Report on an unannounced inspection of

HMYOI Wetherby

by HM Chief Inspector of Prisons

27 October – 6 November 2025

Contents

Introduction

HMYOI Wetherby is an establishment in Yorkshire that can hold up to 288 boys between the ages of 15 and 18. However, a combination of recent reductions in the number of children in custody across England and Wales and the higher demand for places in the south east and north west meant that just 97 children were held at the time of this inspection. We judged outcomes for children to be not sufficiently good for safety, reasonably good for care, not sufficiently good for purposeful activity, and good for resettlement.

While there had been progress in some areas since our last inspection in 2023, significant weaknesses remained, particularly in safety and education. Levels of violence were high, and many incidents involved weapons. Although leaders had improved the recording and investigation of incidents, the prevalence of violence continued to undermine the safety of children and staff.

Relationships between staff and children were inconsistent. In our survey, only 49% of children said they felt cared for, and more than half reported experiencing verbal abuse from staff. Leaders had invested in cultural change and introduced team leaders to improve visibility and support, but these efforts had not yet delivered the level of trust and engagement required to sustain a safe and respectful environment.

Purposeful activity remained a serious concern. Ofsted judged the quality of education, skills and work provision to be inadequate. Leaders had not rectified weaknesses identified at the previous inspection, and too many children continued to make slow progress and leave without achieving qualifications. Attendance at classes was low, teaching was weak, and professional development for teachers was insufficient. While the governor had expanded work opportunities and enrichment activities for the children, these improvements did not compensate for the poor quality of the core education provision.

In contrast, resettlement work was a strength. Children benefited from a well-resourced resettlement team who worked collaboratively with other departments and the community. Release on temporary licence was used effectively to maintain family ties and support reintegration. Most children had accommodation arranged in good time before release, which supported the provision of education or employment placements for them.

The governor had started to make progress in addressing our previous concerns, but many outcomes for children remained frustratingly unchanged since 2023. The recent reduction in population, dramatically increasing the resources available per child, does however, provide an opportunity to accelerate the pace of change and to address the long-running concerns; in particular, about safety and education.

Charlie Taylor
HM Chief Inspector of Prisons
December 2025

What needs to improve at HMYOI Wetherby

During this inspection we identified 11 key concerns, of which five 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 were high; many incidents were serious and involved the use of weapons.**

2. **The rate of self-harm was very high and much higher than in other comparable prisons.**

3. **There were notable weaknesses in staff-prisoner relationships.** Some children reported that they had been subjected to verbal abuse by staff, and their treatment by staff was inconsistent.

4. **Leaders did not have effective oversight of the quality of education and skills**. The actions they had taken had not improved the education and training that children received.

5. **Leaders did not make sure that teachers, including those on outreach, received targeted professional development to help improve the quality and effectiveness of teaching which we judged to be weak.**

Key concerns

6. **Staff did not routinely draw body-worn cameras, or they did not activate them during use of force incidents. There was insufficient oversight of use of force by senior leaders.**

7. **Drug strategy meetings were poorly attended, generated limited actions, and lacked focus on harm reduction.**

8. **Children were not always transferred to a mental health hospital promptly**.

9. **There was ineffective governance of medicines administration and children did not always receive medications safely**.

10. **Leaders had not made sure that children's attendance in education and vocational training had improved sufficiently.**

11. **Provision for visitors was inadequate.** The visitors' centre was not always open, and it lacked facilities, including hot drinks and food, despite the long journeys that visiting families had made.

Care Quality Commission regulatory recommendation

Care and treatment must be provided in a safe way for service users, including the proper and safe management of medicines.

About HMYOI Wetherby

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

Certified normal accommodation and operational capacity (see Glossary) as reported by the establishment during the inspection
Children held at the time of inspection: 97
Baseline certified normal capacity: 318
In-use certified normal capacity: 288
Operational capacity: 288

Population of the establishment
- An average of three children a week were received.
- 14 foreign national children.
- 48.5% of children from black and minority ethnic backgrounds.
- 30.9% of children on remand.
- 10 children released into the community each month.
- 55% will become adults while in custody on their current sentence or remand.
- 35% of children had been excluded from mainstream education prior to custody.

Establishment status (public or private) and key providers
Public

Physical health provider: Leeds Community Healthcare NHS Trust
Mental health provider: South West Yorkshire Partnership and NHS Foundation Trusts Children and Mental Health Services
Substance misuse treatment provider: Change Grow Live
Dental health provider: Time for Teeth
Dedicated Social Work Team: Leeds City Council
Prison education framework provider: Novus
Escort contractor: GEOAmey

Prison department
Youth Custody Service

Prison Group Director
Sonia Brooks

Brief history
HMYOI Wetherby began life as HMS Ceres, a naval base, before it was converted into a borstal in 1958. It evolved into an open youth custody centre and later a young offender institution for children aged 15–18. Key developments include the construction of new accommodation blocks in the 1970s and 1997, the opening of the Keppel unit in 2009, and the Napier enhanced support unit in 2019. Today, it operates under HMPPS, focusing on

education, sentence planning and rehabilitation for young people from across England and Wales.

Short description of residential units
Anson: closed for refurbishment
Benbow: segregation unit and restricted status
Collingwood: mainstream services
Drake: mainstream services
Exmouth: mainstream services
Frobisher: mainstream services
Keppel: mainstream services; first night and induction; low-risk workers
Napier: enhanced support unit

Name of governor and date in post
Mark Scott, 2024

Changes of governor since the last inspection
Peter Gormley, 2020–2024

Independent Monitoring Board chair
Catherine Porter

Date of last inspection
20 November – 7 December 2023
[Independent Review of Progress, 22 October – 6 November 2024]

Section 1 Summary of key findings

Outcomes for children

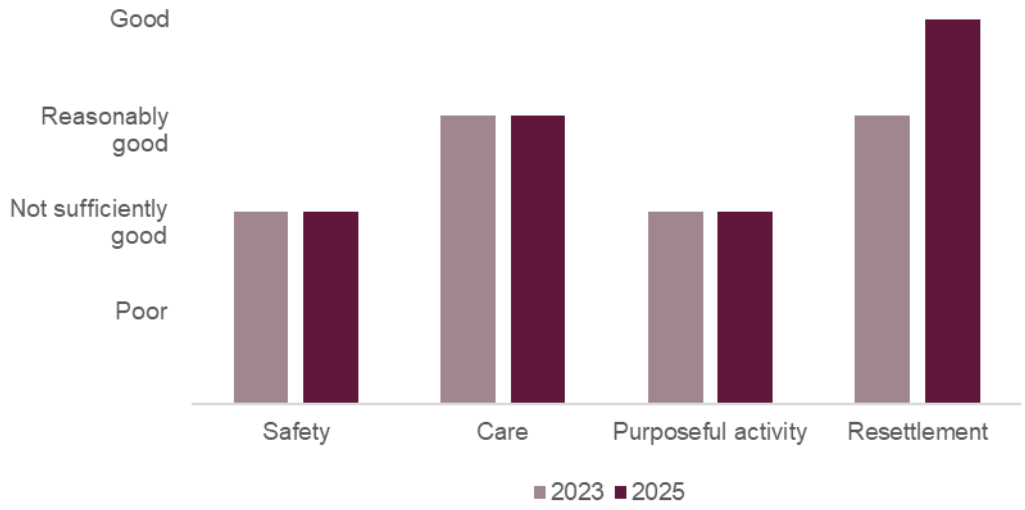
1.1 We assess outcomes for children against four healthy establishment tests: safety, care, purposeful activity and resettlement (see Appendix I for more information about the tests). We also include a commentary on leadership in the establishment (see Section 2).

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

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

1.3 We last inspected HMYOI Wetherby in 2023. Figure 1 shows how outcomes for children have changed since the last inspection.

Figure 1: HMYOI Wetherby healthy establishment outcomes 2023 and 2025



Progress on priority and key concerns from the last inspection

1.4 At our last inspection in 2023, we raised 11 concerns, seven of which were priority concerns.

1.5 At this inspection we found that six of our concerns had been addressed and four had not been addressed; the concern about girls was no longer relevant. 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 four 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)	A full-time family therapist was available to help children and families explore and repair relationships, both while in custody and through preparation for release.	See paragraph 6.7
b)	Leaders requested regular feedback from MAPPA (multi-agency public protection arrangements) coordinators on the written submissions for MAPPA meetings. This had led to contributions that were always detailed and well-evidenced, adding clear value to multi-agency discussions.	See paragraph 6.23
c)	The co-location of resettlement practitioners and social workers was highly effective, supporting good communication and fostering a collaborative approach to addressing children's needs, particularly concerning their entitlements and resettlement.	See paragraph 6.26
d)	Through the gate support for children by the In2Out charity, which offered mentors and follow-up visits by resettlement practitioners, helped to support the child during their transition back into their community.	See paragraph 6.32

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 The governor had been appointed shortly after the previous inspection. He had a clear vision and was ambitious for the establishment, focusing on improving access to education, employment and other daily activities by reducing the number of children who needed to be kept apart from each other to prevent violence.

