Inspection of Woodlands Juvenile Justice Centre

May 2008

Criminal Justice Inspection
Northern Ireland
a better justice system for all

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Presented to the Houses of Parliament by the Secretary of State for Northern Ireland under Section 49(2) of the Justice (Northern Ireland) Act 2002.

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Contents

List of abbreviations

AQA	Assessment and Qualifications Alliance
ASSET	A structured assessment tool for young offenders
CAMHS	Child and Adolescent Mental Health Services
CJCO	Criminal Justice (Children) (Northern Ireland) Order 1998
CJI	Criminal Justice Inspection Northern Ireland
DDSW	Deputy Director of Social Work
DHSSPS	Department of Health, Social Services and Public Safety
ELC	Education and Learning Centre (in Woodlands)
ICR	Independent Complaints Reviewer
JJC	Juvenile Justice Centre
JJCO	Juvenile Justice Centre Order
KPT	Key Performance Target
LAC	Looked-after child
NIACRO	Northern Ireland Association for the Care and Resettlement of Offenders
NIO	Northern Ireland Office
NISSC	Northern Ireland Social Care Council
OBP	Offending Behaviour Programme
PACE	Police and Criminal Evidence legislation
PCC	Physical Control in Care
PBNI	Probation Board for Northern Ireland
PSNI	Police Service of Northern Ireland
RQIA	Regulation and Quality Improvement Authority
SLA	Service Level Agreement
TCI	Therapeutic Crisis Intervention
UNCRC	United Nations Convention on the Rights of the Child
YJA	Youth Justice Agency

Chief Inspector's Foreword

This report outlines the findings of a full, announced inspection of Woodlands Juvenile Justice Centre (the JJC). Unlike the rest of the UK, the JJC in Northern Ireland is not legally required to be licensed, so inspection is particularly important to assess the management and care of children who are held there.

The last full inspection of the JJC took place in October 2004, when the centre was still accommodated in the former Rathgael training school. Inspectors have also undertaken unannounced inspections on three occasions each in 2005 and 2006, plus an investigation that reported in February 2007. This inspection concentrated on developments in the new JJC which opened in January 2007 after several years planning. We were particularly keen to analyse the profile of children sent to the JJC and its interface with residential care, as these have been areas of concern in the past.

The inspection was based on the Juvenile Justice Centre (Northern Ireland) Rules 1999 which provide basic requirements for operation of the centre and include supporting principles. The Rules provide the structure for this report.

The inspection was undertaken in November 2007, led by Tom McGonigle. I am grateful for the contributions of colleagues from the Regulation and Quality Improvement Authority (RQIA) and the Education and Training Inspectorate (ETI) who provided detailed assessments of performance in their specialist areas.

I am also grateful for the open access provided by the JJC and its parent organisation the Youth Justice Agency of Northern Ireland (the YJA).

This report contains recommendations which we hope will contribute to the development of the JJC before we undertake the next full inspection in three years' time. In the interim, CJI will maintain a programme of smaller scale inspections, both announced and unannounced, to ensure ongoing independent oversight of this facility.

Kit Chivers
Chief Inspector of Criminal Justice in Northern Ireland
May 2008

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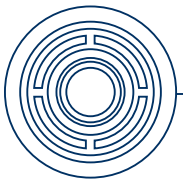

Executive Summary

This inspection found that significant progress had been made by the JJC since CJI's 2004 inspection. There were many examples of good practice and no matters of substantive concern about the management or care of children while in the centre. We make a single main recommendation which is beyond the sole control of the JJC and requires attention from the wider youth justice system. The remaining recommendations involve housekeeping points or reinforce matters which the JJC already has in hand that the Inspectorate would want to see being progressed.

The 2004 inspection made 57 recommendations, mainly relating to the former centre. We found that the relevant recommendations had been implemented in full or partially, and the JJC, YJA and Northern Ireland Office (NIO) had also taken account of relevant recommendations from Northern Ireland Human Rights Commission (NIHRC) investigations.

As in previous JJC inspections, Inspectors' main concern arises from the high turnover rate of children, and the fact that a disproportionate number of children come directly from residential care placements. These are longstanding features of juvenile custody in Northern Ireland.

Available information suggested that many of the children whom Inspectors met were neither serious nor persistent offenders. They were troubled children whose JJC placements often resulted from benign intent on the part of courts or police. When unsure about how to deal with them, they were placed in custody as much for their own safety as in response to their offending behaviour. Such placements breach international safeguards, and inappropriate use of custody for children remains a more pronounced problem in Northern Ireland than elsewhere in the UK. The JJC and the NIO were working hard to remedy the problem, but required better support from the youth courts and childcare agencies.

The new JJC building incorporated many positive design features that considerably enhanced the management and care of children. Comprehensive safety precautions were sympathetically integrated with robust security arrangements to provide a pleasant living and working environment.

Inspectors found the centre was well-managed. Governance arrangements were clear and good personnel practices were in evidence. Staff qualification levels were much improved and the staff group was better integrated, both internally and beyond the centre, than in the past.

The JJC was generating useful management information, and its planning processes should become more detailed and specific to address areas highlighted by this information. While it was a costly facility, the JJC compared favourably with other UK providers in this respect.

Children were very well cared for in the JJC. New initiatives, particularly Therapeutic Crisis Intervention (TCI) and a structured assessment model called ASSET were proving beneficial. Daily delivery of personal development programmes was an important innovation. Children told Inspectors that they were content with their care, and this was confirmed by families and other agencies involved with them. Provision of primary and secondary level healthcare was to a high standard, but the practice of secondary dispensing described at paragraph 7.20, needs to cease.

There was good management and leadership in the Education and Learning Centre (ELC). A strong educational ethos applied, delivered by able and caring staff, though teachers required better access to mainstream training. Children were more engaged in schooling than in the past, and outcomes were positive in relation to their backgrounds.

Recommendations

- The interface between residential care and the JJC should be continuously addressed in order to secure compliance with international conventions. This process should include dialogue with courts on the appropriate use of custody for children; and it should aim to improve the quality of information provided to the centre by external agencies (paragraph 1.12).

- The JJC should improve its data capture in order to accurately analyse the offending profile and needs of the population (paragraph 1.15).

- The new JJC Rules should be promptly introduced; and once implemented all staff should receive training in the new policies, procedures and rules (paragraph 2.4).

- More meaningful and challenging performance management objectives should be set by the JJC henceforth (paragraph 2.8).

- Targets should be set for reduction of overtime and staff sickness; the targets should be kept under review in order to reduce the risk of staff burnout (paragraph 2.13).

- The JJC should appoint a Deputy Director of Social Work promptly (paragraph 3.2).

- The YJA should monitor composition of the JJC workforce and address imbalances (paragraph 3.4).

- The centre should improve the management of staff training records, including IT systems and ensure they are regularly updated and accurately reflect training provided. Training records should be evidently linked to the centre's training and development plan for staff, and the centre should ensure that individual staff training records comply with requirements of the NISCC Code of Practice (paragraph 3.6).

- The YJA should conform fully to the prevailing JJC Rules, including reporting arrangements (paragraph 3.16).

- Case file recording quality and layout should be improved by introducing monthly summaries and regular file audits, to be undertaken by team leaders and unit managers within the supervision process (paragraph 4.8).

- The progressive regime review should ensure full and balanced reporting by staff, and clear explanations to children about their progress within the regime (paragraph 4.12).

- The JJC should apply consistent practice in permitting children to access the kitchens (paragraph 4.17).

- The centre's Child Protection Policy should be updated immediately to fully comply with 'Co-operating to safeguard children' DHSSPS 2003 ACPC Regional Policy 2005 and the YJA Child Protection Policies and Procedures (paragraph 4.18).

- The child protection review should ensure that:
  - child protection information is obtained at an early stage and factored into individual care/case management plans;
  - child protection information is accurately and regularly updated in line with guidance and procedures, in order to provide useful management information and ensure compliance with regulations; and
  - external agencies are vigorously encouraged to promptly fulfil their child protection responsibilities, including feedback to the JJC (paragraph 4.21).

- The purpose, structure and recording format of team meetings should be clarified. Minutes from meetings should include an action plan, and should be signed by all staff; and a proforma should be introduced for handover meetings (paragraph 4.35).

- JJC management should clarify the nature of stages 1 and 2 of the complaints procedure. This clarification should be communicated to children and staff to ensure accurate recording and analysis (paragraph 4.39).

- Steps should be taken to document the fact that parents/carers are advised when a child has made a complaint (paragraph 4.40).

- NIACRO and the JJC should ensure that the attendance of independent representatives is increased to comply with the Service Level Agreement (SLA) between the two organisations (paragraph 4.41).

- The evaluation of programmes should deliver:
  - more consistent timetabling arrangements;
  - an appropriate training and development schedule to enable staff to deliver programmes more confidently;
  - a prospectus of core programmes for all children; and
  - methodology to measure the long term effectiveness of programmes (paragraph 5.9).

