Report on an unannounced inspection of

HMYOI Werrington

by HM Chief Inspector of Prisons

15 April – 2 May 2025

Contents

Introduction

Werrington is a young offender institution near Stoke-on-Trent, which at the time of this inspection held just 81 boys aged between 15 and 18. The high level of risk managed within YOIs, recent poor performance, and the particular vulnerabilities associated with the children held, mean we inspect young offender institutions more frequently than adult prisons. Our last inspection of Werrington in 2023 found an unstable establishment in need of substantial support to address the poor outcomes in our healthy prison tests of safety and purposeful activity.

At this inspection we found a more stable leadership team; in particular, the governor, who had been in post since the previous inspection and had worked well to address the previous staffing shortages. However, many staff needed more support to develop their skills and knowledge. While many were enthusiastic and wanted to improve outcomes, they simply did not have the time to build the relationships needed to achieve this. I was concerned to find that just 34% of children told us that they felt cared for by staff.

Despite clear improvement in safeguarding procedures and some concerted efforts to reduce conflict and violence, the key challenges of weak relationships between staff and children and ineffective behaviour management remained. In the absence of effective systems to motivate children, time for staff to build relationships, or an education curriculum that engaged them, the overwhelming culture was one of control and separation.

The average time out of cell was just three and half hours a day and we found evidence that a small number of children, many of whom were too scared to leave their cell, were not unlocked for several days in a row. This would be poor in any prison but is completely unacceptable in one holding children. Eighty-five per cent of the boys were not receiving their entitlement of 15 hours a week education, and the quality of education they did receive was poor. As a result, very few were released from the prison having learnt anything that would help them move away from offending in the future.

Leaders were aware of these issues and had implemented a plan for improvement in the weeks before our inspection, but there simply had not been enough time for any impact to be seen.

Charlie Taylor
HM Chief Inspector of Prisons
July 2025

What needs to improve at HMYOI Werrington

During this inspection we identified eight 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. **Children were not motivated to behave well and engage in activities, including education, work or offending behaviour programmes.** The incentives schemes were inconsistently applied, and rewards, including additional time out of cell, were rarely delivered.

2. **Children spent far too long locked in their cells.** Some, often those who were most vulnerable or fearful, did not come out at all for days at a time.

3. **Only 34% of children surveyed said they felt cared for by staff.** The limited time out of cell and culture of separation and control inhibited engagement with children.

4. **Very few children received their minimum entitlement to 15 hours of education each week.** Children were still mostly leaving the prison having experienced, learned or achieved little that would improve their prospects of rehabilitation.

5. **Staff were not sufficiently well-trained or skilled at managing children's behaviours, particularly in education classrooms and outreach sessions on the wings.** This meant that children's behaviour was too often poor and severely disruptive in classes, and little learning took place.

Key concerns

6. **The education, skills and work provision was ineffective. The curriculum for children was unambitious and lacked challenge.** It did not help children develop their social, emotional and communication skills or prepare them sufficiently for life in their communities in modern Britain.

7. **Leaders did not promote or support reading and literacy well enough.** The reading strategy had been implemented in part, but was so far ineffective at meeting the needs of those whose reading skills were poor.

8. Release planning with respect to accommodation on release, education placements or work opportunities were poor.

About HMYOI Werrington

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

Certified normal accommodation and operational capacity (see Glossary) as reported by the establishment during the inspection
Children held at the time of inspection: 78
Baseline certified normal capacity: 118
In-use certified normal capacity: 118
Operational capacity: 118

Population of the establishment
- 138 new children received each year (around 12 per month).
- Seven foreign national children.
- 69% of children from black and minority ethnic backgrounds.
- 35% of children were on remand.
- 25% of children had experienced being in the care of the local authority prior to custody.
- 64% will become adults while in custody on their current sentence.
- 48% of children had been excluded from mainstream education prior to custody.

Establishment status (public or private) and key providers
Public

Physical health provider: Practice Plus Group
Mental health provider: Midlands Partnership University NHS Foundation Trust
Substance misuse treatment provider: Midlands Partnership University NHS Foundation Trust
Dental health provider: Time for Teeth
Prison education framework provider: PeoplePlus
Escort contractor: GEOAmey

Prison group/Department
Youth custody service (YCS)

Prison Group Director
Sonia Brooks

Brief history
HMYOI Werrington is in Staffordshire. It was originally opened in 1895 as an industrial school and was purchased by the Prison Commissioners in 1955. It was converted into a senior detention centre in 1957 and then became a youth custody centre in 1985 after the implementation of the Criminal Justice Act 1982. In 1988, it was converted into a juvenile prison, which is its current role.

Short description of residential units
Doulton unit
A wing and B wing – 96 single occupancy rooms.

Denby unit
C1 – Care and Separation Unit (CSU): eight rooms; six of which have in-room showers.
C2 – 22 cells allocated as 10 for induction and 12 for normal living accommodation

Name of governor/director and date in post
Jasmin Steadman, from January 2023

Independent Monitoring Board chair
Lesley Munro

Date of last inspection
31 July – 11 August 2023

Section 1 Summary of key findings

Outcomes for children

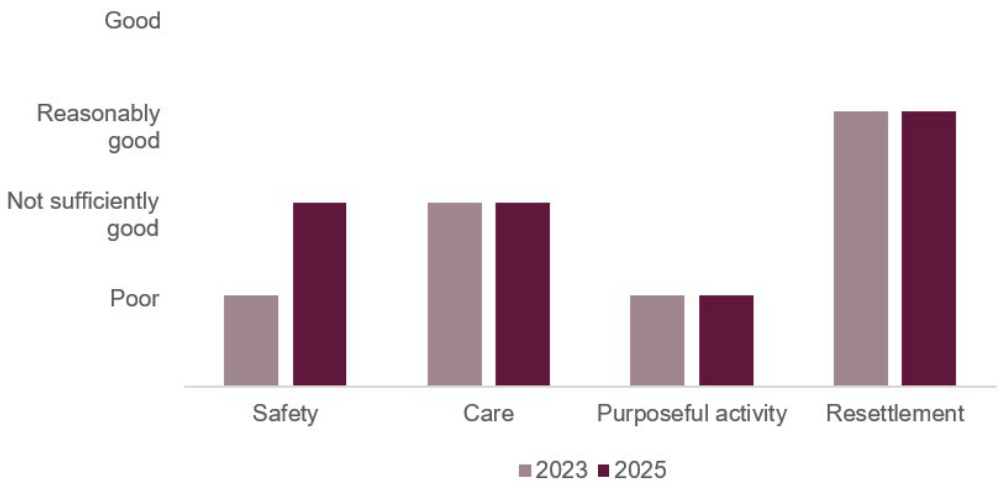
1.1 We assess outcomes for children against four healthy establishment tests: safety, care, purposeful activity and resettlement (see Appendix I for more information about the tests). We also include a commentary on leadership in the establishment (see Section 2).

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

- Not sufficiently good for safety
- Not sufficiently good for care
- Poor for purposeful activity
- Reasonably good for resettlement.

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

Figure 1: HMYOI Werrington 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 15 concerns, seven of which were priority concerns.

1.5 At this inspection we found that four of our concerns had been addressed and eleven had not been addressed. Of the priority concerns raised in safety, two were achieved and one was not achieved. None of the priority concerns raised in care or purposeful activity were achieved. For a full list of progress against the concerns, please see Section 7.

Notable positive practice

1.6 We define notable positive practice as:

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

1.7 Inspectors found six 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)	During this inspection we saw two sets of child peer mentors: those who greeted and offered support to newly arrived children in reception and on the first night centre and also took part in the induction programme; and equality and diversity peer representatives, who helped leaders to know better the views of children by representing their peers and their opinions in the equalities meetings.	See paragraphs 3.5 and 4.29
b)	The quarterly safeguarding partnership meeting, where members of the leadership team, the social work team and the local authority reviewed every safeguarding referral and the associated actions for the preceding quarter provided useful follow up and assurance.	See paragraph 3.14
c)	Four staff were trained to assess and deliver the harmful sexual behaviours programme, and two resettlement workers were trained in the assessment element so they can carry out joint assessments and interventions with children.	See paragraph 4.84
d)	A ‘welcome pack’ from health care for children arriving in prison was an effective way of engaging children to better support their day-to-day physical and mental well-being.	See paragraph 4.69
e)	Children about to be released from prison were given a map which showed the route from their accommodation to the GP and was a supportive tool to encourage them to attend future appointments.	See paragraph 4.79
f)	It was positive that when children were injured, health care staff contacted parents or carers upon request,	See paragraph 4.78

to share information and reassure the family that appropriate care had been given.

