Criminal Justice Inspection
Northern Ireland
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Report on an announced inspection of

Hydebank Wood Young Offender Centre

by HM Chief Inspector of Prisons and the
Chief Inspector of Criminal Justice in
Northern Ireland

5 – 9 November 2007

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Introduction

This full announced inspection of Hydebank Wood Young Offender Centre was undertaken by HM Inspectorate of Prisons on behalf of Criminal Justice Inspection Northern Ireland (CJI) and was supported by CJI inspectors and staff from the Employment and Training Inspectorate of Northern Ireland.

While some progress had been made since our last visit, the young offender centre was struggling to deal adequately with the complex and competing tasks of managing a variety of remanded and sentenced juvenile and young adult men, on a site that also contained a women's facility (the subject of a separate report). The plight of juveniles was of particular concern. Problems for managers were compounded by antiquated industrial relations and anomalous staffing arrangements.

Safety is the cornerstone of a healthy prison and, from the outset, the experience and perceptions of young people were poor. There was insufficient separation of juveniles and young adults in escort vans and an overuse of handcuffs while travelling. Reception was grim and procedures were ill-suited to juveniles, particularly the use of routine strip-searching. Staff made an effort to be supportive on the first night, but had little guidance. Similarly, although there was a good written induction policy, staff were largely unaware of it and so it was not consistently delivered.

The new governor was aware of the need to address the previous lack of attention to bullying and violence reduction, but many young people still reported feeling unsafe. There was also a need for the centre and its partners to formalise children's safeguarding issues. Use of force was relatively low, but adjudication punishments were excessive. Too much staff time was spent on ineffective cell searches. While it was positive that there was relatively little self-harming, particularly given the level of suicides in the community from which many young people came, a more caring and therapeutic approach was required for those at risk and those withdrawing from substance use.

The standard of accommodation had improved, although the closure for refurbishment of Cedar unit meant there was overcrowding elsewhere. The designation of Ash House as a women's prison restricted young people's movement around the site. Relationships between staff and young people were distant and not supported by a personal officer scheme.

Work on equality and diversity was underdeveloped and required a clear central policy steer from the Northern Ireland Prison Service (NIPS). However, the chaplaincy played an active part in the life of the centre, including supporting those from different backgrounds. The quality of food was poor and young people had little confidence in the request and complaints systems. Healthcare remained inadequate and it was disappointing that the promised transfer to the HSSPS had not yet occurred.

There was too little purposeful activity and opportunities were poorly utilised. Those allocated an activity spent a reasonable amount of time out of their cell, but many others spent most of the day in their cells. Matters were made worse by unpredictable cancellations of association, often blamed on staff shortages, which we found hard to reconcile with the number of staff on duty. Young people rarely had exercise in the fresh air. Opportunities for work, learning and skills were limited. The quality of education was mixed. However, the gym provided a beacon of committed staff and good quality activity.

Resettlement arrangements at the young offender centre had not progressed sufficiently and had suffered disproportionately from recent cut-backs. The resettlement policy remained aspirational and there was a need to focus more on interventions that could actually be delivered. While it was commendable that most young people, including those on remand, had sentence plans, these were of limited quality and too little was then done to deliver against them. Public protection arrangements were adequate and there were some useful reintegration services, with good drug services and impressive support to maintain contact with families.

Overall, this inspection found that Hydebank Wood Young Offender Centre was not performing effectively against any of our four tests of a healthy establishment: safety, respect, purposeful activity and resettlement. This should not obscure the pockets of improvement and good practice that we found, nor the scale and complexity of the task facing managers. Indeed, there can be few custodial settings with so many competing risks and vulnerabilities in one small site. In our view, it should remain the goal of NIPS to house juveniles and women in separate, dedicated establishments that can address their particular needs. Meanwhile, the new governor will need considerable support to address the many shortcomings we identify.

Anne Owers — March 2008
HM Chief Inspector of Prisons

Kit Chivers
Chief Inspector of Criminal Justice in Northern Ireland

Fact page

Task of Hydebank Wood Young Offenders Centre
To accommodate male young offenders between the ages of 18 and 21 and male juvenile offenders.

Brief history
Hydebank Wood was opened as a category C young offender centre in 1979 and comprises five self-contained houses (Ash, Beech, Cedar, Elm and Willow), each of which can accommodate approximately 60 young people in single cell accommodation. As well as housing young adults between the ages of 18 and 21, Hydebank Wood holds male juveniles aged under 18 years in separate accommodation in Willow House. In June 2004, women prisoners previously held at Mourne House, Maghaberry, were transferred to Ash House (which was designated as a prison for women prisoners) and the centre was designated as Hydebank Wood young offender centre and prison.

Number held
201

Cost per place per annum
The cost per prisoner place for the Northern Ireland Prison Service (NIPS) is calculated for the service as a whole. The cost per prisoner place for 2007/08 was £81,000.

Certified normal accommodation
261

Operational capacity
201

Last full inspection
14 – 17 March 2005 (unannounced)

Description of residential units
There are four residential units for male offenders: Beech, Cedar, Elm and Willow. Each house has four landings with approximately 16 cells on each landing, although this can vary from house to house. Each landing has showering facilities, association and dining areas and, following completion of a refurbishment project, all cells will have integral sanitation. Hydebank Wood does not differentiate between remanded and sentenced prisoners. All prisoners are engaged from reception and are housed in a number of locations.

- Beech House: contains young male adults on the enhanced regime level and can accommodate up to 90 in single and double occupancy cells. A temporary female reception facility is located on the ground floor.

- Cedar House: closed for refurbishments and scheduled to reopen in March 2008 with an additional landing.

- Elm House: contains young male adults on all regime levels and can accommodate up to 92 in single and double occupancy cells. Elm 1 functions as the committal landing and Elm 2 the assessment unit. A temporary special supervision unit was located in a separated section of Elm 1.

- Willow House: contains young adults and juveniles and can accommodate up to 69 in single and double occupancy cells. Willow 1 functions as the juvenile unit, with up to 19 juveniles, all

in single occupancy cells. Willow 2 accommodates young adults on the enhanced level of regime, all in single occupancy cells, and acts as a 'feeder' landing for Beech House. Willow 3 accommodates young adults on basic, standard and enhanced regime levels in double occupancy cells. Willow also has dormitory-style accommodation for up to 10. At the time of the inspection, was used as a temporary adjudication and administration facility pending the refurbishment of the special supervision unit.

Healthy prison summary

Introduction

HP1 All inspection 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. The criteria are:

Safety	prisoners, even the most vulnerable, are held safely
Respect	prisoners are treated with respect for their human dignity
Purposeful activity	prisoners are able, and expected, to engage in activity that is likely to benefit them
Resettlement	prisoners are prepared for their release into the community and helped to reduce the likelihood of reoffending.

HP2 Under each test, we make an assessment of outcomes for prisoners and therefore of the establishment's overall performance against the test. In some cases, this performance will be affected by matters outside the establishment's direct control and which need to be addressed by others in the Northern Ireland Prison Service (NIPS) and elsewhere within the wider criminal justice sector.

- performing well against this healthy prison test.
There is no evidence that outcomes for prisoners are being adversely affected in any significant areas.

- performing reasonably well against this healthy prison test.
There is evidence of adverse outcomes for prisoners in only a small number of areas. For the majority, there are no significant concerns.

- not performing sufficiently well against this healthy prison test.
There is evidence that outcomes for prisoners are being adversely affected in many areas or particularly in those areas of greatest importance to the well being of prisoners. Problems/concerns, if left unattended, are likely to become areas of serious concern.

- performing poorly against this healthy prison test.
There is evidence that the outcomes for prisoners are seriously affected by current practice. There is a failure to ensure even adequate treatment of and/or conditions for prisoners. Immediate remedial action is required.

HP3 HM Inspectorate of Prisons has also built up a database of survey responses from prisoners in different kinds of prison across England, Wales and Northern Ireland. This provides a comparator against which it can set the responses from an individual establishment. In this report the comparators used are male young adults and juveniles in establishments in England and Wales. While HM Inspectorate of Prisons recognises the particular complexities that Hydebank Wood faces, these comparisons

allow managers to identify those areas where young people feel more positive, or more negative, than in other comparable establishments.

Safety

HP4 All young people were handcuffed on escort vans and there were no separate arrangements for juveniles. The reception facility was poor and initial procedures were brusque. Induction was satisfactory, except there was no formal programme for juveniles. Most young people were treated well on their first night, but formal procedures were inadequate. Many bullying incidents were not investigated. Levels of self-harm were low, but there was too much emphasis on physically preventing self-harm rather than providing emotional support, and the quality of care plans was poor. Some security arrangements were too restrictive. Adjudication punishments were severe, particularly for juveniles. Detoxification was often too rapid. The establishment was not performing sufficiently well against this healthy prison test.

HP5 A very good information leaflet for the young offender centre had been produced, but was not given to prisoners at court or during escort. Few young men had long journeys, but most in our survey reported comparatively negative experiences, including feeling unsafe and finding vans dirty. There were no separate arrangements for juveniles. All were unnecessarily handcuffed in vans without any individual risk assessment, which contributed to their feelings of lack of safety. Property and private cash was not routinely sent to court with young men and some were left without any resources when released on bail. There was good use of the video link.

HP6 The reception area was grim and in urgent need of redesign and refurbishment. The initial procedures were brusque and intimidating, and particularly inappropriate for juveniles. However, staff were efficient and young people did not stay long. All juveniles were routinely strip searched on arrival, which was not appropriate and some strip searches were carried out by a single officer.

HP7 Our survey results indicated a poor first night experience and, although we observed new committals being well treated by staff on the induction landing, guidance for staff was inadequate. Wing file entries indicated good interaction between staff and new arrivals. All were given a comprehensive booklet about a range of prison procedures on their first night, but it did not cover well the essential things they needed to know during their first 24 hours and was little help for poor readers. Insiders were not routinely informed of new arrivals and could not always see them on their first night. Young men were not allowed to associate on their first night, which was unnecessary.

HP8 There was a good written induction policy, but most staff we spoke to were unaware of it and it was not being followed. There was no formal induction programme for juveniles. However, all new arrivals met key staff to assess and deal with their immediate needs without undue delay.

HP9 Significantly more young adults than the comparator said they sometimes felt unsafe and that they had been victimised by other prisoners and staff. The units were not easy to supervise and there was a need to develop a strategy to protect young men who were vulnerable because of their offences. There had been only 15 bullying investigations to date in 2007, only five of which had been substantiated. However, we found a number of incidents of apparent bullying, some of which involved young

men on prisoner at risk (PAR) procedures, that had never been investigated. Other than relocation, there was little effective response to challenge bullying behaviour. There had been no staff training in bullying awareness. A joint safer custody meeting under the chairmanship of the new governor was now better focused and we welcomed proposals to move towards a case management approach. The same meeting dealt with safer custody issues for young men and women, which made it difficult to ensure that the needs of the different groups were effectively dealt with.

HP10 There was a relatively low level of self-harm and the young offender centre's record was commendable when compared with the high suicide rate among young men in the community. However, there was still too much reliance on isolation and the use of protective clothing for those at risk of self-harm rather than a more therapeutic response. The suicide prevention coordinator (SPC) had no allocated time for the role. PAR1 forms were poorly completed, with little apparent awareness of the need to provide individual support. Few had good quality entries or comprehensive reviews and there was little evidence of formal multidisciplinary involvement despite the helpful role of others, such as chaplains and Opportunity Youth. There was no Listener scheme.

HP11 There was no policy for managing children and no adequate child protection policy. There was also a lack of involvement from the area child protection committee (ACPC) and health and social service trusts. Only 23 of the 39 staff working with children on Willow House had received child protection training. Few of the staff in posts involving strip searching, such as in reception, had been trained. There was no confirmation that protection of children and vulnerable adults (POCVA) checks had been carried out on staff working with children. In the absence of any involvement from the ACPC, the establishment was inappropriately investigating its own child protection referrals. Some of the principles that underpinned the published child protection statement contrasted with the poor treatment of children that we witnessed, including punishments that were tantamount to lengthy cellular confinement and removal of contact with families.

HP12 Security information for young male adults and women was not analysed separately, which made it difficult to understand different issues affecting these groups. There were relatively few security reports as some staff remained reluctant to commit information to paper, but this was improving. Security information was managed in a timely fashion, but was inadequately shared with appropriate staff. The lack of an appropriate classification system and the split site led to unnecessary security restrictions. Although there were some security concerns about drugs, too much staff time was spent on cell searching to little effect and there was too much strip searching without a risk assessment.

HP13 The special supervision unit (SSU) had just closed for much needed refurbishment. The temporary arrangements were not ideal, but efforts were being made to keep the numbers formally segregated low. There had previously been some inappropriate locations of young people at risk of self-harm in the SSU. The general regime for prisoners in the SSU was very restricted and daily showers and exercise were not always provided on busy days. The oversight of the use of special accommodation was inadequate, although under review.

HP14 The continuing lack of written records of adjudications meant there was little quality checking, but those we listened to on tape were well conducted. A good advocacy service was provided for juveniles by Opportunity Youth. Disciplinary outcomes were

overly punitive, with too much use of cellular confinement as a punishment for minor offences. Use of the telephone was often stopped as a punishment, which was inappropriate, particularly for children. Some children were locked in their cells on a basic regime for long periods in conditions similar to cellular confinement. One child was held this way for six weeks and had been denied a visit with his mother because of a minor altercation with staff.

HP15 Recorded use of force was relatively low, but the quality of completed records varied. Reasons given for the use of force were often mechanistic or vague. In cases when the search and standby team came to take over an incident, landing staff did not always complete records, so it was difficult to be sure what had led up to the initial use of force and whether it was reasonable. A committee to review use of force was a positive initiative, but it had met only twice in 2007, was not chaired at sufficiently senior a level and did not scrutinise individual incidents rigorously.

HP16 Substance use assessments were not comprehensive and prescribing regimes were not flexible enough to meet individual needs. It was difficult to establish that the detoxification policies were followed as record keeping was poor and detoxification was often very swift. There was little psychosocial help for those withdrawing from alcohol or drugs as part of a structured programme, but Opportunity Youth provided some good support.

Respect

HP17 Relationships between staff and young people were remote and there was no personal officer scheme to provide more structured support. Accommodation was generally clean, but as one house was being refurbished many young men had to share cramped single cells. The food was poor. Equality and diversity work needed more attention. Health services did not meet needs. The establishment was not performing sufficiently well against this healthy prison test.

HP18 There continued to be relatively little informal interaction between staff and young people, and relationships were not positive or based on trust. In our survey, significantly fewer than in other young offender institutions said most staff treated them with respect and more said they were victimised by staff. Only 50%, against a comparator of 67%, said they had a member of staff they could turn to for help. Most staff addressed and referred to the young men by their surnames. There was still no personal officer scheme to support young men and underpin resettlement work. Many said the only way to get staff attention was to self-harm or misbehave. Entries in wing files were frequent, but almost wholly about behaviour.

HP19 The standard of accommodation in Beech House was good and the accommodation on Elm and Willow was mostly reasonable. However, many young people shared cells, particularly as Cedar was closed for refurbishment. These cells were too cramped and toilets were inadequately screened. A small number of cells on Elm 4 and Willow 3 were in poor condition, with broken furniture and graffiti. One young man had been held in a cell for a week without a window pane. The installation of laundries on the landings was a positive development, but the policy on own clothes was too restrictive.

HP20 The progressive regimes and earned privileges (PREP) policy was clear and prisoners were required to sign their weekly reports. There were good pay incentives, but decisions about regime level were almost wholly based on behaviour rather than compliance with resettlement targets. Basic level prisoners got only 30-minute visits, which limited contact with families. Some young men spent too long on basic without proper support to encourage them to progress. It was unclear how the special privileges category fitted with the PREP scheme and the criteria was not sufficiently transparent.

HP21 In our surveys, 65% of young adults and 77% of the juveniles said the food was bad or very bad and many complained to us about it. The food we sampled was poor and often cold. Lots of the food was never eaten and many young men used the well-regarded tuck shop to supplement their poor diet. No action seemed to be taken as a result of consultation about food quality.

HP22 There was a lack of clear central guidance from the Northern Ireland Prison Service (NIPS) about equality and diversity. An equality and diversity committee had been set up, but was poorly attended and made little progress. Monitoring by religion was carried out for the whole of Hydebank Wood, including the women's prison at Ash House, and showed some over-representation of Catholics in key areas. The figures were not disaggregated by sex to focus on possible areas of inequality in the young offender centre and there was no analysis over time or a system to flag up when action needed to be taken or differences explained. Our survey results indicated some significant differences between Catholics and Protestant young men in a small number of important areas.

HP23 There was a general lack of understanding about issues relating to diversity. Apart from staff directly involved in this area of work, there was little active promotion of diversity. There were few black or minority ethnic prisoners, but this was beginning to change as the increasingly diverse Northern Ireland population was reflected in the prison population. Race-related complaints were dealt with using the generic complaints systems, but the absence of a specific system meant that it was difficult to be sure that racist incidents were identified and dealt with properly.

HP24 Some good individual support was provided to foreign national prisoners, particularly to maintain family contact. Diversity officers aimed to ensure that the special needs of each individual foreign national were met, but links with immigration officials were weak. The chaplains also provided good support to young men who were foreign nationals.

HP25 Most young men in our survey were positive about the ability to speak to a religious leader of their faith in private, although, while still positive, Catholics were less so. Chaplains visited the units every day and catered for all denominations, helping with welfare as well as spiritual matters and providing good support to those in need. Appropriate Christian services were held on Sundays.

HP26 Young men in our survey were overwhelmingly negative about requests and complaints. The forms were not freely available on all units and the process lacked confidentiality, which did not engender young men's confidence in the system. Replies often failed to answer the points made or were overly defensive. There was no ongoing analysis of complaints by subject and location.

HP27 Healthcare services had yet to transfer to the HSSPS and, although senior staff had been reorganised in preparation, no date had been agreed. Some divisions within the healthcare staff group had impacted negatively on the delivery of a decent service and there were a number of examples of poor patient care and inadequate record-keeping. There was no secondary health screen after reception to ensure that important health concerns were not missed. Some resuscitation and emergency equipment was out of date. There were daily GP sessions, although some were very short. There was 24-hour GP cover, but no evening sessions. The dentistry service was good and there was no waiting list. Pharmacy policies were out of date and did not reflect actual practice. The mental health in-reach team provided only cognitive behavioural therapy and there was only one session of a consultant psychiatrist to provide secondary care for young men, which was insufficient.

Purposeful activity

HP28 Time out of cell was reasonable for the half of young men with allocated activity, but not for the others and there were too many unpredictable lock downs. With no scheduled exercise period, young men spent very little time in the fresh air. Allocation to activities took too long, there were insufficient places available and few opportunities to acquire useful skills. Juveniles were particularly poorly catered for and the education and training provision did not meet young people's needs. Access to the library was poor. The gym provided a good service. The establishment was performing poorly against this healthy prison test.

HP29 For those with an allocated activity place (only around half the young men), time out of cell was reasonable. Those who were not allocated to an activity could spend most of the day in their cell. There was no scheduled time for exercise and some young men had very little opportunity for fresh air. Association was scheduled every day, but there were frequent cancellations due to apparent staff shortages. However, seven juveniles were denied association on one day even though there were two staff to supervise. Agreed routines were not adhered to and there were frequent late starts and early lock-ups.

HP30 There was no strategic approach to delivering education and training and activities were not sufficiently well coordinated. Education and training places available were under-utilised, despite waiting lists for most courses. In particular, there was little, if any, planning to meet the individual needs of the juveniles. Education and training were not linked effectively to resettlement planning or to structured education and training plans for the young people.

HP31 There was poor provision for young men assessed at below entry level two in numeracy, so those with the most educational deficits did not have them met. Data from the previous 12 months indicated that 80% of young men coming into Hydebank Wood had been assessed at or below entry level three in literacy and numeracy, but at the time of the inspection less than 15% were having their needs met.

HP32 Despite the lack of strategic approach, some of the standards of work and quality of teaching were good and staff were supportive of the young men. The majority of those involved in education and training gained accreditation, but mostly at a low level. There were 272 education places each week, of which about 200 were allocated, but attendance was very poor. Approximately half of the young adults had

some involvement with education, even if somewhat limited, but this was much worse for juveniles.

HP33 There was not enough work to keep all young men fully active and relatively few opportunities for skills training. Assessments for work took too long and 48% of prisoners were not allocated. There were 82 training places each week, of which about 74 were allocated. As with education, attendance was often very low.

HP34 Although there was a reasonably well-stocked library, access was poor. There was limited space for self study and only one computer and printer with no access to the internet and no CDs for prisoners' use. Appropriate legal materials and prison information were held.

HP35 Young men in our survey were positive about access to gym and significantly more than in other young offender institutions indicated they went at least twice a week. The gym was a good and well-equipped facility. It ran programmes suitable for young men and provided some good training opportunities, but participation in external adventure activities had stopped. Some good remedial gym with individualised care was provided.

Resettlement

HP36 There was no resettlement team or resettlement culture and cuts in resources had left staff demoralised. There was no recognition of the different needs of young adults and juveniles in the resettlement policy. The policy was insufficiently focused on practical outcomes and lacked a cohesive framework. Most young men had some resettlement plans, but few were aware of them. Reintegration services were generally suitable and there was some good work to support relationships and parenting. Drug services were satisfactory. The establishment was not performing sufficiently well against this healthy prison test.

HP37 There was no resettlement team or recognisable resettlement culture at Hydebank Wood. Staff were demoralised by what they considered to be disproportionate cuts that had been imposed on resettlement areas. This area had not progressed sufficiently since our inspection in 2005.

HP38 The resettlement policy was aspirational rather than focusing on what was actually delivered and how it could be improved. It described some elements, for example personal officers, that did not exist. There was no separate policy setting out the different needs of young adults and children. The resettlement committee included all the key players, but did not concentrate enough on reviewing outcomes or set targets for improvement. Provision was fragmented and individuals and agencies operated in isolation from each other, with no cohesive team structure. There was a comprehensive resettlement database, but it was not used effectively to target provision and plan ahead. A range of offending behaviour programmes was provided.

HP39 Almost all young men had a resettlement plan and it was commendable that this included those on remand and those serving short sentences, although there was very little awareness of these plans. Young men attended home leave boards and special privileges boards to outline their views and plans, but there were no resettlement boards. It was difficult to see the value of the plans, which did not fully

engage the young people in addressing their likelihood of reoffending. Although file recording had improved, case management remained poor and much of the required data was missing.

HP40 Public protection arrangements were effective, mostly because of probation input, particularly at home leave and discharge stages. Those with sentences that brought them into contact with the probation service were routinely subject to detailed risk assessment and management. The process for identifying other prisoners who posed public protection issues also worked satisfactorily. Although only seven young men were subject to the multi-agency sex offender risk assessment and management (MASRAM) arrangements, it was positive that 148 staff had been trained in MASRAM awareness. However, designated risk managers' communication with prisoners needed to improve.

HP41 The Housing Rights Service provided help with accommodation issues, but the prison was not playing its part by providing officers to deliver this work. There was no dedicated debt counselling, although NIACRO provided useful benefits advice and employability input. Education and training were not linked effectively to resettlement planning or to the specific education and training needs of the young men. Home leave was well used to help those coming towards the end of sentence prepare for release. Young men who did not have a GP were helped to register with a doctor and there were some links with local mental health workers.

HP42 There were six young men sentenced to life imprisonment and a number of potential lifers for whom there were no structured arrangements. Few lifers reported much contact with their lifer liaison officers. All the lifers had had their cases reviewed in conjunction with the Maghaberry lifer management unit, but it was regrettable that all lifer progression was to Maghaberry, although arrangements had been made to move at least one lifer to Martin House there rather than the main lifer house.

HP43 Good transport was provided for visitors, but poor signage made locating the prison difficult for those using their own cars. The visitors' centre gave helpful and friendly first contact and the staff there had strong links with community-based agencies and were able to offer relevant practical support. However, there was a lack of refreshment facilities. Good use was made of child and family centred visits to allow young men to spend time with their family to help strengthen family bonds. All babies were routinely searched without specific intelligence to justify this intrusive measure. Consultation arrangements with visitors were poor and there was not enough capacity for visits at weekends when there was peak demand. There were some delays with mail being issued.

HP44 There was a drug and alcohol strategy specifically for the young offender centre, but this needed to be updated and required a comprehensive needs assessment. Alcohol problems were a big issue and some alcohol management groups had been run in the previous year. Opportunity Youth saw all new arrivals and assessed them and ran some individual treatment programmes. Opportunity Youth also provided key workers for a throughcare programme that provided services in the prison and the community. Voluntary drug testing was linked to the progressive regimes and earned privileges scheme (PREPS) and was, therefore, compliance testing. Many tests had been missed in the previous six months.

Main recommendations

HP45 The reception area should be redesigned and refurbished to provide an appropriate environment to meet the needs of children and young people arriving in custody.

HP46 First night procedures should be agreed so that all new arrivals receive consistent and supportive care on arrival, including private interviews to assess immediate needs, access to peer support and appropriate supervision.

HP47 A personal officer scheme should be established to support young people at Hydebank Wood, liaise with families and encourage effective resettlement.

HP48 An effective anti-bullying and violence reduction strategy should be developed to ensure that all alleged incidents of bullying are investigated and vulnerable young people protected.

HP49 The suicide and self-harm prevention policy should be revised to reflect the specific needs of children and young adults and to develop a more therapeutic response to support young people at risk at Hydebank Wood.

HP50 The Northern Ireland Prison Service should either remove young men under the age of 18 from Hydebank Wood or provide appropriately resourced, dedicated accommodation with a regime capable of meeting the needs of this population.

HP51 The Northern Ireland Prison Service should issue clear guidance on the implementation of a diversity strategy indicating areas to be prioritised and provide relevant staff training including in religious and cultural differences.

HP52 The transfer of responsibility for health services should be completed expeditiously so that health services can be planned, provided and quality assured through integrated working.

HP53 An education and training policy for young people should be developed, including a coherent and distinct strategy for juveniles, that provides sufficient work and education places to keep all young people purposefully occupied.

HP54 All young people should have at least 10 hours out of their cells on weekdays including a daily scheduled period of one hour's exercise in the open air.

HP55 The Hydebank Wood resettlement strategy should be rewritten to show clearly how the establishment contributes to the Northern Ireland resettlement strategy. The new strategy should specify roles and responsibilities, set SMART objectives, outline provision for specific groups such as juveniles and lifers, and include arrangements for regular review.

Section 1: Arrival in custody

Courts, escorts and transfers

Expected outcomes:
Children and young people travel in safe, decent conditions to and from court and between different establishments. During movement the individual needs of young people are recognised and given proper attention.

1.1 Young men and juveniles often travelled in the same vans as adult women. The vans were uncomfortable and some were dirty. Prisoners waited too long outside reception due to inadequate staffing arrangements. All young people were handcuffed in the vans and to and from reception. Most journeys were short, but some prisoners arrived too late for all reception procedures to be carried out. The video link was well used.

1.2 Young people often travelled in the same vans as adult women. There were no separate transport arrangements for juveniles. All young people were handcuffed in the vans and to and from reception without individual risk assessment. Escort staff usually alerted the prison that they were returning from court, specifying if they were bringing a new committal and giving an estimated arrival time. Despite this, vans sometimes had to wait outside reception if they arrived when reception was closed over staff lunch and afternoon meal breaks. We noted some prisoners on a van that arrived during the tea break shouting to be let out. This was intimidating for others, particularly new committals.

