Report on an unannounced inspection of

Hydebank Wood Prison and Young Offender Centre

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

14–17 March 2005

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Introduction

As part of the inspection regime, the Prisons Inspectorate of England and Wales carries out short unannounced inspections to follow up recommendations made at full inspections, and to chart an establishment's progress. This pattern has also been adopted by the Criminal Justice Inspectorate of Northern Ireland, in relation to prisons inspecting.

This short unannounced inspection of Hydebank Wood young offender centre (YOC) followed up a full inspection carried out in 2001. During the intervening years, both the YOC and the Northern Ireland Prison Service have experienced some difficulties and upheavals: poor industrial relations and consequent industrial action, and the removal of women prisoners from Mourne House to one of the houses at the YOC.

These had posed significant challenges for managers, and the consequences were evident during this inspection. Managers had had to focus on the needs, and problems, associated with the arrival of women prisoners in a far from suitable prison environment. Industrial action, during the inspection, meant that staff were working to rule and as a result young prisoners were confined to their cells for very lengthy periods. Overall, these factors had blocked some of the positive developments that were beginning, or had been promised, at the time of the last inspection.

Only one of the main recommendations made at that time had been fully achieved – improved systems for managing suicide and self-harm. Others, such as in-cell sanitation, sufficient education and training, and improved time out of cell had not: even discounting the effect of the current industrial action. We were concerned that managers did not always know about, or fully appreciate, some of the deficiencies that inspectors found.

Some aspects of the care of young people at Hydebank Wood deserve praise. The accommodation and environment were of a high standard. It is also noticeable that in a society where the suicide rate among young men is alarmingly high, there had been no self-inflicted deaths at Hydebank Wood. Indeed, some young people told us that they felt safer inside the YOC than outside. However, some key procedures, such as first night and anti-bullying, needed development; and too many vulnerable young people were routinely placed in strip-clothing and special cells as a first response to fears of self-harm. We had particular concerns about the severity of punishments in the 'special supervision' unit, (or the 'block' as it was routinely called); and the lack of formal records and evidence of support or a structured regime for young people held there.

Relationships between staff and young prisoners had improved slightly, and many staff knew their prisoners well; but there was still too little positive engagement. Officers were likely to be behind their desks, rather than engaging with young prisoners on the landings. It was also unacceptable that young people were still slopping out: and indeed the so-called night sanitation system did not operate throughout the night. We also found evidence of informal, or double, punishments, sanctioned at officer level. Systems, procedures and management of healthcare were poor, though young people were very positive about the care given by individual healthcare staff.

Time out of cell had been severely affected by the industrial action at the time of the inspection. Even under more normal circumstances, though, we were concerned that the advertised 10-hour core day for young prisoners was not routinely available, and there was no regular exercise in the fresh air. It was very welcome that a new education centre had been built – but there was still insufficient work and training for young prisoners. A significant number – half of the young adults, and a third of juveniles – had no access to education at all. There were only 68 vocational spaces; and only a quarter of young people had access to

them. There was little communication between employment and education staff. Reducing reoffending, particularly among young people, is critically dependent on trying to remedy their educational and skills deficits. Hydebank Wood was still some way from being able to offer those opportunities to all its young prisoners.

Resettlement, however, was an area where Hydebank Wood was performing well. The new Visitor Centre managed by NIACRO, and the arrangements for child-centred visits have enhanced the quality of interaction between young prisoners and their visitors. Opportunity Youth, a non-governmental organisation, engaged actively with the many young people who had drug or alcohol problems, providing courses during imprisonment and also support afterwards. Probation staff developed resettlement plans for all young adults, working with relevant agencies in the community. However, this was largely done without the involvement of the residential staff, who worked alongside the young people and could have been instrumental in developing and implementing resettlement plans.

We recognise that this inspection took place at a particularly difficult time for the establishment; but nevertheless it revealed three fundamental underlying problems that have not been addressed. The first is to ensure that there is sufficient meaningful and integrated activity and training for the young men at Hydebank Wood. The second is to develop and support the work of residential staff, who can play a key role in motivating and supporting young prisoners. The third is to ensure that there is active and visible management, to support staff and to ensure that regimes and management systems are implemented.

Hydebank Wood can play a key role in the criminal justice system of Northern Ireland: providing an environment where young adults – the most prolific reoffenders – can be challenged and supported to change. We have no doubt that staff, managers and the Northern Ireland Prison Service want to move Hydebank Wood forward. This report contains nine new main recommendations to assist in doing that. We hope that the next inspection will be able to record real progress towards implementing them.

Anne Owers June 2005
HM Chief Inspector of Prisons

Kit Chivers
Chief Inspector of Criminal Justice in Northern Ireland

Fact page

Task of the unit
Hydebank Wood is a prison and young offender centre holding sentenced and remanded young men and women including juveniles, sentenced and remanded adult women and adult and young women immigration detainees.

Brief history
Hydebank Wood was opened on 1 June 1979.

Number held
231

Cost per place per annum
Not available as the cost is worked as a cost per prisoner across the service.

Certified normal accommodation
304 (excluding healthcare and special supervision unit accommodation).

Operational capacity
Not applicable. To be reviewed if single occupancy cell allocation is exceeded.

Last full inspection
4 – 8 February 2002

Description of residential units
There are five residential units: Ash, Beech, Cedar, Elm and Willow Houses. Ash House is for women prisoners and inspected separately. Beech and Cedar Houses each contained 60 single occupancy cells divided into four landings of 15 cells respectively. Each landing has showering facilities, association and dining areas. 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 standard and basic compact. It is currently occupied on three out of four landings. The staff training department is situated on the ground floor.

- Cedar House contains enhanced and special privilege young adults and is fully occupied. The video link suite is located on the ground floor.

Beech and Cedar Houses do not have access to integral sanitation but occupants have access to night toilet facilities.

- Elm House has 56 single occupancy cells and one dormitory holding three young adults. Elm 1 and 2 landings contain the committal/induction landings. Elm 3 landing holds standard and basic compact young male adults. Elm House also has responsibility for the special supervision unit, which is housed directly below Elm 1 landing. This has 10 single occupancy cells.

- Willow House has 64 single occupancy cells. Willow 1 and 2 landings hold the juvenile population. Willow 3 landing and Elm 4 landing hold young male adults on the standard and basic compact.

All cells in Elm and Willow Houses have integral sanitation and sprinkler systems.

Section 1: Healthy prison summary

Introduction

HP1 Inspection reports include a summary of an establishment's performance against the model of the healthy prison. The four criteria for a healthy prison 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 release into the community, and helped to reduce the likelihood of reoffending.

HP2 This inspection was a follow-up to the last full inspection of Hydebank Wood young offender centre in February 2002, and we examined progress in meeting the recommendations from that inspection. Since that inspection, a major change had been the transfer of women prisoners from Mourne House at Maghaberry prison to Ash House at Hydebank Wood. This report does not deal with the treatment and conditions for women prisoners at Ash House, which was subject to a separate unannounced inspection in December 2004.

HP3 In a short unannounced inspection such as this, an in-depth assessment cannot be made across the full range of the Inspectorate's published *Expectations*, which set out our criteria for assessing the treatment of and conditions for prisoners. Opportunities for checking outcomes are limited and some areas were examined in more detail than others. A major difficulty at the time of this inspection was that the Prison Officers' Association in Northern Ireland was in dispute about terms and conditions of employment, had withdrawn its goodwill and was operating a ban on overtime. This had a significant impact at Hydebank Wood, which was heavily reliant on overtime and had formally agreed high levels of staffing for unlocking. The regime was unable to operate normally and many young men who would usually have been out were instead locked in their cells. This curtailed a lot of the informal interaction we would normally have with the young people and made it difficult to observe activities taking place as many were cancelled. Opportunities to observe staff–young prisoner relationships were also more limited than usual. Nevertheless, we were satisfied that with the benefit of surveys and focus groups we were able to look behind the immediate difficulties faced by the establishment at the time of the inspection and form a picture of how much progress had been achieved since we last inspected.

HP4 Some progress had been made but it was a matter of concern that very few of the main recommendations from the last report had been achieved. Overall, we found that 76 of the 138 recommendations we examined again had been achieved or partially achieved. Fifty-six had not been achieved and the remaining six either could not be inspected or were no longer applicable. There was still an issue, emphasised to us by the industrial relations situation, that the generous levels of staff available were not being used to maximise opportunities for young people. For example, there was still no effective personal officer scheme, there was an over-emphasis on

security with too many staff being used for escorts within the establishment and too many staff being required before any young people were unlocked. There was a lack of education and training to meet the needs of young people. Most cells did still did not have integral sanitation.

HP5 Based on documentary evidence, our observations and discussions with staff, young people and others, the following is our assessment, based on the four tests of a healthy prison.

Safety

HP6 While Hydebank Wood provided a basically safe environment for young people there were some areas of concern. Reception was basic but clean and there had been some improvements in induction. First night arrangements for juveniles were unsatisfactory. Although not a major problem, bullying was mostly dealt with informally rather than through the agreed procedures. There were low levels of self-harm but extreme measures were taken to protect those at risk. Punishments at disciplinary hearings were over severe with too much use of cellular confinement. Too few staff were trained in use of force and there was insufficient monitoring of its use. Staff were not well enough aware of child protection procedures.

HP7 There were few problems with escorts and movements to courts. However, young people were not given any information about Hydebank Wood at court, which might have helped reduce anxieties, particularly for those new to custody. Most journeys were short but young people found the vans uncomfortable. They were handcuffed in vans with no seatbelts and said the vans were driven too fast. In our survey, they were positive about their general treatment by escort staff. As well as being handcuffed in the vans, all young people were unnecessarily handcuffed to and from reception without any individual risk assessment.

HP8 Reception had changed little since our last inspection. It was clean but remained austere, and little information was displayed. Young people were still being locked in individual changing cubicles, which was not satisfactory. In our survey, 74% of respondents, much higher than the benchmark, said they had the opportunity to shower on the day of their arrival. New arrivals were given basic provisions and an education induction pack but procedures to assess vulnerability and risk were underdeveloped. Staff said they knew the young people well but there was a danger that familiarity could lead to changed risks being missed. First night cells for juveniles were stark and unwelcoming. New arrivals were now held together and the induction process had improved, with 67% of respondents to our survey, against a benchmark of 52%, saying that it covered all they needed to know.

HP9 A bullying survey had been undertaken in 2003 but the results had never been disseminated or considered by the anti-bullying committee, which had not met for over a year. In this out of date survey, almost all said they felt safe. However, over 40% also said that they had some experience of bullying. Staff described dealing with bullying informally and there was little recorded monitoring. There were no separate records for the women at Ash House and most of the recent entries in the anti-bullying register involved women. The register also confused bullies with victims. There had been only eight recorded substantiated cases of bullying since 1 January 2004 and monitoring in those cases was poor. No anti-bullying training had been

delivered. Our survey indicated that victimisation from other young people was similar to the benchmark but it was a concern that significantly more young prisoners (14% against 6%) said they had been assaulted by staff. It was positive that 18% of young people, against a benchmark of 9%, said they had reported incidents of bullying to staff.

HP10 There were low levels of self-harm. Despite a relatively high suicide rate among young men in the community, there had been no deaths at Hydebank Wood for almost five years. This was a significant achievement. However, protective clothing and special cells were too often used as a first and extreme measure, rather than a more therapeutic approach. In some cases, vulnerable young men were forcibly stripped and placed in suicide suits. There was good awareness of the vulnerability of high profile cases. PAR1 (prisoner at risk) reviews were poorly recorded and there was too much emphasis on physical protection rather than emotional support. Some good support was provided by the Opportunity Youth organisation but there was no peer support scheme. There had been no staff training in suicide awareness and only some limited instruction to senior officers about the PAR1 process. There was no separate strategy for the young men and the women at Hydebank Wood.

HP11 A child protection policy had been developed in 2003 but there had been little strategic development and there were no links to bullying and suicide and self-harm to incorporate a wider safeguarding approach. The policy contained no guidance for staff about how and when to make a child protection referral. This was reflected in a lack of staff awareness and there had only ever been one referral. Only 10 of the group of 30 staff who could work with children at Hydebank Wood had child protection training.

HP12 The punishment unit had officially changed its name to the special supervision unit (SSU) but was still mostly referred to as the punishment block. There was no specific training for staff in the SSU. All young people, including children, entering the unit were required to be strip-searched (or full body-searched as it was termed). There was little structured regime to address the anti-social behaviour that might have led to a young man being placed in the SSU, although there were some examples of individuals being helped. Young people in the SSU did not always get daily exercise. Punishments at adjudications were inconsistent and often over punitive. There was too much use of cellular confinement with loss of all privileges, essentially leaving young people, some of whom were children, in bare cells with no means to pass the time. This was informally operated by staff who would allow some concessions but this was not adequate. No formal monitoring records were kept on those serving punishments of cellular confinement.

HP13 Only 52% of staff were trained in use of force, handcuffs were now being used appropriately and staff were using de-escalation procedures. There was no monitoring of trends of use of force or the use of strip-conditions to hold people in the SSU. On the wider security front, contingency plans had been developed and were well tested.

HP14 Alcohol misuse was a problem for many young men at Hydebank Wood. Over 70% of new admissions were drinking regularly before their committal, and 20% of them were defined as problem drinkers. Drink was a factor in the majority of offences. There were few alcohol detoxifications and healthcare staff had received very little training in substance use awareness. There was an annual survey about drug problems and new arrivals on committal were being tested. In our survey 36% against a benchmark

of 22% said it was easy to get illegal drugs in the prison. Without random mandatory drug testing, it was difficult to get a fuller picture.

Respect

HP15 There had been a slight improvement in the quality of relationships between staff and the young people since we last inspected but there was still relatively little proactive staff engagement. The external environment and the accommodation were clean and in good condition. However, the electronic unlock system did not operate for the full time that young people were locked in cells and some were effectively still slopping out. The incentives and earned privileges (IEP) system did not involve young people sufficiently and in some areas operated unfairly. Equal opportunities monitoring was not taking place. While young people were positive about the individual care they received from healthcare staff some healthcare procedures and services were poor and improvement was needed.

HP16 Our survey results indicated some good relationships between staff and young people, which appeared to have improved since the last inspection. However, these were based mainly on young people approaching staff rather than vice versa. While some staff interacted well, many kept their distance. In our survey, 69% said most staff treated them with respect and 70% said they had someone to turn to if they had a problem. While these results were consistent with the benchmark, there were indications that many of the staff they relied on were Opportunity Youth workers or chaplains rather than prison officers. Young people were universally called by their surname alone and some staff were surprised by our use of 'Mr' to address young people. The personal officer scheme was not working well, even though the generous staffing levels in Northern Ireland meant there was the potential to deliver an effective scheme.

HP17 The standard of accommodation was generally good and almost all young people had single cells. Both the external and internal areas of the establishment were well maintained and clean. Young people had good access to clean clothes, bed sheets, cleaning materials and showers. Almost all were smartly dressed but there were still no machines to wash their own clothes and some told us of problems getting soap powder for hand washing. Only Elm and Willow Houses had integral sanitation; the others relied on electronic unlocking systems but these were operative only up to a certain time, after which the young people had to use pots, so were effectively slopping out.

HP18 Due to the industrial action, the amount of association time was very poor. We accepted, however, that this was usually good, particularly in Cedar House where young people were seldom locked in their cells during the day. Facilities for entertainment during association remained poor.

HP19 Little information was provided about the IEP scheme, and the scheme as it operated was not reflected in the written policy. The scheme was complicated but the young people seemed to understand it, although they did not feel it operated fairly. They were not involved in reviews and the criteria for movement within the scheme were not defined in the policy. Although there was no reference to this in the IEP policy, pay rates were based on IEP level rather than on activity, which was unfair. In some

units, young people found guilty at adjudication were automatically placed on the basic level for six weeks without review. This was unacceptable.

HP20 In our survey, 27% of respondents, significantly higher than the benchmark, said the food was good or very good. However, many complained that the food was cold, which was due to poor handling and serving arrangements. Food lifts were not being used and young adults were required to carry food containers up stairs. Young people serving food were not properly dressed and opportunities for training in the kitchen were still being missed.

HP21 Young people were generally positive about the range of goods in the shop and their access to it.

HP22 Chaplains were formally notified of all new arrivals but were not allocated sufficient time to see them all within 24 hours or to take part in prison meetings such as the suicide prevention committee. However, young people received good pastoral care and support from the chaplaincy team.

HP23 No analysis of equal opportunity data was taking place. A document outlining the young offender centre's meeting structure listed an equality and diversity committee but this committee had never met. We were told that monitoring would not begin until the introduction of a new computer system in May 2005. We used the raw data available to analyse the IEP scheme and allocation to activity by religious affiliation and the indications were that these were fair. However, it was a matter of concern that such monitoring was not being done routinely by the establishment. There was still no equal opportunities policy and data on ethnicity was unreliable.

HP24 There had been a review of the complaints systems but changes had yet to be implemented, as a new Northern Ireland system was to be introduced. Our survey suggested there was relatively poor access to application and complaint forms and there was also little satisfaction with the outcome of applications. Survey results in this area were less positive than in 2001 and 2002. There was no regular analysis of complaints by area or type and no independent advocacy and support for young people. Access to external legal services was good.

HP25 The review of healthcare services due after the last inspection had only recently been completed. As a consequence, the staff skill mix review, training needs analysis and increase in staffing levels had not yet been implemented and few of the healthcare recommendations had been achieved. Mental health services in particular needed development. Despite this, young people were very positive about their overall experience of healthcare and rated the care given by the doctors, nurses and the dentist highly.

Purposeful activity

HP26 Time out of cell was difficult to measure because the industrial action was severely curtailing the regime. Our previous recommendation that there should be a target of 10 hours minimum time out of cell was not accepted, although this should have been possible for many when a full regime was running. There was generally insufficient purposeful activity to meet the needs of the population and too little emphasis on developing a learning culture, with too few young men involved in education.

HP27 The industrial action meant that the usual regime was not operating. Consequently, hours of unlock were very poor and not healthy for young people. We tried to establish the position before the industrial action began. According to the core day, the planned time out of cell when a full regime was running would be over 10 hours on weekdays and at weekends. However, there was little evidence that this core day was routinely followed or supervised. With apparently institutionalised late unlocks and early lockups, the amount was significantly reduced. With the available level of staff, much more should have been possible to achieve but this needed better management supervision.

HP28 There was no planned regular exercise in the open air for young people and only 3%, against a benchmark 27%, said they got exercise in the open air three or more times a week. This was unacceptable.

HP29 There had been some positive developments in education and training but much of it was still aspirational and had yet to be delivered. A new learning and skills centre provided a better focus but education and training remained too low a priority. The new centre had been badly designed with little natural light. The education department carefully monitored attendance rates and attendance had clearly improved significantly since the last inspection. While there was a considerable amount of absence, the vast majority were for good reasons; unexplained or unjustified absences were less than 10%. Overall, however, there were too few education and training places available and too few young people participating.

HP30 Irrespective of the existing employment relations problems, staffing difficulties, particularly sickness, were adversely affecting access to courses. One third of juveniles did not attend education at all and the remaining two-thirds attended only between one and four sessions. Only a half of the young adults attended any education. The curriculum was narrow and did not meet the needs of the students in terms of the lack and type of course offered. Some were insufficiently challenged.

HP31 The library was attractive and well-resourced but was rarely used even when the regime was operating fully. Only 15 young people had got to visit the library in February and the position for the last months of 2004 was not much better. In our survey, only 13% of respondents, well below the benchmark, said they were able to get to the library once a week.

HP32 There was a reasonable range of vocational options on offer but only 68 available places. At the time of the inspection, 25% of the young people were orderlies, 25% were in vocational training and 50% had not been allocated to any activity. We understood that discussions taking place to introduce new courses to help match the unmet need. There was poor communication between employment and education staff, particularly at the induction stage when important decisions about allocation were made.

HP33 There was poor access to physical education. Only 11% of respondents to our survey, against a benchmark of 19% and compared to 32% in our survey in 2002, said they got to the gym at least three times a week. It was difficult to establish what the usual position was and we accepted that to some extent the poor survey showing reflected the current problems. The resolution of these problems and the additional staff member being recruited should improve access.

Resettlement

HP34 There was a good resettlement policy and good delivery of services from a range of agencies. However, landing officers were insufficiently involved in resettlement issues and there was a need for resettlement to become the core focus of all staff. Home leave was appropriately targeted for resettlement purposes. Opportunity Youth provided a good service for those with substance use problems.

HP35 There had been good progress in resettlement work since our last inspection and the relevant agencies in the establishment were well integrated and working in conjunction with those responsible for resettlement at the Northern Ireland Prison Service headquarters. A resettlement policy committee had been established and was taking the policy forward.

HP36 However, more needed to be done to promote a resettlement culture as part of the responsibilities of all staff. Resettlement work was not seen as integral to the work of officers in residential units.

HP37 An improved model for sentence and custody planning had been put in place in the form of resettlement plans for all young people, whether sentenced or not, which integrated offending behaviour and resettlement needs. We saw evidence of young people being involved in the process and signing off their plans, although the survey and our interviews with them suggested they were sceptical about their value. There was no systematic analysis of the quality of resettlement plans and there was a need for a meaningful personal officer scheme in order for them to become meaningful for young people and staff.

HP38 There was some good analysis of the criminogenic profile of young people at Hydebank Wood that helped inform the provision of programmes. Northern Ireland Prison Service-accredited programmes (car crime, enhanced thinking skills and anger management) were run and had met their targets in the previous years. However, the industrial action and more importantly, the loss of officer facilitators had now put delivery in doubt for the current year.

HP39 At the time of our last inspection, no young adults at Hydebank Wood were sentenced to life imprisonment. There were now six young lifers with a further 12 facing potential life sentences. Arrangements were in place to get information from the police at conviction to help inform risk assessments. Families of the young lifers were invited to the establishment and had the tariff and life sentence system explained to them. This was good practice. All the lifers had life sentence plans and regular reviews.

HP40 A good new visits facility had recently opened. Visitors were now being searched, which had reduced searching of young people. Visitors were offered a closed visit on a single drug dog indication without any further intelligence or the use of discretion in individual cases. This was too rigid. Visits were timed to ensure that young people and their visitors received their entitlement but the minimum visit time of 30 minutes was too short and the young men received shorter visits than women in Ash House. Good special children's visits had recently been introduced and were run by an enthusiastic family liaison officer.

HP41 Young adults had their reintegration needs assessed through the resettlement plan system. There were some opportunities to work out in the community towards the end of sentence for a small number of eligible young adults. Home leave was being used

positively as an aid to successful reintegration with a requirement for each home leave to incorporate resettlement objectives.

HP42 The drug and alcohol strategy was up to date and there was a comprehensive action plan with timescales and responsibilities clearly set out. A good service was provided by Opportunity Youth for both drugs and alcohol. Opportunity Youth was well integrated in the establishment and provided key workers during sentence and after release, accredited courses, counselling services and family support with throughcare. Group work was open to all on the basis of need. Voluntary drug testing (or, more accurately, compliance testing) was also open to all. There was an overall positive rate of 9% but with some significant variation between houses. In our survey, 24% of young people, significantly higher than the benchmark, considered that they would have an alcohol problem when they left prison.

Main recommendations

HP43 First night procedures should be developed to ensure that a comprehensive vulnerability assessment is made and that all young people, particularly children, are held in appropriate supportive accommodation with regular monitoring.

HP44 A new safer custody strategy should be developed to ensure the anti-bullying procedures work effectively with the involvement of young people. Appropriate links should be made with between suicide and self-harm issues and peer support should be provided for victims of bullying and those at risk of self-harm.

HP45 Alternative and more therapeutic responses to self-harm for young people, other than the use of strip-conditions, should be developed. Anti-suicide suits and unfurnished accommodation should be used only as a last resort, and should be fully justified and recorded. Staff should be available to interact with and support young people deemed at risk of self-harm.

HP46 The child protection policy should be reviewed to ensure that systems and procedures are in place to ensure child protection referrals are raised appropriately and dealt with efficiently, with all staff and managers working with children trained in child protection.

HP47 A personal officer scheme should be developed to encourage residential staff to engage more actively with young people and take an active part in the development of resettlement plans, and to help ensure that resettlement becomes an integral aspect of the centre's purpose.

HP48 Integral sanitation should be provided for all young people. Until then, there should be genuine 24-hour access to toilets so that young people do not have to use pots after a cut-off time.

HP49 All young people should have at least 10 hours a day out of their cells, including a minimum of one hour's access to exercise in the open air and a period of association each day.

HP50 Sufficient education and work skills training should be provided to meet the needs of young people, to occupy them fully and equip them with the qualifications and skills they require.

HP51 An up to date full health needs analysis should be completed including a review of the skill mix of staff to ensure that the young people at Hydebank Wood receive an appropriate healthcare service.

Section 2: Progress since the last report

Introduction

2.1 We used the recommendations from our last inspection of February 2002 as a framework to examine progress achieved. We have commented where we have found significant improvements, and where we believe little or no progress had been made and work remained to be done.

2.2 During this inspection, we concentrated on aspects that most directly affected the treatment of conditions for young people and so did not examine all the recommendations from the last inspection. The paragraph reference numbers at the end of each recommendation below refer to its location in the previous inspection report.

Respect

2.3 As soon as the Justice (Northern Ireland) comes into force, a regime focused on the needs of 17-year olds and based in its own residential location should be established. This should mirror the arrangements that are intended in the new juvenile justice centre with which Hydebank Wood should develop a close working relationship. (HPS60)

Partially achieved. A dedicated unit for the juveniles had been established. On the first day of the inspection, 34 young people under 18 (including four 16-year olds) were located in Willow House on separate landings to the young adult population. However, the facilities and regime for juveniles at Hydebank Wood did not mirror that of the juvenile justice centre, nor would that be possible in view of the vastly different resources available to the two establishments.

2.4 There had been some ad hoc discussions between the two establishments about transfers. These related to two cases of difficult and vulnerable girls who had been transferred from the juvenile justice centre because their behaviour was too difficult to be managed there. Pre-transfer meetings and case conferences had taken place to assist with the planning for their care. However, there was no formal system to deal with all young people transferred from the juvenile justice centre to Hydebank Wood.

Further recommendation

2.5 A formal system should be set up with the juvenile justice centre to ensure that information-sharing and pre-transfer planning takes place for all young people transferred to Hydebank Wood.

See also main recommendations HP48 and HP49.

Accommodation and facilities

2.6 All cells should have in-cell sanitation. (2.10)

Not achieved. Only Elm and Willow Houses had integral sanitation. The other houses relied

on electronic unlocking systems for access to sanitation but these were available only up to a given time, after which young adults had to use pots. Some were therefore still slopping out. See main recommendation HP48.

Clothing and possessions

2.7 Consideration should be given to installing washing machines to allow young people to develop responsibility for washing their own clothes. (2.22)

Not achieved. We were told that this had not been possible due to power loading issues. However, washing machines had been provided in Ash House when women prisoners transferred there in June 2004, which suggested that the loading issues could be overcome. Young people clearly took pride in their appearance and the provision of washing machines would help develop their personal responsibility.

Further recommendation

2.8 Washing machines should be provided to allow young men to wash their own clothes.

Prevention of suicide and self-harm

2.9 The review, development and implementation of a new policy on suicide and self-harm should be an urgent priority for both the Northern Ireland Prison Service and Hydebank Wood youth offender centre (YOC). (3.19)

Achieved. The prisoner at risk (PAR1) procedures had been introduced throughout the Northern Ireland Prison Service in March 2004. A governor, principal psychologist and suicide prevention coordinator (healthcare senior nurse) had key roles in managing its implementation at Hydebank.

Applications and complaints

2.10 There should be an urgent review of the current systems and the new pilot scheme in England should be considered. A policy of independent advocacy should be considered. (3.65)

Not achieved. The complaints system had been reviewed internally but no changes had been implemented due to the pending introduction of a new Northern Ireland Prison Service-wide system.

2.11 There was no system of independent advocacy. This was a particular concern for those under 18 whose legal status as children needed to be acknowledged. The visiting committee was reluctant to take up complaints on behalf of young people because it believed this could compromise its independence. The Northern Ireland Prison Service had recently introduced a prisoner ombudsman as an independent point of appeal against complaints but he had not yet taken up his appointment.

Further recommendation

2.12 A system of independent advocacy for those under 18 should be introduced.

Additional information

2.13 In our survey, 75% of juveniles, against a significantly higher benchmark of 85%, said they knew how to make a complaint. In the young adult survey, responses to questions about access to request and complaints forms and the fairness with which applications were sorted out were significantly worse than the benchmark. We examined a sample of requests and complaints, and these had been dealt with as a record for the file rather than as a personal response to the young person. It was unclear how the young person had been informed of the outcome, which might have contributed to the levels of dissatisfaction. Many recent complaints related to the effects of the industrial action, which may also have impacted on current perceptions.

2.14 There was some analysis of requests and complaints but no routine ongoing analysis to provide useful management information about patterns and trends.

2.15 Staff were not alert to the need to cross-reference requests and complaints to bullying and child protection procedures. We found examples of both concerns in complaints that had not been passed on appropriately.

Further recommendations

2.16 Requests and complaints should be routinely analysed over time to provide useful management information about patterns and trends.

2.17 Requests and complaints should be monitored for matters relating to bullying and child protection and cross-referred as appropriate.

Education and work skills training

2.18 The serious imbalance between the courses students wanted and needed and those provided should be addressed by policy and planning at the highest levels both in the establishment and the Northern Ireland Prison Service. (5.39)

Not achieved. Some progress had been made but there remained a serious imbalance between students' needs and the range of available provision. Twenty-five per cent of young adults were employed as cleaners/orderlies, 50% were 'not yet allocated' and 25% were employed in the vocational workshops. Discussions about increasing the number of vocational options from seven to nine were taking place. Young adults could not attend education full-time. A minority attended education classes for between one and four sessions each week. The range of courses in the new education block was limited to a few core subjects (information and communications technology (ICT), numeracy and literacy) along with very limited provision in craft and music. Specialist facilities were provided for hairdressing and cookery but both rooms were under-used. The hairdressing salon was poorly designed. See main recommendation HP50.

Time out of cell

2.19 The existing Northern Ireland rules and provision in relation to hours spent in the open air should be re-examined. (5.76)

Not achieved. The young men had very little access to fresh air. Many were waiting to be allocated to a job that would take them out of the house but few jobs involved access to fresh air. Only those in the special supervision unit had regular daily access to an hour's exercise in the open air.
See main recommendation HP49.

Security

2.20 The random searching of staff would provide a recognised and approved deterrent to trafficking. (6.08)

Not achieved. We were told that the Prison Officers' Association had objected to staff being searched when visitors were not. Visitor searching had been introduced and staff searching was about to be but this had been overtaken by the industrial action. We were pleased to find that, following the introduction of visitor searching, the routine searching of all young adults before and after visits had been reduced to one in 10.
We repeat the recommendation.

