were administered which were then remedied.

4.89 Prescribing and administration were done on the electronic clinical records and all children had an in-possession risk assessment. Sixty per cent of children who were prescribed medication were supported to have them in their possession, for example antibiotics or inhalers for asthma.

4.90 Medicines were usually administered three times a day by nurses with evening medicines given before 7pm.

4.91 Health care staff routinely asked children to provide their name, date of birth and number before medicines were administered and we observed that health care staff knew the children well. Children were in single cells and could keep their medicines safe.

4.92 Medicines were stored and transported securely and medicines such as vaccines were kept in suitable fridges which were monitored daily.

4.93 Children could have up to two weeks' supply of medicines when they left prison.

Dental services and oral health

4.94 A local dentist provided a range of dental treatments, including standard dental treatments, extractions and access to a hygienist. The service was commissioned to deliver four dental sessions each week and more recently a hygienist for four sessions a month.

4.95 The health care and dental team triaged patients and offered pain relief for those awaiting an appointment if required. The waiting time for a routine appointment was six weeks but urgent referrals were seen at the next available clinic and the GP provided patients with pain relief and antibiotics if necessary.

4.96 There was a referral pathway for children who needed braces, although there was no promotion of this on the units. Children with existing braces were treated for urgent repairs only as this was not a commissioned service. The commissioners were in negotiation with a local community service to provide this, but no start date had been agreed.

4.97 The dental suite remained worn and shabby and did not have a separate decontamination room. The expected national standards of infection prevention and control had been maintained.

Section 5 Purposeful activity

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

Time out of cell

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

5.1 The time children spent unlocked was improving after a deterioration in the second half of 2023. However, too few children enjoyed the full benefits of the well-designed regime, largely due to keep apart issues (see paragraph 3.28) which restricted the numbers attending activities such as education, youth club, gym, association, exercise or eating together.

5.2 Leaders remained suitably ambitious in their plans to continue expansion of the regime which had been designed around one, two or three groups of children (communities) on each unit. The model for one community allowed nine hours unlocked each day, two groups seven hours and three communities five hours. Curlew unit, the platinum unit where children lived as one group, was a positive example of the regime that could be achieved.

5.3 The impact of two or more groups on other units, combined with staff responding to and managing the aftermath of incidents, resulted in children being locked up for longer than leaders and staff wanted. This also impacted on allocation to education which was often based on who children could mix with rather than their needs or aspirations.

5.4 Roll checks completed during the inspection found an average of 13.5% of children locked in their cells during the core day when education and vocational training were taking place.

5.5 Prison data showed that in February 2024 children spent an average of just over four hours out of their cell on weekdays and about 3 hours 40 minutes at weekends. Individual children's experiences ranged from less than one hour to nine hours out of cell each day. We noted inaccuracies in the recording of these data, for example staff rounded figures up rather than recording the actual time spent on exercise or in education. Planned exercise was 30 minutes each day for many children because of the need to keep groups apart and some children joined these sessions late.

5.6 Weekend provision had been strengthened with the introduction of vocational training on Saturdays and Sundays which we had not seen at similar YOIs. This innovative approach offered children the

opportunity to take part in a Junior Cadets programme (delivered by ex-service personnel), horticulture or painting and decorating. A new weekend PE pathway was due to start in April 2024 and there were advanced plans to open the library on Saturdays.

5.7 Plans for further development of constructive leisure activities included the Duke of Edinburgh award scheme, for which places had already been obtained. Fifteen residential staff were scheduled to attend bespoke YCS training to deliver enrichment activities.

5.8 Children could now use a library dedicated to Feltham A. This had opened since the 2022 inspection and was a comfortable, welcoming space. It had a selection of books likely to appeal to the age group, including some easy reads and graphic novels. The stock of DVDs was popular with children.

5.9 The librarians met new arrivals during their induction and signed nearly all the population up as library users. Access was timetabled as part of education and children in the classes that we saw in the library were comfortable approaching the librarian with requests. Books and DVDs could also be ordered from laptops and we saw deliveries being made to units. Bookshelves on the units were available for children who wanted a book more immediately. Library staff promoted the Reading Ahead challenge (in which participants read and record their thoughts on six pieces of written work), had plans to start a book club and were involved in developing a reading strategy.

