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**HM Chief Inspector of Prisons  
PETER CLARKE CVO OBE QPM**

Date: 22 July 2019

The Rt Hon David Gauke MP  
Justice Secretary  
Ministry of Justice  
9<sup>th</sup> floor  
102 Petty France  
London SW1H 9AJ

Dear Secretary of State

**Urgent Notification: HMYOI Feltham A**

**Summary**

In accordance with the Protocol between HM Chief Inspector of Prisons and the Ministry of Justice (MoJ), I am writing to you to invoke the Urgent Notification (UN) process in respect of HMYOI Feltham A.

An announced inspection of HMP/YOI Feltham took place between 4 July and 19 July 2019. I decided to return to Feltham so soon after the last inspection of the young offender institution, in January 2019, in response to deeply concerning information received by HM Inspectorate of Prisons from a number of sources. Our inspection last week identified a dramatic decline across many aspects of the YOI's performance, and numerous significant concerns about the treatment and conditions of children being held in the establishment. My decision to invoke the UN process relates solely to the young offender institution (Feltham A) and not to the prison holding young adults (Feltham B).

As required by the Protocol, in this letter I set out the key evidence underpinning my decision to invoke the UN process and the rationale for why I believe it is necessary. In addition, I attach a summary note which details all the main judgements from the inspection. The summary note is drawn from a similar document provided to the Governor at the end of the inspection last week. The Governor, the Executive Director of the Youth

Custody Service and officials of the MoJ have been informed of my intention to invoke the UN process. I shall, as usual, publish a full inspection report in due course.

### **What the UN process requires of HM Chief Inspector of Prisons**

A decision to invoke the UN process is determined by my judgement, informed by relevant factors during the inspection that, as set out in the Protocol between HM Chief Inspector and the MoJ, may include:

- poor healthy prison test assessments (HMI Prisons’ inspection methodology is outlined in the HMI Prisons Inspection Framework);
- the pattern of the healthy prison test judgements;
- repeated poor assessments;
- the type of prison and the risks presented;
- the vulnerability of those detained;
- the failure to achieve recommendations;
- the Inspectorate’s confidence in the prison’s capacity for change and improvement.

The Protocol sets out that this letter will be placed in the public domain, and that the Secretary of State commits to respond publicly to the concerns raised within 28 calendar days. The response will explain how outcomes for prisoners in the institution will be improved in both the immediate and longer term.

### **Inspections of HMYOI Feltham A since 2014**

Young offender institutions are inspected more frequently than adult prisons because of the risks and vulnerabilities associated with the detention of children. We have inspected HMYOI Feltham A six times since August 2014.

<b>Healthy prison assessments since 2014<sup>1</sup></b>				
	Safety	Care	Purposeful activity	Resettlement
August 2014	2	3	2	3
July 2015	2	4	2	3
January 2017	1	3	1	3
January 2018	3	3	2	3
January 2019	2	2	2	3
July 2019	1	1	1	2

<sup>1</sup> Under each healthy prison 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: outcomes for children are good against this healthy prison test (4), outcomes for children are reasonably good against this healthy prison test (3), outcomes for children are not sufficiently good against this healthy prison test (2) and outcomes for children are poor against this healthy prison test (1). For further information on our healthy prison tests and judgements, please see our Inspection Framework at <https://www.justiceinspectorates.gov.uk/hmiprison/about-our-inspections/>.

Feltham A has for many years been recognised as a challenging and complicated establishment. The variety of scores awarded by HMI Prisons over the years is perhaps a reflection of this. However, in the context of this Urgent Notification, I would like to draw your attention in particular to inspection findings since January 2017.

