Report on an unannounced inspection of

# HMYOI Feltham

by HM Chief Inspector of Prisons

20 May – 5 June 2025

# Contents

# Introduction

While the scores for our healthy prison assessments had not changed – poor for ‘safety’ and ‘purposeful activity’, and reasonably good for ‘care’ and ‘resettlement' – inspectors left with some optimism that things at this West London, under-18 YOI were beginning to improve after a troubled eighteen months.

A new interim governor and deputy had recently taken over the prison and, with an enthusiastic leadership team, had begun to make some progress. ‘Keep-apart’ lists that prevented children from mixing had been reduced, meaning it was now possible to run better regimes on some wings than we had seen at our last inspection. Levels of violence, which although still the highest of any prison in the country, had also begun to reduce over the last few months.

The governor and prison group director had worked with the education provider to improve the service and our colleagues at Ofsted were positive about the quality of some of the teaching. Attendance, however, was very poor at a rate that would never have been acceptable at a school or a college. Sessions in education, the gym and the well-run library were often cancelled at short notice, leading to frustration amongst staff members and boys alike.

Time out of cell remained completely unacceptable for energetic boys and young men who were locked in their cells for 20 hours a day. Those on the enhanced units could expect to be out for much longer, but others described a bleak existence with many hours spent watching daytime television in enforced idleness.

It was good to see the Alpine unit for some of the more troubled boys had reopened with a regained sense of purpose and a committed staff team. Levels of staff sickness, in part linked to the violence and instability at Feltham, were among the highest in the country. This meant staffing in each unit was unpredictable and boys and staff often did not have time to form positive relationships, particularly where they did not know the officers on duty. A lack of confidence meant that poor behaviour was inconsistently managed and some was even rewarded.

Feltham remains a troubled institution that is still not nearly safe enough. For relationships to improve, the rules at the YOI need to be absolutely clear and enforced by confident staff who are supported by their seniors. There need to be sanctions and incentives that are consistently used by staff to maintain standards. Only then will the prison become safer for both children and staff, thereby reducing sickness rates and improving the regime.

With continued support from the PGD and consistency of leadership in the jail, I have some cautious optimism that things will continue to improve.

**Charlie Taylor**
HM Chief Inspector of Prisons
July 2025

# What needs to improve at HMYOI Feltham

During this inspection we identified 12 key concerns, of which seven should be treated as priorities. Priority concerns are those that are most important to improving outcomes for children. They require immediate attention by leaders and managers.

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

## Priority concerns

1. **The rate of sickness among frontline staff was among the highest of all prisons.** This made it difficult for leaders to build effective relationships or deliver a reliable daily routine.

2. **Behaviour management by staff was ineffective.** Inconsistency, combined with a lack of meaningful rewards or sanctions, meant that children were not motivated to improve their behaviour.

3. **The rate of use of force was too high and there was no plan to reduce it.** Staff did not routinely draw or activate their body-worn cameras, which prevented leaders from scrutinising incidents properly and applying learning where required.

4. **Custody support plan meetings between staff and children were frequently not taking place.**

5. **There were regular delays in escorting children for their medicines and other appointments. As a result, some health appointments were curtailed or missed.**

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

7. **Children did not receive their full entitlement to education which significantly limited their chances of finding work and making a positive contribution to the community on release.**

## Key concerns

8. **The emerging problem of illicit substance use among children had not been adequately prioritised by leaders.** Intelligence-led testing and searching were not being conducted consistently, undermining the institution's ability to manage this risk effectively.

9. **The level of self-harm was too high.** Care planning for children at risk of self-harm was weak.

10. **Managers had not provided sufficient vocational training to support children's career ambitions or to help them to find employment on release.**

11. **Teaching staff did not receive sufficient training in phonics to help children with their reading.** Children did not have enough access to the library in order to borrow books and develop their reading skills. Not enough children improved their reading skills by reading for pleasure.

12. **Housing was identified too close to children's release date, impeding planning for education, training and employment in the community.**

# About HMYOI Feltham

**Task of the establishment**
Male children and young adults of 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: 94
Baseline certified normal capacity: 198
In-use certified normal capacity: 140
Operational capacity: 126

**Population of the establishment**

- 250 children received in 2024
- 14 foreign national children
- 76.4% of children from black and minority ethnic backgrounds
- An average of six children released into the community each month
- An average of five children transitioned to the adult estate each month
- 53% of children on remand.

**Establishment status (public or private) and key providers**
Public

Physical health provider: Central and North West London NHS Foundation Trust (CNWL)
Mental health provider: CNWL
Substance misuse treatment provider: CNWL
Dental health provider: NHSE commissioned an independent provider for dental care
Prison education framework provider: The Shaw Trust
Escort contractor: Serco

**Prison group/Department**
Youth Custody Service

**Prison Group Director**
Sonia Brooks OBE

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

**Short description of residential units**
Alpine: Enhanced support unit
Bittern: Normal location
Curlew: Platinum community

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

**Name of governor and date in post**
Gary Sillifant (interim), 10 January 2025

**Changes of governor since the last inspection**
Natasha Wilson, April 2022 – 9 January 2025 (secondment)

**Independent Monitoring Board chair**
Jane Shalders

**Date of last inspection**
March 2024

# Section 1 Summary of key findings

## Outcomes for children

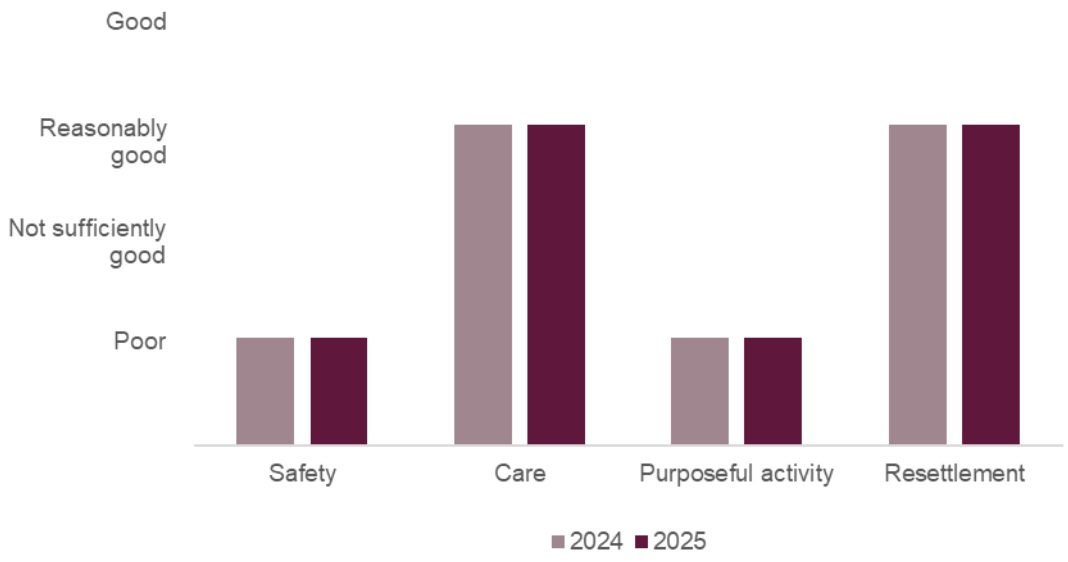
1.1 We assess outcomes for children against four healthy establishment tests: safety, care, purposeful activity and resettlement (see Appendix I for more information about the tests). We also include a commentary on leadership in the establishment (see Section 2).

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

- poor for safety
- reasonably good for care
- poor for purposeful activity
- reasonably good for resettlement.

1.3 We last inspected Feltham in 2024. Figure 1 shows how outcomes for children have changed since the last inspection.

**Figure 1: HMYOI Feltham healthy establishment outcomes 2024 and 2025**




## Progress on priority and key concerns from the last inspection

1.4 At our last inspection in 2024, we raised 10 concerns, seven of which were priority concerns.

1.5 At this inspection we found that four of our concerns had been addressed and six had not been addressed. There were five concerns in purposeful activity, of which three had been addressed, but neither of the concerns in resettlement had been addressed. 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 three 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) | Training children to be zero responders (a member of the public who is the first on the scene in an emergency and provides immediate assistance before professionals), gave them a sense of purpose, helped to create empathy and compassion, and had the potential to save lives. | See paragraph 4.44 |
| b) | The mental health team were involved in the recruitment and selection of youth justice workers, which helped to ensure that they had the appropriate skills, values and behaviours to support children. | See paragraph 4.63 |
| c) | As a member of the multi-agency Hounslow Drug and Alcohol Partnership Board, the substance misuse service had access to intelligence on current and emerging substance use in the community and associated risks. | See paragraph 4.69 |

# Section 2 Leadership

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

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

2.2 The period since the previous inspection had been turbulent at Feltham. A new interim governor and deputy governor had taken up post in January 2025 and had worked with the Youth Custody Service (YCS) to formulate a credible plan for improvement. This had energised their leadership team, but it was only implemented in April and so it was too soon to assess the impact on outcomes for children.