Library

5.10 The gym facilities were good, albeit with temporary reduction in access to the cardiovascular (CV) suite while the gym showers were refurbished. Some CV equipment had been moved into the sports hall

as an interim measure. The PE team of PE instructors and sports and games trained officers made good use of the available facilities to run sessions with two groups of children at the same time.

Sports hall

5.11 In our survey, only 33% of children said that they could attend the gym each week compared to 70% at our 2022 inspection. The gym timetable provided for children to have at least three sessions a week, including the weekend and evening, but this was dependent on there being no more than two groups on their unit. Most children attended at least twice a week and those who mixed as one group or were taking part in one of the two PE vocational pathways offering level 1 qualifications had more gym time. Children who were separated (see paragraph 3.45) or not mixing with others had less opportunity to attend the gym.

5.12 Induction sessions took place each week but no remedial gym was available. PE staff checked with children who did not go to the gym to see if their reasons for not attending could be addressed.

Education, skills and work activities

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

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

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

Overall effectiveness: Inadequate

Quality of education: Inadequate

Behaviour and attitudes: Requires improvement

Personal development: Requires improvement

Leadership and management: Inadequate

What does the prison do well and what does it need to do better?

5.14 Leaders and managers did not make sure enough children took part in a full timetable of education to enable them to progress well with their studies. This severely curtailed children's progress towards their education goals while at the YOI. Over the previous three months, the number of children receiving their entitlement to education had increased, but it remained too low with children being kept locked in their residential units during the school day.

5.15 Leaders and managers had a clear rationale for the curriculum, including English, mathematics, music and art. They had only recently started to offer useful qualifications in information technology, which meant that children had not had good opportunities to develop important digital skills. Children participated in useful financial literacy lessons that helped them to become more responsible in managing their money. However, leaders did not offer enough training or

education at advanced levels, although they had plans to offer more training at level 3 and above.

5.16 Leaders offered vocational courses in a range of useful subjects where children gained qualifications to help them progress in their next steps. For example, in painting and decorating, children gained a construction skills certification scheme card. In 'cadets', children earned the Duke of Edinburgh award. As a result, a few children understood how most vocational courses could lead to further study or employment on release. A few children studied horticulture, cadets and painting and decorating at weekends.

5.17 Where staff recognised a child had an individual educational need, they made appropriate arrangements to meet it. For example, staff taught one-to-one lessons in history to a child who struggled to take part in lessons. As a result, the few children in receipt of bespoke training were involved in learning activities and continued to develop their knowledge.

5.18 The small number of 18-year-olds housed at the prison were able to apply for internal jobs. These were available in the gym, library, horticulture and painting and decorating. Most of these jobs took place in the evening and at weekends so these children could continue with education. Staff supported applicants to write a curriculum vitae and covering letter and taught them interview skills ready for their interview. However, younger children working in servery or cleaning roles available to them had not benefitted from the same support. The very few who took part in work valued the opportunity to have paid employment and additional responsibility.

5.19 Leaders and managers provided a comprehensive induction to the offer of education, skills and work opportunities across the prison. Staff set a range of useful assessments to identify children's needs. They used the outcomes of these assessments to give children with special educational needs and/or disabilities (SEND) the resources they needed to study effectively, such as extra time, coloured overlays and in class support.

5.20 Staff agreed with children the activities they could take part in before appropriately discussing their career aspirations with careers advisers. While staff considered children's aspirations when allocating them to activities, for many children, security concerns determined the activities they were offered. This meant that not all children were undertaking the activities that would benefit their educational progress the most.

5.21 A number of partners taught different elements of the education and personal development offer for the children. Leaders managed these discretely and did not have an accurate oversight of the full range of activities that the children were taking part in. Leaders and managers had not been sufficiently rigorous with their evaluation of education and held an overly positive view of the quality of their provision. Although they had identified some of the weaknesses across education, skills and work they had been too slow to improve the quality of education

and training. Consequently, they had not met three of the recommendations from the previous inspection and only partially met one.