- The JJC should ensure opportunity for the staff to discuss regularly their classroom practices to enable a more balanced focus on developing children's learning and their levels of accreditation (paragraph 6.6 a).

- The ELC should develop further the coherence of its curriculum e.g. using programmes of work as a context for the extension and development of literacy and providing a greater emphasis on the development or oral skills – helping children to listen to one another and to reason and discuss ideas (paragraph 6.6 b).

- Procedures should be strengthened to provide a more robust link between the ELC/JJC and community services, including links with the Education and Library Boards and Health Trusts (paragraph 6.8).

- The JJC should establish a more formal approach to data collation and analysis to inform self-evaluation, and enable improvement, which can be celebrated within and beyond the centre (paragraph 6.10 a).

- ELC staff should be enabled to access professional training (by provision of substitute cover) to develop their awareness of and knowledge of the wider educational system and the implications of changes in the external education environment for the ELC (paragraph 6.10 b).

- The layout of children's files should ensure that specific health care information is easily accessible to all relevant care staff involved with the child (paragraph 7.3).

- The healthcare staffing complement should be filled. Healthcare staff development and supervision arrangements should also be reviewed to ensure they are able to pursue relevant professional development through clinical supervision and development work (paragraph 7.4).

- Management should reinforce the need for good infection control procedures with relevant staff (paragraph 7.16).

- A policy for the safe administration of medications should be put in place to inform all relevant staff (paragraph 7.18).

- Secondary dispensing should cease. The administration of medications to children when nursing staff are not on duty should be immediately reviewed to ensure that correct procedures are adhered to and the health and safety of the child is not compromised. Where there is no alternative, care staff administering medications to children should have training in relation to this matter (paragraph 7.20).

- Additional control measures should be immediately implemented for distribution and return of sharp implements as follows:
  - house kitchens and workshops in the education block: consider providing latching locks on all drawers/cupboards containing risk items; and
  - use inventories/sign out-in and/or shadow boards for all education areas. (paragraph 8.5).

- Annual validation of ventilation rates against design values should be carried out particularly to living accommodation/bedrooms (paragraph 8.13 a).

- A maintenance regime for the dental area, including servicing of the benchtop sterilizer and flushing of water system periodically when not in use and prior to use, should be put in place immediately. Reference should be made to the MDRA guidance on the *purchase, operation and maintenance of benchtop steam sterilizers* and to the guidance contained in Department of Health's Health Technical Memoranda (HTM) 04-01 – *Water Systems: control of legionella, hygiene, safe hot water and drinking water systems*. (paragraph 8.13 b).

- The emergency standby generator should be run on load for one hour on a monthly basis. Reference should be made to the requirements of BS5839-1:2002 section 44.3 a. (paragraph 8.13 c).

- Regular cleaning of external pathways of algae and moss to remove or reduce slipping hazards should be carried out as found necessary, beginning as soon as possible. The suitability of surfaces should be considered and modified accordingly as necessary (paragraph 8.13 d).

- The baseline fire risk assessment should be reviewed periodically – annually is recommended. The review should consider and reassess the effectiveness of the evacuation procedures against the security arrangements in the centre (paragraph 8.18 a).

- The corrective action plan in the fire risk assessment should be addressed and signed off without delay (paragraph 8.18 b).

- Additional fire safety training, particularly relating to the evacuation procedure, should be afforded to all staff on a six-monthly basis (paragraph 8.18 c).

- Attendance by staff at fire safety training and fire evacuation practices should be recorded routinely so that individual non-attendance is flagged (paragraph 8.18 d).

Section 1

Inspection Report

CHAPTER 1:

Introduction

1.1 Woodlands Juvenile Justice Centre is the custodial directorate of the YJA, which has two other operational directorates – Community Services and Youth Conferencing. The YJA is sponsored by the NIO as a 'next steps' agency with its own management board that includes the Woodlands director.

1.2 The Criminal Justice (Children) (Northern Ireland) Order 1998 (CJCO) provides the legislative basis for the JJC's operation. The Order is modelled on international best practice, particularly three sets of United Nations rules and guidelines for the:

- Protection of Juveniles Deprived of their Liberty;
- Prevention of Juvenile Delinquency; and
- Administration of Juvenile Justice.

1.3 Consequently the JJC is premised on the expectation that only serious or persistent offenders should be sent there, and that custody should be used as a last resort. For example the United Nations Convention on the Rights of the Child Article 40 states that '*Deprivation of liberty should be avoided wherever possible and alternative disposals provided*;' and Article 12 of the CJCO presumes in favour of bail.

1.4 The JJC is the only custodial facility for children in Northern Ireland. It moved into new purpose-built accommodation at Bangor in January 2007. This marked the culmination of a 10-year process to reduce numbers of juveniles in custody from an average 250, located on four different sites, to a single, purpose-built facility for a maximum of 48 children.

1.5 High levels of security and safety are designed into the centre which comprises six self-contained living units clustered around an education area. While Woodlands has a strong childcare ethos, it is fundamentally a custodial facility for children who are charged with criminal offences.

1.6 Children are sent to the JJC by two different routes: by criminal courts, either on remand or on a sentence; or by police on foot of Police and Criminal Evidence Order (PACE) proceedings. As a custodial facility the JJC must accept any child who is sent there by a criminal court, and there is no right to exclude nor option to assess suitability.

Profile of the children

1.7 The nature of the JJC population has important implications for all aspects of its functioning. On 30 November

2007, the JJC population comprised 30 children:

- 25 boys/5 girls
- 21 remanded/9 sentenced
- Age 17 - 2
  16 - 20
  15 - 4
  14 - 4

Table 1 illustrates the JJC population over a 22-month period.

Table 1 JJC population January 2006 – October 2007

STATUS	2006		2006 TOTAL	Jan – Oct '07		Jan - Oct '07 TOTAL
	Male	Female		Male	Female	
PACE	155	20	175	121	17	138
Remand	114	19	133	130	29	159
Sentenced	24	3	27	21	2	23
TOTAL	**293**	**42**	**335**	**272**	**48**	**320**

1.8 Of the 655 admissions between January 2006 - October 2007

- 48% were PACE placements – which are very seldom used in other UK jurisdictions. The purpose of PACE is to ensure that children are held securely pending a court appearance, often overnight or at longest over a weekend. 132 (42%) of these children were subsequently released at court, which calls into question the value of placing them in custody in the first instance, in terms of individual impact as well as the disruption to other children living in the JJC. JJC managers were working with police and others to minimise inappropriate placements, but the volume and nature of PACE admissions remained a problem;
- 45% were remand placements - yet only 8% of remanded children went on to receive a custodial sentence. Average JJC remand placements lasted 25 days, compared to the English average of 41 days;
- Only 7% of children were actually sent to the JJC on sentence. There was no doubt that this group of children were correctly placed in terms of the seriousness or persistence of their offending, and the JJC held some dangerous children. However with a maximum sentence of two years, which attracted 50% remission (the remaining 50% was served under PBNI supervision in the community), and credit awarded for time served on remand, very few children spent longer than a few months in the centre as sentenced offenders. The average sentenced placement lasted 63 days compared to the English average of 162 days;
- It may be considered positive that shorter remand and sentenced JJC placements were better than the English experience of longer placements, though it was suggested to Inspectors that shorter stays

actually reflected less serious offenders. However the high population turnover was destabilising: the JJC's average turnover (1 admission and 1 discharge per day) was approximately three times higher than other secure centres in the UK. It posed a number of challenges that were compounded by poor information on admission, and a range of ages, abilities, behaviour and offending patterns that affected group stability and cohesion, continuity of education, and healthcare;

- Individual children ranged from 1- 8 admissions;
- Daily occupancy levels fluctuated between 26 - 42 children;
- On any given day females and younger children were often in a distinct minority; and
- The religious balance of children sent to custody was broadly representative of demographics for the 12-17 year old age group (In the 2001 census 47.9% of 12-17 year-olds said they were Catholics and 39.5% were from other Christian denominations): Catholic children - 52% Protestant children - 45%.

1.9 Another important feature of the population profile was that a disproportionate number of children came from Looked-after Care (LAC) backgrounds:

- 30% of all admissions during 2006-07 (199 admissions of 97 children) came from LAC backgrounds;
- the percentage of LAC children in the JJC fluctuated between 22% - 58% of all residents on any given day; and
- Looked-after children had on average twice as many admissions (4.4) as non-looked after children (2.7). This was not unique to the JJC, as children from care backgrounds were also over-represented in other areas of the criminal justice system.