2.3 The governor's priorities in his self-assessment report were appropriate and ambitious. These included the aim to expand the number of units where all the children could mix and to co-locate staff from different departments on individual wings to support the framework for integrated care (see Glossary).

2.4 Local leaders had received considerable support from the Deputy Director of Operations in the YCS including reducing the population, capital expenditure to improve living units, the expansion of key teams and intervention to improve the education provision. With this support, leaders from the YOI and education had addressed some of the previous weaknesses. However, this was fundamentally undermined by the continued issue of limited time out of cell and poor attendance. In addition, leaders had not addressed the chronic delays getting children to activities and appointments.

2.5 Front-line staff reported that communication from leaders had improved and was now supported by regular staff briefings and newsletters. The previous high turnover of front-line staff had been reduced, but there was still a significant issue with sickness which affected the ability of managers to deliver a consistent daily routine.

2.6 Leaders had not addressed weaknesses in behaviour management, and we saw several examples of rules not being enforced, poor behaviour being rewarded and children reacting aggressively to staff. The custody support plan (facilitated through weekly meetings between children and members of staff they knew well) was not delivered effectively despite a far higher number of residential staff than children and a large management team who could support this work. This undermined the relationships needed to manage poor behaviour.

2.7 During this inspection we saw many staff who were committed and knowledgeable, but there was substantial variability in the capability of youth justice workers that leaders had not addressed.

2.8 The effectiveness of oversight of the use of force had deteriorated since our last inspection. A lack of body worn camera footage hindered leaders' ability both to disseminate good practice and take action in response to concerning incidents.

2.9 Project management was not good enough; for example, there were significant delays with the delivery of a new health care facility for children at Feltham A. In addition, no real progress had been made on the daily delays in moving children to health care appointments, education and other activities. As a result, we continued to see a wealth of resources that could support improving outcomes for children being wasted.

# 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 Reception processes were working well. Children arriving at Feltham had initial interviews which identified their immediate risks and needs, and a member of the health care team provided a health screen in private.

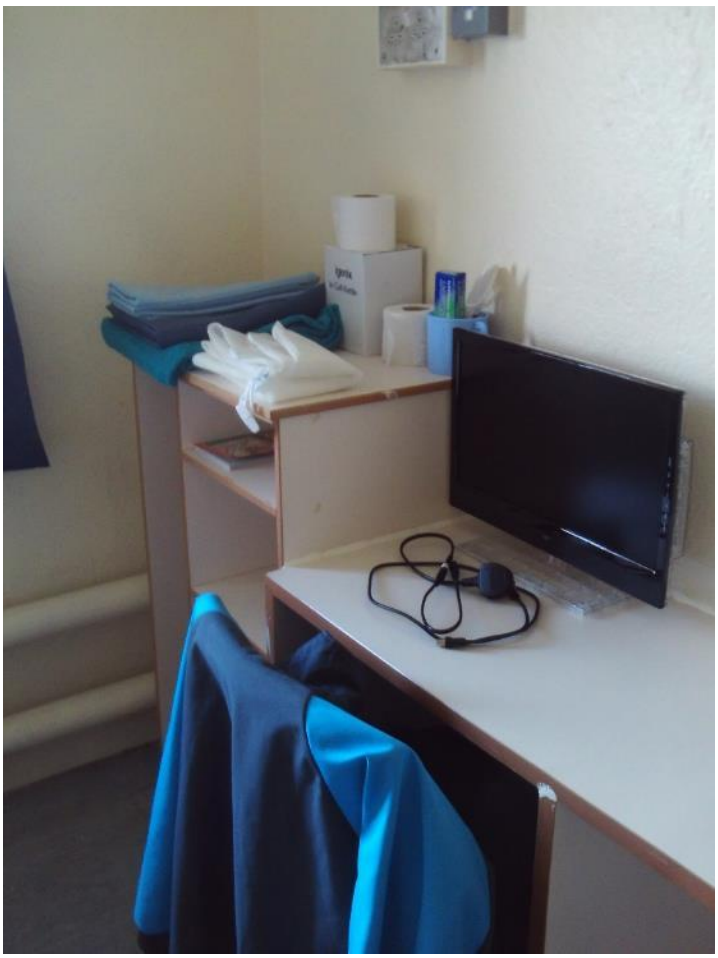
3.2 Children could have a hot meal and shower on arrival and youth justice workers (YJWs) made sure that they were able make a phone call if they wished. Quality assurance checks were taking place to ensure that the correct processes were being followed.

3.3 The reception area was clean and tidy, with comfortable furniture, a television and relevant information displayed for children. In our survey, 80% of children told us that they were treated well on admission, and recently arrived children spoke positively of their treatment by reception staff.

3.4 First night and induction had moved to a dedicated unit, which had only been running for two weeks at the time of our inspection. For much of the previous year, children had been placed directly on one of the residential units after their arrival. We found evidence that this had affected them adversely. Some children had found the experience overwhelming and received little time out of their cells as staff struggled to move them to induction meetings.

3.5 Processes on the new unit were still being embedded; quality assurance checks for first night cells were not consistent, and not all staff had received training in reception, induction and first night duties. However, feedback from staff and children was clear, the new unit was a significant improvement on the previous system. New arrivals were now checked hourly during their first night at Feltham and had opportunities to socialise with their peers on the unit.

3.6 First night cells were well equipped and reasonably clean, although many had worn or damaged flooring. Local leaders had secured funding for renovations.



**Frist night cell prepared for a new arrival**

3.7 In our survey, only 56% of children said that they were told everything they needed to know about life at Feltham A. This reflected weaknesses in the previous system of induction. Induction now took place over two weeks, separated into a series of modules. Key departments in the YOI also visited children during this period, including the chaplaincy, the family services provider, the conflict resolution team and resettlement practitioners.

3.8 Children still faced delays in getting telephone numbers approved, which impeded contact with their families and friends during their first few days at Feltham.

## Safeguarding of children

Expected outcomes: The establishment promotes the welfare of children, particularly those most at risk, and protects them from all kinds of harm and neglect.

3.9 Safeguarding procedures continued to work well. The number of referrals had increased since our last inspection from 150 to 278. Leaders monitored referrals to make sure they came from a wide range

of sources. Training was delivered for departments who did not submit them.

3.10 Safeguarding referrals were swiftly triaged by an independent social worker or the duty governor at weekends, and those that met the threshold were forwarded to the local authority within 24 hours. Thirteen referrals had been escalated, of which six had been fully investigated by the local authority designated officer (LADO). Three of these had been substantiated.

3.11 In the sample of referrals that we viewed, we found an impressive level of multi-agency contact, notably that the child concerned was always informed and regularly kept up to date. It was also good to see that families were involved.

3.12 Relationships with the local authority were very good and the LADO regularly attended meetings, quality assuring safeguarding referrals and providing independent scrutiny in areas such as use of force. The governor regularly met senior leaders from the local authority to discuss safeguarding and any themes they had identified.

3.13 There were three tiers of safeguarding meetings: a quarterly strategic meeting chaired by the governor which the LADO attended; a monthly meeting that provided oversight and scrutiny of safeguarding and identified trends; and a weekly meeting that considered immediate support for children. These forums were well attended and comprehensive data were provided, ensuring leaders were aware of the causes and trends in safeguarding referrals.

3.14 At our last inspection we highlighted that night staff carried cell keys that were not sealed, creating a safeguarding risk. This had been rectified: a seal now had to be broken and justification provided for its use once the prison was secured for the night.

## Suicide and self-harm prevention

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

3.15 The rate of self-harm over the previous year had remained unchanged since our last inspection (16 incidents per 100 children each month). Serious self-harm remained rare, with two instances in the preceding 12 months. In both cases there had been a thorough investigation.

3.16 Constant supervision had been used four times in the previous 12 months, three of which had been for the same child. In each case it was appropriately authorised and reviewed frequently to make sure

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

3.17 Immediate support actions for children at risk of self-harm were considered at an effective weekly meeting which monitored their progress. A wide range of data was considered at the monthly safety meeting. Leaders were aware of the causes of self-harm, but too few actions were being taken to reduce the overall level of it.

3.18 Four ACCTs (assessment, care in custody and teamwork – case management for children at risk of suicide or self-harm) were open at the start of the inspection. In the selection of current and previous ACCTs that we reviewed, we found that most held good, detailed information about the child, their triggers for self-harm and the reasons why staff were concerned. ACCT reviews were timely, and it was good to see attendance by a range of professionals involved in the child's care.

3.19 The children we spoke to who had been subject to the ACCT process told us they felt cared for and well supported. Formal care plans, however, were inconsistent in quality. Too many were generic and did little to support the child. This presented a risk given the regular cross-deployment of staff. This had been identified by internal quality assurance but had not been addressed.

## 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.

3.20 The previous security department covering both Feltham A and B had been split, which potentially enabled leaders to focus on the specific risks presented at Feltham A. However, the priority security objectives were underdeveloped and poorly communicated, leading to a lack of understanding among youth justice workers and leaders about actions that were needed to address the most urgent threats.