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 In contrast to our previous inspection, Werrington was benefiting from stability in the leadership team. The governor had been in post since the previous inspection and had worked to address the chronic staffing shortfalls identified at that time. Investment in new colleague mentors, a focus on reducing high levels of sickness and substantially improved retention rates, had given leaders an opportunity to develop the skills of the staffing group.

2.3 The key challenge for leaders continued to be behaviour management, which remained poor in most departments at Werrington. There was a lack of meaningful incentives or sanctions, and managers had not addressed the continuing inconsistency in application of the behaviour management schemes in education and the residential units. Consequently, poor behaviour, bullying and violence were still commonplace.

2.4 Leaders had not improved time out of cell, and we were very concerned that some children did not leave their cell for days at a time. In addition, managers in education were delivering one of the worst services we have seen: 85% of children were not receiving their entitlement to 15 hours of education a week; teaching in the core subjects of English and maths was weak; and far too many children were leaving Werrington having not learned or achieved anything that would improve their prospects of rehabilitation. This was the third consecutive inspection where Ofsted gave their lowest grading of inadequate at the YOI.

2.5 In the absence of effective systems to motivate children, time for staff to build relationships, or an education curriculum that engaged them, the overwhelming culture was one of control and separation.

2.6 Leaders were aware of these shortcomings; the governor and her senior team having implemented a three-year improvement plan supported by the Youth Custody Service (YCS). However, this had only started the month before our inspection, and it was too early to judge any impact.

2.7 The YCS had supported the site through recent funding for additional staff which local leaders hoped would improve time out of cell and access to activity. The YCS deputy director of operations visited the YOI regularly and had a good understanding of the issues at the establishment.

2.8 Despite a change in policy and substantial efforts by the YCS to move most 18-year-olds to the adult estate, Werrington continued to hold a substantial number of young adults without having the services to meet the needs of this group.

2.9 Senior leaders in health care worked effectively with the prison; however, getting children escorted to health care appointments remained a challenge.

2.10 Leaders had substantially improved safeguarding processes which were now good.

2.11 Leadership of the chaplaincy was exceptional. In addition to their statutory responsibilities, chaplains worked hard to meet the needs of all children at Werrington and provided a wide range of interventions to engage children and improve their time out of cell.

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 One or two new children were received each week, which was similar to our last inspection. Seven children had arrived after 10pm in the last six months from as far afield as Norwich and the south coast. The latest arrival was after one in the morning. This impacted on the ability for staff at Werrington to engage with these children before they were locked up on their first night.

The reception building

3.2 Most new arrivals were transported in vehicles designed for children, but there had also been an increase in children arriving in cellular vehicles more commonly used in the adult estate, which was often due to risks the child presented.

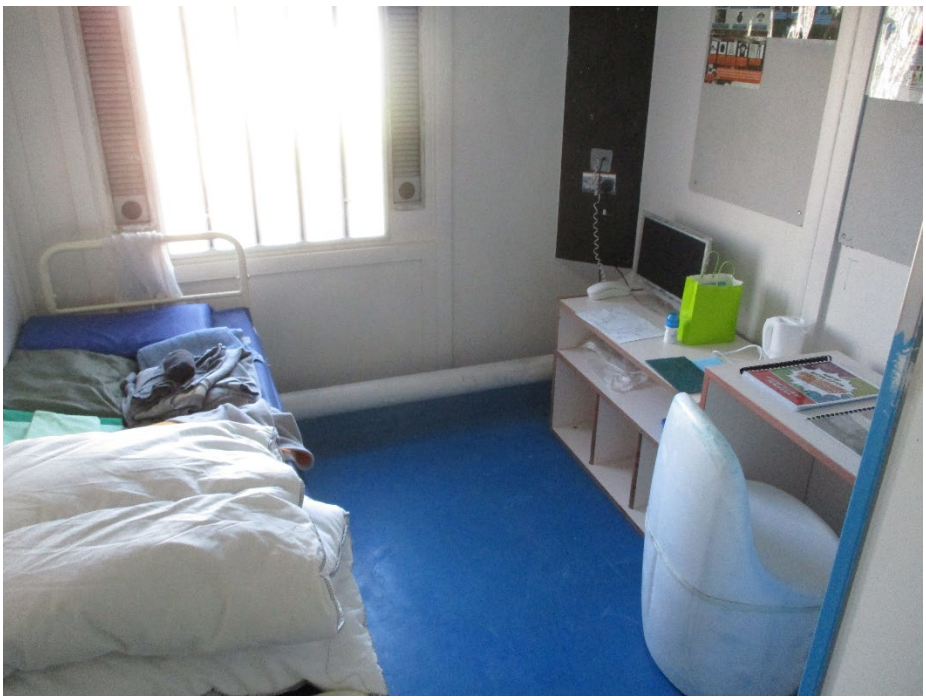
3.3 The reception area was clean and well presented; staff had gone to some lengths to make it feel welcoming for children. The waiting room had a television and comfortable seating; it was carpeted and bright.

Reception holding room

3.4 Both prison and health care staff interviewed children privately and conducted a thorough risk screening. It was disappointing to note that during our night visit not all the risks identified through this process had been passed on to staff on the first night unit.

3.5 There were two reception peer mentors who met every child on arrival to offer support and answer any questions that children new to custody or Werrington may have. Each child was allowed a call home and given a hot meal and drink. They were also offered a reception pack of snacks or phone credit. Those from minority ethnic backgrounds could also choose from a selection of cultural items if they needed them.

3.6 The first night cells we saw were in good condition, clean, with very little graffiti. They were well equipped, with working phones and televisions.



Prepared first night cell

3.7 Induction started the next day, and this was also partly peer led. It lasted for five days and was comprehensive.

Induction unit

3.8 The few arrivals and the restrictive mixing rules for new children, meant that some could be quite isolated with few opportunities to mix with their peers.

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.

3.9 Safeguarding procedures had improved considerably since our last inspection. The number of safeguarding referrals that were received had increased; there had been 301 in the preceding 12 months. These were dealt with swiftly and any that met the threshold for referral to the local authority were sent within 24 hours.

3.10 During the week, every referral was triaged by one of two full-time social workers who were employed by the local authority. At weekends, this responsibility fell to the manager in charge of the prison, being reviewed again by the social work team on Monday mornings.

3.11 In the 12 months prior to this inspection 55 concerns had been referred to the local authority, and 15 of those were investigated further, with most involving violence between children. These investigations were completed in a timely fashion; there were only four outstanding at the time of the inspection. The delays were appropriate due to other agencies, such as the police, conducting further investigations.

3.12 Every child mentioned in a safeguarding referral was seen by one of the social workers, which was good, but these meetings generally took place through a locked cell door which was not appropriate.

3.13 Oversight by leaders was good; there was a monthly safeguarding meeting that looked at the reasons for referrals and any trends, and it also looked to ensure that referrals were received from a broad spectrum of sources, both internally and externally.

3.14 There were good links with the local authority; there was a quarterly safeguarding partnership meeting, which was attended by the Staffordshire local authority designated officer (LADO; responsible for child protection investigations) senior leaders from Werrington and the social work team. Every safeguarding referral from the preceding quarter was discussed in this meeting to ensure that no actions had been missed and that each case had been handled correctly.

3.15 The Governor also attended the quarterly Staffordshire Safeguarding Children Partnership board.

3.16 Safeguarding was promoted well through a monthly newsletter circulated to all staff that looked at different areas of concern, such as use of force, and discussed learning points from staff. It explained the safeguarding process and gave details of who to go to with any concerns. There was also a section recognising staff and giving awards for good work in the previous month.