Recommendations

To the Governor

Young people in Hydebank Wood

2.21 Child protection policies and procedures should be drawn up in consultation with the local area child protection committee of which the governor should become a full member. (HPS56)

Partially achieved. A child protection policy had been in place since February 2003. There were, however, some important gaps, such as links with bullying and suicide and self-harm, and, fundamentally, guidance for staff on how to make a child protection referral. We believed there was significant under-reporting of child protection matters by staff, due partly to the shortcomings of the personal officer scheme (see paragraph 2.214). Only a third of staff in the juvenile units had been trained in child protection. Significantly, only four of 11 managers who could be responsible for making preliminary assessments of child protection referrals had received any training. Since the implementation of the policy, there had been only one child protection referral across the establishment, which we believed was partly due to the fact that the policy was not a dynamic working tool that was understood and implemented by staff at all levels.

2.22 An environment in which child protection was central to working with young people had not been established. There had been little strategic development of child protection since the implementation of the policy. There were no ongoing links with the area child protection committee (ACPC), despite some efforts on the part of the establishment. The ACPC had not responded to a request to assist with drawing up the child protection policy. The governor was not a member of the ACPC and the establishment was not formally represented. A children's

safeguards committee drawing together all aspects of safeguarding children had not been established despite our previous recommendation (see paragraph 2.24).

Further recommendation

2.23 Further efforts should be made to engage the area child protection committee (ACPC) in the work of safeguarding children at Hydebank Wood.

See also main recommendation HP46.

2.24 A children's safeguards committee should be established, and as a priority task it should carry out a full audit of all aspects of the safety of children within Hydebank Wood. (HPS57)

Not achieved. See paragraph 2.22.
See also main recommendation HP46.

2.25 Arrangements for custody, care and training plans for all 17-year olds, and which involve all departments of the establishment, should be introduced. (HPS58)

Achieved. The resettlement plans were drawn up with all young people, including 17-year olds.

2.26 An education and training culture should be established across the establishment that meets the needs of young people. (HPS59)

Not achieved. The new education building and learning and skills centre had helped to raise the profile and underline the importance of education and training. There were, however, a number of fundamental problems that limited the development of education and training in meeting the needs of young people. Too few places were available in education and workshops to meet demand, many of the courses and options had waiting lists and staff shortages and sickness in education were limiting young people's access to planned programmes. The long-term absence of one bricklaying instructor, for example, had meant that classes had been cancelled for some time. Initial assessment and induction arrangements linked to education and training were poorly coordinated and time-consuming, although there was some joint planning through the personal development plan group.

Reception

2.27 The holding room in reception should be repaired and refurbished so that it is made suitable for the purpose of holding young people. Young people should not be secured in the individual changing cubicles. (1.19)

Not achieved. The holding room in reception was basic, with no bench seating, information or means to pass the time while waiting. On one morning of the inspection, there was too little seating for all the young people waiting to go to court. On arrival, young people still waited in line alongside a wall to be processed. They also continued to be locked in confined cubicles, a practice highlighted in our last report as having the potential to increase fear and anxiety. When the reception area was not staffed during the lunch and dinner periods, young people could be locked in cubicles for some time or kept waiting in escort vans or police cars

immediately outside reception.
We repeat the recommendation. See also main recommendation HP43.

2.28 There should be a range of accessible information notices and posters in reception to introduce new arrivals to Hydebank Wood. (1.20)

Not achieved. No specific information about what to expect or detailing the routines, rules and services was displayed. The only information in the cubicles concerned searching procedures. Two printed information sheets were handed out in reception but neither was well presented and it was clear from the language used that little thought had been given to the age range and reading ability of the target audience. An informative video was used during induction but was not shown in reception.
We repeat the recommendation.

Additional information

2.29 Reception had not changed. Although clean, it was unwelcoming and unattractive and was not an appropriate environment for children. There was nowhere to speak to a young person in private and no planned opportunity for a young person to speak to a reception officer in confidence about any immediate needs. We heard staff shouting questions to young people locked in the cubicles. Reception staff clearly knew many of the young people and the atmosphere was friendly and relaxed. Reception procedures were usually completely quickly but the impression was still one of a production line. However, 74% of respondents to our survey, against a benchmark of 28%, said they had been able to shower on arrival.

2.30 Young people did not travel long distances to the establishment but many of those surveyed complained that the vans were uncomfortable. All young people were handcuffed between the reception area and court without risk assessment, including while travelling in vans. Prison officers from the Prisoner Escort Group (PEG) undertook escorts. Young people said they were generally well treated by PEG and reception staff, and that they arrived at court on time. We were told that young people often spent long days at court but we were unable to verify this because reception staff were not given prisoner escort records.

2.31 A video link to 21 courts was available and was also used by probation staff in the community to speak to young men in custody. It was regularly staffed by four trained officers from a pool of officers. On average, the video link was used for 45 court appearances and 55 consultations with legal representatives each week.

Further recommendation

2.32 Young people should not routinely be handcuffed to and from reception and while travelling on escort vans without an individual risk assessment indicating a need for this level of security.

First night arrangements

2.33 New receptions should be located together so that they are carefully and consistently monitored during their first 24 hours in custody. (1.27)

Partially achieved. All newly arrived young men were accommodated in Elm 1 and juveniles

in Willow 1. No consistent, recorded monitoring was taking place. Induction staff in Elm 1 said they monitored new arrivals every 15 minutes during the first night, although this was not formally recorded. Children in Willow 1 were monitored only if they were subject to a PAR1.

Further recommendation

2.34 New arrivals should be carefully and consistently monitored during their first 24 hours in custody and this should be recorded.

See also main recommendation HP43.

Additional information

2.35 Induction cells in Elm 1 were equipped with a television but newly arrived children in Willow 1 were accommodated in anti-ligature cells with no television, radio or curtains. No information was displayed and no books or magazines were provided. The cells were basic and the isolating environment could have increased feelings of fear and anxiety. Staff explained that children were placed in these cells 'for their own safety' even though no individual risk assessments were undertaken. The assumption was that children might harm themselves in an ordinary cell and televisions were not provided because the glass screen could be used for this. It was inconsistent that newly arrived children were believed to present a high enough risk to justify being placed in an anti-ligature cell but not enough of a risk to warrant effective monitoring (see paragraph 2.33).

2.36 New arrivals, both young adults and juveniles, could not join other young people in association until they had been seen by a doctor. This usually took place the following morning, although this was not the case on one day of the inspection because the following day was a bank holiday. Juveniles in Willow 1 therefore had nothing to occupy them during the bank holiday apart from an education pack of drawing paper, coloured pencils and quizzes (see paragraph 2.42).

Further recommendations

2.37 Children should not be accommodated automatically in bare anti-ligature cells without a television for their first days in custody unless an individual risk assessment suggests that this is necessary.

2.38 Televisions should be provided in first night cells in Willow 1.

2.39 A system of identification for staff, which should include the wearing of name badges, should be introduced. (1.28)

Not achieved.
We repeat the recommendation.

2.40 Efforts should be made to reinforce verbal information provided to new arrivals by other means, for example, by providing cassette tapes or written information to be displayed around the residential unit. (1.29)

Partially achieved. An informative video had been produced and was shown during induction

but no supporting information was available either on cassette or displayed in the units. We repeat the recommendation.

2.41 New receptions should be provided with a pack containing an initial supply of tea, sugar, coffee etc until they are able to purchase their own. (1.32)

Achieved. Newly arrived young people were given a pack in reception.

2.42 The education induction pack should be provided for young people to occupy themselves during their first night in custody. (1.33)

Achieved. Everyone was given a pack on their first evening.

2.43 The establishment should devise a comprehensive vulnerability procedure along the lines of some of the best models devised by the Youth Justice Board for England and Wales. (1.36)

Not achieved. No appropriate or effective vulnerability procedure was in place. See further recommendation 2.47.

Additional information

2.44 None of the information contained in young people's core records, such as post-sentencing reports, was forwarded to induction staff in Elm 1 and Willow 1. Unless officers already knew the young person, all initial information was taken directly from the young person himself. Induction staff completed an induction committal interview form for each new young prisoner on the day of his arrival and this was placed in his wing file. This recorded basic personal details, offence information and any history of drug misuse or self-harm. Although the form allowed officers to include their initial impressions of the young person, young people were not given the opportunity or encouraged to talk to staff other than on a superficial level. No questions were asked about any previous convictions, any history of violence or any behavioural and/or emotional issues. Equally, the young person was not asked how he was feeling, if he had any immediate problems, if he was expecting to be visited and if he had children.

2.45 All young people received credit to use the telephone on arrival on the wing and, if requested, induction staff would also make a telephone call to their parents or carers on their behalf.

2.46 Young people were seen by a nurse on the day of their arrival and by workers from Opportunity Youth and probation the following day. A governor was supposed to interview each young person the day after arrival but none of the randomly selected 12 files that we saw contained a completed interview form. It was clear that young people had a number of individual interviews but the information was not drawn together in a single document.

Further recommendation

2.47 The induction process should be streamlined, with a single document containing all the initial information gathered about young people, and managers should ensure that it contains all necessary and relevant information.

Induction

2.48 The amount of information included in the first day programme should be reduced, and some modules transferred to the more intensive five-day programme. (1.39)

Achieved. The five-day programme no longer existed. New arrivals now attended a one-day induction programme on the second day after arrival. The detail of this appeared to be sufficient and 67% of respondents to our survey, against a benchmark of 52%, said the programme covered everything they needed to know. Due to the industrial action, we could not see the induction programme delivered in its dedicated room but we did see some induction information being given in Elm 1. This was delivered in a relaxed and friendly way, with young adults freely asking questions.

2.49 New arrivals should be escorted to Ash One on the day following their initial induction so that they may participate in the five-day programme. (1.43)

No longer applicable. The five-day programme was no longer running.

2.50 Disruptive young people should not be located with those newly arrived in custody. (1.44)

Achieved. This no longer happened.

Legal rights

2.51 The small number of appellants could be dealt with by direct reference to outside solicitors. (1.45)

Achieved. Access to solicitors was still good and was not reliant on internal systems in the establishment.

Accommodation and facilities

2.52 The induction unit, Ash Two, should not be used to hold those young people who have had to be moved from other units because of behaviour or management problems. (2.04)

Achieved. See paragraph 2.50.

2.53 Recreational facilities in Beech House should be increased and consistency introduced across the residential houses. (2.14)

Not achieved. One table tennis table, a selection of board games, a PlayStation and a television with a DVD player were provided on each of the three landings in use in Beech House. This was in line with the recreational facilities in other units. However, the air hockey tables had been removed and no pool tables or other physically interactive games were available, although some exercise equipment was planned. Many staff told us that the young men preferred to watch television after 7pm.
We repeat the recommendation.

2.54 The establishment should agree upon a nucleus of essential information and notices to be displayed in the residential units, to include anti-bullying, equal opportunities, requests and complaints, the daily routine and the incentives and earned privileges (IEP) scheme etc. These notices should be regularly updated and renewed. (2.15)

Not achieved. There was no consistency in terms of which notices were displayed. While there were some excellent anti-drug posters designed by young men at Hydebank Wood, there were large gaps in the provision of information about the house routines, complaints, bullying and who young people should contact if they were feeling low.
We repeat the recommendation.

2.55 A hairdresser should be employed. (2.16)

Not achieved. A hairdresser had been employed but, contrary to what we had anticipated, young men had been charged for the service. It had not been used because it was too expensive. The equipment had been distributed to each house and some young men cut each other's hair.

Further recommendation

2.56 Professional haircutting should be available to young men without charge.

2.57 An additional telephone should be installed in Beech House. (2.17)

Achieved. A telephone had been installed on each landing in Beech House.

2.58 The pool tables in Cedar House should be returned. (2.19)

Not achieved. All pool tables had been removed in the wake of the disturbances in 2001. We were told that a risk assessment had indicated a risk of serious injury or death. As pool tables are routinely provided in prisons and young offender institutions it was difficult to see why the risks at Hydebank Wood would be any higher than elsewhere.
We repeat the recommendation.

Further recommendation

2.59 Pool tables and other table games should be provided in all units.

2.60 A second telephone should be installed on C2. (2.19)

Achieved. Although there was still only one telephone on C2 landing, one had also been installed on C1. This provision was now adequate.

Anti-bullying – the importance of creating a safe environment

2.61 A full survey should be undertaken to establish where and how bullying takes place within the establishment. This information should be disseminated to staff and be included in the anti-bullying policy. The survey should be repeated every two years. (3.02)

Partially achieved. A survey conducted in September 2003 found that 88% of respondents felt quite or very safe. However, 43.5% had experienced some form of bullying, most of which occurred in the residential units and involved verbal abuse or threats. Forty-two per cent had not told anyone about the bullying. These and other findings had not been disseminated to staff or discussed at the anti-bullying committee meeting.

2.62 In our own survey, responses to most questions about safety were not significantly different from the benchmarks. The exception was that 14% of respondents, against a benchmark of 6%, said they had been victimised (hit, kicked or assaulted) by staff.

Further recommendation

2.63 Bullying surveys should be undertaken every two years, with particular attention given to young people's perceptions of bullying by staff. The results should be disseminated to staff and used to inform the anti-bullying policy.

2.64 An anti-bullying committee, led by a senior manager, should be set up. It should include representatives from all areas of the establishment and have representations from young people and children. (3.03)

Not achieved. Several meetings of the anti-bullying committee had been held at the end of 2003 and had included representatives of the young people. However, only three people had attended the meeting in March 2004 and the committee had not met since.
We repeat the recommendation.

2.65 All staff and managers should receive anti-bullying training, specifically tailored to adolescence. (3.04)

Not achieved. At one meeting of the anti-bullying committee, training in anti-bullying and child protection were described as a 'bolt on' to the nature of adolescence training. None of this training had taken place in recent years.
We repeat the recommendation.

2.66 Staff actively should challenge young people's language and boisterous behaviour and set a proper standard of behaviour through pro-social modelling and positive engagement with young people. (3.07)

Not inspected. The industrial action prevented us from observing much interaction between staff and young people.

2.67 A senior manager should have oversight and be an integral part of the anti-bullying processes. (3.09)

Partially achieved. Some meetings to consider incidents of bullying were convened by the director of custody when required, but these did not include the young person involved and the records did not indicate on what evidence decisions had been made.
See main recommendation HP44.

2.68 In order to be a credible scheme the anti-bullying strategy should have links to child protection and other prison strategies such as suicide prevention. (3.10)

Not achieved.
We repeat the recommendation.

Additional information

2.69 The anti-bullying processes were not clear. Forms included in the policy document were not being used and the register confused bullies with victims. Some incidents of bullying recorded on BI 1 forms (records of investigations) were not recorded on the register.

2.70 According to the register, there had been 24 investigations in 2004 and only three of the 13 in the last six months had involved young people from the centre. There was no single document to follow incidents of bullying from investigation through to closure and no systems to ensure communication between departments about those identified as potential bullies. There was no job description for the anti-bullying coordinator (the director of custody) and there were no unit liaison officers. The anti-bullying policy document had last been reviewed in September 2003. See main recommendation HP44.

Further recommendation

2.71 Records relating to incidents of bullying within the young offender centre should be kept separately from those held on women.

Prevention of suicide and self-harm

2.72 The development of the model for the management of sex offenders and vulnerable young people should be made a priority for the psychologist's role. (3.18)

Achieved. The principal psychologist took a prominent role in the management of these cases, and was able to describe individual circumstances in detail. She attended and chaired reviews where possible and coordinated support from other agencies. She also produced an 'Inmate Awareness Register' listing brief details about young people about whom there were concerns but who may not be on a PAR1 (prisoner at risk) form. This was regularly circulated to residential managers. Thirty-three young people were currently on the list.

Additional information

2.73 The suicide awareness and prevention team (SAPT) met monthly. We looked at the minutes of the last six meetings. The deputy governor was responsible for chairing the meetings and attendance had improved over recent months. The team was responsible for the development of local policy for both young men and women. It did not include representatives of the young men, although this was planned, or from the chaplaincy, education and workshops. Statistics of the numbers of those who self-harmed were produced but there was little analysis of what approaches could be developed to help young people in distress.

2.74 Only senior officers and managers had received training in the PAR1 process, which aimed to move away from the previous healthcare-dominated system (inmate medical records 21). There was some evidence from PAR1 forms of tensions between healthcare and residential officers' approach to self-harm and the care of those at risk.

2.75 Most reviews included a representative from healthcare, probation and residential staff. Reviews chaired by the psychologist were recorded to a better standard and included more focused support plans. Some had gaps in the written record. There were significantly more qualitative entries by probation and psychology staff. Some staff were unable to explain what level of watches had been agreed and these were not recorded at reviews.

2.76 The policy was a generic one for the whole service and more needed to be done locally to meet the specific needs of young people.

2.77 A register indicated when PAR1 forms were opened, when case conferences took place and when the forms were closed. Reviews were held promptly. The register indicated that 78 PAR1 forms had been opened since June 2004, when women prisoners first arrived at Hydebank Wood; 34 of these had been for women. We looked at the three PAR1 forms currently open on young men and a selection of those that had recently been closed. Several indicated that staff saw threats of self-harm simply as manipulative behaviour and did not question why a young person might have been making them. Other forms showed a clear link with bullying but contained no indication that the incident would be referred for investigation under anti-bullying procedures.

2.78 Strip-gowns or anti-suicide suits were used frequently, even when the young person had been disclosing feelings of vulnerability rather than actually self-harming. There was little evidence that emotional support had been offered beforehand. One young person had refused to put on an anti-suicide suit until staff had applied control and restraint, and another's refusal to wear strip-clothing had escalated to the point where he had been placed in the special supervision unit. In another case, a young man had spoken to staff about the distress caused by being in an anti-ligature cell for two weeks.

2.79 Young people did not attend their PAR1 reviews, which convened on an ad hoc basis and were usually chaired by a senior officer. There was no guarantee, however, that the same person would chair subsequent reviews.

2.80 There was no peer support scheme but we were told that a special privilege prisoner would be asked to offer informal support if appropriate. Around 56 young adults aged 18 or over were serving sentences of 24 months or more, which provided some opportunity to develop peer support.

Further recommendations

2.81 There should be separate suicide awareness and prevention team (SAPT) meetings for women and young men to oversee the development and implementation of local policy for their care based on the Northern Ireland Prison Service policy document. The local policy should be based on an analysis of need and the statistics to help to improve the level of care for those at risk of self-harm.

2.82 Young people should be represented on the suicide awareness and prevention team (SAPT). Other important areas of the prison, including Opportunity Youth, the chaplaincy and education, should also be represented.

2.83 Multidisciplinary training in the PAR1 (prisoner at risk) process should be provided for all staff working directly with young people.

2.84 All young people should be invited to attend their PAR1 reviews and to make a written contribution. Where possible, reviews should be planned in advance to ensure that staff from a range of other disciplines can attend and that they are chaired consistently.

2.85 A peer support scheme should be developed.

Substance use

2.86 The establishment should undertake a regular audit of the drug problems amongst its population to ensure that the appropriate services are in place to meet identified need. (3.23)

Achieved. Urine testing of all new arrivals had taken place since December 2004 and the data informed the drug steering committee (DSC) meetings. The drug strategy and service development were also informed by the results of an annual questionnaire survey conducted by staff from Queen's University as part of a wider research programme.

2.87 The DSC should review the provision of the counselling service and ensure that it is appropriately supported and supervised. (3.26)

Achieved. The work of the Positive Steps throughcare programme delivered by Opportunity Youth had achieved this. The part-time counsellor post was soon to become full-time and there were now regular meetings between Opportunity Youth, psychology and healthcare staff to share information on young people's progress and avoid duplication.

2.88 The DSC should review the delivery of the group work programme to ensure that it is offered on the basis of need rather than the participants' location within the centre. (3.29)

Achieved. All new arrivals were seen by Opportunity Youth within 24 hours and followed up as necessary. The Open College Network (OCN) programme was open to all young people who were motivated and showed commitment, not just those on the drug-free wing.

2.89 The DSC should ensure that there are clear measurements and targets against which its efficacy can be measured. (3.30)

Achieved. Targets in the new drug strategy action plan were now explicit and would be evaluated as part of the Queen's University evaluation.

2.90 Voluntary drug testing (VDT) should be open to all young offenders according to their need, rather than being a location-based scheme. (3.31)

Achieved. VDT took place throughout the centre, although it was effectively compliance testing. The overall VDT positive rate (January – December 2004) was 9%, with considerable variation between units (Cedar 6.2%, Willow 23.2%). The absence of mandatory drug testing (MDT) meant there were limited means to substantiate drug use.

Additional information

2.91 Substance use services were well developed and the drug and alcohol strategy had been updated. Its comprehensive action plan included explicit targets, responsibilities and milestones.

2.92 Successive annual surveys by researchers at Queen's University showed the continued and increasing problems faced by young men coming into the centre. A high proportion had substantial criminal histories, had previously been in custody in the youth justice system and had been subjected to paramilitary threats and punishments. Of the 108 new committals between December 2004 and March 2005, over 30% had tested positive for drugs, of which most were cannabis and benzodiazepines. These surveys, which were part of an evaluation of the Opportunity Youth project, confirmed that young people were receiving a very good service and it was encouraging that the project included support for those with alcohol problems. We were pleased to see it had recently been absorbed into mainstream funding. The cornerstone of the service were the key workers. Young people sentenced to over six months received the throughcare package. Of 135 young men who had taken part in the programme in the past two years, 113 had been released, 80 of whom were still engaged with it at six weeks and 63 at six months.

2.93 A high proportion of young men drank alcohol so excessively that their physical and mental health were at risk, and many related their use of alcohol to their offending behaviour. Although the numbers of clinical alcohol detoxifications were relatively small, they were not routinely monitored and we were concerned to find that healthcare staff had received very little training in substance use awareness.

Further recommendations

2.94 Healthcare staff should receive substance use awareness training.

2.95 Alcohol and drug use among new committals should be monitored and services modified to meet changing needs.

2.96 Clinical detoxification protocols should be updated regularly in line with best practice.

Equal opportunities

2.97 There should be regular analysis of statistical data in respect of adjudications, requests and complaints, home leave and early release and incentives and earned privileges. Senior management should regularly monitor these statistical returns in order to address discrimination on the basis of religion or other grounds. (3.39)

Not achieved. We were told that this would take place when a new computer system was installed in May 2005. We carried out a quick analysis of allocations to activity and incentives and earned privileges levels, which suggested no immediately apparent evidence of discrimination by religion. All the raw data was readily available and it was unsatisfactory that this relatively simple but important monitoring was still not being done, irrespective of an enhanced computer system.
We repeat the recommendation.

2.98 The definitions of discrimination and intimidation, and the systems put in place to address these issues for staff, should also be applied to the young prisoners of Hydebank Wood. (3.46)

Not achieved. There was no equal opportunities policy statement except for staff. An equality and diversity committee was referred to in Hydebank Wood's meeting structure but such a committee had never been formed. No representatives of the young people were listed as potential attendees at this meeting. Information on ethnic background was unreliable.
We repeat the recommendation.

Further recommendation

2.99 The equality and diversity committee should be established as soon as possible and should include representatives of the young people.

Maintaining contact with family and friends

2.100 A formal written system should be introduced to ensure that complaints or suggestions from visitors could be routinely audited. (3.49)

Not achieved. Whenever possible, complaints were resolved informally by managers in the visitors' centre by speaking to visitors personally. One visitor told us that a complaint he had sent to the governor had been resolved to his satisfaction. A complaint book was held in the visitors' centre but complaints were not routinely recorded and there was no system for complaints or suggestions to be audited.
We repeat the recommendation.

2.101 The policy relating to the passive drug dog should be kept under review to ensure that closed visits are only used where there is reasonable suspicion that an attempt has been made to smuggle drugs into the centre. (3.50)

Not achieved. See paragraph 2.179.

2.102 Management should address the current inability to search male visitors. (3.51)

Achieved. All visitors received a rubdown search.

2.103 The requirement to stand until one's visitors enter the room should be dispensed with, as it serves no real purpose. (3.52)

Achieved. Visitors took their seats before the young people arrived.

2.104 The card telephones should be repaired immediately. (3.62)

Achieved.

2.105 A telephone call appointment booking system should be introduced on every wing. (3.63)

Achieved. Young people booked evening telephone calls in 10-minute blocks.

2.106 A direct helpline into the establishment should be provided for visitors and friends of young people to report incidents to senior managers. Helpline numbers should be printed on reception letters. (3.64)

Not achieved. Visitors did not know who to contact with any concerns, and no name or contact number was advertised in the visits hall.
We repeat the recommendation.

Additional information

2.107 Visits could be booked by telephone or in person at the visitors' centre. Visitors said they had no problems booking a visit and were well treated by staff.

2.108 A new visitors' centre had recently been opened. It was bright and comfortable and visitors were not kept waiting for their visits. Clothing and cash could be handed in to staff without advance notice. Staff working in the centre were friendly and helpful and engaged well with visitors. Workers from NIACRO (Northern Ireland Association for the Care and Resettlement of Offenders) managed the play area in the visits hall and could also provide information and advice to visitors. No information about local or national support groups was displayed.

2.109 The young men and young and adult women all shared the visits hall. Although in this inspection we were not specifically examining provision for women, many told us they felt intimidated sharing the hall with the young men.

2.110 Visits were timed from when the young person sat down. Remanded young people could have three visits a week while sentenced young people had one weekly visit. Visits for those on the basic regime lasted 30 minutes, for those on the standard level 45 minutes and for those on enhanced one hour. Women prisoners in Ash House had visits that lasted 90 minutes, which the young men considered unfair.

2.111 The parents or carers of those under 18 were invited to their child's resettlement meetings and could tour the wing and see the child's individual cell.

2.112 Young people could apply for a 'family centred visit' with their child(ren) when they had been at the establishment for five weeks. The establishment aimed to offer these visits, including the child's primary carer, on a monthly basis. They took place in a dedicated room in the visitors' centre, which was equipped with comfortable furniture, age-appropriate toys and reading material. Any necessary checks were made with probation and social services and a family liaison officer (FLO) was on hand outside the room to supervise and assist. The FLO had received limited child protection training.

Further recommendations

2.113 Information about support groups should be displayed in the visitors' centre and a confidential helpline should be introduced and advertised.

2.114 All visits should last at least one hour.

2.115 Appropriate training should be provided to assist and enhance the role of the family liaison officers (FLOs).

Healthcare

2.116 The current accommodation for healthcare is not satisfactory and the time scale for reopening the healthcare centre should be clearly defined. (4.02)

Achieved. The refurbished healthcare centre opened on time in September 2002.

2.117 An identified doctor should attend those management meetings which would benefit from their clinical input. (4.03)

Partially achieved. The recently appointed consultant psychiatrist had started to provide clinical input to management meetings but there was little involvement by the GPs.

2.118 An increase in the nurse staffing complement should be seen as a priority in line with NHS practice. (4.04)

Not achieved. Agreement to increase the healthcare staffing establishment from eight to 14 had been reached but only 10 staff, including one agency nurse, were in post. The addition of the women's unit in Ash House had stretched the capacity of the staff even further. We understood that further progress on recruitment was dependent on the outcome of a health services review.

We repeat the recommendation.

2.119 A skills analysis should be conducted to facilitate working in partnership with the NHS. (4.05)

Not achieved. No skills analysis has been undertaken and consequently, the staff skill mix did not reflect the new demands on staff.

We repeat the recommendation.

2.120 Administration or clerical support should be provided to allow nursing staff to spend more time in clinical activities. (4.06)

Not achieved. No administrative or clerical support had been provided for healthcare staff, who were therefore unable to provide a full range of clinical care regularly.

We repeat the recommendation.

2.121 A health needs analysis should be carried out with the help of the local health authority public health doctors and should 'feed' into the review of healthcare in Northern Ireland. This assessment should also inform the establishment as to the skills and qualifications needed by the nursing staff who will be required to deliver the services as specified in any resultant action plan. (4.07)

Not achieved. We understood that work on a health needs analysis had been undertaken three years before but this had been only in draft form and no copy was available.

We repeat the recommendation.

2.122 Policies currently under review should be rewritten in line with NHS standards of care and the advice of professional organisations. (4.08)

Not achieved. Policies were largely out of date, although there was evidence that some

redrafting was underway.
We repeat the recommendation.

2.123 Serious injury reports should be audited every six months to determine trends and causes so that action can be taken. (4.09)

Partially achieved. Information on all serious injury reports was collected and regularly forwarded to prison headquarters. The only reports audited locally were those relating to self-inflicted injury, information from which was discussed at the monthly suicide awareness meetings.

2.124 A mental health analysis should be carried out. (4.12)

Not achieved. No mental health needs analysis had been undertaken either separately or as part of an overarching health needs assessment. A new consultant psychiatrist had recently been appointed who we understood was keen that a mental health needs analysis be completed.
We repeat the recommendation.

Pharmacy

2.125 A maximum/minimum thermometer should be provided. Records of daily maximum/minimum temperatures should be kept. The fridge should be defrosted at regular intervals. (4.18)

Achieved. The drugs fridge in the treatment room had a minimum/maximum thermometer and readings were taken and recorded daily. The fridge was defrosted monthly.

2.126 Movements and possession of the pharmacy keys should be logged and monitored. (4.21)

No longer applicable. The pharmacy room in the healthcare centre was no longer in use. Keys for the controlled drugs cupboard were stored in the centre key room.

2.127 The transcribing of prescriptions on to an order sheet should stop and the original prescriptions should be faxed through to the pharmacy. The pharmacist should make regular visits (at least monthly) to inspect the original prescriptions. (4.25)

Achieved. Prescriptions written by the doctors were faxed direct to the pharmacy. A new pharmacist was in post and had begun regular visits to the centre.

2.128 A written in-possession policy should be adopted. (4.28)

Achieved. Patients could have all but psychotropic medicines in-possession weekly or monthly following a risk assessment. They signed a compact to do so and this was also signed by the prescribing doctor. Patients taking psychotropic medicines were given them daily.

2.129 A written special sick policy should be adopted. (4.30)

Achieved. A policy on special sick (or discretionary medicines) was in place and was being rewritten in light of changes to the availability of 'over the counter' medicines from the tuck shop.

2.130 Patients should be supplied with patient information leaflets (PILs) with their medication. A notice should be displayed at the treatment room to ensure that young people are aware of the availability of the relevant leaflet for them to consult where a leaflet is not able to be supplied directly to them. (4.31)

Partially achieved. Patients were issued with a PIL when first prescribed their medication. No notices were displayed informing young people of the availability of relevant leaflets, although staff had started to keep a folder of PILs so that these would be available on request.

2.131 The pharmacist responsible for supply of medicines should take a more active role in the provision of pharmaceutical services, and should make regular visits to review procedures. (4.36)

Partially achieved. The pharmacist had only recently been appointed but was beginning to take a more active role with monthly visits to the centre. The pharmacist provided services to all three prisons.

2.132 The pharmacist should be involved in the reviews of pharmacy-related procedures, have input into the formulary and attend the drugs and therapeutics committee. The introduction of pharmacy clinics should be considered. (4.38)

Not achieved. However, we were assured that the new pharmacist would be taking a more active role in the centre. Drugs and therapeutics committee meetings were held at HMP Maghaberry.
We repeat the recommendation.

Dental services

2.133 Proper temporary surgery facilities should be provided until such time as the hospital wing is reopened containing the refurbished dental facilities. (4.44)

No longer applicable. The refurbished dental facilities had been available since September 2002.

2.134 All dental treatment for young people should be carried out in the establishment. (4.45)

Achieved. All except specialist dental treatment was undertaken in the centre.