3.21 Disorder remained a significant concern, including children climbing to height in protest, refusing to return to their cells or come in from the exercise yard. In the past 12 months, there had been 312 such incidents. In many cases children were protesting about spending long periods locked in their cells.

3.22 The weapons strategy introduced over two years ago had led to a reduction in the number of weapons found. Over the previous year, 123 had been found, compared with 343 during the same period before the last inspection. However, the presence and use of weapons remained a concern among children and had led to serious injuries in some cases.

3.23 Over the past year, 6,547 intelligence reports had been submitted, primarily related to fights, threats (towards both staff and children), drugs and weapons. There were some weaknesses in the response to intelligence. Drug testing and cell searches were often not carried out, and leaders lacked a clear understanding of the amount of drug use and contraband. We observed one child who appeared to be under the influence who admitted to using cannabis. Of the few (17) intelligence-led drug tests conducted in the last 12 months, 11 had returned positive results, mostly for cannabis.

3.24 In our survey, 23% of children said they had had a drug problem on arrival in custody, but only 56% of these said they had received any support, which was concerning. Leaders lacked sufficient oversight of the emerging issue of illicit substance use and did not have a coherent plan to address it. Only one drug strategy meeting had taken place since January 2025. Very limited data had been reviewed and it had not been attended by key leaders.

3.25 Children were only strip-searched in response to intelligence. During the last 12 months, 41 children had been strip-searched. The introduction of improved oversight of strip-searching in 2024 had given leaders greater assurance about the necessity and proportionality of this type of search. As a result, the number had reduced, and Illicit items had been found in 39%.

3.26 At the time of this inspection, no children were on restricted status (the highest security category) and one was detained under the Terrorism Act 2000 (TACT). National leaders provided Feltham with appropriate and regular support to ensure effective handling of information about those charged or found guilty of TACT offences.

3.27 Two children were subject to escape list (E-list) procedures, which applied if they needed to leave the YOI under staff supervision. Most staff we spoke to were familiar with E-list protocols and knew the identities of these children. Handcuffing arrangements for external appointments were proportionate.

## 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.

3.28 Behaviour management remained a significant weakness. In our survey, only 31% of children said that behaviour schemes motivated them to behave well and just 28% said these were applied fairly.

3.29 The instant reward scheme commonly referred to by children as the yellow and green card system (with yellow issued for negative behaviour and green for positive) was designed to encourage good behaviour through small, prompt incentives. However, leaders

acknowledged that oversight of the scheme had collapsed, and staff often failed to follow through with promised rewards which undermined its effectiveness.

3.30 The three-tier incentives scheme remained in place but was applied inconsistently across the YOI. Apart from Curlew (the gold wing), there were problems with the application of incorrect incentive levels either because reviews were missed or errors were not corrected on the electronic system. Incentive level changes were often not clearly recorded, and explanations were not consistently provided to help children understand or address poor behaviour. As a result, some were unable to access their full canteen entitlements, which was unfair and frustrating for many of them. In addition, those who had been promoted to gold, but were not living on Curlew, were less likely to receive key incentives, most notably additional time out of cell.

3.31 Curlew unit offered additional privileges to those on the highest tier, such as more time out of cell and an extra social visit at the weekend. These privileges were appreciated by children and the wing had a more relaxed and positive atmosphere. Some on Curlew told us that more time out of cell helped them to build stronger relationships with staff. Staff were engaging in wing-based activities with children rather than supervising from a distance. This proactive engagement supported stronger relationships and helped motivate and sustain consistently positive behaviour on that wing.

3.32 Alpine unit had reopened as the enhanced support unit (ESU) (see paragraph 4.63) and three children were held there at the time of inspection. Children on Alpine received strong multi-agency support and youth justice workers were well acquainted with their individual needs. These children benefited from more time out of cell and dedicated facilities for interventions including a music room, art room and dedicated exercise area.

**Enhanced Support Unit exercise room (left) and music room (right)**

3.33 In the last 12 months, there had been 2,357 adjudications. Of these 214 were dismissed or not proceeded with, 26 were referred to an independent adjudicator (district judge), 624 related to assaults, 420 to weapons, phones or drugs, and 358 involved destruction of property.

3.34 Most adjudications were appropriate and proportionate to the seriousness of the charge and were conducted within the required time frames.

## 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.

3.35 Despite a reduction from the very high levels we saw in October 2024, violence remained frequent and rates were higher than at comparable YOIs.

3.36 Over the past 12 months, there had been 253 assaults on children and 193 assaults on staff. Forty of these incidents were recorded as serious. One-hundred-and-twenty-six incidents involved weapons, ranging from sharp blades to dangerous liquids.

3.37 The violence reduction strategy was up to date and comprehensive, providing clear guidance to staff on how to report incidents and manage children. Most incidents were investigated, although the investigations were largely data driven and lacked exploration of the circumstances behind the violence. Crucially, they failed to talk to the children about what had caused the incidents. While many were categorised as spontaneous or driven by seemingly minor disputes, some children we spoke to said that that these outbursts were often symptoms of deeper frustration. Common triggers included the unpredictability of the daily routine and unmet basic requests such as showers or replacement handsets for broken in-cell phones.

3.38 There had been a notable reduction in the number of ‘keep-apart’ restrictions, from more than 400 at the last inspection to 161. This progress had allowed children on three wings to mix fully with each other, which they preferred. The improvement had come about following better oversight and a more structured, focused approach to helping children understand the benefits of mixing. Nevertheless, the 161 remaining keep-aparts continued to adversely affect many aspects of life at Feltham.

3.39 Between January and May 2025, the conflict resolution team had faced staff shortages but had commendably kept up to date with referrals.

3.40 Monthly behaviour management meetings were well attended and key data on violence, such as frequency, time of day and the individuals involved, were regularly reviewed. However, the lack of information about the causes hampered plans to reduce overall levels of violence.

## The use of force

Expected outcomes: Force is used only as a last resort and if applied is used legitimately by trained staff. The use of force is minimised through preventive strategies and alternative approaches which are monitored through robust governance arrangements.

3.41 The rate of use of force remained high and was considerably higher than in any other YOI. Over the past 12 months, there had been 1,407 recorded incidents, most of which were in response to attempts to prevent fights or assaults. In our survey, 70% of children said they had been restrained, yet only 45% said that someone had spoken to them about the incident afterwards, compared with 74% in other YOIs.

3.42 There was a substantial backlog in key use of force documentation, with 342 incidents lacking staff reports. Body-worn cameras were not consistently worn or activated by staff during incidents involving restraint. This lack of footage, combined with limited inquiry into the context of the incidents, undermined oversight. Leaders did not, therefore, always have a clear or complete understanding of why force had been used and were poorly placed to take effective action to reduce it.

3.43 Almost every incident that we reviewed included a post-incident debrief which gave a clear factual account of what had happened, although very few included the child's account of the incident.

3.44 Pain-inducing techniques had been used on five occasions in the previous year. Record-keeping for these incidents was robust, and each incident was scrutinised by the independent restraint minimisation panel.

## 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.

3.45 During the previous 12 months, 177 children had been separated on either Rule 49 (see Glossary) or self-isolation. Falcon was the designated unit for children placed on rule 49, while those who were self-isolating usually did so on one of the other wings.

3.46 In the last 12 months, children had been placed on Rule 49 for an average of 10 days, and self-isolators for an average of 12 days, which was too long in both cases. The distinction had become muddled, and many staff used the two terms interchangeably in written records and on wing roll boards.

3.47 While good records were kept of the support offered to children on rule 49 on Falcon, the same level of detail was not kept for those who were self-isolating. Children on Falcon saw a governor, nurse and member of the chaplaincy daily and had very good levels of engagement with youth justice workers. Unfortunately, leaders were unable to provide assurance that the same level of oversight was given to children self-isolating on the wings. These children often received less time out of cell and had much less consistent intervention from specialist staff.


**Falcon unit cell**

3.48 On Falcon the day-to-day routine was operated by a dedicated team of staff who knew the children and their responsibilities well. They had engaged three children to mix with a long-term plan to reintegrate back to the residential units.

3.49 Falcon unit was clean and largely free of graffiti and the mould and dirt in the showers and the dirty corner rooms had been rectified since our previous inspection. Staff encouraged children to keep their rooms clean and tidy. The exercise yard had a table tennis table and staff and children interacted in the fresh air.

**Falcon unit exercise yard (left), games room (centre) and corner room (right)**

3.50 Key records such as authority to segregate, segregation reviews and authority to segregate beyond 14 days by more senior leaders were appropriately recorded and on time.

# Section 4 Care

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

## Relationships between staff and children

Expected outcomes: Children are treated with care by all staff, and are expected, encouraged and enabled to take responsibility for their own actions and decisions. Staff set clear and fair boundaries. Staff have high expectations of all children and help them to achieve their potential.

4.1 In our survey, just 57% of children said they felt cared for by staff. Many staff were knowledgeable about those in their care but inconsistency among staff and an inability to respond quickly to everyday requests undermined relationships. While we saw some positive interactions during the inspection, the number of complaints against staff was high and comprised 33% of all complaints investigated.