Suicide and self-harm prevention

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

3.17 The amount of recorded self-harm had reduced since our last inspection and was lower than in other comparable establishments over the preceding 12 months. Prison data indicated 10.9 instances of self-harm per 100 children per month, compared to 14.2 at our last inspection. The need for constant supervision had also reduced. This was used once in the previous year and the records showed that the child was appropriately removed from these conditions once their risk had reduced.

3.18 Each child who was at risk of self-harm was being supported through assessment care in custody and teamwork (ACCT; see Glossary). In the ACCT document viewed there was plenty of detailed information about the child, the reasons for concern and triggers for crisis. While reviews were multidisciplinary and took place on time. the resulting care plans were weak. This had been identified through quality assurance of ACCT documents but had not yet been addressed.

3.19 Children at risk of self-harm felt well supported by individual case managers, whom they saw regularly while being supported through the ACCT process.

3.20 Children subject managed through the ACCT process were discussed at the weekly safety interventions meeting (SIM; see Glossary), and their progress reviewed. Leaders understood the reasons for self-harm and monitored trends at monthly strategic meetings.

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.

3.21 Security intelligence reported continued to show the key threats remained violence and disorder. Leaders were focused on reducing the number of weapons that children carried around the establishment and limiting the opportunities for serious disorder we found at the previous inspection.

3.22 The weapon strategy has been reviewed three times since our last inspection, with additional safety measures being introduced, including metal-detectable cutlery and toothbrushes, and the removal of razor

blades. We found six children being identified as ‘prolific weapon users’ and subject to a weapon prevention plan. The plan places the individual on a four-week programme and subject to additional safety measures, including an increase in cell searches; restriction of dine out privileges; and the requirement to move cells when directed.

Weapons

3.23 Post-incident investigations took place with security and safety staff reviewing CCTV where a weapon was found in possession/used during an incident. Lessons identified and areas for improvement were well communicated to staff. While these measures had been successful in deterring both the making and use of weapons this remained a substantial challenge with 214 weapon finds over the last 12 months.

3.24 The previous problem of large groups of children kicking their way through doors in the education department, (identified at our last inspection) had been resolved by investment in more secure doors. This had helped reduce much of the volatility seen at our last visit.

Kingsway security door

3.25 Intelligence was generally assessed and triaged quickly, and actions were carried out in a timely manner. This included intelligence-led cell searches, and 42 children being strip searched over the last six months, 18 of whom were classified as restricted status (RS) and were strip searched in reception as part of RS procedures.

3.26 There was some evidence that, while not at the scale we see in the adult estate, the use of drugs was an emerging threat. Staff had carried out 32 intelligence-led drug tests over the previous six months. Six of these were positive; all relating to the same incident.

Behaviour management

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

3.27 Behaviour management continued to be ineffective. Staff were inconsistent in their approach and failed to motivate children to behave

well. Consequently, poor behaviour was commonplace. This impacted almost every aspect of life at Werrington, and 20% of children felt unsafe at the time of our inspection.

3.28 Leaders had designed a system of instant, weekly and longer-term incentives to try and motivate children to behave well. However poor implementation fundamentally undermined their effectiveness. Instant rewards (merits) were used inconsistently, with some children demanding merits to stop disruptive behaviour. This was a particular problem in education where too often compliance was rewarded over effort or good work. In addition, key incentives in the weekly rewards scheme (the incentives and earned privileges, IEP, scheme) were not delivered because time out of cell was so limited. Similarly, because leaders were not able to deliver statutory basics including daily association there was nothing to take off children who were consistently breaking the rules.

3.29 The weaknesses in these shorter-term schemes meant many children were unable to achieve more meaningful longer-term incentives including release on temporary licence and early release for those serving detention and training orders.

3.30 During the previous 12 months there had been 2,274 adjudications, and comparable to other YOIs, most charges were dealt with within appropriate time scales. There was good analysis of the data to help leaders address emerging issues during the quarterly segregation monitoring and review group (SMARG). The quality of enquiry was variable; this had been identified by quality assurance checks conducted by the deputy governor but not yet addressed.

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.

3.31 Levels of violence had increased since our last inspection but were comparable with the other YOIs. During the previous 12 months, there had been 324 assaults, 26 of which had been recorded as serious, and 44 required treatment in hospital. Speaking to several children, we learnt they feared being attacked by other children, which directly impacted on their motivation to attend activities, or in some cases, to leave their cell at all.

3.32 All incidents of violence were investigated by the head of safety, and where appropriate children took part in conflict resolution sessions, facilitated by trained staff. Leaders were focused on minimising the number of children on ‘keep-aparts’ (children who were in conflict with others and could not mix), recognising the negative impact this had on time out of cell and children’s access to education. There had been some success and the number of keep-aparts had been reduced by

67%. However, there remained 125 keep-aparts in a population of 81 children, which was unwieldy to manage.

3.33 Leaders were managing this problem though the use of conflict pictures and maps. The conflict pictures outlined the non-association, internal and external conflicts and gangs that impacted the population at Werrington, while conflict maps identified the conflict, risk and gang violence that a child may have. This assisted staff in reintegrating children back into a group more quickly.

3.34 Children who were self-isolating, often because they were too scared to come out of their cell, were not managed well. Their time out of cell was minimal, with little to no encouragement from staff to engage with purposeful activity. We were concerned that several of these children did not leave their cells for any reason, sometimes for days at a time.

3.35 A well-attended weekly SIM discussed the current risks and emerging issues posed by the children. The minutes showed good sharing of knowledge about children and informed leaders' decision-making at the strategic safety meeting.

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.

3.36 The rate of use of force incidents remained similar to the previous inspection. There had been 811 incidents where force had been used over the previous 12 months. Injuries caused as a result of use of force had decreased, but children and staff continued to be more likely to be injured during a use of force incident at Werrington than at other YOIs.

3.37 Oversight by leaders had improved through daily screening and weekly meetings. In our review of recorded video footage, we observed that senior leaders routinely attended incidents to provide support to staff and attended planned intervention briefings. However there continued to be a backlog of use of force reports with 101 outstanding at the time of our inspection.

3.38 Pain-inducing techniques had been applied eight times in the last 12 months and on some occasions, they had been deemed inappropriate by the independent review of restraint panel. Leaders had provided advice, and guidance had been provided to some of the staff involved.

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.

3.39 The number of children separated had reduced since our last inspection, with 85 children being subject to Rule 49 (segregation) in the last six months. This fall was largely down to a change in definitions. Self-isolating children, who were previously subject to rule 49, were now recorded on self-isolation documents (see paragraphs 3.34, 4.87 and 5.1).

3.40 There was more clarity about the purpose of the designated segregation unit (referred to locally as the care and support unit/CSU; see Glossary) with a focus on addressing offending behaviour and reintegration back onto the wings. However, the average time children spent separated had increased to 13 days. This was largely due to a two-stage process lasting at least eight days. This was applied inflexibly without taking into account an individual assessment of risk.

3.41 We found the cells in the CSU were reasonably clean but had a significant amount of graffiti on the walls. The cells were in need of decoration.

3.42 Oversight of use of segregation had improved with a designated leader for the CSU and regular assurance being conducted through the SMARG. Reviews of separated children had improved since the last inspection.

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, only 34% of children said they felt cared for by staff, which was significantly lower than at other YOIs. Staff were primarily focused on keeping non-associations separated and enabling movements. As a result, we observed mostly transactional interactions.

4.2 The limited time out of cell (see paragraph 5.1) impeded the development of positive relationships between staff and children. The frequent last-minute class cancellations led to frustrations from the children, who did not know what to expect on any given day (see paragraph 5.2). This negatively impacted attitudes towards staff, with only half the children we surveyed feeling that staff encouraged them to attend education.

4.3 Too much interaction with children took place through a locked door, and the lack of association periods during the week further limited everyday engagement between staff and children. The most personalised interactions that were observed during the inspection happened during an evening meal in which some of the children were able to eat together out of their cells (see paragraph 4.14).

