Report on an unannounced short follow-up inspection of

# Hydebank Wood Young Offenders Centre

**21 - 25 March 2011**

by the Chief Inspector of Criminal Justice in Northern Ireland, Her Majesty's Chief Inspector of Prisons and the Regulation and Quality Improvement Authority

October 2011

HM Inspectorate of Prisons

The Regulation and Quality Improvement Authority

Criminal Justice Inspection Northern Ireland
*a better justice system for all*

Report on an unannounced short follow-up inspection of

# Hydebank Wood Young Offenders Centre

**21 - 25 March 2011**
by the Chief Inspector of Criminal Justice in Northern Ireland, Her Majesty's Chief Inspector of Prisons and the Regulation and Quality Improvement Authority.

October 2011

Laid before the Northern Ireland Assembly under Section 49(2) of the Justice (Northern Ireland) Act 2002 (as amended by paragraph 7(2) of Schedule 13 to The Northern Ireland Act 1998 (Devolution of Policing and Justice Functions) Order 2010) by the Department of Justice.

HM Inspectorate of Prisons

The Regulation and Quality Improvement Authority

Criminal Justice Inspection Northern Ireland
*a better justice system for all*

# Contents

# List of abbreviations

| | |
|---|---|
| **ACPC** | Area Child Protection Committee |
| **CAMHS** | Child and Adolescent Mental Health Services |
| **CJI** | Criminal Justice Inspection |
| **DoJ** | Department of Justice |
| **ETI** | Education and Training Inspectorate |
| **HMIP** | Her Majesty's Inspectorate of Prisons in England and Wales |
| **JJC** | Woodlands Juvenile Justice Centre |
| **NIACRO** | Northern Ireland Association for the Care and Resettlement of Offenders |
| **NIPS** | Northern Ireland Prison Service |
| **OMU** | Offender Management Unit |
| **POCVA** | Protection of Children and Vulnerable Adults |
| **PREPS** | Progressive Regime and Earned Privileges Scheme |
| **PRISM** | Prison Record and Inmate System Management |
| **RCPC** | Regional Child Protection Committee |
| **RMN** | Registered Mental Nurse |
| **RQIA** | Regulation and Quality Improvement Authority |
| **SEHSCT** | South Eastern Health and Social Care Trust |
| **SPAR** | Supporting Prisoners at Risk Procedure |
| **SPC** | Suicide Prevention Co-ordinator |
| **SSU** | Special Supervision Unit |
| **UKBA** | United Kingdom Border Agency |
| **YJA** | Youth Justice Agency |
| **YOC** | Hydebank Wood Young Offenders Centre |

# Chief Inspectors' Foreword

This unannounced short follow-up inspection of Hydebank Wood Young Offenders Centre (YOC) was undertaken by Criminal Justice Inspection Northern Ireland (CJI), Her Majesty's Inspectorate of Prisons for England and Wales (HMIP), and was supported by staff from the Education and Training Inspectorate for Northern Ireland and the Regulation and Quality Improvement Authority (RQIA). The inspection focused on the progress the YOC had made in implementing the recommendations contained in our last full inspection in 2007.

In 2007 we found that the YOC was not performing effectively against any of our four tests of a healthy establishment: safety, respect, purposeful activity and resettlement. This inspection found that reasonable progress was being made in each area, apart from purposeful activity. However, the need for further progress was tragically underlined when one young prisoner was found dead shortly after the inspection.

Care of children at the YOC had improved, with a better environment and more staff engagement. However the distinct needs of this age group were far from adequately met and it remained a fundamentally unsuitable place to hold children under the age of 18. It did not have the focus necessary to deal with the most troubled and troublesome children. Excellent new safeguarding children procedures had been introduced but were not effectively implemented. Discipline processes were not age-appropriate and the quality of education and training was far short of what was required. It is anomalous that while there is surplus bed space in Woodlands Juvenile Justice Centre (the JJC), many 17-year-old boys are still held in the YOC. The Northern Ireland Prison Service (NIPS) was focused on managing an adult population with a custodial rather than parental model, and it has faced significant criticisms of its provision for children. This situation begs early implementation of the obvious remedy – transfer of 17-year-old boys from the YOC to the JJC – on the grounds of both good practice and value for money.