4.2 Custody support plan (CuSP) meetings between staff and children frequently did not take place. Most of those that did take place were cursory in nature. Quality assurance of CuSP was detailed with leaders receiving feedback on both the frequency and quality of assessments. However, this had not improved the delivery of the scheme.

4.3 Staff, including resettlement practitioners and psychologists, were now located on residential units to support joint working with youth justice workers.

4.4 This initiative was to support the delivery of Integrated care meetings and the resulting plans. Meetings with children took place every eight weeks or when a need for intervention was identified. The content of children's formulations and communication passports were comprehensive. However, despite the proximity of these staff, many frontline youth justice workers remained absent from these meetings and unaware of some essential information about the children in their care.

## Daily life

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

### Living conditions

4.5 The overall environment varied but had been improved by a refurbishment programme. Cells had been painted and were generally well equipped, and curtains, rails and toilet covers had been installed. Investment had been made in in-cell showers which was an improvement since the previous inspection.

**Enhanced wing – Curlew**

4.6 Many cells were untidy and children needed more encouragement from staff to keep their cells clean.

4.7 Access to clean bedding, towels, clothing and cleaning materials was generally good.

4.8 Laptops provided useful information about Feltham and were used by leaders to communicate with children. Leaders had been proactive in making sure that the information provided was accurate and timely. A new induction presentation, which included a spoken narrative for those who could not read and provided information about the services available, was an example.

### Residential services

4.9 The food was unpopular. In our survey, just 27% of children said the food was good or quite good, and 33% that they usually had enough to eat.

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

4.11 Evening meals were divided into portions in the main kitchen to maintain consistency and fairness. The increase in the number of wings where all children could mix in one group had led to more meals being eaten together. However, most children continued to eat the majority of meals alone in their cell. Most serveries were clean. Servery staff had received training for their role and appropriate utensils and personal protective equipment were provided to allow food to be served correctly.

4.12 In our survey, 56% of children said that the shop sold the things that they needed, which was similar to comparable YOIs. They could order from the shop each week and were able to buy items from a small choice of catalogues available on their laptops.

### Consultation, applications and redress

4.13 The facilitation of consultation meetings had improved since our last inspection. Wing community meetings took place each week and youth council meetings once a month. The youth council meetings only had representatives from Bittern and Curlew wings and did not include the views of most children. Monthly newsletters communicated the discussion and outcome of council meetings to all children.

4.14 Children used their laptops to make applications. Over the previous 12 months, an average of 1,568 applications had been made each month, and responses were timely. Leaders routinely quality assured about 20% and the quality of the sample we viewed was good.

4.15 Children had made 165 complaints in the last year. These were made on paper to maintain confidentiality and blank forms were available on the residential units.

4.16 The responses to complaints we sampled were generally polite and addressed the issues raised. Most investigations included a discussion

with the child. Quality assurance was completed by leaders for their own areas of responsibility and a comprehensive monthly review of all complaints was carried out. Despite this, 18% of children in our survey said they had felt too scared to make a complaint. Leaders were unable to provide an explanation, and it was a source of concern given the large number of complaints against staff.

4.17 Children could access information on their legal rights and sentencing on their laptops. Other legal information could be requested from the library and children had pin phone numbers to make free calls to their legal advisers. Legal visits took place on weekday mornings and one afternoon in private rooms and children also had access to remote video link visits with their solicitors and other professional visitors.

## Fair treatment and inclusion

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

### Strategic management

4.18 Oversight of fair treatment and inclusion at Feltham was reasonably good, although a period of reduced staffing over the previous six months had affected the range of work undertaken to support children from different backgrounds.

4.19 The monthly diversity and inclusion management meeting (DIMM) was an effective vehicle for monitoring and addressing issues across the YOI. It was well attended by senior managers. It was positive that children continued to attend these meetings to talk about issues that affected them, and we saw actions being identified from these discussions.

4.20 A good range of data continued to be scrutinised at DIMM meetings, including on adjudications, children being separated from their peers, complaints and access to interventions and services. We saw examples of potential disproportionality being thoroughly investigated.

4.21 The YOI had received 57 discrimination incident report forms (DIRFs) in the previous year, a similar number to our last full inspection. It was disappointing that many of the investigations that we reviewed were weak. Too often, they were not thorough enough or failed to explain the outcome adequately to the child who had made the complaint. Quality assurance by the diversity adviser had identified many of these issues, but this had not yet led to noticeable improvements.

4.22 The peer mentor scheme had lost momentum and leaders lacked oversight of which children, if any, were fulfilling the role on each residential unit.

**Protected characteristics**

4.23 A diversity and inclusion adviser and officer gave children good support with individual issues including adaptations and access to specific self-care products, and children could ask to see them on their laptops. There was also effective use of podcasts to keep children up to date with events and make them aware of the support available. Forums for protected characteristic groups were no longer taking place consistently, which limited leaders' oversight of emerging issues.

4.24 Leaders had continued to deliver a good range of religious and cultural celebrations and events, and the diversity team had a well-planned calendar of events for the year ahead. A good event for Stephen Lawrence Day had taken place recently when community agencies had attended to talk about their work and hear from children about their experiences (see paragraph 5.19). Staff had received training on adultification bias (see Glossary).

4.25 Local data identified 41 children as having a disability. There were few with physical disabilities and only one had a personal emergency evacuation plan (PEEP) in place for an injured limb, which had been quickly identified on his arrival. The greater need was for support for neurodiversity. There had been no dedicated lead for children with neurodiverse needs for a number of months, and this role was being covered by the diversity adviser in the interim. The well-being team was providing good individual support to these children. Good materials had been developed to provide advice on caring for children with neurodiverse needs, although youth justice workers on residential units had limited awareness of what was available.

4.26 At the time of our inspection, 74% of the population at Feltham were from an ethnic minority background other than white. In our survey, children from minority ethnic backgrounds generally had similar perceptions of their treatment to white children, although black children highlighted continuing challenges with accessing hair care. This affected their confidence, particularly during appearances at court. Leaders had taken some steps to address this by hiring a barber service to attend each week and allowing visitors and staff to style children's hair.

4.27 The few children who identified as gay, bisexual or transgender were given additional support.

4.28 At the time of the inspection, 15% of children were foreign nationals. They could meet Home Office staff on request, although this was not always well co-ordinated with resettlement case workers. Two children had been identified as speaking little or no English and youth justice workers on their units were knowledgeable about their needs. Local

data showed that staff made good use of interpretation services across the establishment, including during ACCT reviews and on reception.

4.29 At our last two inspections, we highlighted the poor access that children had to corporate worship in the mosque or chapel because of the keep apart system. Despite efforts by leaders to address this, access remained poor and some could still only attend corporate worship about once every eight weeks.

**Catholic chapel**

4.30 The chaplaincy was active around the YOI conducting regular one-to-one pastoral care for children. In our survey, 84% of children who had a religion said that their religious beliefs were respected and 80% told us that they could speak to a chaplain in private if they wanted to. The chaplaincy continued to produce regular motivational videos which children could access through their laptops.

4.31 The chaplaincy actively supported children to maintain family contact and support them during compassionate visits. They had recently hosted an Eid celebration that was attended by children's families.

## 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.

4.32 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

4.33 Central and North West London NHS Foundation Trust (CNWL) was the main health provider, which subcontracted GP services to Dr PA Secure Health Solutions. NHS England (NHSE) commissioned an independent provider for dental care.

4.34 Since the last inspection, there had been a more defined separation of Feltham A and B with a new governor and senior management team for each side. NHSE had instigated a health and well-being needs assessment which was near completion, to consider the impact of these changes on current and future health needs. A revised staffing model had very recently been agreed to meet the needs of each side, to be implemented over the coming months.

4.35 Overall, the quality of the health care provision remained good with a child-focused approach underpinning the delivery of the service. However, there were still delays in children being escorted for their medicines and some health appointments, which had been identified at previous inspections. This was compounded by a lack of appropriate clinic rooms that did not meet infection, prevention and control guidelines, and confidential therapy rooms. Additional space had been identified but there had been considerable delays in providing it.

4.36 A regular local delivery board was led by the health provider rather than the prison and attendance by the prison and NHSE had been intermittent for several months. This undermined the effectiveness of the meeting to deliver strategic oversight and monitoring of the health provision to optimise patient outcomes.

4.37 Services were well led and patients benefited from access to skilled primary care, paediatric and child and adolescent mental health practitioners. Health care staff knew the children well and we observed caring and compassionate interactions between staff and patients. There was less reliance on agency nurses than at the time of our previous inspection and increased use of existing staff as bank nurses and managers supporting any deficits.

4.38 Clinical governance systems and processes were in place and incidents were promptly investigated, remedial actions undertaken and outcomes shared appropriately. The team attended the youth council and sought feedback from the children about different services which helped to drive improvements.

4.39 Health care staff used SystmOne, the electronic medical record, and patient records that we reviewed were comprehensive and in line with expected standards.

4.40 Compliance with mandatory training was good and staff felt supported through annual appraisal and regular managerial and clinical supervision. Further professional development to meet the needs of this age group was encouraged.