2.3 The reduced population had the impact of significantly increasing the resources available for each child. Staffing ratios were now very high. Leaders had not fully exploited this opportunity to increase the pace of improvement at the YOI.

2.4 The deputy director of operations at the Youth Custody Service was supportive of the governor's three-year plan and had provided capital investment since our previous inspection. She had an accurate understanding of the progress that had been made, as well as the challenges that remained.

2.5 The governor's vision was undermined by very weak leadership in education, which Ofsted judged to be inadequate. As a result, education outcomes for children at Wetherby had declined, children making slow progress and, ultimately, few achieving qualifications. The governor had tried to mitigate this by increasing the number of workplaces children could access through the introduction of 'Q branch' (see paragraph 4.4), a horticulture and waste management initiative. In our survey, far more children than at other young offender institutions (YOIs) said they were in paid work (29% compared with 5%). They were particularly enthusiastic about these new opportunities, which gave some access to more than 11 hours a day out of cell. The governor had well-advanced plans to expand these opportunities through the employment of four more instructors and the opening of a laundry and bakery at the site.

2.6 Leaders had rightly prioritised changing the culture and building trust between children and staff. However, weaknesses remained; in our survey, just 49% of children said they felt cared for and, concerningly, 54% said they had experienced verbal abuse from staff. Despite the

number of frontline staff and the reduced population, leaders had been unable to make sure that children received a meaningful weekly meeting with a member of staff they knew well. The lack of effective staff-children relationships undermined the significant investment in the framework for integrated care (see glossary).

2.7 The introduction of team leaders across the site had, however, improved the visibility of leaders and provided support to frontline staff and children.

2.8 Leaders had been successful in making sure that each living unit now mixed as one group. This had substantially improved time out of cell, as well as creating a more relaxed atmosphere. In addition, the governor had improved the cleanliness and invested in the appearance of residential units, which now looked much better than at the previous inspection.

2.9 Despite some considerable effort, leaders had not reduced self-harm, violence or the frequent use of weapons at the site.

2.10 Leaders in the resettlement unit had successfully expanded release on temporary licence opportunities for children. This had improved support for family ties, as well as education and work.

2.11 Leadership within health services was effective and children had swift access to health care at the site.

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 The number of new receptions had decreased markedly since the previous inspection, and the number of children arriving late after 9pm had also reduced. On average, two to three children were received each week, and only seven had arrived after 9pm in the previous three months.

3.2 Initial assessments of risk and needs among new arrivals were prompt and effective. These took place in private and were carried out by health care professionals and prison staff trained in first night procedures. Children were given a hot meal and drink on arrival and the opportunity to contact their families. They could also place a shop order immediately and received a welcome pack containing snacks and essential items. This initiative was viewed positively and helped offset the risk of children accruing debt from peers.

3.3 The use of holding rooms had decreased, with most children arriving individually and transferred promptly to the first night centre. While these rooms remained sparsely furnished, the addition of cushions to the hard benches was an improvement.

3.4 The first night centre had been relocated to the Keppel unit. The environment was bright and adequately furnished, but contained little information for new arrivals. The first night cells we saw were clean and largely free of graffiti. Staff conducted additional hourly checks on children through the night when they first arrived.

First night centre (left), and prepared cell for new arrival (right)

3.5 Induction commenced the following day. We observed children engaging with the process, and those we spoke to described it as informative and helpful. During induction, children met staff from key departments including health care, education, conflict resolution and the chaplaincy. Following completion of the induction programme, children were typically transferred to one of the residential units within seven days.

3.6 Time out of cell for children on induction was similar to their peers on other units, and when not on induction they could mix with other children on the unit.

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.

3.7 Safeguarding procedures had improved since our last visit. The number of referrals had increased from 288 to 502 and came from a broad range of sources, including children and their families. This increase was driven by improved awareness of the safeguarding team across the establishment.

3.8 The onsite dedicated social work team, which consisted of four local authority social workers and a team manager, helped to triage every referral and saw every child who was the subject of a safeguarding investigation. Most referrals were dealt with swiftly and those that met the threshold were referred to the local authority designated officer (LADO) within 24 hours. Records showed a few occasions, mostly at weekends, when referrals exceeded the 24-hour limit.

3.9 Over 50 referrals had been escalated to strategy meetings by the local authority, and a further six had been fully investigated by the LADO in the previous 12 months. The actions from these interventions were dealt with promptly and there were very few outstanding investigations.

3.10 There were two weekly meetings; one every Monday to set and check any actions form the previous week's referrals, and one later in the week with the governor who checked progress and quality assured the triage process. The LADO attended a quarterly meeting and provided independent scrutiny.

3.11 Despite these processes, children continued to have little confidence in them; in our survey, only 20% of children said they would report bullying or victimisation by other children and 48% that they would report it by staff.

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.

3.12 The rate of self-harm had reduced since our previous inspection but remained much higher than in other YOIs. Wetherby did care for several children who self-harmed prolifically, which contributed to these high levels.

3.13 Assessment, care in custody and teamwork (ACCT) case management for children at risk of suicide or self-harm supported those in crisis reasonably well. Records showed that triggers for self-harm were identified well and care plans contained actions that aimed to reduce self-harming behaviours. Children told us that when on ACCT they felt supported and staff went out of their way to help them, which they appreciated. Reviews were prompt and well attended, and the records were detailed and demonstrated that staff had a good knowledge of the children and their issues.

3.14 Children assessed as at the greatest level of risk had an enhanced support team to help them. These teams consisted of a broad range of professionals involved in their care, including the child and adolescent mental health service (CAMHS), psychology, resettlement practitioners and the chaplaincy. These teams provided bespoke support plans and there was good evidence that they reduced the prevalence of self-harm by the children they were supporting.

3.15 Every child at Wetherby had a 'formulation' completed on arrival, a one-page document with a brief history about them and important information to aid staff in their day-to-day management. Most staff knew about these, but few told us they had the time to read them or use them to support the children in their care.

3.16 Immediate support for children identified as at risk of self-harm was discussed at a well-attended weekly meeting, which monitored individual cases effectively. A broader range of data was reviewed at the monthly safety meeting, and leaders had a good understanding of the underlying causes of self-harm; however, there was insufficient coordinated action to reduce the overall prevalence of self-harm.

3.17 Constant supervision had been used 11 times in the previous 12 months, with more than half of uses for the same two children. Each case was authorised appropriately and reviewed frequently to make

sure that children only spent the minimum time necessary under this level of supervision.

Security

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

3.18 The security department had three senior leaders who had recently taken up post. They were developing the local security strategy to support wider prison priorities, including addressing violence and combating the rise in weapons made by children.

3.19 In the previous 12 months, 12,475 incident reports had been submitted, most relating to disorder, violence and self-harm. These data were used to inform the local threat assessment and intelligence objectives; however, too few frontline staff we spoke to were aware of the three priority intelligence objectives.

3.20 There had been 512 cell searches in the previous 12 months, of which 152 had resulted in the discovery of unauthorised items, mostly weapons. A total of 742 weapons had been found in the previous 12 months; many more than at the last inspection. Children told us they made weapons to feel safer, as they knew of others who carried them at the site. Despite some initiatives such as weapons amnesties, leaders needed to do more to address the problem of makeshift weapons made by children.

3.21 Leaders had been proactive in reducing the strip searching of children and now made sure that all those carried out were in response to intelligence. As a result, far fewer of these searches had taken place in the previous 12 months compared with the same period before the last inspection. All were authorised by a duty governor.

3.22 Security arrangements, including handcuffing for external appointments, were generally proportionate. The physical security concerns we had at the last inspection, such as broken cell windows and poor exterior lighting in the grounds, had mostly been addressed. Most CCTV cameras were functioning, and leaders reported fast repair times when they were out of action. One child was on restricted status (see Glossary) and leaders had sensibly integrated him into prison life, so he was able to attend activities and education alongside his peers. The three children imprisoned for Terrorism Act 2000 (TACT) offences were discussed at the pathfinder meeting, and there was good support from the police and other key agencies to manage their risk.