Reception, first night and induction arrangements at the YOC had improved since 2007. Most young prisoners said they felt safe but the anti-bullying and violence reduction strategies needed to be further developed. The NIPS suicide and self-harm prevention policy did not sufficiently reflect the needs of children and young adults. At the time of the inspection, levels of self-harm were not high and overall support for prisoners at risk had improved with less reliance on physical measures such as the use of observation cells and protective clothing. Managers and staff needed to learn more systematically from incidents and complete care plans consistently. Security measures were not sufficiently intelligence-led and punishments for disciplinary offences were generally too severe.

The interactions we saw between staff and prisoners were much better than previously and the chaplains played a valuable role in the life of the establishment. The general environment was good. However there was still no guidance from the NIPS on how the YOC should tackle diversity issues and work in this area was under-developed.

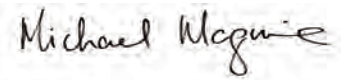
Despite the transfer of responsibility to the South Eastern Health and Social Care Trust (SEHSCT), health services were under-resourced, poorly managed and there was sometimes unsatisfactory attention to the needs of patients. The needs of young men and children with mental health problems were a particular concern. Mixing children, young adult men and women in the health centre made it

difficult to provide an appropriate regime. First night treatment and symptomatic relief for substance-dependent young men was not sufficiently robust and we were particularly concerned that those undertaking alcohol detoxification were put at risk because they were not always admitted to the health centre. Addiction services were under-resourced.

The lack of opportunity for young adults and children to spend time in the open air and exercise remained a major concern and association was too often cancelled at short notice. It was also still very poor that, for this age group, there was no coherent learning and skills strategy that differentiated between the needs of the various prisoner groups held on the Hydebank Wood site, or matched them to the needs of employers and provision in the community. Only 27% of previous education recommendations had been implemented in comparison to over 50% of all other recommendations. While access to the library had improved, physical education facilities were good, and we observed examples of good teaching, some was clearly inadequate and there had been no achievement of an ICT qualification for years. There was insufficient work to keep young people occupied. We suggest it is now necessary to establish effective collaborative partnerships with external education and training providers – such as further education and/or work-based learning suppliers – as a matter of urgency.

Resettlement provision had improved. There was a detailed resettlement strategy, though insufficient focus on the needs of life-sentence prisoners. The Offender Management Unit (OMU) was well-established but its personnel were not sufficiently linked into their colleagues in the residential areas. There was generally good support to help young prisoners with practical needs when they left the YOC. The Northern Ireland Association for the Care and Resettlement of Offenders (NIACRO) visitors centre offered good facilities and support for prisoners to maintain or rebuild relationships with their family and friends.

In 2007 Inspectors described 'pockets of improvement' at Hydebank Wood YOC. During this inspection we found more substantial improvement. However, there are three significant themes where major progress is essential. First, where better procedures now exist, such as those involving the care of vulnerable young people, they need to be implemented more consistently, including the delivery of appropriate health services. Second, the regime needs to be more closely tailored to the needs and ages of the YOC prisoners, and in particular the inadequacies of the learning and skills provision need to be addressed as a priority. Third, and most importantly, as we have said before, Hydebank Wood YOC is quite simply an unsuitable place to hold children under the age of 18. The NIPS must collaborate with the Youth Justice Agency (YJA) and Department of Justice (DoJ) to urgently relocate all male children from Hydebank Wood YOC to Woodlands Juvenile Justice Centre (the JJC).



**Dr Michael Maguire**
Chief Inspector
of Criminal Justice in Northern Ireland
October 2011

**Nick Hardwick**
Her Majesty's Chief Inspector of Prisons
in England and Wales
October 2011

Criminal Justice Inspection
Northern Ireland
*a better justice system for all*

# Fact page

### Task of the establishment
To accommodate male young offenders between the ages of 18 and 21 years and male juvenile offenders (children under the age of 18).