1.3 Most young people had short journeys of around 30 minutes, with the longest journey of two hours being for young people coming from Derry. However, some arrived too late in the evening for all reception procedures to be carried out. In the previous five months, 11 young people, including three new committals, arrived after 8pm. Two new committals arrived after 8.30pm during the inspection.

1.4 Some vans were reasonably clean, but others contained a considerable amount of graffiti in some cubicles. One of the newer vans had cushioned seats. None had seatbelts, but all carried appropriate emergency equipment. In our survey, responses to questions about treatment by escort staff, personal safety, cleanliness and comfort of the van were significantly worse than the comparators.

1.5 An excellent information leaflet about Hydebank Wood had been produced and would have helped ease the anxiety of new committals before arrival, but was not issued at court or during escorts. None of the young people we asked had seen it. In our survey, none of the juvenile respondents and only 9% of young adult respondents said they had received any written information before arrival.

1.6 The young people were asked if they had any complaints about escort staff, but this was done in front of escort staff, which was inhibiting. Unsurprisingly, staff said young people rarely complained about escort staff.

1.7 The video link was well used. Young people going to court were given breakfast and provided with a packed lunch. No property or private cash was taken to court, so anyone released at court had to return to the prison to collect their stored property.

Recommendations

1.8 Young men, juveniles and women prisoners should be transported separately.

1.9 Young people should not routinely be handcuffed on vans or to and from reception without the need for this being determined through individual security risk assessment.

1.10 Staffing should be arranged so that young people do not wait unnecessarily on vans because reception is closed.

1.11 Young people should arrive before 7pm.

1.12 Young people should be escorted in vehicles that are safe, clean and comfortable.

1.13 Property and private cash should accompany unsentenced young people to court.

1.14 Young people should be given the information leaflet about Hydebank Wood at court by Northern Ireland Prison Service escort staff.

1.15 Young people should not be asked about their treatment by escort staff in the presence of these staff.

First days in custody

Expected outcomes:
Children and young people feel safe on their reception into the establishment and for the first few days. Their individual needs, both during and after custody, are identified and plans developed to provide help. During induction into the establishment young people are made aware of establishment routines, how to access available services and given help to cope with being in custody.

1.16 The reception area was austere and unwelcoming. Reception procedures were efficient and young people were moved through quickly, but the overall approach was brusque and intimidating, particularly for new committals and juveniles. Interpreting services were not always used when necessary. All young people, including juveniles, were routinely strip searched and some strip searches were carried out by only one officer, which was inappropriate. Waiting facilities were poor. No peer supporters were based in reception and young people were not given enough information. First night care was inconsistent and late arrivals were not adequately helped to settle in. Induction did not cover everything young people needed to know and did not always start within the first week.

Reception

1.17 In the previous six months, there had been 382 new committals, including 52 juveniles. They arrived with little information, often nothing more than the warrant. Staff therefore had to rely on information given by the young people when making important risk assessments.

1.18 The reception facility was austere and unwelcoming, and the brusque way staff carried out reception procedures was intimidating, particularly for new committals. The first instruction

given to young people, for example, was to stand with their back straight against the wall. In our survey, only 49% of young adults, significantly worse than the comparator of 64%, said they were treated well or very well in reception. The juvenile response was similar to the comparator.

1.19 Young people returning from court were dealt with efficiently and all were moved to their houseblocks within 10 minutes. New committals were routinely dealt with last. During the inspection, we observed the process for three young people, a child under 18 and two young adults who were Lithuanians, who had never been in custody before. Their personal details were checked and instructions, such as how to address staff, were formally read out by the reception officer from a written checklist. All were required, and reminded, to stand up straight during this.

1.20 One of the Lithuanians could not speak English and, despite staff having advance notice, no proper interpreting arrangements had been organised and the other was asked to interpret. This was despite the fact that both were co-defendants facing a serious charge of attempted murder. When the reception officer asked them if they knew why they were at Hydebank Wood, they entered into a discussion that staff could not understand. The procedure was stopped and another young person called in to interpret, which was inappropriate.

1.21 After fingerprints and photographs had been taken, the procedure became slightly less formal. The young people were asked whether their family knew they were in prison and told that they would be allowed to make a telephone call on their houseblock. The juvenile was taken to a private office to call his mother, but reception staff said this was most unusual.

1.22 Young people were not offered refreshments in reception. If young people arrived early enough, reception staff ordered a meal to be taken to the houseblock. Staff said there was also a supply of snacks in a locked fridge for anyone who would miss their evening meal. However, only 73% of young adults, significantly worse than the comparator of 82%, said they had been given something to eat on the day of their arrival. Staff on the juvenile unit said they often made toast for children who had missed the evening meal.

1.23 All new committals were required to have a shower in reception and undergo a strip search. This included juveniles, which was inappropriate. Not all reception staff had received child protection training. Strip searching took place in small individual cubicles. We saw three carried out with only one officer in attendance. In one case, the second officer was out of sight of the search and in another, two searches were conducted by two officers with their backs to each other.

1.24 Young people were usually left to wait in the cubicles rather than using the holding room, which was in poor condition. We were told that occasionally the room was used for up to eight young people, although there was bench seating for only up to five. There was nothing to occupy young people waiting other than some torn magazines in the holding room.

1.25 There was no useful information in reception to assist or reassure new committals. A printed information sheet was neither useful nor accessible to those with reading difficulties. In contrast, there were large notices to staff about child protection and the management of those at risk of self-harm. Two young people were employed as reception orderlies, but there was no peer support.

1.26 Young people could wear their own clothes and there was a good supply of additional clothing in a range of sizes and in good condition. All new committals were given a reception pack (either a smoker's pack or a bag of sweets) to last until they could use the tuck shop the next

day. After reception, new committals were taken to healthcare for an initial health screening before going to an induction landing.

First night

1.27 There was no policy or staff guidance covering first night care. The induction policy included a statement about the need for arrangements to ensure prisoners' safety and well being on their first night, but did not detail what these should be. It also included a list of 'matters for consideration', but this did not include specific requirements for staff observation, the importance of peer support and the role of, and access to, Insiders, or guidance on completing cell-sharing risk assessments.

1.28 Cell-sharing risk assessments were always completed by the senior house officer, with a contribution from healthcare, before new committals were located. In most of those we looked at, the healthcare contribution said there was insufficient evidence to make an assessment and therefore a medium risk was associated with sharing.

1.29 All new committals were supposed to be monitored every 15 minutes throughout their first night, but in practice records indicated that this happened only for juveniles. Children had their own first night and induction landing. They were never located in a double cell on their first night, although most young adults shared on their first night. Sharing was restricted to those with a low risk score, so some young adults were moved from the induction landing before completing their interviews and induction programme to make way for new committals. This did not prevent those scheduled for formal induction sessions from completing their programme.

1.30 Staff completed a committal initial interview booklet before young people were locked up on their first night. However, new committals who arrived on the induction landings after 7pm were simply told basic rules before being locked up, which was insufficient to reassure them and help them feel safe. They had their initial interviews and assessments the following day. This happened four times during the inspection. There was an unwritten policy to keep all new committals in their cells for the first 12 hours or until staff deemed it safe to allow them to associate with others. One young person said staff had told him he would have to spend his first day in his cell in case he posed a threat. In both the juvenile and young adult surveys, significantly fewer than the comparators said they had felt safe on their first night.

1.31 A free £1 credit was made to each young person's telephone account for use on the first night. However, several young people said they had not been offered a telephone call as staff had telephoned their family on their behalf. Late arrivals were not allowed to make a telephone call.

1.32 New committals were given a first night and general information booklet. This was too detailed and contained too much information, including a lengthy section on offences against prison discipline and how prisoner at risk (PAR) procedures worked. It was not a suitable first night guide for young people, most whom had poor reading skills.

1.33 Three Insiders were available to meet new committals, but were not automatically informed when they arrived. Often they could not see new committals even when they were aware of them because they were not allowed to carry out their duties after 7.30pm and one needed an escort (see section on suicide and self-harm).

Induction

1.34 There was a good written induction policy, but it was not being followed and several staff were not aware of it.

1.35 There was a formal induction programme for young adults, but not for juveniles, for whom a specific programme was being developed. In the meantime, basic induction information was delivered to juveniles by class officers as part of the initial interview process and most records demonstrated a good level of interaction between staff and young people as part of this. However, in our survey, only 17% of juveniles, significantly worse than the comparator of 52%, said induction had covered everything they needed to know.

1.36 The formal induction presentation for young adults covered a half-day session and was usually delivered to small groups. Young adults sometimes waited up to a week before staff decided there was a viable group. In our survey, only 39% of young adults, significantly fewer than the comparator of 70%, said they had been on an induction course in their first week and significantly fewer also said it had covered everything they needed to know.

1.37 Most new committals (juveniles and young adults) had an initial induction interview and met key staff such as probation, Opportunity Youth, Family Links and chaplains without undue delay. However, too many young adults did not undertake any form of induction or have access to specialist support. Staff said those on remand often missed formal induction when court appearances and visits clashed with scheduled sessions. Those who had been to Hydebank Wood before were considered not to require induction and fine defaulters or those with less than three weeks in the prison were usually regarded as not needing it.

1.38 Young adults usually stayed on the induction landing for two to three days, while juveniles stayed on the same landing throughout their stay at Hydebank Wood. Education assessments were not carried out for at least two weeks and there was little to occupy new committals during the early days and weeks in custody.

Recommendations

1.39 Reception procedures should be less intimidating with young people greeted courteously by staff and permitted to sit at a table with an appropriate degree of privacy for initial procedures to be carried out.

1.40 Full information should be available to reception and first night staff to inform initial assessments.

1.41 Juveniles should not be routinely strip searched.

1.42 Strip searches should always be conducted by two officers.

1.43 Other young prisoners should not be used to interpret for new committals charged with serious offences or in circumstances where personal information is divulged.

1.44 All new committals should be able to make a free telephone call in private in reception or on their first night location.

1.45 All new committals should be given a meal on their first night.

1.46 Reception waiting areas should be decent and contain relevant information in a range of formats so that it is accessible to all.

1.47 Insiders should be available in reception and for all new committals on their first night.

1.48 The first night guide for new committals should be revised and produced in a range of formats to contain only essential information to enable young people to cope with their first 24 hours.

1.49 All new arrivals, including juveniles, should receive appropriate and consistent induction.

Section 2: Environment and relationships

Residential units

Expected outcomes:
Children and young people live in a safe, clean, decent and stimulating environment within which they are encouraged to take personal responsibility for themselves and their possessions.

2.1 The refurbished Beech House provided good accommodation. Elm and Willow Houses contained some shared cells in poor condition. Toilet screening in double cells was inadequate. External and internal areas were clean and well maintained. Young people had access to clean clothes, but bed linen and mattresses were sometimes grubby. Not all young people were able to use the public telephones easily.

2.2 Beech, Elm and Willow Houses were occupied, but Cedar House was closed for refurbishment (see fact page). Beech House had recently been refurbished and now provided integral sanitation in line with all other units. The programme of refurbishment had led to increased numbers of prisoners having to share cells, many of which were very cramped, with inadequately screened toilets. Juveniles had their own separate landing and all were in single cells. However, they mixed with young adults at education or work, the chapel and visits. This was not risk assessed, although staff had a good informal knowledge of where difficulties might arise.

2.3 Accommodation on Beech House was good. Cells were clean and comfortably equipped and all had duvets and curtains. Accommodation on Elm and Willow was reasonable for those in single cells, but some of the shared cells were in poor condition, including one where the window pane had been missing for a week. This was rectified as soon as we brought it to managers' attention. The cell furniture in Elm and Willow was generally adequate, although some shared cells had broken cupboards and some contained graffiti. The policy on offensive displays (April 2007) was generally enforced except on Beech House.

2.4 Cell-sharing risk assessments were carried out on the committal wing, but new committals often arrived with little background information so most decisions on allocation of cells were based on information given by the young people (see section on first days in custody). The files showed that staff were appropriately cautious when allocating shared cells and tried to ensure than smokers were not located in cells with non-smokers.

2.5 All cells had integral sanitation and sinks, and the tap water was suitable for drinking. Each landing had a hot water urn for making hot drinks. Young people could buy flasks, but these were expensive at £7. Each servery also contained a toaster and microwave oven for use by young people, although instructions on some landings said the microwaves were only for heating up food provided by the kitchen, which was too restrictive.

2.6 No cells had been adapted for people with disabilities. A number of young people were on crutches and had to negotiate stairs. Staff said anyone with a serious disability was located in the hospital wing.

2.7 Cell bells were checked daily and there was little evidence of misuse. Staff responded to them quite promptly. Observation panels were clear.

2.8 Apart from prisoners on the basic level of the progressive regimes and earned privileges scheme (PREPS), all young people had a television in their cell. The association areas were mostly clean and reasonably well equipped, with table football, table tennis and some board games. Notice boards on all residential landings contained most of the basic information, but none explained how to make a complaint (see section on applications and complaints).

2.9 The layout of residential areas, which contained a lot of short corridors, made them difficult to supervise. This was particularly true of the shower areas, which were some distance from staff offices. In our survey, 18% of young people said they had felt unsafe in association areas and a similar proportion said the same of wing showers.

2.10 Young people were not routinely consulted about facilities on the wing. Opportunity Youth had carried out some useful focus groups in June 2007, but there was no indication that any of the issues raised were going to be addressed.

Hygiene, clothing and possessions

2.11 Staff placed a lot of emphasis on high standards of hygiene and young people were encouraged and given the means to keep their cells clean. Young people were expected to keep themselves clean and smart and most did so. In our survey, 78% of young people, significantly better than the comparator of 57%, said they could shower every day. However, many young people in shared cells complained about having to share the toilet facilities, which they regarded as degrading and embarrassing. Young people were issued with basic toiletry items on arrival and replacements where readily available.

2.12 All young people could wear their own clothing, although the policy on permissible clothes was too restrictive. Items had to be washable at 30 degrees and above and suitable for tumble drying. Anyone choosing not to wear their own clothes was offered reasonable quality prison-issue garments. All prisoners had duvets and curtains in their cells. Bedding was laundered centrally every week and young people could use landing washing machines and tumble dryers for their own clothes. Irons were available on request. Some mattresses and pillows were grubby. Many prisoners complained that they were given only one towel a week, which they found difficult to keep dry.

2.13 Property was stored at reception and young people had to make a formal request for any stored items. This usually took two to three days. In our survey, 48% of young people, significantly better than the comparator of 36%, said they could normally get their stored property when they needed it.

Recommendations

2.14 Cells designed for one should not be used for two people.

2.15 All cells should be regularly checked and kept in good condition.

2.16 Toilets in shared cells should be adequately screened.

2.17 Some cells should be adapted for young people with disabilities.

2.18 Soiled mattresses and pillows should be replaced promptly.

2.19 All young people should be provided with flasks.

2.20 Young people should be provided with at least two clean towels each week.

2.21 The offensive display policy should be uniformly applied.

2.22 Young people should be able to use microwaves for products from the tuck shop.

2.23 The policy on the type of clothes young people can wear should be less restrictive.

Relationships between staff and young people

Expected outcomes:
Children and young people are treated respectfully by all staff, throughout the duration of their custodial sentence, and are encouraged to take responsibility for their own actions and decisions. Staff listen, give time and are genuine in their approach. Healthy establishments demonstrate a well-ordered environment in which the requirements of security, control and welfare are balanced and in which all children and young people are treated fairly and kept safe from harm.

2.24 There was relatively little informal interaction or trust between staff and young people. Relationships were not positive and appeared to have deteriorated since our last inspection. Many young men did not believe they were treated with respect or that there was a member of staff who would support them. Most were addressed by surname alone.

2.25 Previous apparent progress in staff-prisoner relationships had not been maintained. Significantly fewer than the comparator and than at the time of the 2005 survey said staff treated them with respect. More also said they had been victimised by staff. Only 50%, compared to 70% in 2005 and against a comparator of 67%, said they had a member of staff they could turn to for help.

2.26 Young men were not positive about their relationships with prison officers and indicated they did not trust them. Many said officers were obstructive and difficult and that some were bullies. They said even some senior managers could be very aggressive towards them and we saw a surprising example of this. All groups had particularly poor opinions of night staff, who they said made lots of noise and were deliberately provocative. The governor confirmed that there had been some recent incidents involving night staff and this had been dealt with.

2.27 Most staff referred to and addressed young men by their surnames alone, although there was an occasional use of first names. There was relatively little informal interaction between staff and prisoners and no regular consultation with them. Some young men said that often the only way to get staff attention was to misbehave or self-harm. However, while relationships were often distant, this was not universal and we saw some good examples of positive and friendly interactions, particularly on the induction and juvenile landings. Young people themselves acknowledged that the generally negative views did not apply to all staff and that some treated them well and could be relied on.

Recommendations

2.28 A prisoners' council should be established to allow senior managers to consult with the young men about routines and facilities and include discussions about how to improve relationships, with regular feedback to all staff and prisoners on action taken.

2.29 Managers should ensure that officers make active efforts to engage positively with prisoners and make regular recorded checks that this is happening.

2.30 Staff should routinely use first names or title and surname when speaking or referring to young men in their care.

Personal officers

Expected outcomes:
Personal officers are the central point of contact for children and young people, providing frequent purposeful contact within the establishment, and proactively establishing and maintaining links with external agencies (especially youth offending teams) and friends, families or carers.

2.31 There was no personal officer scheme and residential officers had little involvement with decisions about young men's resettlement needs.

2.32 There was still no personal officer scheme and therefore no named individual member of staff to whom young men could go for help. There was little engagement by residential staff with individual prisoners about their personal circumstances and they did not usually get involved with prisoners' resettlement needs. There were frequent entries in wing files, but these were almost wholly about behaviour, with little evidence of any in-depth knowledge of the young men, their background or resettlement plans.

Section 3: Duty of care

Bullying and violence reduction

Expected outcomes:
Children and young people feel safe from bullying and victimisation (which includes verbal and racial abuse, theft, threats of violence and assault). Active and fair systems to prevent and respond to bullying behaviour are known to staff, children and young people and visitors, and inform all aspects of the regime.

3.1 Anti-bullying procedures were not sufficiently effective and staff had not been trained in the strategy. The issue had a relatively low profile in the broader context of safer custody work, which also included Ash House. Not all incidents of bullying were reported or investigated, but investigations that did take place were prompt and thorough. There was a need to ensure that young people charged with sex offences and other vulnerable young people were properly protected.

3.2 A safer custody strategy policy and document (2005) consolidated various aspects of safer custody, including anti-bullying, and was overseen by a safer custody committee. This met monthly and was responsible for developing safer custody work across Ash House and Hydebank Wood. The meeting was usually chaired by a senior manager and was generally well attended by managers from most departments except the security department. Insiders also attended, a representative from Willow 1 (juveniles) had been introduced recently and there were plans to include prisoner representatives from all house units. They participated towards the end of meetings and made valuable contributions, but were not specifically asked about their perceptions of the extent of bullying. There was no officer involved in the meeting.

3.3 Most of the discussion at the safer custody meeting related to prisoner at risk (PAR) procedures, often dominated by cases from Ash House. Discussion about bullying was usually limited to a report on the number of investigations and their outcome. The agenda and structure did not sufficiently address the distinct needs and concerns of each group.

3.4 Few potential indicators of bullying were monitored. There was no routine monitoring of non-accidental injuries. The IMR 12 record sheet was used to record all types of injuries seen by a nurse, but did not include a code for non-accidental injuries. The number of and reasons for requests for cell or landing moves were not monitored. There were no effective links with the security department or links made between adjudications for violent acts and bullying. Not all possible bullying incidents were followed up. Some references to bullying in PAR 1 forms had not been referred for investigation. The head of residence had a nominal role as the anti-bullying coordinator, but there was no dedicated safer custody coordinator.

3.5 An anti-bullying incident log recorded all reported incidents of bullying and their outcomes. There had been 23 investigations in 2006 and 15 to date in 2007, only five of which had been substantiated. This was low for this type of population. Officers were reluctant to find incidents substantiated without clear evidence from victims or witnesses. They usually required victims to make a formal statement, which was difficult to obtain as many were concerned about reprisals. In the centre's own survey (2006), five of the seven young people who said they had been bullied had not reported it. A care hotline in visits for families had not been used to report bullying.

3.6 Bullying incident reports (BR1s) could be completed by the victim, witness or the person to whom the incident had been reported, but were not readily accessible to young people. On receipt, senior officers together with other officers completed an investigation (BR2). Those we saw were prompt, thorough and well documented. When allegations were substantiated, the strategy required the anti-bullying committee to convene to decide the most appropriate action, but this rarely happened and decisions were made by the senior officer and the initial enquiry team. When it was deemed there was insufficient evidence to take action, alleged victims were usually offered a move to another unit. Where investigations were unsubstantiated, a verbal warning could be given and formally recorded, but this did not often happen.

3.7 The anti-bullying policy and procedures had last been revised in September 2005 and were being reviewed. The current procedures were ineffective and relied too much on acquiring written evidence or statements from victims before any action was taken.

3.8 No work was done with the few young people identified as bullies to challenge or explore their behaviour. Most were charged with disciplinary offences and relocated. In the previous year, only one had been referred for one-to-one work with the psychologist.

3.9 In our survey, significantly more young adults than the comparator (52% against 31%) said they had felt unsafe at some time. Responses to queries about victimisation by staff and prisoners were also mostly significantly higher than the comparator.

3.10 Managers suggested that most bullying was associated with a small core of young people located on specific landings for prisoners on basic or standard levels and who had become entrenched in negative behaviour. Some were associated with trafficking drugs. Establishing a close supervision unit for the most difficult-to-manage young people was being considered and it was believed that this would encourage more victims to report bullying without fear of reprisal.

3.11 Increasing numbers of young people at risk because of their offence or notoriety were being sent to Hydebank Wood, but their protection was not included as part of the anti-bullying strategy and they were not segregated. Over half of the 14 sex offenders were held on Elm 2 and identified as 'not to move' and some were escorted separately from other young adults. Some said they were afraid to attend the gym when they did not know who else would be there and one had made a formal complaint following threats from young people in a work party visiting his landing. Managers were sensitive to the fact that the last three suicides, albeit several years ago, were young people convicted of sex offences. Others were targeted because of mental health, looks or because they had generally less robust personalities. A small number did not want to join work parties off the landing.

3.12 In our survey, 16% of Catholics, but no Protestants said they had been victimised by staff because of their race or ethnic origin. Twenty-two per cent of Catholics, compared to 7% of Protestants, said they had been victimised by staff because of their religion or religious beliefs. Allegations of bullying by staff were inappropriately included as part of the anti-bullying procedures. If the initial investigation by a principal officer or above was substantiated, the matter was then referred to the deputy governor for a formal investigation, but this was unlikely to inspire confidence among young people. In one case, the officer's name appeared on the anti-bullying log. This was not a satisfactory way to investigate what could be a serious allegation against a member of staff. Young people who believe they have been victimised by staff should be able to complain confidentially to the governor (see also section on applications and complaints).

3.13 There had been no training delivered in the anti-bullying strategy since 2005. This was an issue raised regularly at the safer custody meetings. Although the establishment had identified anti-bullying training as one of its own priorities, we were told that training priorities set by Prison Service headquarters inappropriately restricted the opportunities for more essential and relevant training to be undertaken at Hydebank Wood.

Recommendations

3.14 A safer custody committee specifically for Hydebank Wood young offender centre should be established focusing on anti-bullying, the prevention of suicide and the reduction of self-harm.

3.15 All potential indicators of bullying should be monitored and, where there are concerns that bullying may be involved, the incident should be investigated irrespective of whether the alleged victim has made a written statement.

3.16 The profile of anti-bullying should be improved to create an environment where young people have faith in the anti-bullying strategy, including appointing safer custody liaison officers for each house.

3.17 Effective interventions to challenge bullies and support victims should be developed.

3.18 All staff in direct contact with young people should receive training in the anti-bullying strategy.

Self-harm and suicide

Expected outcomes:
Children and young people at risk of self-harm or suicide are identified at an early stage, and a care and support plan is drawn up, implemented and monitored. Assessment of risk/vulnerability is an ongoing process. Children and young people who have been identified as vulnerable should be encouraged to participate in appropriate purposeful activity. All staff are aware of and alert to vulnerability issues, are appropriately trained and have access to proper equipment and support.

3.19 There had been no self-inflicted deaths in recent years and there were relatively few incidents of self-harm. However, there was an over-reliance on isolation and the use of protective clothing for those at risk, rather than a therapeutic approach. The suicide prevention coordinator did not have enough time to help improve the quality and effectiveness of suicide and self-harm procedures, which were often poor. Training in suicide awareness and peer support for those at risk were insufficient.

3.20 The suicide and self-harm prevention policy for the young offender centre and Ash House had been revised in September 2006, following the publication of the McClelland report commissioned after six non-natural deaths in custody in the service between 2002 and 2004. The report contained some criticism of PAR 1 procedures and some changes were planned. The revised policy included separate annexes for women and juveniles. The short annex for juveniles acknowledged some specific needs, highlighted potential problems faced by children in custody and outlined the role of the Opportunity Youth advocacy service. The service-wide

policy, which was otherwise comprehensive, said little about the specific needs of young people.

3.21 The suicide and self-harm prevention strategy was overseen by the monthly safer custody meeting for both Ash House and the young offender centre (see section on bullying and violence reduction). A senior residential officer acted as the suicide prevention coordinator (SPC) for both the women and young men. Despite the high-risk populations (women, young adults and children), she had no dedicated time for the role. On one morning each week, she provided suicide awareness training for staff. Other tasks included compiling monthly and annual reports for the safer custody committee and liaising with the Samaritans. When time allowed, she monitored the quality of open and closed PAR 1 forms, but sometimes found it difficult to challenge fellow senior officers about poorly completed documents. She was also a point of contact and advice for staff.

3.22 The high suicide rate among young men in the community was not reflected within the centre. There were few self-harm incidents, with an average of two or three a month over the previous year usually involving one or two young people. Cases of particular concern were raised as part of the SPC's report and discussed at the monthly safer custody meetings. There had been few serious near-fatal incidents, but there were no established procedures for investigating these. The SPC had analysed a small number of incidents on her own initiative and this had demonstrated the potential for learning from such analyses (see Ash House 2007 report).

3.23 Initial interviews with new committals included identifying the risk of suicide and self-harm, but these did not always take place on the day of arrival (see section on first days in custody). In our survey, more than twice the comparator said they had felt depressed or suicidal when they first arrived, but only half as many as the comparator said they had received information about support for feeling depressed or suicidal.

3.24 The register of all PAR 1 forms recorded when forms were opened and closed. About six forms were opened each month and stayed open for an average of six or seven days. Two PAR 1s were open at the time of the inspection and the young men involved were in the healthcare centre, where most people requiring observation were usually moved. Healthcare staff were often the only staff apart from class officers present at PAR 1 reviews and there was an over-reliance on healthcare to manage those at risk of self-harm, although there was little therapeutic input.

3.25 Reviews of prisoners at risk were held promptly, arranged by senior officers and coordinated by a safer custody administrative officer. Most reviews were not usually multidisciplinary, despite the important role that others, such as the chaplains and Opportunity Youth, played in the day-to-day support of young people at risk. The chaplains were not always notified of forthcoming PAR 1 reviews (see section on faith and religious activity). The discussion and development of support plans was therefore very limited.