3.23 In our survey, 32% of children said they had had a drug problem when they arrived at the prison, of whom 64% said they had received support for this. The site was not conducting random mandatory drug testing (MDT). In the previous 12 months, 141 suspicion drug tests had been attempted; 32 children had refused to be tested. Of those tested, 26%

tested positive for illicit substances, which was high and could possibly have been much higher if all children had agreed to be tested. This indicated good intelligence on illicit drug use at the site. Most positive tests were for cannabis and amphetamines, and the main entry routes for drugs were through visits and reception.

3.24 Support from regional police dog handlers was intermittent. Leaders had limited interventions at their disposal to disrupt supply routes, but they used these effectively and positive tests had reduced since July 2024.

3.25 While drugs use was not widespread, oversight in this area was limited. Quarterly drug strategy meetings were poorly attended and had generated very few meaningful actions targeted at reducing drug use at the YOI. The absence of a comprehensive drug strategy was a significant shortfall. Although this had been an agreed action point in August 2024, there was still no formal strategy at the time of our inspection. The current approach was reactive with less focus on demand reduction.

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.

3.26 The incentives and earned privileges (IEP) policy had been updated and was more innovative than we typically see at similar YOIs. Leaders had introduced a range of short-, medium- and long-term incentives for children who behaved well, and this approach was proving effective. Almost half of all children were on the highest level, and only 15% were on the lowest. Reviews and rewards were applied consistently, and children we spoke to had confidence in the system. The policy was easy to understand and child-friendly. Combined with new work opportunities and increased access to release on temporary licence (ROTL), this had created a more meaningful offer for those who engaged.

3.27 The weak point of this otherwise improved system was limited oversight of the merit scheme. This made is difficult to track which staff awarded merits and how often.

3.28 There was no longer an enhanced-status wing, as at the previous inspection, and the differences between incentive levels were wider. This had ensured that children on the highest level of the scheme could access incentives regardless of their location.

3.29 There had been 2,437 adjudications in the last 12 months. The adjudications we reviewed were appropriately applied for the most serious charges but there was not always evidence that children were offered advocates if they needed them. Outcomes were proportionate

and monitored through adjudication standardisation meetings. The separation monitoring and review group (SMARG) reviewed relevant data on adjudications, and the deputy governor conducted quality assurance.

3.30 Keppel unit no longer had a national role as a specialist unit to support more vulnerable children. Local managers were using the fours spurs as induction, normal location and a unit for workers.

3.31 The enhanced support unit (ESU) on Napier aimed to provide support for those with the highest level of need. However, at the time of our inspection only one of the six cells was operable because of damage. As a result, most children who had been placed at the YOI to receive ESU support were living elsewhere at Wetherby. This impacted negatively on the consistency of the care they received.

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.

3.32 Violence remained too high. There had been 491 assaults in the previous 12 months, of which 63 were recorded as serious. Assaults on staff were higher than child-on-child assaults, at 199 and 163 respectively. There had also been 129 fights. The rate of violence was slightly higher than at similar YOIs and remained too high, as at the last inspection.

3.33 There had been notable improvements in the recording and investigation of violent incidents, and leaders had a good understanding of the drivers of violence. All incidents were investigated thoroughly, and findings informed the safety action plan; this was an improvement since the previous inspection. Most incidents were either an escalation of play fighting (which usually occurred on the exercise yard; around 50% escalated into a fight), children joining in assaults to support friends, or frustration with staff instructions. As a result, staff were briefed and encouraged to stem playfighting as quickly as possible, and many to whom we spoke were alert to this.

3.34 Interviews with children following incidents were detailed; staff gave them time and space to explain what had happened as clearly as they could, which helped inform measures to prevent recurrence. Children involved in violence were screened at the weekly safety intervention meeting, and where appropriate (based on risk and levels of violence) a single case manager was identified to work with the child on a plan to reduce their involvement in violent incidents. Case reviews were individual, and relevant information was shared to support reintegration or reparations as soon as possible.

3.35 The conflict resolution team was active and engaged children as soon as they were ready. The culture of addressing issues through informal

resolution at the earliest opportunity meant small problems were dealt with before they escalated. This reduced the need for prolonged separation and allowed more children to mix.

3.36 The number of children kept apart from others that we saw at the last inspection was being addressed, and most children now mixed on their wings, which was a significant achievement. This meant children could access more activities with greater fluidity than previously. Leaders had continued to work on this, and the number of 'keep-aparts' had fallen from 520 to 252 in the last 12 months. Some children spoke positively about this, particularly those who could now access working parties such as Q Branch and horticulture (see paragraph 4.4).

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 In the last 12 months, 950 incidents of use of force were recorded. Set against the now smaller population, this was an increase from the previous inspection. The rate of violence remained, however, the lowest among similar YOIs, although a typical 80 incidents per month remained a concern in an institution holding 97 children.

3.38 Pain-inducing techniques had been used on 11 occasions (10 mandibular and one inverted wrist flexion), compared with nine previously. These techniques were not always applied appropriately or proportionately, and leaders had acted where staff practice fell short. Minimising and managing physical restraint (MMPR) handling plans were in place for children with medical conditions that could be exacerbated by restraint, and staff were aware of them, which helped to keep children safe.

3.39 The governor had prioritised reducing the backlog of use of force reports, with some success. Very few documents were outstanding, and the quality of those we reviewed were more detailed than we have seen in other YOIs. All children were interviewed following a restraint; the interviews we reviewed provided important context from the child's perspective about what had happened and how to prevent recurrence.

3.40 MMPR coordinators reviewed all incidents, with weekly meetings for higher-level restraints and discussion at the monthly MMPR meeting, although there were still insufficient reviews of body-worn camera footage by senior leaders. Some use of force incidents that we reviewed were not managed well. Leaders were aware of this weakness and had plans to upskill middle managers.

3.41 Nearly all staff were now up to date with their use of force training. However, they still did not routinely wear or activate cameras during

incidents. This limited the ability to conduct thorough reviews and made it difficult to ascertain what had happened in the sample we examined.

3.42 PAVA incapacitant spray had been issued to a few specialist staff since the previous inspection. It had been drawn once in the last 12 months, during an incident involving two children and a weapon, but was not deployed. Record-keeping for this incident was detailed and had been scrutinised by the quarterly independent MMPR review panel, which raised no ongoing concerns.

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.

3.43 In our survey, 73% of children said they had been kept locked up or prevented from mixing with others as a punishment. In the last 12 months, separation had been used 495 times, 135 of which were for self-isolation. Most separations were initiated to prevent harm to others or for self-isolation and took place on Benbow or Napier (the enhanced support unit). Children were separated for an average of 12 days, which was too long, although planning for reintegration was robust and well structured.

3.44 Benbow, the designated segregation unit, was tired and grubby but there were plans to relocate it to Anson, which had recently been redecorated and furnished; this would be a positive development.

Separation cell on Benbow

3.45 All children on the unit were assigned a single case manager, and most children we spoke to knew who this was and the date of their next review. They were also able to explain why they had been separated and what their plan involved. However, at the time of our inspection, four children had been separated for more than 50 days while awaiting clinical assessments or transfers to other establishments, which understandably caused frustration. These children often experienced a very limited daily routine. Authority from the prison group director or area manager to extend segregation was sought and granted promptly.

3.46 Reintegration planning was very strong. Each child had a plan tailored to their individual needs and was reviewed through a multidisciplinary team. Each plan included clear actions with named staff responsible for specific tasks, which was better than we often see. Plans explained why the child was separated, captured their views and voice, and included a detailed risk assessment to support them during and after separation. The approach was thoughtful, child-focused and impressive.

3.47 Oversight of record-keeping had improved. Records were well maintained and reviews were held on time. A single case management approach for all segregated children was a positive development. A sensible, risk-based approach allowed children to mix with peers and access education and gym sessions while segregated, which was commendable. Most children spoke positively about segregation staff and said they were treated with respect, which mirrored our observations.

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 In our survey, just 49% of children said they felt cared for by staff. However, we observed some good interaction between staff and children, most notably while children were undertaking enrichment activities and Q Branch (see paragraph 4.4). Many staff were knowledgeable about those in their care, but inconsistency from a minority, reported to us by children, and an inability to respond quickly to everyday requests, undermined relationships.

4.2 In our survey, 54% of children said that they had received verbal abuse from staff. The number of complaints about staff had also increased, but poor oversight hindered managers' understanding of both the scale of the problem and the issues raised (see paragraph 4.14). Children also informed us that they had witnessed staff using abusive language, most commonly in response to children swearing at them, or making inappropriate comments that they justified as banter.

4.3 Custody support plan meetings between staff and children were frequent but varied in the quality of plans and goals agreed. There was useful quality assurance of plans with leaders receiving feedback on both the frequency and quality of assessments. Alongside more structured one-to-one sessions, an identified officer conducted fortnightly check-ins with each child; children reported that these officers were mainly based on the same wings, making contact more regular.