In January 2017, we found that Safety and Purposeful Activity had declined to our lowest grading of poor – a clearly unacceptable finding in an institution holding children. In the introduction to the report of that inspection, I wrote:

*“I understand very well that staff should be able to work in a safe environment, and not be in constant fear of being assaulted. The current approach is failing to deliver that reasonable expectation and, from the evidence available to us, is actually making it worse. The focus on keeping people apart rather than trying to change their behaviour has not worked. Feltham A is, quite simply, not safe for either staff or boys.”*

When we next inspected in January 2018 there had been a marked improvement. For the first time since 2011, we were able to report that safety was of an acceptable standard, and had improved by two grades in our scores. However, I also warned that:

*“... the progress could easily prove to be fragile if investment falls away or leadership loses its focus.”*

Sadly, when we next inspected in January 2019, we found there had been a marked decline in standards:

*“In light of the clear warning in our last report, it was disappointing to be told that since our last visit, there had been an interregnum when Feltham had been left without a governor for a period of five months. A new governor was now in post and beginning to stabilise the establishment, but it was evident to us that there had been a degree of drift resulting in deteriorating outcomes, notably in safety and care.”*

By the time of that inspection, a new governor had been in post for some three months, and we hoped that the prison could now stabilise and improve after the decision to leave it without a governor for so long in 2018. However, in the months since our January 2019 inspection, I received information from a number of sources which suggested that Feltham A was struggling to deliver safe or decent conditions for the children being held there. I therefore decided that we should not wait until the next scheduled inspection in December 2019, but should make an announced full inspection as soon as practicable.

The findings of this announced inspection were such that I believe it essential to bring them directly to your attention through the UN process. We found that in the six months since the last inspection there had been what can only be described as a collapse in performance and outcomes for the children being held in Feltham A. There had been a decline in each of our tests, and in three of them our grades were now at the lowest possible level. The speed of this decline has been extraordinary, and is particularly

disturbing when one takes into account the overall scale of deterioration in the 18 months since the January 2018 inspection. I believe that such a severe fall in standards is especially concerning given the young age of those being held at Feltham A.

### **What this decline means for the treatment and conditions of children detained**

My concerns are set out in broad terms in the attached debrief summary document, but the key findings are as follows:

#### **Safety**

- The scale of the problems in safety had overwhelmed the systems designed to safeguard children. In our survey, 40% of children said they had felt unsafe at some point during their stay at Feltham A. Nearly half of the children reported victimisation by their peers. Around two-thirds of children said they had been victimised by staff, with more children reporting verbal abuse or physical assault by staff than at similar establishments. The number of violent incidents had risen by 45% since our previous inspection just six months ago. During this period, the number of children held at Feltham A had also reduced – meaning the increase in the rate of violence was actually even higher.
- Violence against staff had continued to rise dramatically. The number of assaults against staff, some of which were very serious, had risen by around 150% since January.
- The levels of violence between children was higher than at similar establishments.
- The YOI’s systems and policies to manage behaviour were implemented neither on residential units nor in education. We saw members of staff failing to manage persistent poor behaviour, and as a result the number of adjudications dealt with by managers had risen sharply.
- Levels of self-harm had tripled since the previous inspection. Levels of self-harm were now 14 times higher than they were in January 2017.

Inspection date	Number of self-harm incidents in the previous six months	Rate of increase since the previous inspection
January 2017	17	N/A
January 2018	34	100%
January 2019	76	124%
July 2019	242	218%

- We assessed that a key cause of this increase was frustration with the poor and unpredictable regime. Many children spent long periods of time locked in their cells with little to occupy them. Our health care inspectors judged that this had a

negative impact on their well-being. Efforts by managers to understand and address the increase in self-harm were undermined by inaccurate data.

- Despite the increase in self-harm, only 25% of children told us that their emergency cell bell was normally answered within five minutes. Inspectors also found a member of night staff working during the inspection without keys and, contrary to national HMPPS policy, the establishment did not immediately call an ambulance in response to emergency codes.
- Use of force had risen to very high levels. Seventy-four per cent of children reported they had been physically restrained at Feltham A. There had been over 700 incidents in the last six months. Governance of this area was overwhelmed: nearly 300 incidents had not been reviewed by specialist staff and over 900 use of force reports were outstanding at the time of the inspection. These failings had led to significant delays in the initiation of child protection investigations, and it was not possible for managers to be sure that force was always used legitimately.
- Managers had separated more than 80 children to maintain good order and discipline over the previous six months. For much of this period the separation of children pending adjudication was not recorded, meaning the total number of separated children was actually higher. The longest period of separation was 89 days. In most cases these children spent more than 22 hours in their cell without any meaningful interaction with staff or peers. Key management safeguards, including daily welfare checks by nurses and managers, were often late or did not happen.