3.26 Almost all support plans were restricted to comments on whether the young person should be in strip clothing, the levels of observations required and whether he should be located in an observation cell. Very few named specific individuals as responsible for ensuring tasks were completed. In most cases, 'all staff' were responsible, which risked no one taking ownership. There was little clear evidence of management checks of any of the PAR 1 procedures.

3.27 One of the open PAR 1s involved a vulnerable young man who claimed to have been bullied. He told us he had been assaulted in his cell, but had not told staff for fear it would get worse. He had been on the basic regime and had no television or credit on his telephone account. He was held in an observation room in the healthcare centre and objected to being put in strip

clothing. His care plan was poor and did not properly address the issues raised. Another young person who had cut himself shortly before the anniversary of his mother's death had been placed in an observation room in safe clothing with safe bedding and without a lighter, but otherwise was given little support.

3.28 Most case reviews failed to identify the underlying reasons for the distress or identify, with the young person, what would help to reduce the risks. It was difficult to find suitable quiet locations for PAR 1 reviews, which usually took place in class offices on unit landings. Staff said the young person was always invited, however the records did not make clear whether they attended. Senior officers were responsible for chairing reviews, but did not retain responsibility for particular cases to maintain continuity. The safer custody meeting had identified the need to train senior officers for their role in PAR 1 procedures, but this had not happened.

3.29 Two safer rooms on most landings had some in-built safety features, however these still contained ligature points. They had no electricity. One safer room on Elm 1 was used as a store room. Young people at risk who needed to be observed were usually put in cells in the special supervision unit (SSU) or healthcare. The safer custody meeting (May 2007) had noted that use of the SSU was inappropriate and the policy rightly identified the SSU should be used only as a last resort for young people at risk if they presented a serious control problem.

3.30 Records kept by the SPC showed that observation rooms in healthcare had been used 10 times for young people at risk of self-harm between July 2006 and August 2007. Use of the SSU for observation was not reported to the safer custody meeting and how long someone was in an observation room was not monitored. Strip clothing was recorded to have been used four times in the same period, however the figures were unreliable and we found a number of references to its use in PAR 1s that did not appear in the monthly statistics.

3.31 There were few good quality entries in the daily record of supervision and most simply recorded observations rather than any interaction with the young person. There was no follow-up interview on closure of a PAR 1.

3.32 A family hotline provided a direct line to healthcare for families who were concerned about their relative. Resources available to support young people at risk included two mental health trained nurses, CRUSE (bereavement counselling), the chaplaincy, Samaritans and Opportunity Youth. However, there were no named key workers to support them at times of crisis and play a central role in their support plans, and only half of the young men in our survey said they had a member of staff they could turn to for help. Calls to the Samaritans from the landing telephones incurred a charge. A free dedicated telephone was also available and young people could request to use it at night by sliding a card under the cell door for the attention of the night guard. A log to record how often it was used was introduced only during the inspection.

3.33 An Insider peer support scheme launched in February 2007 was advertised around the centre. Three young people had been recruited as Insiders, all resident on Beech House. They had received little formal training and few support meetings had been held. They had the potential to provide good support to new committals, but access to them was difficult and it could take up to three days before they made contact. One Insider did not have special privilege status and had to be escorted around the centre. Insiders did not provide peer support for young people during the night and were not involved in induction (see also section on first days in custody).

3.34 Some staff confused the Insider role with that of Samaritan-trained Listeners. The local Samaritan branch had tried to establish a Listener scheme, but had been unsuccessful due to insufficient volunteers. Some staff were not in favour of Listeners because of unease about the Samaritans code of confidentiality, which applied to Listeners.

3.35 Many officers had not received suicide awareness training, a problem regularly discussed at the safer custody meeting. Of around 335 prison grade staff, only 130 had completed a 1.5 hour suicide awareness training session. Twenty-three non-prison grade staff had completed this training. Emergency response boxes were held in class offices, but their contents were not routinely checked. Only night guard staff carried ligature knives. We were given a draft governor's order detailing procedures for the issue of ligature knives to all officers drawing keys, but this had not been implemented.

3.36 Separate to the PAR 1 register was an inmate awareness register completed by healthcare and psychology and circulated to managers. This listed young people who might not have been subject to PAR 1 procedures, but were considered at risk and vulnerable for reasons of age, offence or coping abilities. In September 2007, there were 60 young people on this register. It was not clear how effective this was, but it suggested a need for more case management of individuals to improve the care offered.

Recommendations

3.37 There should be a suicide prevention coordinator (SPC) exclusively for the young offender centre with sufficient allocated time to carry out this role.

3.38 Formal investigations should be conducted into serious or near-fatal incidents to establish what, if any, lessons could be learned.

3.39 Prisoner at risk (PAR 1) procedures should be improved. Reviews should be multidisciplinary, but with less reliance on the role of healthcare staff, and care plans should reflect the individual needs identified.

3.40 Trained senior officers should provide continuity in the management of cases.

3.41 Managers should make regular checks on open PAR 1 forms and make written comments on the quality of care offered.

3.42 Key workers should be identified to work alongside young people at risk of self-harm or suicide. Entries in the daily supervision record should be improved and follow-up interviews conducted following the closure of PAR 1 forms.

3.43 The length of time young people are placed in the observation rooms in healthcare and the special supervision unit (SSU) should be monitored by the safer custody meeting.

3.44 Alternative therapeutic responses to the use of observation rooms and strip clothing should be developed for those at risk of self-harm.

3.45 Young people at risk of self-harm should be held in the SSU only in exceptional circumstances.

3.46 Young people should be able to contact the Samaritans free of charge from landing telephones.

3.47 Peer support should be improved, with a clear programme of training and regular support meetings for Insiders.

3.48 All staff in contact with young people should receive suicide awareness training.

3.49 A Listener scheme should be developed.

3.50 All officers should carry ligature knives.

Housekeeping points

3.51 A suitable quiet location should be found for PAR 1 reviews.

3.52 The contents of emergency response boxes should be checked regularly.

Child protection

Expected outcomes:
The establishment provides a safe and secure environment, which promotes the welfare of the children and young people in its care, protects them from all kinds of harm, and treats them with dignity and respect. There is an openness on the part of the establishment to external agencies and independent scrutiny, including openness with families and the wider community

3.53 The child protection policy had been reviewed and revised, but was still in draft form. Despite the best efforts of the Prison Service, the policy lacked formal agreement with the local area child protection committee or the local health and social services board. In the absence of necessary agreements and working protocols, there was almost no external scrutiny of child protection arrangements and Hydebank Wood was inappropriately investigating its own referrals. Too few staff had been trained in child protection and there was no evidence that protection of children and vulnerable adults (POCVA) checks had been carried out on staff working with children. The environment was not conducive to safeguarding children and promoting their welfare.

3.54 There was no policy for the management of children at Hydebank Wood and in many areas their different and distinct needs were not being met. Some of the fundamental principles of the child protection statement displayed across the centre were not reflected in some of the examples of poor treatment of children that we observed. These included punishments that were tantamount to cellular confinement, depriving children of contact with their families, routine strip searching, a complaints system that lacked confidentiality and the lack of a purposeful regime to meet children's individual needs. Such an environment was inconsistent with safeguarding children and promoting their welfare.

3.55 During the previous 12 months, the child protection policy had been reviewed and revised by a working party involving all three Northern Ireland prisons. A revised draft had been produced in 2007 and sent out for consultation to a range of agencies and stakeholders, including the local health and social services board. It was now being finalised to take into account responses. Its main weakness was that it was reliant on extensive agreement and involvement with the area child protection committee (ACPC) and the local health and social services trust, which had yet to be secured. Health and social services trusts nationally were in a state of flux following a major reorganisation. The child protection coordinator at Hydebank Wood described continuing

difficulties in engaging the local health and social services trust in child protection arrangements. ACPCs nationally were also restructuring and were shortly to become local safeguarding children boards. There were some distinct differences between the relationship between Hydebank Wood and the ACPC and the juvenile justice centre and the ACPC that were difficult to reconcile. For example, the juvenile justice centre was represented on the ACPC, but Hydebank Wood was not.

3.56 The child protection coordinator attended safer custody meetings and individual child protection referrals were discussed. No representative from the local health and social services trust attended. Together with the absence of any involvement with the ACPC, there was no forum for the strategic development of child protection.

3.57 There was no ongoing monitoring or analysis of child protection referrals, but the log showed that most referrals related to fights between young people. There had been 22 child protection referrals since August 2005, only three of which had been made in the previous 10 months. This suggested a level of under-reporting.

3.58 Only 23 of the 39 dedicated staff on Willow House had been trained in child protection. Few staff in key posts involving children who carried out intrusive and sensitive procedures (such as strip searching in reception and visits) had been trained and only three members of healthcare had received child protection training. Managers said that all new staff and staff transferring from other Northern Ireland prisons were required to have completed POCVA checks. New legislation was about to be introduced requiring all staff in contact with children or vulnerable adults to have POCVA checks and a working group had been set up at Northern Ireland Prison Service (NIPS) headquarters to implement retrospective checks on existing staff. However, there was currently no information to confirm how many staff had POCVA checks.

3.59 There was no protocol or agreement between Hydebank Wood and the local health and social services trust about how child protection referrals would be processed and investigated. It had become custom and practice for the child protection coordinator to telephone the local health and social services duty team, who would confirm that they had noted the referral, but no further action was taken on their part. Hydebank Wood was investigating its own referrals, which was inappropriate.

3.60 We examined two serious allegations against members of staff. One was an allegation of physical assault and one an allegation of sexual assault. The former had been investigated by a principal officer from Ash House. The investigation did not have any child protection focus and concluded that 'this was a proportionate and measured response which used minimum force against a perceived aggressor'. The investigation into the alleged sexual assault had been carried out by the senior officer from the juvenile unit. The senior officer had taken a statement from the young person involved and the allegation was subsequently withdrawn.

Recommendations

3.61 The agreement of the local area child protection committee (ACPC) with the revised child protection policy should be secured and a protocol agreed with the local health and social services trust to make the policy and related practices a reality.

3.62 A formal request should be made that the governor of Hydebank Wood is granted membership of the area child protection committee (ACPC).

3.63 An appropriate forum for the strategic development of child protection should be established and should include input from the local health and social services trust.

3.64 Child protection referrals should be monitored and analysed for patterns or trends.

3.65 All staff who come into contact with children should have comprehensive inter-disciplinary child protection training.

3.66 Urgent steps should be taken to ensure that all staff coming into contact with children have protection of children and vulnerable adults (POCVA) checks.

Equality, race and foreign nationals

Expected outcomes:
All children and young people experience equality of opportunity during every aspect of their time in custody, are treated equally and are safe. Diversity is embraced, valued, promoted and respected. The idea that different people have different backgrounds and values is introduced to young people as an integral part of communal living. All prisoners experience equality of opportunity in all aspects of prison life, are treated equally and are safe. Racial diversity is embraced, valued, promoted and respected. Foreign national prisoners should have the same access to all prison facilities as other prisoners. All prisons are aware of the specific needs that foreign national prisoners have and implement a distinct strategy, which aims to represent their views and offer peer support.

3.67 There was a lack of clear guidance about equality and diversity work. Attendance at diversity committee meetings was limited and progress was slow. Equality monitoring broke down access to services by religious background, but combined the figures with women prisoners at Ash House. There was no straightforward way of identifying significant patterns and trends in the young offender centre. There was little awareness of race issues and only a few prisoners were from a black and minority ethnic background. Irish Travellers were a distinct minority group, but staff had little awareness of their particular needs. Work with foreign nationals was increasing and specialist staff were providing some good input.

Equality

3.68 An equality and diversity committee covered both male and female prisoners and was scheduled to meet quarterly, although meetings were not always convened. It was chaired by the governor with overall responsibility for diversity. Not all committee members attended meetings and representatives from the community were seldom present. There tended to be a core group of four or five members, usually members of the chaplaincy team or representatives from education and probation. Male foreign national prisoners attended some meetings and their views were actively sought. Discussions at the equality and diversity committee lacked focus and progress appeared to be inhibited by lack of clear guidance from headquarters in crucial areas, for example what work should be prioritised and what training carried out.

3.69 Of those staff who stated a religion, approximately 93% were Protestant and only 7% were Catholic. However, about 60% of young people were Catholic. Monitoring now broke down access to services and use of discipline measures by prisoners' religious background. This was presented on a monthly spreadsheet, but was not available in a format that allowed

significant patterns or trends to be easily identified. There was some evidence that Catholic prisoners were over-represented at adjudications and on the basic regime. The figures incorporated results for male and female prisoners and it was therefore impossible to distinguish the experiences of each group.

3.70 Two equality and diversity officers worked on diversity issues with young men in addition to their regular wing-based duties. They had not received any specialist training. A job description had been produced, which required them to 'promote equality and eliminate discrimination, to supply guidance and advice to staff and prisoners, to act as a central source of information and to ensure equality of opportunity for all prisoners'. The officers did an effective job assisting individual prisoners, but, without any dedicated time for the role, did not have the time or resources to do more. We spoke to one of these officers, who was professional, fair and respected by his peers and prisoners. He believed his lack of specialist understanding of the Irish Traveller community culture hindered his work.

3.71 Advice from Prison Service headquarters about the responsibilities of public authorities in relation to the Disability Equality Act had been passed to Hydebank Wood in April 2007. To date, no work had been done to address the relevant issues identified.

3.72 Apart from those directly involved in this area of work, there was no evidence that diversity was embraced, valued or promoted. Staff lacked awareness and understanding of issues relating to diversity in general and to sexuality in particular.

Race relations

3.73 There was a published report on the operating instructions relating to race relations. This provided a helpful description of the role of the equality and diversity committee and the equality and diversity officers as well as simple definitions of racial groups and what types of action constituted discrimination. Unfortunately, the document was of little practical value because staff generally had little interest in, or understanding of, race relations.

3.74 Only four young people were from a black and minority ethnic background. We spoke to two, both of whom were on the enhanced wing and appeared content with their treatment. There had been four race-related incidents in the previous year, all of which had been investigated by equality and diversity officers using the generic complaints procedure. The records indicated that investigations had been carried out fairly, but the officers had not received specialist training.

3.75 Eleven young men were registered as having an Irish Traveller background. Those we spoke to were generally negative about their experience in prison. They said they were not properly understood by staff or other prisoners and were sometimes treated disrespectfully. We heard a number of inappropriate comments made by staff about Irish Travellers. Staff had not been trained to appreciate the specific needs of those young people. In the previous week, a representative from an Irish Traveller support organisation, An Munia Tober, had visited Hydebank Wood to establish a formal link.

Foreign nationals

3.76 Ten young male prisoners were from a foreign national background (excluding those from the Republic of Ireland). Those we spoke to were positive about their treatment by staff and other prisoners. In addition to receiving visits from family members, they were given free letters and a free 10-minute telephone call to their home country every week, which was a very good help

in maintaining contact. One young man from Argentina received weekly printed copies of emails from his family.

3.77 One of the equality and diversity officers was also the designated foreign national coordinator. He interviewed all foreign national new committals and made sure their basic needs were met. He also attempted to maintain links with immigration officials, although this was difficult because there was no named link person to deal with. Often decisions were made at a very late stage by the Border and Immigration Agency, which made it difficult to help prisoners plan for their release.

3.78 Translation and interpreting services had been used, but staff preferred where possible to use prisoners or staff to interpret. While this was often appropriate and done with the individual's consent, professional services were not always used when dealing with legal matters, issues relating to vulnerability or other confidential matters.

3.79 A notice to staff (August 2007) reminded them of foreign national prisoners' rights to communicate with officials from their own country. Records in files showed that this instruction was followed.

Recommendations

3.80 The equality and diversity committee should meet regularly, with all designated members or representatives attending, to consider and take action on any identified or potential areas of discrimination.

3.81 A system of monitoring that identifies and highlights areas of under and over-representation should be introduced and monitoring data should distinguish between male and female prisoners.

3.82 The equality and diversity officers should receive specialist training and should be allocated dedicated time to carry out their additional duties.

3.83 Links with Irish Traveller support groups should be strengthened and consolidated.

3.84 A separate system for investigating racist complaints should be introduced and staff appropriately trained.

3.85 The Border and Immigration Agency should be asked to supply a named liaison person so that the prison can help foreign national prisoners prepare for their release or removal.

3.86 Professional interpretation services should be used when legal matters or issues relating to vulnerability are discussed with young people with little or no English.

Good practice

3.87 *The use of email to allow foreign national prisoners to maintain contact with their families was a constructive and progressive initiative.*

3.88 *Weekly 10-minute telephone calls home were a good help to maintain contact with families abroad.*

Contact with the outside world

Expected outcomes:
Children and young people are encouraged to maintain contact with family and friends through regular access to mail, telephones and visits.

3.89 Prisoners found it difficult to access the telephones and there were avoidable delays in mail getting through. Facilities for visitors were good. There was easy access by public transport and the visitors' centre provided a good service. Visiting capacity at weekends was insufficient. Good use was made of family visits to help maintain family bonds.

Telephones and mail

3.90 There were telephones on each landing, but significantly more young people in our survey than the comparator said access was difficult. Young people said they had to ask staff before using the telephones and that telephones were often in use when they wanted to make a call. Not all telephones had privacy hoods. Prisoners found the cost of calls high, particularly to mobile telephones. Arrangements on the juvenile landing were adequate.

3.91 In our survey, 43% of young people, similar to other young offender institutions, said they had problems sending or receiving mail. Incoming mail was logged by searching officers in the visitors' centre and passed to censoring staff before it arrived on the units. As searching officers did not work on Mondays, mail arriving on Saturdays or Mondays was delayed.

Visits

3.92 The prison was reasonably well served by public transport, with special buses from the city centre and outlying areas. Poor signage at the entrance made locating the prison difficult for those travelling by car. In our survey, many more than in other young offender institutions said they received their first visit within their first week. Convicted prisoners were entitled to one visit a week and those on remand three a week. The length of the visits was based on incentives and earned privileges level, which was inappropriate as this penalised families.

3.93 The visitors' centre immediately outside the prison was a good resource. It was well designed, with a comfortable waiting area, toilets accessible to people with disabilities and a well-equipped baby change room. Staff provided visitors with a helpful and friendly first point of contact. Visitors were offered a wide range of practical support, including referrals to the Family Links organisation, NIACRO. This service provided advice and help with transport to prisoners' families in the community.

3.94 The visits area was shared with women prisoners from Ash House and three of the 16 tables were designated for use by them, which was an unsatisfactory arrangement for both. The visits hall was spacious, well decorated and comfortable. The hall was supervised discreetly and the fact that staff at Hydebank Wood did not wear uniform helped. A small crèche was supervised by qualified staff from the visitors' centre. Visitors could buy hot and cold drinks and chocolate from vending machines, but not light meals or snacks. This was a problem for visitors who had travelled some distance and particularly for those taking extended visits over morning and afternoon sessions.

3.95 Visits took place every day apart from Mondays. There were no evening visits. The booking system was efficient and visitors could book in person, by telephone or online. There was only one session on Sundays and visits at weekends were often booked up quickly.

3.96 Usually, 10% of prisoners taking visits were subject to a full search, but this applied to all prisoners during the inspection due to intelligence relating to the smuggling of illegal drugs. Babies were routinely given a rub down search before entering the visits area, which was unduly intrusive.

3.97 Good use was made of monthly two-hour child and family-centred visits. These took place in a specially designed private room and aimed to help prisoners with children and juveniles to spend time with their families and strengthen family bonds. A leaflet explaining the scheme was displayed in the visitors' centre. Prisoners wanting to take part filled out an application form and background checks were carried out in accordance with child protection legislation. Visits were arranged and booked by designated family officers who consulted families. The scheme allowed prisoners to record stories on DVD for their child, have family photographs taken and help children with their homework. In an exceptional example of outreach, we saw one young man estranged from the mother of his child who was able to see his young daughter because visitors' centre staff were prepared to collect her from home and return her at the end of the visit. The scheme was popular and demand was increasing, but it had not yet been necessary to introduce a waiting list.

3.98 Three closed visits rooms were located immediately alongside the main visits area. They were separated from the visits hall only by full-size glass screening, so there was little privacy.

3.99 In the previous six months, there had been an average of 2,200 domestic visits a month to young men in Hydebank Wood and women in Ash House. The drug dog had indicated about 10 times a month and about six visitors a month had been offered and accepted a closed visit. There was no guidance about when such restrictions should be reviewed.

3.100 Despite the generally good arrangements, consultation with visitors was not well developed. The comments book was not readily accessible and contained only one entry for 2007. It was not clear whether this had received a response. A visitors' survey of the whole of the Northern Ireland Prison Service (NIPS) had been carried out in November 2007, but the results were too general to be of much use to Hydebank Wood.

Recommendations

3.101 Access to the telephones should be improved.

3.102 Telephones should be enclosed in booths to allow privacy.

3.103 There should be no unnecessary delays in prisoners receiving their mail.

3.104 There should be clear signposts to the prison, particularly at the entrance.

3.105 All prisoners should be allowed visits of at least one hour.

3.106 Visitors should be able to purchase hot meals or snacks either in the visitors' centre or in the visits hall.

3.107 Babies should be searched only when there is specific intelligence, agreed by a senior manager, that this is necessary.

3.108 Privacy screening should be introduced between the closed visit rooms and the general visits area.

3.109 Guidance on closed visits should specify when decisions to impose restrictions should be reviewed.

3.110 Arrangements for consulting visitors about their experience should be improved.

Good practice

3.111 *The family/child centred visits scheme was an innovative practice that helped to maintain good relationships.*

Applications and complaints

Expected outcomes:
Effective application and complaint procedures are in place, are easy to access, easy to use and provide timely responses. Children and young people feel safe from repercussions when using these procedures and are aware of an appeal procedure. Independent advocates are easily accessible and assist young people to make applications and complaints.

3.112 Young people had to make requests daily for basic regime routines such as showers and telephone calls. Most young people were negative about how requests and complaints were dealt with. Forms were not freely available on all the residential units and the system lacked confidentiality. There was no analysis of requests or complaints to provide useful management information. Responses were not always helpful or respectful and there was no quality assurance. Advocates offered good support to children needing help with complaints.

3.113 Posters explaining the role of the Independent Monitoring Board and the Ombudsman were displayed on the houseblocks, but there was nothing similar to explain how the request and complaints systems worked. The general information booklet given to new committals (see section on first days in custody) included details about requests and complaints, but it was too complicated for young people with poor reading skills. Staff said young people were told how to make requests and complaints at their initial interview, but this was not on the interviewing officer's checklist and there was no evidence in individual files that the information had been given. Requests and complaints were covered at induction, but not all young people attended and there was no formal induction on the juvenile landing. Many young people said they had found out what to do from other young people. Children were helped to make requests and complaints through the advocacy scheme.

3.114 Most young people were negative about how requests and complaints were dealt with and responses in our survey were significantly worse than the comparators. None of those under 18 said it was easy to make a complaint or believed that complaints were sorted out fairly.

3.115 Only Willow House had request and complaint forms freely and confidentially available. Otherwise there were no complaint boxes on houseblocks. All requests and complaints were

entered daily on a database. While this provided a good audit trail, it also meant that every member of staff could access all complaints, which undermined the credibility of the system.

3.116 The system aimed for informal resolution of complaints initially, but this was aspirational given the lack of a personal officer scheme or any organised consultation arrangements. Some staff interpreted instructions to resolve disputes informally as positively discouraging young people from complaining formally and would issue complaint forms only if the young person discussed the complaint first. This inhibited some from making complaints, contributed to the overall lack of confidence in the system and was reflected in the relatively high figures in our surveys for those who said they had been made or encouraged to withdraw a complaint. The promotion of informal resolution of complaints contrasted with the requirement that young people make formal requests daily for basic matters such as a daily shower or telephone call.

3.117 There was no analysis of requests or complaints to identify patterns or trends and no ethnic monitoring of complaints. In the sample examined, most complaints were about verbal abuse and unfair treatment by staff. Most had been dealt with promptly, but the quality of some investigations was poor. All responses were typed and legible, but not all were courteous or helpful and some did not adequately address the nature of the complaint in age-appropriate language. We were told a principal officer quality assured all replies, but there was no evidence of this. Child protection considerations were correctly identified and passed to the child protection coordinator.

Recommendations

3.118 The complaints procedure should be promoted more effectively through notices on houseblocks, individual interviews and induction programmes to ensure that young people know they have a right to complain and how to go about it.

3.119 Young people should be able to access and submit complaint forms confidentially.

3.120 Young people should not be required to make a formal request for a telephone call or a shower or other routine matters.

3.121 There should be a formal system of quality assurance of complaints to ensure that they are fully investigated and that replies are courteous, and directly and clearly address the nature of the complaint.

3.122 Requests and complaints should be routinely analysed to identify patterns or trends.

Substance use

Expected outcomes:
Children and young people with substance-related needs are identified at reception and receive effective support and treatment throughout their stay in custody, including pre-release planning. All children and young people are safe from exposure to and the effects of substance use while in the establishment.

3.123 Substance use assessments were not comprehensive and detoxification protocols did not appear to be followed. Record-keeping was poor. Only voluntary drug testing was carried out

and was effectively compliance testing. Over a third of young adults said it was easy to get illegal drugs.

Clinical management

3.124 The clinical management of young people dependent on long-term prescribed medications, such as benzodiazepines, or alcohol was a cause of concern. New committals were given a urine dip test. According to establishment figures, over 20% of committals at Hydebank Wood and Ash House in August 2007 recorded a dependence on alcohol, 14% on cannabis, nearly 2% on prescription drugs and under 1% on heroin. The figures were not broken down between Ash House and the young offender centre. Nursing staff determined whether a young person required first night symptomatic relief and there were several examples where this had not been provided, despite dependence being recorded. Due to poor documentation, it was not possible to judge whether this was appropriate. There were no specialist staff to complete a comprehensive assessment on the day after arrival and recording of previous substance use was poor.

3.125 The detoxification protocols were not followed. Young people did not receive effective support during or after clinical interventions. Substitution prescribing was undertaken by the visiting psychiatrist.

3.126 All young people were seen by Opportunity Youth within their first week and a committal assessment was carried out. Opportunity Youth staff then identified goals for each individual, including an Open College Network-accredited two-day course that all young people were encouraged to attend regardless of any previous drug or alcohol use or offences.

Drug testing

3.127 Only voluntary drug testing was carried out and was effectively compliance testing. Young people who failed a test were not always referred to health services or Opportunity Youth. Of the 672 new committals to Hydebank Wood and Ash House since January 2007, 513 tested positive to drugs. Eighty-six young people had tested positive (excluding those receiving prescribed medications) in subsequent tests in the same period. The statistics did not state what type of drugs had been identified.

3.128 In our survey, 37% of young adults, against a comparator of 21%, said it was easy or very easy to get illegal drugs. The amount of drugs entering the centre was the main security issue and had increased significantly in the recent weeks. Part of the reason for this was that some young people had been released by the courts on temporary compassionate bail to attend a drug rehabilitation centre and the security department suspected that some were trafficking drugs back in.

Recommendations

3.129 All those who require first night treatment/symptomatic relief following screening and testing should have it prescribed and administered.

3.130 Specialist staff should complete a comprehensive assessment of need to determine suitable stabilisation, maintenance or detoxification regimes.

3.131 Prescribing regimes should be flexible and meet individual need.

3.132 Young people should receive effective support during and post clinical intervention.

Section 4: Health services

Expected outcomes:
Children and young people are cared for by a health service that assesses and meets their needs for healthcare while in custody and which promotes continuity of health and social care on release. The standard of healthcare provided is equivalent to that which children and young people could expect to receive in the community.