### Number held
201.

### Cost per place per annum
The cost per prisoner place for the Northern Ireland Prison Service (NIPS) is calculated for the service as a whole. The cost per prisoner place for 2007-08 was £81,000. The forecast cost for 2010-11 is £74,746 against a target of £76,500. The forecast for Hydebank Wood YOC alone is £66,660.

### Certified normal accommodation
261.

### Operational capacity
201.

### Last full inspection
5 - 9 November 2007 (announced).

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

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

- **Beech House:** contains young male adults and can accommodate up to 90 in single and double occupancy cells. The induction landing is on the first floor (Beech 1) and the

assessment unit is on Beech 2. The ground floor has recently been refurbished to provide classrooms.

- **Cedar House:** has five landings for enhanced prisoners and Cedar 5 is seen as the ultimate goal of all enhanced prisoners. Those held there can move unescorted through the centre. They work in the outside grounds and can cook their own meals.

- **Elm House:** contains young male adults on all regime levels and can accommodate up to 92 in single and double occupancy cells. This unit is awaiting refurbishment when funds allow.

- **Willow House:** contains young adults and juveniles and can accommodate up to 69 in single and double occupancy cells. Willow 1/2 functions as the juvenile unit and can accommodate up to 35 juveniles, all in single occupancy cells. Willow 3 accommodates young adults on basic, standard and enhanced regime levels. The special supervision unit is on the ground floor with accommodation for eight prisoners. Juveniles complete awards in their own cell in Willow.

### Escort contractor
The Northern Ireland Prison Service: Prison escort and court custody service.

### Health service commissioner and provider
Health services are commissioned by the Health and Social Care Board and were provided by South Eastern Health and Social Care Trust.

### Learning and skills providers
The Northern Ireland Prison Service.

Section 1

# Inspection Report

CHAPTER 1:

# Healthy prison assessment

## Introduction

1.1 The purpose of this inspection was to follow up the recommendations made in our last full inspection of 2007 and the progress achieved against the recommendations. All full inspection reports include a summary of outcomes for prisoners against the model of a healthy prison. The four criteria of a healthy prison are:

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

1.2 Follow-up inspections are proportionate to risk. Short follow-up inspections are conducted where the previous full inspection and our intelligence systems suggest that there are comparatively fewer concerns. Sufficient Inspector time is allocated to enable inspection of progress.

1.3 The assessments of outcomes for prisoners and therefore of the establishment's overall performance against these tests, made in 2007, are detailed below. In some cases, this performance was affected by matters outside the establishment's direct control, which need to be addressed by the Northern Ireland Prison Service (NIPS). In this inspection we have commented where we have found significant improvements, and where we believe little or no progress has been made and work remains to be done.

## Safety

1.4 In 2007, Hydebank Wood Young Offenders Centre (the YOC) was not performing sufficiently well against this healthy prison test. Out of 78 recommendations in this area, 23 had been achieved, 14 partially achieved and 41 not achieved. We have made three further recommendations.

1.5 Children under the age of 18 continued to travel in vans with other prisoners. Young adults and children were still handcuffed in vans, which contributed to them feeling unsafe. Some of the escort vans we examined were dirty.

1.6 The reception area had been fully refurbished and refitted and now provided a bright and appropriate environment for young people arriving in custody. Some young men and children said they found the experience intimidating but we saw reception staff helping to put new arrivals at ease. However, it was inappropriate that children were still routinely strip searched in reception without a risk assessment.

1.7 All new arrivals were now given a meal and the opportunity to make a telephone call. First night procedures had improved, with better interviews to assess needs and vulnerabilities. A limited peer support scheme had been introduced but there was none for juveniles. The quality of induction was generally satisfactory but the relatively

small numbers meant some could wait a while to attend formal sessions.

1.8 An outdated and ineffective 2005 anti-bullying and violence reduction strategy was still used. As previously, there were relatively few investigations into allegations of bullying, which were often not pursued when allegations were withdrawn. However, the investigations we looked at were thorough. There were few effective interventions to support victims and challenge bullies to change their behaviour and in most cases either the victim or perpetrator was moved. No staff had been trained in anti-bullying arrangements. Although the YOC appeared generally safe, some prisoners who were vulnerable because of the nature of their offences experienced victimisation. Most prisoners in groups said they felt safe and a relatively recent survey undertaken by Opportunity Youth supported this, with 77% of young adults saying they had never felt unsafe in the centre.