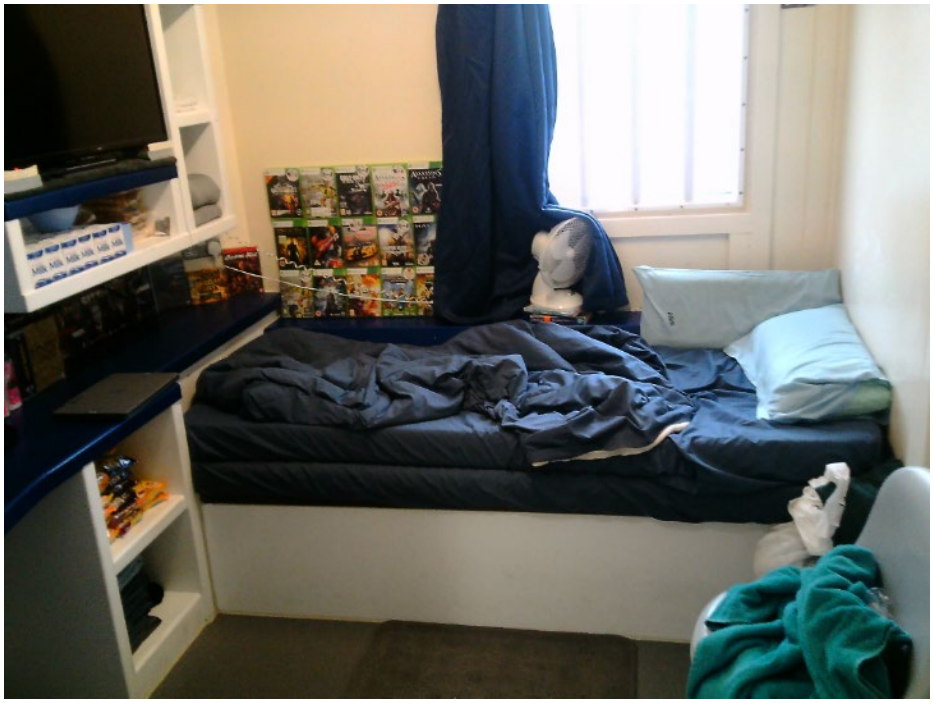
4.4 We observed some excellent staff and child relationships within the Q Branch, where they worked together to carry out minor repairs and horticultural activities across the establishment. A positive culture of mutual respect and trust was evident during all the activities observed.

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

4.5 Cells were in good condition and well equipped with adequate furniture. Graffiti was regularly removed, and in-cell repairs were generally dealt with promptly by Q Branch or contracted maintenance teams. However, some children reported issues with temperature regulation and that they were cold during the winter.



Typical cell

4.6 A cell refurbishment programme under way was providing damage-resistant surfaces, and curtains and rails for additional privacy. Communal and association areas were clean and tidy, with access to a good range of entertainment and recreational equipment. Children had reasonable access to their stored property and clean clothes, towels and bedding.

Living unit

4.7 Each child was allocated a laptop which they used to communicate with different departments, make meal selections, order items or view content uploaded by leaders. Laptops provided useful information about the establishment and were used by leaders to communicate with children. Leaders had been proactive in making sure that the information provided was accurate and timely. For example, the information about how to submit complaints was effective, with 91% of children in our survey understanding how to submit one.

Residential services

4.8 While only 38% of children surveyed said the food was good, we found its quality and quantity were adequate. The serving of meals was well-supervised, but in our survey only 31% of children thought they got enough to eat. Servery staff had received training for their role and used appropriate utensils and personal protective equipment to serve food correctly.

Servery

4.9 Children ordered meals on their laptops from a standard menu, which offered a four-week cycle of six daily meal choices. The options catered for religious and other dietary requirements, and Ramadan had been accommodated appropriately. Eight children were on a special diet created in consultation with the catering manager to meet their personal needs.

4.10 Children could order from the shop each week and were able to buy items from a few catalogues available on their laptops. New admissions could buy a range of items, including toiletries, food and confectionery, from reception (see paragraph 3.2). This was a positive initiative aimed at making sure that children did not go without items before their first shop order and risk getting into debt, with the amount spent recouped through their weekly allowance at a reasonable rate.

4.11 Children could submit requests for additional cultural grooming products, and other items not available on the standard shop list, through their laptops. They could also suggest additional items through the monthly youth council meetings. The introduction of a financial reward scheme to encourage good behaviour allowed children to buy additional items, including sportswear clothing.

Consultation, applications and redress

4.12 Consultation arrangements were good, with monthly youth council meetings providing an opportunity for wing representatives to raise concerns and suggestions. In addition, Kinetic Youth workers (see Glossary) consulted children across the wings and fed back to the youth council. Improvements had been made as a result of the consultation and changes were well communicated through a newsletter and updates on the laptops.

4.13 Children used both laptops and electronic kiosks to make applications, with action taken promptly. In the last 12 months, 18,800 applications had been submitted and we found only 21 remained outstanding.

4.14 There had been 592 complaints in the last 12 months, an increase since our previous inspection. All complaints were responded to in a respectful and evidence-based manner and within seven days. As a result of poor analysis of complaints, leaders were unsighted on growing trends and missed opportunities to resolve thematic issues. Despite regular quality assurance of responses, the incorrect categorisation of some complaints had affected decision-making. One example was that of the 10% of staff complaints that we reviewed, only half directly related to staff conduct and others were about the regime. An inaugural monthly complaints meeting took place during the inspection; it was too early to assess its impact.

4.15 Barnardo's (a national children's charity) continued to offer a well-used advocacy service: supporting children to resolve day-to-day issues; attending adjudications where requested; and helping in the submission of applications and complaints. Wings had dedicated Barnardo's 'child advocates', who provided a personal support service that understood the individual needs of children.

4.16 Legal mail was handled appropriately. There were suitable facilities for legal visits, with private rooms for official prison video conferencing calls with legal representatives (see Glossary) and booths for in-person meetings.

4.17 Library resources did not include any up-to-date legal texts for children to access, but information about legal rights and prison service instructions were available through their in-cell laptops.

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

4.18 There was reasonably good oversight of fair treatment and inclusion work at Wetherby. An analyst helped to provide data for the equality action group (EAG) that met monthly and was chaired by the governor or his deputy. These data were used to identify potential disproportionate treatment of children across a range of areas, such as adjudications, separation and complaints. Where concerns were raised, we saw good investigations and actions for resolution in EAG meeting records.

4.19 There was a well-developed equality strategy, informed by regular consultation with children. These consultations focused on issues relating to the protected characteristics, and leaders had also introduced wider topics of interest, such as the impact of recent race-related riots, and ways to build confidence in the complaints process and the use of discrimination incident reporting forms (DIRFs). Records of these forums showed that children engaged openly and provided detailed feedback. Leaders acted on these views; for example, managers from different units now responded to DIRFs, following concerns that responses from managers within the same unit could lead to bias.

4.20 The number of DIRFs submitted over the previous 12 months had increased from 67 at the last inspection to 234 this time. Previously we found that many responses to them were late, but this was no longer the case; the process was now timely and monitored closely. The quality of responses was good. In our sample, most were investigated thoroughly, and answers were detailed. The equality team and the governor quality assured the DIRFs. As there was no independent scrutiny, leaders had decided to use a peer review system as part of the consultation process, in which children reviewed responses to several redacted DIRFs, which was a good idea.

4.21 Three equality peer mentors helped to raise issues for their peers with the equality team, but their impact was restricted as they could not visit their peers on other units, limiting the number they could help.

Protected characteristics

4.22 In our survey, children from different backgrounds mostly had similar perceptions of their treatment.

4.23 Just under half of the population told us that they had a disability, with most being hidden disabilities. At the time of the inspection, only one child was subject to a personal emergency evacuation plan (PEEP). This plan was comprehensive, well-advertised and detailed, including his place of work as well as his wing. In our survey, 90% of those who had a disability said they had been physically restrained, compared with 54% of those without a disability; leaders were unsighted on the reasons for this.

4.24 A neurodiversity lead officer offered one-to-one support for children, but there was too little coordinated action between agencies such as the education provider, the prison lead and health care provider for this group.

4.25 In our survey, 56% of children told us that they were from an ethnicity other than white. There was good support for children from a minority ethnic background and regular consultation, with some tangible results; for example, a barber experienced in minority ethnic hair had been recruited.