## Care

- Relationships between staff and children had deteriorated and were poor. In our survey, fewer than one in five children felt cared for by staff, less than half felt most staff treated them with respect, and only 45% reported there was a member of staff they could turn to for help.
- The environment was such that it was difficult to build the effective relationships needed to manage poor behaviour, violence and self-harm. Frontline staff were working in an extremely challenging environment and were frequently victims of antisocial behaviour and violence. Children were also often the victims of violence. The regime was so poor that it could not guarantee them access to basic entitlements such as showers and phone calls. We saw some staff acting inappropriately, including swearing at or in front of children.
- Records showed that, on average, children were out of their cells for just 4.2 hours on weekdays in June. This was an average, so some were out for longer, and some, therefore, for less time. In our survey, a third of children said they were out of their cells for fewer than two hours during the week. At the weekend this figure rose to nearly three-quarters.

- The poor regime and delays in moving children around the establishment disrupted life at Feltham A. Resources were being wasted as health care staff, education facilities and resettlement intervention services stood idle waiting for children to arrive. These had all been contracted and paid for.
- For instance, health care services were undermined by the fact that children did not attend or were late for more than half of GP and dentist appointments. Several children did not receive medication at the right time. We found examples of antibiotics or medication for epilepsy administered up to six hours late. Inspectors saw two health care professionals waiting to administer medicines, but only two out of the scheduled 15 patients attended in a period of an hour-and-a-half.

### **Purposeful activity**

- Children are entitled to receive 27 hours of education and three hours of physical education (PE) each week. At Feltham A the amount actually received by children had gone down each month since January 2019, and by June had slumped to just eight hours and 18 minutes. During the same period, attendance had fallen from 64% to 37% – an unacceptably low level. There was no plan in place to improve this.
- Outreach education delivered to small groups of children on the wings was also wasted. In the last four weeks, education managers had planned 796.5 hours of outreach education but only 250 hours were actually delivered. The remaining 546.5 hours were cancelled by prison managers for ‘operational reasons’.
- Language used by some managers, teachers and officers was inappropriate, disrespectful or too informal. Children also demonstrated poor behaviour and they were not being helped to understand that their behaviour was unacceptable. In the vast majority of sessions, inappropriate behaviour such as swearing and derogatory language was not challenged by teachers. Behaviour was poorly managed to such an extent that a teacher left the site halfway through a lesson without telling either the children or colleagues what he was doing.
- As a result of the multiple failings, outcomes had declined in most subjects and Ofsted judged the education provision to be ‘inadequate’ in all areas.

### **Resettlement**

- The poor regime impeded work to resettle children back into the community. Caseworkers and other professionals were often unable to gain access to children and had to communicate through a locked door.
- Many children were being released from Feltham A without stable accommodation, without education, training or employment being in place, and without support from family or friends. The establishment’s own data showed that in the past six months only one child had been released to and subsequently attended an education, training or employment placement on release.

- Family visits were regularly cancelled. Only one of the monthly family days had actually gone ahead since January, and this was attended by only one child. Fewer children than at other YOIs told us they had been helped to maintain contact with family or friends, and only just over a quarter reported being able to make a phone call each day.

## **Conclusion**

I do not for one moment underestimate the challenges facing the leaders and staff at HMYOI Feltham A. During recent months they have often faced violence, some of it very serious. The atmosphere feels tense, and I could sense that many staff were anxious. Some were clearly frustrated about the situation in which they found themselves. They wanted to do their best for the children in their care, but were prevented from doing so because of the reasons I set out in this letter. Meanwhile, the fabric of the buildings is deteriorating, and significant investment will be required to bring them back to an acceptable condition.