2.135 The new dental surgery facilities and equipment should be inspected prior to use to ensure conformity to modern standards and regulations. (4.46)

Achieved. The facilities had most recently been inspected by the Eastern health board dental practice adviser in December 2004 and had passed well.

2.136 Subsequent to the chief dental officer's review and dental health needs assessment, both quantitative and qualitative monitoring procedures should be put in place to provide assurance to the appropriate authorities and ensure cost effectiveness of the service. (4.47)

Not achieved. However, the contractual arrangements for all three establishments in Northern Ireland were being changed to separate the provider/monitoring function. Dental care at HMPs Maghaberry and Magilligan will be provided by local general dental service practitioners. The

dentist at Hydebank Wood was still directly employed by the Prison Service on a locum basis. We repeat the recommendation.

2.137 Sufficient escort services should be provided to ensure an adequate flow of patients to the dental practitioner. (4.48)

Not achieved. The practitioner still frequently had to wait to treat patients, which reduced the numbers who could be seen at each session. The waiting list for dental treatment was about nine weeks, although anyone in pain was seen at the next clinic.
We repeat the recommendation.

2.138 The dental practitioner and the surgery assistant should undertake annual CPR training. (4.49)

Achieved. Both the dentist and dental nurse had up to date CPR training.

Additional information

2.139 The healthcare centre was a two-storey purpose-built building near the entrance to the prison. It had been refurbished and was generally very clean. Only the ground floor was in regular use. It included an inpatient facility comprising two observation cells with safer cell furniture and closed circuit television, two three-bed dormitories and a cell where one of the hospital orderlies slept. The waiting room was small and completely bare with no health promotion material or anything for patients to look at while waiting to be seen. The solid door to the waiting room meant that patients could be observed only through closed-circuit television. With only one waiting room, women and young men attended at different times.

2.140 The inpatient association room was also quite small and barely furnished with only moulded plastic chairs to sit on. Patients could watch television and play board games but very little else. The only pictures on the walls were those painted by one of the patients. There was no dedicated exercise area, although staff would take patients for walks around the grounds when numbers were small and staffing levels permitted. Problems with escorts meant that inpatients had very little access to education or library services.

2.141 The review of healthcare due after the last inspection had only recently been completed. The long delay meant that the health needs analysis, staff skill mix review, training needs analysis and increases in staffing levels had not taken place. We did not find evidence of work to meet the specific needs of juveniles, such as training on child protection issues.

2.142 Young people had good access to primary care services and a range of visiting specialists but healthcare staff did not follow triage algorithms and nurse-led clinics were available only on an ad hoc basis when staffing levels permitted. Nevertheless, the young adults in our survey were very positive about their overall experience of healthcare, with 61%, against a benchmark of 43%, rating it as good or very good. The ratings for the doctors, nurses and the dentist were also all significantly better than the benchmark.

2.143 Levels of medication among young men were not very high and the majority of those on regular medicines had them weekly or monthly in-possession following a risk assessment. Medicines were administered three times a day. A member of healthcare staff packed each young person's medicines in a small brown envelope and these were taken to the house blocks in a locked case. Depending on whether or not patients were locked in their cells, the nurse would either take the medicines to the patient's cell or administer them from a desk in

the office (Elm and Willow) or on the main landing (Beech and Cedar). This was neither safe nor legal and meant there was little privacy or confidentiality for patients.

2.144 Young people had had improved access to specialist mental healthcare since the appointment of a new consultant psychiatrist. She and a staff grade psychiatrist provided two sessions a week each, seeing four to six patients at each session, although lock downs and lack of runners sometimes prevented this. We understood that 15 medium secure beds were due to be opened in the nearby Knockbracken Hospital in April 2005, which should facilitate the transfer to appropriate care of young adults with acute mental health problems. There was no healthcare secure accommodation for juveniles in the province.

2.145 Primary mental healthcare was limited, although the healthcare officers were very experienced. The introduction of multidisciplinary working between healthcare, psychology and Opportunity Youth counsellors was welcome but the community psychiatric nurse (CPN) input was insufficient to meet the needs of the young people.

2.146 The oral health of the young people was very poor and the two dental sessions a week currently offered were not adequate to meet the needs.

Further recommendations

2.147 The facilities in the inpatient association room should be improved and made more comfortable.

2.148 A therapeutic regime should be developed for inpatients and include better access to education and the library.

2.149 There should be a designated exercise area for inpatients.

2.150 A separate waiting room should be available for men and women and health promotion material should be available.

2.151 The recently completed healthcare review should be communicated to all concerned, agreed and implemented as a matter of urgency.

2.152 Changes to the staffing skill mix should ensure that there is appropriate clinical and managerial leadership in healthcare.

2.153 Healthcare staff training should include child protection.

2.154 Regular clinical supervision for staff should be introduced.

2.155 Algorithm-based nurse triage should be introduced.

2.156 Primary mental healthcare provision should be increased following a needs assessment.

2.157 Secure, confidential arrangements should be made for the administration of medicines and secondary dispensing stopped.

2.158 Further community psychiatric nurse input should be provided to meet the needs of the young adults.

2.159 The numbers of dental sessions should be increased and oral health promotion introduced.

Education and work skills training

2.160 More and better opportunities for learners to achieve qualifications are needed. (5.16)

Partially achieved. There were increasing opportunities for learners to gain qualifications but they were not always taken up due to limited access to courses. Positive steps had been taken to offer individual programmes of study leading to external qualifications for a number of students at level 2 or above.

2.161 Attendance at education and training should be dramatically improved. (5.17)

Achieved. Progress had been made in improving the attendance of young people at education and training sessions. Attendance rates were carefully recorded and monitored. The headline figure of an attendance rate of 65% for education classes did not include those who were absent for good reason (such as attending court or visits).

Further recommendation

2.162 Records should be kept of 'approved absences' to reflect a more realistic attendance rate for performance management for monitoring purposes.

2.163 Arrangements should be improved and formalised to provide opportunities for young people that more accurately reflect their individual circumstances. (5.20)

Partially achieved. See paragraph 2.18.
See also main recommendation HP50.

2.164 There should be an urgent review of the appropriateness of the targets set and the extent to which they are achieved. (5.21)

Partially achieved. Education and training managers were conscious of the importance of, and need to meet, targets set by external bodies. For example, the education manager was making good progress in meeting the target of 100 accreditations in essential skills and 150 AQA (Assessment and Qualifications Alliance) units for the current year. The training manager was responding to and reporting on targets set relating to vocational training options. Targets were being set for individual young adults as part of the personal development programme planning process and improvements had been made in this area of work.

2.165 Education and training staff should oversee the Welfare to Work programme. (5.25)

Not inspected. The Welfare to Work programme had been suspended in 2004 due to funding and staffing difficulties. It was reported that there were plans to re-introduce the programme later in 2005 with the education manager having general oversight of the work.

2.166 Better use of the library should be made by both staff and learners. (5.29)

Not achieved. The library in the new education block was attractive, spacious and reasonably well resourced. It had a good range of fiction titles but no talking books and little to meet the

needs of young people with reading difficulties. It was open on Tuesday evenings and for two three-hour sessions a week (Monday and Thursday afternoons) with a librarian in attendance. Very little use was made of this valuable resource. In December 2004, 45 young adults had visited the library and borrowed books. In February 2005, the figure was 15. The librarian was prepared to spend more time on site but saw little point given the low attendance rates.
We repeat the recommendation.

2.167 There should be a broad, balanced, relevant and differentiated curriculum that will meet the needs of all learners. (5.40)

Not achieved. See paragraph 2.18. While we acknowledged some progress such as one-to-one sessions offered to young people with specific literacy and numeracy needs and attempts being made to organise individual programmes for those at level 2 or above, there was still some way to go to meet the needs of all learners.
We repeat the recommendation.

2.168 There should be more help given to learners on the importance of their training plans and the link between the initial assessment process and any informal targets so that the learners can feel a sense of ownership. (5.43)

Achieved. A review of student files in education indicated that careful attention was being given to individual target setting at initial assessment and induction. All new arrivals were interviewed by the education manager and specific targets were discussed and agreed before the personal development planning meetings. Young adults placed on the essential skills programme were asked to complete a number of in-house assessments to identify specific learning goals. The training manager interviewed young people on the residential wings as part of the induction process to identify specific areas of vocational interest. A major barrier to learning was the overall lack of opportunities in education and training. The process of target setting linked to the training plans was generally effective but much of the good work was wasted because of the waiting lists and the limited number of places on offer in education and training.

2.169 There should be a step change in the efficiency with which the education programme is delivered. (5.52)

Not achieved. There was no overall planning and coordination of education and training provision. The education and training departments worked independently of each other even though there were some examples of cooperative working (joint attendance at weekly planning meetings to, among other things, allocate young people to the limited number of places on offer). Young adults were interviewed by the education and training managers (see paragraph 2.168) but there was no overall 'menu' explaining the range of education and training places on offer. Young people could not mix education and training courses as all training courses were full-time and all education courses were part-time (see paragraph 2.18).
We repeat the recommendation.

Physical education

2.170 Urgent attention should be given to reviewing physical education (PE) staffing levels to ensure that the provision is maintained. (5.60)

Achieved. Although access to the gym was poor, an additional post had been created and recruitment was underway.

2.171 Detailed information about the individual needs of each trainee should be made available to staff. (5.62)

Achieved. PE staff were now provided with sufficient information on individual needs to allow them to make informed assessments.

2.172 The cancellation of competitions should be avoided. (5.63)

Achieved. We were told that the only competition cancelled for some time was a staff–young people football match. This required staff to attend in their own time, which they chose not to do.

Faith and religious activity

2.173 The administrative systems in place to support chaplains, in particular with access to new receptions, should be reviewed. (5.71)

Partially achieved. There had been no change to the limited administrative support available to chaplains from the establishment and they still used administrative services at their headquarters. However, this was not reported to be a problem and the particular issue of notification of new arrivals had been resolved. All new arrivals were seen by a chaplain but not always within 24 hours of arrival. This was due in part to the fact that all chaplains were part-time. In our survey, only 19% of juveniles and 20% of young adults, against much higher respective benchmarks of 40% and 46%, reported seeing a chaplain within 24 hours.

Further recommendation

2.174 Chaplaincy hours should be increased to ensure that all young people are seen within 24 hours of arrival.

2.175 Chaplains should be included in all policies and procedures involving sentence planning, resettlement and personal officer work. (5.73)

Not achieved. Chaplains played an important role in the pastoral care of young people and had a lot to offer in relation to many aspects of their care. However, they were not involved in individual care planning meetings for young people (such as self-harm reviews) or strategic management meetings because of the constraints on their time (see paragraph 2.173).
We repeat the recommendation.

Time out of cell

2.176 The daily target for minimum hours out of cell should be raised to 10 hours. (5.75)

Not achieved. The Nothern Ireland Prison Service had rejected this on the basis that it would have 'serious resource implications' and that it was already meeting its own target of seven hours a day. Our expectation is for a minimum of 10 hours out of cell each day and the published core day would provide for 15 minutes more than this. Staffing levels were high and we could see no justification for rejecting this recommendation.
See main recommendation HP49.

2.177 A much more imaginative approach to out of cell activities is needed. (5.76)

Not achieved. See paragraph 2.53. There was no consultation or survey of young people to identify their preferences or needs. Many young people relied on computer games and television, which was unacceptable given the lack of access to fresh air and the gym.
We repeat the recommendation.

Security

2.178 The establishment should review all its contingency plans and include additional essential scenarios that are not part of the plans. (6.02)

Achieved. The contingency plans had been reviewed and included a full range of scenarios that could apply at Hydebank Wood. A full test of one scenario and two tabletop exercises had been held in 2004.

2.179 The interpretation of search dog evidence should be reviewed and closed visits only be given to visitors where there is additional and reliable intelligence to support the dog evidence. (6.07)

Not achieved. The governor considered that an indication by a passive dog alone was sufficient basis for requiring a closed visit. This policy was unnecessarily strict, given the possible reasonable explanations for a positive indication (including error by the dog). To require a closed visit for young people was disproportionate without other supporting intelligence.
We repeat the recommendation.

Incentives and earned privileges scheme

2.180 The establishment should consider reproducing the information contained within the IEP information leaflet through other mediums, such as videos or cassette tapes. (6.16)

Not achieved. The IEP information leaflet, which was not user friendly, had been withdrawn. A video produced for new arrivals contained some reference to the IEP scheme but this was not sufficiently detailed. In our survey, one young person said, "I still didn't understand everything and how things were supposed to be done for a while after".

2.181 The IEP scheme and drug strategy contained some discrepancies about punishments. In some units, for example, any young person found guilty on adjudication was automatically placed on the basic level for six weeks without review. This amounted to double jeopardy.

2.182 Most of the young adults we met said they understood how the scheme worked but many complained that the system did not operate fairly. Additional privileges that staff could award or withdraw were not clearly defined in the policy, which provided too much scope for staff discretion. In contrast, 58% of young adult respondents to our survey, against a significantly lower benchmark of 49%, said they had been treated fairly in their experience of the IEP scheme.
We repeat the recommendation.

Further recommendation

2.183 Young people who are found guilty on adjudication should not automatically be placed on the basic level.

2.184 There should be explicit links between the IEP scheme and compliance with sentence planning targets. (6.17)

Achieved. The revised IEP scheme made reference to 'inmate resettlement plans' and explained how IEP status would be linked to individual targets regarding behaviour, work and general progress. All departments had input to the points system, which was reviewed weekly and used to calculate movement within the scheme. In our survey, only 47% of juveniles, against a significantly higher benchmark of 59%, said that the different levels in the IEP scheme would make them change their behaviour.

2.185 A young person should be given the opportunity to add a written comment of their own to the weekly assessment report. (6.19)

Not achieved. Although young people were required to sign the staff/contribution/input form, they were not permitted to make a contribution or to make representations at review boards (see paragraph 2.186). This may well have contributed to the perception expressed to us by many young people that the scheme did not operate fairly.
We repeat the recommendation.

2.186 Formal boards should be held to enable young people to make representations before they are demoted to the basic level of the IEP scheme. (6.22)

Not achieved. The revised scheme did not include formal boards to enable young people to make representations before being demoted to basic level. Staff told us that young people always knew exactly how many points they had acquired or lost during the week and therefore were never surprised by decisions to promote or demote. Young people to whom we spoke confirmed this but said that lack of surprise did not equate to acceptance of the fairness of the decision. We examined a sample of young people's personal history records and found that the daily recording of behaviour required by the IEP scheme was rarely done. Decisions about movement within the IEP scheme appeared to be little more than an administrative function based on mathematical calculations.
We repeat the recommendation.

2.187 Young people should not be penalised in terms of movement within an IEP scheme that is location based. (6.25)

Achieved. The revised scheme was no longer location-based.

2.188 The establishment should consider placing young people on the standard level in reception. (6.26)

Achieved. All new arrivals were now placed on the standard level.

Prisoner disciplinary procedures

2.189 The adjudicating governor should be more imaginative in setting awards for receiving contraband in visits. (6.34)

Not achieved. The prison's action plan indicated that the deputy governor would review privileges and sanctions but this had not taken place.

Additional information

2.190 There were no standardisation meetings of adjudicators to ensure that punishments were more consistent. The governor told us that he had avoided this because the courts had criticised the use of tariffs. In the cases we examined where a young adult had been found guilty of possession of drugs, there were marked differences between the punishments imposed by different adjudicators: one generally imposed an average of five days cellular confinement with loss of all privileges (including books, wristwatch and radio); the other preferred to stop association and canteen for two weeks. We found one juvenile held in cellular confinement for two consecutive but overlapping periods of seven days. He could have been held for 10 days without any possessions, books, writing materials, radio, television or wristwatch. All he had was a newspaper every other day and his clothes. The punishment was remitted after we raised the issue but not until the following afternoon when he had served seven days in these very restrictive conditions, which were unsuitable for a child. There were no independent advocates to represent children.

Further recommendations

2.191 Standardisation meetings should be held quarterly to ensure that punishments are consistent between adjudicators.

2.192 When cellular confinement is imposed, the assumption should be that no other privilege will be lost except in exceptional circumstances.

2.193 Children should always have the opportunity to be represented at adjudications and cellular confinement should not be used as a punishment for children unless they have been represented.

Use of force

2.194 All staff who may be required to use it should be certificated in the use of control and restraint (C&R). (6.38)

Not achieved. Only 52% of eligible staff had received initial or refresher training in the last year.
We repeat the recommendation.

2.195 Full de-escalation procedures should be adopted throughout the establishment. (6.40)

Achieved. The incident reports examined and interviews with young people and staff indicated that de-escalation was used routinely and young people were, where practicable, given the

opportunity to calm down before any force was used. When force was used, staff tried to de-escalate the incident to avoid its continued use.

2.196 A review should be set up to ensure the use of force when used is necessary and used correctly. This group should have the powers to recommend further investigations to the governor. (6.42)

Not achieved. The C&R coordinator reviewed all uses of force but the senior management team did not routinely discuss his findings and trends were not monitored. No group had reviewed the use of force.
We repeat the recommendation.

2.197 The visiting committee should form part of the review body and should be actively included in the processes, providing the governor with independent information. (6.43)

Not achieved. There had been no review.

2.198 All staff who receive training in the use of force should be trained to use handcuffs as a means of de-escalating a situation. (6.44)

Achieved. The use of handcuffs for moving young people under restraint and as a less intrusive method of C&R was included in basic and refresher C&R training.

2.199 All future training should incorporate information relating to the procedures in managing Positional Asphyxiation and Excited Delirium. (6.46)

Achieved. These matters were covered in basic and refresher C&R training.

Additional information

2.200 There was no record of the use of the unfurnished accommodation in the special supervision unit. The forms used for this had been taken from an out of date Northern Ireland Prison Service security manual. The new manual did not contain the forms and the prison had stopped recording the use of the accommodation, the behaviour of the young person, the authorisation or when the use ceased. We were therefore unable to inspect this but were told that young people were often put in unfurnished accommodation after having a full body search, even when compliant. We watched a video recording of one such incident.

Further recommendation

2.201 Records of the use and authorisation of unfurnished accommodation, its duration, and the behaviour of the young person there should be maintained.

Segregation unit (punishment unit)

2.202 The name of this unit should be changed to reflect the nature of the work that is taking place and that promotes its caring and dynamic environment. (6.49)

Achieved. After several changes, the unit had been named the special supervision unit (SSU).

However, many staff and young people continued to refer to it as the punishment house or the block.

2.203 The development of the Punishment Unit should include cognitive skills training links and other behavioural programmes that seek to address anti-social behaviour. (6.50)

Not achieved. There were no monitoring records for those held in the SSU and there was no system for identifying the needs of those segregated for good order or discipline or for planning with them what they need to achieve in order to return to their house. Individual work was undertaken by SSU staff and healthcare and psychology and some notably difficult young men had been able to make considerable progress. However, these were the minority and all those segregated needed to know what was required of them to allow them to return to their house.

Further recommendations

2.204 Monitoring records should be kept for all those held in the special supervision unit (SSU) recording their well being and progress.

2.205 Young people segregated for good order or discipline should be given clear targets of what they need to do to return to their house and should be helped to achieve those targets.

2.206 The IEP scheme should be included in the punishment unit compact. (6.56)

Achieved. Those in the SSU retained their IEP status.

Resettlement

2.207 An integrated approach to resettlement and policy should be developed. (7.01)

Partially achieved. Although a local policy had not yet been developed, Hydebank Wood's agencies (Northern Ireland Prison Service resettlement staff, the Probation Board for Northern Ireland, NIACRO and Opportunity Youth) worked collaboratively with Northern Ireland Prison Service headquarters to fulfil the Northern Ireland resettlement strategy. Ninety-one per cent of eligible young adults were working to initial resettlement plans and 74% to full resettlement plans. However, there was little ownership of the resettlement concept by many discipline staff. Staff redeployment had also caused difficulties, with most of the 32 officers trained in the assessment case management and evaluation (ACE) method by the Probation Board for Northern Ireland since moved to positions where they did not apply the training.

2.208 A resettlement policy committee should be established. (7.02)

Achieved. The committee was representative of relevant agencies. It had met regularly and had made persuasive business cases for resourcing and development.

2.209 The developing home leave policy should incorporate a home leave board which the young person has the opportunity to attend. (7.04)

Achieved. The current home leave board met weekly and young people were allowed to attend.

Reintegration planning

2.210 The scope for expanding work initiatives and opening the opportunity for others should be explored. (7.09)

Partially achieved. Some good Outside Work scheme placements were available for the small number of eligible young people, and resettlement personnel were constantly seeking fresh opportunities. However, there had not been any expansion of placements or enhancement of eligibility. The requirement for home leave to incorporate explicit resettlement objectives was a positive development.

Sentence planning

2.211 More emphasis should be placed on the young person's offending behaviour and what needs to be done to address this along with his resettlement needs. (7.16)

Achieved. The resettlement files examined showed good linkage between resettlement needs and criminogenic issues.

2.212 A smaller informal forum than the personal development plan (PDP) meeting should be considered. Some thought should be given on how best to deal with sensitive information before the young person joins the meeting. (7.17)

Achieved. Attendance at the resettlement meetings was tailored to the circumstances of individual young people. Those aged under 18 could identify a community-based mentor to attend meetings with them. We saw a good example of sensitive information being dealt with discreetly.

2.213 A system to monitor the quality of personal development plans (PDPs) should be put in place. (7.18)

Not achieved. The plans we looked at were thoroughly completed and adhered to a consistent format. While there was no system to monitor the quality of resettlement plans, the resettlement manager had undertaken a one-off dipstick sample of two plans per house in 2004. However, this type of quality control was not taking place on a regular, planned basis.
We repeat the recommendation.

2.214 A personal officer scheme should be developed involving officers in monitoring, motivating, and recording the progress of the young person to ensure progress is being made against the plan. (7.20)

Not achieved. Staff in the residential units did not operate as personal officers to particular young people. The inmate record system introduced just before our last inspection had been instrumental in focusing personal officers to interact with young people to record their progress but was not being used as diligently as it had been originally. We saw no evidence to back up the establishment's claim that it was developing a personal officer scheme to meet the needs of the young people.
We repeat the recommendation.

Offending behaviour work

2.215 Further analysis of the work on the establishment's population should be used to focus resources when developing offending behaviour work. (7.23)

Achieved. Good profiling data available from the monthly Northern Ireland Prison Service statistical report had been supplemented by some local analysis, leading to targeted offending behaviour programmes. These included car crime, anger management and enhanced thinking skills.

2.216 All young people should be engaged with at an early point to offer them the opportunity to attend courses that address offending behaviour. (7.24)

Achieved. Remanded and sentenced young adults were given the opportunity to agree resettlement plans soon after arrival. The low reconviction rate for young adults released from Hydebank Wood on to custody probation order supervision (43% reconvicted within two years, compared to 74% of young adults released from immediate young offender centre custody) reflected positive outcomes from the interventions of the Probation Board for Northern Ireland and others.

2.217 Young people who have difficulties reading and writing should be identified during the pre-course assessment and supported through the course. (7.25)

Achieved. This was confirmed by feedback from young people in Elm and Willow Houses.

2.218 The involvement of more officers in group work programmes should be promoted to develop a culture of working constructively with young people. (7.26)

Not achieved. The number of officers deployed as group work facilitators had fallen from four to two. Efforts to recruit replacements had been unsuccessful, possibly because the role was not made attractive enough, for example, through different shift patterns.
We repeat the recommendation.

Key workers (personal officers)

2.219 A regular forum should be created in which new initiatives can be routinely discussed between operational staff and their managers. A system for the ongoing supervision and support, as well as accountability, of all staff by their managers should be developed. (7.37)

Not achieved. The system for disseminating information about new initiatives to staff was contained in the revised communication and information sharing strategy, which had not been implemented (see paragraph 2.220). A system of staff supervision and support had not been developed and we were told this was pending the proposed review of the personal officer scheme. Staff told us that unit staff meetings did not take place routinely.
We repeat the recommendation.

2.220 The communication and information sharing strategy should be reviewed. (7.38)

Partially achieved. The communication and information sharing strategy had been reviewed but the revised version had not been disseminated to staff and the recommendations within the

strategy had not been implemented. We spoke to a number of residential unit staff who were not aware that a communication strategy had been developed.

Further recommendation

2.221 The communication and information sharing strategy should be disseminated to staff in a systematic way.

Catering

2.222 Staffing levels in the kitchen should be reviewed to enable national vocational qualifications (NVQs) to be made more widely available. (8.03)

Partially achieved. This recommendation had been rejected on the basis that the primary function of the kitchen was to provide food for the centre rather than to be a training resource. More staff had qualified as assessors but few NVQs had been achieved: three young adults had achieved NVQ level 1 in catering in 2004 and one to date in 2005; two others were working towards this qualification. One young person had achieved a NVQ level 2 in 2003. We repeat the recommendation.

2.223 Prison staff should consult with a nutritionist to ensure that healthy food options are regularly offered. The menus should be reviewed as a matter of urgency to ensure a balanced and varied diet is provided. (8.04)

Partially achieved. We were told that any changes in menus were emailed to the nutritionist at Belfast City Hospital for comment and we saw a note from the kitchen principal officer about such contact concerning a woman prisoner's diet. A three-week rotating menu had been introduced but the quality of the choices available had not been externally assessed. We repeat the recommendation.

2.224 Lifts should be repaired immediately. (8.05)

Achieved. Young adults were still carrying food upstairs from heated trolleys. Some staff said this was because the food lifts were broken while another member of staff said they did not have a key for the lift door. According to the works manager and recent lift engineer reports, the lifts had recently been serviced and only the one in Ash House had been reported broken. It was clear that established policy was to not use these lifts, which was a health and safety concern.

Further recommendation

2.225 Food lifts should be used.

2.226 Protective gloves should be made available for staff and young people to protect themselves when handling hot trays. (8.05)

Achieved. One pair of protective gloves was available and being used on each of the serveries we visited.

2.227 Training should be provided in manual handling techniques. (8.05)

Partially achieved. Young people were required to undertake manual handling training as part of gym induction but there was no check that all servery orderlies had completed it. This was the responsibility of residential unit staff but there was no audit trail.

Further recommendation

2.228 A record should be kept of all those who have been trained in manual handling techniques and all servery orderlies should be required to complete the training before taking up their jobs.

2.229 Staff should not smoke in the kitchen area. (8.05)

Achieved. We did not observe any staff smoking near to where food was being served.

2.230 The practice of putting plastic plates in the hot cupboard should cease immediately. Food should be kept in the metal trays in the hot cupboard. (8.06)

Not achieved. Food was still being served on to plastic plates and left on top of the hot plate cupboard until collected. In one house, we also saw meals on plastic plates that had been placed directly in the hot cupboard. We were told this was only until the person returned to the unit from the court video link.
We repeat the recommendation.

2.231 Some of the serveries require general maintenance, and a number of the refrigerators require seals to be cleaned and in some cases renewed. Additional 13 amp sockets should be provided to avoid refrigerator plugs being removed to operate toasters. (8.06)

Achieved.

2.232 The taking and recording of all food temperatures should be consistently carried out at the point of delivery and immediately before food is served. (8.07)

Not achieved. Food temperatures were recorded from preparation to the point where the trays of food were loaded on to heated trolleys. These were collected from the main kitchen by residential officers and servery workers. The temperature of food was not taken at the point of serving. One officer believed this was not necessary and had not been trained to do it. One manager said that staff associations had objected to this task. A report from the senior environmental health officer (26 November 2004) stated, 'There appears to be no temperature monitoring of the service of food at any of the satellite units, and this has the potential to weaken any due diligence defence'.
We repeat the recommendation.

2.233 The establishment should ensure that all young people who serve and handle food are appropriately dressed at all service times and that staff are trained in basic food hygiene. (8.07)

Not achieved. In one unit, no young people were wearing appropriate whites but most had completed a basic food hygiene course or were about to complete it. We observed one servery worker completing an interactive computer course on the essentials of food safety. Since July 2002, 87 young adults had completed this one-hour course and 42 others had completed a six-

hour food safety course since October 2001. None of the staff to whom we spoke had completed training in food safety.
We repeat the recommendation.

2.234 More use should be made of consultative groups for menus and purchasing. (8.08)

Not achieved. We saw the minutes of some meetings between a governor and groups of young people during September 2004 but there were no regular consultative groups. Food surveys continued to be completed annually and 44% of respondents to this survey in January 2004 said they were not happy with the variety of choice of menu.
We repeat the recommendation.

Additional information

2.235 There were pro-formas for weekly servery hygiene checks by kitchen staff but these were being completed less frequently than this. There was insufficient management oversight of food safety and hygiene standards once meals had left the main kitchen, although some guidelines had been provided for staff.

Further recommendation

2.236 There should be greater management accountability of standards of food safety and hygiene standards after food has left the main kitchen.

Prison shop (canteen)

2.237 The reception pack should be increased to include a telephone card of sufficient value to enable a young person to make daily contact with his family during the first few days of custody. (8.14)

No longer applicable. All young people received personal identification number telephone credits on arrival.

2.238 The practice of displaying individual finance records should stop. (8.17)

Achieved.

2.239 Canteen lists including prices of individual items should be issued showing the amount of private cash available to spend on each occasion. (8.18)

Achieved. Young people received individual order forms complete with the cost of items and including details of how much money they had to spend.

2.240 The establishment should consider setting up formal arrangements with local newsagents to enable young people to purchase newspapers and magazines. (8.20)

Achieved. A local newsagent supplied pre-ordered newspapers and magazines.

Section 3: Summary of recommendations

3.1 The following is a list of repeated and further recommendations included in this report. The reference numbers in brackets refer to the paragraph location in the main report.