4.26 Home Office enforcement staff saw foreign national children regularly. There was access to interpreting services for non-English speakers, and records showed this was used frequently, although staff told us there was a shortage of the necessary phones on some units. There was little evidence of access to independent immigration advocacy.

4.27 Gypsy, Roma and Traveller children were well catered for, and had regular support groups and cultural events.

4.28 There was little in place for gay or transgender children. Leaders told us they would refer to the national policy if a trans child were received, and they already had product lists and sources for the needs of girls who had recently stopped being sent to Wetherby.

4.29 Activity to celebrate or inform children about the various protected characteristics and other cultures was underdeveloped and centred mostly on food choices. There were fewer such events to engage children than we usually see.

4.30 The chaplaincy was well integrated and provided good pastoral care for children. Sessional and visiting chaplains were available to cover most faiths. The team attended all ACCT reviews and saw separated children daily.

4.31 The chapel was well attended by several faith groups, and there were weekly one-to-one support sessions. Although corporate worship took place each week, because children were not able to mix across the site Muslim children only received prayers every third Friday and Christian children every other weekend, which was inappropriate. The chapel and multi-faith rooms were large but needed refurbishment.

Chapel

4.32 The coordinating chaplain maintained a calendar of religious events and made sure that children were encouraged to participate. For example, all children were allowed to celebrate Eid with a suitable menu available for all.

Health services

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

4.33 The inspection of health services was jointly undertaken by the Care Quality Commission (CQC) and HM Inspectorate of Prisons under a memorandum of understanding agreement between the agencies. The CQC found breaches of regulations and issued a request for an action plan following the inspection (see Appendix III).

Strategy, clinical governance and partnerships

4.34 The partnership worked well together at strategic and local level. There had been new contract arrangements between NHS England and the providers since April 2025; this had had no detrimental impact on the care of children. It was evident that the clinical services and prison staff were highly focused on meeting the needs of children. An up-to-date health needs analysis was used for service delivery and development.

4.35 A broad range of governance meetings covered all aspects of the service, but had failed to identify the risks we observed in medicines administration.

4.36 The overall quality of health provision was good with an appropriate range of child-focused services and 24-hour nursing presence. The services were very well led and delivered by a conscientious and skilled staff group.

4.37 Some children spontaneously told us that health care was good. It was evident throughout the inspection that staff knew the children well and were caring and respectful with them. Children had good access to the service, with an allocated officer(s) to escort them to their appointments.

4.38 Primary care staffing was fragile with several vacancies, and agency and bank staff were used regularly to cover the service. The child and adolescent mental health service (CAMHS) had only one vacancy. Both teams were in the process of recruitment.

4.39 Health staff received good training with any outstanding mandatory training scheduled for completion, and they all received clinical and

managerial supervision. They also had appropriate life support training, with easy access to emergency resuscitation equipment that was in good order.

4.40 Clinical incidents were promptly reported and investigated, and learning was shared to make sure that services were safe and effective. Health care staff had made 125 safeguarding referrals in the previous 12 months.

4.41 Feedback from children about services, regular audits and involvement in the youth council informed service delivery.

4.42 All health teams were co-located, which promoted good communication and joint working. Daily multidisciplinary handovers and complex case reviews also encouraged integrated working and child-centred care. This was further embedded through health staff representation at key meetings in the prison. Patient records were written comprehensively and in line with expected standards.

4.43 Some health care rooms were not fit for purpose and required refurbishment. The newly opened dental suite had a musty smell, suggesting potential damp. Health services were delivered on the wings from treatment rooms that met infection prevention and control standards.

4.44 There were very few complaints about health services, and these were addressed and resolved through face-to-face meetings with the child.

Promoting health and well-being

4.45 The health promotion strategy was in development with plans to consult with children about what should be included. A weekly health promotion drop-in session covered different topics each week. Children were offered sexual health screening at various points while in Wetherby and treatment was initiated as required. Individual sexual health advice was provided during appointments.

Primary care and inpatient services

4.46 The primary care team delivered a responsive 24-hour service with a caring staff group providing many services on the units.

4.47 Children had quick access to a variety of nurse-led services, such as minor injuries, wound care and vaccinations. The uptake of vaccinations was low, despite staff providing education and advice about the potential benefits. There were regular vaccination clinics and, if a child changed their mind, they could receive any vaccinations for which they were eligible.

4.48 Children had minimal waits for a routine GP appointment, with GPs from a local practice visiting daily, Monday to Friday.

4.49 The initial reception ‘CHAT’ (comprehensive health assessment tool, developed for young people in the criminal justice system)

assessments were completed on arrival, with a follow-up physical health CHAT usually completed the following day. Urgent needs were managed and children given information on how to access health care.

4.50 Children mostly made requests for health appointments on their laptops, although verbal and written requests were also accepted. Applications were triaged and urgent need prioritised, although most children were seen quickly for routine matters. Visiting professionals, such as the physiotherapist, managed their own waiting lists and there were reasonable waits for these services.

4.51 Long-term health conditions were well managed with staff making considerable efforts to engage relevant children in reviews and provide education about their condition. Care plans were reasonably detailed, and children were offered a copy.

4.52 There was good oversight of external hospital appointments and joint working with the prison made sure that officer escorts were provided for most appointments.

Mental health

4.53 The integrated CAMHS provision operated seven days a week and comprised a highly skilled, competent and child-focused team. The service offered a wide range of therapeutic and clinical interventions, with staff working within specialist pathways that promptly identified the appropriate care for the child. The team had strong leadership and management, a clear structure and defined pathways.

4.54 A trauma-informed approach was clearly embedded throughout the service and had influenced practice across health care. Staff took the opportunity to educate custodial staff, particularly in understanding the behaviours of the most vulnerable and complex children. Officers were invited to health-led learning events.

4.55 Children's mental health needs were assessed on arrival with specialist follow-up within 72 hours. Following assessment, allocation and interventions were agreed at weekly multidisciplinary meetings, or sooner in urgent cases.

4.56 The team had good oversight of all the children and therapeutic interventions took place promptly. The team had no waiting list except for a small number of children waiting for diagnostic assessments for autism.

4.57 The most complex patients received enhanced monitoring and case management. Staff worked closely with custodial staff to manage children's risks and needs. They actively contributed to all ACCT reviews.

4.58 A dedicated team supported children with neurodevelopmental needs. They undertook initial screening for children with potential neurodiverse conditions, identifying those who needed further assessment. Following

assessment, all children were seen to support their understanding of the diagnosis and guide any further care.

4.59 The team had a robust pathway to the harmful sexualised behaviours service provided by regional forensic CAMHS, and three children were on the caseload receiving treatment.

4.60 Five children had been referred for Mental Health Act assessment in the last year. These took place within time, and all were deemed to require hospital treatment. Three of the children did not transfer to hospital within 28 days, which was unacceptable and delayed the onset of treatment. In addition, one of these children turned 18 while waiting for a hospital bed and this contributed to further delays in his treatment, with the potential risk of a decline in mental health.

Substance misuse

4.61 Change Grow Live (CGL) provided drug and alcohol support to the children and worked in partnership with the prison. The team offered a range of psychosocial interventions, reflecting the needs of the population. There were clinical arrangements to support detoxification, although these had not been required since the last inspection.

4.62 Children's needs were assessed during the reception health screening. CGL staff saw every child and followed up with specialist assessments if needed. There were no waiting lists.

4.63 The team had skilled and knowledgeable staff who provided a range of one-to-one interventions based on individual needs. They had been running small group interventions, which was a positive step for the children. All children received harm reduction advice, which was reiterated before release.

4.64 The team responded to information and intelligence from the prison and other health care teams by seeing patients promptly; for example, following positive drug tests or with symptoms indicating substance misuse.

4.65 The service received very good feedback from children that demonstrated their increased awareness of substance misuse.

4.66 It was positive that staff visited the wing one weekday evening during association, which had increased self-referral from children.

Medicines optimisation and pharmacy services

4.67 Medicines were supplied from a nearby pharmacy and delivered to the prison promptly. The small pharmacy team undertook medicines administration, medication ordering and audits. The team followed written procedures that supported the safe storage and management of medications.

4.68 Following a risk assessment children could have in-possession medicines, which were limited to those such as inhalers. The

pharmacist scrutinised all prescriptions and worked collaboratively with prescribers to make sure children received the most appropriate medication. There were systems to make sure that children attending court and/or being released received their medication.

4.69 Medicines administration was not always performed by registered health care professionals. On one wing we observed an unregistered team member who had been delegated responsibility for handing over medicines. We identified several concerns, including the administration of controlled drugs without a second checker, gaps in knowledge and failure to adhere to protocols. These concerns also demonstrated a lack of oversight, and we were not assured that medicines administration to the children was safe.