4.41 Safeguarding supervision took place regularly and staff understood their safeguarding responsibilities. They knew how to raise concerns and had done so, which was positive.

4.42 Complaints remained uncommon (four in six months). Each complaint elicited a response which was polite, focused, usually timely and offered an apology as necessary. The senior nurses saw patients face to face about their concerns and also spoke to concerned relatives by telephone, which had alleviated the anxiety of several parents. There were other examples of staff liaising with family or carers to provide reassurance and feedback on patient care. Health staff had also attended family days in the visits centre to engage directly with families and carers.

4.43 CNWL equipment for emergency resuscitation was placed strategically around both sites and was increasing from six to 10 sets as we inspected. It was checked regularly and health staff were suitably trained and up to date in use of the kit.

4.44 The prison had recently trained four children to be ‘zero responders’, enabling them to assist their peers who had collapsed until first aiders arrived. Training of more boys was planned.

**Promoting health and well-being**

4.45 There was no whole-prison health promotion strategy to drive a fully integrated approach between key services. Health and well-being information was available on the children’s laptops, but limited information was displayed across the establishment and none was displayed in the waiting area, which was a gap.

4.46 The health promotion practitioner was following the CNWL calendar of events based on national initiatives and working with all the health teams to encourage a more coordinated and child-focused approach. Telephone translation services were used for health consultations. Health promotion information was only available in English but could be translated when needed.

4.47 Despite additional clinics and encouragement by the nursing team, the uptake of immunisations and vaccination was low. Some clinics had been cancelled or cut short because of the prison regime. This delayed treatment and wasted clinical time.

4.48 Blood-borne virus testing and sexual health screening were offered and there was access to sexual health services. Barrier protection and related health advice were available on release. The Hepatitis C Trust was due to visit in the near future to offer mass testing.

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

**Primary care and inpatient services**

4.50 All children were assessed for immediate health needs by a registered nurse within two hours of arrival using the comprehensive health assessment tool (CHAT). A secondary physical health screening usually took place the next day. The assessments were thorough and children were promptly referred to other services as required.

4.51 Children could make health care appointments through their laptops or in person. Applications were clinically triaged and appointments allocated to the most appropriate health care professional.

4.52 The primary care service was well led, with good managerial oversight and a conscientious team committed to the children's well-being. It operated a seven day, 24-hour nursing service.

4.53 Urgent need was prioritised and nurses attended the units when needed. They also ran a range of clinics, but delays in escorting children meant that some routine treatments had to be rearranged, causing frustration for the patient and wasting clinical time.

4.54 Dedicated GP clinics were held at Feltham A and children could be seen within a week for a routine appointment. All children could access urgent appointments promptly and out-of-hours cover was delivered by the same GPs, which provided continuity.

4.55 Children with long-term conditions were well managed, with annual reviews and care plans in place which were discussed with the child to encourage them to manage their own condition. The nurse liaised with the GP and community specialists for a coordinated approach when needed.

4.56 Health care staff visited segregated children on Falcon unit every day and a weekly drop-in clinic enabled children to choose to have their weight or blood pressure checked and to discuss any health concerns, which was positive.

4.57 Health care staff contributed to the risk assessment of children who might need to be restrained. They provided regular updates on children with a health condition that may be adversely affected by restraint and attended the weekly meeting convened by the prison to discuss any

restraint incidents. They were clear on their responsibilities about when to intervene during a restraint which had improved since the last inspection, although we found that the restraint handling plans were not routinely available on SystmOne. This was raised with senior managers who assured us that this would be addressed.

4.58 An appropriate range of allied health professionals visited and waiting times were reasonable, apart from long waits to see the physiotherapist and the optician, which were reducing.

4.59 There was effective administrative and clinical oversight of external hospital appointments, with only a few cancelled or rearranged. Children who needed to go to the local emergency department did so promptly, with health care and prison staff working together effectively to minimise any potential delay.

**Mental health**

4.60 CNWL provided a well-led child and adolescent mental health service as part of an integrated health and well-being team.

4.61 The team comprised highly skilled and competent practitioners from an impressive range of disciplines including psychology, psychiatry, mental health nursing, occupational therapy, speech and language therapy and creative art therapy.

4.62 A trauma-informed culture was clearly embedded throughout the service and had influenced practice across health care. This helped to promote a whole-prison integrated approach centred around the child, with mental health care and treatment provided alongside prison-led interventions.

4.63 Mental health staff were key members of the team on the enhanced support unit and the core support teams on the other units and had been involved in the recruitment and selection of the youth justice workers in these teams. This helped to ensure that the staff had the appropriate skills, values and behaviours to support children in line with the Secure Stairs framework (see Glossary).

4.64 At the time of the inspection, the team had 83 patients on its caseload out of a population of 93. Around 17 patients were in receipt of prescribed medicines for mental health conditions. Most patients received psychological interventions. The team had minimal waiting lists and they attended ACCT reviews and worked closely with youth justice workers to manage patients' risks and needs.

4.65 Children's mental health needs were assessed during their reception health screening and followed up with specialist assessments within 72 hours. Following assessment, allocation and interventions were agreed at weekly multidisciplinary meetings, or sooner if deemed urgent. Staff reviewed patients at these meetings, with an enhanced focus on complex and high-risk patients. Where needed, staff developed

formulations with patients to understand better their experiences, and these informed the interventions needed.

4.66 The team identified and assessed children with potential neurodiverse conditions. Staff supported children who had diagnoses of attention deficit hyperactivity disorder (ADHD), autism spectrum disorder (ASD) and learning disabilities, linking in with prison staff to advise on patients' individual communication needs and any adjustments required.

4.67 There had been one transfer under the Mental Health Act since our last inspection which had taken 61 days, exceeding the national guideline. This was partly caused by the team ensuring there was a safe and effective transfer pathway for the patient who was nearing his 18th birthday. Accordingly, the mental health team had made referrals to both children's and adults' inpatient units and facilitated a joint assessment.

**Substance misuse**

4.68 The highly experienced and knowledgeable substance misuse team comprised a specialist psychiatrist and psychosocial workers. They worked closely with the mental health team as part of an integrated health and well-being service, adopting a holistic approach to assessment and treatment.

4.69 The substance misuse service lead was a member of the multi-agency Hounslow Drug and Alcohol Partnership Board, and had access to up-to-date information and intelligence on current and emerging substance use in the community and associated risks. This was a valuable resource to enhance the service provision.

4.70 Children's substance misuse needs were assessed during their reception health screening and routinely followed up by specialist assessments within five days (24 hours if they appeared to be under the influence of substances). Complex or urgent cases were allocated immediately. Patients were reviewed at weekly multidisciplinary meetings.

4.71 Robust clinical arrangements were in place to support detoxification, including access to out-of-hours prescribing if needed. At the time of our inspection, no children were requiring opiate substitution therapy or alcohol detoxification. The main drug of choice for this cohort in the community had been cannabis and increasingly 'LEAN' (also known as purple drank), which is a harmful addictive polysubstance drink. Consequently, the team was supporting some children who were experiencing a range of physical withdrawal symptoms. The service worked with the prison and other health care teams to ensure these patients had access to the appropriate care and monitoring, including symptomatic medication if required.

4.72 The service provided a range of psychosocial interventions, including brief interventions such as harm reduction, relapse prevention and

psychoeducation. They also offered in-cell packs and information sheets on illicit substances and their risks. The service had short waiting lists for specific psychosocial interventions; staff regularly 'checked in' with these patients in the meantime.

4.73 The service actively supported release and transfer planning; they provided handovers to receiving prisons and made referrals to community substance misuse services. Naloxone was available to any patients who had undertaken detoxification.

**Medicines optimisation and pharmacy services**

4.74 Overall, the governance and oversight of the pharmacy service and the management of medicines were effective. Medicines were supplied in a timely manner from the pharmacy at St Charles Hospital which was part of the same NHS Trust.

4.75 Medicines were stored and transported safely, although a small stock of medical gas cylinders was held by health care and it was unclear if the storage area had been reviewed recently with respect to the cylinders or the signage. Once identified, the head of health care gave assurances that this would be addressed.

4.76 Medicine cupboards were neat and tidy and appropriately secured. Temperature sensitive medicines such as vaccinations were kept in suitable fridges which were monitored daily, and room temperatures were also checked. Controlled drugs were well managed and records were audited at regular intervals.

4.77 There was good access to a GP and the head of health care was a non-medical prescriber. It was also possible for prescriptions to be written out of hours and an appropriate range of medicines were on site, which minimised any delay in receiving critical medicines. The prescribing of medicines that were open to abuse was well controlled.

4.78 Medicines prescribing and administration were documented on SystmOne, and all children had an in-possession risk assessment. Where appropriate, children were encouraged to hold appropriate medicines in possession and submitted repeat requests for on-going medicines. Children were in single cells and could keep their medicines safe. Cell checks were undertaken, but they lacked a structured approach to identify themes and trends.

4.79 Medicines were administered twice a day. We observed competent medicine administration by nurses, including controlled drugs. However, delays in children being escorted for their medicines at the appropriate time often happened, which meant that they either missed their medicine or received it late, if this could be facilitated. This wasted clinical time. Staff explained that non-administered medicines were followed up after one missed dose for critical medicines and three days for other medicines.