Main recommendation **To the Director General**

3.2 Integral sanitation should be provided for all young people. Until then, there should be genuine 24-hour access to toilets so that young people do not have to use pots after a cut-off time. (HP48)

Main recommendations **To the Governor**

3.3 First night procedures should be developed to ensure that a comprehensive vulnerability assessment is made and that all young people, particularly children, are held in appropriate supportive accommodation with regular monitoring. (HP43)

3.4 A new safer custody strategy should be developed to ensure the anti-bullying procedures work effectively with the involvement of young people. Appropriate links should be made with between suicide and self-harm issues and peer support should be provided for victims of bullying and those at risk of self-harm (HP44)

3.5 Alternative and more therapeutic responses to self-harm for young people, other than the use of strip-conditions, should be developed. Anti-suicide suits and unfurnished accommodation should be used only as a last resort, and should be fully justified and recorded. Staff should be available to interact with and support young people deemed at risk of self-harm. (HP45)

3.6 The child protection policy should be reviewed to ensure that systems and procedures are in place to ensure child protection referrals are raised appropriately and dealt with efficiently, with all staff and managers working with children trained in child protection. (HP46)

3.7 A personal officer scheme should be developed to encourage residential staff to engage more actively with young people and take an active part in the development of resettlement plans, and to help ensure that resettlement becomes an integral aspect of the centre's purpose. (HP47)

3.8 All young people should have at least 10 hours a day out of their cells, including a minimum of one hour's access to exercise in the open air and a period of association each day. (HP49)

3.9 Sufficient education and work skills training should be provided to meet the needs of young people, to occupy them fully and equip them with the qualifications and skills they require. (HP50)

3.10 An up to date full health needs analysis should be completed including a review of the skill mix of staff to ensure that the young people at Hydebank Wood receive an appropriate healthcare service. (HP51)

Recommendations To the Director General

3.11 A formal system should be set up with the juvenile justice centre to ensure that information-sharing and pre-transfer planning takes place for all young people transferred to Hydebank Wood. (2.5)

Recommendations To the Governor

Clothing and possessions

3.12 Washing machines should be provided to allow young men to wash their own clothes. (2.8)

Applications and complaints

3.13 A system of independent advocacy for those under 18 should be introduced. (2.12)

3.14 Requests and complaints should be routinely analysed over time to provide useful management information about patterns and trends. (2.16)

3.15 Requests and complaints should be monitored for matters relating to bullying and child protection and cross-referred as appropriate. (2.17)

Security

3.16 The random searching of staff would provide a recognised and approved deterrent to trafficking. (2.20)

Young people in Hydebank Wood

3.17 Further efforts should be made to engage the area child protection committee (ACPC) in the work of safeguarding children at Hydebank Wood. (2.23)

Reception

3.18 The holding room in reception should be repaired and refurbished so that it is made suitable for the purpose of holding young people. Young people should not be secured in the individual changing cubicles. (2.27)

3.19 There should be a range of accessible information notices and posters in reception to introduce new arrivals to Hydebank Wood. (2.28)

3.20 Young people should not routinely be handcuffed to and from reception and while travelling in escort vans without an individual risk assessment indicating a need for this level of security. (2.32)

First night arrangements

3.21 New arrivals should be carefully and consistently monitored during their first 24 hours in custody and this should be recorded. (2.34)

3.22 Children should not be accommodated automatically in bare anti-ligature cells without a television for their first days in custody unless an individual risk assessment suggests that this is necessary. (2.37)

3.23 Televisions should be provided in first night cells in Willow 1. (2.38)

3.24 A system of identification for staff, which should include the wearing of name badges, should be introduced. (2.39)

3.25 Efforts should be made to reinforce verbal information provided to new arrivals by other means, for example by providing cassette tapes or written information to be displayed around the residential unit. (2.40)

3.26 The induction process should be streamlined, with a single document containing all the initial information gathered about young people, and managers should ensure that it contains all necessary and relevant information. (2.47)

Accommodation and facilities

3.27 Recreational facilities in Beech House should be increased and consistency introduced across the residential houses. (2.53)

3.28 The establishment should agree upon a nucleus of essential information and notices to be displayed in the residential units, to include anti-bullying, equal opportunities, requests and complaints, the daily routine and the incentives and earned privileges (IEP) scheme etc. These notices should be regularly updated and renewed. (2.54)

3.29 Professional haircutting should be available to young men without charge. (2.56)

3.30 The pool tables in Cedar House should be returned. (2.58)

3.31 Pool tables and other table games should be provided in all units. (2.59)

Anti-bullying – the importance of creating a safe environment

3.32 Bullying surveys should be undertaken every two years, with particular attention given to young people's perceptions of bullying by staff. The results should be disseminated to staff and used to inform the anti-bullying policy. (2.63)

3.33 An anti-bullying committee, led by a senior manager, should be set up. It should include representatives from all areas of the establishment and have representations from young people and children. (2.64)

3.34 All staff and managers should receive anti-bullying training, specifically tailored to adolescence. (2.65)

3.35 In order to be a credible scheme the anti-bullying strategy should have links to child protection and other prison strategies such as suicide prevention. (2.68)

3.36 Records relating to incidents of bullying within the young offender centre should be kept separately from those held on women. (2.71)

Prevention of suicide and self-harm

3.37 There should be separate suicide awareness and prevention team (SAPT) meetings for women and young men to oversee the development and implementation of local policy for their care based on the Northern Ireland Prison Service policy document. The local policy should be based on an analysis of need and the statistics to help to improve the level of care for those at risk of self-harm. (2.81)

3.38 Young people should be represented on the suicide awareness and prevention team (SAPT). Other important areas of the prison, including Opportunity Youth, the chaplaincy and education, should also be represented. (2.82)

3.39 Multidisciplinary training in the PAR1 (prisoner at risk) process should be provided for all staff working directly with young people. (2.83)

3.40 All young people should be invited to attend their PAR1 reviews and to make a written contribution. Where possible, reviews should be planned in advance to ensure that staff from a range of other disciplines can attend and that they are chaired consistently. (2.84)

3.41 A peer support scheme should be developed. (2.85)

Substance use

3.42 Healthcare staff should receive substance use awareness training. (2.94)

3.43 Alcohol and drug use among new committals should be monitored and services modified to meet changing needs. (2.95)

3.44 Clinical detoxification protocols should be updated regularly in line with best practice. (2.96)

Equal opportunities

3.45 There should be regular analysis of statistical data in respect of adjudications, requests and complaints, home leave and early release and incentives and earned privileges (IEP). Senior management should regularly monitor these statistical returns in order to address discrimination on the basis of religion or other grounds. (2.97)

3.46 The definitions of discrimination and intimidation, and the systems put in place to address these issues for staff, should also be applied to the young prisoners of Hydebank Wood. (2.98)

3.47 The equality and diversity committee should be established as soon as possible and should include representatives of the young people. (2.99)

Maintaining contact with family and friends

3.48 A formal written system should be introduced to ensure that complaints or suggestions from visitors could be routinely audited. (2.100)

3.49 A direct helpline into the establishment should be provided for visitors and friends of young people to report incidents to senior managers. Helpline numbers should be printed on reception letters. (2.106)

3.50 Information about support groups should be displayed in the visitors' centre and a confidential helpline should be introduced and advertised. (2.113)

3.51 All visits should last at least one hour. (2.114)

3.52 Appropriate training should be provided to assist and enhance the role of the family liaison officers (FLOs). (2.115)

Healthcare

3.53 An increase in the nurse staffing complement should be seen as a priority in line with NHS practice. (2.118)

3.54 A skills analysis should be conducted to facilitate working in partnership with the NHS. (2.119)

3.55 Administration or clerical support should be provided to allow nursing staff to spend more time in clinical activities. (2.120)

3.56 A health needs analysis should be carried out with the help of the local health authority public health doctors and should 'feed' into the review of healthcare in Northern Ireland. This assessment should also inform the establishment as to the skills and qualifications needed by the nursing staff who will be required to deliver the services as specified in any resultant action plan. (2.121)

3.57 Policies currently under review should be rewritten in line with NHS standards of care and the advice of professional organisations. (2.122)

3.58 A mental health analysis should be carried out. (2.124)

3.59 The pharmacist should be involved in the reviews of pharmacy-related procedures, have input into the formulary and attend the drugs and therapeutics committee. The introduction of pharmacy clinics should be considered. (2.132)

3.60 Subsequent to the chief dental officer's review and dental health needs assessment, both quantitative and qualitative monitoring procedures should be put in place to provide assurance to the appropriate authorities and ensure cost effectiveness of the service. (2.136)

3.61 Sufficient escort services should be provided to ensure an adequate flow of patients to the dental practitioner. (2.137)

3.62 The facilities in the inpatient association room should be improved and made more comfortable. (2.147)

3.63 A therapeutic regime should be developed for inpatients and include better access to education and the library. (2.148)

3.64 There should be a designated exercise area for inpatients. (2.149)

3.65 A separate waiting room should be available for men and women and health promotion material should be available. (2.150)

3.66 The recently completed healthcare review should be communicated to all concerned, agreed and implemented as a matter of urgency. (2.151)

3.67 Changes to the staffing skill mix should ensure that there is appropriate clinical and managerial leadership in healthcare. (2.152)

3.68 Healthcare staff training should include child protection. (2.153)

3.69 Regular clinical supervision for staff should be introduced. (2.154)

3.70 Algorithm-based nurse triage should be introduced. (2.155)

3.71 Primary mental healthcare provision should be increased following a needs assessment. (2.156)

3.72 Secure, confidential arrangements should be made for the administration of medicines and secondary dispensing stopped. (2.157)

3.73 Further community psychiatric nurse input should be provided to meet the needs of the young adults. (2.158)

3.74 The numbers of dental sessions should be increased and oral health promotion introduced. (2.159)

Education and work skills training

3.75 Records should be kept of 'approved absences' to reflect a more realistic attendance rate for performance management for monitoring purposes. (2.162)

3.76 Better use of the library should be made by both staff and learners. (2.166)

3.77 There should be a broad, balanced, relevant and differentiated curriculum that will meet the needs of all learners. (2.167)

3.78 There should be a step change in the efficiency with which the education programme is delivered. (2.169)

Faith and religious activity

3.79 Chaplaincy hours should be increased to ensure that all young people are seen within 24 hours of arrival. (2.174)

3.80 Chaplains should be included in all policies and procedures involving sentence planning, resettlement and personal officer work. (2.175)

Time out of cell

3.81 A much more imaginative approach to out of cell activities is needed. (2.177)

Security

3.82 The interpretation of search dog evidence should be reviewed and closed visits only be given to visitors where there is additional and reliable intelligence to support the dog evidence. (2.179)

Incentives and earned privileges

3.83 The establishment should consider reproducing the information contained within the IEP leaflet through other mediums, such as videos or cassette tapes. (2.180)

3.84 Young people who are found guilty on adjudication should not automatically be placed on the basic level. (2.183)

3.85 A young person should be given the opportunity to add a written comment of their own to the weekly assessment report. (2.185)

3.86 Formal boards should be held to enable young people to make representations before they are demoted to the basic level of the IEP scheme. (2.186)

Prisoner disciplinary procedures

3.87 Standardisation meetings should be held quarterly to ensure that punishments are consistent between adjudicators. (2.191)

3.88 When cellular confinement is imposed, the assumption should be that no other privilege will be lost except in exceptional circumstances. (2.192)

3.89 Children should always have the opportunity to be represented at adjudications and cellular confinement should not be used as a punishment for children unless they have been represented. (2.193)

Use of force

3.90 All staff who may be required to use it should be certificated in the use of control and restraint (C&R). (2.194)

3.91 A review should be set up to ensure the use of force when used is necessary and used correctly. This group should have the powers to recommend further investigations to the governor. (2.196)

3.92 Records of the use and authorisation of unfurnished accommodation, its duration, and the behaviour of the young person there should be maintained. (2.201)

3.93 Monitoring records should be kept for all those held in the special supervision unit (SSU) recording their well being and progress. (2.204)

3.94 Young people segregated for good order or discipline should be given clear targets of what they need to do to return to their house and should be helped to achieve those targets. (2.205)

Sentence planning

3.95 A system to monitor the quality of personal development plans (PDPs) should be put in place. (2.213)

3.96 A personal officer scheme should be developed involving officers in monitoring, motivating, and recording the progress of the young person to ensure progress is being made against the plan. (2.214)

Offending behaviour work

3.97 The involvement of more officers in group work programmes should be promoted to develop a culture of working constructively with young people. (2.218)

Key workers (personal officers)

3.98 A regular forum should be created in which new initiatives can be routinely discussed between operational staff and their managers. A system for the ongoing supervision and support, as well as accountability, of all staff by their managers should be developed. (2.219)

3.99 The communication and information sharing strategy should be disseminated to staff in a systematic way. (2.221)

Catering

3.100 Staffing levels in the kitchen should be reviewed to enable national vocational qualifications (NVQs) to be made more widely available. (2.222)

3.101 Prison staff should consult with a nutritionist to ensure that healthy food options are regularly offered. The menus should be reviewed as a matter of urgency to ensure a balanced and varied diet is provided. (2.223)

3.102 Food lifts should be used. (2.225)

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3.104 The practice of putting plastic plates in the hot cupboard should cease immediately. Food should be kept in the metal trays in the hot cupboard. (2.230)

3.105 The taking and recording of all food temperatures should be consistently carried out at the point of delivery and immediately before food is served. (2.232)

3.106 The establishment should ensure that all young people who serve and handle food are appropriately dressed at all service times and that staff are trained in basic food hygiene. (2.233)

3.107 More use should be made of consultative groups for menus and purchasing. (2.234)

3.108 There should be greater management accountability of standards of food safety and hygiene standards after food has left the main kitchen. (2.236)

Appendix I: Inspection team

Anne Owers	HM Chief Inspector of Prisons
Michael Loughlin	Team leader
Tom McGonigle	Inspector (CJINI)
Fay Deadman	Inspector
Brett Robinson	Inspector
Joss Crosbie	Inspector
Paul Fenning	Inspector

Specialist inspectors

Tish Laing Morton	Healthcare inspector
Bill Massam	Ofsted

Researchers

Julia Fossi	Research officer
Charlotte Owiredu-Oppong	Student

Appendix II: Prison population profile

Population breakdown by:

(1) Status	Number of young people	%
Sentenced	99	50.25
Convicted but unsentenced		
Remand	98	49.75
Detainees (single power status)		
Detainees (dual power status)		
Total	197	

(2) Number of sentenced young people

Sentence	6 mths	12 mths	18 mths	24 mths	30 mths	36 mths	42 mths	48 mths	Over 48 mths	No. of custody probation orders	No. of JJCO	Life /HMP	Total
Age													
15 years													
16 years	2							1		(4)			3
17 years	4	1	1	1		1				(10)		1	9
18 years	13	4	9	12	3	10	5	14	12	(65)		5	87
Total	19	5	10	13	3	11	5	15	12	(79)*		6	99

(The custody part of the 79 on the custody probation orders are included.)

(3) Length of stay for unsentenced by age

Length of stay	<1 mth	1-3 mths	3-6 mths	6-12 mths	1-2 yrs	2 yrs +	Total
Age							
15 years							
16 years		1		1			2
17 years	5	6	6	4			21
18 years and over	19	23	14	12	7		75
Total	24	30	20	17	7		98

(4) Main offence	Number of young people	%
Violence against the person	51	25.89
Sexual offences	6	3.04
Burglary	27	13.71
Robbery	38	19.29
Theft & handling	22	11.17
Fraud and forgery		
Drugs offences	7	3.55
Driving offences	23	11.68
Other offences	19	9.64
Breach of custody/probation orders	4	2.03
Civil offences		
Offence not recorded/Holding warrant		
Total	197	

(5) Age	Number of young people	%
15 years		
16 years	5	2.54
17 years	29	14.72
18 years and over	163	82.74
Total	197	

(6) Home address	Number of young people	%
Within 50 miles of the centre	157	79.7
Between 50 and 100 miles of the centre	32	16.24
Over 100 miles from the centre		
Overseas		
NFA	8	4.06
Total	197	

(7) Location	Number of young people	%
Greater Belfast	95	48.22
Co. Down	23	11.68
Co. Antrim	17	8.63
Co. Londonderry	16	8.12
Co. Armagh	17	8.63
Co. Fermanagh	6	3.05
Co. Tyrone	15	7.61
England	0	0
Scotland	0	0
Wales	0	0
Republic of Ireland	0	0
Other	0	0
NFA	8	4.06
Total	197	

(8) Nationality	Number of young people	%
British	196	99.49
Foreign nationals	1	.51
Total	197	

(9) Ethnicity	Number of young people	%
Data on ethnicity not included as the YOC was unable to provide accurate figures.		

(10) Religion	Number of young people	%
Catholic	109	52.66
Protestant	63	30.43
Church of Ireland	18	

Presbyterian	38	
Methodist	6	
Free Presbyterian	1	
Other Protestants	0	
Other Religion	34	16.43
No Religion	1	.48
Not Known	0	
Total	207	

Report on an unannounced inspection of

Hydebank Wood Prison and Young Offender Centre

14 – 17 March 2005

by HM Chief Inspector of Prisons

and

the Chief Inspector of Criminal Justice in Northern Ireland

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Introduction

As part of the inspection regime, the Prisons Inspectorate of England and Wales carries out short unannounced inspections to follow up recommendations made at full inspections, and to chart an establishment's progress. This pattern has also been adopted by the Criminal Justice Inspectorate of Northern Ireland, in relation to prisons inspecting.

This short unannounced inspection of Hydebank Wood young offender centre (YOC) followed up a full inspection carried out in 2001. During the intervening years, both the YOC and the Northern Ireland Prison Service have experienced some difficulties and upheavals: poor industrial relations and consequent industrial action, and the removal of women prisoners from Mourne House to one of the houses at the YOC.

These had posed significant challenges for managers, and the consequences were evident during this inspection. Managers had had to focus on the needs, and problems, associated with the arrival of women prisoners in a far from suitable prison environment. Industrial action, during the inspection, meant that staff were working to rule and as a result young prisoners were confined to their cells for very lengthy periods. Overall, these factors had blocked some of the positive developments that were beginning, or had been promised, at the time of the last inspection.

Only one of the main recommendations made at that time had been fully achieved – improved systems for managing suicide and self-harm. Others, such as in-cell sanitation, sufficient education and training, and improved time out of cell had not: even discounting the effect of the current industrial action. We were concerned that managers did not always know about, or fully appreciate, some of the deficiencies that inspectors found.

Some aspects of the care of young people at Hydebank Wood deserve praise. The accommodation and environment were of a high standard. It is also noticeable that in a society where the suicide rate among young men is alarmingly high, there had been no self-inflicted deaths at Hydebank Wood. Indeed, some young people told us that they felt safer inside the YOC than outside. However, some key procedures, such as first night and anti-bullying, needed development; and too many vulnerable young people were routinely placed in strip-clothing and special cells as a first response to fears of self-harm. We had particular concerns about the severity of punishments in the 'special supervision' unit, (or the 'block' as it was routinely called); and the lack of formal records and evidence of support or a structured regime for young people held there.

Relationships between staff and young prisoners had improved slightly, and many staff knew their prisoners well; but there was still too little positive engagement. Officers were likely to be behind their desks, rather than engaging with young prisoners on the landings. It was also unacceptable that young people were still slopping out: and indeed the so-called night sanitation system did not operate throughout the night. We also found evidence of informal, or double, punishments, sanctioned at officer level. Systems, procedures and management of healthcare were poor, though young people were very positive about the care given by individual healthcare staff.

Time out of cell had been severely affected by the industrial action at the time of the inspection. Even under more normal circumstances, though, we were concerned that the advertised 10-hour core day for young prisoners was not routinely available, and there was no regular exercise in the fresh air. It was very welcome that a new education centre had been built – but there was still insufficient work and training for young prisoners. A significant number – half of the young adults, and a third of juveniles – had no access to education at all. There were only 68 vocational spaces; and only a quarter of young people had access to

them. There was little communication between employment and education staff. Reducing reoffending, particularly among young people, is critically dependent on trying to remedy their educational and skills deficits. Hydebank Wood was still some way from being able to offer those opportunities to all its young prisoners.

Resettlement, however, was an area where Hydebank Wood was performing well. The new Visitor Centre managed by NIACRO, and the arrangements for child-centred visits have enhanced the quality of interaction between young prisoners and their visitors. Opportunity Youth, a non-governmental organisation, engaged actively with the many young people who had drug or alcohol problems, providing courses during imprisonment and also support afterwards. Probation staff developed resettlement plans for all young adults, working with relevant agencies in the community. However, this was largely done without the involvement of the residential staff, who worked alongside the young people and could have been instrumental in developing and implementing resettlement plans.

We recognise that this inspection took place at a particularly difficult time for the establishment; but nevertheless it revealed three fundamental underlying problems that have not been addressed. The first is to ensure that there is sufficient meaningful and integrated activity and training for the young men at Hydebank Wood. The second is to develop and support the work of residential staff, who can play a key role in motivating and supporting young prisoners. The third is to ensure that there is active and visible management, to support staff and to ensure that regimes and management systems are implemented.

Hydebank Wood can play a key role in the criminal justice system of Northern Ireland: providing an environment where young adults – the most prolific reoffenders – can be challenged and supported to change. We have no doubt that staff, managers and the Northern Ireland Prison Service want to move Hydebank Wood forward. This report contains nine new main recommendations to assist in doing that. We hope that the next inspection will be able to record real progress towards implementing them.

Anne Owers June 2005
HM Chief Inspector of Prisons

Kit Chivers
Chief Inspector of Criminal Justice in Northern Ireland

Fact page

Task of the unit
Hydebank Wood is a prison and young offender centre holding sentenced and remanded young men and women including juveniles, sentenced and remanded adult women and adult and young women immigration detainees.

Brief history
Hydebank Wood was opened on 1 June 1979.

Number held
231

Cost per place per annum
Not available as the cost is worked as a cost per prisoner across the service.

Certified normal accommodation
304 (excluding healthcare and special supervision unit accommodation).

Operational capacity
Not applicable. To be reviewed if single occupancy cell allocation is exceeded.

Last full inspection
4 – 8 February 2002

Description of residential units
There are five residential units: Ash, Beech, Cedar, Elm and Willow Houses. Ash House is for women prisoners and inspected separately. Beech and Cedar Houses each contained 60 single occupancy cells divided into four landings of 15 cells respectively. Each landing has showering facilities, association and dining areas. 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 standard and basic compact. It is currently occupied on three out of four landings. The staff training department is situated on the ground floor.

- Cedar House contains enhanced and special privilege young adults and is fully occupied. The video link suite is located on the ground floor.

Beech and Cedar Houses do not have access to integral sanitation but occupants have access to night toilet facilities.

- Elm House has 56 single occupancy cells and one dormitory holding three young adults. Elm 1 and 2 landings contain the committal/induction landings. Elm 3 landing holds standard and basic compact young male adults. Elm House also has responsibility for the special supervision unit, which is housed directly below Elm 1 landing. This has 10 single occupancy cells.

- Willow House has 64 single occupancy cells. Willow 1 and 2 landings hold the juvenile population. Willow 3 landing and Elm 4 landing hold young male adults on the standard and basic compact.

All cells in Elm and Willow Houses have integral sanitation and sprinkler systems.

Section 1: Healthy prison summary

Introduction

HP1 Inspection reports include a summary of an establishment's performance against the model of the healthy prison. The four criteria for a healthy prison 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 release into the community, and helped to reduce the likelihood of reoffending.

HP2 This inspection was a follow-up to the last full inspection of Hydebank Wood young offender centre in February 2002, and we examined progress in meeting the recommendations from that inspection. Since that inspection, a major change had been the transfer of women prisoners from Mourne House at Maghaberry prison to Ash House at Hydebank Wood. This report does not deal with the treatment and conditions for women prisoners at Ash House, which was subject to a separate unannounced inspection in December 2004.

HP3 In a short unannounced inspection such as this, an in-depth assessment cannot be made across the full range of the Inspectorate's published *Expectations*, which set out our criteria for assessing the treatment of and conditions for prisoners. Opportunities for checking outcomes are limited and some areas were examined in more detail than others. A major difficulty at the time of this inspection was that the Prison Officers' Association in Northern Ireland was in dispute about terms and conditions of employment, had withdrawn its goodwill and was operating a ban on overtime. This had a significant impact at Hydebank Wood, which was heavily reliant on overtime and had formally agreed high levels of staffing for unlocking. The regime was unable to operate normally and many young men who would usually have been out were instead locked in their cells. This curtailed a lot of the informal interaction we would normally have with the young people and made it difficult to observe activities taking place as many were cancelled. Opportunities to observe staff–young prisoner relationships were also more limited than usual. Nevertheless, we were satisfied that with the benefit of surveys and focus groups we were able to look behind the immediate difficulties faced by the establishment at the time of the inspection and form a picture of how much progress had been achieved since we last inspected.

HP4 Some progress had been made but it was a matter of concern that very few of the main recommendations from the last report had been achieved. Overall, we found that 76 of the 138 recommendations we examined again had been achieved or partially achieved. Fifty-six had not been achieved and the remaining six either could not be inspected or were no longer applicable. There was still an issue, emphasised to us by the industrial relations situation, that the generous levels of staff available were not being used to maximise opportunities for young people. For example, there was still no effective personal officer scheme, there was an over-emphasis on

security with too many staff being used for escorts within the establishment and too many staff being required before any young people were unlocked. There was a lack of education and training to meet the needs of young people. Most cells did still did not have integral sanitation.

HP5 Based on documentary evidence, our observations and discussions with staff, young people and others, the following is our assessment, based on the four tests of a healthy prison.

Safety

HP6 While Hydebank Wood provided a basically safe environment for young people there were some areas of concern. Reception was basic but clean and there had been some improvements in induction. First night arrangements for juveniles were unsatisfactory. Although not a major problem, bullying was mostly dealt with informally rather than through the agreed procedures. There were low levels of self-harm but extreme measures were taken to protect those at risk. Punishments at disciplinary hearings were over severe with too much use of cellular confinement. Too few staff were trained in use of force and there was insufficient monitoring of its use. Staff were not well enough aware of child protection procedures.

HP7 There were few problems with escorts and movements to courts. However, young people were not given any information about Hydebank Wood at court, which might have helped reduce anxieties, particularly for those new to custody. Most journeys were short but young people found the vans uncomfortable. They were handcuffed in vans with no seatbelts and said the vans were driven too fast. In our survey, they were positive about their general treatment by escort staff. As well as being handcuffed in the vans, all young people were unnecessarily handcuffed to and from reception without any individual risk assessment.

HP8 Reception had changed little since our last inspection. It was clean but remained austere, and little information was displayed. Young people were still being locked in individual changing cubicles, which was not satisfactory. In our survey, 74% of respondents, much higher than the benchmark, said they had the opportunity to shower on the day of their arrival. New arrivals were given basic provisions and an education induction pack but procedures to assess vulnerability and risk were underdeveloped. Staff said they knew the young people well but there was a danger that familiarity could lead to changed risks being missed. First night cells for juveniles were stark and unwelcoming. New arrivals were now held together and the induction process had improved, with 67% of respondents to our survey, against a benchmark of 52%, saying that it covered all they needed to know.

HP9 A bullying survey had been undertaken in 2003 but the results had never been disseminated or considered by the anti-bullying committee, which had not met for over a year. In this out of date survey, almost all said they felt safe. However, over 40% also said that they had some experience of bullying. Staff described dealing with bullying informally and there was little recorded monitoring. There were no separate records for the women at Ash House and most of the recent entries in the anti-bullying register involved women. The register also confused bullies with victims. There had been only eight recorded substantiated cases of bullying since 1 January 2004 and monitoring in those cases was poor. No anti-bullying training had been

delivered. Our survey indicated that victimisation from other young people was similar to the benchmark but it was a concern that significantly more young prisoners (14% against 6%) said they had been assaulted by staff. It was positive that 18% of young people, against a benchmark of 9%, said they had reported incidents of bullying to staff.

HP10 There were low levels of self-harm. Despite a relatively high suicide rate among young men in the community, there had been no deaths at Hydebank Wood for almost five years. This was a significant achievement. However, protective clothing and special cells were too often used as a first and extreme measure, rather than a more therapeutic approach. In some cases, vulnerable young men were forcibly stripped and placed in suicide suits. There was good awareness of the vulnerability of high profile cases. PAR1 (prisoner at risk) reviews were poorly recorded and there was too much emphasis on physical protection rather than emotional support. Some good support was provided by the Opportunity Youth organisation but there was no peer support scheme. There had been no staff training in suicide awareness and only some limited instruction to senior officers about the PAR1 process. There was no separate strategy for the young men and the women at Hydebank Wood.

HP11 A child protection policy had been developed in 2003 but there had been little strategic development and there were no links to bullying and suicide and self-harm to incorporate a wider safeguarding approach. The policy contained no guidance for staff about how and when to make a child protection referral. This was reflected in a lack of staff awareness and there had only ever been one referral. Only 10 of the group of 30 staff who could work with children at Hydebank Wood had child protection training.

HP12 The punishment unit had officially changed its name to the special supervision unit (SSU) but was still mostly referred to as the punishment block. There was no specific training for staff in the SSU. All young people, including children, entering the unit were required to be strip-searched (or full body-searched as it was termed). There was little structured regime to address the anti-social behaviour that might have led to a young man being placed in the SSU, although there were some examples of individuals being helped. Young people in the SSU did not always get daily exercise. Punishments at adjudications were inconsistent and often over punitive. There was too much use of cellular confinement with loss of all privileges, essentially leaving young people, some of whom were children, in bare cells with no means to pass the time. This was informally operated by staff who would allow some concessions but this was not adequate. No formal monitoring records were kept on those serving punishments of cellular confinement.

HP13 Only 52% of staff were trained in use of force, handcuffs were now being used appropriately and staff were using de-escalation procedures. There was no monitoring of trends of use of force or the use of strip-conditions to hold people in the SSU. On the wider security front, contingency plans had been developed and were well tested.

HP14 Alcohol misuse was a problem for many young men at Hydebank Wood. Over 70% of new admissions were drinking regularly before their committal, and 20% of them were defined as problem drinkers. Drink was a factor in the majority of offences. There were few alcohol detoxifications and healthcare staff had received very little training in substance use awareness. There was an annual survey about drug problems and new arrivals on committal were being tested. In our survey 36% against a benchmark

of 22% said it was easy to get illegal drugs in the prison. Without random mandatory drug testing, it was difficult to get a fuller picture.

Respect

HP15 There had been a slight improvement in the quality of relationships between staff and the young people since we last inspected but there was still relatively little proactive staff engagement. The external environment and the accommodation were clean and in good condition. However, the electronic unlock system did not operate for the full time that young people were locked in cells and some were effectively still slopping out. The incentives and earned privileges (IEP) system did not involve young people sufficiently and in some areas operated unfairly. Equal opportunities monitoring was not taking place. While young people were positive about the individual care they received from healthcare staff some healthcare procedures and services were poor and improvement was needed.

HP16 Our survey results indicated some good relationships between staff and young people, which appeared to have improved since the last inspection. However, these were based mainly on young people approaching staff rather than vice versa. While some staff interacted well, many kept their distance. In our survey, 69% said most staff treated them with respect and 70% said they had someone to turn to if they had a problem. While these results were consistent with the benchmark, there were indications that many of the staff they relied on were Opportunity Youth workers or chaplains rather than prison officers. Young people were universally called by their surname alone and some staff were surprised by our use of 'Mr' to address young people. The personal officer scheme was not working well, even though the generous staffing levels in Northern Ireland meant there was the potential to deliver an effective scheme.

HP17 The standard of accommodation was generally good and almost all young people had single cells. Both the external and internal areas of the establishment were well maintained and clean. Young people had good access to clean clothes, bed sheets, cleaning materials and showers. Almost all were smartly dressed but there were still no machines to wash their own clothes and some told us of problems getting soap powder for hand washing. Only Elm and Willow Houses had integral sanitation; the others relied on electronic unlocking systems but these were operative only up to a certain time, after which the young people had to use pots, so were effectively slopping out.

HP18 Due to the industrial action, the amount of association time was very poor. We accepted, however, that this was usually good, particularly in Cedar House where young people were seldom locked in their cells during the day. Facilities for entertainment during association remained poor.

HP19 Little information was provided about the IEP scheme, and the scheme as it operated was not reflected in the written policy. The scheme was complicated but the young people seemed to understand it, although they did not feel it operated fairly. They were not involved in reviews and the criteria for movement within the scheme were not defined in the policy. Although there was no reference to this in the IEP policy, pay rates were based on IEP level rather than on activity, which was unfair. In some

units, young people found guilty at adjudication were automatically placed on the basic level for six weeks without review. This was unacceptable.

HP20 In our survey, 27% of respondents, significantly higher than the benchmark, said the food was good or very good. However, many complained that the food was cold, which was due to poor handling and serving arrangements. Food lifts were not being used and young adults were required to carry food containers up stairs. Young people serving food were not properly dressed and opportunities for training in the kitchen were still being missed.