4.70 Prison officers managed the queue for medicines administration, although sometimes a few children gathered and shouted through to staff, which created a risk of distraction and error. Some officers did not respond to requests to bring children to collect their medication, nor were health care staff always advised why they had not been brought to the hatch. There was effective monitoring and sharing of information about children who had not received their medication.

4.71 A list of children due to attend medicines administration was generated and included a section to advise of patients with similar names, to make sure they received the correct medication. Children were always asked for their name and date of birth before receiving medication, which was good practice.

4.72 The pharmacy team responded suitably to medication incidents and identified opportunities to reduce the risk of errors.

Dental services and oral health

4.73 The dental service had recently restarted with Time for Teeth taking on the new contract. The provision had increased with a dentist on site for two days a week and a dental nurse available five days a week to provide triage and oral health advice. Urgent need was prioritised, and the primary care team could assist with pain relief between dental sessions. Discussions about establishing an orthodontic pathway were ongoing.

4.74 The waiting list had been reduced with around 20 routine patients remaining; the provider was confident this would be cleared within the following two weeks.

4.75 Time for Teeth had provided some new dental equipment and had arranged the servicing of the prison's fixed equipment. The dental room smelled musty, and this had been reported to the prison. Infection control practice was good, with a separate decontamination room in use. Dental staff received appropriate support and professional development.

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 During our random roll check, we found just 12% of children locked up during the school day, compared with 42% at our last inspection. Records showed that children received an average of five hours and 20 minutes a day out of their room during the week and three hours and 43 minutes at weekends. Both were substantial improvements from the previous inspection, although the average masked substantial variation: children employed by Q Branch on repair work and horticultural projects (see paragraph 4.4) could get 11.5 hours a day out of cell during the week while those subject to rule 49 (segregated from the main population) received an average of just over two hours.

5.2 The governor was aware of the substantial weaknesses in the education provision and had worked to mitigate the impact by the YOI providing more work and vocational training. Many more children than at other sites were engaged in prison work. The governor had well-advanced plans to increase the provision further through the employment of four more vocational training instructors.

5.3 Children received a consistent daily routine, with the addition of evening association and a new range of enrichment activities that they valued. We observed staff in meaningful activities with children, including a pumpkin-decorating competition for Halloween.

5.4 The library provided a valued service but access to it remained limited for those not in education. Children were made aware of the library during their induction, and they could watch a promotional video on their laptops.

5.5 The library was a welcoming space with a good selection of age-appropriate books, including some easy-reads and graphic novels, but did not stock any legal books. Children who attended education were allocated one period a week to visit the library. Those not in education could request attendance through their laptops. Since our last inspection, designated library officers had been introduced to collect children from the wings to attend the library.

Library

5.6 Children were encouraged to read by taking part in the Reading Together scheme and keeping reading diaries. Both initiatives were incentivised with the award of merits for those actively reading. Novus staff were active in identifying children who did not attend the library and approaching them directly on the wings to encourage them to read. Easy-read books were offered to all children on admission, and wings had a small selection of books.

5.7 Children spoke highly about their access to the gym and other sporting activities. This was confirmed in our survey, in which 68% of children said they had access to the gym or could play sports more than once a week, compared with 38% in other YOIs.

5.8 Gym provision was excellent, and the number of physical education instructors (PEIs) ensured frequent and reliable delivery of activities for children. Children valued the facilities and the atmosphere we observed when they were engaging in PE was positive.

5.9 Facilities included a rock-climbing wall, a sports hall, an outside pitch, and a cardiovascular and weights area. These, coupled with smaller gyms on several wings, enabled children to have easy access to physical training. Keppel unit also had two dedicated PEIs, which enabled all new physically able children to receive a gym induction within 48 hours of admission. Children on Keppel could also take part in a Parkrun (see Glossary) every other week.


Gym and outdoor exercise facilities

5.10 A range of vocational training was available through the gym. The introduction of the Sports Performance course was promising; it could take approximately 10% of children at Wetherby at a time on an eight-week course leading to several qualifications.

5.11 Release on temporary licence (ROTL) had been used effectively at weekends to enable children to participate in community projects, including supporting the local food bank. Several expeditions had also taken place, including one in Snowdonia to enable children to gain bronze and silver awards in the Duke of Edinburgh's Award scheme.

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.

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

Overall effectiveness: inadequate

Quality of education: inadequate

Behaviour and attitudes: inadequate

Personal development: requires improvement

Leadership and management: inadequate.

5.13 Leaders had not rectified any of the weaknesses found at the previous inspection. Leaders had been too slow to make the improvements to the quality of education and vocational training and this remained poor. Too many children had not achieved their qualifications and were making slow progress.

5.14 Most of the actions that the education provider had put in place since the previous inspection had had little impact on improving the quality of the children's education experience. During the past 12 months, there had been changes to the education leadership team and a focus on recruiting and retaining teachers. This meant that progress against improving the quality of teaching and assessment had stalled. Prison leaders responsible for the oversight of education, skills and work held frequent meetings to review the progress made against key areas of concern. However, the improvement actions were heavily focused on compliance and did not consider the quality of education, skills and work sufficiently.

5.15 Leaders had developed a curriculum in education and training that mostly met the needs of children. Children benefited from a core curriculum where they studied English, mathematics, information technology, and personal, social and health education (PSHE). Children accessed the appropriate hours that met their core educational needs. Leaders ensured that there were sufficient spaces for the children. However, the curriculum was too narrow for the very few children who had already achieved level 2 in English and mathematics. There was no opportunity for those children to develop their skills and knowledge further. In a very few instances, those children were attending GCSE classes. This meant that they were repeating learning.

5.16 Leaders created a range of work opportunities so that children developed the skills they would need to gain future employment. They reviewed this annually and carefully considered labour market information and children's transition to the adult estate. This ensured that the curriculum met most children's needs and developed the skills they needed for their next steps. In industries and work, children studied a meaningful curriculum. They learned valuable work and life skills, such as how to cook food based on both individual and multiple portion sizes. Children on the site working parties practised forklift truck

driving and carried out routine maintenance activities around the prison, such as repainting cells and fixing new curtain rails and curtains.

5.17 Leaders had planned the induction process carefully. They carried out initial assessments which supported, and progression coaches used, to inform their discussions with children about their education and future career goals. Children benefited from high-quality information, advice and guidance that helped them to make informed choices about their education. The support and progression coaches were skilled in holding challenging discussions with individual children to ensure that appropriate personal learning plans were created to reengage them back into education. The allocations board used this information to allocate children to relevant education courses, vocational pathways or work swiftly. Allocations were fair and equitable, and most children received either their first or second pathway choice.

5.18 Work for the children was paid at a higher rate than education. However, this did not disincentivise children from attending education. All children attended education either full or part time. The pay policy incentivised positive behaviour in education and work.

5.19 Novus provided the education and vocational training in the prison. Although managers had developed a suitable curriculum that met the educational needs of most children, they did not use the outcomes of assessments to ensure that all children were enrolled on the correct level of course. In too many instances, children were enrolled on the incorrect level for English or mathematics. The teaching on the core curriculum and most of vocational training was weak. Teachers did not use the outcomes of assessments effectively to plan learning well enough. Too many lessons lacked purpose or clarity of what knowledge and skills children would learn. This led to children completing a range of activities that were not connected. Too many learning activities were pitched at the incorrect level. This meant that children either could not access the curriculum or found it too easy. Too many children withdrew from their courses before completing them. Most children studying English and mathematics made slow progress. Too few children achieved their English and mathematics qualifications on time.

5.20 The few children who were engaged in education but were temporarily confined to their units did not receive good outreach education. Teaching staff did not provide work to outreach support workers that was of an appropriate level. Children completed workbooks on topics that they could already do and found the work too easy. Conversely, staff planned and taught tailored learning activities for the very few children who refused to attend education. These activities were designed around children's specific needs and interests to develop their confidence to reengage in English and or mathematics classes. For example, support workers used children's favourite films to reintroduce language and sentence structure.

5.21 Most teachers and instructors were suitably qualified and experienced to teach and instruct in their subject areas. However, leaders had not provided sufficient training to improve teachers' teaching skills. They did not use their quality processes well enough to identify areas for development or put appropriate actions in place to improve teaching. Staff did not benefit from targeted development to improve their teaching practices. This resulted in weak teaching.

5.22 Teachers did not use effective teaching strategies. They did not recap previous learning or use appropriate activities to consolidate learning. Too many children were unable to recall or explain what they had learned over time. Teachers did not provide children with developmental feedback on their work or during practical activities. Feedback was mostly confirmatory and did not tell children what they needed to do to improve. Teachers did not use this feedback to inform their lessons and they did not track the progress that children made well enough. Too many children were on courses for too long as they made slow progress.