1.10 In many cases courts, social services and even children themselves felt they were better off in the JJC than living at risk in the community or in residential care. Inspectors also heard of good practice with LAC children who offended and breached bail on numerous occasions, but were kept in care rather than be transferred to custody. Minutes of a September 2007 meeting between the Office of Social Services (OSS), Department of Health, Social Services and Public Safety (DHSSPS) and NIO outlined their views clearly: "*Courts too readily accept the reluctance or inability of social services to provide accommodation.*"

1.11 Many LAC children were already damaged and criminalised, with an estimated 75% of those who entered secure care having accrued criminal convictions. Research suggested that the gatekeeping process for secure care could actually lead to children being placed in the JJC if they did not meet the strict secure care criteria; and trivial offences provided the opportunity to use custody as quasi-care. However, that was not the JJCs purpose and it could be of no benefit for marginalised children to experience custody for insufficient reason.

1.12 A range of initiatives at strategic and operational levels had been undertaken to deal with this problem. These included a bail support scheme (42% of whose clientele had a care background), research projects, and

individual case reviews by the OSS in an attempt to ensure that custody was appropriately used for LAC children. There was a degree of tension between statutory criminal justice and social care agencies about this issue, to the extent that it was suggested social services might be billed for those LAC children who had been granted bail by the criminal courts, but whose bail has not been perfected because of social services' inability to accommodate the child. Forthcoming legislative changes – meaning that care orders will remain in force during a LAC child's time in the JJC - will also tighten arrangements. **We recommend that the interface between residential care and the JJC should be continuously addressed in order to secure compliance with international conventions. This process should include dialogue with courts on the appropriate use of custody for children; and it should aim to improve the quality of information provided to the centre by external agencies.**

1.13 A range of index offences was represented in the JJC population. The main offence categories of children admitted to the JJC between January 2006 and October 2007 were:

- Violence - 21%;
- Criminal Damage - 13%;
- Theft - 11%;
- Burglary - 7%;
- Other - 6%;
- Robbery - 3%;
- Motoring - 3%;
- Sexual - 1%; and
- Unknown - 35%

1.14 The spread of offence types was fairly normal for any custodial setting. While Inspectors were told that many admissions were for trivial offences which would not merit detention in the case of an adult, a higher proportion of the average daily population was detained for grave crimes of either a violent or sexual nature.

1.15 The number of unknown offences was surprisingly high, and there was no cumulative data available in relation to previous convictions. Given the fundamental criminal justice function of the centre **we recommend the JJC should improve these aspects of data capture in order to accurately analyse the offending profile and needs of the population.**

CHAPTER 2:

Purpose and function

2.1 The YJA's stated aim was 'preventing offending by children,' which was to be delivered by providing a range of services including secure custody. This aim was underpinned by a detailed set of values which expressed the YJA's commitment to:

- the needs of the children as the most important consideration;
- the rights of victims; and
- providing a low risk working environment for staff and using their talents to best effect.

2.2 These corporate messages were all perfectly appropriate, and they were all relevant to the JJC. It is very important that the JJC's unique role as Northern Ireland's only custodial establishment for children is articulated in a clear statement of purpose. The current statement required development and updating, and staff were being consulted about a redraft at the time of inspection for this purpose.

2.3 Nine standards and detailed performance measures that specifically addressed the work of the JJC were incorporated within an interim policies and procedures document. These standards and measures were appropriate, though could not be finalised until proposed new JJC Rules were prepared. The new rules are intended to update the statutory framework for management of the JJC.

2.4 The draft Rules were circulated for comment in December 2006 with a closing date of 2 March 2007, but had not yet been introduced. Much depended on these rules which were primarily a matter for the NIO. Once they are available it will be important that everyone is clear about their relationship to the JJC policies and procedures. While the draft policies were provided to staff in January 2007, it was apparent to Inspectors that some staff were not familiar with the contents. **We recommend prompt introduction of the new JJC Rules; and once implemented all staff should receive training in the new policies, procedures and rules.**

2.5 Six statutory agencies and three voluntary sector organisations responded to an invitation to comment on the JJC's performance. They identified improvements in recent years and were content with the current operation and collaborative approach to inter-agency working. Their main concern was about inappropriate placements of children in the JJC, while lesser concerns were expressed about excessive security levels and suitability of the complaints process.

Planning

2.6 Inspectors found that YJA Corporate Plans, Business Plans and Annual Reports did not do justice to the work of the JJC; and some relevant objectives did not meet SMART (specific, measurable, achievable, realistic and time-bound) criteria. In its 2006-07 review of performance the YJA outlined 10 Key Performance Targets (KPTs), of which three were specific to custody. The same three KPTs were being applied for custody during 2007-08:

- all admissions have a risk assessment conducted within 24 hours – **Met;**
- no high risk escapes from the JJC - **Not Met** (there was an escape from within the new JJC in February 2007); and
- 90% of children remanded by the courts have a bail assessment completed within seven days – **Met.**

2.7 Within the key business area 'Ensuring safe and appropriate use of custody' there were four development objectives (23 for the entire YJA):

- complete transfer of children to the new centre – **Met;**
- ensure all new committals have their mental health needs assessed – **Met;**
- extend the availability of bail support throughout Northern Ireland – **Met;** and
- support family involvement while children are in custody – **Met.**

2.8 The YJA quite reasonably explained that its priority had to be on ensuring safe transfer to the new centre. Now that this has successfully been achieved, Inspectors suggest that there should be clearer focus on the JJCs fundamental custodial role. For example, there could be an objective dealing with public protection; another objective might address the important area of integrating the custodial environment with relevant external agencies and the local community; and there could be more detailed objectives in relation to internal JJC matters such as personnel management, staff training and cost reductions. **We recommend that more meaningful and challenging performance management objectives should be set by the JJC henceforth.**

Costs

2.9 Child custody is very staff intensive, and therefore costly, in any jurisdiction. The most significant financial aspect of the new JJC was that it was more cost-effective than in the past. Better design, contracting-out of some functions and improved staffing arrangements meant that annual running costs had reduced from £7m in 2003-04 to £6m in 2007-08.

2.10 Data was provided by the Secure Accommodation Network, the Scottish Executive and the DHSSPS. It suggested that Woodlands was more expensive than local residential care facilities, but cheaper than comparable secure facilities in England and Scotland.

2.11 Such simplistic data does not truly compare like with like and needs to be contextualised. Among the factors to be considered are:

Facility	Location	Nightly cost per child (£)
Woodlands	N. Ireland	444
Eastmoor	Leeds	468
St Mary's	Glasgow	520
Redbank	Liverpool	580
Sutton Place	Hull	610
Scotland (average)		629
Childrens' Residential Care		
Lakewood (NI secure care)		346
NI Open Care (average)		257

- Most English facilities sold bedspaces on a demand-led, contractual basis. They could operate a mixed economy of accommodating offenders and non-offenders, and could charge more for emergency beds. Woodlands funding arrangements were very different as it was awarded a block grant and was compelled to take any child sent there by the courts;
- Costs were also influenced by other factors, such as free provision of education and personnel functions by a headquarters; and by the size of a facility and its turnover - higher costs are incurred in the first week of a child's stay, and Woodlands turnover was much higher than its comparators;
- Some costs were calculated on the basis of available bedspaces, and others on actual occupancy. The Woodlands figure was calculated on the basis that it had 48 available bedspaces, which it must fill if required, even though its average occupancy had been 30;
- Lakewood – the most relevant local comparator – was smaller than Woodlands and had different staffing levels and operating methods.

2.12 Woodlands was heavily overtime dependent: 383 overtime shifts were required in October 2007, to cover annual leave, sick leave, training and staff vacancies. A total of 72% of these were covered by permanent staff and 28% by casual staff, which had the benefit of ensuring reasonable consistency of staffing – an important feature in residential life.

2.13 Extensive use of overtime can represent a false economy. However, the fact that Northern Ireland only had one juvenile custodial facility meant that the pool of potential recruits was smaller than in other jurisdictions. Inspectors were told that 20 staff were on long term sick leave, though this was reported as no higher than in other similar centres in England. While these levels of overtime and sick leave may not have been unusual in residential settings **we recommend that targets be set for reduction of overtime and staff sickness; and that the targets be kept under review in order to reduce the risk of staff burnout.**

CHAPTER 3:

Management and staffing

3.1 The JJC had a total staff group of 169, comprising:

- Senior managers -3
- Unit managers - 6
- Team leaders -18
- Care staff - 113
- Education - 16
- Healthcare staff - 3
- Ancillary staff - 10

3.2 One senior managerial post - Deputy Director of Social Work (DDSW) – had been vacant since October 2006 due to illness. This vacancy, which incorporated a range of important functions including child protection monitor, had impacted on line management of care and healthcare staff. Although partially compensated for by the Head of Education overseeing child protection, the Director fulfilling a supervisory role for unit managers, and by extended involvement of an external advisor, it is an important post that needs to be filled. **We recommend the JJC appoint a DDSW promptly.**

3.3 The workforce gender and religious breakdowns were:

- 53% male/47% female;
- 66% Protestant/19% Catholic/15% Other

3.4 No child or staff member raised concerns about any type of discrimination with Inspectors; and the breakdown of 20 new appointees (70% Protestant/30% Catholic/0% Other) since November 2004 represented an improvement in religious balance. Nonethless, the overall religious imbalance among staff was marked, and merits attention. **We recommend the YJA should monitor composition of the JJC workforce and address imbalances.**

3.5 There were much higher levels of qualified staff than at the time of the last inspection:

- The director, all six unit managers and 11 team leaders were professionally qualified social workers;
- The other seven team leaders were either pending a social work qualification or NVQ 4 in Community Justice;
- 41 care workers (three at last inspection) held the NVQ 3 in Community Justice;
- 17 staff were NVQ assessors;
- 12 staff were qualified to deliver Therapeutic Crisis Intervention (TCI) and Physical Control in Care (PCC) training, which delivered savings and flexibility of training times.