As HM Inspectorate of Prisons has reported in the past, the overriding issue behind the extraordinary decline in performance over the past 18 months is the approach to dealing with violence and managing the behaviour of children. Of course, there is a need to keep children safe from each other, and for staff themselves to be safe in their workplace. However, the response at Feltham A, for many years, has been to focus too heavily on containing the problems rather than addressing them. As a result, ‘keep apart’ policies – developed so that children from rival gangs, or who for other reasons are likely to be violent to each other, are kept separate – have come to dominate. This has led to a collapse of any reasonable regime, prevented many children from getting to education or training, delayed their access to health care, isolated them from meaningful human interaction and frustrated them to the point where violence and self-harm have become the means to express themselves or gain attention. There clearly needs to be a new approach which looks fundamentally to change behaviour and goes beyond merely trying to contain violence through ever more restrictive security and separation. This has been needed at Feltham A for many years, has been encouraged by HM Inspectorate of Prisons and others, but has never been successfully implemented.

I have decided to invoke the UN process because the treatment and conditions currently experienced by the children held in Feltham A are, I believe, totally unacceptable. There has been an accelerating decline in the past 18 months, the speed and scale of which has overwhelmed the processes and procedures intended to allow children to serve their sentences constructively, safely and in such a way as to re-join their communities less likely to reoffend.

I believe that the leadership and staff at Feltham A do want to change and to improve conditions for the children in their care. I was invited to moderate my response to what inspectors found at Feltham A on the basis of some very recent improvements, which had apparently taken place since this latest inspection was announced a few weeks ago. I could

not do so: the pattern and level of our healthy prison test judgements, together with the vulnerability of those detained, demand decisive action. The Urgent Notification process was developed precisely for this kind of situation, where the personal authority of the Secretary of State can be brought to bear and strategic intervention can be provided to support a failing establishment. The problems at Feltham A are deep-seated, and to recover from the current appalling situation I believe that significant and enduring support from HMPPS and the Youth Custody Service will be needed.

Yours sincerely

A handwritten signature in black ink that reads "Peter Clarke". The signature is written in a cursive style with a horizontal line underneath the name.

**PETER CLARKE**





Debriefing paper by HM Inspectorate of Prisons

Full inspection of : HMYOI Feltham A 4<sup>th</sup> to 19<sup>th</sup> of July 2019

## Contents

### Healthy prison assessments

1. Safety
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### Healthy prison assessments

Outcomes for children are good against this healthy prison test.  
There is no evidence that outcomes for children are being adversely affected in any significant areas.

Outcomes for children are reasonably good against this healthy prison test.  
There is evidence of adverse outcomes for children 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 against this healthy prison test.  
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 against this healthy prison test.  
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.

## I. Safety

### Overview

**Outcomes had deteriorated in all aspects of safety since our last inspection. The safeguarding team was overwhelmed and we could not be assured action was always taken to safeguard children from harm. Violence, self-harm and use of force had all risen significantly since the previous inspection just six months ago. Management of these areas was weak: data on self-harm was poor, oversight of use of force was inadequate, and behaviour management processes were not implemented effectively. The regime for separated children was poor. Security procedures to keep children apart impacted on the delivery of key work in every area of the prison. Significant action was required over a sustained period to halt the decline, stabilise the establishment and improve outcomes for children.**

**Outcomes for children were poor against this healthy prison test.**

### Early days in custody

- Reception processes remained prompt, focussed on identifying risk and checking wellbeing. Despite this, fewer children than at other Young Offender Institutions (YOIs) said they had been helped by staff to deal with problems or worries when they first arrived.
- First night accommodation was adequate and children were encouraged to mix with their peers through communal dining and association.
- Despite a full induction programme being available, fewer children than at other YOIs said they were told everything they needed to know about Feltham in their first few days. Key sessions were only delivered at weekends, which meant some children waited several days before receiving this information.