4.1 Plans to transfer the commissioning and provision of health services to the HSSPS had been postponed. This had caused uncertainty for staff and had delayed the introduction of new contracts for visiting health professionals and much needed changes, all of which directly impacted on the delivery of good health services. There were many examples of poor patient care and inadequate record-keeping. GP sessions were very short, although there was 24-hour cover. Dentistry provision was good. There was some primary mental health care provision and a consultant psychiatrist provided one session a week, which was insufficient. An in-reach service provided only cognitive behavioural therapy.

4.2 Health service staff at Hydebank Wood were employed by the Northern Ireland Prison Service (NIPS). There were plans for health services to be commissioned by the HSSPS, but the transfer of funding had yet to take place. The healthcare manager post had been held by someone acting into the post, but the substantive manager commenced duties during the inspection. There had been no recent health needs assessment.

4.3 The healthcare centre comprised an in-patient unit, offices and a treatment room, a dental suite and a pharmacy room. Emergency equipment, including a defibrillator, was kept in the treatment room. Some of it was out of date and there were no documented checks of the equipment.

Clinical governance

4.4 The clinical governance lead was seconded from South Eastern Health and Social Services Trust to cover all three prison establishments in Northern Ireland. Clinical governance meetings were held jointly. Some work to introduce clinical governance policies and practices had been undertaken, as had a couple of clinical audit reviews, but the work was hindered by the uncertainty over arrangements for the future provision of health services.

4.5 There were 12 staff in post, including the healthcare manager, seven nursing officers and four hospital officers. Only three staff were mental health-trained, including the healthcare manager who was also a registered general nurse. The other five nurses were registered general nurses. There were four vacant posts, including the senior nursing officer post as a deputy to the healthcare manager. There were usually five staff on duty for the whole establishment during the core day, three in the evening and one at night. Not all staff had received resuscitation training within the previous 12 months, nor had they been trained in child protection. There was no formal clinical supervision in place for the team.

4.6 A GP attended the department every day except Sunday. Sessions were scheduled for three hours, but we saw the doctor spend less than 30 minutes on site. The same GP group provided all out-of-hours cover for the young people.

4.7 Various allied health professionals, including an optician and a podiatrist, provided sessions. The dental service was commissioned from the local Community Dental Service for six sessions a week over four days for both the young offender centre and Ash House. Two experienced practitioners, assisted by qualified dental nurses, covered the sessions, with locum support as necessary. There was one full-time administrative officer based in the main healthcare centre. Various specialist consultants such as an orthopaedic surgeon, a dermatologist and a general surgeon also provided clinics. Staff said occupational therapy equipment had not previously been needed so there were no formal arrangements to obtain any should it be required.

4.8 An electronic clinical information system (EMIS) had been introduced in July 2007, although all the young people also had a paper record. There were several examples of poor record-keeping, including omissions of treatment provided. Treatment plans were sparse. Dental clinical records were generally satisfactory, but dental staff did not routinely consult the clinical records and individual full paper proforma medical histories were not completed.

4.9 The EMIS system was used for prescribing. Prescriptions were faxed to the pharmacy provider, with the original subsequently sent and a photocopy kept at the prison. A card index was also filled out and signed by the doctor and this was considered to be a written order and was used by the nurses to authorise the administration of the medication. A separate administration chart was used to record each dose administered and this was cross-referenced to the card index using code letters to identify the individual medicines. Healthcare staff had already identified that the system was complicated and confusing.

4.10 Special sick supplies were recorded on the EMIS system, but the system did not appear to be subject to audit. Controlled drug registers were maintained in accordance with requirements.

4.11 Paper records were kept and electronic records were stored on the EMIS system on discharge so both could be retrieved if needed later.

4.12 There was a clear policy in the event of an outbreak of a communicable disease and other appropriate healthcare policies. However, the pharmacy polices were out of date and there was no information-sharing policy.

Primary care

4.13 New committals were given an initial reception screen in the healthcare centre, but there was no secondary health screen. They were not seen by a GP unless the nurse deemed it necessary. We saw some examples where young people were not seen, but should have been. One young person who had letters on file from his legal representatives and social worker stating that he was a vulnerable adult with ADHD had his medications prescribed the following day without seeing the GP. Healthcare staff contacted community GPs to confirm medications and other health details, but there was no documented evidence that patients gave consent for this. Young people were given a leaflet about the health services, but this was only available in English.

4.14 Appointments to see a member of the health services team were made through a class officer, who used the prison record information system to book to see a nurse. The nurse used documented triage algorithms before adding them to the GPs next clinic or contacting the GP for a verbal order for medications. The nurse sometimes did not see young people before they left for work.

4.15 There was a range of clinics, but not all were currently run due to staff shortages and young people were not always aware of what was on offer or when. The sexual awareness education clinic had run only once in the previous three months and the smoking cessation clinic twice. Hepatitis B vaccinations were given, but not using the rapid administration course so those who stayed only a short time could have missed out on a course of treatment. Condoms and other barrier protection were not available.

4.16 Sessions provided by allied health professionals such as the optician and the podiatrist were arranged only when it was decided there were enough patients on the list, but waiting lists were not routinely validated. Young people therefore did not always receive timely services. There had not been an optician's session for over four months, which was unacceptable.

4.17 Physiotherapy services were provided by a well qualified member of the physical education department who had excellent facilities, but had only one session a week. He provided excellent individual care and in one case had arranged daily physiotherapy in the form of a walk around the prison grounds to aid a young person's recovery from specialised surgery and treatment. Healthcare staff were unaware of this young man until we brought him to their attention. He had not received regular dressings and did not have sufficient aids to rest comfortably in his cell. Health services staff were not aware of the range of treatments provided within the physical education department.

Pharmacy

4.18 Pharmacy services were provided by a local community pharmacy, with a pharmacist based at the prison. Medicines were stored in wooden cupboards fitted with flimsy locks. Stocks were low. Most medicines were dispensed by the pharmacy provider and labelled for named patients, apart from emergency stock for evenings and weekends. There were also a small number of pre-packs that were not dual-labelled. Named-patient medicines were dispensed in accordance with prescriptions and all other stock was requisitioned using requisition sheets signed by the doctor. Date-checking was carried out regularly by nursing staff. Controlled drugs were stored in suitable cupboards in the treatment room. The controlled drug cupboards were tidy, with date-expired stock separated to await destruction.

4.19 There were twice-daily treatment times for administration of medication. Wherever possible, a twice-daily dosage was prescribed. Young men we spoke to were surprised to hear that health services staff were available at night because they had experienced difficulties in obtaining analgesics during the night. Young men going to court who did not have their medications in possession were given them before they left.

4.20 Medication was delivered to houses by a member of the health services team in a lockable briefcase. However, young people said this often arrived after they had left to go to work or education. Staff said they would take the medication to the patient if this happened, but young people could not recall this ever happening.

4.21 The in possession medication policy we were given was dated 2002, but the pharmacist, who was on leave at the time of the inspection, later indicated that a more recent policy had been adopted in 2005. Not all medications were supplied with patient information leaflets. Each young person signed a medications compact and there was a documented risk assessment to ascertain their suitability for in possession medications. The decision about whether they would have daily, weekly or monthly in possession medications was at the subjective discretion of the nurse and such decisions were not documented.

4.22 There were patient group directions (PGDs) in place for Hepatitis B vaccinations and Chlamydia treatment, but vaccinations such as meningitis C, MMR and influenza had to be prescribed for each individual. Young people could not buy over-the-counter medicines from the tuck shop.

4.23 Young people could not see the pharmacist. The pharmacist received prescribing data, which she reviewed and reported to the medicines and therapeutic committee. This was a joint committee for all three Northern Ireland prisons.

4.24 As there was no GP at the prison in the afternoon or evening, nurses took a verbal order for new committals requiring medication, which was not a satisfactory arrangement. There were several examples of young people not receiving adequate support for their dependency or withdrawal symptoms while in prison. In our survey, one young adult commented: '*I'm in fear for my own safety because I'm on prescription tablets from the doctor and they were taken from me when I came in so now I turn to illegal drugs again which is the reason I went to see the GP at the start.'*

4.25 In our survey, 67% of juveniles said they had a problem coming off drugs when they first arrived and 33% had alcohol problems. Significantly more young adults than the comparator said they had problems with drugs and alcohol when they arrived.

4.26 Some young men were taken off prescribed medications too quickly and the prison's detoxification policies were not followed. Assessments of clinical signs and symptoms were not documented and the decision to prescribe either symptomatic relief or detoxification medication was at the sole discretion of nursing staff. One young adult had been prescribed opiate-based analgesics following orthopaedic surgery, but on his arrival at the prison, one medication had been stopped and the other was prescribed at only half the dose prescribed by the orthopaedic surgeons. Health services staff had also told him that he could have the medication for only a limited time, which was unacceptable. Medical staff said they were guided by nurses about what to prescribe.

Dentistry

4.27 There was a large, airy and well-equipped dental surgery. Emergency oxygen was not available in the surgery, but, together with emergency drugs, was easily accessible. Two experienced dentists, assisted by qualified dental nurses, covered the sessions, with locum support for leave cover. Emergency care was readily available and all patients were seen at the first available opportunity. Weekend emergencies were seen by one of the practitioners on request.

4.28 The dental team managed the appointment system and liaison between surgery and the patients was good. The range of treatments provided was appropriate. There were about 40 new applications a week including Ash House and the sessional throughput of patients was satisfactory, with effectively no waiting list. Oral hygiene instruction was provided for individual patients. General oral hygiene literature and promotion was limited to posters and leaflets. However, the dental team had carried out a needs assessment and intended to provide oral health education to all. Discussions were ongoing regarding the availability of good quality toothpastes and brushes and other oral hygiene aids from the shop.

Secondary care

4.29 A number of secondary care consultants from the acute trust attended the establishment to provide clinics. Arrangements for attending a health services appointment in the community were made with escort services. There appeared to be few cancellations and we were told that any cancellations were monitored monthly by the clinical governance manager, but it was not clear that this also included waiting times. Healthcare staff did not always receive timely information about the outcome of outside hospital appointments.

In-patients

4.30 There were nine in-patient beds, all of which were on the certified normal accommodation of the centre. At the time of the inspection, there was a maximum of five residents, one of whom was the orderly. At least two of the young men were there because of difficulties coping in the main centre and had been there for some time. Most young people admitted to the unit spent no more than a couple of days as an in-patient. One 19 year-old young man was admitted to the observation cell during our visit due to concerns expressed by landing staff. He had serious thoughts of self-harm and suicide and was obviously deeply troubled. A nurse made the decision to put him in protective anti-ligature clothing, but when we met him three hours after admission, he was cold, distressed and angry. There was insufficient documentation to explain the decision to put him into what were effectively strip conditions. Staff said he had a history of drug and alcohol abuse, but his clinical records were sparse and he was not receiving any medication (see also section on self-harm and suicide).

Mental health

4.31 One registered mental health nurse took responsibility for primary mental heath care for the whole establishment including Ash House. Young people were referred to him by landing staff or other agencies such as probation and Opportunity Youth. Patients could not self-refer. The nurse undertook an initial assessment and could refer patients to psychology, Opportunity Youth for counselling or drug and alcohol issues, or to the cognitive behavioural therapy (CBT) in-reach team. He saw most patients within a week of referral, although records showed that the wait had been longer over the summer. Some patients had been discharged from primary mental health services following little or no interventions. There were no day services for those less able to cope with prison life.

4.32 The CBT in reach team was employed by Belfast Trust and had been at the establishment since July 2005. They were commissioned by the Northern Ireland Office following the move of the women to Ash House, but now provided CBT services for the whole establishment. There were 2.2 whole time equivalent therapists who provided 14 therapy sessions a week. Twenty young people were receiving care. The team took referrals from health services staff, the psychiatrist and other agencies. Team members undertook an initial referral consultation to confirm the appropriateness of the referral and to ensure that the patient was aware of the services they could offer. They then provided one-to-one sessions to clients on their caseload. They had an arrangement with the library so that they could suggest available self help books as part of ongoing therapy. They recorded all patient interventions in their own clinical records and did not use the EMIS system. The team was involved in multidisciplinary case conferences about its clients when necessary. The team provided peer clinical supervision to each other.

4.33 A consultant psychiatrist undertook two sessions a week, one of which was supposed to be for the young people. However, she did not always attend the prison on the days specified. She

kept her own client list and organised when she would see her patients. No child and adolescent mental health services were provided.

Recommendations

4.34 The health needs assessment of the young people at Hydebank Wood should be reviewed and services to meet their specific needs should be commissioned and provided.

4.35 All emergency equipment should be checked regularly to ensure that it is in date and fit for purpose; documented evidence of such checks should be kept.

4.36 All health services staff, including allied health professionals, should have annual training in resuscitation and child protection.

4.37 Clinical supervision should be available to all health services staff.

4.38 There should be formal arrangements for the loan of occupational therapy equipment and specialist advice to ensure that patients are able to access mobility and health aids if required.

4.39 Dental staff should have access to young people's clinical records and complete medical history sheets for each patient.

4.40 The special sick policy should be reviewed regularly by the medicines and therapeutic committee to ensure that all appropriate medicines can be supplied.

4.41 All pharmacy polices should be formally reviewed and adopted via the medicines and therapeutic committee.

4.42 There should be an information-sharing policy with appropriate agencies to ensure efficient sharing of relevant health and social care information. It should include the need to obtain a patient's consent when appropriate.

4.43 Following a reception screening, a further health assessment should be carried out by trained staff no later than 72 hours after the young person's arrival in custody.

4.44 The rapid vaccination course for Hepatitis B should be adopted.

4.45 Barrier protection (condoms and lubricants) should be freely available.

4.46 Health services staff should liaise with the physical education department to ensure that young people can take full advantage of the physiotherapy services offered.

4.47 All pre-packs should be dual-labelled. When the pre-pack is dispensed against a prescription, one label should be removed and attached to the prescription chart, which should then be faxed to the pharmacy provider so that the pharmacist can satisfy him/herself that the prescription was appropriate and that the correct item has been supplied.

4.48 Patient information leaflets should be supplied wherever possible. A notice should be displayed to advise patients of the availability of leaflets on request.

4.49 Decisions about daily, weekly or monthly in possession medications should be clearly documented.

4.50 There should be patient group directions (PGDs) for all vaccinations.

4.51 Over-the-counter medicines should be available for young people to buy from the tuck shop.

4.52 Young people who arrive with ongoing dependence on prescription medications should be carefully assessed and monitored before any detoxification regime is commenced.

4.53 Arrangements for attendance at outside hospital appointments, including waiting times and cancellations, should be subject to audit.

4.54 The in-patient beds should not form part of the prison's certified normal accommodation.

4.55 Admission to the in-patient unit should be decided on clinical need.

4.56 Day services should be available for those less able to cope with prison life.

4.57 Psychiatric services should be reviewed to ensure that there are sufficient resources to meet the needs of young people, including child and adolescent services.

Housekeeping points

4.58 All clinical records should be contemporaneous and conform to professional guidance from regulatory bodies.

4.59 The use of prescription forms, card index and administration charts should be revised to avoid the need for duplication and transcription. One chart should be used for prescriptions and administration record.

4.60 All policy documents should be up to date and redundant documents removed.

Section 5: Activities

Education, training and library provision

Expected outcomes:
Learning and skills provision meets the requirements of the specialist education inspectorate's Improving Quality: Raising Standards Inspection (IQ: RS) Framework (separately inspected by specialist education inspectors).

5.1 There was no strategic approach to the provision of education and training for young people. There were waiting lists for most courses, but available places were under-utilised. Juveniles had few opportunities to acquire useful work-related skills. Education and training were not linked effectively to resettlement planning. Access to the library was poor.

5.2 There was no strategic approach to the provision of education and training for young people. Lines of communication were weak and there was no education and training policy that clearly articulated how the learning and skills needs of all of young people were to be met. Planning to meet the individual needs of juveniles was particularly poor and access to a coherent package of education and training to meet their particular needs was inadequate.

5.3 The provision of education and training was not linked effectively to resettlement planning or to young people's specific education and training needs. Resettlement plans were reviewed, but these were largely ineffective in identifying whether individual learning needs had been addressed or met.

5.4 About 200 of the 272 education places and 74 of the 82 work places were allocated. This under-use of capacity was due to conflicts in the scheduling of other elements of the education and training provision. In both, class sizes were often small, attendance was generally poor and waiting lists were held for most courses. In education, there was poor infilling of young people from the waiting lists. Over the previous year, 80% of all young people had been assessed at or below entry level three in literacy and numeracy. However, at the time of the inspection, only about 14% were having their literacy needs addressed and only 13% their numeracy needs.

5.5 Young adults could work in a good range of workshops including plumbing, carpentry and joinery, bricklaying, industrial cleaning, catering, and painting and decorating. Workshops were well equipped and young people produced good standards of work. With the exception of industrial cleaning and catering, progression opportunities were limited due to the low level accreditation offered.

5.6 Literacy and numeracy classes were available across a range of levels. However, there was no provision in numeracy for those assessed as below entry level two, which was unsatisfactory. Although initial assessment procedures now included a tool to screen for dyslexia, the process was not sufficiently robust. Young people were not always required to produce a piece of free writing of sufficient length to allow a judgement to be made on their level of need. English for speakers of other languages (ESOL) classes were available, but no accreditation was offered.

5.7 A satisfactory range of courses was offered to develop young people's personal and social skills. These included money management, cookery, art, craft, parenting, music and enhanced thinking skills. In art, young people were encouraged to submit pieces of work for competitions and were often successful in gaining awards. Cookery was a popular class and attendance was good.

5.8 The provision of education and training opportunities for juveniles was very poor. The only discreet provision offered was craft. Only one juvenile was accessing vocational training. Many were on waiting lists for literacy, numeracy and personal and social development classes, which was unsatisfactory. The need to provide a discreet, coherent provision of education and training for those under 18 was not recognised.

5.9 In the previous year, achievement rates had been good in literacy and numeracy for the few young people who completed their courses. Achievement rates were also good on many of the courses aimed at improving personal and social skills. All those attending drug and alcohol awareness programmes were successful in achieving some level of certification. In industrial cleaning and catering, achievement rates were good and effective external links had been established to allow young people to complete their qualification or to progress to employment. Achievements in plumbing and information and communications technology (ICT) were poor. The collection and analysis of data regarding young people's achievements were poor in many areas of the education and training provision.

5.10 Teaching was good across most of the provision. In literacy, teachers planned well to meet the needs of individual prisoners and in catering, literacy support had been introduced for those experiencing difficulties in completing tasks for their vocational portfolios. Some of the teaching in numeracy relied heavily on the use of worksheets or material that was of little interest or relevance to young people.

5.11 Quality assurance and self-evaluation procedures were weak and underdeveloped, and there was no coherent approach to the coordination of the quality assurance processes. The use of data and key performance indicators to inform decision-making and development planning was ineffective. Evaluation of the quality of teaching and learning was insufficient.

Library

5.12 The library was managed by the Northern Ireland Prison Service (NIPS), but was stocked by the South Eastern Education and Library Board (SEELB). It was staffed part-time for two full days a week by an appropriately qualified and experienced librarian employed by the prison. Use of the library was recorded satisfactorily daily and monthly.

5.13 The library provided a good range of fiction and non-fiction books, but had a limited selection of resources that matched the range of training provision on offer, including underpinning book resources for plumbing and brickwork. There was only limited access to a range of suitable magazines and no daily newspapers. A range of easy learning books and quick reads for the less confident reader, large print and talking books was sufficient to support those with literacy and language needs. There was appropriate access to Prison Service information.

5.14 There was a range of books in a number of Eastern European and European languages as well as Chinese to meet the increasing number of foreign national young people. There were also a number of Polish newspapers and magazines.

5.15 There was limited space for self study and access to only one computer and printer with no link to the internet. There were no appropriate CDs. A touch screen information point provided

access to Northern Ireland Government sites giving information on employment, housing and welfare benefits.

5.16 Access to the library was poor and significantly fewer than the comparator in our survey said they were able to attend once a week. Young people who attended education classes on Monday and Wednesday could use the library at that time, but those in work had to rely on prison officers being available to escort them. Access in the evenings depended on regime movements and availability of escorts. Those going in the evening could exchange books, but could not ask the advice of a professional about suitable books or resources. The librarian provided a range of books to the secure unit every six months.

Recommendations

5.17 The use of existing education and training capacity should be improved.

5.18 Links between education and training provision and resettlement planning should be improved.

5.19 Young people should have improved access to the library. Access to the ICT facilities in the library should be improved.

Physical education and health promotion

Expected outcomes:
Physical education and related facilities meet the requirements of the specialist education inspectorate's Improving Quality: Raising Standards Inspection Framework (IQ: RS) (separately inspected by specialist education inspectors).

5.20 There were good physical education (PE) facilities with suitable programmes for young men and several good training opportunities. The young people who attend the gym regularly were positive about the opportunities available. Good remedial gym was provided.

5.21 Indoor and outdoor facilities included a large sports hall, a gym with resistance machines and free-standing weights as well as cardio-vascular machines, two grass and two all-weather pitches. The indoor facilities were being refurbished.

5.22 The physical education (PE) provision was staffed by two managers and seven instructors. Staff interacted effectively with young people and encouraged them to take active part in the sessions. Effective one-to-one coaching helped young people develop their skills and levels of enjoyment. The activities included indoor and outdoor soccer, volleyball, basketball, badminton, unihoc and softball. Young people also improved their fitness levels through weight training and the use of cardio-vascular machines. Staff arranged occasional soccer matches against visiting teams and encouraged young people to take part to increase their confidence and self-esteem.

5.23 Courses on offer included weight-lifting star awards, canoeing, gym instructor's awards, the Duke of Edinburgh Award scheme, manual handling and first aid. Achievements and outcomes were good. Some of the opportunities to take part in outdoor and adventurous activities had recently been curtailed.

5.24 Fitness assessments were voluntary. Sports therapy treatment, adapted PE sessions and one-to-one weight loss programmes were offered to those who did not visit the gym regularly. Juveniles were offered three sessions a week and other young people were offered five. In our survey, 59% of young people, significantly better than the comparator of 49%, said they went to the gym at least twice a week.

5.25 Changing and showering facilities were satisfactory and supervised appropriately. Recent refurbishment work had provided good levels of individual privacy. Clean kit and fresh towels were issued to all young people each time they used the gym.

Recommendations

5.26 The range of vocational courses leading to qualifications should be developed further to meet the needs and interests of all young people, particularly those who do not attend the gym regularly.

5.27 The range of outdoor and adventurous activities available should be developed further subject to suitable risk assessments.

Faith and religious activity

Expected outcomes:
All children and young people are able to practise their religion fully and in safety. The chaplaincy plays a full part in the establishment's life and contributes to the overall care, support and resettlement of children and young people.

5.28 The spiritual and pastoral needs of all young people were well catered for. The chaplaincy team was well respected and played an active and prominent role in the work of the young offender centre.

5.29 In our survey, significantly more than the comparator said it was easy to see a religious leader of their faith in private and more said their religious beliefs were respected. Just under 62% of young people were registered as Catholic. The others were from a variety of Christian denominations, with one young person registered as Muslim. In our survey, Catholic young people were less positive in some of their responses than Protestants. Only 67% of Catholics, compared to 83% of Protestants, said they could speak to a religious leader of their own faith in private and 22% of Catholics, compared to just 7% of Protestants, said they had been victimised by staff because of their religion or religious beliefs.

5.30 Two religious services were held each week, one conducted by a Catholic chaplain and the other, a combined service, by a Methodist chaplain. Both took place on Sundays and could be attended by up to 60 prisoners. Young people were asked on the morning of the service if they wanted to attend. They had to be registered for the appropriate service to do so, but could change this by completing a simple form. Ecumenical services open to young people from all religious backgrounds were held twice a year.

5.31 A chaplain visited each residential area every weekday. He knew a lot about the personal circumstances of many young people and, being a local chaplain, was often familiar with their family circumstances. He introduced himself to all new committals and was prepared to come in at weekends if necessary, such as if someone suffered bereavement. He had a high profile

on the units and appeared to be trusted and respected by staff and young people. His engaging style made it easy for young people to speak to him and he went to impressive lengths to attend to their pastoral and spiritual needs. The chaplain occasionally attended prisoner at risk (PAR 1) reviews for those he had knowledge about, but was not always notified of these.

5.32 The chaplaincy team had access to a fund provided by the Saint Vincent de Paul Society. This was widely used to support prisoners without funds, such as those who needed money to make telephone calls. The chaplaincy also advocated on behalf of individuals when they thought they were not getting proper care.

5.33 The chaplaincy gave good support to those from minority groups, particularly foreign nationals, by making arrangements for them to practice their faith. With an increasing number of Eastern European young men, this had meant identifying religious leaders from Orthodox faiths.

5.34 The chaplaincy team was made up entirely of Christian ministers. Members held regular meetings and worked well together. There was no designated lead chaplain, but the chaplains respected each other's approach.

Recommendation

5.35 Chaplains should be formally invited to all prisoner at risk (PAR 1) reviews.

Time out of cell

Expected outcomes:
All children and young people are actively encouraged to engage in out of cell activities, and the establishment offers a timetable of regular and varied extra-mural activities.

5.36 For those with an allocated activity place, time out of cell was adequate. However, there were wide fluctuations and young people not allocated an activity spent most of the day in their cell. There was no scheduled time in the fresh air. Evening association was regularly cancelled due to unnecessarily restrictive staff-prisoner ratios. The times in the published core day were not adhered to.

5.37 The written core day routines allowed for young people to be unlocked for a maximum of just under 10 hours a day. However, very few young people were actually unlocked for this amount of time. The reality for most was that those with an allocated activity place had a reasonable amount of time out of their cells, but those without one (a considerable proportion) could spend up to 20 hours a day in their cell. In our survey, only 8% of young people said they spent 10 hours or more out of their cell and 30% said they spent less than four hours a day unlocked.

5.38 There were insufficient activity places to occupy all young people and poor take-up of available places (see section on education, training and library provision). In the middle of one afternoon, we found 95 young people (nearly 50%) on their wings, only about 30 of whom were involved in scheduled purposeful activity (mostly cleaning). The rest were either locked in their cells or had been unlocked by staff to use the shower, make a telephone call or to do some unpaid cleaning. There was no scheduled time for exercise in the fresh air and some young people went for some time without outside exercise.

5.39 Evening association was scheduled every weekday, but was frequently cancelled. Industrial action in the summer had meant it was cancelled almost every day. Three staff had to be available on each landing before young people could be unlocked for association, which was extremely restrictive and not based on any objective assessment of risk. During the inspection, seven children on the juvenile unit remained locked up one evening even though there were two staff on duty unoccupied.

5.40 Scheduled core day times were also not adhered to. Late starts to sessions and early lock-ups were routine. Staff were usually to be found at the main gate, waiting to break off at least 15 minutes early. Again, this impacted adversely on prisoners' time unlocked.

Recommendations

5.41 Unlock and lock-up should take place at the published times.

5.42 Staffing ratios should be reviewed to ensure they are appropriate to the risk posed by prisoners.

Section 6: Good order

Security and rules

Expected outcomes:
Security and good order are maintained through positive relationships between staff and young people based on mutual respect as well as attention to physical and procedural matters. Rules and routines are well publicised in a format that children and young people are able to understand, proportionate, fair and encourage responsible behaviour.