4.4 Due to the ineffective and inconsistent delivery of custody support plans (CuSP a care plan developed by a dedicated officer who works with the young person on a regular basis), a less intensive approach had recently been introduced. This involved fortnightly check-ins with each child by an identified officer. Children reported that these officers were predominantly based on the same wings, making contact more regular, alongside the more structured one-to-one sessions. It was too early to assess the effectiveness of this approach, and there was still some pessimism among children as to how long this would continue.

4.5 At the time of the inspection there were two peer workers in place, supporting multiple functions including reception, the gym and consultation. This was a positive initiative based on trust that role-modelled progression within the prison. The further extension of this scheme was limited by the extensive arrangements to separate different groups of children.

Daily life

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

Living conditions

4.6 Cells had been refurbished to include showers and toilets and were well equipped with adequate furniture. Graffiti was regularly removed, and in-cell repairs were generally dealt with promptly by maintenance teams. However, some children reported issues with temperature regulation and being very cold during the winter.

Refurbished cell

4.7 The main residential units (A and B) remained too large and were similar to those we see in the adult estate. This hindered behaviour management and the creation of positive relationships between children and staff.

4.8 Standards for tidiness and cleanliness in the communal areas were not good enough. Some tables and chairs were observed which had not been cleaned following the previous evening's meal, and litter was visible outside cells.

4.9 Access to cleaning equipment was sufficient and staff encouraged the children to keep their cells clean, holding a competition with prizes for the best-kept cell. However, we found the cleaning cupboards were disordered and, in one case, unclean.

4.10 Children had reasonable access to stored property and clean clothes, towels and bedding. However, some children complained that the laundry detergent used irritated their skin and stained clothes.

4.11 There were adequate recreation rooms with entertainment facilities, however this was undermined by limited use as there was no evening association during the week (see paragraph 5.3).

4.12 Each child was allocated a laptop which they used to communicate with different departments, make meal selections, order items or watch content uploaded by leaders. However, children complained that the range of content to watch was severely limited, which caused frustration given the minimal time out of cell.

Residential services

4.13 The food was of reasonable quality, although in our survey, only 38% of children said it was good and only 30% said they got enough to eat. Some children reported that they supplemented meals with canteen orders.

Evening Meal

4.14 Opportunities for children to eat their meals together were too limited, with separate landings dining out for evening meals on a rotation

basis, and subject to cancellations. All breakfast and lunch meals were delivered to doors and children ate them alone while locked in their cells.

4.15 Halal and non-halal utensils were used and stored separately; however not all servery workers wore the appropriate personal protective equipment.

4.16 Children were consulted on their preferences for future meals using surveys administered on laptops, and special menus were put on for religious festivals.

4.17 Children could shop from a range of catalogues and make orders on their laptops. Efforts had been made to provide additional items where needs were not being met by the catalogues, with an additional list of hair products catering to ethnic minorities available. In our survey, 58% of children said the shop provision catered for them.

Consultation, applications and redress

4.18 The student council was active and was well attended by senior leaders, including the governor. There were challenges maintaining sufficient representation from each wing due to issues with conflict and mixing. However, Kinetic Youth workers (see Glossary) consulted children across the wings and fed back to council meetings. Separate wing forums had also been introduced. Some improvements had been made as a result of the consultation; however, more could have been done to communicate these changes.

4.19 Children used in-cell laptops to make applications, and this was working effectively, with 98% actioned on time in the previous six months.

4.20 There had been 375 complaints in the last year, this was a decrease from the last inspection. Trends were monitored through monthly senior leadership team (SLT) meetings, and the quality of responses was regularly reviewed. Responses were respectful, fair and evidence based, and children were routinely visited in person regarding their complaint.

4.21 However, 25% of the complaints made in the previous 12 months had been responded to late. This was not good enough, particularly considering the size of the population and the relatively small numbers of complaints.

4.22 Barnardo’s continued to offer a well-used service: supporting children to resolve day-to-day issues; attending adjudications where requested; and making referrals to the Prisons and Probation Ombudsman (PPO) and the Howard League.

4.23 Legal mail was handled appropriately, and suitable facilities were in place to enable legal visits. There were private rooms available in reception for video calls with legal representatives and booths in the visits hall for in-person meetings.

4.24 Although additional library resources had been acquired (see paragraph 5.6), this did not include any up-to-date legal texts for children to access. Information about legal rights and prison service instructions were available to children through their in-cell laptops. Barnardo's staff also delivered a session on children's rights as part of the induction programme.

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

4.25 Work to promote equality and ensure fair treatment of children had improved since our last inspection. There was now an establishment lead in place and a comprehensive strategy that was informed by consultation with children.

4.26 A detailed action plan had been developed that looked at strategic objectives but also looked to improve outcomes for children. This plan was frequently reviewed to ensure actions were progressing.

4.27 Work to promote each diversity strand was led by a member of the SLT. Each strand lead produced useful data to identify potential disproportionate treatment of children and presented this at the monthly equalities meeting alongside potential actions for resolution.

4.28 The quality and oversight of discrimination incident reporting forms (DIRFs) was also much better than last time; there had been 21 submitted in the six months prior to this inspection. DIRFs were now responded to promptly, and the quality of investigation was very good. Responses were polite and got to the crux of the issue. Most DIRFs were upheld. Quality assurance of this process had been strengthened by independent scrutiny of all DIRF responses by the Zahid Mubarak Trust (see Glossary), which provided a detailed written report on each form.

4.29 Consultation with children who identified with one or more of the protected characteristics had also improved, and forums were held every two weeks. Leaders had overcome the mixing issues (see paragraph 3.33) that prevented group forums taking place by appointing five equalities peer mentors who could mix with each other. These peer mentors talked to children on their respective wings, canvassed their opinion and brought them back to the forum.

Protected characteristics

4.30 In our survey, 64% of children said they came from an ethnic group other than white and there was good support for these children. Regular forums and the lived experience of the establishment lead meant that thought and understanding had improved the quality of cultural products, such as hair combs and skin creams, and this was appreciated by the children we spoke to. A hairdresser who specialises in black hair had been appointed and was due to take post. It is hoped that children will also be taught haircare as part of this initiative.

4.31 Through forums, children have said staff do not fully understand their religious or cultural needs; leaders have responded with quarterly cultural awareness and race ally training for all staff.

4.32 There was a full timetable of cultural events, including most religious festivals and celebrations as well as events such as Black History Month and Holocaust Memorial Day.

4.33 There were seven foreign national children in Werrington at the time of the inspection. There was one resettlement practitioner (see paragraph 6.6) who oversaw all these and arranged for regular clinics with Home Office enforcement staff to ensure that children were kept up to date with their case.

4.34 Translation service 'thebigword' was used, and staff had recently run refresher courses for induction staff, so they knew how to use it.

4.35 A Gypsy, Roma and Traveller peer mentor had recently been appointed who would greet any new children from these backgrounds on arrival at the prison. Leaders were working with him to develop a programme of events and meals for the Gypsy, Roma and Traveller community.

4.36 Very few children openly identify as gay or transgender while in custody. The prison had a policy for both in place.

4.37 There were no children with physical disabilities that required a personal emergency evacuation plan at the time of our inspection. We viewed some previous examples, and they were of good quality.

4.38 There were lots of groups that neurodivergent children benefitted from through Kinetic Youth, including fun events such as the sensory bush tucker trial, alongside emotional well-being and managing stress and sessions.

4.39 The chapel had been refurbished prior to our last inspection. The space available was used well for all faiths, and things such as ablutions had been well thought out and were available for staff and children.

4.40 There was a team of permanent and sessional chaplains who catered for most religions. Chaplaincy staff provided inspirational support for

children's mental and emotional well-being and were well led by a caring and dynamic coordinating chaplain. This team visited every separated child; those isolating themselves; and those being supported through ACCT, every day.

4.41 Children had good access to corporate worship and faith-based classes, although Friday prayers were impacted by the number of groups of children that could not mix. Despite two services being held each Friday, Muslim children could only worship in two out of every three weeks.

