Report on an independent review of progress at

HMYOI Wetherby

by HM Chief Inspector of Prisons

22 October – 6 November 2024

Contents

Section 1 Chief Inspector's summary

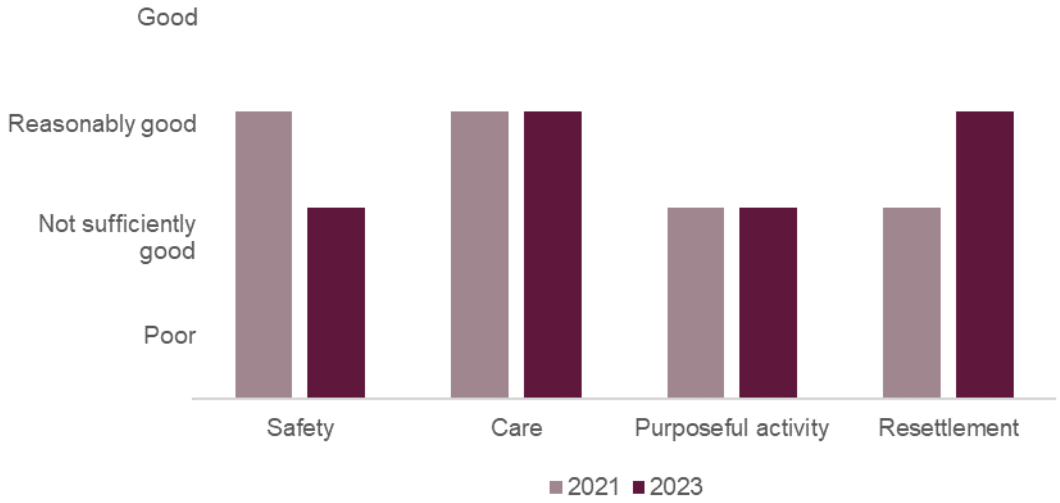
1.1 Wetherby is the largest young offender institution (YOI) in the country, located in Yorkshire, holding children aged between 15 and 18. At the time of our visit the establishment housed 149 children, catering to a diverse range of needs. This included provision for children convicted and on remand; serving as a national resource for the most vulnerable children in prison; providing the highest levels of security due to some children's risks; and remaining an option for girls in custody.

1.2 This review visit followed up on the concerns we raised at our last inspection of HMYOI Wetherby in 2023.

What we found at our last inspection

1.3 At our previous inspections of HMYOI Wetherby in 2021 and 2023 we made the following judgements about outcomes for children.

Figure 1: HMYOI Wetherby healthy establishment outcomes in 2021 and 2023.



1.4 At our last inspection in 2023, we found a decline in children's safety outcomes, raising concerns about the care of some extremely vulnerable girls; the poor treatment of separated children; and the use of force, particularly during strip searches. Children still spent too much time locked in their cells, and daily routines were nowhere near the levels we reported on before the pandemic with evening association and dining out rare. The teaching of English and maths remained poor, with too few children having access to high-quality teaching.

What we found during this review visit

1.5 Progress at the prison had been slow but a new governor had now been appointed. Rising rates of violence, disorder, and self-harm at the prison since our inspection had presented further challenges to leaders, highlighting the volatile nature of these institutions. The new

governor had strengthened oversight, and in the months since arriving, had made marked improvements with respect to the concerns raised at the last inspection and other areas where governance had weakened.

1.6 During our review, there were no girls at Wetherby. Although they had been at the prison until recently, it was encouraging that they hadn't been placed in recent months. However, Wetherby was still considered a potential placement of last resort, making it challenging for leaders to plan effectively. An independent review of the placement of girls had been announced by ministers during the week of our visit, which would help national leaders in developing a longer-term strategy for the very small number of girls in custody.

1.7 The daily routine for children had changed on the week of our visit, which aimed to significantly improve the impoverished regime that too many children had been experiencing for too long. Oversight of strip searching had been strengthened, and the much-needed refurbishment of residential units was underway.

1.8 There was still much work to do, particularly for those children separated on normal residential units who often would not leave their cell for days. More needed to be done to deliver regular and meaningful interactions with children, and the delivery of education needed much more focus from leaders to ensure that it met children's needs.

1.9 Overall, while progress had been slow, the new governor and deputy had taken real action since arriving, and as a result, change was taking place at a much quicker pace. We were optimistic about their ability to drive further improvements at Wetherby.