6.1 Dynamic security was improving, but systems were underdeveloped. A considerable amount of illegal drugs had entered the establishment recently and presented a significant risk to security and to safety generally. Searching practices were excessive and ineffective.

6.2 A security and standards audit in February 2007 had been critical of the lack of local policies. Hydebank Wood had subsequently reviewed many areas of practice and produced a local security document that reflected the Northern Ireland Prison Service (NIPS) corporate plan of 2007-09. Other areas reviewed included drug and substance misuse.

6.3 Physical security was good. Following the escape in 2006 of a young offender, the fence perimeter had been reinforced and additional cameras installed. A palm recognition system and cell door key fobs strengthened physical security. Movement within the prison was very controlled, with most prisoners escorted during movements. The only exception to this was young adults on Beech House assessed as low risk.

6.4 Security issues were given a high priority and there were ongoing concerns about the risks posed by known gang members, feuding families and those with a paramilitary background. The restrictions in accommodation (Hydebank Wood comprising the entire young offender and female estate in Northern Ireland) resulted in some operational difficulties about how to manage individuals and their interactions. Managers could only separate women on different landings.

6.5 Dynamic security was improving and was noticeably better than in the other establishments in Northern Ireland. However, some staff remained reluctant to commit information in writing and the number of security information reports (SIRs) was relatively low. Security staff often had to submit SIRs on behalf of other staff who would only telephone through information informally. The security department had recently identified residential staff to act as security liaison officers, but these new roles were not yet embedded.

6.6 The main security issue was the amount of drugs entering the establishment, which had increased significantly in the weeks before the inspection. This was suspected to be directly related to prisoners being released by the courts on temporary compassionate bail to attend a drug rehabilitation centre. The security department suspected some of trafficking drugs back in on their return. Other than following a drug dog indication on a visitor, a young person could not be placed on closed visits unless he was found guilty on adjudication of attempting to receive unauthorised items. There was no protocol for placing someone on closed visits based on intelligence, no matter how firm, that he was planning to smuggle drugs or other contraband in through visits. This severely hindered Hydebank Wood's supply reduction strategy as staff

had to try and intercept drugs as they were passed rather than take proactive steps to prevent the drugs entering in the first place.

6.7 Security information was reasonably well managed and dealt with promptly, although there was only limited sharing of information and no differentiated analysis of security information between women and young people. The search and standby team responded quickly to most targeted intelligence for searching, but the amount of illicit items found in random and targeted searches was very low. The establishment had just reintroduced intelligence-based target testing of prisoners for drugs, but as yet had no meaningful management information on trends of usage.

6.8 The number of cell searches and strip searches of young people (routine and targeted) was unnecessary and disproportionate to the risk posed. Every cell was searched on average every two to three weeks, but there had been no more than 20 confirmed drug finds from searches in the previous six months. The level of searches was justified as a measure to find illegal drugs, but the large amount of drugs coming in was a relatively recent problem and the low volume of drug finds called into question the efficacy of this practice as a supply reduction measure. Rather it reflected a too restrictive approach to security arrangements for young people, including very little free movement around the site, with almost all young people having to be escorted. This was exacerbated by having to share the site with women.

Categorisation

6.9 There was no formal categorisation system for prisoners in Northern Ireland operating at the time of the inspection. There were some assessments of risk, but these were largely linked to the initial offence and invariably young people (apart from those having temporary release) were classified as high risk of escape. Consequently, most prisoners were escorted in handcuffs, which was excessive. A few young people transferred to Maghaberry and Magilligan, but most spent their whole time in custody at Hydebank Wood.

6.10 New arrangements were about to be implemented that would result in prisoners' security categories being reviewed.

Recommendations

6.11 Procedures governing closed visits should be reviewed to enable proactive decisions to be made based on firm intelligence.

6.12 The number of routine cell searches should be reduced and the searching strategy should be reviewed to find more efficient and effective ways of tackling supply reduction.

6.13 Dynamic security should continue to be promoted and clear job descriptions drawn up for the security liaison officers.

6.14 Opportunities for more free movement around the young offender centre should be increased.

6.15 The role of the security liaison officers should be reinforced by residential managers and staff should be encouraged to submit security information based on their own observations.

6.16 Security bulletins should be posted on the prison intranet for staff information and guidance.

6.17 The security committee should include representatives for education, workshops and other departments that have direct dealings with prisoners.

Discipline

Expected outcomes:
Disciplinary procedures, the use of force and care and separation are minimised through preventative strategies and alternative approaches: they are not seen in isolation but form part of an overall behaviour management strategy in the establishment. Disciplinary procedures are applied fairly and for good reason. Children and young people understand why they are being disciplined and can appeal against any sanctions imposed on them. Children and young people are physically restrained only as a last resort and when no other alternative is available to prevent risk of harm to the young person or others. Children and young people are held in the care and separation unit for the shortest possible period.

6.18 Disciplinary procedures were carried out appropriately, but punishments were harsh, particularly for children, and alternative ways of improving young people's behaviour were not considered. Agreed guidance on punishment levels was often not followed and unofficial punishments were used. Use of force levels were reasonably low, but the quality assurance processes were not sufficiently robust. The special supervision unit was temporarily closed for refurbishment, but had previously been overly punitive and austere. The governance arrangements for special accommodation were inadequate.

Disciplinary procedures

6.19 Adjudications were held in a room above the temporary special supervision unit (SSU). The procedures were reasonable, but the environment was over-formal and not age-appropriate.

6.20 Opportunity Youth had started an advocacy service for juveniles about six months previously. After a slow start, this was becoming embedded and accepted by staff. Awareness of the service among young people had increased, mainly through word of mouth. However, the service still relied on SSU staff informing Opportunity Youth daily of any adjudications involving juveniles, which risked some being missed.

6.21 All adjudications were tape-recorded, but there were no written records so senior managers could not easily carry out quality checks. The hearings we listened to were thorough and full explanations were given. There was some evidence that Catholic prisoners were over-represented at adjudications. The punishment guidance was two years old, not regularly reviewed through standardisation meetings and overly punitive. Regular punishments included cellular confinement for minor offences such as being rude to staff; loss of all association often for long periods of time, which effectively amounted to cellular confinement and was inappropriate for young people; and no use of the telephone, again for long periods of time and inappropriate, particularly for children.

6.22 One juvenile was subject to six weeks loss of all association and banned from using the telephone for 28 days. Following an argument with a member of staff while on his way to the visits hall, he was then also denied his planned visit with his mother. He was very distressed

as he had not been able to communicate with his mother even by letter because he could not read or write.

6.23 In all the cases we reviewed, the adjudicating governor ignored published tariff guidance and gave more severe punishments without justification or reason. The overall emphasis of the adjudication process was exclusively punitive. No consideration was given to introducing concepts of restorative justice, partial remission of punishments based on improved behaviour or other motivational tools.

6.24 There were several examples of staff issuing unofficial or group punishments, including removal of the wing microwave, a ban on using the hairdresser and denying access to association.

Use of force

6.25 There were about 75 uses of control and restraint a year, which was a relatively low number for a young offender institution.

6.26 Four staff members were detailed to work in a search and standby team (SST) every day. The team carried out the rare planned interventions and acted as the response team to any general alarms. When a spontaneous incident occurred, residential staff would contain it and hand over any restrained prisoners to the SST, who would relocate them in their cell or the special supervision unit (SSU). The SST had been established a couple of years before in response to a perceived increased risk caused by overcrowding while Ash, Beech and Cedar Houses were refurbished. It was due to be disbanded in January 2008.

6.27 Most of the paperwork relating to incidents in 2007 was adequate. However, the reasons given for use of force on a significant number of completed forms were mechanistic and vague and the information about incidents was insufficient. Reports completed by the SST were better than those by residential staff, but the latter were more critical as they should have detailed why force was deployed in the first instance. A few of the reports from spontaneous incidents contained no paperwork from staff who initiated the incident and it was therefore not possible to determine that the force used had been appropriate or legitimate.

6.28 A use of force committee had been set up in 2006, but had met only twice in 2007. Meetings were chaired by the senior officer who managed the SST and was also the control and restraint coordinator. No senior managers routinely attended. The committee's main role was to review all incidents where force was used, but there was no evidence this was happening. In a few incidents, it was not clear that force had been used as a last resort and there were other situations that could have been resolved differently. None of these had been identified by the use of force committee.

6.29 Only around 60% of staff had undergone control and restraint refresher training in the previous year. The reason given was staff shortages.

6.30 When an alarm bell sounded, the entire establishment was locked down until the incident was resolved. This was disproportionate and unnecessary.

Special accommodation

6.31 Two cells in the SSU referred to as observation cells were totally bare apart from a concrete plinth and were clearly special accommodation. None of the safeguards required with the use

of designated special accommodation were in place and the governance arrangements for these cells were unacceptable. No records were kept of their use, no prior authorisation was ever obtained and no continual observation logs were maintained. The cells were mainly used for de-escalation when young people were brought to the SSU under restraint or close escort. Staff said young people were kept there only a short time until they had calmed down, but during our pre-inspection visit we found two young men in the cells who were calm and compliant. Use of force forms also showed that young people had been put in these cells as punishment for misbehaviour while in the SSU.

6.32 The establishment recognised the previous shortcomings and was preparing draft protocols for the use of special accommodation. It was unclear what would happen while the SSU was refurbished.

Segregation

6.33 The special supervision unit (SSU) had closed for refurbishment the week before the inspection and was due to remain closed for at least three months. In the interim, segregated young people were located in four cells at the end of the committal landing separated by a gate. This was not ideal as the staff were located upstairs, but efforts had been made to keep numbers down. During the inspection, only two young people were in the temporary SSU, both serving adjudication punishments of cellular confinement. However, the records indicated that some young people had inappropriately been placed in the SSU solely for self-harm issues.

6.34 The SSU regime was basic. Young people were offered a shower, exercise and a telephone call, but even these could not be guaranteed on busy days, such as when there were several adjudications in the morning. The SSU exercise yard was closed during the refurbishment. Young people were supposed to be able to use the yard outside Elm House, but this did not happen. One young person in the SSU had been out on exercise only once in seven or eight days. There was no input from education or the gym.

6.35 In-cell provision for young people on cellular confinement had improved and they were now allowed basic possessions, such as reading material and a radio. They were not allowed tobacco in possession, but staff could issue up to four cigarettes a day. This arrangement, which was not included in any written policy, was open to abuse and likely to exacerbate bad behaviour.

6.36 Young people on Rule 32 were also held in segregation cells for 48 hours following a positive indication from the passive drugs dog. There were no records of any drugs being recovered from a young person under these procedures.

6.37 Relations between staff and young people in the old SSU had been formal and relatively distant. Staff around Hydebank Wood, including those working on the SSU, continued to refer to the unit as the punishment unit verbally and in writing.

Recommendations

6.38 A behaviour management strategy should be developed for Hydebank Wood, incorporating recognised best practice in managing the behaviour of young people and in consultation with Opportunity Youth and other external youth agencies.

6.39 The adjudication room should be made a more age-appropriate environment for children.

6.40 There should be a written record of adjudication hearings to ensure that managers are able to scrutinise and evaluate disciplinary procedures.

6.41 The reasons for the disproportionate number of Catholic prisoners placed on report should be investigated and appropriate action taken as necessary.

6.42 A more robust system for ensuring that the advocacy service is made available to all children facing disciplinary charges should be introduced.

6.43 Guidance on appropriate levels of punishments should be updated to make punishments more commensurate with offences and should be subject to regular review through standardisation meetings.

6.44 Adjudicating governors should not make punishments in excess of the published tariffs without providing a reason or justification.

6.45 Partial remission of punishments and other means of encouraging good behaviour should be considered for prisoners in the special supervision unit (SSU).

6.46 Prisoners should not be subject to informal or group punishments without the safeguard of going through a formal disciplinary process.

6.47 All staff involved in an incident involving the use of force should complete the relevant paperwork on the same day.

6.48 The use of force committee should be chaired by a senior manager, meet monthly and robustly analyse every use of force incident in order to satisfy members of the legitimacy of the intervention.

6.49 All staff should be refreshed in control and restraint techniques every 12 months.

6.50 The practice of locking down the entire establishment whenever an alarm bell is activated should cease and more appropriate arrangements introduced.

6.51 All unfurnished cells should be formally designated as special accommodation with a protocol specifying how they are to be used, with authorisation at an appropriately senior level, and the formal procedures for the use of special accommodation followed.

6.52 Young people should not be located for up to 48 hours in the segregation unit solely on the basis of an indication by the passive drug dog.

6.53 SSU staff should be selected to work there by the governor based on their commitment to work constructively with difficult and challenging young people and a willingness to move away from the customs, practices and terminologies of the past.

6.54 Young people in the SSU should be allowed tobacco in possession.

6.55 All young people in the SSU should receive the minimum regime entitlements of a shower, telephone call and time in the fresh air every day, regardless of the number of adjudications scheduled.

Incentives and earned privileges

Expected outcomes:
The primary method of maintaining a safe, well-ordered and constructive environment is the promotion and reward of good behaviour. Unacceptable behaviour is dealt with in an objective and consistent manner as part of an establishment-wide behaviour management strategy. Children and young people play an active part in developing standards of conduct.

6.56 The progressive regimes and earned privileges scheme was clear and understood by young people. There were sufficient financial incentives to motivate young people, but the inclusion of visits and telephone access penalised families and risked undermining resettlement prospects. Some prisoners remained on the basic regime too long. Monitoring was not sufficiently robust.

6.57 A Northern Ireland Prison Service framework for a progressive regimes and earned privileges scheme (PREPS) was in draft. It included annexes to allow each establishment to incorporate its own location-related policy elements. For Hydebank Wood, this included separate policy elements for Ash House and the young offender centre.

6.58 The policy for the young offender centre was last revised in April 2007. All young people signed a PREPS compact. They started on the standard regime and promotion required them to engage in development activity as outlined in their resettlement plan. Resettlement plans were officially linked to PREPS and anyone not consenting to a plan was reduced to basic level. In practice, however, there was not enough work or activity for all young people (see section on activities). Young people who received 'good' reports from their class officer could be promoted to the enhanced regime. They also had to take a drug and alcohol test and agree to a random test. Anyone receiving two 'poor' weekly reports in any four-week period was demoted. The policy was clear and young people signed to confirm they had seen their weekly reports.

6.59 Marks for each day could be poor, average or good, with officers giving a 'poor' mark required to give the reasons in writing. Eleven or more 'good' marks gave an overall assessment of good. Staff from activities rarely contributed reports to help class officers' overall assessments. The absence of an adverse report led to a 'good' report being recorded.

6.60 Failing or refusing a voluntary drugs test resulted in demotion and therefore amounted to compliance testing. Anyone who refused or failed a drugs test lost the privilege of an in-cell television. Young people found guilty of one serious or two lesser offences in any three-month period were demoted. A house governor or principal officer could exercise discretion when considering the circumstances of a serious offence. There was no evidence that young people were routinely punished twice through the PREPS and disciplinary procedures. Young people who were not promoted from basic to standard regime within four weeks could risk losing their job if someone on standard or enhanced regime required a placement.

6.61 All levels received an activity payment of £6, with those on enhanced getting an additional regime payment of £14 and those on standard getting £5. Young people on basic got nothing extra and could have their activity payment reduced from £6 to £4 if they consistently failed to engage in developmental activity. Enhanced young people were allowed a mini-fridge, extra CDs and video games. The number and length of visits and the amount young people could spend on telephone credits were linked to the scheme. This was inappropriate as it penalised families and risked undermining resettlement prospects.

6.62 Young people on basic lost their in-cell television, although discretion could be used if the young person was considered at risk of self-harm where the distraction of a television could be helpful. Some young men, some of whom were persistently involved in drug use, spent too long on basic without being encouraged or helped to progress.

6.63 Six young people had been granted special privileges (SP) status or become 'trustee prisoners'. SP prisoners were allowed to move unescorted around the centre. The status was also associated with home leave privileges in the last year of sentence and SP prisoners could also be considered for outside working and working from home schemes. Class officers put young people forward for SP status, which was not part of PREPS and the criteria were not transparent or formalised.

6.64 Fifty-five per cent of young people were enhanced, 34% were standard and 11% were basic. Some equality monitoring was taking place. In our survey, 52% of young people said they were treated fairly under the scheme, with Catholic and Protestant prisoners giving similar responses. On one day of the inspection, Catholic young people accounted for 62% of the population, but for 91% (21) of those on basic. They also accounted for 57% of those on enhanced and 61% of those on standard. This information was produced by the new prison record information system (PRISM), but it was not monitored routinely.

6.65 Enhanced young people were located throughout all houses. Willow 2 landing was an assessment landing for Beech House, where all were enhanced. Beech House provided facilities such as multi-gyms and more time out of cell that were not available to other enhanced young people. All those on enhanced were allowed to keep their television on after 11pm regardless of location.

6.66 Managers checked the operation of the scheme on each house unit, but not how fairly the scheme was applied across all house units.

Recommendations

6.67 Visits and telephone allowances should not be part of the progressive regimes and earned privileges scheme (PREPS).

6.68 There should be more sustained efforts to help those on the basic regime for lengthy periods to progress to standard.

6.69 The procedures for applying for special privileges status should be published, transparent and monitored.

6.70 PREPS should be routinely monitored by religion by the equality and diversity committee.

6.71 The operation of PREPS across all house units should be monitored for fairness by a senior manager.

Housekeeping point

6.72 Reference in the PREPS policy to voluntary testing should be replaced by compliance testing.

Section 7: Services

Catering

Expected outcomes:
Children and young people are offered varied meals to meet their individual requirements, in particular as growing adolescents, and food is prepared and served according to religious, cultural and prevailing food safety and hygiene regulations.

7.1 Many young people complained about the quality of the food, which was poor. Little attempt had been made to consult them about the catering and there was no evidence that any consultation had resulted in any action. Prisoners were able to eat communally.

7.2 The kitchen was clean and arrangements for storing and preparing food were hygienic. Cleaning schedules were displayed and checked by managers. All personnel wore clean protective clothing. The serveries on each landing were mostly clean, but some prisoners serving food did not wear protective hats. The most recent inspection by the local environmental health department had been satisfactory and documentation was up to date and well maintained.

7.3 A light meal was served at noon and a cooked meal at 5pm. Breakfast was freshly prepared and served on the morning it was eaten. Prisoners ate meals together. The pre-select menu ran on a three-week cycle. Low fat, healthy and vegetarian meals were available every day. There was no routine halal option, but a local supplier provided halal products when required. These were prepared, stored and served separately. Special health diets were available following receipt of medical confirmation, although one doctor reported problems with these. The catering manager had regular contact with a professional dietician and the menu had been changed to provide a more balanced diet.

7.4 Prisoners working in serveries and the kitchen completed a brief on-line food hygiene course. Staff and prisoners involved in handling food were required to complete a questionnaire declaring that they had not suffered from any ailment that might affect their ability to do so, but were not subject to a routine health check. Some young adults working in the kitchen were undertaking national vocational qualifications.

7.5 In our survey, only 16% of young people, significantly worse than the comparator of 27%, said the food was good or very good and 65% said it was bad or very bad. Many young people complained to us that the food was unappetising, greasy, lacked variety and often not hot by the time it was served. The meals we sampled confirmed these views. Large quantities of food were often left uneaten at the end of each meal. A number of young people gave anecdotal accounts of staff preparing elaborate breakfasts for themselves using their own food and equipment, which some said only served to reinforce the poor quality of the food they had to eat. Others were happy to wash up for the reward of any leftovers.

7.6 An internal food survey carried out in February 2007 had produced a reasonably good return of 41%. The results were more positive than our own findings, but the survey did not provide sufficient information to allow a critical evaluation. There was no effective means for young people to express their views about food. There were no comments books on the wings and catering staff did not attend any of the consultation meetings.

Recommendations

7.7 The standard of food should be improved.

7.8 All personnel responsible for handling food should be subject to a health check.

7.9 The consultation arrangements about food should be improved so that views expressed by prisoners are considered seriously and, when valid, acted on.

Housekeeping points

7.10 All personnel involved in handling food should wear protective clothing.

7.11 There should be clear and reliable arrangements to obtain special diets.

Canteen/shop

Expected outcomes:
Children and young people can purchase a suitable range of goods at reasonable prices to meet their ethnic, cultural and gender needs, and can do so safely, from an effectively managed shop or canteen system.

7.12 There were good arrangements for young people to access the prison shop. The range of products was good and prices were reasonable, although spending allowances were different to those for women on Ash House.

7.13 The tuck shop was an in-house service. Two members of staff had recently taken on working in the shop and had relatively quickly made improvements.

7.14 The range of products was good, including fresh fruit, and prices were reasonable. In our survey, significantly more young adults than the comparator said the shop sold a wide enough range of goods to meet their needs. Tuck shop staff were flexible and young people could apply to buy items not listed, such as CDs and video games.

7.15 Spending allowances were reasonable and were based on progressive regimes and earned privileges scheme (PREPS) status. However, there were some disparities between allowances at Hydebank Wood compared with those on Ash House, which young people perceived as unfair. Bagged items were delivered to wings, with each wing having its own delivery date. Any mistakes were usually rectified the same day.

7.16 There were no formal consultation arrangements, although informal consultation was taking place and a number of new items had been introduced recently based on prisoners' suggestions.

Recommendation

7.17 Young people in Hydebank Wood should have the same spending allowances as women prisoners in Ash House.

Section 8: Resettlement

Resettlement strategy

Expected outcomes:
Resettlement underpins the work of the whole establishment. The resettlement strategy is informed by assessment of the needs of children and young people. Resettlement is supported by strategic partnerships in the community, and in particular youth offending teams, to assist the reintegration of children and young people into the community and to prevent them reoffending on release.

8.1 There was no resettlement team or resettlement culture and cuts in resources had left committed staff demoralised. Some good resettlement work was being done, but most of it by partner agencies rather than prison officers. The local resettlement strategy was aspirational and there was no specific strategy for juveniles.

8.2 Resettlement had a relatively low priority and had been disproportionately affected by a 10% staff reduction (80% of which had come from activities) at the beginning of 2007, five months work to rule by prison officers over the summer and poor morale due to an investigation into malpractice. The new governor in charge had recently obtained extra resources for resettlement, but it was unlikely that consistent staff would be available. Interagency partnerships were good.

8.3 The resettlement needs of the population had last been canvassed in 2003 and the findings were still relevant. The resettlement database provided an up-to-date picture of individual and collective needs, but was not used to plan future provision.

8.4 The model for assessing prisoner risk and need was comprehensive, focusing on all remand and sentenced young people expected to remain in the prison for longer than two weeks. However, this was offset by the failure to establish a resettlement team or implement a personal officer scheme. Some resettlement work was taking place and was often high quality and delivered by committed staff, but the various strands were not systematically integrated.

8.5 The Northern Ireland Prison Service (NIPS) had undertaken or commissioned a number of reviews relevant to resettlement, including on lifers, security classification, programme facilitators and offending behaviour programmes. However, few had yet yielded any tangible outcomes.

8.6 The local resettlement strategy was based on the Northern Ireland resettlement strategy launched in June 2004. The Criminal Justice Inspection Northern Ireland (CJINI) 2007 inspection recommended that the Northern Ireland strategy be updated, including more input from strategic partners. The local strategy was aspirational and did not clearly specify the roles and responsibilities of prison staff or identify SMART objectives. It was inaccurate in several respects, including references to a resettlement team and personal officer scheme that did not exist. There was no evidence it had been agreed with partners. There was no meaningful resettlement strategy for juveniles.

8.7 Hydebank Wood staff worked productively with other agencies, but were heavily dependent on them. Few prison officers considered their role to include a resettlement component.

8.8 Resettlement work was overseen by an acting governor with several other responsibilities. He had made repeated efforts to promote a resettlement culture among managers and staff at all levels. He was supported by a principal officer, whose role was to coordinate weekly assessment and planning, and an administrative assistant. All three were committed to promoting resettlement, but demoralised by the low priority given to resettlement activity. Agencies contributing to resettlement were based in different areas of the Hydebank site and there was no cohesive identity or interagency team working opportunities.

8.9 In the absence of managerial direction and prioritisation, the resettlement governor could not quality assure all the resettlement activity, particularly the input of staff he did not line manage. The resettlement model described monthly strategic and weekly operational resettlement meetings, but these frequently did not take place. Four had been held in 2007. The minutes noted operational difficulties in delivering resettlement, including problems with completing assessments in time for the meetings, prisoners not being brought down in time for classes and programmes being cancelled when no facilitator was available. There was plenty of discussion about forward planning, but less reflecting on achievements. The meetings tended to confuse management and delivery processes and had insufficient focus on outcomes.

Recommendations

8.10 A resettlement team should be established along the lines of the teams that exist in the other two Northern Ireland prisons.

8.11 The weekly operational and monthly strategic resettlement meetings should be reprioritised and should have clear terms of reference that clarify their distinct purposes.

Offender management and planning

Expected outcomes:
All children and young people have a training plan based on an individual assessment of risks and needs, which is regularly reviewed and implemented throughout and after their time in custody.

8.12 The model for resettlement planning was sound and it commendably included remand and short-term prisoners. However, its delivery was disjointed and little more than a paper exercise. Documentation was completed and recording and quality assurance had improved, but the process did not purposefully involve prisoners or staff and there was no case management approach. Young people were mostly sceptical about Hydebank's attempts to engage them productively. Public protection work was good.

8.13 Every prisoner, including those on remand and expected to spend more than two weeks in the young offender centre had their risk and resettlement needs assessed. Initial assessments were completed within four weeks and reviews were held quarterly, but these were mainly conducted by the resettlement principal officer with little input from prisoners or staff. Resettlement needs documentation was comprehensive and addressed all the requisite areas to deliver resettlement properly. Each new committal was interviewed by numerous specialists, but the 13 departmental interviews frequently did not culminate in a written or verbal report to inform resettlement planning.

8.14 Most sentenced prisoners already had a probation assessment, case management and evaluation (ACE) completed for their court appearance. If not, an ACE assessment was undertaken where there were risk concerns.

8.15 All relevant prisoners had a written resettlement plan underpinned by a comprehensive database that identified individual progress towards resettlement goals. The components of resettlement plans and quarterly reviews were meant to be determined at the weekly resettlement meeting, but these were often cancelled due to unavailability of staff. All three meetings scheduled during the inspection were cancelled. When this happened, the resettlement principal officer conducted a desktop exercise using any available contributions from contributing departments to complete plans and reviews. His minute (1 November 2007) indicated that 49% of required information was missing in the cases of all 12 prisoners under consideration, yet plans and reviews were still compiled. In the absence of these contributions or prisoner input, resettlement planning was reduced to a meaningless paper exercise.

8.16 In our survey, 85% did not know they had a resettlement plan and only a few had signed elements of them. Many were unaware that resettlement meetings, which discussed their plans, took place. Those who were aware of their plans tended to feel that they were asked to sign a document about their future even though they had had little or no opportunity to contribute to its preparation.

8.17 The resettlement database was comprehensive and up to date, but did not appear to be used for analytical or management information purposes to target provision and plan ahead. It showed backlogs in translating referrals into programme participants for each programme, such as parenting (April 2007), car crime (March 2006), anger management (February 2007) and alcohol management (June 2006). These delays may have been appropriate in relation to prisoners' stages of sentence, but the records showed no discussion or analysis to indicate such a rationale.