### Safeguarding of children

- In our survey, 40% of children reported having felt unsafe during their time at Feltham and 16% felt unsafe at the time of the inspection. Nearly half of children reported victimisation by their peers and two thirds said they had been victimised by staff.
- Managers had fallen behind in some crucial areas of safeguarding work. Managers at a local and national level had failed to identify these problems quickly enough; and additional support to address risks created by the significant backlog of work had only recently been provided.
- Oversight of identified child protection concerns remained mostly good and there was prompt consultation with the local authority designated officer.
- However, this was undermined by weaknesses elsewhere in safeguarding arrangements. Leaders and managers could not be certain all potential child protection issues were identified swiftly enough to enable suitable action to protect children from further harm.
- Incidents of self-harm and the number of children supported on (Assessment, Care in Custody and Teamwork) ACCT documents had - again - increased significantly since the previous inspection. The incidence of self-harm was over three times that at the previous inspection, even although the population was lower. Many self-harm incidents were caused by frustrations with the poor and unpredictable regime.
- We had concerns that an ambulance was not immediately called in response to emergency codes.
- Data considered at regular safeguarding meetings was inaccurate, which undermined efforts to understand and address the increase in levels of self-harm.
- ACCT documentation was reasonably good. However, review meetings were not always multi-disciplinary and entries on daily logs did not consistently demonstrate meaningful interaction.

## **Security**

- Security arrangements continued to impede access to a purposeful regime and some measures were not proportionate.
- Good levels of intelligence were processed and were generally actioned promptly, but were still not used to set specific objectives to address the challenges faced by Feltham.
- The drug strategy was comprehensive and it was positive that there was a multi-disciplinary plan to address substance misuse within the prison. However, it had not been fully implemented.
- Closed visits were not managed effectively, were not linked to intelligence and appeared punitive in some cases.

## **Behaviour management**

- The number of violent incidents had risen since the previous inspection and was high. Assaults on staff had risen by nearly 150% since January and levels of assault were extremely high. Some of these incidents were serious in nature.
- The rate of violence amongst children had also risen and was high.
- The behaviour management strategy was not being implemented across the establishment. There was a lack of consistency and we saw many examples of staff struggling to manage poor behaviour.
- Staff did not always model good behaviour both on residential units and in education.
- Managers needed to ensure frontline staff were confident in implementing policies and needed to support them to deal with the high levels of poor behaviour and violence.
- Implementation of the Incentives and Earned Privileges (IEP) scheme and instant reward scheme was poor; IEP reviews did not take place on time and it was not always clear why a child was placed on the bronze regime. In addition, the instant rewards scheme was underused on residential units and some staff were unaware of its existence.
- The numbers of adjudications had doubled since our last inspection and was very high. Many were low level incidents that should have been managed on residential units.
- The introduction of a gold unit on Eagle was positive, but children on bronze could not access a shower and a phone call each day.

## **The use of force**

- In our survey, 74% of children reported that force had been used against them.
- Use of force had risen from 488 incidents in the six months prior to our last inspection to 727 in the six months prior to this inspection, and was very high.
- There were several concerning incidents, including one where seven batons were drawn.
- Governance of this area had continued to decline and was inadequate. Despite support from outside the establishment, at the time of the inspection there were over 900 use of force reports missing and over 280 incidents that had not been reviewed by specialist staff.
- Children were not routinely debriefed within 48 hours of being involved in minimising and managing physical restraint (MMPR).
- Consequently, it was impossible for managers to identify safeguarding concerns or be assured that force was used legitimately.

## **Separation/removal from normal location**

- Children had been separated using rule 49 on 82 occasions during the previous six months. The average length of time children spent separated was 14 days, although this masked large variations; the longest period of separation was 89 days.
- For much of this period, managers were not recording children separated pending an adjudication. This practice had ceased in the weeks before the inspection, which was positive.