5.23 Leaders rightly recognised that support was not routinely put in place swiftly enough for children who had special educational needs or disabilities, or education and health care plans. These children represented around three-quarters of the prison population. Although they achieved as well as their peers, support strategies to secure their learning and development were limited. Staff had very recently been trained on how to better support children, but at the time of the inspection staff did not use identified strategies. This meant that children made slow progress on their course.

5.24 Leaders had developed a useful reading strategy, but had been too slow to implement this across the prison. Children who were in vocational training or work did not have timeslots in the library allocated to them and instead relied on requesting books through the prison application system. Children who were in education received allocated time in the library. They carried out a range of activities to encourage reading for pleasure, which included completion of reading diaries. However, teachers did not support children adequately to find books of an appropriate reading level. Too many children chose books that were of too low a level so that they could complete a reading diary quickly and gain a reward.

5.25 Attendance was too low. Just over half the children attended their lessons in education. This was due to children attending interventions or appointments. Teachers did not have high enough expectations of children in education and vocational training. They did not challenge inappropriate behaviour or use effective strategies to deescalate poor behaviour. Too many children used highly inappropriate language to each other or demonstrated instances of poor behaviour. This resulted in learning being disrupted and, in a few instances, children were sent back to their rooms.

5.26 The few children in work-related activities benefited from disciplined and professional settings. They changed into their personal protective

equipment swiftly and were ready for work on time. Children were respectful to staff and their peers and felt privileged to be in the roles. Those working in horticulture appreciated working in a calm and peaceful outdoor environment. Children were enthusiastic about their learning in work. In the kitchens, children prepared a range of dishes to develop their culinary skills. Children valued the knowledge and skills that they learned and planned to use these upon their release by gaining employment in the construction or hospitality industries.

The 'Hive (top), the polytunnel (bottom, left), and horticulture (bottom, right)

5.27 Leaders had put in place a personal development and personal, social, health and economic curriculum that mostly increased children's confidence and developed their understanding of how to become a more active citizen. Leaders worked with a range of external organisations, such as high-profile football clubs, charities and the local council, to provide enrichment opportunities for children. Children valued the access to gym activities and community events. However, there was limited opportunity for children to engage in competitions. Leaders had plans in place to reintroduce writing competitions and enter awards such as the Koestler awards.

5.28 The few children eligible for release on temporary licence were prepared well for employment and further training. They took part in a range of activities, such as volunteering in the community as part of the Duke of Edinburgh's Award. Children developed their communication skills and learnt to work as part of a team. They valued highly the opportunities to learn how to integrate into a community before release. However, opportunities to learn how to search for jobs and write CVs were in their infancy. Guest speakers provided children with information on future job opportunities in the hospitality industry.

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 There was reasonable provision for children to stay in contact with the outside world. In-person visits took place every evening and weekend at suitable times, although children could only receive up to two visits a week. This was due to a rota system in which residential units could only book visits on particular days.

Visits hall

6.2 Provision for visitors was inadequate. For example, the visitors' centre was not always open and lacked facilities including hot drinks and food; this was unacceptable considering that most children's homes were between 50 and 100 miles away. However, visitors we talked to spoke highly of the treatment they received from staff at Wetherby.

6.3 The use of technology to promote contact between children and families was reasonable. There had been 249 secure video-call visits (see Glossary) for 40 children in the last six months. Leaders acknowledged there was more that could be done to promote this service. Each child had an in-cell laptop and phone and was given £5 a week phone credit to support family contact.

6.4 Family days had continued to operate, and each unit had run at least one in the last few months. However, a lack of centralised coordination meant there were limited records to confirm what children and staff had told us about them taking place. In addition, there had been several themed family days, including for Mother's Day and Eid.

6.5 Five of the children were fathers and they received good support. Social workers made sure that they could contribute to their child's plan. The chaplaincy offered a Time for Dads course to provide guidance and assistance for fathers. Storybook Dads (enabling prisoners to record a story for their children) had only recently restarted and there had been one recording so far.

6.6 There was effective and purposeful use of release on temporary licence (ROTL) to maintain and strengthen family relationships. There had been 42 ROTL events for 14 children in the previous 12 months, enabling parents and families to spend meaningful time with their children in the community.

6.7 A full-time family therapist was able to help children and families to explore and repair relationships, both while in custody and also to prepare for release. Ten children had completed work in the year so far, and a further nine were engaging at the time of the inspection.

Pre-release and resettlement

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

6.8 The population at Wetherby had reduced by more than 40% since the last inspection. Currently, just under a third were on remand and almost two-thirds were sentenced, mostly for serious offences, predominately linked to violence.

6.9 The resettlement team were well resourced, and, given the current reduced population, their caseloads were low. This meant children received good care from their individual resettlement practitioner (see paragraph 6.15). Leaders had sourced a range of training for them since the last inspection, and they had good oversight.

6.10 The processes for early release and home detention curfew (HDC) were well managed. In the previous 12 months, nine children had been

released on HDC and 23 under the early release scheme, reflecting effective planning and oversight.

6.11 The use of ROTL had increased since the last inspection, which was impressive given the reduction population. In the last 12 months, it had been used on 407 occasions for 26 children. Many children were not eligible because they were on remand or an indeterminate sentence.

6.12 ROTL was used creatively to support resettlement and community reintegration. There was strong evidence of multi-agency and interdepartmental discussion to determine suitability and identify the most appropriate placements. Records we reviewed showed sustained positive changes in children's behaviour once they began attending ROTL, demonstrating its value as a progression tool. However, while some ROTL paperwork showed clear, thoughtful and robust consideration of risk, others lacked the same level of rigour, with not all potential risk factors explicitly identified or mitigated. This inconsistency undermined the defensibility of decision-making in a few cases, although overall, practice reflected a well-considered approach to supporting reintegration.

6.13 In the last year, 73 eighteen-year-olds had transferred to the adult estate. Despite good efforts by staff at Wetherby, there were significant delays for some, typically due to adult prisons refusing to accept the placement. It was positive that Wetherby staff visited the adult establishment at least once post-transition to support the young adults to settle.

6.14 The reducing reoffending strategy and associated needs analysis had not been updated since before our previous inspection, despite some significant changes at Wetherby; for example, the prison no longer accepted girls, and the Keppel unit was no longer a specialist unit. While this had not affected outcomes at the time of the inspection, it undermined the ability of leaders to monitor the resettlement services at the YOI.

Training planning and remand management

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

6.15 Relationships with resettlement practitioners (RPs) were a real strength, and children we spoke to were positive about the support they received. RPs maintained regular contact with children, typically weekly or fortnightly, but this increased at significant points in their sentence, such as during trials, pre- and post-sentence, and in the lead up to release. RPs were responsive to incidents, providing appropriate

challenge and praise with strong promotion of responsibility and consequential thinking.

6.16 In the cases we reviewed, we found evidence of RPs supporting children in additional tasks, such as facilitating solicitor contact, making sure they had suitable clothes for court and persistently chasing up information to assist them. Children spoke positively about RPs' support with both sentence-related discussions and general welfare checks, saying they felt cared for and that this helped them remain engaged.

6.17 Sentence and remand review meetings were held regularly and consistently attended by the youth offending team, social workers and education staff. Contributions from other professionals were evident, and families were encouraged to attend.

6.18 On some occasions children did not participate in meetings, which was a missed opportunity to increase engagement. Children gave a variety of reasons for non-attendance, including feeling overwhelmed or disengaged by the frequency of meetings; however, their RPs kept them updated on the discussions.

6.19 Information sharing by professionals between meetings was strong, with regular updates on key milestones, such as IEP changes, unit moves, ACCT, and education or work access.

6.20 Sentence, remand and resettlement plans were reasonable overall; however, some had insufficient focus on risk reduction, and a few lacked sufficient analysis of risk identification, management and mitigation. RPs knew the children well and demonstrated a clear understanding of the risks they presented, but this insight was not always evident in the written plans.

Public protection

6.21 All new arrivals had initial screening for public protection concerns, and it was positive that this was redone at the point of sentence, which enabled relevant action to be taken to safeguard others.

6.22 The monthly interdepartmental risk management team meeting was well structured to discuss issues such as upcoming high-risk releases, those on monitoring, and Terrorism Act and restricted status prisoners. Attendance at this meeting was, however, too variable, and it was notable that there was a lack of contribution from residential staff. Leaders had acknowledged this in the minutes we reviewed and were addressing it.