Charlie Taylor
HM Chief Inspector of Prisons
November 2024

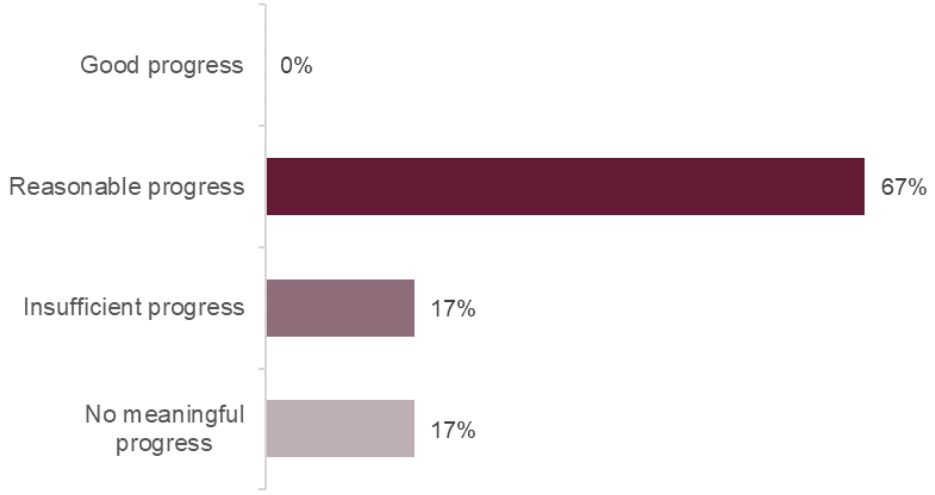
Section 2 Key findings

2.1 At this IRP visit, we followed up six concerns from our most recent inspection in December 2023 and Ofsted followed up two themes based on their latest inspection or progress monitoring visit to the establishment, whichever was most recent.

2.2 HMI Prisons judged that there was good progress in no concerns, reasonable progress in four concerns, insufficient progress in one concern and no meaningful progress in one concern.

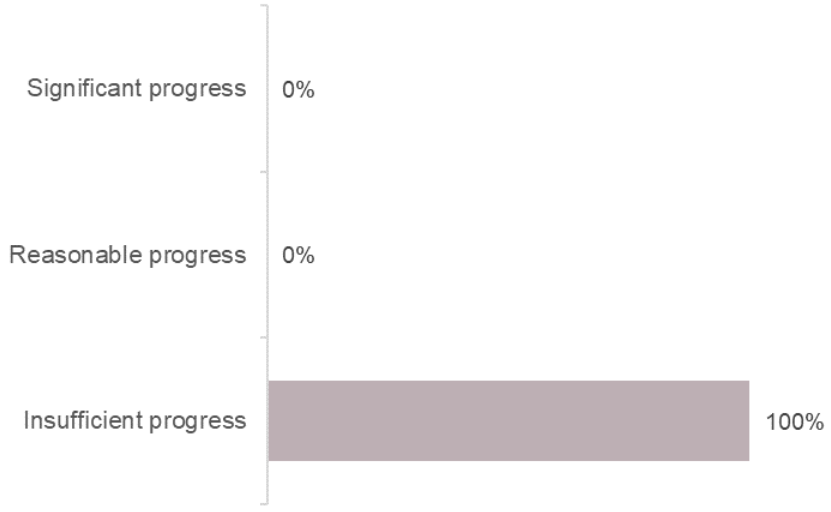
Figure 2: Progress on HMI Prisons concerns from December 2023 inspection (n=6).

This bar chart excludes any concerns that were followed up as part of a theme within Ofsted's concurrent monitoring visit.



Ofsted judged that there was significant progress in no themes, reasonable progress in no themes and insufficient progress in two themes.

Figure 3: Progress on Ofsted themes from December 2023 inspection (n=2).



Notable positive practice

2.3 We define notable positive practice as:

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

2.4 Inspectors found no examples of notable positive practice during this IRP visit.

Section 3 Progress against our concerns and Ofsted themes

The following provides a brief description of our findings in relation to each concern followed up from the full inspection in 2023.

Safety

Concern: The level of self-harm among girls was extremely high and this resulted in very high levels of use of force and assaults on staff. There was still no effective model of custody for these very vulnerable children and, despite the best efforts of staff, the YOI was not able to meet their needs.