3.6 The Centre had made commendable investment to provide relevant training for staff. However, it was evident from an examination of records and discussion with the training co-ordinator that the management of records and IT systems needed to be developed. **We recommend that the centre should improve the management of staff training records, including IT systems and ensure they are regularly updated and accurately reflect training provided. Training records should be evidently linked to the centre's training and development plan for staff, and the centre should ensure that individual staff training records comply with requirements of the NISCC Code of Practice.**

3.7 Staff were vetted prior to employment and required to register with the Northern Ireland Social Care Council (NISCC) where relevant. They were clear about their roles and responsibilities and line management arrangements. New staff confirmed they had proper induction, regular supervision and appraisal.

3.8 Staffing levels were calculated on formulaic ratios to ensure safety of children and staff. Despite some suggestions of shortages, it was significant that the JJC was able to second four staff to Youth Conferencing in July 2007 and still adhere to safe staffing levels. JJC staffing ratios were very high in comparison to adult and youth custody, and they also compared favourably with children's homes. Normal ratios were adjusted to reflect changing numbers of children and to help manage particularly challenging behaviour, to the extent of three staff/one child where necessary.

3.9 Management data and interviews with staff confirmed that thorough management was in place. Inspectors found staff members were generally committed to the goals and values of the YJA. Data provided by the YJA outlined appropriate handling of disciplinary cases and grievances. During 2005 - 2007 all five of the YJA's disciplinary cases related to the JJC. They were appropriately handled, and resulted in two summary dismissals; one final warning; one resignation in advance of dismissal; and one case ongoing.

3.10 Seven YJA grievances (out of a total of nine which were listed for Employment Tribunal hearings) during 2005 - 2007 had involved JJC employees. The outcomes were two cases won by the YJA; one withdrawn; three ongoing; and one apology issued.

3.11 While Inspectors heard some negativity and professional rivalry between disciplines – mainly due to differences in terms and conditions of employment – staff generally recognised their working arrangements and remuneration were more favourable than in comparable settings. For example, the new centre's rota meant that care workers did not work more than four days in succession (unless doing overtime) whereas the previous rota could entail them working for nine consecutive days.

The change process

3.12 The change process that had been undertaken since the last inspection provided a good indication of the JJC's progress. When all children were amalgamated on a single site at Rathgael for the first time in October 2003, the process was poorly handled in many respects including:

- holidays, sick leave and training were not factored into the rota;
- there was no assessment of staff fitness for specific posts, and some staff were allowed to refuse to work with children;
- the process was undermined by staff who did not want to change and the mismanaged transfer of some very disruptive children led to substantial damage;
- only the education department had been given sufficient time to plan; and
- significant physical defects had not been remedied.

3.13 In contrast design of the new centre and the move in January 2007 were much better planned. From inception it was a comprehensive, project-managed exercise, evidenced by documentation and staff feedback.

- The building was delivered on time and within budget. Its design was carefully planned to incorporate a single storey with ensuite accommodation, clear sight lines, enhanced finish, fixtures and fittings. These provided the opportunity for staff to focus more on positive interaction with children and less on managing safety and security issues. Inevitable snagging faults such as incomplete accommodation in the education area were being remedied as part of the two year post-commissioning maintenance contract.
- Involvement of staff reduced resistance to the change. They were closely engaged in working groups and exposed to the experience of other practitioners by visiting centres in Scotland, England and the Republic of Ireland.
- All day care staff had two weeks preparation time on-site before children arrived, and other staff had preparation time commensurate with their role.
- The physical security and central control functions were externally contracted, in order to separate care and security functions.

3.14 A range of improved childcare, management and staffing practices had been introduced in order to deliver a radical culture shift. Besides staff training, TCI and ASSET these included;

- Staff supervision and appraisal processes were formally introduced. They were recorded and linked to training and promotion.
- Quality management information needs were identified, and data was being generated in relation to restraint, overtime, child protection and complaints.
- Internal integration between staff disciplines had improved. For example, night staff – who formerly had a limited monitoring role – had taken on an explicit childcare function and shared the same office as daytime workers. Both night staff and teachers now contributed to childrens' unit records.
- External integration with other agencies was better. For example, the centre had a family worker seconded in from the YJA's Community

Services; YJA bail support workers and NIACRO staff were based on-site; and staff participated in external working groups such as the Secure Accommodation Network.

- Communication systems had been formalised. There were a range of regular meetings, with minutes electronically available to all staff. Examination of minutes and Inspectors' observation of meetings suggested appropriate topics were addressed and that there were clear expectations, roles, boundaries, levels of support and accountability. Difficult topics were not avoided, decisions were taken and appropriate delegation was applied.
- The on-call system worked well and ensured a clear line of managerial support at all times.
- An increasing number (60% at the time of inspection) of court appearances were conducted by video-link.

Governance

3.15 Governance arrangements for the JJC were clear, with appropriate reporting lines and management structure, policy framework, financial checks and balances and independent audit arrangements. The only anomaly was that the JJC Rules made the Director accountable to the Secretary of State for Northern Ireland, rather than to the YJA Chief Executive who was the line manager. There had not been any difficulties with this matter which arose due to the fact that the YJA had no legal identity in law; and in practice appropriate lines of accountability were adhered to. Nonetheless it will be important for it to be remedied administratively, as is planned when a new framework document for the JJC is introduced.

3.16 While the JJC received regular visits from YJA board members, no monthly board reports were prepared as required under Rule 9. This is an important aspect of external oversight, and **we recommend that the YJA should conform fully to the prevailing JJC Rules, including reporting arrangements.**

CHAPTER 4:

Care of children

Assessment and planning

4.1 Inspectors found that the centre stood strongly by the requirement for a valid order of commitment authorising a child's detention, and all case files contained a copy of the relevant authorisation.

4.2 The amount of prior notice received by the JJC in relation to arrival of a child varied considerably. Management were constant in their attempts to engage with children's homes and other agencies to improve the communication flow, but it was often a difficult process and staff had become skilled in obtaining information from external sources.

4.3 Health and educational assessments were undertaken at an early stage. Risk assessment was a priority and the duty team leader completed the standard ASSET assessment on arrival, using any information available. Staff erred on the side of caution until they had verified information about a child. In order to put a risk management plan in place at the earliest opportunity and avoid paper-based delays, the JJC were planning to introduce an electronic version of the ASSET process.

4.4 Admissions were not normally allowed after 10pm, nor discharges before 8am. When the Immigration and Naturalisation Service (INS) recently wanted to remove a child at 4am, their request was denied, reflecting the fact the child's welfare was paramount.

4.5 On arrival a child would receive a pat down search (no towel or full body searches were undertaken), have their property recorded and removed for safe storage. The JJC held money for children in a 'bank account' and gave them information on how much their account contained on a regular basis. At discharge JJC managers were careful to ensure childrens' money was handed over to those with parental responsibility for the child, in order to prevent misspending. All children had a shower upon arrival and house units had spare clothes and toiletries for them to use until their own clothing became available.

4.6 New children were given information about the JJC and its rules, including a copy of the complaints leaflet. The information comprised essential 'need to know' details, rather than swamping children with too much information at a difficult time. Inspectors were told by both staff

and children that the reception procedures worked well, and children said they received the right amount of information.

4.7 Comprehensive files were opened on each child at the point of arrival. Recording was very detailed, sometimes to the point of being dense and difficult to follow. Children confirmed they were encouraged to participate in centre life, both individually in planning for their future, and collectively in relation to group living arrangements. They had access to relevant sections of their files, though the loose folder format made it difficult to follow a sequence of events, and sometimes key information was not apparent.

4.8 There was variation between files in terms of recording quality and accessibility of information. The structure and content of case files could be enhanced by the use of a ring binder file, and retention of individual work records in a separate file. Incorporation of monthly summaries and managerial audit would facilitate ease of access to records, quality control and analysis of progress and outcomes. **We recommend case file recording quality and layout should be improved by introducing monthly summaries and regular file audits, to be undertaken by team leaders and unit managers within the supervision process.**

Inspectors attended an initial planning meeting for a 16-year-old sentenced girl. It included herself, her mother, the keyworker, the case manager, the Deputy Head of School, the family links worker and the child's mentor from Opportunity Youth. The meeting was held nine days after the girl's arrival and developed a plan based on:

- the assessments undertaken by the keyworker, education and the medical department;
- the girl's offences and involvement with other agencies;
- parental visits during custody and assistance available with this;
- the girl's behaviour since her arrival at the Centre;
- plans during the custodial period with regard to education and offending and life skills programmes and;
- subsequent plans after release.