6.23 There were systems to make sure that all children had multi agency public protection arrangements (MAPPA) in place in the months leading to release, including a tracking system, and escalation was used where necessary. At the time of the inspection, 14 children were subject to higher risk level two and three MAPPA, Prison staff attended and contributed to all MAPPA meetings. MAPPA contributions had

improved as a result of staff training and leaders requesting feedback from MAPPA coordinators in the community to drive up standards. The MAPPA contributions we reviewed were of a high standard, and demonstrated good professional judgement, analytical assessment and clear understanding of risk.

Indeterminate and long-sentenced children

6.24 At the time of the inspection, seven children were serving a life sentence, and a further five on remand were potentially facing one if convicted. As the population had reduced, this was a decrease from the previous inspection. These children received support from their resettlement practitioner and other services at the point of sentence. However, there was no other dedicated or specialist support or intervention to help this group understand and come to terms with the impact of such a significant sentence.

Looked after children

6.25 The demand for support for looked after children was high. In our survey, 56% of children said they had been in local authority care before custody. Additionally, all children on remand were also deemed looked after children.

6.26 Four social workers were co-located with resettlement practitioners; this arrangement was highly effective as it provided good lines of communication. The proximity of these teams fostered a collaborative approach to addressing children's needs, particularly for their entitlements and resettlement. The social workers and RPs were particularly positive about this arrangement.

6.27 The onsite social workers were proactive in supporting children. For example, on arrival they wrote to the child's relevant local authority listing what should be provided, such as pocket money. In addition, where the local authority was responsible for finding accommodation on release, the escalation process was used when an address had not been sought at four weeks before release.

Reintegration planning

Expected outcomes: Children's resettlement needs are addressed prior to release. An effective multi-agency response is used to meet the specific needs of each individual child to maximise the likelihood of successful reintegration into the community.

6.28 There had been 163 releases into the community in the year to date, of which 61% were planned releases; the remainder were an immediate release from court due to receiving bail, a community sentence or time served.

6.29 All children released had accommodation to go to, except for two over-18s who were met by appropriate agencies and supported to go to the

local authority for housing on the day of release. Most accommodation addresses were confirmed in time; 84% had an address a week before release, and 77% had it confirmed at two weeks to release, which was better than we usually see and helped to enable more effective release planning.

6.30 A range of support and progression coaches at the prison helped children from their arrival with setting goals and learning plans. Towards the end of the child's sentence, they completed work such as CV writing and helped source placements in the community. In the last six months, 47% of the planned releases we reviewed had left with an education or employment placement in the community, which was higher than we have seen at similar establishments.

6.31 Department for Work and Pensions (DWP) staff attended where needed, and there were schemes for children to access a bank accounts and IDs. It was positive that 16-year-olds were now eligible for this provision, as previously only those over 18 had access to this service.

6.32 All children at three to six months before release were offered a mentor by In2Out (a charity that aims to reduce reoffending among young people aged 15 to 21). This enabled a mentor to be allocated and build a relationship with the child prior to release and offered both practical and emotional support post release. The offer was led by the child and their needs; this could include attending appointments with professionals or meeting in the community to spend time with the child. The team were currently working with around 40–50 children, both in the community and within Wetherby.

6.33 It was positive that RPs were encouraged to meet with children post release. In the previous three months, around 40% of children released had received a visit in the community. This enabled practitioners to use the relationships built in custody to support the child during their transition back into their community.

Interventions

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

6.34 The resettlement practitioner completed an initial assessment of risk and needs of each child, typically on sentencing. This was then passed to the psychology and the programmes teams to make a suitability decision for which intervention was needed.

6.35 Children had access to Youth Custody Service-approved interventions, including: 'Life Minus Violence' for violent behaviour; Timewise, for custodial violence; Aggression Replacement Training (ART); the Juvenile Estate Thinking Skills (JETS) programme; 'Feeling It' for emotional awareness; and motivational work in the A-Z programme.

Most programmes were only for sentenced children, except for A-Z and Timewise; any other referral was by exception.

6.36 The onsite psychology team provided consultation, assessment, and formal and bespoke interventions to children based on their needs.

6.37 The programme team had experienced some staffing shortfalls in the previous 12 months. Leaders had completed quarterly population reviews to make sure that available resources were used well and delivered interventions that were needed for the current population. As a result of regular meetings to allocate children to interventions, all children with sufficient time to serve (52) had completed any necessary interventions, with only one exception, for whom leaders had completed a learning review and had put measures in place to prevent this from recurring.

6.38 Children completed specialist work to address harmful sexual behaviours delivered by the forensic CAMHS team.

Health, social care and substance misuse

6.39 At the time of our inspection, no children were in receipt of social care, and no needs had been identified since our last inspection. Children with disabilities and any support needs for daily living activities were identified as part of the reception screening, and a local operating procedure made sure that children requiring support could be referred for an assessment promptly.

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 2023, we found that outcomes for children were not sufficiently good against this healthy establishment test.

Priority 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.
No longer relevant

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.
Addressed

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.
Addressed

Care

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

At the last inspection, in 2023, we found that outcomes for children were reasonably good against this healthy establishment test.

Priority concerns

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

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

Key concerns

Almost half the complaints about discrimination were responded to late, which undermined children's confidence in the process.
Addressed

Waiting times for routine dental treatment were too long and there was no local orthodontic pathway for new referrals.
Addressed

Purposeful activity

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

At the last inspection, in 2023, we found that outcomes for children were not sufficiently good against this healthy establishment test.

Priority concerns

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

The teaching of English, including reading and mathematics, was not good enough.
Not addressed

Key concern

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.
Not addressed

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 2023, we found that outcomes for children were reasonably good against this healthy establishment test.

Key concern

The quality of risk assessment work by resettlement practitioners was inconsistent. Some assessments lacked depth and not all available interventions and management tools were considered.
Not addressed

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 Expectations – HM Inspectorate of Prisons (justiceinspectorates.gov.uk)). 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:

Sandra Fieldhouse	Representing the Chief Inspector
Angus Jones	Team leader
David Foot	Inspector
Esra Sari	Inspector
Dionne Walker	Inspector
Donna Ward	Inspector
John Wharton	Inspector
Emma Crook	Researcher
Tareek Deacon	Researcher
Alicia Grassom	Researcher
Emma King	Researcher
Samantha Moses	Researcher
Samantha Rasor	Researcher
Sarah Goodwin	Lead health and social care inspector
Helen Jackson	General Pharmaceutical Council inspector
Matthew Tedstone	Care Quality Commission inspector
Ian Frear	Ofsted inspector
Alison Humphreys	Ofsted inspector
Zoe Ibotson	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

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

Framework for integrated care
The framework aims to improve the quality of care and outcomes for children through training staff to provide more psychologically-informed care, which is centred around comprehensive, assessments of children's needs to ensure that all needs are identified.

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

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

Official prison video conferencing (OPVC)
Available in all prisons to enable remote court hearings, as well as official visits and meetings (including legal and probation visits). OPVC is not used for social visits.

Parkrun
A non-profit organisation that supports communities across the country to coordinate free, volunteer-led events for walkers and runners.

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

Restricted status
Introduced in children's and women's prisons to manage prisoners whose escape would present a risk of serious harm to the public; see: https://cloud-platform-e218f50a4812967ba1215eaecede923f.s3.amazonaws.com/uploads/sites/19/2024/02/Restricted-status-thematic-web-2023.pdf

Secure social video calling
A system commissioned by HM Prison and Probation Service (HMPPS) to enable calls with friends and family. The system 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 Care Quality Commission action plan request

Care Quality Commission (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

The inspection of health services at HMYOI Wetherby was jointly undertaken by the CQC and HMI Prisons under a memorandum of understanding agreement between the agencies (see Working with partners – HM Inspectorate of Prisons (justiceinspectorates.gov.uk)). The Care Quality Commission issued a request for an action plan following this inspection.

Breach of Regulation

Provider: Leeds Community Healthcare NHS Trust
Location: Young Offenders Institute HM YOI Wetherby
Location ID: RY691
Regulated activities: Diagnostic and screening procedures and treatment of disorder, disease or injury.

Regulation 12 Safe Care and Treatment – Ensure care and treatment is provided in a safe way to patients.

12 (1) Care and treatment must be provided in a safe way for service users.

(2) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include –

(g) the proper and safe management of medicines.

How the regulation was not being met:

- The administration of medicines was not always safe. Staff were administering medicines alone; this included the administration of controlled drugs without the assurance of a second checker.
- The systems for ensuring the competency of staff to administer medicines, including controlled drugs, were not fully effective.

Appendix IV 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:

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: Our reports – HM Inspectorate of Prisons (justiceinspectorates.gov.uk)

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