4.42 There was good pastoral support, and several groups took place each week for all faiths. In our survey, 91% of children said they could speak to a Chaplain of their faith in private if they wanted to.

4.43 The chaplaincy continued to offer good support to children who had limited time out of their cells with a good range of activities including arts and crafts sessions and movie nights.

4.44 Prison visitors now attended the chapel and met with children who did not get visits. Groups, such as the afternoon tea group and the community group, took place regularly.

4.45 A festival week had been arranged recently where children could try meals from different cultures and faiths. The coordinating chaplain ensured every child could take part. These events totalled approximately 300 visits to the chapel by children each month.

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.

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

Strategy, clinical governance and partnerships

4.47 Practice Plus Group was the prime provider of health care services and subcontracted mental health and substance misuse services to Inclusion (Midlands Partnership University NHS Foundation Trust) and dental services to Time for Teeth.

4.48 There was a positive working relationship between senior leaders in health care and the prison. However, enablement to health care appointments continued to be adversely affected by the combined impact of regime pressures and the prison's 'keep-apart' policy. This

meant that valuable clinical resources were not used to greatest effect and was a waste to the public purse.

4.49 The well-attended local delivery board had a regular schedule of meetings and provided effective oversight of the service. Actions were monitored, which included steps that had been taken to reduce the number of missed appointments, but this remained a persistent concern.

4.50 Clinical governance structures were effective, with a schedule of clinical audit and the results of these informing clinical practice. Staff promptly reported any incidents or safeguarding concerns. Incident investigation outcomes were shared with the team either at the daily 'buzz' handover meeting, via email or at team meetings.

4.51 The health care leadership team was stable and had very good oversight of the service. Managers were supportive of service changes and development which we observed through notable practice in primary care and Inclusion.

4.52 Children told us that staff were friendly, caring and approachable. We observed staff who focused on ensuring that care was child-focused and took account of the psychological and social development of the children.

4.53 Mandatory training was up to date, and staff had the opportunity to access further professional development to meet the needs of this age group. Clinical and managerial supervision arrangements were embedded, and all staff we spoke to felt supported and valued by the leadership team.

4.54 There were few health care complaints, and there was an emphasis on talking with the child to address the matter face-to-face, which was appropriate. Providers sought patient feedback following clinics.

4.55 Information governance structures were robust and information-sharing agreements supported the sharing of patient information and risks. All health staff maintained the electronic medical record, SystmOne, and the standard of entries was very good.

4.56 Clinical rooms were clean, well-organised and met infection prevention standards.

4.57 Systems to safeguard children were robust. Health care staff were confident making referrals to the safeguarding team. Managers had effective oversight of the referrals and worked well with Safer Custody and local authority social workers to address any concerns. Safeguarding supervision was not yet embedded, but managers facilitated and supported any member of staff who required it.

4.58 Emergency resuscitation equipment was in good condition and subject to regular, documented checking.

Promoting health and well-being

4.59 Health promotion was very good. Children were involved in the production of films about health issues, such as vaccines and overdose awareness. The films could be viewed on laptops held by the children and had improved the uptake of vaccinations.

4.60 Health promotion initiatives were delivered with a range of materials that were designed to appeal to children. The same information was shared with carers at the prison Family Days, which was good practice.

4.61 Information about national campaigns was available to children in a way they could understand, which included other languages and a variety of formats.

4.62 All children were offered age-appropriate health checks, disease prevention and screening programmes. Where they declined such offers, they were asked again at regular intervals to ensure the opportunity remained ongoing.

4.63 Sexual health services adhered to NICE guidance for this age group, and if necessary, children could be referred to the local specialist service which took place within the appropriate timescale. Relevant and appropriate sexual health advice was provided throughout their stay and before release.

4.64 There were no peer support workers within health care due to 'keep-aparts' and regime issues. This was a missed opportunity to improve outcomes for children.

Primary care and inpatient services

4.65 Children's attendance at health care was dependent on the regime pressures. Clinicians often spent more time waiting for children to be brought to appointments than seeing them. Despite this challenge, primary health care was good.

4.66 The primary care team operated a seven-day, 24-hour nursing service, with locum GP clinics delivered two days a week. Recruitment for a permanent GP was ongoing. An out-of-hours service was available and regularly used by health care to address any patient needs.

4.67 The team used every opportunity to engage and support the children, as some had revealed they asked to see a nurse because they needed time out of cell due to the regime and its impact on their well-being.

4.68 There was a good range of age-appropriate primary care services, and children could ask to see health care via an app on their laptop. At the time of the inspection, there was no waiting list to see the GP.

4.69 On arrival, children were screened using the comprehensive health assessment tool (CHAT). The assessments were thorough, and

children were promptly referred to other services as required. It was notable that every child received a 'welcome pack' from health care which included some toiletries, a distraction pack, colouring pencils and health promotion material, for example, How to Look After Your Skin, a leaflet about spots.

4.70 In exceptional circumstances children who arrived after 10pm had a health-risk screening to identify any immediate concerns before they went to bed. The full health screening was conducted the following day.

4.71 At the secondary health screen, children were asked for their consent to contact next of kin to clarify any health information or concerns that had been identified. Staff considered this telephone call was a valuable source to better understand the needs of the child and was good practice.

4.72 When required, children's health care information was shared with the prison throughout their time there.

4.73 The number of children who required referral to hospital was low, but where necessary, this was undertaken promptly and there was effective oversight of external hospital appointments. Children who needed to go to the local emergency department usually did so promptly with health care and prison staff working together effectively to minimise any potential delay.

4.74 At the last inspection an initiative to ensure all children received an annual health review was commended. It was positive that this review had become embedded practice and a valuable opportunity to engage children.

4.75 Children with long-term conditions were cared for well. Records and care plans were to a high standard, but we could not always identify the child's involvement and were assured that this would be addressed.

4.76 Health care staff were very flexible in their approach, and often this would entail care being delivered on the wings to make sure that health needs, such as vaccination, were met.

4.77 Health care staff contributed to the risk assessment of children who might have had to be restrained. Health care staff were automatically called to every incident and to review the child.

4.78 It was positive that when children were injured, health care staff contacted parents or carers upon request, to share information and reassure the family that appropriate care had been given.

4.79 Children were seen by a nurse before being released, were given any medication that they needed to take home and a copy of the GP summary. In a new initiative it was notable that to support the child to attend their GP they were given a map. The map highlighted the route from the release address to the GP, and the nurse would talk through

the route to encourage the child to continue to attend health appointments.

Mental health and substance misuse

4.80 Midlands Partnership University NHS Foundation Trust was sub-contracted to deliver the integrated mental health and psychosocial substance misuse Inclusion service.

4.81 A dedicated and caring team provided a wide range of therapies and treatment for children, including speech and language therapy, drama therapy, neurodiversity assessment, mental health nursing, formulation and care planning, psychology interventions, psychiatry and psychosocial substance misuse interventions. During our inspection we learnt that 71% of prison staff had received training in mental health, and 47% had received training in emotional and mental well-being.

4.82 The team worked hard to promote the integrated care framework and encourage staff across the prison to engage in children's formulations which the psychology team developed for all children. There was work underway to increase prison staff's time and resource to enable them to utilise the integrated care framework tools, such as formulations.

4.83 All children arriving at Werrington received a full range of assessments promptly using the CHAT mental health and substance misuse tools. They received harm minimisation advice from psychosocial recovery workers. Referrals were accepted from any source in any form, including self-referrals, and were discussed daily to identify risk and allocate children to the most appropriate worker.

4.84 All children were allocated to a member of the Inclusion team and received regular welfare checks to monitor their mental well-being and identify any treatment needs. There were four staff members trained to assess and deliver the Harmful Sexual Behaviours programme. Health care and resettlement teams worked collaboratively to support the two children accessing the programme at the time of the inspection.

4.85 Interventions were delivered on a one-to-one basis, and it was not possible to deliver group therapy due to conflict among children. A well-being centre offered a positive therapeutic space for the Inclusion team, but they were unable to utilise this due to a lack of officer presence or general alarms. This had been an ongoing issue for several years, which was poor.