All parties, including the girl, were encouraged to give an input.

4.9 When release dates were known, a preparatory meeting was arranged, ideally two weeks prior to release. This was usually not possible with remanded children since they would be discharged at court; and totally impossible to plan for in the numerous cases of children placed in the JJC under PACE legislation.

Entitlements

4.10 A five level progressive regime (Bronze to Platinum Plus) system of rewards, privileges and incentives was in operation for children in the JJC. Each child had a report record and any staff member could make an

entry in regard to the child's positive and negative behaviour.

4.11 Unit Managers and Team Leaders reviewed the reports on a weekly basis and regime decisions were related to the number of adverse reports. Three outcomes were possible – promotion, no change or demotion – which could be appealed. The policy and procedure provided guidance to staff and indicated that young people should see their report and be permitted to comment on it.

4.12 Privileges were always linked to the child's risk assessment, and unit managers also had discretion to adapt the progressive regime to meet the specific needs and capabilities of children. While the scheme was well-designed, a sample of report cards examined indicated some areas for improvement in its implementation:

- report cards were not always fully completed or signed off and dated by the unit manager and team leader;
- entries made by staff appeared to highlight more negative than positive behaviours. There was a lack of evidence on records of staff involving children in this process and an absence of their signatures and/or comments; and
- children indicated they did not always understand how they were moved from one level to another.

The Progressive Regime was under review at the time of inspection. **We recommend the review should ensure full and balanced reporting by staff, and clear explanations to children about their progress within the regime.**

Accommodation and food

4.13 Each of the six residential units had eight single bedrooms with en-suite facilities. Six bedrooms were of the same design and two others were described as 'safe bedrooms' due to additional safety features. The bedrooms were found to have satisfactory levels of cleanliness and hygiene. The open plan living and dining areas with small kitchens were bright and comfortable and provided views and access to the courtyard/garden and recreation areas. Childrens' level on the progressive regime could significantly enhance their bedroom in terms of personal effects, posters and access to a cd player, radio, television and computer games console.

4.14 Some children complained about hardness of the mattresses. Managers explained they were aware of these complaints but had to strike a balance between comfort and risk. Inspectors were informed that mattresses conformed to Home Office guidelines and were deemed to be the best quality available. Bedding was viewed as adequate and laundered regularly.

4.15 As part of their training programmes, children were expected to keep their bedrooms clean and tidy and to share responsibility for the maintenance of other areas in the unit. An important group of ancillary staff who cleaned regularly, undertook laundry and sewing duties, were noted to have positive interactions with the children.

4.16 Inspectors sampled the food and found it to be of good quality, wholesome and varied. Children had a menu choice, and numbers were sufficiently small to ensure individual preferences could be catered for.

4.17 Apart from one unit which applied a risk-based approach, children were not permitted to enter the kitchen areas at any time. This practice was at variance from the Young Person's Guide to the Centre (page 17) and the policy and procedure statement in the Staff Handbook (page 105-107) which cited guidance in regard to 'Managing the Use of Cutlery'. **We recommend the JJC should apply a consistent approach in permitting children to access the kitchens.**

Safeguarding

4.18 Child protection was treated seriously, not only while children were held in the centre but also in relation to handling allegations of abuse that they suffered before being sent to Woodlands. However, the child protection policy cited within the Staff Handbook did not comply with the area child protection committees or the YJA's Child Protection Policy. **We recommend the centre's Child Protection Policy should be updated immediately to fully comply with 'Co-operating to safeguard children' DHSSPS 2003, ACPC Regional Policy 2005 and the YJA Child Protection Policies and Procedures.**

4.19 A total of 12 child protection allegations covering the period October 2006 – October 2007 were examined by Inspectors. They included claims of assault by PSNI officers, prison staff, escort staff, care staff, family members and paramilitaries. Inspectors were told that the centre's attempts to track these referrals with Social Services and the Office of the Police Ombudsman (OPONI) suggested delays in response and lack of information about progress. At the time of the inspection seven referrals were outstanding: five from Social Services and two from the OPONI.

4.20 It was clear from the child protection files that staff were vigilant in respect of child protection during the JJC admission process, especially if physical injuries were apparent. However there were some discrepancies between manually held child protection records and computerised summary data. It was also difficult to obtain accurate information about the number of children in the JJC whose name was on the Child Protection Register, or the categories of abuse for which they were registered – even in the case of LAC children.

4.21 Whilst some case files contained case conference documentation, child protection plans were not routinely provided by social services to JJC staff; nor were they always incorporated in case planning even when available. The child protection policy was being reviewed and updated at the time of inspection. **We recommend the child protection review should ensure that:**

- **child protection information is**

obtained at an early stage and factored into individual care/case management plans;

- **child protection information is accurately and regularly updated in line with guidance and procedures, in order to provide useful management information and ensure compliance with regulations; and**
- **external agencies are vigorously encouraged to promptly fulfil their child protection responsibilities, including feedback to the JJC.**

4.22 All staff had received initial training in Therapeutic Crisis Intervention (TCI) and Physical Control in Care (PCC), and regular refresher training was also prioritised. This training, combined with individual planning for each child, represented a major change in the underlying philosophy and approach to managing juveniles in custody. It had contributed significantly to staff skills and confidence in understanding and addressing challenging behaviours, and most staff suggested they preferred to use their relationships with children rather than resort to physical restraint. Staff were also observed to be vigilant about the potential for bullying, harassment and scapegoating.

4.23 The value of TCI was best reflected in data available from residential unit logbooks. For the period January - November 2007 there was an average 17 restraints per month. This compared with an average of 62 restraints per month in English Secure Training Centres. Detailed entries were countersigned by the team leader and unit manager. They identified reasons for restraint, names of staff involved, effectiveness and consequences, duration and any injuries caused. The main outcome was removal of the child to their bedroom.

4.24 While the building design, staffing ratios and training all helped minimise incident levels, injuries to staff were still an unfortunate reality of residential work: a total of 27 staff were injured as a result of assault during January – December 2007, of which 12 resulted in sick leave and seven were deemed sufficiently serious to report to police. This average of two assaults per month compares with an average 3.5 assaults per month by trainees across the Secure Training Centre, secure children's home and Young Offender Institution estate in England and Wales during April 2007 – January 2008.

4.25 JJC managers were clear that no assaults on staff were acceptable, and at a minimum all such incidents were dealt with under progressive regime arrangements. As a predominantly non-pain compliant method of restraint, PCC was the preferred approach, and there were no records of serious injuries to children during restraints at the JJC. Nonetheless all staff were alert to the risks involved in restraining children, and the director participated in the national PCC Management Board in order to share best practice.

4.26 Another log showed 157 instances of single separations during January – November 2007 – mainly for threats,

aggression and refusal to comply with instruction. Recording distinguished whether separation was at the instigation of staff or at the child's request. Again the recording was detailed, as were the logs to record self harm by children, of which there were 12 incidents by three children during January – November 2007.

4.27 While most staff were positive about the new methods of working with children, a few were uncomfortable and felt their personal value base was compromised. Their philosophy prioritised static security measures over dynamic intervention. It will be important for managers to continuously reassess staff motivation and maintain the emphasis on training, in order to deploy the workforce to best effect.

Communication

4.28 The centre's policies and procedures emphasised the important role of families, carers and significant others in providing support for young people whilst in custody and following release. The role and responsibility of staff to promote and encourage young people to maintain contact with others was also emphasised.

4.29 While the rights of young people to visits, to send and receive mail and make and receive telephone calls in private were clearly indicated, it was equally clear that in certain circumstances these rights would be restricted, and the young people's guide was commendable in its honesty and clarity about such matters.

4.30 Children confirmed that they were actively encouraged to keep in contact with family and friends. Although the centre had specific visiting times they were flexible in interpreting these. Inspectors received positive external feedback about the JJC: visitors confirmed that they were happy with their childrens' care, their access to visit the children, and their involvement in planning about their child's future. Purpose-built accommodation was provided for family visitors who were travelling from afar. Other supports included transport provided by NIACRO, who also ran a weekly parents support group in Belfast along with the JJC family worker.

4.31 Interaction between staff and children was viewed as positive by Inspectors, and the atmosphere was generally relaxed in all areas of the centre. At the same time, staff remained vigilant to group dynamics and individual children, and were able to use their authority appropriately when necessary. Discussion and documentary evidence confirmed staff members efforts to work in partnership with others to meet the needs of young people.

4.32 Sentenced children were eligible to be considered for off-site mobility and home leave, subject to risk assessment. Inspectors saw instances where this had worked successfully to help maintain community links, such as a child undertaking a pre-release visit to his new children's home.

4.33 Each child was allocated a key worker on admission. While some

expressed negative views about their relationships with particular staff, all were able to identify someone with whom they had a positive relationship.