- At the time of our inspection, children could be separated on the Enhanced Support Unit (ESU), Falcon Unit or normal location. The role of these specialist units was unclear.
- The regime for these children was very poor. Many children received fewer than two hours out of their cell each day without any meaningful contact from staff or peers.
- The quality of rule 49 paperwork was poor. Key safeguards, including a daily visit by a duty governor or nurse, were absent.
- In addition to weaknesses in internal oversight, there were also delays in 21 day reviews by the prison group director.

## 2. Care

### Overview

**Relationships between staff and children were poor. Staff simply did not have the time to form effective relationships with children and we observed a minority of staff using inappropriate language in front of children. Living conditions were adequate but children could not access a daily shower. The complaints system worked well. Consultation was reasonably good. The strategic management of equality work was reasonable, but managers no longer had any tools to identify and address disproportionate treatment. Good health services were undermined by the inability to get children to appointments and significant weaknesses in the administration of medicines.**

**Outcomes for children were poor against this healthy prison test.**

### Relationships between staff and children

- Children's perceptions of staff were very poor across all areas; only 19% of children in our survey felt cared for by staff, fewer than half felt most staff treated them with respect and only 45% said they had someone they could turn to if they had a problem; all of which were significantly worse than at other YOIs.
- Over recent months, staff had been working in an incredibly challenging environment, in which violence towards them had been very high.
- Many staff had low expectations of the children in their care and we observed examples of inappropriate language used by staff to describe children in several different areas of the prison.
- The limited regime meant many staff did not have the time to engage meaningfully with children. Consequently, they were unable to develop suitable levels of trust with children or cultivate caring relationships.

### Daily life

- Since the last inspection, attempts had been made to stop the deterioration in the residential environment. Communal areas had new seating and cell painting was ongoing, but there was still too much graffiti and in cell furniture that needed repairing. The windows did not allow adequate ventilation and children complained they were too hot during the summer months. Few cells were personalised. There was frequent cleaning of communal areas, but this was often superficial.
- Showers remained in a poor state. In our survey, less than a quarter of children said they could take a shower every day, which was poorer than at other similar establishments.

### Residential services

- Only 25% of children in our survey felt the food at Feltham was good.
- Kitchen managers had produced a varied menu with good healthy options and provision for religious and medical diets.
- Wing serveries were dirty, and staff and children who served the food did not wear the required clothing.
- The shop had improved since the previous inspection, increasing the selection of general items and items for various cultural and religious groups.

### Consultation, applications and redress

- Despite very negative perceptions of the complaints system, we found the system was well managed and most children received a timely reply that addressed the issues raised.

- There had been 317 complaints in the six months prior to inspection, which was higher than in comparable establishments.
- The application system provided good outcomes for children when the request could be dealt with by wing staff, but was less effective when a reply was needed from other departments.
- Consultation arrangements were reasonably good.

### **Equality and diversity**

- Leadership and management of equalities was reasonable; equalities meetings were well attended and generated some useful actions.
- There had been 26 Discrimination Incident Reporting Forms (DIRFs) submitted in the six months prior to inspection, which was lower than in comparable prisons. Management and assurance of all DIRFs was good with independent scrutiny from the Zahid Mubarek Trust.
- The withdrawal of smart data from the hub had left a gap in the governance of equalities; this had led to potential disproportionate treatment of children which had gone unnoticed by managers.
- Some effort had been made to consult with children about equalities issues; however, this engagement was not regular and there was no evidence that it had been used to improve outcomes for children.

### **Health services**

- Some elements of the governance of healthcare had improved, but risks associated with the administration of medicines were too high.
- The prison's delivery of children to their health appointments was grossly inefficient. More than 50% of patients failed to arrive on time for appointments with the dentist and GPs.
- We observed good care by prison officers and healthcare staff on Wren (inpatients), albeit children were still being admitted for non-clinical reasons.
- Medicines administration was extremely wasteful. We observed two healthcare professionals being available to administer medicines, but only two out of 15 patients attended in 1.5 hrs.
- We found several examples of patients not receiving essential medicines at prescribed times, which mitigated against them receiving optimal therapeutic benefit.
- The dental, mental health and substance misuse services remained good.
- Prison officers did not encourage children to take sufficient responsibility for their own healthcare and learn how to behave as responsible patients.