3.1 After three years of girls being placed at Wetherby no new placements had been made for three months prior to our visit, and the last girl was transferred to the adult estate in October. However, while a national review was ongoing, there was continued uncertainty over the future model of custody for girls. At the time of our visit Wetherby remained a placement option for girls, but such placements had to be approved by the deputy director of operations at the Youth Custody Service (YCS).

3.2 In the absence of long term plans local managers and staff had done their best to create short term solutions in an attempt to meet the needs of the girls at Wetherby. It was clear from the local management meetings that leaders at Wetherby were struggling to plan or improve care for this particularly vulnerable group of children. Ministers had announced an independent review into the placements of girls in custody, which should support the YCS in providing a more sustainable arrangement.

3.3 We saw examples of staff and managers providing good care, but outcomes for girls remained very concerning. They continued, for example, to be significantly over-represented in self-harm, use of force and assaults. In the six months before this visit the rate of self-harm for girls was more than 100 times that of boys and they were more than 20 times as likely to be subject to use of force, which was often used as a response to self-harm.

3.4 We considered that the YOI had made reasonable progress in this area.

Separation

Concern: Too many children were separated for too long. Children who were separated in their own cells on the main wings experienced very little time out of their cell, particularly at weekends.

3.5 Since the beginning of this year there had been 264 instances of separation, involving 136 children or young adults, because they posed a risk to others or for their own protection. This was an increase in the rate of separation since our previous inspection. However, average periods of separation were 16.67 days in the three months before our visit: a reduction from 21 days in the year before our inspection.

3.6 There continued to be inconsistencies between local data and the national recording tool, but leaders at Wetherby informed us that the local data was correct. This undermined oversight of separation.

3.7 Children on specialist units received a predictable, if limited, daily routine including exercise, education and some enrichment activities. However, time out of cell was much worse for children on the mainstream wings, many of whom were separated as they were too scared to leave their cell. The prison's own monitoring showed very poor time out of cell, and while it remained a particular problem at weekends, in some instances children did not leave their cell for up to five days at time.

3.8 We were particularly concerned about the delays some children with mental health conditions faced before they were transferred to hospitals. These children were almost always separated while they awaited transfer.

3.9 We considered that the YOI had made no meaningful progress in this area.

Use of force

Concern: There was a high number of pain-inducing restraint techniques and strip-searches under restraint. Many of these incidents were not in accordance with national policy and were not properly authorised. Scrutiny of video footage and support on the scene by leaders were poor.

3.10 Leaders had improved oversight of strip searching and as a result the number of strip searches carried out under restraint had reduced by more than half. There were 11 incidents of children being strip searched under restraint in the previous six months compared to 30 in the six months before the inspection. All but one of them had been properly authorised and the incident that was not had been identified by leaders and was under investigation at the time of our visit.

3.11 There had been eight incidents where pain-inducing techniques were used which was a similar rate to before the inspection and higher than other YOIs. These techniques continued to be used to gain compliance which was outside the national policy.

3.12 Footage of all incidents where force was used was now reviewed by the duty governor who identified issues for further investigation. However, despite many staff being present at most incidents very few turned on their body-worn cameras. This limited leaders' ability to quality assure incidents effectively.

3.13 Leaders had ensured that a large backlog of quality assurance had been cleared, but we were concerned that some issues, including bad language from staff, poor practice and use of unorthodox techniques, were not identified or addressed during local or national quality assurance.

3.14 We considered that the YOI had made reasonable progress in this area.

Relationships between staff and children

Concern: The implementation of custody support plans was weak. Many sessions did not take place and those that did were opportunistic or cursory in nature.

3.15 Progress was being made with the quality of custody support plan (CuSP) work being delivered to children, but the number of sessions delivered was similar to the time of our last inspection, and overall, it was not yet regular or consistent enough for all children.

3.16 Despite the work being done, there was no discernible improvement in our survey of children's views of having someone they could turn to for help if they had a problem.

3.17 Leaders had increased the pool of officers who had a CuSP role. Rather than only allocate children to staff who worked on the residential unit where the child lived, leaders included officers who worked in specialist teams or areas (for example, reception or safer custody). This meant each officer had responsibility for one child and there was no need to change the CuSP officer when a child moved units, which increased consistency. Some staff said they found it harder to see their allocated child if they did not work on the unit where the child lived.