4.34 Some staff suggested a need to improve communication between the six residential units; and Inspectors were also told that the team leaders needed better opportunities for meeting to share experiences, and to transfer learning and good practice. Such logistics are always difficult in a residential setting, and centre managers were alert to the concerns and were able to demonstrate existing opportunities. Inspectors were not persuaded of the need to introduce further formal meetings, but suggest all opportunities should be utilised to assist integration of all staff groups.

4.35 Each residential unit had three staff teams who held regular team meetings which were minuted, though their purpose and follow-up arrangements were not always clear. There were also daily handover meetings for staff coming on shift. Observation of handover meetings revealed key issues were addressed though there was an absence of written records of key information shared and/or actions agreed. **We recommend the purpose, structure and recording format of team meetings should be clarified. Minutes from meetings should include an action plan, and should be signed by all staff; and a proforma should be introduced for handover meetings.**

Complaints

4.36 The JJC's four stage complaints procedure had been subject to two reviews during 2007: a thematic CJI inspection of *complaint handling across the criminal justice system;* and a review by the JJC's own Independent Complaints Reviewer (ICR). It was not the place of this inspection to revisit such recent exercises in detail. However, Inspectors checked progress against their recommendations and noted that most had been addressed by the time of this inspection.

4.37 Good practice included monthly analysis of complaints by the senior management team. In addition to the formal complaints process a variety of other events – such as residents meetings – were used to distinguish between 'complaints' and 'matters for clarification.' These were minuted, showing which staff and children attended, issues raised and outcomes achieved. This was an effective method to enable children to raise issues when it was not necessary to resort to a formal complaint.

4.38 Children confirmed that they were aware of the procedure and felt comfortable to raise their complaints with staff. Although some commented that '*staff don't do anything with the complaints forms*' and '*staff always side with staff*', Inspectors noted that complaints forms were always signed off by the child to confirm the issue had been addressed, and noted that in appropriate instances staff had apologised or acknowledged if an

error had been made. The centre had still to address a recommendation to provide children with easy access to writing materials when they wished to make a complaint.

A 17-year-old girl made a complaint about her educational programme. She was working towards GCSEs and felt that she was not benefiting from non-academic subjects such as woodwork. Teachers discussed the issues with her and agreed that she would work towards the GCSE subjects on her own and be treated as an 'adult learner'.

4.39 Inspectors did not note any matters of serious concern that were raised through the complaints procedure. A total of 45 complaints were recorded between October 2006 – October 2007, of which 20 originated from one child. The dominant themes were about food, the progressive regime, activities and clothing. Of the 22 complaints that were recorded as being resolved at the second stage, it was apparent that many were inappropriately recorded – they were only raised with a unit manager because the child had specifically requested the unit manager address the issue in the first instance, usually on the basis that they felt the managers' authority would secure a quicker or better outcome. **We recommend that JJC management clarify the nature of stages 1 and 2 of the complaints procedure. This clarification should be communicated to children and staff to ensure accurate recording and analysis.**

4.40 The ICR and Inspectors also noted that although the JJC complaints procedure states that parents or carers should be informed as a matter of course when a complaint was made, this did not always happen. This could be addressed by including an opportunity on the complaints form for the member of staff to confirm notification had taken place. **We recommend that steps be taken to document the fact that parents/carers are advised when a child has made a complaint.**

4.41 The JJC also had an Independent Representative (IR) scheme which was delivered by NIACRO volunteers. Children were aware of the role of the IRs but remarked that they did not visit very often. JJC records indicated that actual IR attendance was on average twice a month, rather than weekly as agreed in the service level agreement with NIACRO. The IR co-ordinator explained that there had been resourcing difficulties with the scheme and that they were in the process of recruiting volunteers who would be available from the start of 2008. **We recommend that NIACRO and the JJC ensure the attendance of independent representatives is increased to comply with the Service Level Agreement between the two organisations.**

Religion

4.42 Religious observance and instruction was primarily provided by two chaplains – a Presbyterian and a Roman Catholic - who visited on average once per week. Inspectors

were also told that the chaplains could arrange alternative religious provision if there was a specific requirement. For example an Imam visited when a Muslim boy was held in the centre.

4.43 Requests from children for denominational religious instruction were infrequent, but the chaplains provided an important pastoral support – the religious provision was described as *"pastoral not preachy."*

4.44 The chaplains made a point of meeting new residents and confirmed that the centre was very open to them having free access to the children. They (and other external visitors) respected managements' request to attend at mealtimes or in the evenings, in order to avoid interrupting the school day. They published a quarterly denominational notes booklet, and they played a lead role in seasonal events such as Christmas and harvest festivals.

4.45 Children and staff stated they were satisfied with the religious provision. The children knew who the chaplains were and when they were due to visit, and were fully aware of the religious opportunities available in the centre.

CHAPTER 5:

Addressing offending behaviour

5.1 An integral element of moving into the new centre was to embed programme delivery into the daily routine, with each child undertaking an hour of programme work every weekday. There were three core programmes: offending behaviour, substance misuse and lifestyle choices.

5.2 Extensive programme delivery was an ambitious undertaking because of the daily population fluctuations and the high numbers on remand – whose pending criminal charges could not be compromised by participating in offending programmes. Children on remand took part in the non offence-specific programmes, which addressed many of the social difficulties that contributed to their placement in custody.

5.3 The fluctuating population meant it was difficult to tailor specific programmes to the offences of children in the centre. Offence-specific programmes, such as for violent offenders or sexual perpetrators were therefore individually delivered by keyworkers or the psychologist, although group sessions could be delivered for more common offences such as car crime if sufficient numbers of children were consistently available.

5.4 Programme delivery was an optional role for care staff, in which approximately 50% were engaged. Some unqualified staff suggested they were uncomfortable when asked to deliver programmes, and not all found the support or training adequate for purpose. Management explained that staff were encouraged, rather than forced to run programmes. They recognised staff limitations, and explained that several had discovered hidden talents and gained personal fulfilment from delivering programmes.

5.5 Inspectors observed some high quality facilitation skills, and this was confirmed by comments from children. The drugs programme was mentioned as being particularly good. It extended to members of staff taking a convicted drugs offender – who was shortly due for release – from the centre to a local community group where he shared his experiences with children and leaders.

5.6 Children were receptive to the programmes, and they were delivered in an age-appropriate manner. The programmes manager had a good selection of resources which enabled

facilitators to deliver programmes in a creative and interesting way. She had also made creative use of external agencies such as the Health Promotion Agency and the Fire and Rescue Service. One child suggested they 'needed a break' from programmes and that they should run less frequently. However, as the programmes seek to address offending behaviour and its underlying causes it is important that they continue to be prioritised.

5.7 Several of the programmes were linked to awards, and ceremonies were held to recognise childrens' achievements. There were plans to have some programmes accredited, and there may be benefit in liaising with the Youth Justice Board for England and Wales in this matter.

5.8 There were some logistical problems with programme delivery: three programmes ran simultaneously over a 12-week period, based on the rationale that the majority of sentences in custody were for three months. Timetabling was complicated because the programmes and education timetables were not fully compatible. There were also occasional difficulties of staff being released to deliver programmes.

5.9 There was little evaluation of programme content, or of the impact on children. The JJC intends to evaluate its programme delivery during 2008. In light of the issues highlighted above **we recommend that the evaluation should deliver:**

- **more consistent timetabling arrangements;**
- **an appropriate training and development schedule to enable staff to deliver programmes more confidently;**
- **a prospectus of core programmes for all children; and**
- **methodology to measure the long term effectiveness of programmes.**

CHAPTER 6:

Education and vocational training

6.1 Children have always been required to attend education while in Woodlands, irrespective of their age. However it was a welcome development since the last inspection that misbehaviour in class no longer led to exclusion from school.

6.2 Despite some minor initial accommodation and resource problems, children and staff had settled well into the ELC. Children were benefiting from the new facility and extended vocational curriculum and accreditation pathways.

6.3 Records showed that the children came to the ELC with challenging histories of disrupted schooling as well as other complex needs. As a result, their starting attainment was below average compared to that typical for their age groups. Standards overall were below average but the majority of the children who attended for eight weeks or more achieved well during their time in the ELC. For example, 80% of the children, after an eight-week admission period, gained one level in number and literacy. On average, all children gained accreditation in four unit awards through Assessment and Qualifications Alliance (AQA) essential skills over this time period.

6.4 The children worked towards CCEA accreditation in essential skills; both these and the AQA awards had the advantage of providing a ladder of progression on which small steps could be acknowledged. The negative side was that they could overly dominate the teaching. In addition, a small number of the children had been and continue to be supported to achieve GCSE accreditation in one - four subject areas.

6.5 The teaching staff enjoyed good working relationships with the children, based on sensitive understanding of their needs and secure professional knowledge which underpinned the most successful lessons. In a cookery class, for example, the children's understanding of safety was enhanced by the emphasis on the correct use of implements and general safety around cooking and food preparation.