8.18 There were 16 sex offenders, including one juvenile and five on remand. It was not always clear if new committals whose current offence was not sexual had a sex offending history, which would have helped staff to manage them appropriately such as at home leave boards. Seven prisoners were engaged in the multi-agency sex offender risk assessment and management (MASRAM) process and several others were identified as presenting a risk of causing harm to others. In each case, NIPS depended heavily on probation staff to lead in public protection arrangements. Probation Board Northern Ireland files showed that prisoners were involved in discussions about managing their risk and aware of their position and avenues for challenge.

8.19 A total of 148 staff had been trained in MASRAM awareness. However, feedback to prisoners about outcomes of their MASRAM meetings by designated risk managers was slow. Some prisoners said that their cases had been discussed on 29 August, but they had still not been given any information about important outcomes that would impact on their future home leave and release planning.

8.20 The Probation Board Northern Ireland (PBNI) quality assured resettlement plans for its own cases, mainly custody probation orders and life-sentenced prisoners. The probation quality assurance process was thorough and complied with PBNI standards. Quality assurance activity by the resettlement governor and principal officer had also improved, but it was not so comprehensive and not required by the local resettlement policy.

8.21 Few prisoners or staff linked resettlement plans with types and levels of activity. The local resettlement policy was theoretically linked to the progressive regimes and earned privileges

scheme (PREPS), but it was far from being fully integrated. Prisoners believed regime level, work and home leave was based more on their current conduct than their needs, although we observed some good deliberation at a home leave board that was well informed by and explicitly related to prisoners' personal needs.

8.22 Between April and October 2007, eight young men had been transferred to Magilligan and five to Maghaberry. Some were able to transfer directly to Magilligan with its lower emphasis on security. It was not clear whether their resettlement plans travelled with them. The 13 transfers were due to pressure on spaces at Hydebank Wood. It was therefore commendable that Hydebank Wood continued to hold several young prisoners serving longer than its normal four-year maximum sentence in order to avoid, or at least delay, their entry to the adult penal system. The 2007 CJI resettlement report showed that those released into the community under PBNI supervision experienced continuity of interventions, but it was not possible to measure progress for unsupervised prisoners as there was no follow-up post-release.

8.23 Between July and October 2007, 80 young people had applied for home leave and 62 had been granted. Home leave and other statistics were collated by religion, but there was no evidence of managerial analysis or equality planning. Home leave and resettlement leave were identified as separate provisions for different purposes by NIPS, but the information was jointly collated.

8.24 None of the current prisoners had been recalled or had their licence revoked, but some had breached probation requirements. They understood the reasons for being breached and were involved in planning for subsequent supervision.

8.25 Young people could progress to special privileges (SP) status in the last six months of sentence and if they were enhanced status, drug-free, not a self-harmer and a low security risk. Once granted, they were eligible for home leave each weekend. Some could also apply to work outside the centre, if a suitable placement was available. A small number of relevant and imaginative placements such as with the Northern Ireland Children's Cancer Fund had been obtained.

Recommendations

8.26 Prisoners should be invited to attend their resettlement meetings and meaningfully engaged in preparing for these meetings.

8.27 Resettlement plans should actively inform allocation to activities and programmes and decisions about regime status.

8.28 Home leave and resettlement leave statistics should be disaggregated and separately reported.

Indeterminate-sentenced prisoners

8.29 Opportunities for life-sentenced prisoners were limited. Lifers were well known to staff and families had been involved. Formal case review processes had improved. There was still no structured approach for potential lifers.

8.30 There were six lifers and 10 potential lifers, all of whom were well known to staff. They ranged from three years served of a 15-year tariff to six years served of a 12-year tariff. They said they received no different treatment from other prisoners, either during remand or after sentence. In a positive move, lifers could now be released under escort for compassionate reasons. One young lifer had such an escort for a grandparent's funeral earlier in 2007.

8.31 Some staff were trained in lifer management, but had insufficient opportunity to play a meaningful role due to the small number of lifers. Young people felt that their involvement was limited to meeting with them shortly before annual reports were required for internal lifer management unit deliberations. Draft standards for the case management of lifers had been developed in February 2007, but not progressed any further.

8.32 There were arrangements to get information from the police at conviction to help inform risk assessments. Families of young lifers were invited to visit and had the tariff and life sentence system explained to them.

8.33 Lifer reviews under the auspices of the Maghaberry-based lifer management unit were first undertaken in November 2006 and there were subsequent reviews of all six lifers in June 2007. This represented a more coordinated approach than previously. The lifers understood the life sentence review commissioners system, but were sceptical about their opportunities to demonstrate progress for its hearings due to Hydebank Wood's limited regime and scope.

8.34 Life-sentenced prisoners were prevented from acquiring the on-site privileges of special privileges status, such as freer movement within the prison, simply because of their indeterminate sentence, which was unfair.

8.35 Young lifers transferred to Maghaberry once they had reached 21 or shortly afterwards. This was a regressive move from medium security to a maximum security prison. However, the last transferee had been moved directly to the lower security regime at Martin House in Maghaberry in recognition of his vulnerability. Multidisciplinary meetings were also held before a lifer was transferred. A NIPS internal 2005 thematic review of lifers had recommended that they should be able to transfer to Magilligan, but this was not yet the case. Each of the young lifers was looking forward to moving to the lifer house at Maghaberry, where they believed they would have a better regime.

8.36 There was little special provision for lifers or recognition of their different needs through lifer days or other specific events in the young offender centre. Without these provisions, it was difficult for lifers to discern formal stages in their sentence beyond annual reviews and many believed they were just marking time at Hydebank Wood and made little progress.

8.37 The lifer governor had developed some good proposals for a new lifer regime in Cedar House when it reopened in 2008, which would better meet their needs.

Recommendations

8.38 Lifer liaison officers should fulfil the role of personal officers for lifers and keep in regular touch with them about their progress.

8.39 A fundamental review of the lifer regime should be undertaken to recognise their specific needs and to allow them more responsibility, including the possibility of earning special privileges status.

8.40 A formal process should be agreed to identify and support potential lifers.

Resettlement Pathways

Although Northern Ireland did not use the resettlement pathways model, the pathways were equally applicable in this jurisdiction, and were expected to be addressed by the Northern Ireland Prison Service in its work with prisoners.

Reintegration planning

8.41 Some good accommodation work was undertaken by the Housing Rights Service, but there was little input from prison officers. Education and training were not linked effectively to resettlement planning, but some good individual contacts had been established with prospective employers. When necessary, young people were helped to register with a GP on discharge and there were links to local mental health services in appropriate cases. NIACRO offered a limited benefits advice service, but few young people knew who to contact for help with financial problems.

Accommodation

8.42 NIPS funded the Housing Rights Service (HRS) to provide a worker, who visited Hydebank Wood once a week on average. Her post was primarily designed to train prison staff to engage with prisoners' accommodation issues and she was also directly involved in some more difficult cases. The service was well advertised and prisoners were aware of it.

8.43 Prison officers were inclined to leave all accommodation problems to the specialist accommodation worker or probation officers. This was contrary to the contract agreed between NIPS and the HRS. This was being addressed, but progress was slow and not helped by the lack of a personal officer scheme (see section on personal officers).

8.44 Prisoners said retention of existing accommodation was possible and the system had worked effectively when they met the relevant criteria. However, several prisoners had been unsettled before entering prison and their post-release options were limited.

8.45 Six approved premises in Northern Ireland provided 77 places for prisoners who required post-release supervision. Probation officers made referrals where appropriate, although the facilities were primarily for the supervision of high-risk offenders rather than to accommodate those with no fixed address.

Education, training and employment

8.46 Education and training were not linked effectively to resettlement planning, with an inadequate focus on specific education, training and employment needs, and little evaluation of the extent to which their individual needs had been addressed or met.

8.47 Young adults could work in a good range of workshops (see section on education, training and library provision), but opportunities were limited by the low level of accreditation offered. Some vocational training staff had developed close and effective links with employers to identify work

placement opportunities for young people on release. This included work in painting and decorating and industrial cleaning companies. These links had been established through the personal efforts of individual staff. Companies in the industrial cleaning sector had asked for young people to be referred to them for employment on release.

8.48 A satisfactory range of courses was offered to develop young people's personal and social skills (see section on education, training and library provision) and NIACRO provided individual young adults with useful information and advice on employment opportunities. Other departments used their professional expertise, but agreed actions for some young people were often conflicting and the process was not well coordinated.

Physical and mental health

8.49 Young people subject to multi-agency sex offender risk assessment and management (MASRAM) or custody probation orders were subject to a multidisciplinary meeting to plan their discharge including health services staff. The cognitive behaviour therapy in-reach team aimed to link young people known to them who were not covered by these procedures with community services.

8.50 Most young people had a GP in the community and health services staff simply sent them a letter detailing the young person's treatment in custody. Those without a GP were helped to register with one. Young people were given the remains of any prescribed medications held in possession. Those receiving 'see to take' medications were given enough to last at least three days before release.

Finance, benefit and debt

8.51 In our survey, 58% of young people said finance and benefits would be a problem after their release. The resettlement model included an offer of financial assessment for newly-committed prisoners. This was provided by NIACRO and incorporated an element of housing benefit assessment and intervention if necessary. This could extend to assistance with retention of public housing, provided the Northern Ireland Housing Executive criteria were met.

8.52 In reality, many prisoners, especially those in for short periods, did not manage to access the service because its scope was limited. The service was individually based and did not extend to delivery of budgeting courses to groups of prisoners. Few prisoners were helped to open bank accounts.

8.53 Debt and financial services were advertised, but there was limited evidence on resettlement files of prisoners actually using the service. In our survey, only 35% of young people knew who to contact for assistance with financial problems.

Recommendation

8.54 Advice on finances should be provided to all young people who need it.

Drugs and alcohol

8.55 The draft drug and alcohol strategy was not informed by a comprehensive needs assessment. Opportunity Youth assessed all new committals and provided an intensive support programme for young people who presented with drug or alcohol misuse problems. As part of this, key workers supported young people in custody and for six months after release.

8.56 The head of security was the drug strategy lead. There was a draft drug and alcohol strategy, but it did not contain a comprehensive needs assessment. All young people were seen by Opportunity Youth in their first week in custody and a committal assessment was carried out. Opportunity Youth staff then identified goals for each individual as required, including an Open College Network accredited two-day course that all young people were encouraged to attend regardless of their previous drug or alcohol use or offences. A total of 130 young men had undertaken the programme in the previous 12 months.

8.57 Opportunity Youth provided a very good throughcare intensive support programme for young people who presented with either drug or alcohol misuse problems. The programme required the young person to sign a permission compact and included a detailed assessment of need. A key worker worked with the young person in custody and for six months after release. Between September 2006 and 2007, 101 young men had participated in the programme. A monthly report on their progress was recorded. Opportunity Youth also co-delivered an alcohol management course with probation staff. Three courses had run in 2006-07 and two since April 2007. No other treatment programmes were available. Counselling was available from a counsellor employed by Opportunity Youth for all young people. She had 15 young people on her caseload, with a similar number on the waiting list.

8.58 Opportunity Youth also liaised with outside agencies such as NIACRO, Job Track and housing authorities for its clients and was involved in the multidisciplinary meetings for young people subject to MASRAM or custody probation orders.

Recommendation

8.59 The drug and alcohol strategy should be informed by a comprehensive needs assessment and any identified gaps in service provided.

Children and families of offenders

8.60 Young people received good support to maintain important family ties.

8.61 Two initiatives were designed to encourage and support young people to remain in contact with their children, partners and families. The collaboration with the Family Links organisation and the family and child-centred visits gave prisoners good opportunities to maintain contact with people important to them (see section on contact with the outside world). In addition, some good Barnardos parenting programmes were run.

8.62 The chaplaincy team were usually involved with passing on significant or sensitive information. One member of the team was always on call and would come in to the prison if required.

8.63 Young people with family members in other prisons could take inter-prison visits. Family members serving sentences in different parts of Hydebank Wood could also be granted permission to see each other through 'booked visits'. Where visitors had to travel long distances, prisoners could request all-day visits and governors were flexible and considerate when making such decisions.

Attitudes, thinking and behaviour

8.64 Hydebank Wood did not provide a therapeutic or motivational environment where young people were likely to undertake meaningful personal change. Shortages of facilitators made it difficult to deliver planned offending behaviour programmes, although delivery of personal development programmes was more successful.

8.65 The focus on motivating prisoners was inconsistent and there was little for those serving short periods or who would not be subject to probation supervision after release. Prison staff were insufficiently engaged in promoting change in attitudes, thinking and behaviour. Programme planning and delivery timetables were not well communicated.

8.66 Most offending behaviour programmes (OBPs) were delivered by probation officers co-facilitated by prison officers. Shortages of facilitators meant interventions were difficult to schedule and deliver, but this was rarely communicated to prisoners, who complained of being ill-informed about progress. OBPs provided between August 2006 and October 2007 included alcohol management (61 starters/48 completers), anger management (33 starters/ 24 completers), enhanced thinking skills (6 starters/4 completers) and car crime (24 starters/16 completers). The OBPs delivered were locally accredited by a joint Probation Board Northern Ireland/NIPS planning group.

8.67 Nothing was available for those in denial of their offence. The position was better for personal development programmes, including Opportunity Youth's counselling, throughcare, Open College Network programmes, bereavement counselling with the Cruse organisation, Barnardos parenting programmes and Duke of Edinburgh Award modules. These engaged large numbers of participants. Between April 2006 and March 2007, 17 prisoners had enrolled for the Duke of Edinburgh programme and four had achieved bronze awards, 96 had completed the Open College Network programme and 13 had completed the parenting courses.

8.68 Programme planning took good account of prisoners' ability levels and there was no indication of discrimination.

8.69 Prison staff were not involved in the delivery of offending behaviour programmes and were therefore unlikely to reinforce such work on the landings. However, they were better at supporting personal development activity.

Recommendation

8.70 The Northern Ireland Prison Service should provide interventions for young people in denial about their current offence to address previous offending, the consequences of being imprisoned and future risks.

Section 9: Recommendations, housekeeping points and good practice

The following is a listing of recommendations and examples of good practice included in this report. The reference numbers at the end of each refer to the paragraph location in the main report.

Main recommendations to NIPS

9.1 The Northern Ireland Prison Service should either remove young men under the age of 18 from Hydebank Wood or provide appropriately resourced, dedicated accommodation with a regime capable of meeting the needs of this population. (HP50)

9.2 The Northern Ireland Prison Service should issue clear guidance on the implementation of a diversity strategy indicating areas to be prioritised and provide relevant staff training including in religious and cultural differences. (HP51)

Main recommendations to the governor

9.3 The reception area should be redesigned and refurbished to provide an appropriate environment to meet the needs of children and young people arriving in custody. (HP45)

9.4 First night procedures should be agreed so that all new arrivals receive consistent and supportive care on arrival, including private interviews to assess immediate needs, access to peer support and appropriate supervision. (HP46)

9.5 A personal officer scheme should be established to support young people at Hydebank Wood, liaise with families and encourage effective resettlement. (HP47)

9.6 An effective anti-bullying and violence reduction strategy should be developed to ensure that all alleged incidents of bullying are investigated and vulnerable young people protected. (HP48)

9.7 The suicide and self-harm prevention policy should be revised to reflect the specific needs of children and young adults and to develop a more therapeutic response to support young people at risk at Hydebank Wood. (HP49)

9.8 The transfer of responsibility for health services should be completed expeditiously so that health services can be planned, provided and quality assured through integrated working. (HP52)

9.9 An education and training policy for young people should be developed, including a coherent and distinct strategy for juveniles, that provides sufficient work and education places to keep all young people purposefully occupied. (HP53)

9.10 All young people should have at least 10 hours out of their cells on weekdays including a daily scheduled period of one hour's exercise in the open air. (HP54)

9.11 The Hydebank Wood resettlement strategy should be rewritten to show clearly how the establishment contributes to the Northern Ireland resettlement strategy. The new strategy

should specify roles and responsibilities, set SMART objectives, outline provision for specific groups such as juveniles and lifers, and include arrangements for regular review. (HP55)

Recommendations to NIPS

Courts, escorts and transfers

9.12 Young men, juveniles and women prisoners should be transported separately. (1.8)

9.13 Young people should arrive before 7pm. (1.11)

First days in custody

9.14 Full information should be available to reception and first night staff to inform initial assessments. (1.40)

Child protection

9.15 The agreement of the local area child protection committee (ACPC) with the revised child protection policy should be secured and a protocol agreed with the local health and social services trust to make the policy and related practices a reality. (3.61)

9.16 A formal request should be made that the governor of Hydebank Wood is granted membership of the area child protection committee (ACPC). (3.62)

Contact with the outside world

9.17 Guidance on closed visits should specify when decisions to impose restrictions should be reviewed. (3.109)

Security and rules

9.18 Procedures governing closed visits should be reviewed to enable proactive decisions to be made based on firm intelligence. (6.11)

Resettlement pathways

9.19 The Northern Ireland Prison Service should provide interventions for young people in denial about their current offence to address previous offending, the consequences of being imprisoned and future risks. (8.70)

Recommendations to the governor

Courts, escorts and transfers

9.20 Young people should not routinely be handcuffed on vans or to and from reception without the need for this being determined through individual security risk assessment. (1.9)

9.21 Staffing should be arranged so that young people do not wait unnecessarily on vans because reception is closed. (1.10)

9.22 Young people should be escorted in vehicles that are safe, clean and comfortable. (1.12)

9.23 Property and private cash should accompany unsentenced young people to court. (1.13)

9.24 Young people should be given the information leaflet about Hydebank Wood at court by Northern Ireland Prison Service escort staff. (1.14)

9.25 Young people should not be asked about their treatment by escort staff in the presence of these staff. (1.15)

First days in custody

9.26 Reception procedures should be less intimidating with young people greeted courteously by staff and permitted to sit at a table with an appropriate degree of privacy for initial procedures to be carried out. (1.39)

9.27 Juveniles should not be routinely strip searched. (1.41)

9.28 Strip searches should always be conducted by two officers. (1.42)

9.29 Other young prisoners should not be used to interpret for new committals charged with serious offences or in circumstances where personal information is divulged. (1.43)

9.30 All new committals should be able to make a free telephone call in private in reception or on their first night location. (1.44)

9.31 All new committals should be given a meal on their first night. (1.45)

9.32 Reception waiting areas should be decent and contain relevant information in a range of formats so that it is accessible to all. (1.46)

9.33 Insiders should be available in reception and for all new committals on their first night. (1.47)

9.34 The first night guide for new committals should be revised and produced in a range of formats to contain only essential information to enable young people to cope with their first 24 hours. (1.48)

9.35 All new arrivals, including juveniles, should receive appropriate and consistent induction. (1.49)

Residential units

9.36 Cells designed for one should not be used for two people. (2.14)

9.37 All cells should be regularly checked and kept in good condition. (2.15)

9.38 Toilets in shared cells should be adequately screened. (2.16)

9.39 Some cells should be adapted for young people with disabilities. (2.17)

9.40 Soiled mattresses and pillows should be replaced promptly. (2.18)

9.41 All young people should be provided with flasks. (2.19)

9.42 Young people should be provided with at least two clean towels each week. (2.20)

9.43 The offensive display policy should be uniformly applied. (2.21)

9.44 Young people should be able to use microwaves for products from the tuck shop. (2.22)

9.45 The policy on the type of clothes young people can wear should be less restrictive. (2.23)

Relationships between staff and young people

9.46 A prisoners' council should be established to allow senior managers to consult with the young men about routines and facilities and include discussions about how to improve relationships, with regular feedback to all staff and prisoners on action taken. (2.28)

9.47 Managers should ensure that officers make active efforts to engage positively with prisoners and make regular recorded checks that this is happening. (2.29)

9.48 Staff should routinely use first names or title and surname when speaking or referring to young men in their care. (2.30)

Bullying and violence reduction

9.49 A safer custody committee specifically for Hydebank Wood young offender centre should be established focusing on anti-bullying, the prevention of suicide and the reduction of self-harm. (3.14)

9.50 All potential indicators of bullying should be monitored and, where there are concerns that bullying may be involved, the incident should be investigated irrespective of whether the alleged victim has made a written statement. (3.15)

9.51 The profile of anti-bullying should be improved to create an environment where young people have faith in the anti-bullying strategy, including appointing safer custody liaison officers for each house. (3.16)

9.52 Effective interventions to challenge bullies and support victims should be developed. (3.17)

9.53 All staff in direct contact with young people should receive training in the anti-bullying strategy. (3.18)

Self-harm and suicide

9.54 There should be a suicide prevention coordinator (SPC) exclusively for the young offender centre with sufficient allocated time to carry out this role. (3.37)

9.55 Formal investigations should be conducted into serious or near-fatal incidents to establish what, if any, lessons could be learned. (3.38)

9.56 Prisoner at risk (PAR 1) procedures should be improved. Reviews should be multidisciplinary, but with less reliance on the role of healthcare staff, and care plans should reflect the individual needs identified. (3.39)

9.57 Trained senior officers should provide continuity in the management of cases. (3.40)

9.58 Managers should make regular checks on open PAR 1 forms and make written comments on the quality of care offered. (3.41)

9.59 Key workers should be identified to work alongside young people at risk of self-harm or suicide. Entries in the daily supervision record should be improved and follow-up interviews conducted following the closure of PAR 1 forms. (3.42)

9.60 The length of time young people are placed in the observation rooms in healthcare and the special supervision unit (SSU) should be monitored by the safer custody meeting. (3.43)

9.61 Alternative therapeutic responses to the use of observation rooms and strip clothing should be developed for those at risk of self-harm. (3.44)

9.62 Young people at risk of self-harm should be held in the SSU only in exceptional circumstances. (3.45)

9.63 Young people should be able to contact the Samaritans free of charge from landing telephones. (3.46)

9.64 Peer support should be improved, with a clear programme of training and regular support meetings for Insiders. (3.47)

9.65 All staff in contact with young people should receive suicide awareness training. (3.48)

9.66 A Listener scheme should be developed. (3.49)

9.67 All officers should carry ligature knives. (3.50)

Child protection

9.68 An appropriate forum for the strategic development of child protection should be established and should include input from the local health and social services trust. (3.63)

9.69 Child protection referrals should be monitored and analysed for patterns or trends. (3.64)

9.70 All staff who come into contact with children should have comprehensive inter-disciplinary child protection training. (3.65)

9.71 Urgent steps should be taken to ensure that all staff coming into contact with children have protection of children and vulnerable adults (POCVA) checks. (3.66)

Equality, race and foreign nationals

9.72 The equality and diversity committee should meet regularly, with all designated members or representatives attending, to consider and take action on any identified or potential areas of discrimination. (3.80)

9.73 A system of monitoring that identifies and highlights areas of under and over-representation should be introduced and monitoring data should distinguish between male and female prisoners. (3.81)

9.74 The equality and diversity officers should receive specialist training and should be allocated dedicated time to carry out their additional duties. (3.82)

9.75 Links with Irish Traveller support groups should be strengthened and consolidated. (3.83)

9.76 A separate system for investigating racist complaints should be introduced and staff appropriately trained. (3.84)

9.77 The Border and Immigration Agency should be asked to supply a named liaison person so that the prison can help foreign national prisoners prepare for their release or removal. (3.85)

9.78 Professional interpretation services should be used when legal matters or issues relating to vulnerability are discussed with young people with little or no English. (3.86)

Contact with the outside world

9.79 Access to the telephones should be improved. (3.101)

9.80 Telephones should be enclosed in booths to allow privacy. (3.102)

9.81 There should be no unnecessary delays in prisoners receiving their mail. (3.103)

9.82 There should be clear signposts to the prison, particularly at the entrance. (3.104)

9.83 All prisoners should be allowed visits of at least one hour. (3.105)

9.84 Visitors should be able to purchase hot meals or snacks either in the visitors' centre or in the visits hall. (3.106)

9.85 Babies should be searched only when there is specific intelligence, agreed by a senior manager, that this is necessary. (3.107)

9.86 Privacy screening should be introduced between the closed visit rooms and the general visits area. (3.108)

9.87 Arrangements for consulting visitors about their experience should be improved. (3.110)

Applications and complaints

9.88 The complaints procedure should be promoted more effectively through notices on houseblocks, individual interviews and induction programmes to ensure that young people know they have a right to complain and how to go about it. (3.118)

9.89 Young people should be able to access and submit complaint forms confidentially. (3.119)

9.90 Young people should not be required to make a formal request for a telephone call or a shower or other routine matters. (3.120)

9.91 There should be a formal system of quality assurance of complaints to ensure that they are fully investigated and that replies are courteous and directly and clearly address the nature of the complaint. (3.121)

9.92 Requests and complaints should be routinely analysed to identify patterns or trends. (3.122)

Substance use

9.93 All those who require first night treatment/symptomatic relief following screening and testing should have it prescribed and administered. (3.129)

9.94 Specialist staff should complete a comprehensive assessment of need to determine suitable stabilisation, maintenance or detoxification regimes. (3.130)

9.95 Prescribing regimes should be flexible and meet individual need. (3.131)

9.96 Young people should receive effective support during and post clinical intervention. (3.132)

Health services

9.97 The health needs assessment of the young people at Hydebank Wood should be reviewed and services to meet their specific needs should be commissioned and provided. (4.34)

9.98 All emergency equipment should be checked regularly to ensure that it is in date and fit for purpose; documented evidence of such checks should be kept. (4.35)

9.99 All health services staff, including allied health professionals, should have annual training in resuscitation and child protection. (4.36)

9.100 Clinical supervision should be available to all health services staff. (4.37)

9.101 There should be formal arrangements for the loan of occupational therapy equipment and specialist advice to ensure that patients are able to access mobility and health aids if required. (4.38)

9.102 Dental staff should have access to young people's clinical records and complete medical history sheets for each patient. (4.39)

9.103 The special sick policy should be reviewed regularly by the medicines and therapeutic committee to ensure that all appropriate medicines can be supplied. (4.40)

9.104 All pharmacy polices should be formally reviewed and adopted via the medicines and therapeutic committee. (4.41)

9.105 There should be an information-sharing policy with appropriate agencies to ensure efficient sharing of relevant health and social care information. It should include the need to obtain a patient's consent when appropriate. (4.42)

9.106 Following a reception screening, a further health assessment should be carried out by trained staff no later than 72 hours after the young person's arrival in custody. (4.43)

9.107 The rapid vaccination course for Hepatitis B should be adopted. (4.44)

9.108 Barrier protection (condoms and lubricants) should be freely available. (4.45)

9.109 Health services staff should liaise with the physical education department to ensure that young people can take full advantage of the physiotherapy services offered. (4.46)

9.110 All pre-packs should be dual-labelled. When the pre-pack is dispensed against a prescription, one label should be removed and attached to the prescription chart, which should then be faxed to the pharmacy provider so that the pharmacist can satisfy him/herself that the prescription was appropriate and that the correct item has been supplied. (4.47)

9.111 Patient information leaflets should be supplied wherever possible. A notice should be displayed to advise patients of the availability of leaflets on request. (4.48)

9.112 Decisions about daily, weekly or monthly in possession medications should be clearly documented. (4.49)

9.113 There should be patient group directions (PGDs) for all vaccinations. (4.50)

9.114 Over-the-counter medicines should be available for young people to buy from the tuck shop. (4.51)

9.115 Young people who arrive with ongoing dependence on prescription medications should be carefully assessed and monitored before any detoxification regime is commenced. (4.52)

9.116 Arrangements for attendance at outside hospital appointments, including waiting times and cancellations, should be subject to audit. (4.53)