5.22 The main education contractor, Shaw Trust, did not teach a sufficiently well-planned or ordered curriculum in mathematics or English. Teachers of mathematics and English overly relied on setting worksheets, which did not effectively build on children's knowledge over time. While children's starting points were recorded, staff teaching English and mathematics did not use this information to fill gaps in children's knowledge or effectively monitor the progress that children made. Not enough children had achieved their functional skills mathematics and English qualifications within the expected timeframe. Managers recognised that this was partly impacted by children not taking part in enough lessons to complete their studies. Overall achievement was too low across most core subjects. While a high proportion of children achieved GCSE qualifications, only a small number gained grades 4 and above.

5.23 Teaching staff were appropriately qualified and experienced. Mathematics teachers used the recently installed information technology equipment well to support children to solve fractions and equations. In English and mathematics lessons, teachers used verbal questioning well to check children's understanding. For example, they checked that children worked through multiplication and division problems accurately and, in English, that they used a variety of adjectives to describe pictures of prison settings.

5.24 However, teachers of mathematics and English did not consistently provide helpful feedback on children's work. Too often, children's work was not completed or marked. Too many teachers did not set children clear targets on what do during lessons or support sessions. Often, children did not have an aim for the lesson or in their learning plan. As a result, children lacked focus in lessons and did not know how to make progress or improve their work. Most children found it difficult to recall topics they had been taught. Teaching staff did not consistently implement the strategies that had been identified to support children with SEND. As a result, these children did not achieve as well as their peers.

5.25 In vocational courses, leaders and managers structured the curriculum logically. They used short, unit-based qualifications that built up to vocational pathways. In painting and decorating, the small number of children allocated learned valuable knowledge and skills. They knew how their course would help them in their next steps. They confidently prepared surfaces and used a variety of paint techniques.

5.26 Vocational trainers closely monitored children's progress. For example, in catering, trainers asked learners to recall what they had learned, corrected misconceptions and revisited previous content. As a result, children secured their knowledge of temperatures that impact on bacteria growth and the contact time for different cleaning chemicals.

Trainers clearly linked the content they taught to professional industry requirements.

5.27 Vocational trainers marked learner work thoroughly and made sure children revisited their work to make corrections. These trainers and teachers teaching on residential units set clear targets and monitored children's progress. Trainers also helped improve children's oracy skills by reading out their reflection logs.

5.28 Leaders and managers had been too slow to implement a whole establishment reading strategy. They did not have a clear understanding of children's need for reading support. Leaders and managers had been too slow to implement reading support from The Shannon Trust and only a few children benefitted from this key training. This weakness was particularly impactful to children and their education. While leaders and managers recognised this and planned to increase participation and more learning support staff were being trained in phonics, children made little progress in improving their reading skills. Leaders planned time in lessons for children to read and to visit the library. Vocational trainers encouraged children to read textbooks and manuals.

5.29 During lessons, most children worked purposefully and calmly. Teachers, trainers and induction staff set clear guidelines for behaviour in classrooms and vocational learning. Staff promoted British values well across education, skills and work. They focused on encouraging children to show each other respect and build good relationships with one another. Most children worked together well and supported each other. As a result, children felt safe in education and in vocational training.

5.30 Attendance to education, skills and work was not consistently high. Leaders had made changes to enable more children to attend. For example, they had recently adapted the timetabling of lessons to allow more children to take part in activities and timetabled specific slots for children to attend appointments, but this had not had enough of a positive impact at the time of inspection. Where children moved between lessons in the education department, the lessons rarely started on time. Leaders had not applied the pay structure to consistently incentivise children to take part in all aspects of education, skills and work equally.

5.31 Leaders and managers had set up activities for children to explore their personal interests including music production, yoga and football, including a bi-weekly football match. Leaders had run short courses in puppet-making and video production where children explored their artistic talents. However, leaders had not planned these activities into a curriculum which helped children to develop specific skills from taking part.