6.6 Despite the positive aspects evident in all classes observed, tasks in a small minority of lessons were not always well enough matched to the needs of the individual. Worksheets could be routine and completed with an undue focus on accreditation. As a consequence, expectations of what children could achieve tended to be

too low. It is important to achieve a balance which promotes achievement and accreditation and stretches also the children's understanding and thinking and improves their capacity to address their emotional ordeals.

We recommend

a. **The JJC should ensure opportunity for the staff to discuss regularly their classroom practices to enable a more balanced focus on developing children's learning and their levels of accreditation.**
and
b. **The ELC should develop further the coherence of its curriculum for example, using programmes of work as a context for the extension and development of literacy and providing a greater emphasis on the development or oral skills – helping children to listen to one another and to reason and discuss ideas.**

6.7 Assessment was a central element of the work of the ELC which provided an important baseline to programme planning. The initial assessments and analysis of children's progress before discharge held much potential to enable the ELC to analyse its data and record the value added by the ELC on children's learning, levels of motivation and social engagement, wellbeing and accreditation. Data to date suggested that, of the previous 60 children attending the ELC, some 90% expressed satisfaction with the work of the ELC. The range of information available to the ELC was not yet sufficiently used to identify and celebrate the positive impact of its work and inform staff professional development and discussion.

6.8 The current provision for mainstream school/community liaison and transition was supportive of the initial assessment and curriculum planning and the re-engagement of children following placement in the ELC. It was important that the provision should be subject to frequent review and monitoring to ensure that it was effective and robust in supporting children beyond the JJC over a period of time. To this end, a more strategic, collaborative working agreement across the JJC, community services and health and education authorities should be progressed to support children on exit. **We recommend strengthening of procedures to provide a more robust link between the ELC/JJC and community services, including links with the Education and Library Boards and Health Trusts.**

6.9 Leadership and management of the ELC were good. The supportive and determined leadership of the Deputy Director and the Head of School had ensured a positive direction for this new facility. By establishing a curriculum that addressed the broader needs of the children and promoted a supportive and non-judgmental ethos and structured environment, the education provision offered these children worthwhile opportunities to improve their educational, social and emotional skills. These factors underpinned the capacity of the provision to improve further.

6.10 Much had been achieved in the work of the ELC since the last inspection. Assessment informed better planning of individual programmes for children. Learning pathways, including accreditation routes, had been identified clearly for all children and there was evidence of the integration and application of literacy and numeracy providing greater cohesion across the curriculum. Stronger emphasis on practical and vocational skills had enhanced provision, and inspection findings indicated greater achievement by children across the essential skills and vocational areas. To improve further the progress made in the new facility, it would be important that opportunities for the staff to develop a self-evaluative approach to ensure a balance is maintained between challenging children to think and value their engagement with learning and gaining accreditation. At a strategic level, the need for increased and more robust collaborative working relationships within and beyond the ELC will be significant for further improvement. **We recommend**

a. **The JJC should establish a more formal approach to data collation and analysis to inform self-evaluation, and enable improvement, which can be celebrated within and beyond the centre.**
and
b. **The ELC staff should be enabled to access professional training (by provision of substitute cover) to develop their awareness of and knowledge of the wider educational system, and the implications of changes in the external education environment for the ELC.**

CHAPTER 7:

Healthcare and health promotion

7.1 Children received a healthcare examination at the point of admission or within 24 hours of arrival at the JJC. The examination focused both on physical and emotional health, to minimise the risk of suicide and self harm. Many children who were admitted to the JJC only had limited healthcare services prior to their admission, and their time in custody provided an opportunity for vital intervention and health promotion.

7.2 Good systems were in place in respect of sharing information about risks of self harm or suicide. Daily staff meetings included healthcare representation to ensure proper communication, and observations were recorded in keeping with relevant policies.

7.3 Following the initial assessment, health information was immediately shared with care staff and teachers, and healthcare contributions were incorporated in the child's care plan. However, Inspectors found that some important medical material was not always immediately apparent on files. **We recommend the layout of children's files should ensure that specific health care information is easily accessible to all relevant care staff involved with the child.**

7.4 The healthcare staff group comprised two full-time registered mental health nurses and a part-time registered general nurse. A further full-time nurse was due to commence work in February 2008. While nursing services were scheduled from 7.30am to 9pm each day, this was not possible due to the staffing shortfall. Only one member of nursing staff was on duty at a time which constrained the centre's ability to provide therapeutic services and health promotion to children. The staff shortage had also affected nursing staff members ability to fully implement clinical and social care governance procedures, and quality assurance processes had not yet been put in place. While nursing staff displayed a professional and dedicated approach to their work, their ability to develop further professionally was limited due to staffing and budget constraints. **We recommend the healthcare staffing complement be filled. Healthcare staff development and supervision arrangements should also be reviewed to ensure they are able to pursue relevant professional development through clinical supervision and development work.**

7.5 A General Practitioner visited the centre weekly to provide a surgery. He was satisfied with current arrangements including the environment and communication with the healthcare team. The General Practitioner aimed to see any child who requested to see him, plus new admissions and any children about whom staff were concerned. General Practitioners from the local surgery also provided out-of-hours cover and saw children at their surgery in an emergency.

7.6 Although a fully equipped dental examination room was located within the medical department, due to contractual difficulties, emergency dental services were provided at an external surgery. The provision of dental services at the centre had been reviewed and a dental nurse had been appointed as had a dentist from a local trust, for seven and a half hours per month. Other allied health professionals such as physiotherapists visited the centre when necessary.

7.7 A local Accident and Emergency department provided care where necessary. External visits by children to outpatient departments could create security challenges and staffing difficulties, so staff attempted to obtain domiciliary visits if possible.

7.8 An audit query had led to removal of the services of a complementary therapist following the move to the new Juvenile Justice Centre. This was a valuable therapeutic service for children (and staff) when previously available. Opportunities for such creative initiatives should continuously be explored if and when resources become available.

Child and Adolescent Mental Health Services

7.9 Many children in the JJC had poor mental health and other negative indicators. Of the 30 children in residence on 30 November 2007:

- 20 had a diagnosed mental health disorder;
- 17 had a history of self harm;
- 8 had at least one suicide attempt on record;
- 8 were on the child protection register; and
- 14 had a statement of educational needs.

7.10 The complex mental health needs of the children were met by a full-time psychologist, supported by a psychiatrist who visited on a bi-monthly sessional basis. The psychologist and psychiatrist identified increased levels of stress, unresolved trauma and problems associated with alcohol and drugs among the JJC population.

7.11 Healthcare staff identified a need to develop better links with Child and Adolescent Mental Health Service (CAMHS) teams within the community. Continuity of this service for relevant children was vital while they were in the JJC, and staff endeavoured to maintain links.

Health Promotion

7.12 Woodlands adopted a proactive approach to health promotion, and was non-smoking. Tobacco and other illicit substances were removed at

admission and policies and procedures were in place to facilitate regular searches of bedrooms. Healthcare staff advised that most children adapted quickly, and they provided assistance with smoking cessation if required.

7.13 It would be beneficial to engage healthcare staff in programme delivery once improved staffing arrangements are in place, since the programmes included components on sexual health and relationships, lifestyle, exercise and healthy eating.

7.14 Care staff made an important contribution to delivery of individual health education programmes in matters such as personal care, personal hygiene, physical activity and healthy eating. We commend the JJC proposal to access the skills of care staff who have therapeutic or counselling skills and qualifications to complement the skills of the healthcare staff.

First Aid

7.15 Staff throughout the centre (including ancillary, catering and education staff) had been provided with first aid training. A list of staff who were first aid trained was displayed at the main office in each house unit ensuring that adequately trained staff were on duty throughout the 24-hour period. First aid boxes were also in place.

Infection Control

7.16 An infection control policy was in place. Although healthcare staff advised that considerable investment had been made to introduce resources for prevention of infection control into house units, care staff displayed varying levels of understanding in relation to infection control practices. Not all were aware of the location of gloves or emergency packs, and some staff did not display an understanding of good infection control practices. **We recommend that management reinforce the need for good infection control procedures with relevant staff.**

Medicines storage and administration, and home remedies

7.17 Arrangements were in place with a local pharmacy for delivery of medications to the centre. Medications including controlled drugs were stored appropriately in a locked cabinet within the medical department's treatment room. Individual prescription records were in place for each child. A small supply of medications was given to the child at the point of discharge prior to them seeing their General Practitioner.

7.18 A *'Management of errors and incidents in the administration of medicines'* policy was in place. This approach was retrospective and should be amended to become more proactive in its focus. **We recommend that a policy for the safe administration of medications should be put in place to inform all relevant staff.**

7.19 Children who were brought to the treatment room in the medical department received their medicines directly from registered nurses. This

dealt with conditions such as administration of insulin for diabetics, and children were encouraged to continue to manage conditions within the constraints of the centre.