4.86 Care planning and record keeping was completed to a good standard. Care plans were personalised and included evidence of the child's involvement. Care records were detailed and reflected ongoing communication with children's families, community services and prison resettlement services.

4.87 A member of the Inclusion team attended all ACCT reviews for children and visited the segregation unit regularly. The team

completed comprehensive care plans for all children self-isolating to ensure they received additional monitoring during this period.

4.88 There had been two transfers to secure hospitals under the Mental Health Act since our last visit; both had taken slightly longer than the national guideline of 14 days but had been well planned with a thorough handover to the secure hospital.

Medicines optimisation and pharmacy services

4.89 Medicines were delivered to children in a safe and effective way.

4.90 Day-to-day oversight of the service was by senior nurses who were supported by the regional pharmacist. Patient-named medicines were dispensed from HMP Oakwood and were received into Werrington safely and transported to the pharmacy securely.

4.91 In-possession risk assessments were completed and reviewed as necessary or during children's annual health review. Some children had their medication in possession and were supported by the nurses to be responsible for them.

4.92 During the day, all medicines were administered from the pharmacy. We observed children being called to receive their medication: one child attended. Health care staff asked him to provide his name, date of birth and number before medicines were administered, and we observed that health care staff knew the children well.

4.93 There had been a focus on ensuring administration was completed by 9am to ensure children could get to school. However, this was hampered by regime pressures which could cause delays.

4.94 Night-time medicines were delivered at the cell door, which was opened so that the nurse could observe that any tablets or capsules were swallowed by the child and reduced the risk of hiding or stockpiling medication.

4.95 Stock medicines were appropriate for the age group and well managed. The management of controlled drugs was excellent. Health care staff undertook spot checks of cells to make sure there was compliance with in-possession medicines.

4.96 All prescribing took place on the electronic record, and we saw instances where the out-of-hours GP had been consulted and provided a prescription for antibiotics. The nurses then administered this from stock, also recording it on the same record.

4.97 The local medicines management meeting met regularly to review local policies and procedures, and prescribing trends. Leaders also attended regional medicines management meetings.

Dental services and oral health

4.98 Time for Teeth delivered a community equivalent range of dental services. A regular dentist and dental nurse provided fortnightly clinics, and a dental therapist attended the prison for a monthly clinic.

4.99 The dental room was well equipped with a separate decontamination room. Governance arrangements were robust. Regular audits and patient surveys informed service delivery and evidenced positive feedback from children for the service. Relevant and up-to-date policies, procedures and equipment certifications were in place with annual servicing recently completed. The ultrasonic bath was old and broken at the time of inspection and required urgent replacement.

4.100 The average waiting time to see a dentist was four weeks, which was very good. The dental team risk-assessed patients waiting to be seen and appropriately prioritised patients with pain or swelling. Enablement issues with children not being brought for their appointments meant that clinic utilisation was not always sufficient, however the prison and head of health care monitored this and worked well together to mitigate it as much as possible. Children who missed appointments were followed up promptly and re-booked.

4.101 In the absence of the dental team on site, the primary care team prescribed pain medication and antibiotics where appropriate, and children were booked into the next clinic with the dentist.

Section 5 Purposeful activity

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

Time out of cell

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

5.1 Time out of cell was now worse than at the last inspection, with each child receiving on average just three and a half hours out of cell on weekdays and less at the weekend. This average masked substantial differences; while some children in full time education could receive six hours out of cell, for many others this was much less. Almost every day some children received less than 30 minutes, and a small number, who were scared, did not leave their cell for any reason. In one case, a child did not come out of his cell for 10 days.

5.2 The daily routine was undermined by class cancellations, which were a regular occurrence and led to yet more lock up. Although 75% of the children that we surveyed were in education, in practice this group was not consistently meeting the minimum 15 hours in class per week (see paragraph 5.17).

5.3 This was exacerbated by staff shortages which further limited the regime. There was no association during the week, which meant that all children were locked up from 4.30pm unless they had a visit or were entitled to their one evening gym session a week. Time in the open air was also severely curtailed.

5.4 The constant focus on keeping children apart or in small groups separated (see paragraph 3.39) also increased the time that the children spent locked up. The highly-controlled escorted movements were resource intensive and impacted punctuality. The number of groups who could not associate was high, with divisions within landings as well as between wings and landings. This created a complexity to the operation of daily routines, with a culture of control and separation pervading the prison.

5.5 There was some enrichment activity provided by Kinetic Youth, but this was often for small numbers and did not fully mitigate the regular cancelations in education and the long periods of lock up on the wings.

5.6 Since the last inspection, two librarians had been recruited and a room had been converted into a very limited library, which children had access to for around 30 minutes a week. It contained some tables and

chairs and a very limited number of books. There was no system in place for children to search or access the books available through Staffordshire County Council library service. Therefore, the children still did not have sufficient access to books and learning materials.

Library

5.7 Gym facilities were good and were well used. They included a rock-climbing wall, a sports hall, an outside pitch, and a cardiovascular and weights area. The facilities were valued by the children and the atmosphere we observed when they were engaging in PE was positive.

Climbing wall (left) and workout room

5.8 In addition to the recreational gym offered at the weekend and one evening a week, children were timetabled to have at least one session of gym a week as part of core education hours. Those with enhanced status were offered additional access, and there was a running club one morning a week for each wing landing.

5.9 The PE department had experienced some staffing challenges and had recently trained some new PEIs. Where staffing levels permitted, children would be offered additional time using the facilities when education classes had been cancelled. Weekly sessions were also offered to children who were being separated under Rule 49 or refusing to mix due to safety concerns. The gym therefore offered a valuable resource in the face of the challenges with time out of cell.

5.10 Accredited qualifications had been introduced, including assisting in sport and physical activity; the Duke of Edinburgh; and most recently a first aid course, which was good to see.

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.

5.11 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: Inadequate

Leadership and management: Inadequate.

5.12 Leaders had not improved the quality of education, skills and work (ESW) since the previous inspection. None of the concerns identified at the previous inspection had been resolved successfully. Leaders had been very slow to tackle the many improvement actions needed.

As a result, far too many children were leaving the prison not having learned or achieved anything that would improve their prospects of rehabilitation.

5.13 During the past six months, prison leaders responsible for governance had become more active in their pursuit of improvement. They had conducted detailed evaluations of all aspects of the ESW provision. This included a very recent needs analysis which reflected the views and aspirations of the children. In particular, they had generated the reliable data needed to hold education leaders and managers closely to account. Prison leaders now had a good understanding of the provision's many weaknesses and few strengths.

5.14 Almost all the improvement actions the education provider had initiated since the previous inspection had little or no impact. This was due largely to successive changes of the education provider's management. Each change paused or stopped children's progress and skills development. However, prison leaders recognised and welcomed that the education provider had, since spring this year, introduced new systems or processes for administering the education provision more effectively. However, it was too early to see the positive impact on children of any of these actions.

5.15 Leaders and managers had not prioritised children's learning and development. In our survey, around half of children reported that wing staff did not encourage them to attend education or training. Similarly, around half of children did not believe that what they learned in education or training would help them on release.

Education building (left) and classroom

5.16 Children had poor access to, and experience of, learning. Very few children were receiving their statutory minimum entitlement to 15 hours of education a week. Although there were sufficient activity spaces for the number of children, most of these spaces were only partly used. Leaders had not ensured the curriculums were challenging, ambitious or relevant to children's needs and future plans. Most of the accredited provision offered was only up to level 1, with very little available in terms of progression to higher-level learning.

5.17 Education leaders had created 10 learning pathways but most of these were not available in full because far too many of the core classes

were routinely cancelled. For example, the accredited courses in ICT, bicycle mechanics and barbering were not running. Leaders had reduced the offer in sport, and it now only focused on first aid and a general introduction to sporting activities. Cancellations in these and other subjects had been a regular occurrence since the previous inspection and were largely due to teaching staff shortages. Education leaders had appointed new staff, but most had not started yet.