4.80 The pharmacy staff also offered a telephone pharmacy consultation service. The majority of these calls concerned either improving the children's understanding of medicines or answering questions about the side effects of medicines.

4.81 Pharmacy staff attended a regular medicines management group where learning was shared from medicines related incidents, audits, shortages, alerts and recalls.

**Dental services and oral health**

4.82 The dental surgery was being refurbished to a high standard. Patients commented unfavourably on the extended waiting times due to its temporary closure. Fifty-three patients had waited up to eight weeks for detailed assessment and treatment, compared to 38 children waiting up to two weeks before the refurbishment works.

4.83 The dental team had mitigated the impact of the closure by undertaking dental triage on the wings and providing a limited 'field' surgery and restricted service. Arrangements were in place for external urgent dental care, though none had been required.

4.84 Patients' dental records were integrated into SystmOne and were exemplary, with pictorial dental assessments, linked X-ray records, personalised care plans and unambiguous consultation notes. Notes indicated that patients had been informed of the reasons for longer waiting times, which demonstrated openness.

# 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 Children experienced an average of just three hours out of their cell at weekends and four hours on weekdays. The daily routine was undermined by staff shortfalls and further disrupted by incidents of violence and disorder. As a result, children did not have a clear expectation of what would happen each day.

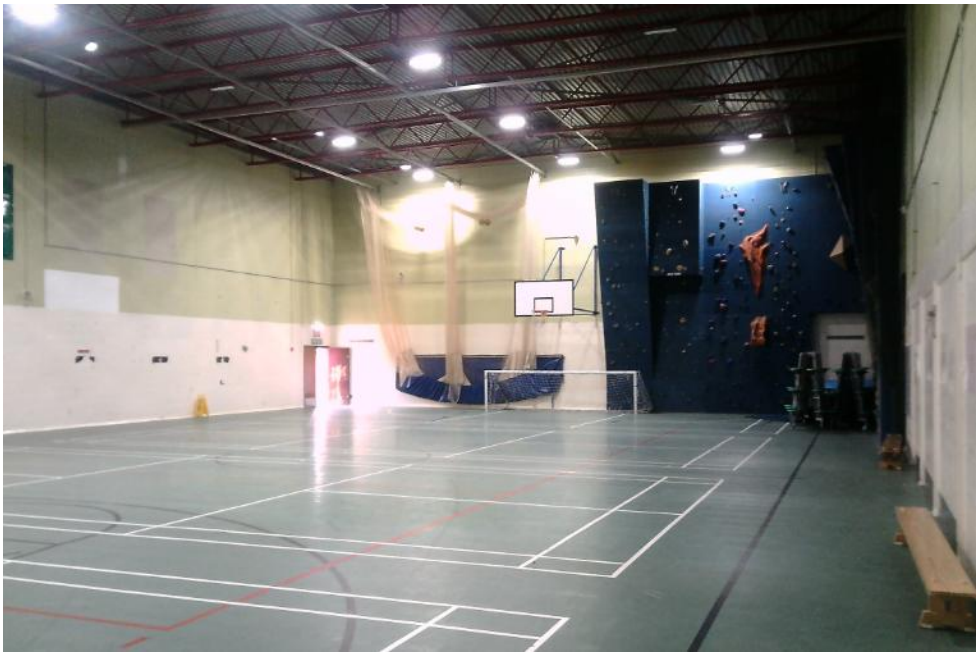
5.2 This average time out of cell masked large differences between groups. Those living on one of the three wings with only one group had far more time out of cell than their counterparts on wings with several different groups. It was not unusual for a small number of children to receive less than an hour out of their cell each day.

5.3 The weekend offer had been strengthened by vocational training on Saturdays and Sundays, although only a limited number of children could attend due to conflict and keep-aparts.

5.4 We found the library to be a welcoming space with a good selection of books likely to appeal to the age group, including some easy reads and graphic novels. Many library sessions were cancelled because of problems moving children around the establishment; this has led to a reduction in book loans. Library staff continued to meet every child during induction and had started offering one-to-one reading sessions with children identified as not using the library. Monthly quizzes had been introduced to incentivise visiting the library. Library staff promoted the Reading Ahead challenge (in which children read and record their thoughts on six pieces of written work).


**Library**

5.5 While gym facilities were good, only 23% of children said in our survey they could go to the gym once a week or more, compared with 54% at other YOIs. Attendance at the gym was affected by staff shortages and the cessation of activities during incidents. However, we found that most children were still able to undertake two periods of physical training a week despite a lack of trained PE staff.



**Gym**

## 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.

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

Overall effectiveness: inadequate

Quality of education: requires improvement

Behaviour and attitudes: inadequate

Personal development: requires improvement

Leadership and management: inadequate.

5.7 Leaders and managers had produced a clear strategy to improve resettlement opportunities; however, this had not been fully implemented. Strong partnership working between the education provider and the Youth Custody Service, health care and wider psychological services supported this vision. Leaders had provided enough places so that children could receive their full entitlement to education, including in English and mathematics. They had not provided sufficient vocational training places to best prepare the children for employment on release.

5.8 Children did not receive sufficient education to meet either their entitlement or need. Leaders and managers planned carefully so that each child who was able to work with others should receive a minimum of 18 hours of teaching and learning. However, for reasons outside of the control of the children, attendance at lessons was very low and punctuality was poor. As a result, most children received only half of the allotted time in lessons, and some even less. This fell far short of what was required to give children sufficient knowledge and skills to

give them the best chance of finding employment and making a positive contribution to community life on release.

5.9 Although leaders and managers had introduced a range of measures to incentivise attendance at education, including bonus payments for examination success and for 'learner of the week' recognition, too often arrangements for children to be escorted to lessons were disrupted. As a consequence, a third of planned attendances at lessons did not take place. Lessons rarely started on time. Frequently, children did not leave the accommodation units until well after the start time for lessons. Children arrived at the education department or vocational workshops regularly over half an hour late. In one example, children arrived at a painting and decorating lesson over an hour late. As a result, not only did children not receive the education to which they were entitled, curtailing their learning time, but they did not develop the disciplines of attendance and timekeeping which employers expect. Pay rates rewarded good behaviour and were fair and equitable.

5.10 Managers had successfully addressed most of the concerns about the quality of education raised at the previous inspection. Staff used children's starting points effectively to teach a well-structured curriculum in English and mathematics. As a result, the number of children who achieved qualifications in these subjects had increased. The level 3 curriculum had been broadened. It included vocational courses in the fundamentals of electricity, accounting and construction, as well as advanced courses in English and mathematics. Following the appointment of an experienced manager with specific responsibility for quality, leaders had an accurate oversight of the areas of weakness within education. They had taken steps which had improved the provision. However, leaders had not made sure that children took part in sufficient education to gain substantial new knowledge and skills to help them in their next steps.

5.11 Managers had planned the induction process carefully. They ensured that staff accurately assessed the educational starting points of the children. Well-qualified and experienced careers, information, advice and guidance (CIAG) staff used these assessments to inform discussions with individual children about future careers and training options. As a result, CIAG staff produced personal learning plans (PLPs) which set appropriate short- and long-term targets and children were well informed about the opportunities for learning at the YOI. The allocations board used this information within a few days to place children on the most relevant education courses and vocational pathways. However, a shortage of CIAG staff meant that PLPs were not reviewed in a timely way. Consequently, some children who needed to change their vocational options did not do so soon enough.

5.12 The Shaw Trust delivered the provision of education and vocational training in the YOI. Leaders had provided a curriculum which met the educational entitlement of the children. Managers planned the teaching of the curriculum purposefully. Teachers used a wide range of learning resources to enhance learning, including information technology and the virtual campus (internet access to community education, training

and employment for children). Teachers sequenced learning appropriately. The small number of children attending regularly built their knowledge and skills incrementally over time. For example, in English, children developed basic knowledge and skills through a topic-based approach that then supported the development of their wider literacy and language skills. In barbering, children first learned in detail about health and safety, including scalp care, before they used cutting and styling tools.

5.13 In most subjects, teachers used helpful strategies to encourage learning. For example, they used clear explanations, verbal prompts, demonstrations and retrieval practice to help children commit concepts to long-term memory. Teachers assessed children frequently and provided helpful and encouraging developmental feedback on their written work. They indicated the areas where children needed to improve, including how to improve their use of language. However, teachers did not use individual learning plans effectively. Most children were not aware of their learning targets. As a result, children were not routinely challenged to develop new knowledge and skills. Too many children were not aware of the level at which they were studying, which limited their ambition. Most children valued their learning and achieved qualifications on the courses they started, though pass rates on level 2 functional skills courses were low. Standards of work in vocational training were high.

5.14 Staff were well qualified and experienced. Managers observed staff teaching frequently and used the outcomes to provide helpful coaching and staff development events. Managers also held weekly training sessions in which they shared good teaching and learning practice and expected assessment standards. These were welcomed and attended by all staff. As a consequence, the quality of teaching had improved, and achievement rates had increased significantly for the few children taking these.