HP21 Young people were generally positive about the range of goods in the shop and their access to it.

HP22 Chaplains were formally notified of all new arrivals but were not allocated sufficient time to see them all within 24 hours or to take part in prison meetings such as the suicide prevention committee. However, young people received good pastoral care and support from the chaplaincy team.

HP23 No analysis of equal opportunity data was taking place. A document outlining the young offender centre's meeting structure listed an equality and diversity committee but this committee had never met. We were told that monitoring would not begin until the introduction of a new computer system in May 2005. We used the raw data available to analyse the IEP scheme and allocation to activity by religious affiliation and the indications were that these were fair. However, it was a matter of concern that such monitoring was not being done routinely by the establishment. There was still no equal opportunities policy and data on ethnicity was unreliable.

HP24 There had been a review of the complaints systems but changes had yet to be implemented, as a new Northern Ireland system was to be introduced. Our survey suggested there was relatively poor access to application and complaint forms and there was also little satisfaction with the outcome of applications. Survey results in this area were less positive than in 2001 and 2002. There was no regular analysis of complaints by area or type and no independent advocacy and support for young people. Access to external legal services was good.

HP25 The review of healthcare services due after the last inspection had only recently been completed. As a consequence, the staff skill mix review, training needs analysis and increase in staffing levels had not yet been implemented and few of the healthcare recommendations had been achieved. Mental health services in particular needed development. Despite this, young people were very positive about their overall experience of healthcare and rated the care given by the doctors, nurses and the dentist highly.

Purposeful activity

HP26 Time out of cell was difficult to measure because the industrial action was severely curtailing the regime. Our previous recommendation that there should be a target of 10 hours minimum time out of cell was not accepted, although this should have been possible for many when a full regime was running. There was generally insufficient purposeful activity to meet the needs of the population and too little emphasis on developing a learning culture, with too few young men involved in education.

HP27 The industrial action meant that the usual regime was not operating. Consequently, hours of unlock were very poor and not healthy for young people. We tried to establish the position before the industrial action began. According to the core day, the planned time out of cell when a full regime was running would be over 10 hours on weekdays and at weekends. However, there was little evidence that this core day was routinely followed or supervised. With apparently institutionalised late unlocks and early lockups, the amount was significantly reduced. With the available level of staff, much more should have been possible to achieve but this needed better management supervision.

HP28 There was no planned regular exercise in the open air for young people and only 3%, against a benchmark 27%, said they got exercise in the open air three or more times a week. This was unacceptable.

HP29 There had been some positive developments in education and training but much of it was still aspirational and had yet to be delivered. A new learning and skills centre provided a better focus but education and training remained too low a priority. The new centre had been badly designed with little natural light. The education department carefully monitored attendance rates and attendance had clearly improved significantly since the last inspection. While there was a considerable amount of absence, the vast majority were for good reasons; unexplained or unjustified absences were less than 10%. Overall, however, there were too few education and training places available and too few young people participating.

HP30 Irrespective of the existing employment relations problems, staffing difficulties, particularly sickness, were adversely affecting access to courses. One third of juveniles did not attend education at all and the remaining two-thirds attended only between one and four sessions. Only a half of the young adults attended any education. The curriculum was narrow and did not meet the needs of the students in terms of the lack and type of course offered. Some were insufficiently challenged.

HP31 The library was attractive and well-resourced but was rarely used even when the regime was operating fully. Only 15 young people had got to visit the library in February and the position for the last months of 2004 was not much better. In our survey, only 13% of respondents, well below the benchmark, said they were able to get to the library once a week.

HP32 There was a reasonable range of vocational options on offer but only 68 available places. At the time of the inspection, 25% of the young people were orderlies, 25% were in vocational training and 50% had not been allocated to any activity. We understood that discussions taking place to introduce new courses to help match the unmet need. There was poor communication between employment and education staff, particularly at the induction stage when important decisions about allocation were made.

HP33 There was poor access to physical education. Only 11% of respondents to our survey, against a benchmark of 19% and compared to 32% in our survey in 2002, said they got to the gym at least three times a week. It was difficult to establish what the usual position was and we accepted that to some extent the poor survey showing reflected the current problems. The resolution of these problems and the additional staff member being recruited should improve access.

Resettlement

HP34 There was a good resettlement policy and good delivery of services from a range of agencies. However, landing officers were insufficiently involved in resettlement issues and there was a need for resettlement to become the core focus of all staff. Home leave was appropriately targeted for resettlement purposes. Opportunity Youth provided a good service for those with substance use problems.

HP35 There had been good progress in resettlement work since our last inspection and the relevant agencies in the establishment were well integrated and working in conjunction with those responsible for resettlement at the Northern Ireland Prison Service headquarters. A resettlement policy committee had been established and was taking the policy forward.

HP36 However, more needed to be done to promote a resettlement culture as part of the responsibilities of all staff. Resettlement work was not seen as integral to the work of officers in residential units.

HP37 An improved model for sentence and custody planning had been put in place in the form of resettlement plans for all young people, whether sentenced or not, which integrated offending behaviour and resettlement needs. We saw evidence of young people being involved in the process and signing off their plans, although the survey and our interviews with them suggested they were sceptical about their value. There was no systematic analysis of the quality of resettlement plans and there was a need for a meaningful personal officer scheme in order for them to become meaningful for young people and staff.

HP38 There was some good analysis of the criminogenic profile of young people at Hydebank Wood that helped inform the provision of programmes. Northern Ireland Prison Service-accredited programmes (car crime, enhanced thinking skills and anger management) were run and had met their targets in the previous years. However, the industrial action and more importantly, the loss of officer facilitators had now put delivery in doubt for the current year.

HP39 At the time of our last inspection, no young adults at Hydebank Wood were sentenced to life imprisonment. There were now six young lifers with a further 12 facing potential life sentences. Arrangements were in place to get information from the police at conviction to help inform risk assessments. Families of the young lifers were invited to the establishment and had the tariff and life sentence system explained to them. This was good practice. All the lifers had life sentence plans and regular reviews.

HP40 A good new visits facility had recently opened. Visitors were now being searched, which had reduced searching of young people. Visitors were offered a closed visit on a single drug dog indication without any further intelligence or the use of discretion in individual cases. This was too rigid. Visits were timed to ensure that young people and their visitors received their entitlement but the minimum visit time of 30 minutes was too short and the young men received shorter visits than women in Ash House. Good special children's visits had recently been introduced and were run by an enthusiastic family liaison officer.

HP41 Young adults had their reintegration needs assessed through the resettlement plan system. There were some opportunities to work out in the community towards the end of sentence for a small number of eligible young adults. Home leave was being used

positively as an aid to successful reintegration with a requirement for each home leave to incorporate resettlement objectives.

HP42 The drug and alcohol strategy was up to date and there was a comprehensive action plan with timescales and responsibilities clearly set out. A good service was provided by Opportunity Youth for both drugs and alcohol. Opportunity Youth was well integrated in the establishment and provided key workers during sentence and after release, accredited courses, counselling services and family support with throughcare. Group work was open to all on the basis of need. Voluntary drug testing (or, more accurately, compliance testing) was also open to all. There was an overall positive rate of 9% but with some significant variation between houses. In our survey, 24% of young people, significantly higher than the benchmark, considered that they would have an alcohol problem when they left prison.

Main recommendations

HP43 First night procedures should be developed to ensure that a comprehensive vulnerability assessment is made and that all young people, particularly children, are held in appropriate supportive accommodation with regular monitoring.

HP44 A new safer custody strategy should be developed to ensure the anti-bullying procedures work effectively with the involvement of young people. Appropriate links should be made with between suicide and self-harm issues and peer support should be provided for victims of bullying and those at risk of self-harm.

HP45 Alternative and more therapeutic responses to self-harm for young people, other than the use of strip-conditions, should be developed. Anti-suicide suits and unfurnished accommodation should be used only as a last resort, and should be fully justified and recorded. Staff should be available to interact with and support young people deemed at risk of self-harm.

HP46 The child protection policy should be reviewed to ensure that systems and procedures are in place to ensure child protection referrals are raised appropriately and dealt with efficiently, with all staff and managers working with children trained in child protection.

HP47 A personal officer scheme should be developed to encourage residential staff to engage more actively with young people and take an active part in the development of resettlement plans, and to help ensure that resettlement becomes an integral aspect of the centre's purpose.

HP48 Integral sanitation should be provided for all young people. Until then, there should be genuine 24-hour access to toilets so that young people do not have to use pots after a cut-off time.

HP49 All young people should have at least 10 hours a day out of their cells, including a minimum of one hour's access to exercise in the open air and a period of association each day.

HP50 Sufficient education and work skills training should be provided to meet the needs of young people, to occupy them fully and equip them with the qualifications and skills they require.

HP51 An up to date full health needs analysis should be completed including a review of the skill mix of staff to ensure that the young people at Hydebank Wood receive an appropriate healthcare service.

Section 2: Progress since the last report

Introduction

2.1 We used the recommendations from our last inspection of February 2002 as a framework to examine progress achieved. We have commented where we have found significant improvements, and where we believe little or no progress had been made and work remained to be done.

2.2 During this inspection, we concentrated on aspects that most directly affected the treatment of conditions for young people and so did not examine all the recommendations from the last inspection. The paragraph reference numbers at the end of each recommendation below refer to its location in the previous inspection report.

Respect

2.3 As soon as the Justice (Northern Ireland) comes into force, a regime focused on the needs of 17-year olds and based in its own residential location should be established. This should mirror the arrangements that are intended in the new juvenile justice centre with which Hydebank Wood should develop a close working relationship. (HPS60)

Partially achieved. A dedicated unit for the juveniles had been established. On the first day of the inspection, 34 young people under 18 (including four 16-year olds) were located in Willow House on separate landings to the young adult population. However, the facilities and regime for juveniles at Hydebank Wood did not mirror that of the juvenile justice centre, nor would that be possible in view of the vastly different resources available to the two establishments.

2.4 There had been some ad hoc discussions between the two establishments about transfers. These related to two cases of difficult and vulnerable girls who had been transferred from the juvenile justice centre because their behaviour was too difficult to be managed there. Pre-transfer meetings and case conferences had taken place to assist with the planning for their care. However, there was no formal system to deal with all young people transferred from the juvenile justice centre to Hydebank Wood.

Further recommendation

2.5 A formal system should be set up with the juvenile justice centre to ensure that information-sharing and pre-transfer planning takes place for all young people transferred to Hydebank Wood.

See also main recommendations HP48 and HP49.

Accommodation and facilities

2.6 All cells should have in-cell sanitation. (2.10)

Not achieved. Only Elm and Willow Houses had integral sanitation. The other houses relied

on electronic unlocking systems for access to sanitation but these were available only up to a given time, after which young adults had to use pots. Some were therefore still slopping out. See main recommendation HP48.

Clothing and possessions

2.7 Consideration should be given to installing washing machines to allow young people to develop responsibility for washing their own clothes. (2.22)

Not achieved. We were told that this had not been possible due to power loading issues. However, washing machines had been provided in Ash House when women prisoners transferred there in June 2004, which suggested that the loading issues could be overcome. Young people clearly took pride in their appearance and the provision of washing machines would help develop their personal responsibility.

Further recommendation

2.8 Washing machines should be provided to allow young men to wash their own clothes.

Prevention of suicide and self-harm

2.9 The review, development and implementation of a new policy on suicide and self-harm should be an urgent priority for both the Northern Ireland Prison Service and Hydebank Wood youth offender centre (YOC). (3.19)

Achieved. The prisoner at risk (PAR1) procedures had been introduced throughout the Northern Ireland Prison Service in March 2004. A governor, principal psychologist and suicide prevention coordinator (healthcare senior nurse) had key roles in managing its implementation at Hydebank.

Applications and complaints

2.10 There should be an urgent review of the current systems and the new pilot scheme in England should be considered. A policy of independent advocacy should be considered. (3.65)

Not achieved. The complaints system had been reviewed internally but no changes had been implemented due to the pending introduction of a new Northern Ireland Prison Service-wide system.

2.11 There was no system of independent advocacy. This was a particular concern for those under 18 whose legal status as children needed to be acknowledged. The visiting committee was reluctant to take up complaints on behalf of young people because it believed this could compromise its independence. The Northern Ireland Prison Service had recently introduced a prisoner ombudsman as an independent point of appeal against complaints but he had not yet taken up his appointment.

Further recommendation

2.12 A system of independent advocacy for those under 18 should be introduced.

Additional information

2.13 In our survey, 75% of juveniles, against a significantly higher benchmark of 85%, said they knew how to make a complaint. In the young adult survey, responses to questions about access to request and complaints forms and the fairness with which applications were sorted out were significantly worse than the benchmark. We examined a sample of requests and complaints, and these had been dealt with as a record for the file rather than as a personal response to the young person. It was unclear how the young person had been informed of the outcome, which might have contributed to the levels of dissatisfaction. Many recent complaints related to the effects of the industrial action, which may also have impacted on current perceptions.

2.14 There was some analysis of requests and complaints but no routine ongoing analysis to provide useful management information about patterns and trends.

2.15 Staff were not alert to the need to cross-reference requests and complaints to bullying and child protection procedures. We found examples of both concerns in complaints that had not been passed on appropriately.

Further recommendations

2.16 Requests and complaints should be routinely analysed over time to provide useful management information about patterns and trends.

2.17 Requests and complaints should be monitored for matters relating to bullying and child protection and cross-referred as appropriate.

Education and work skills training

2.18 The serious imbalance between the courses students wanted and needed and those provided should be addressed by policy and planning at the highest levels both in the establishment and the Northern Ireland Prison Service. (5.39)

Not achieved. Some progress had been made but there remained a serious imbalance between students' needs and the range of available provision. Twenty-five per cent of young adults were employed as cleaners/orderlies, 50% were 'not yet allocated' and 25% were employed in the vocational workshops. Discussions about increasing the number of vocational options from seven to nine were taking place. Young adults could not attend education full-time. A minority attended education classes for between one and four sessions each week. The range of courses in the new education block was limited to a few core subjects (information and communications technology (ICT), numeracy and literacy) along with very limited provision in craft and music. Specialist facilities were provided for hairdressing and cookery but both rooms were under-used. The hairdressing salon was poorly designed. See main recommendation HP50.

Time out of cell

2.19 The existing Northern Ireland rules and provision in relation to hours spent in the open air should be re-examined. (5.76)

Not achieved. The young men had very little access to fresh air. Many were waiting to be allocated to a job that would take them out of the house but few jobs involved access to fresh air. Only those in the special supervision unit had regular daily access to an hour's exercise in the open air.
See main recommendation HP49.

Security

2.20 The random searching of staff would provide a recognised and approved deterrent to trafficking. (6.08)

Not achieved. We were told that the Prison Officers' Association had objected to staff being searched when visitors were not. Visitor searching had been introduced and staff searching was about to be but this had been overtaken by the industrial action. We were pleased to find that, following the introduction of visitor searching, the routine searching of all young adults before and after visits had been reduced to one in 10.
We repeat the recommendation.

Recommendations

To the Governor

Young people in Hydebank Wood

2.21 Child protection policies and procedures should be drawn up in consultation with the local area child protection committee of which the governor should become a full member. (HPS56)

Partially achieved. A child protection policy had been in place since February 2003. There were, however, some important gaps, such as links with bullying and suicide and self-harm, and, fundamentally, guidance for staff on how to make a child protection referral. We believed there was significant under-reporting of child protection matters by staff, due partly to the shortcomings of the personal officer scheme (see paragraph 2.214). Only a third of staff in the juvenile units had been trained in child protection. Significantly, only four of 11 managers who could be responsible for making preliminary assessments of child protection referrals had received any training. Since the implementation of the policy, there had been only one child protection referral across the establishment, which we believed was partly due to the fact that the policy was not a dynamic working tool that was understood and implemented by staff at all levels.

2.22 An environment in which child protection was central to working with young people had not been established. There had been little strategic development of child protection since the implementation of the policy. There were no ongoing links with the area child protection committee (ACPC), despite some efforts on the part of the establishment. The ACPC had not responded to a request to assist with drawing up the child protection policy. The governor was not a member of the ACPC and the establishment was not formally represented. A children's

safeguards committee drawing together all aspects of safeguarding children had not been established despite our previous recommendation (see paragraph 2.24).

Further recommendation

2.23 Further efforts should be made to engage the area child protection committee (ACPC) in the work of safeguarding children at Hydebank Wood.

See also main recommendation HP46.

2.24 A children's safeguards committee should be established, and as a priority task it should carry out a full audit of all aspects of the safety of children within Hydebank Wood. (HPS57)

Not achieved. See paragraph 2.22.
See also main recommendation HP46.

2.25 Arrangements for custody, care and training plans for all 17-year olds, and which involve all departments of the establishment, should be introduced. (HPS58)

Achieved. The resettlement plans were drawn up with all young people, including 17-year olds.

2.26 An education and training culture should be established across the establishment that meets the needs of young people. (HPS59)

Not achieved. The new education building and learning and skills centre had helped to raise the profile and underline the importance of education and training. There were, however, a number of fundamental problems that limited the development of education and training in meeting the needs of young people. Too few places were available in education and workshops to meet demand, many of the courses and options had waiting lists and staff shortages and sickness in education were limiting young people's access to planned programmes. The long-term absence of one bricklaying instructor, for example, had meant that classes had been cancelled for some time. Initial assessment and induction arrangements linked to education and training were poorly coordinated and time-consuming, although there was some joint planning through the personal development plan group.

Reception

2.27 The holding room in reception should be repaired and refurbished so that it is made suitable for the purpose of holding young people. Young people should not be secured in the individual changing cubicles. (1.19)

Not achieved. The holding room in reception was basic, with no bench seating, information or means to pass the time while waiting. On one morning of the inspection, there was too little seating for all the young people waiting to go to court. On arrival, young people still waited in line alongside a wall to be processed. They also continued to be locked in confined cubicles, a practice highlighted in our last report as having the potential to increase fear and anxiety. When the reception area was not staffed during the lunch and dinner periods, young people could be locked in cubicles for some time or kept waiting in escort vans or police cars

immediately outside reception.
We repeat the recommendation. See also main recommendation HP43.

2.28 There should be a range of accessible information notices and posters in reception to introduce new arrivals to Hydebank Wood. (1.20)

Not achieved. No specific information about what to expect or detailing the routines, rules and services was displayed. The only information in the cubicles concerned searching procedures. Two printed information sheets were handed out in reception but neither was well presented and it was clear from the language used that little thought had been given to the age range and reading ability of the target audience. An informative video was used during induction but was not shown in reception.
We repeat the recommendation.

Additional information

2.29 Reception had not changed. Although clean, it was unwelcoming and unattractive and was not an appropriate environment for children. There was nowhere to speak to a young person in private and no planned opportunity for a young person to speak to a reception officer in confidence about any immediate needs. We heard staff shouting questions to young people locked in the cubicles. Reception staff clearly knew many of the young people and the atmosphere was friendly and relaxed. Reception procedures were usually completely quickly but the impression was still one of a production line. However, 74% of respondents to our survey, against a benchmark of 28%, said they had been able to shower on arrival.

2.30 Young people did not travel long distances to the establishment but many of those surveyed complained that the vans were uncomfortable. All young people were handcuffed between the reception area and court without risk assessment, including while travelling in vans. Prison officers from the Prisoner Escort Group (PEG) undertook escorts. Young people said they were generally well treated by PEG and reception staff, and that they arrived at court on time. We were told that young people often spent long days at court but we were unable to verify this because reception staff were not given prisoner escort records.

2.31 A video link to 21 courts was available and was also used by probation staff in the community to speak to young men in custody. It was regularly staffed by four trained officers from a pool of officers. On average, the video link was used for 45 court appearances and 55 consultations with legal representatives each week.

Further recommendation

2.32 Young people should not routinely be handcuffed to and from reception and while travelling on escort vans without an individual risk assessment indicating a need for this level of security.

First night arrangements

2.33 New receptions should be located together so that they are carefully and consistently monitored during their first 24 hours in custody. (1.27)

Partially achieved. All newly arrived young men were accommodated in Elm 1 and juveniles

in Willow 1. No consistent, recorded monitoring was taking place. Induction staff in Elm 1 said they monitored new arrivals every 15 minutes during the first night, although this was not formally recorded. Children in Willow 1 were monitored only if they were subject to a PAR1.

Further recommendation

2.34 New arrivals should be carefully and consistently monitored during their first 24 hours in custody and this should be recorded.

See also main recommendation HP43.

Additional information

2.35 Induction cells in Elm 1 were equipped with a television but newly arrived children in Willow 1 were accommodated in anti-ligature cells with no television, radio or curtains. No information was displayed and no books or magazines were provided. The cells were basic and the isolating environment could have increased feelings of fear and anxiety. Staff explained that children were placed in these cells 'for their own safety' even though no individual risk assessments were undertaken. The assumption was that children might harm themselves in an ordinary cell and televisions were not provided because the glass screen could be used for this. It was inconsistent that newly arrived children were believed to present a high enough risk to justify being placed in an anti-ligature cell but not enough of a risk to warrant effective monitoring (see paragraph 2.33).

2.36 New arrivals, both young adults and juveniles, could not join other young people in association until they had been seen by a doctor. This usually took place the following morning, although this was not the case on one day of the inspection because the following day was a bank holiday. Juveniles in Willow 1 therefore had nothing to occupy them during the bank holiday apart from an education pack of drawing paper, coloured pencils and quizzes (see paragraph 2.42).

Further recommendations

2.37 Children should not be accommodated automatically in bare anti-ligature cells without a television for their first days in custody unless an individual risk assessment suggests that this is necessary.

2.38 Televisions should be provided in first night cells in Willow 1.

2.39 A system of identification for staff, which should include the wearing of name badges, should be introduced. (1.28)

Not achieved.
We repeat the recommendation.

2.40 Efforts should be made to reinforce verbal information provided to new arrivals by other means, for example, by providing cassette tapes or written information to be displayed around the residential unit. (1.29)

Partially achieved. An informative video had been produced and was shown during induction

but no supporting information was available either on cassette or displayed in the units. We repeat the recommendation.

2.41 New receptions should be provided with a pack containing an initial supply of tea, sugar, coffee etc until they are able to purchase their own. (1.32)

Achieved. Newly arrived young people were given a pack in reception.

2.42 The education induction pack should be provided for young people to occupy themselves during their first night in custody. (1.33)

Achieved. Everyone was given a pack on their first evening.

2.43 The establishment should devise a comprehensive vulnerability procedure along the lines of some of the best models devised by the Youth Justice Board for England and Wales. (1.36)

Not achieved. No appropriate or effective vulnerability procedure was in place. See further recommendation 2.47.

Additional information

2.44 None of the information contained in young people's core records, such as post-sentencing reports, was forwarded to induction staff in Elm 1 and Willow 1. Unless officers already knew the young person, all initial information was taken directly from the young person himself. Induction staff completed an induction committal interview form for each new young prisoner on the day of his arrival and this was placed in his wing file. This recorded basic personal details, offence information and any history of drug misuse or self-harm. Although the form allowed officers to include their initial impressions of the young person, young people were not given the opportunity or encouraged to talk to staff other than on a superficial level. No questions were asked about any previous convictions, any history of violence or any behavioural and/or emotional issues. Equally, the young person was not asked how he was feeling, if he had any immediate problems, if he was expecting to be visited and if he had children.

2.45 All young people received credit to use the telephone on arrival on the wing and, if requested, induction staff would also make a telephone call to their parents or carers on their behalf.

2.46 Young people were seen by a nurse on the day of their arrival and by workers from Opportunity Youth and probation the following day. A governor was supposed to interview each young person the day after arrival but none of the randomly selected 12 files that we saw contained a completed interview form. It was clear that young people had a number of individual interviews but the information was not drawn together in a single document.

Further recommendation

2.47 The induction process should be streamlined, with a single document containing all the initial information gathered about young people, and managers should ensure that it contains all necessary and relevant information.

Induction

2.48 The amount of information included in the first day programme should be reduced, and some modules transferred to the more intensive five-day programme. (1.39)

Achieved. The five-day programme no longer existed. New arrivals now attended a one-day induction programme on the second day after arrival. The detail of this appeared to be sufficient and 67% of respondents to our survey, against a benchmark of 52%, said the programme covered everything they needed to know. Due to the industrial action, we could not see the induction programme delivered in its dedicated room but we did see some induction information being given in Elm 1. This was delivered in a relaxed and friendly way, with young adults freely asking questions.

2.49 New arrivals should be escorted to Ash One on the day following their initial induction so that they may participate in the five-day programme. (1.43)

No longer applicable. The five-day programme was no longer running.

2.50 Disruptive young people should not be located with those newly arrived in custody. (1.44)

Achieved. This no longer happened.

Legal rights

2.51 The small number of appellants could be dealt with by direct reference to outside solicitors. (1.45)

Achieved. Access to solicitors was still good and was not reliant on internal systems in the establishment.

Accommodation and facilities

2.52 The induction unit, Ash Two, should not be used to hold those young people who have had to be moved from other units because of behaviour or management problems. (2.04)

Achieved. See paragraph 2.50.

2.53 Recreational facilities in Beech House should be increased and consistency introduced across the residential houses. (2.14)

Not achieved. One table tennis table, a selection of board games, a PlayStation and a television with a DVD player were provided on each of the three landings in use in Beech House. This was in line with the recreational facilities in other units. However, the air hockey tables had been removed and no pool tables or other physically interactive games were available, although some exercise equipment was planned. Many staff told us that the young men preferred to watch television after 7pm.
We repeat the recommendation.

2.54 The establishment should agree upon a nucleus of essential information and notices to be displayed in the residential units, to include anti-bullying, equal opportunities, requests and complaints, the daily routine and the incentives and earned privileges (IEP) scheme etc. These notices should be regularly updated and renewed. (2.15)

Not achieved. There was no consistency in terms of which notices were displayed. While there were some excellent anti-drug posters designed by young men at Hydebank Wood, there were large gaps in the provision of information about the house routines, complaints, bullying and who young people should contact if they were feeling low.
We repeat the recommendation.

2.55 A hairdresser should be employed. (2.16)

Not achieved. A hairdresser had been employed but, contrary to what we had anticipated, young men had been charged for the service. It had not been used because it was too expensive. The equipment had been distributed to each house and some young men cut each other's hair.

Further recommendation

2.56 Professional haircutting should be available to young men without charge.

2.57 An additional telephone should be installed in Beech House. (2.17)

Achieved. A telephone had been installed on each landing in Beech House.

2.58 The pool tables in Cedar House should be returned. (2.19)

Not achieved. All pool tables had been removed in the wake of the disturbances in 2001. We were told that a risk assessment had indicated a risk of serious injury or death. As pool tables are routinely provided in prisons and young offender institutions it was difficult to see why the risks at Hydebank Wood would be any higher than elsewhere.
We repeat the recommendation.

Further recommendation

2.59 Pool tables and other table games should be provided in all units.

2.60 A second telephone should be installed on C2. (2.19)

Achieved. Although there was still only one telephone on C2 landing, one had also been installed on C1. This provision was now adequate.

Anti-bullying – the importance of creating a safe environment

2.61 A full survey should be undertaken to establish where and how bullying takes place within the establishment. This information should be disseminated to staff and be included in the anti-bullying policy. The survey should be repeated every two years. (3.02)

Partially achieved. A survey conducted in September 2003 found that 88% of respondents felt quite or very safe. However, 43.5% had experienced some form of bullying, most of which occurred in the residential units and involved verbal abuse or threats. Forty-two per cent had not told anyone about the bullying. These and other findings had not been disseminated to staff or discussed at the anti-bullying committee meeting.

2.62 In our own survey, responses to most questions about safety were not significantly different from the benchmarks. The exception was that 14% of respondents, against a benchmark of 6%, said they had been victimised (hit, kicked or assaulted) by staff.

Further recommendation

2.63 Bullying surveys should be undertaken every two years, with particular attention given to young people's perceptions of bullying by staff. The results should be disseminated to staff and used to inform the anti-bullying policy.

2.64 An anti-bullying committee, led by a senior manager, should be set up. It should include representatives from all areas of the establishment and have representations from young people and children. (3.03)

Not achieved. Several meetings of the anti-bullying committee had been held at the end of 2003 and had included representatives of the young people. However, only three people had attended the meeting in March 2004 and the committee had not met since.
We repeat the recommendation.

2.65 All staff and managers should receive anti-bullying training, specifically tailored to adolescence. (3.04)

Not achieved. At one meeting of the anti-bullying committee, training in anti-bullying and child protection were described as a 'bolt on' to the nature of adolescence training. None of this training had taken place in recent years.
We repeat the recommendation.

2.66 Staff actively should challenge young people's language and boisterous behaviour and set a proper standard of behaviour through pro-social modelling and positive engagement with young people. (3.07)

Not inspected. The industrial action prevented us from observing much interaction between staff and young people.

2.67 A senior manager should have oversight and be an integral part of the anti-bullying processes. (3.09)

Partially achieved. Some meetings to consider incidents of bullying were convened by the director of custody when required, but these did not include the young person involved and the records did not indicate on what evidence decisions had been made.
See main recommendation HP44.

2.68 In order to be a credible scheme the anti-bullying strategy should have links to child protection and other prison strategies such as suicide prevention. (3.10)

Not achieved.
We repeat the recommendation.

Additional information

2.69 The anti-bullying processes were not clear. Forms included in the policy document were not being used and the register confused bullies with victims. Some incidents of bullying recorded on BI 1 forms (records of investigations) were not recorded on the register.

2.70 According to the register, there had been 24 investigations in 2004 and only three of the 13 in the last six months had involved young people from the centre. There was no single document to follow incidents of bullying from investigation through to closure and no systems to ensure communication between departments about those identified as potential bullies. There was no job description for the anti-bullying coordinator (the director of custody) and there were no unit liaison officers. The anti-bullying policy document had last been reviewed in September 2003. See main recommendation HP44.

Further recommendation

2.71 Records relating to incidents of bullying within the young offender centre should be kept separately from those held on women.

Prevention of suicide and self-harm

2.72 The development of the model for the management of sex offenders and vulnerable young people should be made a priority for the psychologist's role. (3.18)

Achieved. The principal psychologist took a prominent role in the management of these cases, and was able to describe individual circumstances in detail. She attended and chaired reviews where possible and coordinated support from other agencies. She also produced an 'Inmate Awareness Register' listing brief details about young people about whom there were concerns but who may not be on a PAR1 (prisoner at risk) form. This was regularly circulated to residential managers. Thirty-three young people were currently on the list.

Additional information

2.73 The suicide awareness and prevention team (SAPT) met monthly. We looked at the minutes of the last six meetings. The deputy governor was responsible for chairing the meetings and attendance had improved over recent months. The team was responsible for the development of local policy for both young men and women. It did not include representatives of the young men, although this was planned, or from the chaplaincy, education and workshops. Statistics of the numbers of those who self-harmed were produced but there was little analysis of what approaches could be developed to help young people in distress.

2.74 Only senior officers and managers had received training in the PAR1 process, which aimed to move away from the previous healthcare-dominated system (inmate medical records 21). There was some evidence from PAR1 forms of tensions between healthcare and residential officers' approach to self-harm and the care of those at risk.