5.18 Prison leaders had begun to introduce a curriculum to be delivered on the wings. This was to keep children occupied if they could not or would not attend education and training sessions during the core day, for example due to exclusion. This curriculum was at an early stage, focused initially on exploring children's leisure interests or teaching them basic life skills. It had so far had little impact, because leaders had not recruited the specialist staff needed to develop this curriculum further.

5.19 Very few children were released from the prison having progressively gained new knowledge and skills. Prison leaders and neurodiversity staff had established accurately that children with special educational needs or disabilities or education and health care plans represented around half the prison population. Education staff had not been giving these children appropriate support to meet their varied learning needs. Education managers had not been routinely recording children's starting points or prior attainment during their induction to education. Consequently, no-one could measure children's subsequent progress. Education leaders had responded recently by appointing a small team of learning support practitioners to gather the wide range of information needed to identify children's starting points, tailor learning and set meaningful individual targets. However, the strategy was very new and had so far had no demonstrable impact. Most children had little recall of any targets they had been set.

5.20 Leaders did not allocate children to activities that would support them to achieve their career goals, work experience or next steps. A wide range of prison staff attended allocations meetings and had a good knowledge of most of the children under discussion. However, the allocations process was ultimately dominated by considerations of which children could be placed together on learning pathways, restricting what they could opt to learn. Staff assessments of the perceived risk posed by, or to, each child could change week-by-week and prevent a child from continuing learning uninterrupted. Several children studying English or mathematics courses had been allocated to a level they had already attained and consequently achieved little of note. We learnt that eight children had been recommended for release on temporary licence (ROTL; see Glossary) since the start of the year, but none had been approved due to staff concerns about potential risks to the public.

5.21 PeoplePlus provided the education and vocational training in the prison. While the quality of education was mostly effective in the practical and vocational curriculum, teaching in the core subjects of English and mathematics was weak. Teachers in these subjects did

not have the skills or professional training to teach the curriculums so that children improved their understanding over time. Teachers did not provide enough opportunities for prisoners to return to topics and practise what they had been taught. Most children studying English and mathematics made slow or very slow progress. They were unable to talk with fluency about what they had learned over time or explain the sequence of the learning they had experienced. Too many were withdrawn from their courses before completing them because they had exceeded the allotted learning hours for that course. Too few prisoners achieved their qualifications in mathematics, English and ICT. In contrast, in practical subjects, teachers gave clear explanations and provided expert practical demonstrations which helped prisoners gain useful skills. As a result, prisoners were able to explain and demonstrate what they had learned.

5.22 Leaders had developed a comprehensive reading strategy but had been slow to implement it. They had rightly prioritised support for the weakest readers but learning support practitioners had only recently started supporting a very few children who had poor reading skills. Practitioners were using graded texts with age-appropriate content, but phonics were not being used as a teaching tool. Leaders had not extended reading opportunities into all education and training settings. A lack of library staff until very recently meant that librarian support for reading had not been available.

5.23 Children's attendance at ESW activities was poor, averaging only around half of those who were allocated to sessions. Sessions were often noisy, chaotic and frequently involved aggressive behaviour between children or towards teaching staff. This prevented teachers from teaching effectively and children from fully participating and learning.

5.24 Leaders recognised that children's poor attitudes and behaviours during education and training had a severely negative impact on the quality and effectiveness of the ESW provision. However, prison leaders had not ensured that their behaviour management strategy was being followed by all staff, particularly in classroom sessions. Too many staff lacked the training and skills to manage children's often very challenging behaviours effectively.

5.25 Leaders had been slow to develop and implement an effective personal development and work experience strategy for children. They had started to implement new initiatives, but it was too early to see their full impact. There was currently no formal teaching for children about the risks associated with extremism or radicalisation in or outside of prison. Teachers did not teach children about values of tolerance and respect, for example as part of a programme to improve children's behaviours and integration into their communities.

5.26 In sharp contrast, chaplaincy staff provided inspirational support for children's mental and emotional well-being. They ran sessions for children discussing and exploring aspects of equality, diversity and inclusion. The weekly worship and Bible studies sessions were

particularly well attended. The children had great respect for the chaplain.

5.27 Staff worked closely with the resettlement team to support children on release. They ensured children had useful information and guidance on their next steps after leaving HMYOI Werrington.

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 Over three-quarters of the population were being held over 50 miles from home, with a significant minority held more than 100 miles. There were reasonable opportunities for children to keep in contact with their family and the outside world. Visits took place on three evenings during the working week, as well as throughout the weekend. While the visits hall environment was adequate, provision for visitors was poor; there was no place for visitors to wait on arrival at the prison, this despite their (often) long journeys.

The visits hall

6.2 Family days had been restructured at the start of the year; the location had been changed from the gym to the visits hall, with different activities now provided. More sessions were available, which improved access for children. There had been positive feedback from family

members, and children we spoke to were also complimentary about the change of location and structure to the days.

6.3 There had been limited use of secure video calls; the prison only had one laptop on site. This restricted the numbers of calls children could have, and it had also recently been damaged, meaning many calls did not take place for several weeks.

6.4 The dedicated family support worker provided a good service to families, providing each child with an information pack about Werrington upon arrival. The pack included relevant information, regular newsletters, and a point of contact for families. There was no family therapist as the post remained vacant.

6.5 It was positive that leaders provided each child with £5 a week in phone credit to support family contact, and each child had an in-cell phone. The laptops made contact via email much easier, however there was an associated cost: 40p per email received, and an additional cost was incurred if a reply was requested; this charge seemed excessive.

Pre-release and resettlement

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

6.6 Since our last inspection, oversight of resettlement had deteriorated. The needs analysis had not been updated and relied on data from three years ago. Changes in the population included an increase in 18-year-olds, shifts in geographical distribution, and a rise in the number of Muslim children. The strategy had also not been updated and meetings to oversee improvement did not always take place, which led to delays completing actions.

6.7 The resettlement team comprised nine resettlement practitioners (RPs), both operational and non-operational staff. Each RP had a reasonable caseload of children. It was positive that the operational RPs suffered less cross-deployment than at our previous inspection. RPs received regular supervision from their line manager and spoke positively about that support.

6.8 Leaders had good links with local youth offending teams (YOTs), particularly Derby and Birmingham, and regularly sat on community management board meetings. They provided a dedicated space in the resettlement department to allow YOT workers to work when visiting children at Werrington, which had strengthened joint working between the resettlement team and YOTs in the community.

6.9 In the last year, 29 18-year-olds had transitioned to the adult estate, to 10 different adult establishments. The transition process was now managed centrally by the Youth Custody Service. Despite a national policy of moving young adults shortly after they turned 18, many waited much longer for transfers. As a result, more than one-fifth of the population was 18 at the time of this inspection. This put additional pressure on the institution, which did not have the education or work provision for this age group.

6.10 Early release and home detention curfew process were managed well and decisions were made appropriately. It was good that leaders were proactive in reviewing children for ROTL a few months ahead of their eligibility date. This ensured that those children that did meet the criteria and whose behaviour in custody was appropriate where approved. As a result, over the previous year, six children participated in ROTL on 116 occasions, mainly for resettlement activities, volunteering, or enrichment.

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.

6.11 Children experienced good levels of contact from their RP, and RPs were knowledgeable about their children. Children were also positive about their relationship with their RP and were able to give examples of things they had resolved for them. Recording of contacts was, however, inconsistent, and leaders needed to do more to ensure events were recorded correctly and shared.

6.12 Every child had a 'one plan' in place, where targets were set for each child to support them with their period on remand or sentence. However, children's awareness of these plans and engagement with them was undermined by them often being subject to multiple other plans from different departments within the prison. Those we spoke to only recognised the specific targets when prompted.

6.13 Overall, in the cases we reviewed we felt that children had made reasonable progress against their targets.

6.14 On average, there were over 50 reviews of remand and sentence plans conducted each month, which were integrated with Looked After Children meetings to ensure comprehensive assessments and planning for the children's well-being and progress. Attendance was variable, but in the best examples we saw consistent multidisciplinary attendance from within the establishment as well as outside YOTs and local authorities.

Public protection

6.15 All children were screened on arrival for risks they posed to the public, and where there were concerns appropriate actions, such as contact restrictions or monitoring, were imposed.