9.117 The in-patient beds should not form part of the prison's certified normal accommodation. (4.54)

9.118 Admission to the in-patient unit should be decided on clinical need. (4.55)

9.119 Day services should be available for those less able to cope with prison life. (4.56)

9.120 Psychiatric services should be reviewed to ensure that there are sufficient resources to meet the needs of young people, including child and adolescent services. (4.57)

Education, training and library provision

9.121 The use of existing education and training capacity should be improved. (5.17)

9.122 Links between education and training provision and resettlement planning should be improved. (5.18)

9.123 Young people should have improved access to the library. Access to the ICT facilities in the library should be improved. (5.19)

Physical education and health promotion

9.124 The range of vocational courses leading to qualifications should be developed further to meet the needs and interests of all young people, particularly those who do not attend the gym regularly. (5.26)

9.125 The range of outdoor and adventurous activities available should be developed further subject to suitable risk assessments. (5.27)

Faith and religious activity

9.126 Chaplains should be formally invited to all prisoner at risk (PAR 1) reviews. (5.35)

Time out of cell

9.127 Unlock and lock-up should take place at the published times. (5.41)

9.128 Staffing ratios should be reviewed to ensure they are appropriate to the risk posed by prisoners. (5.42)

Security and rules

9.129 The number of routine cell searches should be reduced and the searching strategy should be reviewed to find more efficient and effective ways of tackling supply reduction. (6.12)

9.130 Dynamic security should continue to be promoted and clear job descriptions drawn up for the security liaison officers. (6.13)

9.131 Opportunities for more free movement around the young offender centre should be increased. (6.14)

9.132 The role of the security liaison officers should be reinforced by residential managers and staff should be encouraged to submit security information based on their own observations. (6.15)

9.133 Security bulletins should be posted on the prison intranet for staff information and guidance. (6.16)

9.134 The security committee should include representatives for education, workshops and other departments that have direct dealings with prisoners. (6.17)

Discipline

9.135 A behaviour management strategy should be developed for Hydebank Wood, incorporating recognised best practice in managing the behaviour of young people and in consultation with Opportunity Youth and other external youth agencies. (6.38)

9.136 The adjudication room should be made a more age-appropriate environment for children. (6.39)

9.137 There should be a written record of adjudication hearings to ensure that managers are able to scrutinise and evaluate disciplinary procedures. (6.40)

9.138 The reasons for the disproportionate number of Catholic prisoners placed on report should be investigated and appropriate action taken as necessary. (6.41)

9.139 A more robust system for ensuring that the advocacy service is made available to all children facing disciplinary charges should be introduced. (6.42)

9.140 Guidance on appropriate levels of punishments should be updated to make punishments more commensurate with offences and should be subject to regular review through standardisation meetings. (6.43)

9.141 Adjudicating governors should not make punishments in excess of the published tariffs without providing a reason or justification. (6.44)

9.142 Partial remission of punishments and other means of encouraging good behaviour should be considered for prisoners in the special supervision unit (SSU). (6.45)

9.143 Prisoners should not be subject to informal or group punishments without the safeguard of going through a formal disciplinary process. (6.46)

9.144 All staff involved in an incident involving the use of force should complete the relevant paperwork on the same day. (6.47)

9.145 The use of force committee should be chaired by a senior manager, meet monthly and robustly analyse every use of force incident in order to satisfy members of the legitimacy of the intervention. (6.48)

9.146 All staff should be refreshed in control and restraint techniques every 12 months. (6.49)

9.147 The practice of locking down the entire establishment whenever an alarm bell is activated should cease and more appropriate arrangements introduced. (6.50)

9.148 All unfurnished cells should be formally designated as special accommodation with a protocol specifying how they are to be used, with authorisation at an appropriately senior level, and the formal procedures for the use of special accommodation followed. (6.51)

9.149 Young people should not be located for up to 48 hours in the segregation unit solely on the basis of an indication by the passive drug dog. (6.52)

9.150 SSU staff should be selected to work there by the governor based on their commitment to work constructively with difficult and challenging young people and a willingness to move away from the customs, practices and terminologies of the past. (6.53)

9.151 Young people in the SSU should be allowed tobacco in possession. (6.54)

9.152 All young people in the SSU should receive the minimum regime entitlements of a shower, telephone call and time in the fresh air every day, regardless of the number of adjudications scheduled. (6.55)

Incentives and earned privileges

9.153 Visits and telephone allowances should not be part of the progressive regimes and earned privileges scheme (PREPS). (6.67)

9.154 There should be more sustained efforts to help those on the basic regime for lengthy periods to progress to standard. (6.68)

9.155 The procedures for applying for special privileges status should be published, transparent and monitored. (6.69)

9.156 PREPS should be routinely monitored by religion by the equality and diversity committee. (6.70)

9.157 The operation of PREPS across all house units should be monitored for fairness by a senior manager. (6.71)

Catering

9.158 The standard of food should be improved. (7.7)

9.159 All personnel responsible for handling food should be subject to a health check. (7.8)

9.160 The consultation arrangements about food should be improved so that views expressed by prisoners are considered seriously and, when valid, acted on. (7.9)

Canteen/shop

9.161 Young people in Hydebank Wood should have the same spending allowances as women prisoners in Ash House. (7.17)

Resettlement strategy

9.162 A resettlement team should be established along the lines of the teams that exist in the other two Northern Ireland prisons. (8.10)

9.163 The weekly operational and monthly strategic resettlement meetings should be reprioritised and should have clear terms of reference that clarify their distinct purposes. (8.11)

Offender management and planning

9.164 Prisoners should be invited to attend their resettlement meetings and meaningfully engaged in preparing for these meetings. (8.26)

9.165 Resettlement plans should actively inform allocation to activities and programmes and decisions about regime status. (8.27)

9.166 Home leave and resettlement leave statistics should be disaggregated and separately reported. (8.28)

Indeterminate-sentenced prisoners

9.167 Lifer liaison officers should fulfil the role of personal officers for lifers and keep in regular touch with them about their progress. (8.38)

9.168 A fundamental review of the lifer regime should be undertaken to recognise their specific needs and to allow them more responsibility, including the possibility of earning special privileges status. (8.39)

9.169 A formal process should be agreed to identify and support potential lifers. (8.40)

Resettlement pathways

9.170 Advice on finances should be provided to all young people who need it. (8.54)

9.171 The drug and alcohol strategy should be informed by a comprehensive needs assessment and any identified gaps in service provided. (8.59)

Housekeeping points

Self-harm and suicide

9.172 A suitable quiet location should be found for PAR 1 reviews. (3.51)

9.173 The contents of emergency response boxes should be checked regularly. (3.52)

Health services

9.174 All clinical records should be contemporaneous and conform to professional guidance from regulatory bodies. (4.58)

9.175 The use of prescription forms, card index and administration charts should be revised to avoid the need for duplication and transcription. One chart should be used for prescriptions and administration record. (4.59)

9.176 All policy documents should be up to date and redundant documents removed. (4.60)

Incentives and earned privileges

9.177 Reference in the PREPS policy to voluntary testing should be replaced by compliance testing. (6.72)

Catering

9.178 All personnel involved in handling food should wear protective clothing. (7.10)

9.179 There should be clear and reliable arrangements to obtain special diets. (7.11)

Examples of good practice

Equality, race and foreign nationals

9.180 The use of email to allow foreign national prisoners to maintain contact with their families was a constructive and progressive initiative. (3.87)

9.181 Weekly 10-minute telephone calls home were a good help to maintain contact with families abroad. (3.88)

Contact with the outside world

9.182 The family/child centred visits scheme was an innovative practice that helped to maintain good relationships. (3.111)

Appendix 1: Inspection team

Kit Chivers	Chief Inspector of Criminal Justice in Northern Ireland.
Nigel Newcomen	Deputy Chief Inspector of Prisons
Michael Loughlin	Inspection team leader
Fay Deadman	Inspector
Ian MacFadyen	Inspector
Paul Fenning	Inspector
Jonathan French	Inspector
Tom McGonigle	Inspector Criminal Justice Inspection Northern Ireland
Elizabeth Tysoe	Healthcare inspector
Steve Gascoigne	Pharmacy inspector
John Reynolds	Dental inspector
John Baird	Lead Inspector Education and Training Inspectorate
Angela Whiteside	Inspector Education and Training Inspectorate
Mark Barr	Inspector Education and Training Inspectorate
Alistair Gilmore	Inspector Education and Training Inspectorate
Jayne Walkingshaw	Inspector Education and Training Inspectorate
Bob Cowdrey	Inspector Ofsted
Samantha Booth	Researcher
Sherrelle Parke	Researcher

Appendix 2: Prison population profile

Juvenile population breakdown by:

(i) Status	Nº of juveniles	Percentage
Sentenced / Fined	3	27.27%
Remand / Awaiting Trail	8	72.73%
Total	11	100.00%

(ii) Length of Sentence	Nº of sentenced juveniles	Percentage
6 months to less than 12 months	1	33.33%
18 to 24 months	1	33.33%
Over 48 months	1	33.33%
Total	3	100.00%

(iii) Length of time served	Nº of juveniles	Percentage
Less than 1 month	3	37.50%
1 month to 3 months	5	62.50%
Total	8	100.00%

(iv) Main offence	Nº of juveniles	Percentage
Other offences against the person	7	63.64%
Burglary/Robbery/Theft	2	18.18%
Sex offences	1	9.09%
Drug offences	1	9.09%
Total	11	100.00%

(v) Age	Nº of juveniles	Percentage
17 years	11	100.00%
Total	11	100.00%

vi) Home address	Nº of juveniles	Percentage
Northern Ireland	11	100.00%
Total	11	100.00%

(vii) Location Breakdown	County	Nº of juveniles	Percentage
Northern Ireland	Co. Antrim	9	81.82%
Northern Ireland	Co. Down	2	18.18%
Total		11%	100.00%

(viii) Nationality	Nº of juveniles	Percentage
British	9	81.82%
Irish	2	18.18%
Total	11	100.00%

(ix) Ethnic group	Nº of juveniles	Percentage
White	11	100.00%
Total	11	100.00%

Religion	Nº of juveniles	Percentage
Free Presbyterian	1	9.09%
Roman Catholic	8	72.73%
Other Religion	1	9.09%
Nil	1	9.09%
Total	11	100.00%

Young adult population breakdown by:

(i) Status	Nº of young adults	Percentage
Fine Defaulter	1	0.54%
Sentenced /Fined	81	43.78%
Remand / Awaiting Trail	102	55.14%
Immigration Detainee	1	0.54%
Total	185	100.00%

(ii) Length of sentence	Nº of sentenced young adults	Percentage
Less than 6 months	15	18.29%
6months to less than 12 months	15	18.29%
12 to 18 months	7	8.54%
18 to 24 months	6	7.32%
24 to 30 months	1	1.23%
36 to 42 month	6	7.23%
42 to 48 months	8	9.76%
Over 48 Months	18	21.95%

Life	6	7.23%
Total	82	100.00%
(iii) Length of time served for unsentenced young adults	Nº of young adults	Percentage
Less than 1 month	22	21.36%
1 month to 3 months	34	33.01%
3 months to 6 months	23	22.33%
6 months to 1 year	13	12.62%
1 to 2 years	10	9.71%
Over 2 years	1	0.97%
Total	103	100.00%

(iv) Main offence	Nº of young adults	Percentage
Murder	17	9.19%
Other Offences Against the Person	93	50.27%
Sex Offences	15	8.11%
Burglary/Robbery/ Theft	36	19.46%
Fraud & Forgery	1	0.54%
Drug Offences	10	5.41%
Motoring Offences	6	3.24%
Offences Against the State	1	0.54%
Criminal Damage	4	2.16%
Other Offences	2	1.08%
Total	185	100.00%

(v) Age	Nº of young adults	Percentage
18 years and over	185	100.00%
Total	185	100.00%

vi) Home address	Nº of young adults	Percentage
Northern Ireland	167	90.27%
Republic of Ireland	3	1.62%
England	2	1.08%
NFA	8	4.32%
Not known	5	2.7%
Total	185	100.00%

(vii) Location Breakdown	County	Nº of young adults	Percentage
Northern Ireland	Co. Antrim	91	49.19%
Northern Ireland	Co. Armagh	6	3.24%
Northern Ireland	Co. Down	29	15.68%
Northern Ireland	Co. Fermanagh	4	2.16%
Northern Ireland	Co.Londonderry	27	14.59%
Northern Ireland	Co.Tyrone	9	4.86%
Northern Ireland		1	0.54%
Republic of Ireland	Dublin	1	0.54%
Republic of Ireland	Donegal	1	0.54%
England	London	1	0.54%
England	Staffordshire	1	0.54%

England		8	4.32%
No Fixed Abode		3	1.62%
Not Known		2	1.08%
Total		185%	100.00%

(viii) Nationality	Nº of young adults	Percentage
British	136	73.51%
Irish	39	21.08%
Argentine	1	0.54%
Australian	1	0.54%
Latvian	1	0.54%
Liberian	1	0.54%
Lithuanian	2	1.08%
Moroccan	1	0.54%
Romanian	1	0.54%
Not Known	2	1.08%
Total	185	100.00%

(ix) Ethnic group	Nº of young adults	Percentage
Afro Caribbean	1	0.54%
Arab	1	0.54%
Black African	1	0.54%
Irish Traveller	11	5.95%
White	170	91.89%

	1	0.54%
Total	185	100.00%

Religion	No's young adults	Percentage
Atheist	1	0.54%
Church of Ireland	14	7.57%
Methodist	3	1.62%
Muslim	1	0.54%
Presbyterian	29	15.68%
Roman Catholic	114	61.62%
Other	21	11.35%
Nil	2	1.08%
Total	185	100.00%

Appendix 3: Summary of juvenile and young people questionnaires and interviews

Juvenile survey methodology

A voluntary, confidential and anonymous survey of a representative proportion of the prisoner population was carried out for this inspection. The results of this survey formed part of the evidence-base for the inspection.

Choosing the sample size

At the time of the survey on 3 October 2007, the juvenile population at Hydebank Wood YOC was 13. As there were so few, the survey was distributed to all juveniles present at the time of the visit.

Completion of the survey was voluntary. None of the respondents refused to complete a survey. Interviews were carried out with six respondents who had literacy difficulties.

Methodology

Surveys were distributed to each respondent individually. This gave researchers an opportunity to explain the independence of the Inspectorate and the purpose of the survey, as well as to answer questions.

All completed questionnaires were confidential – only members of the Inspectorate saw them. In order to ensure confidentiality, respondents were asked to do one of the following:

- have their questionnaire ready to hand back to a member of the research team at a specified time
- seal the questionnaire in the envelope provided and hand it to a member of staff, if they were agreeable
- seal the questionnaire in the envelope provided and leave it in their room for collection.

Respondents were not asked to put their names on their questionnaire.

Response rates

All respondents completed and returned their questionnaires. Therefore, 100% of the population was successfully sampled and the response rate was 100%.

Comparisons

The following document details the results from the survey. All missing responses are excluded from the analysis. All data from each establishment has been weighted, in order to mimic a consistent percentage sampled in each establishment.

Presented alongside the results from this survey are the comparator figures for all prisoners surveyed in juvenile establishments. This comparator is based on all responses from prisoner surveys carried out in 15 juvenile establishments since April 2005.

In the above documents, statistical significance merely indicates whether there is a real difference between the figures, i.e. the difference is not due to chance alone. Results that are significantly better are indicated by green shading, results that are significantly worse are indicated by blue shading and where there is no significant difference, there is no shading.

Young adult survey methodology

A voluntary, confidential and anonymous survey of a representative proportion of the young adult population was carried out for this inspection. The results of this survey formed part of the evidence-base for the inspection.

Choosing the sample size

The baseline for the sample size was calculated using a robust statistical formula provided by a government department statistician. Essentially, the formula indicates the sample size required and the extent to which the findings from a sample of that size reflect the experiences of the whole population.

At the time of the survey on 3 October 2007, the young adult population at Hydebank Wood YOC was 186. The baseline sample size was 93. Overall, this represented 50% of the young adult population.

Selecting the sample

Respondents were randomly selected from a LIDS young adult population printout using a stratified systematic sampling method. This basically means every second person is selected from a LIDS list, which is printed in location order, if 50% of the population is to be sampled.

Completion of the questionnaire was voluntary. Refusals were noted and no attempts were made to replace them. One respondent refused to complete a questionnaire. Interviews were carried out with any respondents with literacy difficulties. Three respondents were interviewed.

Methodology

Every attempt was made to distribute the questionnaires to each respondent individually. This gave researchers an opportunity to explain the independence of the Inspectorate and the purpose of the questionnaire, as well as to answer questions.

All completed questionnaires were confidential – only members of the Inspectorate saw them. In order to ensure confidentiality, respondents were asked to do one of the following:

- have their questionnaire ready to hand back to a member of the research team at a specified time
- seal the questionnaire in the envelope provided and hand it to a member of staff, if they were agreeable
- seal the questionnaire in the envelope provided and leave it in their room for collection.

Respondents were not asked to put their names on their questionnaire.

Response rates

In total, 89 respondents completed and returned their questionnaires. This represented 48% of the young adult population. The response rate was 96%. In addition to the one respondent who refused to complete a questionnaire, one questionnaire was not returned and two were returned blank.

Comparisons

The following document details the results from the survey. All missing responses are excluded from the analysis. All data from each establishment has been weighted in order to mimic a consistent percentage sampled in each establishment.

Presented alongside the results from this survey are the comparator figures for all young adults surveyed in young offender institutions. This comparator is based on all responses from young adult surveys carried out in 23 young offender institutions since April 2003. A further comparative document is attached showing statistically significant differences between the responses of Catholic and Protestant young adults.

In both of these documents, statistically significant differences are highlighted. Statistical significance merely indicates whether there is a real difference between the figures, i.e. the difference is not due to chance alone. Results that are significantly better are indicated by green shading, results that are significantly worse are indicated by blue shading and where there is no significant difference, there is no shading.

Juvenile Survey Responses Hydebank Wood YOC 2007

Juvenile Survey Responses (Missing data has been excluded for each question) Please note: Where there are apparently large differences, which are not indicated as statistically significant, this is likely to be due to chance. NB: This document shows (1) A comparison between the responses from all juveniles surveyed in this establishment with all those surveyed for the juvenile comparator Due to changes to the questionnaire not all questions are comparable.

Key to tables

		HMYOC Hydebank Wood 2007	Juvenile Comparator
	Any percent highlighted in green is significantly better than the juvenile comparator		
	Any percent highlighted in blue is significantly worse than the juvenile comparator		
	Percentages which are not highlighted show there is no significant difference.		
	Number of completed questionnaires returned	13	1093
	SECTION 1: ABOUT YOU (Not tested for significance)		
1.1	Are you 18 years of age?	8%	15%
1.2	Do you usually live in this country?	100%	98%
1.3	Is English your first language?	92%	93%
1.4	Are you from a minority ethnic group? (including all those who did not tick White British, White Irish or White Other category	0%	29%
1.5	Do you have any children?	23%	10%
1.6	Have you ever been in care? (either foster care or children's home)	31%	30%
1.7	Are you on a care order now?	17%	12%
	SECTION 2: ABOUT YOUR SENTENCE (Not tested for significance)		
2.2	Are you sentenced?	15%	80%
2.3	Is your sentence 12 months or less?	8%	40%
2.4	Do you have less than six months to serve?	8%	57%
2.5	Have you been in this prison less than a month?	39%	20%
2.6	Have you been to any other YOI during this sentence?	23%	29%
2.7	Is this the first time that you have been in a YOI, secure children's home or secu training centre before either sentenced or on remanc	31%	40%
	SECTION 3: COURTS, TRANSFERS AND ESCORTS		
3.1	We want to know about the most recent journey you have made either to or from cou or between establishments? Was the van clean	23%	42%
3.2	We want to know about the most recent journey you have made either to or from court or between establishments? Was the van comfortable	0%	9%
3.3	We want to know about the most recent journey you have made either to or from court or between establishments? Did you feel safe	83%	62%
3.4	We want to know about the most recent journey you have made either to or from court or between establishments? Did you have enough comfort break	8%	12%
3.5	We want to know about the most recent journey you have made either to or from court or between establishments? Were your health needs looked afte	33%	49%
3.6	Did you spend more than four hours in the van?	0%	7%
3.7	Were you treated well/very well by the escort staff?	62%	63%
3.8	Did you know where you were going when you left court or when transferred fro another establishment	92%	81%
3.9	Did you receive written information about what would happen to you before y arrived?	0%	24%

Key to tables

		HMYOC Hydebank Wood 2007	Juvenile Comparator
	Any percent highlighted in green is significantly better than the juvenile comparator		
	Any percent highlighted in blue is significantly worse than the juvenile comparator		
	Percentages which are not highlighted show there is no significant difference.		
	Number of completed questionnaires returned	13	1093
	SECTION 4: YOUR FIRST FEW DAYS HERE		
4.1	Did you have any problems when you first arrived?	**92%**	**69%**
4.2	When you first arrived here did your property arrive at the same time as you?	**54%**	**80%**
4.3	Were you told what you needed to know by the staff when you first arrived?	**77%**	**70%**
4.4	Were you in reception for less than 2 hours?	**83%**	**80%**
4.5	Were you seen by a member of healthcare staff in reception?	**69%**	**91%**
4.6	When you were searched was this carried out in an understanding way?	**85%**	**83%**
4.7	Were you treated well/very well in reception?	**62%**	**70%**
4.8	Were you able to make a telephone call to your family/friends on your first day here?	**39%**	**82%**
4.9a	Did you have access to a chaplain within the first 24 hours of you arriving at tl prison?	**8%**	**41%**
4.9b	Did you have access to someone from healthcare within the first 24 hours of you arriving at this prison?	**58%**	**62%**
4.9c	Did you have access to a Listener/Samaritans within the first 24 hours of you arriving at this prison?	**25%**	**14%**
4.9d	Did you have access to the prison shop/canteen within the first 24 hours of you arrivi at this prison?	**17%**	**19%**
4.10	Did you feel safe on your first night here?	**69%**	**80%**
4.11	Did you go on an induction course within your first week?	**31%**	**63%**
4.12	Did the induction course cover everything you needed to know about the prison?	**17%**	**52%**
	SECTION 5: DAILY LIFE HERE		
5.1	Is it easy/very easy for you to attend religious services?	**69%**	**53%**
5.2	Does the shop/canteen sell a wide enough range of goods to meet your needs?	**85%**	**46%**
5.3	Do you find the food here good/very good?	**0%**	**21%**
5.4	Have you talked to an advocate since you have been here (an outside person to he you with the authorities)?	**23%**	**29%**
5.5	Are you normally able to shower everyday if you want to?	**62%**	**53%**
5.6	Is your cell call bell normally answered within five minutes?	**42%**	**32%**
	SECTION 6: HEALTHCARE		
6.1	Do you think the overall quality of the healthcare is good/very good?	**39%**	**53%**
6.2a	Is it easy for you to see the Doctor?	**92%**	**51%**
6.2b	Is it easy for you to see the Nurse?	**100%**	**70%**
6.2c	Is it easy for you to see the Dentist?	**54%**	**27%**
6.2d	Is it easy for you to see the Optician?	**39%**	**20%**
6.3	Have you had any problems getting your medication?	**15%**	**15%**
6.4	Have you received any help with any alcohol problems?	**15%**	**28%**
6.5	Have you received any help with any drugs problems?	**46%**	**36%**

Key to tables

		HMYOC Hydebank Wood 2007	Juvenile Comparator
	Any percent highlighted in green is significantly better than the juvenile comparator		
	Any percent highlighted in blue is significantly worse than the juvenile comparator		
	Percentages which are not highlighted show there is no significant difference.		
	Number of completed questionnaires returned	13	1093
	SECTION 7: REWARDS, SANCTIONS AND COMPLAINTS		
7.1	Are you on the enhanced (Top) level of the reward scheme?	8%	26%
7.2	Do the different levels make you change your behaviour?	46%	60%
7.3	Do you feel you have been treated fairly in your experience of the reward scheme?	62%	53%
7.4	Do you know how to make a complaint?	85%	84%
7.5	Is it easy to make a complaint?	0%	43%
7.6	Do you feel complaints are sorted out fairly?	0%	17%
7.7	Have you ever been made to or encouraged to withdraw a complaint?	15%	9%
	SECTION 8: DISCIPLINE AND RESPECT		
8.1	Have you had a 'nicking' (adjudication or minor report) since you have been here?	69%	56%
8.2	Have you been physically restrained (Cand R) since you have been here?	46%	25%
8.3	If you have spent a night in the segregation/care and separation unit, did the staff tre you well/very well?	15%	11%
8.4	Do most staff treat you with respect?	54%	76%
	SECTION 9: SAFETY		
9.1	Have you ever felt unsafe in this prison?	39%	29%
9.3	Has another young person or group of young people victimised (insulted or assaulte you here?	8%	25%
9.4a	If you have felt victimised by a prisoner/group of prisoners, what did the incident(involve: Insulting remarks'	8%	15%
9.4b	If you have felt victimised by a prisoner/group of prisoners, what did the incident(s) involve: Physical abuse?	0%	10%
9.4c	If you have felt victimised by a prisoner/group of prisoners, what did the incident(s) involve: Sexual abuse?	0%	1%
9.4d	If you have felt victimised by a prisoner/group of prisoners, what did the incident(involve: Racial or Ethnic abuse	0%	4%
9.4e	If you have felt victimised by a prisoner/group of prisoners, what did the incident(involve: Drugs?	0%	2%
9.4d	If you have felt victimised by a prisoner/group of prisoners, what did the incident(involve: Having your canteen/property taker	0%	6%
9.4e	If you have felt victimised by a prisoner/group of prisoners, what did the incident(involve: Because you were new here	0%	7%
9.4f	If you have felt victimised by a prisoner/group of prisoners, what did the incident(involve: Being from a different part of the country than other	0%	7%
9.6	Has a member of staff or group of staff victimised (insulted or assaulted) you here?	15%	19%
9.7a	If you have felt victimised by a staff/group of staff, what did the incident(s) involv Insulting remarks?	8%	11%
9.7b	If you have felt victimised by a staff/group of staff, what did the incident(s) involv Physical abuse?	8%	3%
9.7c	If you have felt victimised by a staff/group of staff, what did the incident(s) involv Sexual abuse?	0%	1%
9.7d	If you have felt victimised by a staff/group of staff, what did the incident(s) involv Racial or Ethnic abuse'	0%	2%
9.7e	If you have felt victimised by a staff/group of staff, what did the incident(s) involv Drugs?	8%	1%
9.7f	If you have felt victimised by a staff/group of staff, what did the incident(s) involv Having your canteen/property taken	8%	3%
9.7g	If you have felt victimised by a staff/group of staff, what did the incident(s) involv Because you were new here'	0%	3%
9.7h	If you have felt victimised by a staff/group of staff, what did the incident(s) involv Being from a different part of the country than other	0%	2%
9.9	If you were being victimised by another young person or a member of staff would y be able to tell anyone about it'	77%	63%
9.10	If you did tell a member of staff that you were being victimised do you think it wou be taken seriously?	46%	40%
9.11	When you first arrived here did other young people shout through the windows at you?	54%	38%
9.12	Did you find this shouting threatening?	15%	14%
9.13	Do other young people shout through the windows at you now?	23%	26%
9.14	Do you find this threatening now?	0%	8%
9.15	Do you shout through the windows at others?	39%	25%
9.16	Have staff checked on you personally in the last week to see how you are getting on?	39%	32%

Key to tables

		HMYOC Hydebank Wood 2007	Juvenile Comparator
	Any percent highlighted in green is significantly better than the juvenile comparator		
	Any percent highlighted in blue is significantly worse than the juvenile comparator		
	Percentages which are not highlighted show there is no significant difference.		
	Number of completed questionnaires returned	13	1093
	SECTION 10: ACTIVITIES		
10.1	Were you under the age of 14 when you were last at school?	54%	38%
10.2a	Have you ever been excluded from school?	100%	86%
10.2b	Have you ever truanted from school?	85%	75%
10.3	Are you doing any education here?	15%	82%
10.4	Is education helping you?	8%	55%
10.5	Do you feel you need help with reading, writing or maths?	62%	31%
10.6	Were the teachers understanding with any school problems when you first arrived?	46%	51%
10.7a	Are you learning a skill or trade?	15%	51%
10.7b	Are you in a job here?	33%	33%
10.8	Do you go to the gym more than 5 times each week?	0%	10%
10.9	Do you go on association more than 5 times each week?	77%	48%
10.10	Can you go outside for exercise everyday?	8%	29%
	SECTION 11: KEEPING IN TOUCH WITH FAMILY AND FRIENDS		
11.1	Are you able to use the telephone to speak to someone in your family every day?	77%	50%
11.2	Have you had any problems getting access to the telephones?	39%	33%
11.3	Have you had any problems with sending or receiving mail?	15%	30%
11.4	Is it easy/very easy for you family and friends to get here to visit you?	46%	33%
11.5	Do you get 2 or more visits each month?	77%	46%
11.6	Do you arrive on time for a visit?	69%	67%
11.7	Are you and your family/friends treated well/very well by visits staff?	62%	61%
	SECTION 12: RESETTLEMENT		
12.1	Did you meet your personal officer within your first week here?	42%	42%
12.2	Do you feel helped by your personal officer?	36%	48%
12.3	Do you know what targets you have been set in your training/sentence plan?	17%	63%
12.4	If you want, can you see your training/sentence plan?	8%	35%
12.5	Has your YOT/social worker/probation officer been in touch since you arrived here?	77%	79%
12.6	Do you know how to get in touch with your YOT/social worker/probation officer?	39%	57%
12.7	Do you want to stop offending?	15%	71%
12.9	Have you had a say in what will happen to you when you are released?	67%	41%
12.10	When you are released will you be living with a family member?	54%	68%
12.11	Have you had help with finding accommodation?	8%	25%
12.12	Are you going to school or college on release?	23%	36%
12.13	Has anyone spoken to you about going to college on release?	15%	34%
12.14	Do you have a job to go to on release?	39%	25%
12.15	Have you done anything during your time here that you think will help you to get a job on release?	8%	44%
12.16	Has anyone from here spoken to you about getting a job on release or about New Deal?	8%	24%
12.17	Do you have a Connexions personal adviser?	0%	35%
12.18	Is there anything you would still like help with before you are released?	62%	39%
12.19	Have you done anything or has anything happened to you here that you think will make you less likely to offend in the future	15%	42%

Young Adult Survey Responses Hydebank Wood YOC 2007

Prisoner Survey Responses (Missing data has been excluded for each question) Please note: Where there are apparently large differences, which are not indicated as statistically significant, this is likely to be due to chance.