2.75 Most reviews included a representative from healthcare, probation and residential staff. Reviews chaired by the psychologist were recorded to a better standard and included more focused support plans. Some had gaps in the written record. There were significantly more qualitative entries by probation and psychology staff. Some staff were unable to explain what level of watches had been agreed and these were not recorded at reviews.

2.76 The policy was a generic one for the whole service and more needed to be done locally to meet the specific needs of young people.

2.77 A register indicated when PAR1 forms were opened, when case conferences took place and when the forms were closed. Reviews were held promptly. The register indicated that 78 PAR1 forms had been opened since June 2004, when women prisoners first arrived at Hydebank Wood; 34 of these had been for women. We looked at the three PAR1 forms currently open on young men and a selection of those that had recently been closed. Several indicated that staff saw threats of self-harm simply as manipulative behaviour and did not question why a young person might have been making them. Other forms showed a clear link with bullying but contained no indication that the incident would be referred for investigation under anti-bullying procedures.

2.78 Strip-gowns or anti-suicide suits were used frequently, even when the young person had been disclosing feelings of vulnerability rather than actually self-harming. There was little evidence that emotional support had been offered beforehand. One young person had refused to put on an anti-suicide suit until staff had applied control and restraint, and another's refusal to wear strip-clothing had escalated to the point where he had been placed in the special supervision unit. In another case, a young man had spoken to staff about the distress caused by being in an anti-ligature cell for two weeks.

2.79 Young people did not attend their PAR1 reviews, which convened on an ad hoc basis and were usually chaired by a senior officer. There was no guarantee, however, that the same person would chair subsequent reviews.

2.80 There was no peer support scheme but we were told that a special privilege prisoner would be asked to offer informal support if appropriate. Around 56 young adults aged 18 or over were serving sentences of 24 months or more, which provided some opportunity to develop peer support.

Further recommendations

2.81 There should be separate suicide awareness and prevention team (SAPT) meetings for women and young men to oversee the development and implementation of local policy for their care based on the Northern Ireland Prison Service policy document. The local policy should be based on an analysis of need and the statistics to help to improve the level of care for those at risk of self-harm.

2.82 Young people should be represented on the suicide awareness and prevention team (SAPT). Other important areas of the prison, including Opportunity Youth, the chaplaincy and education, should also be represented.

2.83 Multidisciplinary training in the PAR1 (prisoner at risk) process should be provided for all staff working directly with young people.

2.84 All young people should be invited to attend their PAR1 reviews and to make a written contribution. Where possible, reviews should be planned in advance to ensure that staff from a range of other disciplines can attend and that they are chaired consistently.

2.85 A peer support scheme should be developed.

Substance use

2.86 The establishment should undertake a regular audit of the drug problems amongst its population to ensure that the appropriate services are in place to meet identified need. (3.23)

Achieved. Urine testing of all new arrivals had taken place since December 2004 and the data informed the drug steering committee (DSC) meetings. The drug strategy and service development were also informed by the results of an annual questionnaire survey conducted by staff from Queen's University as part of a wider research programme.

2.87 The DSC should review the provision of the counselling service and ensure that it is appropriately supported and supervised. (3.26)

Achieved. The work of the Positive Steps throughcare programme delivered by Opportunity Youth had achieved this. The part-time counsellor post was soon to become full-time and there were now regular meetings between Opportunity Youth, psychology and healthcare staff to share information on young people's progress and avoid duplication.

2.88 The DSC should review the delivery of the group work programme to ensure that it is offered on the basis of need rather than the participants' location within the centre. (3.29)

Achieved. All new arrivals were seen by Opportunity Youth within 24 hours and followed up as necessary. The Open College Network (OCN) programme was open to all young people who were motivated and showed commitment, not just those on the drug-free wing.

2.89 The DSC should ensure that there are clear measurements and targets against which its efficacy can be measured. (3.30)

Achieved. Targets in the new drug strategy action plan were now explicit and would be evaluated as part of the Queen's University evaluation.

2.90 Voluntary drug testing (VDT) should be open to all young offenders according to their need, rather than being a location-based scheme. (3.31)

Achieved. VDT took place throughout the centre, although it was effectively compliance testing. The overall VDT positive rate (January – December 2004) was 9%, with considerable variation between units (Cedar 6.2%, Willow 23.2%). The absence of mandatory drug testing (MDT) meant there were limited means to substantiate drug use.

Additional information

2.91 Substance use services were well developed and the drug and alcohol strategy had been updated. Its comprehensive action plan included explicit targets, responsibilities and milestones.

2.92 Successive annual surveys by researchers at Queen's University showed the continued and increasing problems faced by young men coming into the centre. A high proportion had substantial criminal histories, had previously been in custody in the youth justice system and had been subjected to paramilitary threats and punishments. Of the 108 new committals between December 2004 and March 2005, over 30% had tested positive for drugs, of which most were cannabis and benzodiazepines. These surveys, which were part of an evaluation of the Opportunity Youth project, confirmed that young people were receiving a very good service and it was encouraging that the project included support for those with alcohol problems. We were pleased to see it had recently been absorbed into mainstream funding. The cornerstone of the service were the key workers. Young people sentenced to over six months received the throughcare package. Of 135 young men who had taken part in the programme in the past two years, 113 had been released, 80 of whom were still engaged with it at six weeks and 63 at six months.

2.93 A high proportion of young men drank alcohol so excessively that their physical and mental health were at risk, and many related their use of alcohol to their offending behaviour. Although the numbers of clinical alcohol detoxifications were relatively small, they were not routinely monitored and we were concerned to find that healthcare staff had received very little training in substance use awareness.

Further recommendations

2.94 Healthcare staff should receive substance use awareness training.

2.95 Alcohol and drug use among new committals should be monitored and services modified to meet changing needs.

2.96 Clinical detoxification protocols should be updated regularly in line with best practice.

Equal opportunities

2.97 There should be regular analysis of statistical data in respect of adjudications, requests and complaints, home leave and early release and incentives and earned privileges. Senior management should regularly monitor these statistical returns in order to address discrimination on the basis of religion or other grounds. (3.39)

Not achieved. We were told that this would take place when a new computer system was installed in May 2005. We carried out a quick analysis of allocations to activity and incentives and earned privileges levels, which suggested no immediately apparent evidence of discrimination by religion. All the raw data was readily available and it was unsatisfactory that this relatively simple but important monitoring was still not being done, irrespective of an enhanced computer system.
We repeat the recommendation.

2.98 The definitions of discrimination and intimidation, and the systems put in place to address these issues for staff, should also be applied to the young prisoners of Hydebank Wood. (3.46)

Not achieved. There was no equal opportunities policy statement except for staff. An equality and diversity committee was referred to in Hydebank Wood's meeting structure but such a committee had never been formed. No representatives of the young people were listed as potential attendees at this meeting. Information on ethnic background was unreliable.
We repeat the recommendation.

Further recommendation

2.99 The equality and diversity committee should be established as soon as possible and should include representatives of the young people.

Maintaining contact with family and friends

2.100 A formal written system should be introduced to ensure that complaints or suggestions from visitors could be routinely audited. (3.49)

Not achieved. Whenever possible, complaints were resolved informally by managers in the visitors' centre by speaking to visitors personally. One visitor told us that a complaint he had sent to the governor had been resolved to his satisfaction. A complaint book was held in the visitors' centre but complaints were not routinely recorded and there was no system for complaints or suggestions to be audited.
We repeat the recommendation.

2.101 The policy relating to the passive drug dog should be kept under review to ensure that closed visits are only used where there is reasonable suspicion that an attempt has been made to smuggle drugs into the centre. (3.50)

Not achieved. See paragraph 2.179.

2.102 Management should address the current inability to search male visitors. (3.51)

Achieved. All visitors received a rubdown search.

2.103 The requirement to stand until one's visitors enter the room should be dispensed with, as it serves no real purpose. (3.52)

Achieved. Visitors took their seats before the young people arrived.

2.104 The card telephones should be repaired immediately. (3.62)

Achieved.

2.105 A telephone call appointment booking system should be introduced on every wing. (3.63)

Achieved. Young people booked evening telephone calls in 10-minute blocks.

2.106 A direct helpline into the establishment should be provided for visitors and friends of young people to report incidents to senior managers. Helpline numbers should be printed on reception letters. (3.64)

Not achieved. Visitors did not know who to contact with any concerns, and no name or contact number was advertised in the visits hall.
We repeat the recommendation.

Additional information

2.107 Visits could be booked by telephone or in person at the visitors' centre. Visitors said they had no problems booking a visit and were well treated by staff.

2.108 A new visitors' centre had recently been opened. It was bright and comfortable and visitors were not kept waiting for their visits. Clothing and cash could be handed in to staff without advance notice. Staff working in the centre were friendly and helpful and engaged well with visitors. Workers from NIACRO (Northern Ireland Association for the Care and Resettlement of Offenders) managed the play area in the visits hall and could also provide information and advice to visitors. No information about local or national support groups was displayed.

2.109 The young men and young and adult women all shared the visits hall. Although in this inspection we were not specifically examining provision for women, many told us they felt intimidated sharing the hall with the young men.

2.110 Visits were timed from when the young person sat down. Remanded young people could have three visits a week while sentenced young people had one weekly visit. Visits for those on the basic regime lasted 30 minutes, for those on the standard level 45 minutes and for those on enhanced one hour. Women prisoners in Ash House had visits that lasted 90 minutes, which the young men considered unfair.

2.111 The parents or carers of those under 18 were invited to their child's resettlement meetings and could tour the wing and see the child's individual cell.

2.112 Young people could apply for a 'family centred visit' with their child(ren) when they had been at the establishment for five weeks. The establishment aimed to offer these visits, including the child's primary carer, on a monthly basis. They took place in a dedicated room in the visitors' centre, which was equipped with comfortable furniture, age-appropriate toys and reading material. Any necessary checks were made with probation and social services and a family liaison officer (FLO) was on hand outside the room to supervise and assist. The FLO had received limited child protection training.

Further recommendations

2.113 Information about support groups should be displayed in the visitors' centre and a confidential helpline should be introduced and advertised.

2.114 All visits should last at least one hour.

2.115 Appropriate training should be provided to assist and enhance the role of the family liaison officers (FLOs).

Healthcare

2.116 The current accommodation for healthcare is not satisfactory and the time scale for reopening the healthcare centre should be clearly defined. (4.02)

Achieved. The refurbished healthcare centre opened on time in September 2002.

2.117 An identified doctor should attend those management meetings which would benefit from their clinical input. (4.03)

Partially achieved. The recently appointed consultant psychiatrist had started to provide clinical input to management meetings but there was little involvement by the GPs.

2.118 An increase in the nurse staffing complement should be seen as a priority in line with NHS practice. (4.04)

Not achieved. Agreement to increase the healthcare staffing establishment from eight to 14 had been reached but only 10 staff, including one agency nurse, were in post. The addition of the women's unit in Ash House had stretched the capacity of the staff even further. We understood that further progress on recruitment was dependent on the outcome of a health services review.

We repeat the recommendation.

2.119 A skills analysis should be conducted to facilitate working in partnership with the NHS. (4.05)

Not achieved. No skills analysis has been undertaken and consequently, the staff skill mix did not reflect the new demands on staff.

We repeat the recommendation.

2.120 Administration or clerical support should be provided to allow nursing staff to spend more time in clinical activities. (4.06)

Not achieved. No administrative or clerical support had been provided for healthcare staff, who were therefore unable to provide a full range of clinical care regularly.

We repeat the recommendation.

2.121 A health needs analysis should be carried out with the help of the local health authority public health doctors and should 'feed' into the review of healthcare in Northern Ireland. This assessment should also inform the establishment as to the skills and qualifications needed by the nursing staff who will be required to deliver the services as specified in any resultant action plan. (4.07)

Not achieved. We understood that work on a health needs analysis had been undertaken three years before but this had been only in draft form and no copy was available.

We repeat the recommendation.

2.122 Policies currently under review should be rewritten in line with NHS standards of care and the advice of professional organisations. (4.08)

Not achieved. Policies were largely out of date, although there was evidence that some

redrafting was underway.
We repeat the recommendation.

2.123 Serious injury reports should be audited every six months to determine trends and causes so that action can be taken. (4.09)

Partially achieved. Information on all serious injury reports was collected and regularly forwarded to prison headquarters. The only reports audited locally were those relating to self-inflicted injury, information from which was discussed at the monthly suicide awareness meetings.

2.124 A mental health analysis should be carried out. (4.12)

Not achieved. No mental health needs analysis had been undertaken either separately or as part of an overarching health needs assessment. A new consultant psychiatrist had recently been appointed who we understood was keen that a mental health needs analysis be completed.
We repeat the recommendation.

Pharmacy

2.125 A maximum/minimum thermometer should be provided. Records of daily maximum/minimum temperatures should be kept. The fridge should be defrosted at regular intervals. (4.18)

Achieved. The drugs fridge in the treatment room had a minimum/maximum thermometer and readings were taken and recorded daily. The fridge was defrosted monthly.

2.126 Movements and possession of the pharmacy keys should be logged and monitored. (4.21)

No longer applicable. The pharmacy room in the healthcare centre was no longer in use. Keys for the controlled drugs cupboard were stored in the centre key room.

2.127 The transcribing of prescriptions on to an order sheet should stop and the original prescriptions should be faxed through to the pharmacy. The pharmacist should make regular visits (at least monthly) to inspect the original prescriptions. (4.25)

Achieved. Prescriptions written by the doctors were faxed direct to the pharmacy. A new pharmacist was in post and had begun regular visits to the centre.

2.128 A written in-possession policy should be adopted. (4.28)

Achieved. Patients could have all but psychotropic medicines in-possession weekly or monthly following a risk assessment. They signed a compact to do so and this was also signed by the prescribing doctor. Patients taking psychotropic medicines were given them daily.

2.129 A written special sick policy should be adopted. (4.30)

Achieved. A policy on special sick (or discretionary medicines) was in place and was being rewritten in light of changes to the availability of 'over the counter' medicines from the tuck shop.

2.130 Patients should be supplied with patient information leaflets (PILs) with their medication. A notice should be displayed at the treatment room to ensure that young people are aware of the availability of the relevant leaflet for them to consult where a leaflet is not able to be supplied directly to them. (4.31)

Partially achieved. Patients were issued with a PIL when first prescribed their medication. No notices were displayed informing young people of the availability of relevant leaflets, although staff had started to keep a folder of PILs so that these would be available on request.

2.131 The pharmacist responsible for supply of medicines should take a more active role in the provision of pharmaceutical services, and should make regular visits to review procedures. (4.36)

Partially achieved. The pharmacist had only recently been appointed but was beginning to take a more active role with monthly visits to the centre. The pharmacist provided services to all three prisons.

2.132 The pharmacist should be involved in the reviews of pharmacy-related procedures, have input into the formulary and attend the drugs and therapeutics committee. The introduction of pharmacy clinics should be considered. (4.38)

Not achieved. However, we were assured that the new pharmacist would be taking a more active role in the centre. Drugs and therapeutics committee meetings were held at HMP Maghaberry.
We repeat the recommendation.

Dental services

2.133 Proper temporary surgery facilities should be provided until such time as the hospital wing is reopened containing the refurbished dental facilities. (4.44)

No longer applicable. The refurbished dental facilities had been available since September 2002.

2.134 All dental treatment for young people should be carried out in the establishment. (4.45)

Achieved. All except specialist dental treatment was undertaken in the centre.

2.135 The new dental surgery facilities and equipment should be inspected prior to use to ensure conformity to modern standards and regulations. (4.46)

Achieved. The facilities had most recently been inspected by the Eastern health board dental practice adviser in December 2004 and had passed well.

2.136 Subsequent to the chief dental officer's review and dental health needs assessment, both quantitative and qualitative monitoring procedures should be put in place to provide assurance to the appropriate authorities and ensure cost effectiveness of the service. (4.47)

Not achieved. However, the contractual arrangements for all three establishments in Northern Ireland were being changed to separate the provider/monitoring function. Dental care at HMPs Maghaberry and Magilligan will be provided by local general dental service practitioners. The

dentist at Hydebank Wood was still directly employed by the Prison Service on a locum basis. We repeat the recommendation.

2.137 Sufficient escort services should be provided to ensure an adequate flow of patients to the dental practitioner. (4.48)

Not achieved. The practitioner still frequently had to wait to treat patients, which reduced the numbers who could be seen at each session. The waiting list for dental treatment was about nine weeks, although anyone in pain was seen at the next clinic.
We repeat the recommendation.

2.138 The dental practitioner and the surgery assistant should undertake annual CPR training. (4.49)

Achieved. Both the dentist and dental nurse had up to date CPR training.

Additional information

2.139 The healthcare centre was a two-storey purpose-built building near the entrance to the prison. It had been refurbished and was generally very clean. Only the ground floor was in regular use. It included an inpatient facility comprising two observation cells with safer cell furniture and closed circuit television, two three-bed dormitories and a cell where one of the hospital orderlies slept. The waiting room was small and completely bare with no health promotion material or anything for patients to look at while waiting to be seen. The solid door to the waiting room meant that patients could be observed only through closed-circuit television. With only one waiting room, women and young men attended at different times.

2.140 The inpatient association room was also quite small and barely furnished with only moulded plastic chairs to sit on. Patients could watch television and play board games but very little else. The only pictures on the walls were those painted by one of the patients. There was no dedicated exercise area, although staff would take patients for walks around the grounds when numbers were small and staffing levels permitted. Problems with escorts meant that inpatients had very little access to education or library services.

2.141 The review of healthcare due after the last inspection had only recently been completed. The long delay meant that the health needs analysis, staff skill mix review, training needs analysis and increases in staffing levels had not taken place. We did not find evidence of work to meet the specific needs of juveniles, such as training on child protection issues.

2.142 Young people had good access to primary care services and a range of visiting specialists but healthcare staff did not follow triage algorithms and nurse-led clinics were available only on an ad hoc basis when staffing levels permitted. Nevertheless, the young adults in our survey were very positive about their overall experience of healthcare, with 61%, against a benchmark of 43%, rating it as good or very good. The ratings for the doctors, nurses and the dentist were also all significantly better than the benchmark.

2.143 Levels of medication among young men were not very high and the majority of those on regular medicines had them weekly or monthly in-possession following a risk assessment. Medicines were administered three times a day. A member of healthcare staff packed each young person's medicines in a small brown envelope and these were taken to the house blocks in a locked case. Depending on whether or not patients were locked in their cells, the nurse would either take the medicines to the patient's cell or administer them from a desk in

the office (Elm and Willow) or on the main landing (Beech and Cedar). This was neither safe nor legal and meant there was little privacy or confidentiality for patients.

2.144 Young people had had improved access to specialist mental healthcare since the appointment of a new consultant psychiatrist. She and a staff grade psychiatrist provided two sessions a week each, seeing four to six patients at each session, although lock downs and lack of runners sometimes prevented this. We understood that 15 medium secure beds were due to be opened in the nearby Knockbracken Hospital in April 2005, which should facilitate the transfer to appropriate care of young adults with acute mental health problems. There was no healthcare secure accommodation for juveniles in the province.

2.145 Primary mental healthcare was limited, although the healthcare officers were very experienced. The introduction of multidisciplinary working between healthcare, psychology and Opportunity Youth counsellors was welcome but the community psychiatric nurse (CPN) input was insufficient to meet the needs of the young people.

2.146 The oral health of the young people was very poor and the two dental sessions a week currently offered were not adequate to meet the needs.

Further recommendations

2.147 The facilities in the inpatient association room should be improved and made more comfortable.

2.148 A therapeutic regime should be developed for inpatients and include better access to education and the library.

2.149 There should be a designated exercise area for inpatients.

2.150 A separate waiting room should be available for men and women and health promotion material should be available.

2.151 The recently completed healthcare review should be communicated to all concerned, agreed and implemented as a matter of urgency.

2.152 Changes to the staffing skill mix should ensure that there is appropriate clinical and managerial leadership in healthcare.

2.153 Healthcare staff training should include child protection.

2.154 Regular clinical supervision for staff should be introduced.

2.155 Algorithm-based nurse triage should be introduced.

2.156 Primary mental healthcare provision should be increased following a needs assessment.

2.157 Secure, confidential arrangements should be made for the administration of medicines and secondary dispensing stopped.

2.158 Further community psychiatric nurse input should be provided to meet the needs of the young adults.

2.159 The numbers of dental sessions should be increased and oral health promotion introduced.

Education and work skills training

2.160 More and better opportunities for learners to achieve qualifications are needed. (5.16)

Partially achieved. There were increasing opportunities for learners to gain qualifications but they were not always taken up due to limited access to courses. Positive steps had been taken to offer individual programmes of study leading to external qualifications for a number of students at level 2 or above.

2.161 Attendance at education and training should be dramatically improved. (5.17)

Achieved. Progress had been made in improving the attendance of young people at education and training sessions. Attendance rates were carefully recorded and monitored. The headline figure of an attendance rate of 65% for education classes did not include those who were absent for good reason (such as attending court or visits).

Further recommendation

2.162 Records should be kept of 'approved absences' to reflect a more realistic attendance rate for performance management for monitoring purposes.

2.163 Arrangements should be improved and formalised to provide opportunities for young people that more accurately reflect their individual circumstances. (5.20)

Partially achieved. See paragraph 2.18.
See also main recommendation HP50.

2.164 There should be an urgent review of the appropriateness of the targets set and the extent to which they are achieved. (5.21)

Partially achieved. Education and training managers were conscious of the importance of, and need to meet, targets set by external bodies. For example, the education manager was making good progress in meeting the target of 100 accreditations in essential skills and 150 AQA (Assessment and Qualifications Alliance) units for the current year. The training manager was responding to and reporting on targets set relating to vocational training options. Targets were being set for individual young adults as part of the personal development programme planning process and improvements had been made in this area of work.

2.165 Education and training staff should oversee the Welfare to Work programme. (5.25)

Not inspected. The Welfare to Work programme had been suspended in 2004 due to funding and staffing difficulties. It was reported that there were plans to re-introduce the programme later in 2005 with the education manager having general oversight of the work.

2.166 Better use of the library should be made by both staff and learners. (5.29)

Not achieved. The library in the new education block was attractive, spacious and reasonably well resourced. It had a good range of fiction titles but no talking books and little to meet the

needs of young people with reading difficulties. It was open on Tuesday evenings and for two three-hour sessions a week (Monday and Thursday afternoons) with a librarian in attendance. Very little use was made of this valuable resource. In December 2004, 45 young adults had visited the library and borrowed books. In February 2005, the figure was 15. The librarian was prepared to spend more time on site but saw little point given the low attendance rates.
We repeat the recommendation.

2.167 There should be a broad, balanced, relevant and differentiated curriculum that will meet the needs of all learners. (5.40)

Not achieved. See paragraph 2.18. While we acknowledged some progress such as one-to-one sessions offered to young people with specific literacy and numeracy needs and attempts being made to organise individual programmes for those at level 2 or above, there was still some way to go to meet the needs of all learners.
We repeat the recommendation.

2.168 There should be more help given to learners on the importance of their training plans and the link between the initial assessment process and any informal targets so that the learners can feel a sense of ownership. (5.43)

Achieved. A review of student files in education indicated that careful attention was being given to individual target setting at initial assessment and induction. All new arrivals were interviewed by the education manager and specific targets were discussed and agreed before the personal development planning meetings. Young adults placed on the essential skills programme were asked to complete a number of in-house assessments to identify specific learning goals. The training manager interviewed young people on the residential wings as part of the induction process to identify specific areas of vocational interest. A major barrier to learning was the overall lack of opportunities in education and training. The process of target setting linked to the training plans was generally effective but much of the good work was wasted because of the waiting lists and the limited number of places on offer in education and training.

2.169 There should be a step change in the efficiency with which the education programme is delivered. (5.52)

Not achieved. There was no overall planning and coordination of education and training provision. The education and training departments worked independently of each other even though there were some examples of cooperative working (joint attendance at weekly planning meetings to, among other things, allocate young people to the limited number of places on offer). Young adults were interviewed by the education and training managers (see paragraph 2.168) but there was no overall 'menu' explaining the range of education and training places on offer. Young people could not mix education and training courses as all training courses were full-time and all education courses were part-time (see paragraph 2.18).
We repeat the recommendation.

Physical education

2.170 Urgent attention should be given to reviewing physical education (PE) staffing levels to ensure that the provision is maintained. (5.60)

Achieved. Although access to the gym was poor, an additional post had been created and recruitment was underway.

2.171 Detailed information about the individual needs of each trainee should be made available to staff. (5.62)

Achieved. PE staff were now provided with sufficient information on individual needs to allow them to make informed assessments.

2.172 The cancellation of competitions should be avoided. (5.63)

Achieved. We were told that the only competition cancelled for some time was a staff–young people football match. This required staff to attend in their own time, which they chose not to do.

Faith and religious activity

2.173 The administrative systems in place to support chaplains, in particular with access to new receptions, should be reviewed. (5.71)

Partially achieved. There had been no change to the limited administrative support available to chaplains from the establishment and they still used administrative services at their headquarters. However, this was not reported to be a problem and the particular issue of notification of new arrivals had been resolved. All new arrivals were seen by a chaplain but not always within 24 hours of arrival. This was due in part to the fact that all chaplains were part-time. In our survey, only 19% of juveniles and 20% of young adults, against much higher respective benchmarks of 40% and 46%, reported seeing a chaplain within 24 hours.

Further recommendation

2.174 Chaplaincy hours should be increased to ensure that all young people are seen within 24 hours of arrival.

2.175 Chaplains should be included in all policies and procedures involving sentence planning, resettlement and personal officer work. (5.73)

Not achieved. Chaplains played an important role in the pastoral care of young people and had a lot to offer in relation to many aspects of their care. However, they were not involved in individual care planning meetings for young people (such as self-harm reviews) or strategic management meetings because of the constraints on their time (see paragraph 2.173).
We repeat the recommendation.

Time out of cell

2.176 The daily target for minimum hours out of cell should be raised to 10 hours. (5.75)

Not achieved. The Nothern Ireland Prison Service had rejected this on the basis that it would have 'serious resource implications' and that it was already meeting its own target of seven hours a day. Our expectation is for a minimum of 10 hours out of cell each day and the published core day would provide for 15 minutes more than this. Staffing levels were high and we could see no justification for rejecting this recommendation.
See main recommendation HP49.

2.177 A much more imaginative approach to out of cell activities is needed. (5.76)

Not achieved. See paragraph 2.53. There was no consultation or survey of young people to identify their preferences or needs. Many young people relied on computer games and television, which was unacceptable given the lack of access to fresh air and the gym.
We repeat the recommendation.

Security

2.178 The establishment should review all its contingency plans and include additional essential scenarios that are not part of the plans. (6.02)

Achieved. The contingency plans had been reviewed and included a full range of scenarios that could apply at Hydebank Wood. A full test of one scenario and two tabletop exercises had been held in 2004.

2.179 The interpretation of search dog evidence should be reviewed and closed visits only be given to visitors where there is additional and reliable intelligence to support the dog evidence. (6.07)

Not achieved. The governor considered that an indication by a passive dog alone was sufficient basis for requiring a closed visit. This policy was unnecessarily strict, given the possible reasonable explanations for a positive indication (including error by the dog). To require a closed visit for young people was disproportionate without other supporting intelligence.
We repeat the recommendation.

Incentives and earned privileges scheme

2.180 The establishment should consider reproducing the information contained within the IEP information leaflet through other mediums, such as videos or cassette tapes. (6.16)

Not achieved. The IEP information leaflet, which was not user friendly, had been withdrawn. A video produced for new arrivals contained some reference to the IEP scheme but this was not sufficiently detailed. In our survey, one young person said, "I still didn't understand everything and how things were supposed to be done for a while after".

2.181 The IEP scheme and drug strategy contained some discrepancies about punishments. In some units, for example, any young person found guilty on adjudication was automatically placed on the basic level for six weeks without review. This amounted to double jeopardy.

2.182 Most of the young adults we met said they understood how the scheme worked but many complained that the system did not operate fairly. Additional privileges that staff could award or withdraw were not clearly defined in the policy, which provided too much scope for staff discretion. In contrast, 58% of young adult respondents to our survey, against a significantly lower benchmark of 49%, said they had been treated fairly in their experience of the IEP scheme.
We repeat the recommendation.

Further recommendation

2.183 Young people who are found guilty on adjudication should not automatically be placed on the basic level.

2.184 There should be explicit links between the IEP scheme and compliance with sentence planning targets. (6.17)

Achieved. The revised IEP scheme made reference to 'inmate resettlement plans' and explained how IEP status would be linked to individual targets regarding behaviour, work and general progress. All departments had input to the points system, which was reviewed weekly and used to calculate movement within the scheme. In our survey, only 47% of juveniles, against a significantly higher benchmark of 59%, said that the different levels in the IEP scheme would make them change their behaviour.

2.185 A young person should be given the opportunity to add a written comment of their own to the weekly assessment report. (6.19)

Not achieved. Although young people were required to sign the staff/contribution/input form, they were not permitted to make a contribution or to make representations at review boards (see paragraph 2.186). This may well have contributed to the perception expressed to us by many young people that the scheme did not operate fairly.
We repeat the recommendation.

2.186 Formal boards should be held to enable young people to make representations before they are demoted to the basic level of the IEP scheme. (6.22)

Not achieved. The revised scheme did not include formal boards to enable young people to make representations before being demoted to basic level. Staff told us that young people always knew exactly how many points they had acquired or lost during the week and therefore were never surprised by decisions to promote or demote. Young people to whom we spoke confirmed this but said that lack of surprise did not equate to acceptance of the fairness of the decision. We examined a sample of young people's personal history records and found that the daily recording of behaviour required by the IEP scheme was rarely done. Decisions about movement within the IEP scheme appeared to be little more than an administrative function based on mathematical calculations.
We repeat the recommendation.

2.187 Young people should not be penalised in terms of movement within an IEP scheme that is location based. (6.25)

Achieved. The revised scheme was no longer location-based.

2.188 The establishment should consider placing young people on the standard level in reception. (6.26)

Achieved. All new arrivals were now placed on the standard level.

Prisoner disciplinary procedures

2.189 The adjudicating governor should be more imaginative in setting awards for receiving contraband in visits. (6.34)

Not achieved. The prison's action plan indicated that the deputy governor would review privileges and sanctions but this had not taken place.

Additional information

2.190 There were no standardisation meetings of adjudicators to ensure that punishments were more consistent. The governor told us that he had avoided this because the courts had criticised the use of tariffs. In the cases we examined where a young adult had been found guilty of possession of drugs, there were marked differences between the punishments imposed by different adjudicators: one generally imposed an average of five days cellular confinement with loss of all privileges (including books, wristwatch and radio); the other preferred to stop association and canteen for two weeks. We found one juvenile held in cellular confinement for two consecutive but overlapping periods of seven days. He could have been held for 10 days without any possessions, books, writing materials, radio, television or wristwatch. All he had was a newspaper every other day and his clothes. The punishment was remitted after we raised the issue but not until the following afternoon when he had served seven days in these very restrictive conditions, which were unsuitable for a child. There were no independent advocates to represent children.

Further recommendations

2.191 Standardisation meetings should be held quarterly to ensure that punishments are consistent between adjudicators.

2.192 When cellular confinement is imposed, the assumption should be that no other privilege will be lost except in exceptional circumstances.

2.193 Children should always have the opportunity to be represented at adjudications and cellular confinement should not be used as a punishment for children unless they have been represented.