### **3. Purposeful activity**

#### **Overview**

**The regime for many children was poor and recent improvements needed to be sustained and built upon. The library and gym facilities were good but most children were unable to access them regularly. Leaders and managers at all levels had failed to provide an acceptable standard of education for the children at Feltham. Only 37% attended education in many sessions and punctuality of children and teachers was unacceptable. Teaching and learning was inadequate and many teachers lacked the knowledge to meet the additional learning needs of children. Behaviour had declined substantially, disrupting what little education was delivered. Consequently, success rates had declined across most subjects.**

**Outcomes for children were poor against this healthy prison test.**

#### **Time out of cell**

- Regime monitoring showed that children spent an average of 4.2 hours out of their cells each day in June.
- Time outside was offered daily, although the need for some children to be kept apart from others made this harder for staff to implement.
- The regime put in place to ensure more consistent access to association during the day meant children were forced to choose between education and staying on their unit. Lengthy movement periods negatively impacted on the time children spent in class.
- Evening association had recently started to be available more consistently, but children expressed doubt that it would continue.
- Although relatively new, it was positive that some children could take part in Parkrun each week and several talked about hoping to be suitable to take part in Duke of Edinburgh activities.

#### **Library and Gym**

- In our survey, only 14% of children said they go to the gym or play sport once a week or more, which was significantly less than in comparable establishments.
- The library was reasonably good but almost half of library sessions were cancelled. On average, only 12 children accessed the library each week.

#### **Leadership and management**

- The restrictions of the regime curtailed the delivery of education, skills and work. Consequently, the average education hours that children received had decreased considerably in the last six months and was now significantly below their entitlement.
- Only a third of children attended education classes as expected. After a continued decline since the previous inspection, attendance had reached a woefully low point.
- There was no recovery plan in place for prison leaders and managers to work together to target the improvement of attendance at education, skills and work.
- Managers at all levels and staff, elsewhere in the prison, did not place sufficient priority on the value of education. Too many outreach sessions were cancelled by other areas of the prison.
- The education governance board was not sufficiently well informed to challenge leaders and managers to improve.
- Managers' self-assessment of the provision of education, skills and work was insufficiently critical and evaluative.
- None of the recommendations made at the previous inspection had been achieved.



### **Quality of teaching, learning and assessment**

- The identification of learners' starting points with regards to behaviours, attitudes and personal development was weak.
- Most teachers lacked the necessary knowledge about the learning needs of children and this meant that the children's needs were not appropriately met. This was particularly concerning in the case of the significant number of learners who had additional learning needs. Teachers failed to consider the education and care plans when they planned learning. They lacked the appropriate strategies, resilience and confidence to manage the frequently present poor behaviour in class.
- The learning environment was in poor condition and learning resources such as IT, support assistants and learning mentors fell below the expectation in a children's educational establishment.

### **Personal development and behaviour**

- We observed staff and managers across the prison using inappropriate and too informal language to communicate with children - thus failing to provide a consistently good role model for children, hindering the development of respectful relationships. Children's behaviour was poor and they were not being helped to understand that their behaviour was unacceptable.
- Punctuality to education was poor. Too many teachers were not in the session or ready when the lesson was due to start. Children did not access vocational areas frequently enough to ensure that their learning continued. Teachers did not pay enough attention to health and safety within the workshops.

### **Outcomes and achievement**

- Leaders and managers did not gather and use data effectively to monitor the quality of the outcomes achieved by all children in order to evaluate the provision. According to the limited information available, qualification achievement rates had declined this year across most subjects, including English, mathematics and ICT.
- Many children did not make enough progress with their learning. The standard of their work in their notebooks demonstrates that they had made insignificant progress across a range of subjects.