3.18 Leaders expected that each child had a weekly contact, called a 'check in', with their allocated officer. Monitoring of CuSP delivery was thorough and showed that in October 49% of required sessions had been completed. The number of sessions delivered was gradually increasing. CuSP was also being used to explore children's involvement in significant incidents which was positive.

3.19 Electronic records showed a variation in the quality of CuSP sessions. Leaders had clear expectations of what constituted an acceptable CuSP session, for example, that it included a goal for the child to work towards. All CuSP entries were quality assured by a case administrator with 10% reviewed by a psychologist. Those that did not meet the required standard were not logged as a completed session, and the CuSP officer received feedback.

3.20 Children's views on CuSP were regularly sought via a questionnaire given to around 10% of children monthly. Results were considered at regular meetings and examples of good CuSP practice were shared with staff in the monthly Wetherby newsletter.

3.21 We considered that the prison had made insufficient progress in this area.

Living conditions

Concern: Residential units required continuing maintenance. Some cells were cold and in poor repair.

3.22 Leaders had taken a number of actions to address this concern, and improvement to the environment was evident on some units.

3.23 A rolling programme to decorate the residential units was ongoing with one unit closed for the work to take place. Leaders were updating their requirements as they learnt from each residential unit completed. For example, they identified that they had not requested in-cell mirrors being replaced during the redecoration of the first unit. Funding had been obtained to upgrade the cells on Keppel unit, including replacing the windows, and work had started on one of the four spurs. We found some window vents on the unit that did not work.

3.24 Some cells were in poor condition, particularly some of the in-cell shower units which had extensive peeling paint. Graffiti was mostly absent from units which had been redecorated but had not been completely eradicated. Cells which had been redecorated were much better and gave a baseline for staff to monitor and challenge graffiti.

Cell that had not yet been refurbished (left) and refurbished cell (right)

3.25 In our survey, children's views about the temperature of their cell were similar to the 2023 inspection. Heating systems had been checked to ensure the heating was working properly, and it was working during our visit. Leaders were trying to address the issue that the heating could only be on or off and there was no thermostatic temperature control.

3.26 Leaders now had a weekly meeting with the contracted estates team to discuss the progress of ongoing and outstanding work and repairs.

3.27 A small team of officers and children, 'Q Branch', had been put together to carry out minor repairs around the site which was a pragmatic response to getting issues sorted out promptly and gave children valuable practical skills.

3.28 We considered that the prison had made reasonable progress in this area.

Time out of cell

Concern: Children spent too much time alone locked in their cells, particularly at weekends.

3.29 There had been careful planning to deliver the changes leaders intended would result in improved time-out-of-cell for children. Leaders had invested time in developing a new staffing profile and daily regime for the YOI which went live as the IRP visit began. The reprofile included reintroducing supervising officers to the residential units for more immediate management of regime, delivery and evening activities.

3.30 There were some very early signs of improvement, for example, movements to and from education and other activity during the day was being completed promptly, and some evening activities had taken place. Up until this change, there had not been any substantial improvement to the time children spent out of their cells, and there was

no significant change in children's perceptions about their regime since the inspection.

3.31 Similar to the last inspection, mixing issues impacted children's time out of cell. Leaders had worked to reduce the number of groups on residential units and the use of Anson as a small-groups unit had helped relieve the pressure of having to provide multiple regimes on the bigger wings.

3.32 Individualised monitoring of each child's daily regime had started two months before this visit. This allowed leaders to identify children who were spending extended periods in their cells and try to address it.

3.33 On the weekend it was not uncommon for between a quarter and a third of children to have had less than two hours unlocked. Leaders were aware of the need to ensure children had a substantially better weekend regime and the revised staffing profile included provision for additional activity at weekends, which was positive.

3.34 It was encouraging that staff were already providing feedback to leaders on how the core day could be further adjusted to provide additional activity time for children.

3.35 We considered that the YOI had made reasonable progress in this area.

Education, skills and work

This part of the report is written by Ofsted inspectors. Ofsted's thematic approach reflects the monitoring visit methodology used for further education and skills providers. The themes set out the main areas for improvement in the YOI's previous inspection report or progress monitoring visit letter.