5.15 Managers had provided effective support for children with special educational needs and disabilities (SEND). A qualified coordinator (SENCO) had been appointed alongside additional learning support assistants (LSAs). Staff used information gathered at induction to identify what support was necessary for children to study effectively. LSAs had clearly defined roles and worked well with teachers to support children's learning. Staff understood how children's different needs impacted on their learning. They used considered approaches to support them; for example, coloured overlays, time out, chunking guidance (see Glossary) and fidget toys. LSAs also visited those children on the units who could not mix with others in order to provide individual support. Too few LSAs had received the training they needed which limited their effectiveness when working in isolation. These children were provided with worksheets to develop their English and mathematics knowledge but did not benefit from group work and challenge from qualified teachers. They did not make as much progress as their peers. Overall, the achievement gap between those children with SEND and the population at large had much reduced over the last year and was minimal.

5.16 Leaders and managers recognised that there were insufficient vocational training places. Analysis of employment opportunities and children's career aspirations indicated a strong need for construction-based courses, yet only four places existed. In the few vocational courses, teachers used small qualifications which enabled the children to achieve within their short stays at the YOI. In painting and decorating, children learned valuable knowledge and skills. They confidently prepared surfaces and used a variety of paint techniques. Children studying vocational subjects benefited from teachers with much relevant industrial experience who planned interesting tasks. They enjoyed learning new skills and made good progress.

5.17 Managers ensured that all children received an assessment of their reading skills on arrival. LSAs provided beneficial individual support for those who required additional help. They also helped these children in lessons during education or vocational training. An experienced librarian who had been trained by Shannon Trust (charity that supports people in prison to learn to read) visited the accommodation units regularly to support those children with the lowest reading skills. All staff, including youth justice workers (YJWs), had received training in the importance of reading and how to encourage children to develop their skills. A weekly 'Drop Everything and Read' session took place in all lessons and workshops during which children were supported to read aloud. This increased their confidence. However, teaching staff, including LSAs, had not received enough training in phonics in order to give children the best possible help. Despite long-standing plans to do so, managers had not involved the Shannon Trust to train peer mentors. As a result, children with existing limited skills did not benefit from peer mentors to help improve their reading. A lack of available YJWs had resulted in over half the children's planned visits to the library being cancelled during the previous month. As a result, loans of books were less than a year previously. Not enough children developed their reading skills by reading for pleasure.

5.18 Managers provided a useful range of enrichment activities to enable children to engage in learning beyond the academic. For example, cooking, art and, in partnership with Chess in Prisons, a chess club. Children had equality of access to this provision. They appreciated and benefited from these activities and developed a wider set of personal skills.

5.19 Leaders and managers had not planned a comprehensive personal development curriculum which involved all children. They recognised that the personal development curriculum was too narrow. For example, the great majority of children did not benefit from learning about healthy eating or discussing the dangers of gambling or alcohol misuse. Managers planned events to raise children's awareness of the importance of equality and inclusion. For example, a well-attended Stephen Lawrence Day involved children, police and the Youth Custody Service. Weekly financial literacy lessons helped children understand how banking and other finance operations work, alongside emphasising financial responsibility. Additionally, managers had built effective partnership working with local organisations to support

personal development activities. For example, voluntary and charity-led organisations helped children reduce their risk of being involved in violence and know how to access community-based services on release.

5.20 The few children attending education displayed mostly positive behaviour and attitudes in lessons. Teachers set clear guidelines for behaviour in classrooms and vocational learning. Children concentrated well on the tasks set by teachers, working purposefully and calmly. Very few incidents of bad language occurred. Children felt safe when in lessons. However, too many examples existed of unacceptable behaviour in the corridors of the education department which resulted in serious disruptions to learning. While YJWs managed the disturbances, other children working in the classrooms became distracted, which hindered their progress. Children generally demonstrated good health and safety awareness, particularly so in cooking, though in painting and decorating children were reluctant to wear all the protective clothing provided.

# Section 6 Resettlement

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

## Children, families and contact with the outside world

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

6.1 In our survey, only 55% of children said that they had been helped to keep in touch with their family and friends, compared to 74% at other YOIs. Just 6% said they received secure video calls, despite efforts to promote the service. Feltham now held children from a wider catchment area and we found that both visits and secure video calls were underused.

6.2 The visits hall had been refurbished and now offered a more welcoming environment. The well-equipped family room gave children the opportunity to spend time with their family in a private setting, which was appreciated.

**Visits centre, which also hosted the Youth Club (left), and the family room (right)**

6.3 The visitor centre had also been refurbished and was now a good facility where visitors could buy refreshments and speak to staff from the family services provider, the Prison Advice and Care Trust (PACT). Visitors spoke positively of their experience of visits and the supportiveness of staff, and leaders had made improvements to the service following consultation.

**Visitor centre**

6.4 Social visits were offered three times a week, with an additional session for children on the enhanced level of the incentives and earned privileges scheme. Two of these sessions continued to coincide with work and school hours, and non-enhanced weekend visits took place in the morning, which was challenging for visitors who were travelling longer distances. During the previous three months, less than half the visits slots had been used.

6.5 Good work was taking place to help children to maintain contact with the outside world and involve families in their care. Local data showed that parents had been present at 39% of resettlement meetings with their children in the previous year, which was positive.

6.6 Creative work was taking place to support children with significant life events through special visits and release on temporary license (ROTL), including a young father receiving ROTL to visit his newborn baby. Family days took place each month; they were appreciated by children and their families, and the chaplaincy was active in supporting family contact (see paragraph 4.31).

6.7 Local leaders regularly monitored children who did not receive visits and some of these children were referred to a family engagement worker for additional support.

## Pre-release and resettlement

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

6.8 Oversight of resettlement was good. There was a separate resettlement policy which was informed by an analysis that reflected the needs of children and was reviewed frequently.

6.9 The reducing reoffending meeting took place monthly; it was well attended and covered all key areas. The monitoring of data had improved since our last inspection and leaders were now tracking

outcomes including the provision of education and training for children on release.

6.10 Over the previous 12 months, 33 children had been eligible for early release; it had not been granted to 13. A further 14 did not apply, which was usually because of their behaviour in custody. In the sample that we viewed, decisions were appropriate and children were informed in a timely manner.

6.11 A very small number of children (three over the previous 12 months) were eligible for home detention curfew (HDC, early release 'tagging' scheme). Two of these were transitioned to the adult estate before a decision could be made.

6.12 Very few children were eligible for ROTL. Four children had been successful during the previous 12 months and inspectors felt ROTL was being used in a considered and purposeful way. Opportunities were well planned, risk assessed and focused on the child's interests and resettlement goals. Monthly ROTL boards included meaningful discussions involving the child and contributions from youth offending teams, safeguarding staff and others. This signified a noticeable shift from previous inspection findings where ROTL use was more limited.

6.13 Children completed a statement outlining their wishes regarding ROTL and there was evidence of volunteering placements and course completions being linked to ROTL outcomes, including horticulture and community work. We observed one board which demonstrated a well-structured approach to decision-making. Discussion was thorough and professionals clearly understood the balance between risk and opportunity.

6.14 The national interim policy to hold 18-year-olds until just before their 19th birthday was no longer in place. For some time, the number held at Feltham had been slowly reducing. However, nearly a quarter of the population was over 18, putting additional pressure on an establishment that was not well placed to meet the needs of these men.

6.15 Transitions to the adult estate for this cohort were well managed. Resettlement practitioners (RPs) contacted the receiving prison and introduced 18-year-olds to their new prison offender manager and a member of the safety team.

6.16 This timely, well-structured support helped 18-year-olds to prepare. They were given opportunities to outline their preferences, compile questions and take part in meaningful handovers. Moves were also coordinated to align with the completion of key education or vocational courses, which the young adults valued.

## 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.

6.17 Leaders had merged sentence and resettlement plans into an 'integrated care plan' (ICP). ICPs were generally of good quality and easy to follow. They identified relevant interventions and were appropriately child focused, although the section on risk and crisis management was blank on all the plans that we reviewed. This was attributed to a lack of confidence by RPs and leaders had started to address this longstanding issue with increased training. Most children were aware of their resettlement targets and said they had been involved in setting them. Their feedback reflected a greater sense of ownership over their plans than we had previously found.

6.18 RPs had worked hard to combine sentence planning with looked-after children reviews to reduce the number of meetings children were expected to attend. While this was a positive step, the implementation remained inconsistent. Meetings were frequently delayed through limited access to interview rooms. Arrangements had recently been made to improve the availability of rooms, but it was too early to assess its impact.

6.19 Integrated care plan meetings were improving and, while attendance by external professionals was good, residential staff were not routinely involved. Despite this, the meetings were mostly purposeful and focused on family involvement, which marked a positive development since the previous inspection. Children reported feeling involved in the planning process and had a clear understanding of what was expected of them.

6.20 AssetPlus assessments (the electronic sentence planning tool for children) remained weak. None of the cases in our sample had an assessment completed within expected timeframes, and most had not been meaningfully updated since the point of sentence. Although some of the original information remained relevant, the absence of reviews prevented current risks and circumstances from being accurately reflected.