Key to tables

		HMYOC Hydebank Wood	Young Adult comparator
	Any percent highlighted in green is significantly better than the young adult prisons comparator		
	Any percent highlighted in blue is significantly worse than the young adult prisons comparator.		
	Percentages which are not highlighted show there is no significant difference between the 2007 survey and the young adult prisons comparator		
SECTION 1: General Information (not tested for significance)			
1	Number of completed questionnaires returned	**89**	**1891**
2	Are you under 21 years of age?	**91%**	**87%**
3	Are you transgender or transsexual?	**1%**	**0%**
4	Are you sentenced?	**46%**	**82%**
5	Are you here under an indeterminate sentence for public protection (IPP prisoner)?	**10%**	**6%**
6	If you are sentenced, are you on recall?	**2%**	**14%**
8	Is your sentence less than 12 months?	**15%**	**19%**
9	Do you have less than six months to serve?	**26%**	**41%**
10	Have you been in this prison less than a month?	**16%**	**16%**
11	Are you a foreign national?	**10%**	**10%**
12	Is English your first language?	**93%**	**93%**
13	Are you from a minority ethnic group? (including all those who did not tick White British, White Irish or White other categories)	**3%**	**28%**
14	Are you Muslim?	**0%**	**19%**
15	Are you gay or bisexual?	**3%**	**2%**
16	Do you consider yourself to have a disability?	**16%**	**10%**
17	Are you a Registered Disabled Person?	**2%**	**3%**
18	Is this your first time in prison?	**36%**	**42%**
19	Do you have any children?	**21%**	**24%**
SECTION 2: Transfers and Escorts			
19a	We want to know about the most recent journey you have made either to or from court or between establishments. How was the cleanliness of the van? (very good/good)	**15%**	**35%**
19b	We want to know about the most recent journey you have made either to or from court or between establishments. How was your personal safety during the journey? (very good/good)	**39%**	**58%**
19c	We want to know about the most recent journey you have made either to or from court or between establishments. How was the comfort of the van? (very good/good)	**4%**	**11%**
18d	We want to know about the most recent journey you have made either to or from court or between establishments. How was the attention paid to your health needs?	**22%**	**33%**
19e	We want to know about the most recent journey you have made either to or from court or between establishments. How was the frequency of comfort breaks? (very good/good)	**11%**	**12%**
20	Did you spend more than four hours in the van?	**4%**	**6%**
21	Were you treated well/very well by the escort staff?	**51%**	**66%**
22a	Did you know where you were going when you left court or when transferred from another establishment?	**88%**	**81%**
22b	Before you arrived here did you receive any written information about what would happen to you?	**9%**	**24%**
22c	When you first arrived here did your property arrive at the same time as you?	**76%**	**86%**

Key to tables

		HMYOC Hydebank Wood	Young Adult comparator
	Any percent highlighted in green is significantly better than the young adult prisons comparator		
	Any percent highlighted in blue is significantly worse than the young adult prisons comparator.		
	Percentages which are not highlighted show there is no significant difference between the 2007 survey and the young adult prisons comparator		
SECTION 3: Reception, first night and induction			
24a	Did you have any problems when you first arrived?	**76%**	**57%**
24b	Did you have any problems with loss of transferred property when you first arrived?	**8%**	**8%**
24c	Did you have any housing problems when you first arrived?	**15%**	**15%**
24d	Did you have any problems contacting employers when you first arrived?	**6%**	**3%**
24e	Did you have any problems contacting family when you first arrived?	**16%**	**21%**
24f	Did you have any problems ensuring dependents were being looked after when you first arrived?	**8%**	**3%**
24g	Did you have any money worries when you first arrived?	**31%**	**20%**
24h	Did you have any problems with feeling depressed or suicidal when you first arrived?	**35%**	**14%**
24i	Did you have any drug problems when you first arrived?	**39%**	**14%**
24j	Did you have any alcohol problems when you first arrived?	**39%**	**11%**
24k	Did you have any health problems when you first arrived?	**22%**	**9%**
24l	Did you have any problems with needing protection from other prisoners when you first arrived?	**5%**	**6%**
25a	Were you offered any help/support from any member of staff in dealing with problems on loss of transferred property within the first 24 hours?	**21%**	**14%**
25b	Were you offered any help/support from any member of staff in dealing with housing problems within the first 24 hours?	**14%**	**33%**
25c	Were you offered any help/support from any member of staff in dealing with problems contacting employers within the first 24 hours?	**18%**	**17%**
25d	Were you offered any help/support from any member of staff in dealing with problems contacting family within the first 24 hours?	**66%**	**63%**
25e	Were you offered any help/support from any member of staff in dealing with problems ensuring dependants were looked after within the first 24 hours?	**31%**	**28%**
25f	Were you offered any help/support from any member of staff in dealing with money problems within the first 24 hours?	**30%**	**21%**
25g	Were you offered any help/support from any member of staff in dealing with problems of feeling depressed/suicidal within the first 24 hours?	**37%**	**36%**
25h	Were you offered any help/support from any member of staff in dealing with drug problems within the first 24 hours?	**39%**	**41%**
25i	Were you offered any help/support from any member of staff in dealing with alcohol problems within the first 24 hours?	**37%**	**39%**
25j	Were you offered any help/support from any member of staff in dealing with health problems within the first 24 hours?	**53%**	**49%**
25k	Were you offered any help/support from any member of staff in dealing with problems in needing protection from other prisoners within the first 24 hours?	**25%**	**18%**
26a	Please answer the following question about reception: were you seen by a member of healthcare staff?	**83%**	**89%**
26b	Please answer the following question about reception: when you were searched, was this carried out in a sensitive and understanding way'	**65%**	**69%**
27	Were you treated well/very well in reception?	**49%**	**64%**
28a	Did you receive a reception pack on your day of arrival?	**74%**	**81%**
28b	Did you receive information about what was going to happen here on your day of arrival?	**35%**	**57%**
28c	Did you receive information about support for feeling depressed or suicidal on your day of arrival?	**26%**	**53%**
28d	Did you have the opportunity to have a shower on your day of arrival?	**89%**	**41%**

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SECTION 3: Reception, first night and induction continued			
28e	Did you get the opportunity to have a free telephone call on your day of arrival?	**61%**	**71%**
28f	Did you get information about routine requests on your day of arrival?	**52%**	**43%**
28g	Did you get something to eat on your day of arrival?	**73%**	**82%**
28h	Did you get information about visits on your day of arrival?	**48%**	**55%**
29a	Did you have access to the chaplain within the first 24 hours of you arriving at this prison?	**15%**	**49%**
29b	Did you have access to someone from healthcare within the first 24 hours?	**74%**	**67%**
29c	Did you have access to a Listener/Samaritans within the first 24 hours of you arriving at this prison?	**11%**	**26%**
29d	Did you have access to the prison shop/canteen within the first 24 hours?	**27%**	**19%**
30	Did you feel safe on your first night here?	**61%**	**80%**
31	Did you go on an induction course within the first week?	**39%**	**70%**
32	Did the induction course cover everything you needed to know about the prison?	**46%**	**59%**
33	Did you receive a 'basic skills' assessment within the first week?	**23%**	**47%**
SECTION 4: Legal Rights and Respectful Custody			
35a	Is it very easy/easy to communicate with your solicitor or legal representative?	**63%**	**62%**
35b	Is it very easy/easy for you to attend legal visits?	**68%**	**67%**
35c	Is it very easy/easy for you to obtain bail information?	**46%**	**46%**
36	Have staff ever opened letters from your solicitor or legal representative when you were not with them?	**46%**	**38%**
37a	Please answer the following question about the wing/unit you are currently on: are you normally offered enough clean, suitable clothes for the week?	**65%**	**56%**
37b	Please answer the following question about the wing/unit you are currently on: are you normally able to have a shower every day?	**78%**	**57%**
37c	Please answer the following question about the wing/unit you are currently on: do you normally receive clean sheets every week?	**87%**	**82%**
37d	Please answer the following question about the wing/unit you are currently on: do you normally get cell cleaning materials every week?	**85%**	**58%**
36e	Please answer the following question about the wing/unit you are currently on: is your cell call bell normally answered within five minutes?	**41%**	**42%**
37f	Please answer the following question about the wing/unit you are currently on: is it normally quiet enough for you to be able to relax or sleep in your cell at night time?	**53%**	**58%**
37g	Please answer the following question about the wing/unit you are currently on: can you normally get your stored property, if you need to?	**48%**	**36%**
38	Is the food in this prison good/very good?	**16%**	**27%**
39	Does the shop/canteen sell a wide enough range of goods to meet your needs?	**64%**	**48%**
40a	Is it easy/very easy to get a complaints form?	**62%**	**79%**
40b	Is it easy/very easy to get an application form?	**59%**	**84%**
41a	Do you feel applications are sorted out fairly?	**14%**	**32%**
41b	Do you feel your applications are sorted out promptly?	**19%**	**30%**
41c	Do you feel complaints are sorted out fairly?	**3%**	**26%**
41d	Do you feel complaints are sorted out promptly?	**14%**	**23%**
41e	Are you given information about how to make an appeal?	**16%**	**34%**
42	Have you ever been made to or encouraged to withdraw a complaint since you have been in this prison?	**22%**	**13%**
43	Do you know how to apply to the Prisons and Probation Ombudsman?	**35%**	**28%**

Key to tables

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SECTION 4: Legal Rights and Respectful Custody continued			
44	Is it easy/very easy to contact the Independent Monitoring Board?	**29%**	**25%**
45	Are you on the enhanced (top) level of the IEP scheme?	**52%**	**30%**
46	Do you feel you have been treated fairly in your experience of the IEP scheme?	**52%**	**46%**
47a	In the last six months have any members of staff physically restrained you (C & R)?	**11%**	**12%**
47b	In the last six months have you spent a night in the segregation/care and separation unit?	**23%**	**16%**
48a	Do you feel your religious beliefs are respected?	**54%**	**47%**
49b	Are you able to speak to a religious leader of your faith in private if you want to?	**68%**	**55%**
50	Are you able to speak to a Listener at any time, if you want to?	**34%**	**51%**
51a	Do you have a member of staff, in this prison, that you can turn to for help if you have a problem?	**50%**	**69%**
51b	Do **most** staff, in this prison, treat you with respect?	**56%**	**67%**
SECTION 5: Safety			
52	Have you ever felt unsafe in this prison?	**52%**	**31%**
53	Do you feel unsafe in this establishment at the moment?	**23%**	**20%**
55	Have you been victimised (insulted or assaulted) by another prisoner?	**35%**	**23%**
56a	Have you had insulting remarks made about you, your family or friends since you have been here? (By prisoners)	**22%**	**14%**
56b	Have you been hit, kicked or assaulted since you have been here? (By prisoners)	**12%**	**10%**
56c	Have you been sexually abused since you have been here? (By prisoners)	**3%**	**1%**
56d	Have you been victimised because of your race or ethnic origin since you have been here? (By prisoners)	**7%**	**3%**
56e	Have you been victimised because of drugs since you have been here? (By prisoners)	**4%**	**2%**
56f	Have you ever had your canteen/property taken since you have been here? (By prisoners)	**6%**	**5%**
56g	Have you ever been victimised because you were new here? (By prisoners)	**12%**	**6%**
56h	Have you ever been victimised because of your sexuality? (By prisoners)	**3%**	**2%**
56i	Have you ever been victimised because you have a disability? (By prisoners)	**3%**	**2%**
56j	Have you ever been victimised because of your religion/religious beliefs? (By prisoners)	**12%**	**3%**
56k	Have you ever been victimised because you were from a different part of the country than others since you have been here? (by prisoners)	**12%**	**6%**
57	Have you been victimised (insulted or assaulted) by a member of staff?	**36%**	**23%**
58a	Have you had insulting remarks made about you, your family or friends since you have been here? (By staff)	**24%**	**13%**
58b	Have you been hit, kicked or assaulted since you have been here? (By staff)	**9%**	**5%**
58c	Have you been sexually abused since you have been here? (By staff)	**1%**	**1%**
58d	Have you been victimised because of your race or ethnic origin since you have been here? (By staff)	**9%**	**4%**
58e	Have you been victimised because of drugs since you have been here? (By staff)	**8%**	**1%**
58f	Have you ever been victimised because you were new here? (By staff)	**8%**	**5%**
58g	Have you ever been victimised because of your sexuality? (By staff)	**2%**	**1%**
58h	Have you ever been victimised because you have a disability? (By staff)	**2%**	**2%**
58i	Have you ever been victimised because of your religion/religious beliefs? (By staff)	**16%**	**4%**

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SECTION 5: Safety continued			
58j	Have you ever been victimised because you were from a different part of the country than others since you have been here? (By staff)	**3%**	**5%**
59	Did you report any victimisation that you have experienced?	**9%**	**11%**
60	Have you ever felt threatened or intimidated by another prisoner/ group of prisoners in here?	**41%**	**28%**
61	Have you ever felt threatened or intimidated by a member of staff in here?	**38%**	**19%**
62	Is it very easy/easy to get illegal drugs in this prison?	**37%**	**21%**
SECTION 6: Healthcare			
64	Do you think the overall quality of the healthcare is good/very good?	**35%**	**46%**
65a	Is it very easy/easy to see the doctor?	**39%**	**40%**
65b	Is it very easy/easy to see the nurse?	**53%**	**59%**
65c	Is it very easy/easy to see the dentist?	**22%**	**17%**
65d	Is it very easy/easy to see the optician?	**15%**	**14%**
65e	Is it very easy/easy to see the pharmacist?	**16%**	**25%**
66a	Do you think the quality of healthcare from the doctor is good/very good?	**35%**	**43%**
66b	Do you think the quality of healthcare from the nurse is good/very good?	**41%**	**56%**
66c	Do you think the quality of healthcare from the dentist is good/very good?	**35%**	**23%**
66d	Do you think the quality of healthcare from the optician is good/very good?	**16%**	**15%**
66e	Do you think the quality of healthcare from the dispensing staff/pharmacist is good/very good?	**15%**	**30%**
67	Are you currently taking medication?	**17%**	**23%**
68	Are you allowed to keep possession of your medication in your own cell?	**13%**	**13%**
SECTION 7: Purposeful Activity			
70a	Do you feel your job will help you on release?	**51%**	**36%**
70b	Do you feel your vocational or skills training will help you on release?	**35%**	**37%**
70c	Do you feel your education (including basic skills) will help you on release?	**48%**	**49%**
70d	Do you feel your offending behaviour programmes will help you on release?	**42%**	**34%**
70e	Do you feel your drug or alcohol programmes will help you on release?	**53%**	**37%**
71	Do you go to the library at least once a week?	**17%**	**28%**
72	Can you get access to a newspaper every day?	**63%**	**36%**
73	On average, do you go to the gym at least twice a week?	**59%**	**49%**
74	On average, do you go outside for exercise three or more times a week?	**2%**	**39%**
75	On average, do you spend ten or more hours out of your cell on a weekday? (This includes hours at education, at work etc	**8%**	**9%**
76	On average, do you go on association more than five times each week?	**52%**	**43%**
77	Do staff normally speak to you at least most of the time during association time? (most/all of the time)	**21%**	**22%**

Key to tables

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SECTION 8: Resettlement			
79	Did you first meet your personal officer in the first week?	**20%**	**31%**
80	Do you think your personal officer is helpful/very helpful?	**23%**	**40%**
81	Do you have a sentence plan?	**15%**	**44%**
82	Were you involved/very involved in the development of your sentence plan?	**14%**	**31%**
83	Can you achieve all or some of your sentence plan targets in this prison?	**14%**	**24%**
84	Are there plans for you to achieve all/some of your sentence plan targets in another prison?	**3%**	**14%**
85	Do you feel that any member of staff has helped you to address your offending behaviour whilst at this prison?	**42%**	**29%**
86	Do you feel that any member of staff has helped you to prepare for release?	**28%**	**16%**
87	Have you had any problems with sending or receiving mail?	**43%**	**38%**
88	Have you had any problems getting access to the telephones?	**39%**	**30%**
89	Did you have a visit in the first week that you were here?	**57%**	**38%**
90	Does this prison give you the opportunity to have the visits you are entitled to? (e.g. number and length visit)	**67%**	**68%**
91	Did you receive five or more visits in the last week?	**0%**	**1%**
92a	Do you think you will have a problem maintaining and/ or avoiding relationships following your release from this prison?	**36%**	**23%**
92b	Do you think you will have a problem with finding a job following your release from this prison?	**62%**	**58%**
92c	Do you think you will have a problem with finding accommodation following your release from this prison?	**47%**	**41%**
92d	Do you think you will have a problem with money and finances following your release from this prison?	**65%**	**55%**
92e	Do you think you will have a problem with claiming benefits following your release from this prison?	**51%**	**35%**
92f	Do you think you will have a problem with arranging a place a place at college or continuing education following your release from this prison	**59%**	**47%**
92g	Do you think you will have a problem with contacting external drug or alcohol agencies following your release from this prison?	**41%**	**18%**
92h	Do you think you will have a problem with accessing healthcare services following your release from this prison?	**25%**	**19%**
92i	Do you think you will have a problem with opening a bank account following your release from this prison?	**31%**	**30%**

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SECTION 8: Resettlement continued			
93a	Do you think you will have a problem with drugs when you leave this prison?	**30%**	**14%**
93b	Do you think you will have a problem with alcohol when you leave this prison?	**37%**	**15%**
94a	Do you know who to contact, within this prison, to get help with finding a job on release?	**41%**	**48%**
94b	Do you know who to contact, within this prison, to get help with finding accommodation on release?	**41%**	**50%**
94c	Do you know who to contact, within this prison, to get help with your finances in preparation for release?	**34%**	**35%**
94d	Do you know who to contact, within this prison, to get help with claiming benefits on release?	**37%**	**46%**
94e	Do you know who to contact, within this prison, to get help with arranging a place at college/continuing education on release?	**32%**	**41%**
94f	Do you know who to contact within this prison to get help with external drugs courses etc	**40%**	**46%**
94g	Do you know who to contact, within this prison, to get help with continuity of healthcare on release?	**39%**	**42%**
94h	Do you know who to contact, within this prison, to get help with opening a bank account on release?	**40%**	**40%**
95	Have you done anything, or has anything happened to you here that you think will make you less likely to offend in the future?	**24%**	**49%**

Key Question Responses (Religion) Hydebank Wood YOC 2007

Prisoner Survey Responses (Missing data has been excluded for each question) Please note: Where there are apparently large differences, which are not indicated as statistically significant, this is likely to be due to chance.

Key to tables

	Any percent highlighted in green is significantly better	Catholic Prisoners	Protestant Prisoners
	Any percent highlighted in blue is significantly worse		
	Percentages which are not highlighted show there is no significant difference		
Number of completed questionnaires returned		54	29
4	Are you sentenced? **(Not tested for significance)**	**34%**	**69%**
10	Are you a foreign national? **(Not tested for significance)**	**14%**	**7%**
11	Is English your first language? **(Not tested for significance)**	**93%**	**97%**
12	Are you from a minority ethnic group? Including all those who did not tick White British, White Irish or White other categories. **(Not tested for significance)**	**5%**	**0%**
17	Is this your first time in prison? **(Not tested for significance)**	**39%**	**28%**
21	Were you treated well/very well by the escort staff?	**52%**	**55%**
22a	Did you know where you were going when you left court or when transferred from another establishment?	**87%**	**87%**
24	Did you have any problems when you first arrived?	**74%**	**83%**
26a	Please answer the following question about reception: were you seen by a member of healthcare staff?	**84%**	**75%**
26b	Please answer the following question about reception: when you were searched, was this carried out in a sensitive and understanding way?	**68%**	**64%**
27	Were you treated well/very well in reception?	**49%**	**48%**
30	Did you feel safe on your first night here?	**62%**	**62%**
31	Did you go on an induction course within the first week?	**36%**	**45%**
35a	Is it very easy/easy to communicate with your solicitor or legal representative?	**63%**	**66%**
37a	Please answer the following question about the wing/unit you are currently on: are you normally offered enough clean, suitable clothes for the week?	**72%**	**59%**
37b	Please answer the following question about the wing/unit you are currently on: are you normally able to have a shower every day?	**77%**	**83%**
37e	Please answer the following question about the wing/unit you are currently on: is your cell call bell normally answered within five minutes?	**45%**	**38%**
38	Is the food in this prison good/very good?	**16%**	**17%**
39	Does the shop/canteen sell a wide enough range of goods to meet your needs?	**73%**	**48%**
40a	Is it easy/very easy to get a complaints form?	**65%**	**50%**
40b	Is it easy/very easy to get an application form?	**62%**	**48%**
41a	Do you feel applications are sorted out fairly?	**10%**	**17%**

Key to tables

	Any percent highlighted in green is significantly better	Catholic Prisoners	Protestant Prisoners
	Any percent highlighted in blue is significantly worse		
	Percentages which are not highlighted show there is no significant difference		
41c	Do you feel complaints are sorted out fairly?	**4%**	**0%**
45	Are you on the enhanced (top) level of the IEP scheme?	**44%**	**62%**
46	Do you feel you have been treated fairly in your experience of the IEP scheme?	**51%**	**52%**
47a	In the last six months have any members of staff physically restrained you (C & R)?	**10%**	**13%**
47b	In the last six months have you spent a night in the segregation/care and separation unit?	**24%**	**25%**
48a	Do you feel your religious beliefs are respected?	**57%**	**62%**
48b	Are you able to speak to a religious leader of your faith in private if you want to?	**67%**	**83%**
50a	Do you have a member of staff, in this prison, that you can turn to for help if you have a problem?	**49%**	**48%**
50b	Do **most** staff, in this prison, treat you with respect?	**60%**	**48%**
52	Have you ever felt unsafe in this prison?	**51%**	**52%**
53	Do you feel unsafe in this establishment at the moment?	**24%**	**21%**
55	Have you been victimised (insulted or assaulted) by another prisoner?	**31%**	**41%**
56d	Have you been victimised because of your race or ethnic origin since you have been here? (By prisoners)	**9%**	**3%**
56j	Have you been victimised because of your religion/religious beliefs? (By prisoners)	**12%**	**13%**
57	Have you been victimised (insulted or assaulted) by a member of staff?	**37%**	**38%**
58d	Have you been victimised because of your race or ethnic origin since you have been here? (By staff)	**16%**	**0%**
58i	Have you been victimised because of your religion/religious beliefs? (By staff)	**22%**	**7%**
60	Have you ever felt threatened or intimidated by another prisoner/ group of prisoners in here?	**40%**	**45%**
61	Have you ever felt threatened or intimidated by a member of staff in here?	**45%**	**31%**
62	Is it very easy/easy to get illegal drugs in this prison?	**37%**	**39%**
64	Do you think the overall quality of the healthcare is good/very good?	**35%**	**32%**
65a	Is it very easy/easy to see the doctor?	**36%**	**39%**
65b	Is it very easy/easy to see the nurse?	**53%**	**50%**
70a	Do you feel your job will help you on release?	**44%**	**59%**
70b	Do you feel your vocational or skills training will help you on release?	**33%**	**35%**
70c	Do you feel your education (including basic skills) will help you on release?	**47%**	**45%**

Key to tables

	Any percent highlighted in green is significantly better	Catholic Prisoners	Protestant Prisoners
	Any percent highlighted in blue is significantly worse		
	Percentages which are not highlighted show there is no significant difference		
70d	Do you feel your offending behaviour programmes will help you on release?	**27%**	**61%**
70e	Do you feel your drug or alcohol programmes will help you on release?	**43%**	**71%**
71	Do you go to the library at least once a week?	**21%**	**10%**
73	On average, do you go to the gym at least twice a week?	**66%**	**52%**
75	On average, do you spend ten or more hours out of your cell on a weekday? (This includes hours at education, at work etc)	**8%**	**3%**
76	On average, do you go on association more than five times each week?	**50%**	**59%**
77	Do staff normally speak to you at least most of the time during association time? (most/all of the time)	**28%**	**10%**
79	Did you first meet your personal officer in the first week?	**23%**	**11%**
81	Do you have a sentence plan?	**9%**	**25%**
91	Have you had any problems with sending or receiving mail?	**41%**	**55%**
92	Have you had any problems getting access to the telephones?	**44%**	**38%**
94	Does this prison give you the opportunity to have the visits you are entitled to? (e.g. number and length of visit)	**59%**	**75%**
99	Have you done anything, or has anything happened to you here that you think will make you less likely to offend in the future?	**10%**	**45%**