Theme 1: What progress had leaders and managers made to improve the teaching of English, including reading and mathematics, to ensure that the children benefitted from high quality teaching and learning so that they improved their skills and made good progress?

3.36 Leaders and managers had effectively revised the schemes of learning for English and mathematics and developed learning resources. In English, teachers followed the same scheme of learning and used the same resources for each week of delivery. Therefore, if a child needed to be removed from one class and placed in another, for security reasons for example, the learning was seamless and the disruption to the child minimal. This strategy was not well embedded in the mathematics curriculum.

3.37 Staff had received training in phonics and trauma informed approaches. As a result, most teachers adapted their teaching and classroom management strategies well to support the children to overcome the barriers that they faced.

3.38 Leaders and managers have developed an effective marking strategy for English teachers that developed the children's skills and knowledge well. The children's work was annotated effectively using 'what went well', and 'even better if'. Teachers provided helpful action points on each piece of marked work to help the children improve. Most teachers used directed improvement and reflection tasks to structure the improvements that children made to their work in class. These strategies were not evident in mathematics classes.

3.39 Leaders and managers had recognised mathematics teaching was weak and had taken positive action to effect much needed improvement. They had appointed a new curriculum manager, managed out some weaker teachers and appointed new ones. Those new to teaching were supported to gain a recognised teaching qualification. The impact on the children's learning and progress was yet to be fully realised.

3.40 Not enough children achieved the whole qualification in functional skills, English and mathematics. The English and mathematics GCSE delivery model was acting as a barrier to the children's success. The children were required to study both subjects to GCSE level simultaneously. Those who had significant gaps in their knowledge in one subject struggled, and this impacted on their progress in both subjects. Currently, no children had achieved a pass in either subject.

3.41 In education, the reading strategy supported and promoted reading well. The children participated in a wide range of activities to develop their reading skills including in English and mathematics classes. However, there was no establishment wide reading strategy to promote and support reading across the establishment.

3.42 Ofsted considered that the YOI had made insufficient progress against this theme.

Theme 2: What action had leaders and managers taken to improve the oversight of quality assurance procedures to make sure that weaknesses, including those found at the previous inspection, had been fully addressed?

3.43 Leaders and managers had taken some action to improve their oversight of quality assurance activities. In 2023 a new prison post, the of head of education, skills and work, was created and commenced in the autumn. Since then, senior leaders and managers had been provided with reports that gave them some oversight of the quality of provision. A range of useful activities took place to review provision, but the outcomes of these activities were often not recorded and as such the impact could not be measured. Prison managers did not have a strategic overview document that collated improvements actions and

identified outcomes and milestones within set timescales. As a result, they could not monitor progress easily.

3.44 In education, quality assurance processes had been slow to effect improvement. The 2024/25 quality improvement plan, informed by the most recent self-assessment, did not drive improvements at pace. Many objectives had been carried over from the previous plan and still needed to be achieved. In recent months, the pace of improvement had increased. The support provided by a regional education quality manager was focused and appropriate. Targeted training and development gave managers and teachers the skills and confidence to do things differently and more effectively. The impact was significant in the teaching of English, but less so in mathematics.

3.45 In education, many issues had not been resolved. Too many children who started a course in English or mathematics did not complete it. Too many children did not turn up for or were taken out of lessons. Leaders and managers identified the reasons why and the number of hours missed from education sessions but had not yet sought solutions to improve these issues.

3.46 There were not enough teachers to deliver the curriculum, which reduced the scope of provision and opportunities to interest and purposefully occupy the children. Vacancies existed in a number of areas including hospitality and construction crafts. The education provider had recruited staff to some vacancies, but they had not yet started. They planned to recruit more staff in the coming months. However, other senior staff and teachers were leaving imminently which created further vacancies.

3.47 Ofsted considered that the YOI had made insufficient progress against this theme.

Section 4 Summary of judgements

A list of the HMI Prisons concerns and Ofsted themes followed up at this visit and the judgements made.