Use of force

2.194 All staff who may be required to use it should be certificated in the use of control and restraint (C&R). (6.38)

Not achieved. Only 52% of eligible staff had received initial or refresher training in the last year.
We repeat the recommendation.

2.195 Full de-escalation procedures should be adopted throughout the establishment. (6.40)

Achieved. The incident reports examined and interviews with young people and staff indicated that de-escalation was used routinely and young people were, where practicable, given the

opportunity to calm down before any force was used. When force was used, staff tried to de-escalate the incident to avoid its continued use.

2.196 A review should be set up to ensure the use of force when used is necessary and used correctly. This group should have the powers to recommend further investigations to the governor. (6.42)

Not achieved. The C&R coordinator reviewed all uses of force but the senior management team did not routinely discuss his findings and trends were not monitored. No group had reviewed the use of force.
We repeat the recommendation.

2.197 The visiting committee should form part of the review body and should be actively included in the processes, providing the governor with independent information. (6.43)

Not achieved. There had been no review.

2.198 All staff who receive training in the use of force should be trained to use handcuffs as a means of de-escalating a situation. (6.44)

Achieved. The use of handcuffs for moving young people under restraint and as a less intrusive method of C&R was included in basic and refresher C&R training.

2.199 All future training should incorporate information relating to the procedures in managing Positional Asphyxiation and Excited Delirium. (6.46)

Achieved. These matters were covered in basic and refresher C&R training.

Additional information

2.200 There was no record of the use of the unfurnished accommodation in the special supervision unit. The forms used for this had been taken from an out of date Northern Ireland Prison Service security manual. The new manual did not contain the forms and the prison had stopped recording the use of the accommodation, the behaviour of the young person, the authorisation or when the use ceased. We were therefore unable to inspect this but were told that young people were often put in unfurnished accommodation after having a full body search, even when compliant. We watched a video recording of one such incident.

Further recommendation

2.201 Records of the use and authorisation of unfurnished accommodation, its duration, and the behaviour of the young person there should be maintained.

Segregation unit (punishment unit)

2.202 The name of this unit should be changed to reflect the nature of the work that is taking place and that promotes its caring and dynamic environment. (6.49)

Achieved. After several changes, the unit had been named the special supervision unit (SSU).

However, many staff and young people continued to refer to it as the punishment house or the block.

2.203 The development of the Punishment Unit should include cognitive skills training links and other behavioural programmes that seek to address anti-social behaviour. (6.50)

Not achieved. There were no monitoring records for those held in the SSU and there was no system for identifying the needs of those segregated for good order or discipline or for planning with them what they need to achieve in order to return to their house. Individual work was undertaken by SSU staff and healthcare and psychology and some notably difficult young men had been able to make considerable progress. However, these were the minority and all those segregated needed to know what was required of them to allow them to return to their house.

Further recommendations

2.204 Monitoring records should be kept for all those held in the special supervision unit (SSU) recording their well being and progress.

2.205 Young people segregated for good order or discipline should be given clear targets of what they need to do to return to their house and should be helped to achieve those targets.

2.206 The IEP scheme should be included in the punishment unit compact. (6.56)

Achieved. Those in the SSU retained their IEP status.

Resettlement

2.207 An integrated approach to resettlement and policy should be developed. (7.01)

Partially achieved. Although a local policy had not yet been developed, Hydebank Wood's agencies (Northern Ireland Prison Service resettlement staff, the Probation Board for Northern Ireland, NIACRO and Opportunity Youth) worked collaboratively with Northern Ireland Prison Service headquarters to fulfil the Northern Ireland resettlement strategy. Ninety-one per cent of eligible young adults were working to initial resettlement plans and 74% to full resettlement plans. However, there was little ownership of the resettlement concept by many discipline staff. Staff redeployment had also caused difficulties, with most of the 32 officers trained in the assessment case management and evaluation (ACE) method by the Probation Board for Northern Ireland since moved to positions where they did not apply the training.

2.208 A resettlement policy committee should be established. (7.02)

Achieved. The committee was representative of relevant agencies. It had met regularly and had made persuasive business cases for resourcing and development.

2.209 The developing home leave policy should incorporate a home leave board which the young person has the opportunity to attend. (7.04)

Achieved. The current home leave board met weekly and young people were allowed to attend.

Reintegration planning

2.210 The scope for expanding work initiatives and opening the opportunity for others should be explored. (7.09)

Partially achieved. Some good Outside Work scheme placements were available for the small number of eligible young people, and resettlement personnel were constantly seeking fresh opportunities. However, there had not been any expansion of placements or enhancement of eligibility. The requirement for home leave to incorporate explicit resettlement objectives was a positive development.

Sentence planning

2.211 More emphasis should be placed on the young person's offending behaviour and what needs to be done to address this along with his resettlement needs. (7.16)

Achieved. The resettlement files examined showed good linkage between resettlement needs and criminogenic issues.

2.212 A smaller informal forum than the personal development plan (PDP) meeting should be considered. Some thought should be given on how best to deal with sensitive information before the young person joins the meeting. (7.17)

Achieved. Attendance at the resettlement meetings was tailored to the circumstances of individual young people. Those aged under 18 could identify a community-based mentor to attend meetings with them. We saw a good example of sensitive information being dealt with discreetly.

2.213 A system to monitor the quality of personal development plans (PDPs) should be put in place. (7.18)

Not achieved. The plans we looked at were thoroughly completed and adhered to a consistent format. While there was no system to monitor the quality of resettlement plans, the resettlement manager had undertaken a one-off dipstick sample of two plans per house in 2004. However, this type of quality control was not taking place on a regular, planned basis.
We repeat the recommendation.

2.214 A personal officer scheme should be developed involving officers in monitoring, motivating, and recording the progress of the young person to ensure progress is being made against the plan. (7.20)

Not achieved. Staff in the residential units did not operate as personal officers to particular young people. The inmate record system introduced just before our last inspection had been instrumental in focusing personal officers to interact with young people to record their progress but was not being used as diligently as it had been originally. We saw no evidence to back up the establishment's claim that it was developing a personal officer scheme to meet the needs of the young people.
We repeat the recommendation.

Offending behaviour work

2.215 Further analysis of the work on the establishment's population should be used to focus resources when developing offending behaviour work. (7.23)

Achieved. Good profiling data available from the monthly Northern Ireland Prison Service statistical report had been supplemented by some local analysis, leading to targeted offending behaviour programmes. These included car crime, anger management and enhanced thinking skills.

2.216 All young people should be engaged with at an early point to offer them the opportunity to attend courses that address offending behaviour. (7.24)

Achieved. Remanded and sentenced young adults were given the opportunity to agree resettlement plans soon after arrival. The low reconviction rate for young adults released from Hydebank Wood on to custody probation order supervision (43% reconvicted within two years, compared to 74% of young adults released from immediate young offender centre custody) reflected positive outcomes from the interventions of the Probation Board for Northern Ireland and others.

2.217 Young people who have difficulties reading and writing should be identified during the pre-course assessment and supported through the course. (7.25)

Achieved. This was confirmed by feedback from young people in Elm and Willow Houses.

2.218 The involvement of more officers in group work programmes should be promoted to develop a culture of working constructively with young people. (7.26)

Not achieved. The number of officers deployed as group work facilitators had fallen from four to two. Efforts to recruit replacements had been unsuccessful, possibly because the role was not made attractive enough, for example, through different shift patterns.
We repeat the recommendation.

Key workers (personal officers)

2.219 A regular forum should be created in which new initiatives can be routinely discussed between operational staff and their managers. A system for the ongoing supervision and support, as well as accountability, of all staff by their managers should be developed. (7.37)

Not achieved. The system for disseminating information about new initiatives to staff was contained in the revised communication and information sharing strategy, which had not been implemented (see paragraph 2.220). A system of staff supervision and support had not been developed and we were told this was pending the proposed review of the personal officer scheme. Staff told us that unit staff meetings did not take place routinely.
We repeat the recommendation.

2.220 The communication and information sharing strategy should be reviewed. (7.38)

Partially achieved. The communication and information sharing strategy had been reviewed but the revised version had not been disseminated to staff and the recommendations within the

strategy had not been implemented. We spoke to a number of residential unit staff who were not aware that a communication strategy had been developed.

Further recommendation

2.221 The communication and information sharing strategy should be disseminated to staff in a systematic way.

Catering

2.222 Staffing levels in the kitchen should be reviewed to enable national vocational qualifications (NVQs) to be made more widely available. (8.03)

Partially achieved. This recommendation had been rejected on the basis that the primary function of the kitchen was to provide food for the centre rather than to be a training resource. More staff had qualified as assessors but few NVQs had been achieved: three young adults had achieved NVQ level 1 in catering in 2004 and one to date in 2005; two others were working towards this qualification. One young person had achieved a NVQ level 2 in 2003. We repeat the recommendation.

2.223 Prison staff should consult with a nutritionist to ensure that healthy food options are regularly offered. The menus should be reviewed as a matter of urgency to ensure a balanced and varied diet is provided. (8.04)

Partially achieved. We were told that any changes in menus were emailed to the nutritionist at Belfast City Hospital for comment and we saw a note from the kitchen principal officer about such contact concerning a woman prisoner's diet. A three-week rotating menu had been introduced but the quality of the choices available had not been externally assessed. We repeat the recommendation.

2.224 Lifts should be repaired immediately. (8.05)

Achieved. Young adults were still carrying food upstairs from heated trolleys. Some staff said this was because the food lifts were broken while another member of staff said they did not have a key for the lift door. According to the works manager and recent lift engineer reports, the lifts had recently been serviced and only the one in Ash House had been reported broken. It was clear that established policy was to not use these lifts, which was a health and safety concern.

Further recommendation

2.225 Food lifts should be used.

2.226 Protective gloves should be made available for staff and young people to protect themselves when handling hot trays. (8.05)

Achieved. One pair of protective gloves was available and being used on each of the serveries we visited.

2.227 Training should be provided in manual handling techniques. (8.05)

Partially achieved. Young people were required to undertake manual handling training as part of gym induction but there was no check that all servery orderlies had completed it. This was the responsibility of residential unit staff but there was no audit trail.

Further recommendation

2.228 A record should be kept of all those who have been trained in manual handling techniques and all servery orderlies should be required to complete the training before taking up their jobs.

2.229 Staff should not smoke in the kitchen area. (8.05)

Achieved. We did not observe any staff smoking near to where food was being served.

2.230 The practice of putting plastic plates in the hot cupboard should cease immediately. Food should be kept in the metal trays in the hot cupboard. (8.06)

Not achieved. Food was still being served on to plastic plates and left on top of the hot plate cupboard until collected. In one house, we also saw meals on plastic plates that had been placed directly in the hot cupboard. We were told this was only until the person returned to the unit from the court video link.
We repeat the recommendation.

2.231 Some of the serveries require general maintenance, and a number of the refrigerators require seals to be cleaned and in some cases renewed. Additional 13 amp sockets should be provided to avoid refrigerator plugs being removed to operate toasters. (8.06)

Achieved.

2.232 The taking and recording of all food temperatures should be consistently carried out at the point of delivery and immediately before food is served. (8.07)

Not achieved. Food temperatures were recorded from preparation to the point where the trays of food were loaded on to heated trolleys. These were collected from the main kitchen by residential officers and servery workers. The temperature of food was not taken at the point of serving. One officer believed this was not necessary and had not been trained to do it. One manager said that staff associations had objected to this task. A report from the senior environmental health officer (26 November 2004) stated, 'There appears to be no temperature monitoring of the service of food at any of the satellite units, and this has the potential to weaken any due diligence defence'.
We repeat the recommendation.

2.233 The establishment should ensure that all young people who serve and handle food are appropriately dressed at all service times and that staff are trained in basic food hygiene. (8.07)

Not achieved. In one unit, no young people were wearing appropriate whites but most had completed a basic food hygiene course or were about to complete it. We observed one servery worker completing an interactive computer course on the essentials of food safety. Since July 2002, 87 young adults had completed this one-hour course and 42 others had completed a six-

hour food safety course since October 2001. None of the staff to whom we spoke had completed training in food safety.
We repeat the recommendation.

2.234 More use should be made of consultative groups for menus and purchasing. (8.08)

Not achieved. We saw the minutes of some meetings between a governor and groups of young people during September 2004 but there were no regular consultative groups. Food surveys continued to be completed annually and 44% of respondents to this survey in January 2004 said they were not happy with the variety of choice of menu.
We repeat the recommendation.

Additional information

2.235 There were pro-formas for weekly servery hygiene checks by kitchen staff but these were being completed less frequently than this. There was insufficient management oversight of food safety and hygiene standards once meals had left the main kitchen, although some guidelines had been provided for staff.

Further recommendation

2.236 There should be greater management accountability of standards of food safety and hygiene standards after food has left the main kitchen.

Prison shop (canteen)

2.237 The reception pack should be increased to include a telephone card of sufficient value to enable a young person to make daily contact with his family during the first few days of custody. (8.14)

No longer applicable. All young people received personal identification number telephone credits on arrival.

2.238 The practice of displaying individual finance records should stop. (8.17)

Achieved.

2.239 Canteen lists including prices of individual items should be issued showing the amount of private cash available to spend on each occasion. (8.18)

Achieved. Young people received individual order forms complete with the cost of items and including details of how much money they had to spend.

2.240 The establishment should consider setting up formal arrangements with local newsagents to enable young people to purchase newspapers and magazines. (8.20)

Achieved. A local newsagent supplied pre-ordered newspapers and magazines.

Section 3: Summary of recommendations

3.1 The following is a list of repeated and further recommendations included in this report. The reference numbers in brackets refer to the paragraph location in the main report.

Main recommendation **To the Director General**

3.2 Integral sanitation should be provided for all young people. Until then, there should be genuine 24-hour access to toilets so that young people do not have to use pots after a cut-off time. (HP48)

Main recommendations **To the Governor**

3.3 First night procedures should be developed to ensure that a comprehensive vulnerability assessment is made and that all young people, particularly children, are held in appropriate supportive accommodation with regular monitoring. (HP43)

3.4 A new safer custody strategy should be developed to ensure the anti-bullying procedures work effectively with the involvement of young people. Appropriate links should be made with between suicide and self-harm issues and peer support should be provided for victims of bullying and those at risk of self-harm (HP44)

3.5 Alternative and more therapeutic responses to self-harm for young people, other than the use of strip-conditions, should be developed. Anti-suicide suits and unfurnished accommodation should be used only as a last resort, and should be fully justified and recorded. Staff should be available to interact with and support young people deemed at risk of self-harm. (HP45)

3.6 The child protection policy should be reviewed to ensure that systems and procedures are in place to ensure child protection referrals are raised appropriately and dealt with efficiently, with all staff and managers working with children trained in child protection. (HP46)

3.7 A personal officer scheme should be developed to encourage residential staff to engage more actively with young people and take an active part in the development of resettlement plans, and to help ensure that resettlement becomes an integral aspect of the centre's purpose. (HP47)

3.8 All young people should have at least 10 hours a day out of their cells, including a minimum of one hour's access to exercise in the open air and a period of association each day. (HP49)

3.9 Sufficient education and work skills training should be provided to meet the needs of young people, to occupy them fully and equip them with the qualifications and skills they require. (HP50)

3.10 An up to date full health needs analysis should be completed including a review of the skill mix of staff to ensure that the young people at Hydebank Wood receive an appropriate healthcare service. (HP51)

Recommendations To the Director General

3.11 A formal system should be set up with the juvenile justice centre to ensure that information-sharing and pre-transfer planning takes place for all young people transferred to Hydebank Wood. (2.5)

Recommendations To the Governor

Clothing and possessions

3.12 Washing machines should be provided to allow young men to wash their own clothes. (2.8)

Applications and complaints

3.13 A system of independent advocacy for those under 18 should be introduced. (2.12)

3.14 Requests and complaints should be routinely analysed over time to provide useful management information about patterns and trends. (2.16)

3.15 Requests and complaints should be monitored for matters relating to bullying and child protection and cross-referred as appropriate. (2.17)

Security

3.16 The random searching of staff would provide a recognised and approved deterrent to trafficking. (2.20)

Young people in Hydebank Wood

3.17 Further efforts should be made to engage the area child protection committee (ACPC) in the work of safeguarding children at Hydebank Wood. (2.23)

Reception

3.18 The holding room in reception should be repaired and refurbished so that it is made suitable for the purpose of holding young people. Young people should not be secured in the individual changing cubicles. (2.27)

3.19 There should be a range of accessible information notices and posters in reception to introduce new arrivals to Hydebank Wood. (2.28)

3.20 Young people should not routinely be handcuffed to and from reception and while travelling in escort vans without an individual risk assessment indicating a need for this level of security. (2.32)

First night arrangements

3.21 New arrivals should be carefully and consistently monitored during their first 24 hours in custody and this should be recorded. (2.34)

3.22 Children should not be accommodated automatically in bare anti-ligature cells without a television for their first days in custody unless an individual risk assessment suggests that this is necessary. (2.37)

3.23 Televisions should be provided in first night cells in Willow 1. (2.38)

3.24 A system of identification for staff, which should include the wearing of name badges, should be introduced. (2.39)

3.25 Efforts should be made to reinforce verbal information provided to new arrivals by other means, for example by providing cassette tapes or written information to be displayed around the residential unit. (2.40)

3.26 The induction process should be streamlined, with a single document containing all the initial information gathered about young people, and managers should ensure that it contains all necessary and relevant information. (2.47)

Accommodation and facilities

3.27 Recreational facilities in Beech House should be increased and consistency introduced across the residential houses. (2.53)

3.28 The establishment should agree upon a nucleus of essential information and notices to be displayed in the residential units, to include anti-bullying, equal opportunities, requests and complaints, the daily routine and the incentives and earned privileges (IEP) scheme etc. These notices should be regularly updated and renewed. (2.54)

3.29 Professional haircutting should be available to young men without charge. (2.56)

3.30 The pool tables in Cedar House should be returned. (2.58)

3.31 Pool tables and other table games should be provided in all units. (2.59)

Anti-bullying – the importance of creating a safe environment

3.32 Bullying surveys should be undertaken every two years, with particular attention given to young people's perceptions of bullying by staff. The results should be disseminated to staff and used to inform the anti-bullying policy. (2.63)

3.33 An anti-bullying committee, led by a senior manager, should be set up. It should include representatives from all areas of the establishment and have representations from young people and children. (2.64)

3.34 All staff and managers should receive anti-bullying training, specifically tailored to adolescence. (2.65)

3.35 In order to be a credible scheme the anti-bullying strategy should have links to child protection and other prison strategies such as suicide prevention. (2.68)

3.36 Records relating to incidents of bullying within the young offender centre should be kept separately from those held on women. (2.71)

Prevention of suicide and self-harm

3.37 There should be separate suicide awareness and prevention team (SAPT) meetings for women and young men to oversee the development and implementation of local policy for their care based on the Northern Ireland Prison Service policy document. The local policy should be based on an analysis of need and the statistics to help to improve the level of care for those at risk of self-harm. (2.81)

3.38 Young people should be represented on the suicide awareness and prevention team (SAPT). Other important areas of the prison, including Opportunity Youth, the chaplaincy and education, should also be represented. (2.82)

3.39 Multidisciplinary training in the PAR1 (prisoner at risk) process should be provided for all staff working directly with young people. (2.83)

3.40 All young people should be invited to attend their PAR1 reviews and to make a written contribution. Where possible, reviews should be planned in advance to ensure that staff from a range of other disciplines can attend and that they are chaired consistently. (2.84)

3.41 A peer support scheme should be developed. (2.85)

Substance use

3.42 Healthcare staff should receive substance use awareness training. (2.94)

3.43 Alcohol and drug use among new committals should be monitored and services modified to meet changing needs. (2.95)

3.44 Clinical detoxification protocols should be updated regularly in line with best practice. (2.96)

Equal opportunities

3.45 There should be regular analysis of statistical data in respect of adjudications, requests and complaints, home leave and early release and incentives and earned privileges (IEP). Senior management should regularly monitor these statistical returns in order to address discrimination on the basis of religion or other grounds. (2.97)

3.46 The definitions of discrimination and intimidation, and the systems put in place to address these issues for staff, should also be applied to the young prisoners of Hydebank Wood. (2.98)

3.47 The equality and diversity committee should be established as soon as possible and should include representatives of the young people. (2.99)

Maintaining contact with family and friends

3.48 A formal written system should be introduced to ensure that complaints or suggestions from visitors could be routinely audited. (2.100)

3.49 A direct helpline into the establishment should be provided for visitors and friends of young people to report incidents to senior managers. Helpline numbers should be printed on reception letters. (2.106)

3.50 Information about support groups should be displayed in the visitors' centre and a confidential helpline should be introduced and advertised. (2.113)

3.51 All visits should last at least one hour. (2.114)

3.52 Appropriate training should be provided to assist and enhance the role of the family liaison officers (FLOs). (2.115)

Healthcare

3.53 An increase in the nurse staffing complement should be seen as a priority in line with NHS practice. (2.118)

3.54 A skills analysis should be conducted to facilitate working in partnership with the NHS. (2.119)

3.55 Administration or clerical support should be provided to allow nursing staff to spend more time in clinical activities. (2.120)

3.56 A health needs analysis should be carried out with the help of the local health authority public health doctors and should 'feed' into the review of healthcare in Northern Ireland. This assessment should also inform the establishment as to the skills and qualifications needed by the nursing staff who will be required to deliver the services as specified in any resultant action plan. (2.121)

3.57 Policies currently under review should be rewritten in line with NHS standards of care and the advice of professional organisations. (2.122)

3.58 A mental health analysis should be carried out. (2.124)

3.59 The pharmacist should be involved in the reviews of pharmacy-related procedures, have input into the formulary and attend the drugs and therapeutics committee. The introduction of pharmacy clinics should be considered. (2.132)

3.60 Subsequent to the chief dental officer's review and dental health needs assessment, both quantitative and qualitative monitoring procedures should be put in place to provide assurance to the appropriate authorities and ensure cost effectiveness of the service. (2.136)

3.61 Sufficient escort services should be provided to ensure an adequate flow of patients to the dental practitioner. (2.137)

3.62 The facilities in the inpatient association room should be improved and made more comfortable. (2.147)

3.63 A therapeutic regime should be developed for inpatients and include better access to education and the library. (2.148)

3.64 There should be a designated exercise area for inpatients. (2.149)

3.65 A separate waiting room should be available for men and women and health promotion material should be available. (2.150)

3.66 The recently completed healthcare review should be communicated to all concerned, agreed and implemented as a matter of urgency. (2.151)

3.67 Changes to the staffing skill mix should ensure that there is appropriate clinical and managerial leadership in healthcare. (2.152)

3.68 Healthcare staff training should include child protection. (2.153)

3.69 Regular clinical supervision for staff should be introduced. (2.154)

3.70 Algorithm-based nurse triage should be introduced. (2.155)

3.71 Primary mental healthcare provision should be increased following a needs assessment. (2.156)

3.72 Secure, confidential arrangements should be made for the administration of medicines and secondary dispensing stopped. (2.157)

3.73 Further community psychiatric nurse input should be provided to meet the needs of the young adults. (2.158)

3.74 The numbers of dental sessions should be increased and oral health promotion introduced. (2.159)

Education and work skills training

3.75 Records should be kept of 'approved absences' to reflect a more realistic attendance rate for performance management for monitoring purposes. (2.162)

3.76 Better use of the library should be made by both staff and learners. (2.166)

3.77 There should be a broad, balanced, relevant and differentiated curriculum that will meet the needs of all learners. (2.167)

3.78 There should be a step change in the efficiency with which the education programme is delivered. (2.169)

Faith and religious activity

3.79 Chaplaincy hours should be increased to ensure that all young people are seen within 24 hours of arrival. (2.174)

3.80 Chaplains should be included in all policies and procedures involving sentence planning, resettlement and personal officer work. (2.175)

Time out of cell

3.81 A much more imaginative approach to out of cell activities is needed. (2.177)

Security

3.82 The interpretation of search dog evidence should be reviewed and closed visits only be given to visitors where there is additional and reliable intelligence to support the dog evidence. (2.179)

Incentives and earned privileges

3.83 The establishment should consider reproducing the information contained within the IEP leaflet through other mediums, such as videos or cassette tapes. (2.180)

3.84 Young people who are found guilty on adjudication should not automatically be placed on the basic level. (2.183)

3.85 A young person should be given the opportunity to add a written comment of their own to the weekly assessment report. (2.185)

3.86 Formal boards should be held to enable young people to make representations before they are demoted to the basic level of the IEP scheme. (2.186)

Prisoner disciplinary procedures

3.87 Standardisation meetings should be held quarterly to ensure that punishments are consistent between adjudicators. (2.191)

3.88 When cellular confinement is imposed, the assumption should be that no other privilege will be lost except in exceptional circumstances. (2.192)

3.89 Children should always have the opportunity to be represented at adjudications and cellular confinement should not be used as a punishment for children unless they have been represented. (2.193)

Use of force

3.90 All staff who may be required to use it should be certificated in the use of control and restraint (C&R). (2.194)

3.91 A review should be set up to ensure the use of force when used is necessary and used correctly. This group should have the powers to recommend further investigations to the governor. (2.196)

3.92 Records of the use and authorisation of unfurnished accommodation, its duration, and the behaviour of the young person there should be maintained. (2.201)

3.93 Monitoring records should be kept for all those held in the special supervision unit (SSU) recording their well being and progress. (2.204)

3.94 Young people segregated for good order or discipline should be given clear targets of what they need to do to return to their house and should be helped to achieve those targets. (2.205)

Sentence planning

3.95 A system to monitor the quality of personal development plans (PDPs) should be put in place. (2.213)

3.96 A personal officer scheme should be developed involving officers in monitoring, motivating, and recording the progress of the young person to ensure progress is being made against the plan. (2.214)

Offending behaviour work

3.97 The involvement of more officers in group work programmes should be promoted to develop a culture of working constructively with young people. (2.218)

Key workers (personal officers)

3.98 A regular forum should be created in which new initiatives can be routinely discussed between operational staff and their managers. A system for the ongoing supervision and support, as well as accountability, of all staff by their managers should be developed. (2.219)

3.99 The communication and information sharing strategy should be disseminated to staff in a systematic way. (2.221)

Catering

3.100 Staffing levels in the kitchen should be reviewed to enable national vocational qualifications (NVQs) to be made more widely available. (2.222)

3.101 Prison staff should consult with a nutritionist to ensure that healthy food options are regularly offered. The menus should be reviewed as a matter of urgency to ensure a balanced and varied diet is provided. (2.223)

3.102 Food lifts should be used. (2.225)

3.103 A record should be kept of all those who have been trained in manual handling techniques and all servery orderlies should be required to complete the training before taking up their jobs. (2.228)

3.104 The practice of putting plastic plates in the hot cupboard should cease immediately. Food should be kept in the metal trays in the hot cupboard. (2.230)

3.105 The taking and recording of all food temperatures should be consistently carried out at the point of delivery and immediately before food is served. (2.232)

3.106 The establishment should ensure that all young people who serve and handle food are appropriately dressed at all service times and that staff are trained in basic food hygiene. (2.233)

3.107 More use should be made of consultative groups for menus and purchasing. (2.234)

3.108 There should be greater management accountability of standards of food safety and hygiene standards after food has left the main kitchen. (2.236)

Appendix I: Inspection team

Anne Owers	HM Chief Inspector of Prisons
Michael Loughlin	Team leader
Tom McGonigle	Inspector (CJINI)
Fay Deadman	Inspector
Brett Robinson	Inspector
Joss Crosbie	Inspector
Paul Fenning	Inspector

Specialist inspectors

Tish Laing Morton	Healthcare inspector
Bill Massam	Ofsted

Researchers

Julia Fossi	Research officer
Charlotte Owiredu-Oppong	Student

Appendix II: Prison population profile

Population breakdown by:

(1) Status	Number of young people	%
Sentenced	99	50.25
Convicted but unsentenced		
Remand	98	49.75
Detainees (single power status)		
Detainees (dual power status)		
Total	197	

(2) Number of sentenced young people

Sentence	6 mths	12 mths	18 mths	24 mths	30 mths	36 mths	42 mths	48 mths	Over 48 mths	No. of custody probation orders	No. of JJCO	Life /HMP	Total
Age													
15 years													
16 years	2							1		(4)			3
17 years	4	1	1	1		1				(10)		1	9
18 years	13	4	9	12	3	10	5	14	12	(65)		5	87
Total	19	5	10	13	3	11	5	15	12	(79)*		6	99

(The custody part of the 79 on the custody probation orders are included.)

(3) Length of stay for unsentenced by age

Length of stay	<1 mth	1-3 mths	3-6 mths	6-12 mths	1-2 yrs	2 yrs +	Total
Age							
15 years							
16 years		1		1			2
17 years	5	6	6	4			21
18 years and over	19	23	14	12	7		75
Total	24	30	20	17	7		98

(4) Main offence	Number of young people	%
Violence against the person	51	25.89
Sexual offences	6	3.04
Burglary	27	13.71
Robbery	38	19.29
Theft & handling	22	11.17
Fraud and forgery		
Drugs offences	7	3.55
Driving offences	23	11.68
Other offences	19	9.64
Breach of custody/probation orders	4	2.03
Civil offences		
Offence not recorded/Holding warrant		
Total	197	

(5) Age	Number of young people	%
15 years		
16 years	5	2.54
17 years	29	14.72
18 years and over	163	82.74
Total	197	

(6) Home address	Number of young people	%
Within 50 miles of the centre	157	79.7
Between 50 and 100 miles of the centre	32	16.24
Over 100 miles from the centre		
Overseas		
NFA	8	4.06
Total	197	

(7) Location	Number of young people	%
Greater Belfast	95	48.22
Co. Down	23	11.68
Co. Antrim	17	8.63
Co. Londonderry	16	8.12
Co. Armagh	17	8.63
Co. Fermanagh	6	3.05
Co. Tyrone	15	7.61
England	0	0
Scotland	0	0
Wales	0	0
Republic of Ireland	0	0
Other	0	0
NFA	8	4.06
Total	197	

(8) Nationality	Number of young people	%
British	196	99.49
Foreign nationals	1	.51
Total	197	

(9) Ethnicity	Number of young people	%
Data on ethnicity not included as the YOC was unable to provide accurate figures.		