6.21 Managers recognised this shortfall and had introduced a back-to-basics training programme and staged deadlines to improve both the timeliness and quality of assessments. While the intention to improve was evident, changeable risk factors were still not highlighted and risk-informed planning was not yet consistent.

6.22 Children's relationships with their allocated RPs had remained strong with good initial contact, usually on the next working day following arrival. Contact was maintained throughout their sentence and, although the majority were well-being checks, there was evidence of meaningful sessions and an increase in contact when important sentence events were approaching. Sessions were used to discuss behaviour and problem-solving and offer guidance on how to respond to challenging situations.

6.23 RPs attended ACCT reviews and maintained regular contact with the youth offending service (YOS) and family members. Importantly, children valued the support of their RPs, who they described as being visible and responsive. The quality of engagement was demonstrated by very good use of multi-agency electronic recording systems (the Youth Justice Application Framework), which reflected purposeful contact and detailed records.

6.24 Records showed good staff contacts with children, but custody support plan (CuSP) contact was less clear as records did not always confirm if or when sessions had taken place. While most children knew who their CuSP worker was, some were unsure about the purpose of the relationship. A few children said that, due to the inconsistent contact, they did not fully trust their worker and therefore did not share concerns or personal information.

**Public protection**

6.25 Oversight of public protection processes had strengthened since our last inspection. A monthly multi-agency integrated risk management meeting (IRMM) identified children who presented a risk – both in the prison and on return to the community – and set suitable actions to reduce or manage that risk.

6.26 There had been a reduction in the quantity of cut-and-paste material in the risk management assessments that we viewed compared to the last inspection, and contributions demonstrated improved relevance. Assessors showed greater skill in capturing and describing harm-related behaviours, and it was positive to see risk being explored using a range of information sources.

6.27 However, there remained some hesitancy in explicitly analysing the underlying risk issues such as immaturity or susceptibility to influence, or in stating whether behaviours were indicative of increasing or decreasing risk.

6.28 There were positive examples of feedback on offending behaviour work being used to inform assessments, including comments from programme facilitators or attached progress reviews. In stronger contributions, assessors reflected on how the child had applied learning from interventions, using evidence of actions or words. This was a constructive way to assess understanding and identify any remaining deficits linked to risk.

6.29 MAPPA (see Glossary) risk levels were identified before release and there had been a marked improvement in the quality of MAPPA contributions since the last inspection.

6.30 Monitoring of children subject to public protection restrictions or harassment orders was up to date and these cases were reviewed regularly.

### Indeterminate and long-sentenced children

6.31 There was no longer a dedicated RP for children who were sentenced to life or long-term sentences. At the time of the inspection, five children were serving life sentences and seven were on remand for attempted murder and 11 for murder.

6.32 Despite these cases being dealt with by different RPs, contact levels remained good and these children reported good relationships with their RP.

6.33 A member of the psychology team continued to offer lifer therapy groups, which children appreciated.

### Looked-after children

6.34 In our survey, 71% of children said they had been in local authority care, which was similar to our last inspection. There was only one social worker in post at the time of the inspection and so RPs were acting as the link between these children and their respective local authorities. RPs told us they were able to provide adequate case management support for these children until new social workers were recruited.

6.35 Both children and RPs said that children had difficulty accessing their entitlements from the local authorities, with most looked-after children experiencing delays with basic items such as pocket money. Children told us they were very frustrated by this.

## 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.

6.36 During the previous 12 months, there had been 69 releases and about five men were transitioned to the adult estate each month.

6.37 Reintegration planning started on arrival at Feltham and, if sentenced, children were seen eight weeks before release by their RP and information, advice and guidance practitioners. Reintegration plans formed part of the ICP and were of good quality. Children were aware

of these plans and took part in discussions about their release arrangements.

6.38 Schemes were available before release for children to access identity cards or their birth certificate and open bank accounts.

6.39 Not all children or 18-year-olds had accommodation on release. During the previous 12 months, two 18-year-olds had been released without accommodation and had been met by probation staff as they left the prison. All children had accommodation on the day of release, but it was regularly confirmed too late to allow for effective release planning.

6.40 Education, training and work outcomes for released children and 18-year-olds had deteriorated, with only 14% of children and 18-year-olds released having any kind of employment or training outcome.

## Interventions

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

6.41 The provision of interventions remained good. During the previous year, 56 children had completed an offending behaviour programme and the number of children who dropped out was low.

6.42 Courses were also made available to children on remand and 14 had completed a course over the last 12 months.

6.43 New arrivals were screened each week by the interventions team to identify children for appropriate courses. Planning for suitable interventions was well thought out and meetings to prioritise children's individual needs were carefully coordinated. Leaders encouraged referrals for course work from around the prison and monitored the sources of these closely.

6.44 Regime slippage and coordination of the number of keep-aparts continued to create difficulties and had a considerable impact on the timeliness of sessions, all of which caused unnecessary disruption and frustration for children.

6.45 PACT (see paragraph 6.3) were delivering their 'strengthening minds' well-being programme to small groups of children; it had received good feedback from participants.

### Health, social care and substance misuse

6.46 Children and young people were seen before leaving. Appropriate interventions by all health teams were carried out in good time and children received appropriate information about ongoing care.

6.47 Children were supported to register with a GP where appropriate and summary discharge reports were produced. Arrangements were made

to supply medicines or prescriptions when needed to preserve continuity of treatment and medication for court attendance was well organised.

6.48 The health and well-being team worked closely with prison staff and community agencies to ensure effective discharges and transfers, including liaison with age-appropriate community services or transition to the adult estate.

6.49 Hounslow Council social workers were based in the prison and had all 93 children on their caseload at the time of the inspection. They worked with the prison and CNWL to safeguard and support children in the prison following their release.

# 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 2024, we found that outcomes for children were poor against this healthy establishment test.

**Priority concerns**

Levels of violence and disorder were very high. Conflict and keep-aparts negatively affected many aspects of life at Feltham, including access to a meaningful regime, medical appointments and visits.
**Not addressed**

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

**Key concern**

Levels of self-harm had increased and were too high.
**Not addressed**

## Care

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

At the last inspection in 2024, we found that outcomes for children were reasonably good against this healthy establishment test.

There were no priority or key concerns for this test.

## Purposeful activity

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

At the last inspection in 2024, we found that outcomes for children were poor against this healthy establishment test.

### Priority concerns

Children spent too much time locked in their cells.
**Not addressed**

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

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

### Key concerns

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

Leaders did not have sufficient oversight of the quality of the education provision and had not improved it significantly.
**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 2024, we found that outcomes for children were reasonably good against this healthy establishment test.

### Priority concerns

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

The identification and review of children's risk levels were weak.
**Not addressed**

# Appendix I About our inspections and reports

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## This report

This report outlines the priority and key concerns from the inspection and our judgements against the four healthy prison tests. There then follow four sections each containing a detailed account of our findings against our *Expectations. Criteria for assessing the treatment of children and conditions in prisons* (Version 4, 2018) (available on our website at Expectations – HM Inspectorate of Prisons (justiceinspectorates.gov.uk)). Section 7 lists the concerns raised at

the previous inspection and our assessment of whether they have been addressed.

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

**Inspection team**

This inspection was carried out by:

| | |
|---|---|
| Charlie Taylor | Chief inspector |
| Angus Jones | Team leader |
| David Foot | Inspector |
| Esra Sari | Inspector |
| John Wharton | Inspector |
| Rick Wright | Inspector |
| Emma King | Researcher |
| Alicia Grassom | Researcher |
| Maureen Jamieson | Lead health and social care inspector |
| Paul Tarbuck | Health and social care inspector |
| Malcolm Irons | Care Quality Commission Inspector |
| Si Hussain | Care Quality Commission inspector |
| Allan Shaw | Ofsted inspector |
| Diane Koppit | Ofsted inspector |
| Andrea McMahon | Ofsted inspector |
| Dionne Walker | Offender management 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.

**Adultification bias**
Adultification is a form of bias where children are perceived as being older, more independent and less in need of protection than their age would suggest.

**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.

**Chunking guidance**
Breaking down tasks into smaller, more manageable steps to support information processing and memory.

**Framework for integrated care (Secure Stairs)**
The framework for integrated care allows for a trauma-informed, collaborative approach to assessment, sentence/intervention planning and care, including input from mental health staff regardless of previous diagnosis, as well as from social care professionals, education professionals and the operational staff working on a day-to-day basis at the setting. It also seeks to ensure that staff have the right skills and support to care for the children and young people appropriately. Co-produced formulation (planning) for each child through the understanding of the child's background story ('My Story') sits at the centre of the framework.

**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.

**MAPPA**
Multi-agency public protection arrangements: the set of arrangements through which the police, probation and prison services work together with other agencies to manage the risks posed by violent, sexual and terrorism offenders living in the community, to protect the public.

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

**Rule 49**
The governor may order a prisoner to be put under restraint where this is necessary to prevent the prisoner from injuring himself or others, damaging property or creating a disturbance.

**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.

**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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