HMI Prisons concerns

The level of self-harm among girls was extremely high and this resulted in very high levels of use of force and assaults on staff. There was still no effective model of custody for these very vulnerable children and, despite the best efforts of staff, the YOI was not able to meet their needs.
Reasonable progress

Too many children were separated for too long. Children who were separated in their own cells on the main wings experienced very little time out of their cell, particularly at weekends.
No meaningful progress

There was a high number of pain-inducing restraint techniques and strip-searches under restraint. Many of these incidents were not in accordance with national policy and were not properly authorised. Scrutiny of video footage and support on the scene by leaders were poor.
Reasonable progress

The implementation of custody support plans was weak. Many sessions did not take place and those that did were opportunistic or cursory in nature.
Insufficient progress

Residential units required continuing maintenance. Some cells were cold and in poor repair.
Reasonable progress

Children spent too much time alone locked in their cells, particularly at weekends.
Reasonable progress

Ofsted themes

Leaders and managers had not given sufficient oversight of quality assurance procedures to make sure that weaknesses, including those found at the previous inspection, had been fully addressed.
Insufficient progress

The teaching of English, including reading and mathematics, was not good enough.
Insufficient progress

Appendix I About this report

HM Inspectorate of Prisons (HMI 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 visits 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.

Independent reviews of progress (IRPs) are designed to improve accountability to ministers about the progress establishments make in addressing HM Inspectorate of Prisons' concerns in between inspections. IRPs take place at the discretion of the Chief Inspector when a full inspection suggests the establishment would benefit from additional scrutiny and focus on a limited number of the concerns raised at the inspection. IRPs do not therefore result in assessments against our healthy establishment tests. HM Inspectorate of Prisons' tests for children's establishments are safety, care, purposeful activity and resettlement. For more information see our website: Expectations – HM Inspectorate of Prisons (justiceinspectorates.gov.uk)

The aims of IRPs are to:

- assess progress against selected priority and key concerns
- support improvement
- identify any emerging difficulties or lack of progress at an early stage
- assess the sufficiency of the leadership and management response to our concerns at the full inspection.

This report contains a summary from the Chief Inspector and a brief record of our findings in relation to each concern we have followed up. The reader may find it helpful to refer to the report of the full inspection, carried out in [MONTH, YEAR] for further detail on the original findings (available on our website at Our reports – HM Inspectorate of Prisons (justiceinspectorates.gov.uk)).

IRP methodology

IRPs are announced at least three months in advance and take place eight to 12 months after a full inspection. When we announce an IRP, we identify which concerns we intend to follow up (usually no more than 15). Depending on the concerns to be followed up, IRP visits may be conducted jointly with Ofsted (England), Estyn (Wales), the Care Quality Commission and the General Pharmaceutical Council. This joint work ensures expert knowledge is deployed and avoids multiple inspection visits.

During our three-day visit, we collect a range of evidence about the progress in implementing each selected concern. Sources of evidence include observation, discussions with children, staff and relevant third parties, documentation and data.

Each concern followed up by HMI Prisons during an IRP is given one of four progress judgements:

No meaningful progress
Managers had not yet formulated, resourced or begun to implement a realistic improvement plan to address this concern.

Insufficient progress
Managers had begun to implement a realistic improvement strategy to address this concern but the actions taken since our inspection had had not yet resulted in sufficient evidence of progress (for example, better and embedded systems and processes).

Reasonable progress
Managers were implementing a realistic improvement strategy to address this concern and there was evidence of progress (for example, better and embedded systems and processes) and/or early evidence of some improving outcomes for children.

Good progress
Managers had implemented a realistic improvement strategy to address this concern and had delivered a clear improvement in outcomes for children.

When Ofsted attends an IRP its methodology replicates the monitoring visits conducted in further education and skills provision. Each theme followed up by Ofsted is given one of three progress judgements.

Insufficient progress
Progress has been either slow or insubstantial or both, and the demonstrable impact on learners has been negligible.

Reasonable progress
Action taken by the provider is already having a beneficial impact on learners and improvements are sustainable and are based on the provider's thorough quality assurance procedures.

Significant progress
Progress has been rapid and is already having considerable beneficial impact on learners.

Ofsted’s approach to undertaking monitoring visits and the inspection methodology involved are set out in the *Further education and skills inspection handbook*, available at https://www.gov.uk/government/publications/education-inspection-framework.

Inspection team

This independent review of progress was carried out by:

Donna Ward	Team leader
Angus Jones	Inspector
Angela Johnson	Inspector
Emma King	Researcher
Samantha Moses	Researcher
Tareek Deacon	Researcher
Alicia Grassom	Researcher
Jasmin Clarke	Researcher
Sheila Willis	Ofsted inspector
Joanne Stork	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

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

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.

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

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