5.32 Children had only recently been able to access the virtual campus. Managers had uploaded useful content to help support learners with

their studies and interests. Staff had introduced informative careers events where employers attended the YOI and met with children.

5.33 Staff worked effectively with children approaching their planned release date to review their options for work or education. In too many instances, staff did not know where looked after children or those on remand were being released to, so were unable to provide effective support to prepare them for release. As a result, too many children did not have suitable education, skills or work to progress to once released. Approximately only a third of children progressed into confirmed work or education placements on release.

Section 6 Resettlement

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

Children, families and contact with the outside world

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

6.1 In our survey, 71% of children said they received support to maintain contact with family and friends, but only 18% said they had used video calls compared with 38% at other YOIs.

6.2 The family services provider, the Prison Advice and Care Trust (PACT), had experienced staff shortfalls and leaders at Feltham had stepped in to address gaps in services.

6.3 Resettlement practitioners and managers had been actively involved in facilitating communication between children and their families. Examples included organising 12 themed family days for 112 children over the past 12 months, which was well received by the children we spoke to, keeping families updated on the children's progress and inviting families to participate in case management meetings in the family room.

Family room

6.4 Social visits were only offered three times a week, with two slots coinciding with school and work hours. Use of these was low, with less than half the allocated visit sessions booked. In our interviews, some children said they did not want their families to visit because of the risk of violence breaking out in front of them (see paragraph 3.30). Similarly, video calling remained underused, with only 92 calls made in the last six months, which was too low and a waste of a valuable service.

The visits hall was clean, but it was austere. Plans to create a more inviting and child-friendly environment had not materialised. The visitors' centre roof leaked heavily, leading to flooding during rain.

Buckets capturing rainwater in the visits centre

Visits hall

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.

6.5 An up-to-date needs analysis was reviewed frequently and reflected children's needs. The reducing reoffending policy covered all key areas and the monthly meeting was well attended. However, important data were not monitored to improve outcomes, such as the provision of education and training on release.

6.6 Most children we spoke to said they met a resettlement practitioner (RP) within a few days of arrival. RPs explained their role and how they could be contacted by children. Records demonstrated efforts to allocate returning children to the same RP to ensure consistency. Contact levels were good and children described RPs as responsive and said they had developed trusting relationships. Conversations often involved challenging behaviours and positive reinforcement. However, meetings with children often took place at the child's door when there were difficulties in getting them unlocked or their availability was limited through engagement in other activities.

6.7 RPs were diligent and enthusiastic and had good knowledge of the children. There was a mutually supportive approach with evidence of good information sharing about children's behaviour with the youth offending team (YOT), social workers and parents/guardians.

6.8 Monthly planning meetings were held for remanded and sentenced children with relevant agencies in attendance, but these tended to be held virtually. Prison managers acknowledged the importance of face-to-face visits as a means of building rapport and there were plans to encourage site attendance, especially from London-based services. Most children we interviewed said they felt involved in the planning and review process, with just one stating that his contribution was minimal because he did not think his opinion would make a difference to the decisions of professionals.

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.

6.9 Most of the resettlement plans we reviewed were of a good standard, addressed emotional and physical well-being and were regularly reviewed. Some did not specifically address offending behaviour but progress could still be identified and measured through the completion of interventions and children engaging with support services to address thinking, behaviour, attitudes and need.

6.10 Three children had been granted home detention curfew in the last 12 months. We reviewed one record and found the paperwork to be in order with a good tracking system in place. The views of the victim were considered and risk factors well assessed by the YOT resulting in the imposition of additional measures (exclusion zone) to protect the victim and public further. Nonetheless, checks on the suitability of the address had started after the eligibility date and release was authorised 23 days late.

6.11 We reviewed 10 release on temporary license (ROTL) assessments and found that contributions were sought from the range of prison departments, wing staff, professionals and community agencies. YOT and intervention facilitators also attended the board which we do not often see in other establishments. ROTL objectives were appropriately linked to resettlement plan targets, including exploring education, training and employment opportunities and engaging in family counselling with a view to rebuilding relationships.