6.16 A monthly risk management meeting took place, which reviewed all children being released; MAPPA level 2 and 3 nominals; those being monitored under public protection arrangements; and oversight of ViSOR (see Glossary) arrangements. Attendance was not recorded. Leaders told us there were often key areas not in attendance, for example, residential staff.

6.17 Despite this meeting, during the inspection we found a weakness in administrative processes that meant we could not be assured that all children had a confirmed MAPPA level on release, and we found one child released during the inspection without a confirmed level. Leaders swiftly rectified this during the inspection, and we were confident that this would prevent a reoccurrence.

6.18 There had been some improvements in risk management planning, but there remained inconsistencies between practitioners.

6.19 Written contributions to MAPPA meetings were reasonably good and offered relevant information and good insight into the presentation of the child. There were some good examples of analysis of information and suggestions for safeguards or restrictions that could be used to manage risks in custody and the community.

Indeterminate and long-sentenced children

6.20 There was good support in place for life-sentenced children, of which there were nine at the time of the inspection. There were two schemes available that provided support and information.

6.21 The resettlement department had established links with adult prisons and found suitable life-sentenced adult prisoners who were nearing the end of their sentence and could provide information and insight into their experiences. This support was provided through supervised video calls and correspondence.

6.22 The chaplaincy team continued to run a scheme called ‘the big stretch', which was a monthly programme open to children serving 10 years or more. It regularly had guest speakers, some from the adult estate or other organisations that could provide information or reflection. It also provided a separate space for these children, away from the residential units. Here, they shared similar experiences, came together and supported each other, which was good.

Looked after children

6.23 In our survey, 61% of children reported having been in local authority care. While, overall, most views were similar to those of other children,

looked after children reported more positively on food and access to healthcare.

6.24 There were dedicated social workers on site that would meet each child shortly after arrival and work with local authorities to ensure statutory obligations were met. However, there were often long delays in getting children their entitled financial support from their local authority.

Reintegration planning

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

6.25 In the last year there had been 66 releases from Werrington. It was positive that leaders had introduced regular leavers meetings that took place at 12, eight and four weeks prior to release. These meetings were not attended by the child but were held among professionals, such as the YOT and social workers, to enable discussions on issues such as accommodation. The child's views were collected from previous meetings and the RP, and any relevant information fed back to the child. A final meeting took place with the child 10 days before release.

6.26 The Department for Work and Pensions attended regularly, linking in with RPs and assisting in careers and benefits advice. There were schemes available for children to access a bank account and obtain identity cards or their birth certificate prior to release.

6.27 While all children had accommodation on the day of release, it was often confirmed too close to the release day to allow for effective release planning. In the last year, just under half of all releases had confirmed accommodation in the 14 days prior to release, and for a small number of children this was confirmed the day prior. Leaders were actively monitoring and escalating cases where accommodation had not been arranged and release was approaching. This impacted on education and training outcomes, only a fifth of all releases having a placement on release.

Interventions

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

6.28 Each sentenced child received an assessment for suitable interventions completed by the programmes team.

6.29 Children had access to the interventions approved for use by the YCS, 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. While some groups had previously been run, all interventions were now delivered on a one-to-one basis, as problems with mixing children together made group sessions more difficult. In the last year, over 50 interventions had been delivered to children; however, because of some staffing shortfalls, a small number of children had been released without having their identified need met in custody.

6.30 The onsite psychology team provided consultation, assessment and formal and informal interventions to children based on children's needs.

6.31 There had been significant improvements to the assessment and interventions available for children convicted of sexual offences. Two RPs had been trained in the assessment tool, which enabled them to identify the specific behavioural areas that needed attention for any child with a sexual offence, and they worked collaboratively with Inclusion to deliver interventions.

Health, social care and substance misuse

6.32 At the time of our inspection, there were no children in receipt of social care, and no needs had been identified since our last inspection. Disabilities and any support needs with daily living activities were identified as part of the reception screening, and a local operating procedure was in place to ensure that any 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 poor against this healthy establishment test.

Priority concerns

Systems for the safeguarding of children had fallen into disarray. Too many child protection referrals were outstanding and there were long delays in referring allegations of abuse to the local authority designated officer.
Addressed

Behaviour management systems were ineffective. Leaders were consistently unable to deliver the incentives on offer and there were limited consequences for poor behaviour by children.
Not addressed

Werrington accounted for 56% of all injuries during use of force in the YOI estate despite holding just 18% of the children. Governance arrangements had not identified or addressed this issue.
Addressed

Key concerns

Oversight of separated children was insufficient. The regime for most separated children was poor, and some children were separated without authority.
Not 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 not sufficiently good against this healthy establishment test.

Priority concerns

Shortfalls of operational staff hindered the development of effective relationships with children and prevented children from accessing other services at Werrington.
Not addressed

Key concerns

In our survey, just 37% of children said they felt cared for by staff. The staff-children interactions we saw were mostly transactional and too few children received meaningful support from their allocated officer.
Not addressed

Identified unfair treatment among different groups of children had not been investigated and addressed. Leaders did not understand the perceptions of protected groups due to a lack of regular consultation.
Addressed

Regime pressures and the policy to keep children apart meant that they were often not taken to health care appointments. This was a major waste of resources and had a negative impact on all services.
Not 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 poor against this healthy establishment test.

Priority concerns

Children spent far too long locked up, particularly on weekends where many were in their cells for up to 22 hours a day.
Not addressed

Senior leaders had not given sufficient priority to delivering a high-quality education, skills and work curriculum.
Not addressed

The quality assurance and improvement arrangements for education were not effective in making sure that children received high-quality learning experiences. Leaders and managers were unaware of the substantial weaknesses in the quality of education.
Not addressed

Key concerns

Leaders did not promote reading and literacy. There had been no library provision for over a year and there was an absence of an appropriate reading curriculum.
Not addressed

Leaders and managers had not made sure that all children accessed their entitlement to education, and that allocations to education, skills and work activities were driven by children's needs and ambitions.
Not addressed

Leaders had not developed a wider curriculum that helped children to develop social, emotional and communication skills or prepare them sufficiently for life in modern Britain.
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 concerns

Children's risk management plans were weak and did not fully address the risks identified.
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:

Charlie Taylor	Chief inspector
Angus Jones	Team leader
Donna Ward	Inspector
Jessie Wilson	Inspector
John Wharton	Inspector
David Foot	Inspector
Martyn Griffiths	Inspector
Alicia Grassom	Researcher
Emma King	Researcher
Helen Ranns	Researcher
Phoebe Dobson	Researcher
Sam Moses	Researcher
Jasmin Clarke	Researcher
Sarah Goodwin	Lead health and social care inspector
Gift Kapswara	Health care inspector
Dayni Johnson	Care Quality Commission inspector
Nick Crombie	Ofsted inspector
Martin Ward	Ofsted inspector
Bev Ramsell	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.

ACCT
Assessment, care in custody and teamwork – case management for prisoners at risk of suicide or self-harm.

Care and separation unit (CSU)
Prisoners can be moved to care and separation units for their own safety if they are at risk of violence from other prisoners.

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.

Kinetic Youth
A not-for-profit social enterprise that primarily works with young people in custody to provide enrichment activity and 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.

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

Release on temporary licence (ROTL)
Being able to leave the prison for a short time for specific activities.

Safety interventions meeting (SIM)
A multidisciplinary safety risk management meeting, chaired by a senior manager.

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

ViSOR
Violent and sexual offenders register.

Zahid Mubarek Trust
Independent national charity founded in 2009 by the family of 19-year-old Zahid Mubarek, who was murdered by his racist cellmate on the morning scheduled for his release from Feltham Young Offender Institution.

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

Appendix III Further resources

Some further resources that should be read alongside this report are published on the HMI Prisons website (they also appear in the printed reports distributed to the establishment). For this report, these are:

Establishment population profile

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

Survey of children – methodology and results

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

Establishment staff survey

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

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

This publication is available for download at: Our reports – HM Inspectorate of Prisons (justiceinspectorates.gov.uk)

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