1.9 The NIPS suicide and self-harm prevention policy did not fully reflect and differentiate the distinct and specific needs of children and young adults at the YOC. Levels of self-harm were not high and some useful investigations into serious incidents had been carried out but learning points did not appear to be identified to inform local practice. Although there was still a need to develop a more therapeutic approach to support people at risk of self-harm, records indicated that there was less reliance than previously on physical measures such as use of observation cells and protective clothing. Supporting prisoners at risk (SPAR) procedures had improved with well-attended multi-disciplinary reviews, although some care plans were not completed. Better entries in monitoring documents demonstrated some good engagement with prisoners at risk. SPAR procedures were supplemented by useful fortnightly safer custody meetings that discussed individual cases and helped ensure appropriate support was provided. Although there was no Listener scheme, Insiders provided some peer support on request and there was appropriate access to Samaritans telephones and other help lines.

1.10 There had been improvements in the care of children in the YOC, which included some changes to the environment, more engagement with staff and better access to activities, although children still spent too long locked up. The introduction of initial case conferences for all committals was a welcome development but too few children had been transferred to the Juvenile Justice Centre (JJC) as a result. The YOC did not have the resources and was not an appropriate place to deal with the most troubled and troublesome children in the criminal justice system. Those resources had been invested in the JJC.

1.11 There was an excellent new safeguarding children framework and guidance document but neither the prison nor the health and social care trusts managed referrals correctly. The YOC did not always make referrals when necessary and, when it did, it was rare for the Gateway team even to acknowledge them. These cases were not pursued and there was an apparent tacit acceptance of the lack of engagement at all levels. Although the framework set out a clear model of governance, this was not being followed. Staff in key areas had been appropriately prioritised for child protection training but there remained some significant gaps, including duty governors and almost two-thirds of officers.

1.12 Communication of general security information had improved with monthly security bulletins but the security meeting still had restricted attendance. More security information reports than previously were being submitted but many staff were still reluctant to commit things to paper. There were still too many cell searches and insufficient analysis of finds to evaluate their effectiveness. Some changes had been made in main moves to activities but there was still much reliance on escorted movements

around the site. The routine practice of strip-searching all prisoners coming from visits had only just stopped and there were still too many.

1.13 There continued to be excessive use of cellular confinement as a punishment for young men and children found guilty at adjudications and punishments were generally severe. The level of force used was not high and there were improved governance arrangements. The segregation unit was often near to capacity and used predominantly for prisoners serving cellular confinement for whom the regime was basic but adequate.

1.14 First night treatment and symptomatic relief for substance-dependent young men and children were available but arrangements for those who were not on an established programme in the community were not sufficiently robust. There were recent policies for managing withdrawal from alcohol and benzodiazepines but it was not clear that these were fully embedded and followed. We were concerned, particularly given the circumstances of a recent death in the YOC, that protocols for those undertaking a clinical alcohol detoxification did not require admission to the health care centre. Addictions services were under-resourced with only one session a week. All five patients on the case load were from Ash House and the lack of referrals from the YOC needed examination. Mandatory drug testing had been introduced but the results were not monitored to give an indication of prevalence or the efficacy of supply reduction arrangements.

1.15 Hydebank Wood YOC was still not an appropriate place for children and there remained a need to develop better support for vulnerable young men and children at risk from others or themselves. However, on the basis of this short follow-up inspection, we considered that some reasonable progress had been made in the area of safety.

## Respect

1.16 In 2007, Hydebank Wood YOC was not performing sufficiently well against this healthy prison test. Out of 65 recommendations in this area, 23 had been achieved, 11 partially achieved, 30 not achieved and one was no longer relevant. We have made nine further recommendations.