6.12 Despite the breadth of information available, there were gaps in some RPs' risk identification and management. This was mitigated by YOT contributions which identified risk considerations and conditions under which ROTL would be supported, such as being accompanied. The completion of interventions was included in each assessment but there was not enough emphasis on demonstrating how learning would assist in exploring the effectiveness and impact on thinking, behaviour and attitudes. During the ROTL board, discussions were held with children on the purpose of ROTL and progress against their resettlement plans were measured. Helpful suggestions were made to children who were declined on how to improve behaviour, meet targets and enhance their suitability should they re-apply for ROTL in the future.

Public protection

6.13 There were weaknesses in identifying children's risk levels. Most of the assessments we reviewed were completed at pre-sentence and

remand stage. The latter often contained blank pages and missing information, including risk levels. Following entry into custody, it was the responsibility of prison staff to review these assessments and reflect the considerable changes in circumstances, but reviews were not being completed because of a shortage of trained RPs. There was, therefore, no identification of resources required to manage risks in custody and the community.

6.14 The interdepartmental risk management meeting (IDRM) was not always well attended by relevant leaders. Updates from those working closely with the children were infrequent and not always of relevance to managing children's risk. Not all high-risk children were discussed which created the potential to miss risk-related issues at the point of release.

6.15 MAPPA levels (multi-agency public protection arrangements) were appropriately confirmed for those with six months or less left to serve. Most of the MAPPA contributions we reviewed lacked analysis and failed to identify relevant risk factors in custody. Information was cut and pasted and not always relevant, with no conclusions drawn from the information and the RPs' in-depth knowledge of each child.

6.16 There appeared to be a lack of training and confidence in RPs to identify risk and the safeguards and/or restrictions that could be imposed to manage and monitor the risk. Aspects of RPs' work lacked robust risk management and, although there were a few good examples, this was not consistent throughout the team.

Indeterminate and long-sentenced children

6.17 Support for children sentenced to life and long-term sentences remained a strength.

6.18 At the time of inspection, eight children were serving indeterminate sentences and 10 were on remand awaiting sentencing for offences of murder or attempted murder. A dedicated RP in the resettlement team continued to oversee support for these children, including regular face-to-face meetings, lifer forums for mutual support and lifer therapy delivered by a psychologist.

Looked-after children

6.19 In our survey, 67% of children said they had been in care which was similar to the last inspection. The need for support from social workers was great and there had been just one social worker until January 2024, when a second one had joined the team with a third scheduled to start later in the year.

6.20 Social workers had identified around 30 children requiring their support. Support centred mostly on case management and making sure children received their entitlements from the local authority.

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.

6.21 Reintegration planning was taking place well in advance and, for those transitioning to the adult estate, links forged with the relevant establishments were robust. RPs set resettlement plan targets for children and 18+ year-olds to devise a list of questions about the process. RPs provided leaflets and booklets where available and were facilitating meetings with adult estate prison offender managers (POMs) at Portland and Swinfen Hall. Children said this opportunity helped to ease some anxieties and it also made sure that they would know a staff member at the receiving establishment once they left Feltham.

6.22 There was evidence of parallel planning for children and 18-year-olds who were due for release but were also at risk of receiving additional sentences. This made sure that children were aware of all the possible outcomes.

6.23 Accommodation was not always confirmed by the time of the child's final review which prevented effective planning for education or other services. Only 41% of children had education or work placements on release, which was too few.

Interventions

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

6.24 The provision for interventions remained good. Children could access interventions as well as other support services.

6.25 The interventions team screened all children weekly for appropriate courses. Planning for suitable interventions was well considered and meetings to prioritise children's individual needs were carefully coordinated.

6.26 At the time of the inspection, 13 children were engaged in programmes. In the last 12 months, 64 children had completed programmes and completion rates were good. Families were involved during award ceremonies and children enjoyed celebrating their achievements.