## 4. Resettlement

### Overview

**Children and families work had deteriorated since the previous inspection. The reducing reoffending strategy was up to date but key actions needed to be implemented. Despite some improvement, planning was overly focussed on behaviour in custody and was not supported by residential staff. The work of case workers and other professionals was undermined by difficulties accessing children. This meant that many children were released or transferred from Feltham having not accessed any offending behaviour programmes. Public protection work was reasonable. Home Detention Curfew (HDC) and early release processes were generally managed well. Preparation for health and substance misuse care post release was good. However, many children did not receive sufficient support to find accommodation or education on release.**

**Outcomes for children were not sufficiently good against this healthy prison test.**

### Children, families and contact with the outside world

- The support available to help children to keep in touch with family and friends had deteriorated and was not sufficiently good.
- Family days were no longer happening regularly; only one child had accessed a family day visit in the last six months.
- In our survey, it was disappointing to find that only 28% of children said they had received support in maintaining contact with their family or friends. This was significantly lower compared to other YOIs. Furthermore, only 27% of children reported that they had access to a telephone each day.
- The prison visits area was adequate, but visits regularly started late.
- Spurgeon's provided some 1-1 parenting support, but Storybook Dads was not available.

### Pre-release and resettlement

- The reducing reoffending strategy had been updated and was based on a needs analysis from 2018. Attendance by all departments at the monthly reducing reoffending meeting remained inconsistent.
- The use of Release on Temporary Licence (ROTL) was positive, but it remained underused. In the last six months, it had only been used specifically for resettlement purposes for one child.
- Case workers and staff from other agencies struggled to access children to conduct rehabilitative work because of the complex unlock arrangements on residential units. It was unacceptable that some conversations with children could only take place through cell doors.
- Early release processes were being managed appropriately. Despite one anomaly, most home detention curfew (HDC) processes remained well managed.

### Training planning and remand management

- The casework department was now fully staffed. They held low caseloads and were motivated to help children progress. They knew the children they were supporting well. However, they lacked the necessary training and supervision to be fully effective in their role. Caseworkers benefitted from community visits to enhance their practice.
- Planning meetings were timely and Youth Offending Team (YOT) staff were present at all meetings.

- Not all plans or reports were focused on resettlement. Targets were not written in child focused language. Meetings prioritised the custodial element of the child's sentence and focused on behaviour management, rather than resettlement planning. Joint working between caseworkers and YOT workers lacked challenge and did not ensure adequate outcomes for children leaving custody.
- Work to manage transitions to Feltham B was well organised, although some other adult prisons were less cooperative which caused delays.

### **Public Protection**

- There was an adequate tracking process in place to manage public protection. arrangements including MAPPA (multi-agency public protection arrangements).
- Mail monitoring and child contact restriction processes were proportionate.

### **Indeterminate and long sentenced children**

- Support for children who were remanded or serving indeterminate sentences remained the same as the last inspection. Some community organisations such as Roadlight and Kinetics provided some I-I support. But, overall, support in this area was under-developed.

### **Looked after children**

- 82% of children placed at Feltham had current involvement with children's social care. Looked-after children were supported by a team of social workers who advocated on their behalf.

### **Reintegration planning**

- The extensive keep-apart list continued to prevent the effective delivery of interventions and offending behaviour programmes for children. There was an excessive waiting list which meant that most children with identified needs were released, or transitioned to other establishments, without completing any offending behaviour work.
- There was evidence of some targeted I-I work from psychology, including a counselling service and family therapist.
- The prison provided some basic guidance on money management and budgeting.
- Primary care nurses continued to identify children due for release and provided medicines for discharge appropriately. The mental health and substance misuse team were proactive in engaging with community agencies to ensure continuity of support.
- Children did not always have a confirmed address at their final review meeting. At the time of our inspection, two children, who were looked-after by the local authority and due to be released imminently, did not have their addresses confirmed.
- For many children, late confirmation of release addresses prevented meaningful reintegration planning, despite the existence of escalation processes.
- Reintegration outcomes in education, training and employment were particularly poor.