7.20 This system worked well when nursing staff were on duty. However, arrangements when nursing staff were not on duty needed to be urgently reviewed - nurses dispensed medication to a member of care staff in an envelope to administer at a later time. Routine secondary dispensing is not appropriate. Medicine administration records need to be completed at the time of administration, and care staff gave examples of medicines being improperly administered.
We recommend secondary dispensing should cease. The administration of medications to children when nursing staff are not on duty should be immediately reviewed to ensure that correct procedures are adhered to and the health and safety of the child is not compromised. Where there is no alternative, care staff administering medications to children should have training in relation to this matter.

7.21 Home remedies were retained within the medical department, accessible to duty team leaders when healthcare staff were not on duty. Arrangements for dispensing home remedies were under review and it was proposed to have a small supply located within each residential unit. This would mean children and staff no longer having to leave the house to access such medications.

Continuity of healthcare

7.22 While Woodlands's discharge planning systems aimed to ensure continuity of healthcare after release, staff identified a number of gaps. Many children were motivated to get help while in custody, but this was not sustained when they returned to the community, due to lack of response from external professionals and/or poor compliance by children in keeping community appointments. This was beyond the control of the JJC, but was nonetheless a matter of concern for them and for the wider childcare and youth justice systems.

CHAPTER 8:

Premises, security and safety

8.1 Woodlands JJC comprised a 7000m^2 facility that housed up to 48 young people within six eight-bed residential units integrated with a range of support facilities. These included:

- educational facilities;
- recreational and sports facilities including swimming pool, gym, outdoor astro-turf pitch;
- spacious outdoor leisure areas within courtyards;
- a medical centre, including dental suite;
- main kitchen;
- main laundry;
- visitors' accommodation; and
- court video link facilities.

8.2 It was clear that the safety and security of the young people had been paramount in the building design. Great care had been taken to create a secure environment without the use of high perimeter fencing and gates. The centre had been made secure by design using the buildings as the main perimeter.

8.3 The design had ensured that maintenance procedures were generally non-intrusive, and engineering services were accessed for maintenance purposes from outside the occupied areas. The design had also ensured that the accommodation minimised hazards in terms of ligature points and providing robust furniture and fittings. Furniture was extremely robust while remaining domestic in appearance. All glazing was toughened and resistant to damage by impact.

8.4 Control of sharp objects such as cutlery in the houses was managed by a sign out/in book in each house kitchen. Cutlery drawers were to be kept locked when not in use. The drawers checked at the time of inspection were found to be unlocked while not in use.

8.5 Control of sharp objects in the educational accommodation was found to vary between activity areas. Distribution and return of tools in the car maintenance class was achieved by the use of a 'shadow board' arrangement - this worked reasonably well, though in other areas, control of tools and utensils was found to be less controlled. **We recommend that additional control measures should be immediately implemented for distribution and return of sharp implements as follows:**

- **house kitchens and workshops in the education block: consider providing latching locks on all**

drawers/cupboards containing risk items; and

- **use inventories/sign out-in and/or 'shadow boards' for all education areas.**

8.6 The facility presented as spatially generous. Room sizes were adequate, corridors were wide and all areas appeared bright and well lit. All bedrooms were equipped with en-suite WC and showering facilities.

8.7 Perimeter security was achieved by the building design, while a range of integrated electronic systems, monitored by a permanently staffed central control hub, ensured a high level of internal security. CCTV cameras positioned throughout the centre gave hub staff a strategic view of all necessary locations. The cameras were activated by movement and recordings were stored for approximately one month.

8.8 Hub staff appeared competent and well-practiced in operating the systems under their control. They co-ordinated the radio pagers, which were carried by all staff and visitors. These recorded details of the holder's movements throughout the facility, as well as receiving and transmitting security and fire-related information and alarms.

8.9 The hub also acted as the main reception point for visitors to the centre, and it controlled vehicular access. Opening and closing of all doors in secure areas was also undertaken and monitored by the hub.

8.10 All doors were fitted with double magnetic locks with a key operated deadlock as a back up. Staff carried fobs which released the magnetic locks and a key which opened the deadlocks.

General Maintenance

8.11 A comprehensive range of maintenance procedures had been put in place at Woodlands. This included planned preventative maintenance as well as fault reporting and repair, by a range of specialist building and engineering services maintenance contractors who were supplemented by several in-house personnel.

8.12 The support services manager had developed these procedures in liaison with the main specialist contractor with whom a positive working relationship was apparent. The paper-based fault reporting system was in the process of being replaced by an electronic version. This was at pilot stage and should prove beneficial when fully operational.

8.13 Regular monitoring of the maintenance procedures was ongoing through monthly review meetings. This highlighted a range of issues such as:

- problems with the foul drainage system – work was in progress to remedy this issue;
- water temperatures outside prescribed limits, though no remedial action or comments were recorded;
- problems with the radio pager system were ongoing - these were also the subject of continuing investigation and corrective action;
- the dental suite was to be used only periodically – perhaps monthly.

Regular maintenance of the benchtop sterilizer and flushing of the water systems in this area is recommended;

- several external surfaces were found to be slippery, which could be hazardous if staff were required to run when responding to emergency situations; and
- several maintenance checks found conditions that were outside prescribed limits. The support services manager has undertaken to address this at the regular maintenance review meetings.

We recommend:

a. Annual validation of ventilation rates against design values should be carried out particularly to living accommodation/bedrooms;

b. A maintenance regime for the dental area, including servicing of the benchtop sterilizer and flushing of water system periodically when not in use and prior to use should be put in place immediately. Reference should be made to the MDRA guidance on the *purchase, operation and maintenance of benchtop steam sterilizers* and to the guidance contained in Department of Health's Health Technical Memoranda (HTM) 04-01 – *Water Systems: control of legionella, hygiene, safe hot water and drinking water systems*;

c. The emergency standby generator should be run on load for one hour on a monthly basis. Reference should be made to the requirements of BS5839-1:2002 section 44.3 a; and

d. Regular cleaning of external pathways of algae and moss to remove or reduce slipping hazards should be carried out as found necessary, beginning as soon as possible. The suitability of surfaces should be considered and modified accordingly as necessary.

Fire Safety

8.14 A comprehensive range of fire policies and a fire management plan had been developed for Woodlands. A fire risk assessment had been carried out and a corrective action plan was included in the assessment report.

8.15 The centre's fire evacuation plan adopted a balanced approach to fire evacuation and the young people's security, and was developed in liaison with the local council's building control office. This involved the use of a time delay on opening of electrically locked doors on fire escape routes when the fire alarm was activated. This was tested and practiced regularly. The system incorporated the facility for staff to override the delay manually.

8.16 All room doors in houses were of one hour fire resisting construction. The locking of all doors throughout the centre made the wedging open of fire doors practically impossible. The fire risk assessment did not make reference to these arrangements which were considered to be an integral part of the fire management policy.

8.17 Staff fire safety training was provided annually. The fire equipment was subject to regular maintenance in compliance with the recommendations of the relevant British standards and

codes of practice. It was good to note that the blanket 'no smoking' policy appeared to be rigidly enforced.

8.18 The integrity of the central server room located in the roof plant area was considered to be of the utmost importance. The fire resisting door to the room was found to be sticking on the floor and some combustible waste in the form of cardboard boxes was found in the room at the time of inspection. **We recommend:**

a. The baseline fire risk assessment should be reviewed periodically – annually is recommended. The review should consider and reassess the effectiveness of the evacuation procedures against the security arrangements in the centre;

b. The corrective action plan in the fire risk assessment should be addressed and signed off without delay;

c. Additional fire safety training, particularly relating to the evacuation procedure, should be afforded to all staff on a six-monthly basis; and

d. Attendance by staff at fire safety training and fire evacuation practices should be recorded routinely so that individual non-attendance is flagged.

Safe Hot Water and Legionellae

8.19 A legionellae risk assessment had been carried out on the domestic water system making reference to the Approved Code of Practice and Guidance L8 *The control of legionellae bacteria in water systems*, issued by the Health and Safety Commission. Adequate control measures appeared to be in place to deal with the risk of legionellae at the facility.

8.20 The hot water outlets were controlled to safe temperatures by the use of thermostatic mixing valves. These were subject to regular maintenance and temperature checks. Heating was provided by ceiling panel emitters thus eliminating hot surface areas.

Ventilation Systems

8.21 The building was equipped with mechanical ventilation systems which were maintained regularly. The houses, particularly the children's bedrooms, did not have openings to the windows and the doors were locked closed by relatively robust doors. These areas therefore were reliant on the mechanical ventilation systems for their fresh air supply and extraction. While regular checks to the ventilation plant were ongoing, periodic checks to the air supply and extract volumes were not included.

Documentation

8.22 Commissioning documentation for the electrical and mechanical building engineering services and equipment was available at the facility.

8.23 Records to support the ongoing maintenance procedures were also available at the facility. These were updated regularly and reviewed at monthly maintenance monitoring meetings.

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