6.27 Regime slippage caused by the number of 'keep aparts' had a considerable impact on seeing children on time, sessions being cancelled or shortened with limited notice, and getting children to their sessions on time. This caused unnecessary disruption to children.

Health, social care and substance misuse

6.28 A memorandum of understanding for the provision of social care was in place between health care and the London Borough of Hounslow Children and Adults services. Social care services were rarely required and there had been no demand for social care support in the past 12 months.

6.29 There was an open referral system and staff understood how to make a referral if required. It was agreed that health care staff would provide support where a need was identified. Additional hours required and equipment needs would be negotiated as the need arose.

Section 7 Progress on concerns from the last inspection

Concerns raised at the last inspection

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

Safety

Children, particularly the most vulnerable, are held safely.

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

Key recommendation

Staff should adhere to policies which make sure that children are properly safeguarded during the night.
Not achieved

Recommendations

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

Pain-inducing techniques should only be used when there is a risk of serious harm to a child or member of staff.
Not achieved

Care

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

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

Key recommendations

Leaders and managers should monitor data in order to identify and address any unequal treatment.
Achieved

Complaints and DIRFs should be thoroughly investigated and children should be routinely interviewed as part of the investigation.
Not achieved

Recommendations

All children should have a designated personal officer.
Achieved

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

Purposeful activity

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

At the last inspection in 2022, outcomes for children were not sufficiently good against this healthy establishment test.

Key recommendations

Children should have 10 hours a day out of their cell.
Not achieved

Leaders and managers should continue to identify the weaknesses in teaching and assessment practices. They should ensure that staff development activities are targeted to improving the quality of individual teachers, and that they monitor closely the impact of these activities on improving teachers' skills so that more children, including those with special educational needs, make more rapid progress in developing their skills and knowledge.
Not achieved

Leaders should increase the time children are timetabled to spend in education and should make sure that the timetable enables more children to access vocational training.
Partially achieved

Leaders should urgently improve the technical resources available in education. They should ensure that the curriculum enables children to develop the essential ICT skills they need to succeed in their lives and careers, and that children are able to achieve appropriate qualifications in this subject.
Not achieved

Leaders and managers should make sure that children receive careers advice and guidance during their custody at the prison. All children should be allocated to activities relevant to their career goals and should have more access to employers. Leaders should make sure that ROTL is used appropriately and that children explore the full extent of the careers available to them.
Not achieved

Leaders should implement robust systems to make sure that children are supported in securing recognised educational and training placements when transitioning from custody to the community.
Not achieved

Resettlement

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

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

Appendix I About our inspections and reports

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

This report

This report outlines the priority and key concerns from the inspection and our judgements against the four healthy prison tests. There then follow four sections each containing a detailed account of our findings against our *Expectations. Criteria for assessing the treatment of children and conditions in prisons* (Version 4, 2018) (available on our website at https://www.hmiprisons.justiceinspectorates.gov.uk/expectations/

Section 7 lists the concerns raised at the previous inspection and our assessment of whether they have been addressed.

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

Inspection team

This inspection was carried out by:

Charlie Taylor	Chief inspector
Angus Jones	Team leader
Angela Johnson	Inspector
David Foot	Inspector
Esra Sari	Inspector
Donna Ward	Inspector
Dionne Walker	Inspector
Alexander Scragg	Researcher
Helen Downham	Researcher
Joe Simmonds	Researcher
Tareek Deacon	Researcher
Sarah Goodwin	Lead health and social care inspector
Maureen Jamieson	Health and social care inspector
Jennifer Olliphant	General Pharmaceutical Council
Bev Gray	Care Quality Commission inspector
Rebecca Jennings	Ofsted inspector
Angela Twelvetree	Ofsted inspector
Steve Lambert	Ofsted inspector
Sarah Favager-Dalton	Ofsted inspector

Appendix II Glossary

We try to make our reports as clear as possible, and this short glossary should help to explain some of the specialist terms you may find.

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

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

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

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

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

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.hmiprisons.justiceinspectorates.gov.uk

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