(10) Religion	Number of young people	%
Catholic	109	52.66
Protestant	63	30.43
Church of Ireland	18	

Presbyterian	38	
Methodist	6	
Free Presbyterian	1	
Other Protestants	0	
Other Religion	34	16.43
No Religion	1	.48
Not Known	0	
Total	207	

ACTION PLAN FOR HYDEBANK WOOD (YOC) HMCIP REPORT 2005

Rec No	Recommendations	Accept Y/N	Driver	Action	Target date
3.2	First night procedures should be developed to ensure that a comprehensive vulnerability assessment is made and that all young people, particularly children, are held in appropriate supportive accommodation with regular monitoring. (HP43)	Yes	Governor & PBNI	New procedures will be drafted to include vulnerability assessments of young people.	Available by 28 Feb 06
3.3	A new safer custody strategy should be developed to ensure the anti-bulling procedures work effectively with the involvement of young people. Appropriate links should be made with between suicide and self harm issues and peer support should be provided for victims of bullying and those at risk of self harm. (HP44)	Yes	Governor	A new safer custody strategy will be developed. Policy will include links between suicide, self harm and peer support. This will be monitored by the Safer Custody monitoring group which had its first meeting on 13 September 05.	New strategy in place by 31 Dec 05
3.4	Alternative and more therapeutic responses to self-harm for young people, other than the use of strip conditions, should be developed. Anti-suicide suits and unfurnished accommodation should be used only as a last resort, and should be fully justified and recorded. Staff should be available to interact with and support young people deemed at risk of self-harm (HP45)	Yes	Governor	Alternative responses are presently being developed and steps being taken to reduce reliance on suicide suits. Currently research is being undertaken and external agencies are being consulted. The remit of the 2CBT mental health nurses, on secondment to Ash House from the local Trust, will be extended to include the males.	Revised policy in place by 30 Jun 06 Extended remit by 31 March 06
3.5	The child protection policy should be reviewed to ensure that systems and procedures are in place to ensure child protection referrals are raised appropriately and dealt with efficiently, with all staff and managers working with children trained in child protection. (HP46)	Yes	Governor	The child protection policy has been revised to include systems and procedures for raising child protection referrals. Further training will be provided on child protection.	Revised policy actioned Further training completed by 31 Oct 05
3.6	A personal officer scheme should be developed to encourage residential staff to engage more actively with young people and take an active part in the development of resettlement plans, and to help ensure that resettlement becomes an integral aspect of the centre's purpose. (HP47)	Yes	HQ	The role of prison officers is being considered as part of a pay and grading exercise. This will include reference to both personal officer responsibilities and the role played by facilitators. It will also consider the difficulty in attracting and retaining staff in these roles.	Management will bring forward proposals by 30 April 06
3.7	Integral sanitation should be provided for all young people. Until then, there should be genuine 24-hour access to lavatories so that young people do not have to use pots after a cut-off time. (HP48)	Yes	HQ/ Estates Management	Installation of integral sanitation has begun in Beech House and a rolling programme is in place for the whole Centre. Arrangements are in place to provide 24-hour access to lavatories in the	Installation completed by 31 Dec 06

ACTION PLAN FOR HYDEBANK WOOD (YOC) HMCIP REPORT 2005

Rec No	Recommendations	Accept Y/N	Driver	Action	Target date
				remaining accommodation during lock-ups (subject to occasional system failures).	
3.8	All young people should have at least 10 hours a day out of their cells, including a minimum of one hour's access to exercise in the open air and a period of association each day. (HP49)	Yes	Governor	New regime arrangements are under consideration by local management which will increase time out of cell and address the issue of exercise outside.	Options available by 31 Dec 05
3.9	Sufficient education and work skills training should be provided to meet the needs of young people, occupy them fully and equip them with the qualification and skills they require. (HP50)	Yes	Governor/HQ	Five new teachers are being appointed plus 2 VT instructors. Further work is ongoing on provision of essential skills training and identification of further work opportunities. Temporary teachers are being sought until permanent appointments made.	Temp teachers by 31 Oct 05 1 VT Instructor by 31 Oct 05; 1 by 31 Jan 06 Perm teaching app'ts by 30 Nov 05
3.10	An up to date full health needs analysis should be completed including a review of the skill mix of staff to ensure that the young people at Hydebank Wood receive an appropriate healthcare service. (HP51)	Yes	Governor/ Associate Director of Healthcare	The Health needs assessment completed in 2004 included Hydebank Wood YOC. The recommendations of that report are currently being worked through. In the longer term lead responsibility for prisoner healthcare is to be transferred.	Options will be examined by 30 June 06 Review Sept 06
3.11	A formal system should be set up with the juvenile justice centre to ensure that information sharing and pre transfer planning takes place for all young people transferred to Hydebank Wood (2.5	Yes	Governor	Visits have already taken place with the Juvenile Justice Centre and discussions included the sharing of training, information and mutual support. Formal protocols will be drawn up. The Youth Justice Agency is also now represented at the Criminal Justice Board with NIPS.	Protocols in place by 30 Nov 05
3.12	Washing machines should be provided to allow young men to wash their own clothes. (2.8)	Yes	Governor & Estate Management	Washing machines will be installed when further refurbishment work takes place in each of the houses.	Programme of installation starts by 31 Dec 05; completed by 31 Dec 06
3.13	A system of independent advocacy for those under 18 should be introduced (2.12)	Yes	HQ / Governor	Consultation is taking place with other agencies about how best to put this service in place.	To be introduced by 31 Jan 06
3.14	Requests and complaints should be routinely analysed over time to provide useful management information about patterns and trends. (2.16)	Yes	Governor	Requests and complaints are routinely analysed by the Custody Manager on a monthly basis and statistics are provided for	Actioned

ACTION PLAN FOR HYDEBANK WOOD (YOC) HMCIP REPORT 2005

Rec No	Recommendations	Accept Y/N	Driver	Action	Target date
				analysis and use by Residential Managers.	
3.15	Requests and complaints should be monitored for matters relating to bullying and child protection and cross referred as appropriate (2.17)	Yes	Governor	Requests and complaints are monitored relating to bullying and child protection and are reviewed by the Custody Manager and Safer Custody Monitoring Group.	Actioned
3.16	The random searching of staff would provide a recognised and approved deterrent to trafficking (2.20).	Yes	Governor	Consideration will now be given to potential arrangements for spot checks of staff and visitors entering the establishment.	Options appraisal completed by 31 Oct 05
3.17	Further efforts should be made to engage the area child protection committee (ACPC) in the work of safeguarding children at Hydebank Wood (2.23)	Yes	Governor	Contact has been established with the Area Child Protection Committee (ACPC) and representatives have been invited to child protection meetings. Corporate membership has also been taken of the British Association of Specialists in Child Protection and Neglect	Actioned
3.18	The holding room in reception should be repaired and refurbished so that it is made suitable for the purpose of holding young people. Young people should not be secured in the individual changing cubicles (2.27)	Yes	Governor & Estate Management	Proposals have been put forward for the refurbishment of the Reception area.	30 Mar 06
3.19	There should be a range of accessible information notices and posters in reception to introduce new arrivals to Hydebank Wood. (2.28)	Yes	Governor	Information notices and posters are now displayed in Reception for new committals	Actioned
3.20	Young people should not automatically be handcuffed to and from reception and while travelling on escort vans without an individual risk assessment indicating a need for this level of security. (2.32)	Yes	HQ	The practice of handcuffing all prisoners leaving the Centre is presently being reviewed. Individual risk assessments will be introduced.	31 Dec 05
3.21	New arrivals should be carefully and consistently monitored during their first 24 hours in custody and this should be recorded (2.34)	Yes	Governor	Monitoring arrangements have been put in place with immediate effect.	Actioned
3.22	Children should not be accommodated automatically in bare anti-ligature cells without a television for their first days in custody unless an individual risk assessment suggests that this is necessary.	Yes	Governor	Inmates will have access to television in a bare anti-ligature cell unless the risk assessment indicates otherwise.	Actioned
3.23	Televisions should be provided in first night cells on Willow 1 (2.38)	Yes	Governor	All these cells have been furnished with a television.	Actioned

ACTION PLAN FOR HYDEBANK WOOD (YOC) HMCIP REPORT 2005

Rec No	Recommendations	Accept Y/N	Driver	Action	Target date
3.24	A system of identification for staff, which should include the wearing of name badges, should be introduced (2.39)	Yes	HQ	This will be further considered by Prison Management. Name badges have been distributed to staff. However, this raises issues (as in GB Services) which go wider than a single establishment.	31 Jan 06
3.26	The induction process should be streamlined, with a single document containing all the initial information gathered about young people, and managers should ensure that it contains all necessary and relevant information (2.47)	Yes	Governor	A single dossier will be revised to include everything that an inmate requires to know on reception to the Centre.	Available by 28 Feb 06
3.27	Recreational facilities on Beech House should be increased and consistency introduced across the residential houses (2.53)	Yes	Governor	Recreational facilities available to inmates across the Centre will be reviewed to provide additional activity for periods of free association.	Additional facilities available by 31 Jan 06
3.28	The establishment should agree upon a nucleus of essential information and notices to be displayed on the residential units, to include anti-bullying, equal opportunities, requests and complaints, the daily routine and the IEP scheme etc. These notices should be regularly updated and renewed.	Yes	Governor	The Communications Officer and Residential Managers will ensure that relevant policies and information are posted on notice boards in all residential areas.	Available by Nov 05
3.29	Professional haircutting should be available to young men without charge (2.56)	Yes	Governor	Presently haircutting is carried out internally. Arrangements will be made to identify an external hairdresser willing to provide the service.	Service available by 31 Dec 05
3.30	The pool tables in Cedar House should be returned (2.58)	Yes	Governor	Accepted in principle. Following previous incidents, careful consideration will be given to this option before it can be implemented.	In place by 31 Jan 06
3.31	Pool tables and other table games should be provided in all units (2.59)	Yes	Governor	Increased recreational facilities (to include consideration of pool tables and other table games) will be provided in all residential houses.	In place by 31 Jan 06
3.32	Bullying surveys should be undertaken every two years, with particular attention given to young people's perceptions of bullying by staff. The results should be disseminated to staff and used to inform the anti bullying policy (2.63)	Yes	Governor	Bullying surveys will be included as part of a programme of inmate surveys and will be completed every 2 years. Anti-bullying has already been included in inmate surveys carried out in June 05 and Sept 05. These surveys will inform policy.	Actioned

ACTION PLAN FOR HYDEBANK WOOD (YOC) HMCIP REPORT 2005

Rec No	Recommendations	Accept Y/N	Driver	Action	Target date
3.33	An anti bullying committee, led by a senior manager, should be set up. It should include representatives from all areas of the establishment and have representations from young people and children (2.64)	Yes	Governor	An anti-bullying committee has been established, chaired by the Custody Manager and representatives include young people and children.	Actioned
3.34	All staff and managers should receive anti-bullying training, specifically tailored to adolescence (2.65)	Yes	Governor	Adolescence will be included in the anti-bullying training programme. All staff have been trained in aspects of anti-bullying. The policy has now been updated and revised training will be delivered.	Revised training delivered by 31 Jan 06
3.35	In order to be a credible scheme the anti-bullying strategy should have links to child protection and other prison strategies such as suicide prevention (2.68)	Yes	Governor /Senior Mgt Team	A Safer Custody monitoring group has been established which will link suicide prevention, child protection, bullying, harassment etc.	Actioned – 1st meeting took place on 5 Sept 05
3.36	Records relating to incidents of bullying within the young offenders centre should be kept separately from those held on women (2.71)	Yes	Governor	Separate records are being kept and both records for males and females are reviewed by the Safer Custody Monitoring Group.	Actioned
3.37	There should be separate suicide awareness and prevention team meetings for women and young men to oversee the development and implementation of local policy for their care based on the NIPS policy document. The local policy should be based on an analysis of need and the statistics to help to improve the level of care for those at risk of self harm (2.81)	No	Governor	The suicide awareness and prevention meetings have been subsumed into the Safer Custody Group meeting which is held monthly. Separate meetings are not held for women and young men but there are separate sessions within the wider meeting which look at their respective needs. This process is working well and oversees the development and implementation of local policy based on the NIPS policy document.	Review by 31 Mar 06
3.38	Young people should be represented on the suicide awareness and prevention team. Other important areas of the prison, including Opportunity Youth, the chaplaincy and education, should also be represented (2.82)	Yes	Governor	All mentioned in the recommendation are represented at the suicide awareness and prevention group.	Actioned
3.39	Multi disciplinary training in the PAR1 process should be provided for all staff working directly with young people (2.83)	Yes	Governor	Training on the use of PAR1s is a corporate priority for 05/06 and is being delivered to staff. To date, all managers have been trained and are cascading this information down to officers. PAR1 training also forms part of Hydebank's suicide awareness training.	All staff trained by 30 Jun 06

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Rec No	Recommendations	Accept Y/N	Driver	Action	Target date
3.40	All young people should be invited to attend their PAR1 reviews and to make a written contribution. Where possible, reviews should be planned in advance to ensure that staff from a range of other disciplines can attend and that they are chaired consistently (2.84)	Yes	Governor	A multi-disciplinary meeting is called to review PAR1s. Young men are encouraged to attend but if they do not feel able to then they are helped to put their thoughts in writing by a member of staff. We are also looking at how we might develop a role here for independent advocates.	Actioned
3.41	A peer support scheme should be developed (2.85)	Yes	Governor & SO Training Manager	A buddy scheme has been developed as part of the suicide/self harm policy. Listener rooms are being installed in Beech and Cedar.	Actioned
3.42	Healthcare staff should receive substance use awareness training (2.94)	Yes	Governor	Substance use awareness training will be provided for Healthcare staff by Opportunity Youth and through outside seminars conducted by the consultant psychiatrist with a specialism in addiction.	Training will start by 31 Jan 06 Reviewed Jun 06
3.43	Alcohol and drug use among new committals should be monitored and services modified to meet changing needs. (2.95)	Yes	Governor	Alcohol and drug use among new committals is monitored by Reception staff and Opportunity Youth, and support services tailored to their individual needs	Actioned
3.44	Clinical detoxification protocols should be updated regularly in line with best practice (2.96)	Yes	HQ - Associate Director Healthcare	Detox protocols will be updated by the senior Prison Pharmacist in consultation with Healthcare staff and the consultant psychiatrist. Certain clinical procedures are being updated locally.	30 Nov 05
3.45	There should be regular analysis of statistical data in respect of adjudications, requests and complaints, home leave and early release and incentives and earned privileges. Senior management should regularly monitor these statistical returns in order to address discrimination on the basis of religion or other grounds (2.97)	Yes	HQ/ Governor	Statistical data will be provided to the SMT meeting on a monthly basis as on as PRISM is fully up and running. New monitoring arrangements will be put in place.	New arrangements in place by 31 Jan 06
3.46	The definitions of discrimination and intimidation, and the systems put in place to address these issues for staff, should also be applied to the young prisoners of Hydebank Wood (2.98)	Yes	Governor/HQ	An ethnicity, diversity and equality committee has been established. A policy will be developed to include definitions of discrimination and intimidation.	Policy in place by 30 Jun 06

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Rec No	Recommendations	Accept Y/N	Driver	Action	Target date
3.47	The equality and diversity committee should be established as soon as possible and should include representatives of the young people (2.99)	Yes	Governor & Director of Inmate Services	An ethnicity, diversity and equality committee has been established. Representatives from external organisations and young people are invited to attend.	Actioned
3.48	A formal written system should be introduced to ensure that complaints or suggestions from visitors could be routinely audited (2.100)	Yes	Governor	A complaints book is available in Visits which will be audited monthly and information provided for the SMT meeting.	Actioned
3.49	A direct help line into the establishment should be provided for visitors and friends of young people to report incidents to senior managers. Help line numbers should be printed on reception letters (2.106)	Yes	Governor	A dedicated telephone helpline has been installed and procedures put in place to ensure inmates families, friends and relatives are aware of its function and purpose. Helpline numbers are displayed by every inmate phone and on pillars, and at the entrance and exit to visits. This will also be delivered as part of the prisoner induction package.	Actioned
3.50	Information about support groups should be displayed in the visitors' centre and a confidential helpline should be introduced and advertised (2.113)	Yes	Governor	Information about support groups and contact details is now displayed in the visitors centre.	Actioned
3.51	All visits should last at least one hour (2.14)	Yes	HQ	Whenever practicable, all sentenced prisoners will receive a one hour visit, although this may occasionally be limited at weekends due to lack of space.	Actioned where practicable
3.52	Appropriate training should be provided to assist and enhance the role of the family liaison officers (2.115)	Yes	Governor	The Training Manager is presently conducting relevant training programmes for family liaison officers.	Training in child protection completed by 31 Oct 05
3.53	An increase in the nurse staffing complement should be seen as a priority in line with NHS practice (2.118)	Yes	Governor HQ	The healthcare complement will be brought up to strength by appointing 3 new members of staff, one of whom will be on internal transfer.	Training starts by 31 Oct 05 Reviewed Jun 06
3.54	A skills analysis should be conducted to facilitate working in partnership with the NHS (2.119)	Yes	HQ – Associate Director of Healthcare	Ministerial agreement has been received to transfer lead responsibility for healthcare management to the health sector. Work to facilitate this is ongoing. A Programme Manager has been appointed by NIPS with	Apr 07

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Rec No	Recommendations	Accept Y/N	Driver	Action	Target date
				DHSSPS.	
3.55	Admin or clerical support should be provided to allow nursing staff to spend more time in clinical activities (2.120)	Yes	Governor	Additional clerical support has been provided from within Hydebank resources.	Actioned
3.56	A health needs analysis should be carried out with the help of the local health authority public health doctors and 'feed' into the review of healthcare in Northern Ireland. This assessment should also inform the establishment as to the skills and qualifications required by the nursing staff who will be required to deliver the services as specified in any resultant action plan (2.121)	Yes	HQ	The Health needs assessment conducted in 2004 included Hydebank Wood YOC. The recommendations of that report are currently being worked through. Work is ongoing across a range of disciplines.	Progress reviewed by 30 June 06
3.57	Policies currently under review should be rewritten in line with NHS standards of care and the advice of professional organisations (2.122)	Yes	HQ	All healthcare services provided will be in line with that provided by NHS.	With immediate effect
3.58	A mental health analysis should be carried out (2.124)	Yes	Governor / Associate Dir of Healthcare	A mental health analysis, co-ordinated with the psychiatrists, will be carried out when the healthcare staffing has been brought up to full complement.	31 May 06
3.59	The pharmacist should be involved in the reviews of pharmacy-related procedures, have input into the formulary and attend the drugs and therapeutics committee. The introduction of pharmacy clinics should be considered (2.132)	Yes	HQ	The pharmacist attends the drugs and therapeutics committee, and is consulted on pharmacy related procedures.	Actioned
3.60	Subsequent to the chief dental officer's review and dental health needs assessment, both quantitative and qualitative monitoring procedures should be put in place to provide assurance to the appropriate authorities and ensure cost effectiveness of the service (2.136)	Yes	HQ	The dental service is in the process of being contracted out to a local HSS Trust. The recent recruitment campaign was unsuccessful and is being repeated. This will delay the introduction of the new arrangements.	New arrangements in place by 30 Mar 06
3.61	Sufficient escort services should be provided to ensure an adequate flow of patients to the dental practitioner (2.137)	Yes	Governor	Escorting of inmates to healthcare has now been identified as a priority task and is in place on a daily basis.	Actioned
3.62	The facilities in the inpatient association room should be improved and made more comfortable (2.147)	Yes	Governor	Soft furnishings and other items have already been put in place.	Actioned
3.63	A therapeutic regime should be developed for inpatients and include better access to education and the library	Yes	Governor	It is intended that a therapeutic regime will be in place, particularly for those prisoners	By 30 June 06

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Rec No	Recommendations	Accept Y/N	Driver	Action	Target date
	(2.148)			who have coping difficulties or personality disorders. Education will be available to in-patients.	
3.64	There should be a designated exercise area for inpatients (2.149)	Yes	Governor	A fenced garden area is available for in-patient use.	Actioned
3.65	A separate waiting room should be available for men and women and health promotion material should be available (2.150)	Yes	Governor & Estate Management	Renovation plans are at an advanced stage for the provision of separate waiting rooms for women and young men. Health promotion material is available both in Ash House and Healthcare.	Work will begin by 31 Dec 05
3.66	The recently completed healthcare review should be communicated to all concerned, agreed and implemented as a matter of urgency (2.151)	Yes	Associate Dir of Healthcare	The Associate Director of Healthcare has consulted with healthcare teams and the POA and briefing information has been provided for all staff.	Actioned
3.67	Changes to the staffing skill mix should ensure that there is appropriate clinical and managerial leadership in healthcare (2.152)	Yes	Governor & HQ	Consideration will be given to management needs of healthcare; a clinical governance manager for NIPS is currently being recruited.	Clinical governance manager in place by Jan 06
3.68	Healthcare staff training should include child protection (2.153)	Yes	Governor	Members of healthcare staff will be trained in child protection.	Training to be completed by 31 Oct 05
3.69	Regular clinical supervision for staff should be introduced (2.154)	Yes	Associate Director of Healthcare	New clinical governance arrangements will be introduced for the Service. Monitoring arrangements are carried out by the Head of Nursing and Associate Dir of Healthcare.	New arrangements in place by June 06
3.70	Algorithm-based nurse triage should be introduced (2.155)	Yes	Governor	This is now in place.	Actioned
3.71	Primary mental health care provision should be increased following a needs assessment (2.156)	Yes	HQ	The remit of the 2CBT mental health nurses, on secondment to Ash from the local Trust, will be extended to include the males. Healthcare complement will include an appropriate gender and skill mix including nurses with mental healthcare registration.	Full complement of staff by Dec 05 Extended remit by Mar 06
3.72	Secondary dispensing should stop and secure, confidential arrangements be made for the administration of medicines	Yes	Governor	Secondary dispensing has ceased. Approval in place for provision of individual	Secure boxes in place by 31 Mar 06

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Rec No	Recommendations	Accept Y/N	Driver	Action	Target date
	(2.157)			secure boxes for medicine.	
3.73	Further community psychiatric nurse input should be provided to meet the needs of the young adults (2.158)	Yes	HQ / Gov	Further mental health trained staff are being transferred to Hydebank; it is planned to include the 2 mental health in-reach nurses currently on secondment to Ash.	By 31 Mar 06
3.74	The numbers of dental sessions should be increased and oral health promotion introduced (2.159)	Yes	HQ	The dental service is in the process of being contracted out to a local HSS Trust. The recent recruitment campaign was unsuccessful and is being repeated. This will delay the introduction of the new arrangements. In the meantime, cover will be provided by Maghaberry and other locum dentists.	Appointment expected by 31 Jan 06
3.75	Records should be kept of 'approved absences' to reflect a more realistic attendance rate for performance management for monitoring purposes (2.162)	Yes	Governor	New recording arrangements will be put in place to record approved absences more accurately. Will form part of roll out of PRISM.	New arrangements in place by 31 Jan 06
3.76	Better use of the library should be made by both staff and learners (2.166)	Yes	Governor	New arrangements have been introduced to ensure more inmates have access to the library on a daily basis.	Actioned
3.77	There should be a broad, balanced, relevant and differentiated curriculum that will meet the needs of all learners (2.167)	Yes	Governor	Currently 5 additional teachers are being recruited and the intention is to offer a broad and balanced curriculum.	Temp teachers in place by 31 Oct 05; perm appointments by 31 Jan 06
3.78	There should be a step change in the efficiency with which the education programme is delivered (2.169)	Yes	Governor	A review will be carried out to increase access to education provision when the new teachers are appointed.	Review to begin by 31 Mar 06
3.79	Chaplaincy hours should be increased to ensure that all young people are seen within 24 hours of arrival (2.174)	Yes	HQ	A comprehensive review of the role of chaplains is underway. New arrangements will ensure chaplains are available to see new committals within 24 hours	Arrangements for 24hr coverage in place by 31 Dec 05
3.80	Chaplains should be included in all policies and procedures involving sentence planning, resettlement and personal officer work (2.175)	Yes	HQ/ Governor	Chaplains have a greater part to play in resettlement and sentence planning and are included in meetings.	Actioned
3.81	A much more imaginative approach to out of cell activities is needed (2.177)	Yes	Governor	The Governor is chairing a multi-disciplinary meeting including external representatives	Options available by 31 Jan 06

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Rec No	Recommendations	Accept Y/N	Driver	Action	Target date
				to identify additional constructive activity which will include activities for association periods.	Reviewed Jun 06
3.82	The interpretation of search dog evidence should be reviewed and closed visits only be given to visitors where there is additional and reliable intelligence to support the dog evidence (2.179)	No	HQ	Not accepted. The role of the search dog is kept under constant review, and we are mindful in every case of the human rights of both prisoners and visitors. However, the existing arrangement appears to have the desired effect of minimising illegal drugs getting into establishments. This has been the subject of a Judicial Review and the Court accepted the Prison Service policy.	
3.83	The establishment should consider reproducing the information contained within the IEP leaflet through other mediums, such as videos or cassette tapes (2.180)	Yes	Governor	A review of PREPS is currently underway; this will include the development of explanation material for those with reading problems.	Review complete by 31 Dec 05
3.84	Young people who are found guilty on adjudication should not automatically be placed on the basic level (2.183)	Yes	Governor	Young people following adjudication will not automatically be placed on basic level.	Actioned
3.85	A young person should be given the opportunity to add a written comment of their own to the weekly assessment report (2.185)	Yes	Governor	As part of the review the documentation will be changed to permit a young person to comment on their assessment report.	By 31 Dec 05
3.86	Formal boards should be held to enable young people to make representations before they are demoted to the basic level of the IEP scheme (2.186)	Yes	Governor	Inmates will be permitted to make representations if demotion is under consideration.	In place by Nov 05
3.87	Standardisation meetings should be held quarterly to ensure that punishments are consistent between adjudicators (2.191)	Yes	Governor	This is now included as a quarterly item on the Safer Custody management group agenda.	Actioned
3.88	When cellular confinement is imposed, the assumption should be that no other privilege will be lost except in exceptional circumstances (2.192)	Yes	Governor	Cellular confinement will not automatically include loss of other privileges. Reading material, radios and tobacco will be available at all times (subject to risk assessment).	Actioned

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Rec No	Recommendations	Accept Y/N	Driver	Action	Target date
3.89	Children should always have the opportunity to be represented at adjudications and cellular confinement should not be used as a punishment for children unless they have been represented (2.193)	Yes	HQ/Governor	Advocacy arrangements are under consideration with other agencies. In the meantime, cellular confinement will be used only as a last resort.	Introduced by 31 Jan 06
3.90	All staff who may be required to use it should be certificated in the use of C&R (2.194)	Yes	Governor	C&R training is a corporate priority and arrangements are in place to ensure all staff are offered certificated training.	Actioned through a rolling programme of staff training
3.91	A review should be set up to ensure the use of force when used is necessary and used correctly. This group should have the powers to recommend further investigations to the Governor (2.196)	Yes	Governor/HQ	A use of force manual provides advice on those occasions when force should be used. The C&R co-ordinator reviews current practice against the manual each time C&R is used. The Security PO will instigate procedures to inform senior management of trends and patterns.	31 Dec 05
3.92	Records of the use and authorisation of unfurnished accommodation, and its duration, and the behaviour of the young person there should be maintained (2.201)	Yes	HQ	Forms to be provided as part of Security Manual. Monitoring arrangements will be put in place to ensure the SMT is provided with details of use of unfurnished accommodation.	In place by 31 Jan 06
3.93	Monitoring records should be kept for all those held in the SSU recording their well being and progress (2.204)	Yes	Governor	Monitoring arrangements are in place in the SSU to record progress and well being of inmates.	Actioned
3.94	Young people segregated for good order or discipline should be given clear targets of what they need to do to return to their house and should be helped to achieve those targets (2.205)	Yes	Governor	Prisoners held in the SSU are subject to a multi-disciplinary case conference and exit strategies will be identified for each individual.	Actioned
3.95	A system to monitor the quality of PDPs should be put in place (2.213)	Yes	Gov	The Head of Resettlement will put a procedure in place to monitor the quality of PDPs.	Procedure formalised by 31 Dec 05
3.96	A personal officer scheme should be developed involving officers in monitoring, motivating, and recording the progress of the young person to ensure progress is being made against the plan (2.214)	Yes	HQ	The role of prison officers is being considered as part of a pay and grading exercise. This will include reference to both personal officer responsibilities and the role played by facilitators. It will also consider the difficulty in attracting and retaining staff	Management will bring forward proposals by 30 April 06

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Rec No	Recommendations	Accept Y/N	Driver	Action	Target date
				in these roles.	
3.97	The involvement of more officers in group work programmes should be promoted to develop a culture of working constructively with young people (2.218)	Yes	HQ	The role of prison officers is being considered as part of a pay and grading exercise. This will include reference to both personal officer responsibilities and the role played by facilitators. It will also consider the difficulty in attracting and retaining staff in these roles.	Management will bring forward proposals by 30 April 06
3.98	A regular forum should be created in which new initiatives can be routinely discussed between operational staff and their managers. A system for the ongoing supervision and support, as well as accountability, of all staff by their managers should be developed (2.219)	Yes	Governor	Regular staff meetings are held in the chapel with the SMT. House meetings are organised with the Head of Custody and Deputy Governor and opportunities provided for routine discussion on current developments. Minutes are kept.	Actioned
3.99	The communication and information sharing strategy should be disseminated to staff in a systematic way (2.221)	Yes	Governor	The Communications Officer will ensure that consistent procedures are in place for passing communications to staff. The Communications Strategy was reviewed in May 05 and has been re-issued throughout the Centre.	Actioned
3.100	Staffing levels in the kitchen should be reviewed to enable NVQ qualifications to be made more widely available (2.222)	Yes	Governor & HQ	Discussions are ongoing to identify procedures for making NVQs more widely available to prisoners.	Options available by 31 Oct 05; reviewed Jun 06
3.101	Prison staff should consult with a nutritionist to ensure that healthy food options are regularly offered. The menus should be reviewed as a matter of urgency to ensure a balanced and varied diet is provided (2.223)	Yes	Governor	The HQ catering adviser reviews menus regularly and the advice of dieticians is sought to ensure the menu is balanced and provides the necessary nutrition required daily. A recent 2-day audit conducted by Hallmark Quality Assurance Ltd concluded that NIPS catering services continued to meet the requirements of BS ENISO9001:2000 and continued certification was approved.	Actioned
3.102	Food lifts should be used (2.225)	Yes	Governor	House managers have been instructed to ensure this recommendation is complied with	Actioned

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Rec No	Recommendations	Accept Y/N	Driver	Action	Target date
3.103	A record should be kept of all those who have been trained in manual handling techniques and all servery orderlies should be required to complete the training before taking up their jobs (2.228)	Yes	Governor	Records are kept and training is provided for orderlies in manual handling techniques and basic food hygiene. All inmates are required to complete the manual handling course during induction.	Actioned
3.104	The practice of putting plastic plates in the hot cupboard should cease immediately. Food should be kept in the metal trays in the hot cupboard (2.230)	Yes	Governor	This practice has stopped. All food will be stored in the recommended metal trays.	Actioned
3.105	The taking and recording of all food temperatures should be consistently carried out at the point of delivery and immediately before food is served (2.232)	Yes	Governor	Arrangements are in place to ensure that food temperatures are monitored at the point of delivery and periodically before serving.	Actioned
3.106	The establishment should ensure that all young people who serve and handle food are appropriately dressed at all service times and that staff are trained in basic food hygiene. (2.233)	Yes	Governor	House managers ensure all servery orderlies are correctly dressed. Basic food hygiene training is made available to staff.	Actioned
3.107	More use should be made of consultative groups for menus and purchasing (2.234)	Yes	Governor	Catering managers meet with the HQ Catering Adviser and Procurement frequently. Arrangements are in place to ensure inmates are consulted on choice of menu. Food surveys are carried out annually.	Actioned
3.108	There should be greater management accountability of standards of food safety and hygiene standards after food has left the main kitchen (2.236)	Yes	Governor / NIPS Catering Manager	Current systems for transportation of food will be reviewed by the Catering Adviser, and recommendations provided for the Governor's attention.	Review completed by 31 Dec 05