1.17 Although some prisoners said there were some officers who were difficult to talk to, interactions we saw between staff and prisoners were mostly positive and much better than previously. More officers than previously addressed prisoners by their first names. Officers had a negative and punitive approach to the progressive regimes and earned privileges (PREP) scheme and too many young men and children on basic remained on that level too long. There was no personal officer scheme. Wing file entries said very little and most comments were negative.

1.18 The general environment of the YOC was good. The grounds were well kept and the exterior of buildings brightened up by ceramic work created by prisoners. Some excellent artwork was displayed in corridors. Cells were of a reasonable standard. Shower areas were mostly good but those in Elm and Willow Houses were in poor condition. Landing consultation meetings were held but not all actions were properly followed up.

1.19 There was still no clear guidance from the NIPS on diversity. There had been little training in religious and cultural differences and 70% of staff, including the diversity manager and diversity officer, had not received any diversity training. Equality was not actively promoted and some staff had little enthusiasm for or understanding of equality issues. The diversity committee did not always meet as scheduled and attendance was generally poor. There was insufficient routine analysis and monitoring of data to help ensure equality of treatment by religion, race, nationality or other diversity areas.

Foreign national prisoners mostly received good individual support.

1.20 The spiritual and pastoral needs of prisoners continued to be well catered for and chaplains played an active role in the life of the prison, including in safer custody and diversity areas.

1.21 Many prisoners complained about the quality of food, which they said was bland and stodgy and lacked variety, but there was only limited consultation about food. It was good that most prisoners were able to eat their meals together rather than in their cells and there were welcomed opportunities for those on the enhanced landing of Cedar House to cook for themselves.

1.22 Replies to complaints were often impersonal and did not always deal fully with the issues raised. The process allowed them to be closed after discussion but some were closed by senior officers when the prisoner did not believe the matter had been resolved. There was no analysis of complaints or formal quality assurance to examine the standard of replies.

1.23 Although it was nearly three years since the transfer of responsibility for the delivery of health services to the SEHSCT, there was little evidence that services had improved and progressed. The health needs assessment was insufficiently thorough. Prisoners had good access to a GP but primary care services were not well structured or managed to ensure resources were well used and we found and heard some examples of unsatisfactory attention to the needs of patients. Some improvements were needed to medicines management. Mixing young men, women and children in the health care centre made it difficult to provide a satisfactory in-patient regime. Mental health services were under-resourced, primary mental health nurses did not have protected time for their role, there was no group work and very little consultant time. The absence of a regular child and adolescent mental health service in a prison holding children was a concern. There was a long waiting list for mental health services even though not all prisoners who needed help were referred.

1.24 We had some serious concerns about the delivery of health services and noted that the improvement in relationships was not consistent across all houses. However, on the basis of this short follow-up inspection, we considered that some reasonable progress had been made in the area of respect.

## Purposeful activity

1.25 In 2007, Hydebank Wood YOC was performing poorly against this healthy prison test. Out of nine recommendations in this area, none had been achieved, three partially achieved and six not achieved. We have made no further recommendations.

1.26 Young men and children still did not get appropriate opportunities to spend time in the open air each day and there was no regular scheduled period of exercise. Association was too often cancelled at short notice. In the 2010 Opportunity Youth survey, only 30% of young adults said they were able to get association time most days of the week and none said they had daily exercise. At a check during the inspection, we found relatively few prisoners locked in their cells during the day, although in groups the amount of time spent locked in cells was identified by prisoners as one of the most negative aspects of life at Hydebank Wood YOC. Prisoners were regularly unlocked late and locked up early.

1.27 There was no coherent learning and skills strategy that provided any differentiation according to sentence length or the specific needs of different groups such as children. The curriculum was outdated and did not match the needs of the prisoners, employers or the local labour market. Given the inadequate progress since the last inspection, there was a need to establish effective collaboration partnerships with external

education and training providers, such as further education and/or work-based learning suppliers, as a matter of urgency. There was insufficient identification of learning needs to address barriers to learning and quality assurance and review arrangements were weak. Some serious problems of teaching and under-achievement had not been identified and many young adults and children with low levels of literacy and numeracy did not have their needs met. While some of the teaching observed was good, standards in ICT and some of the essential skills were inadequate. In ICT, there had been no achievement of a qualification for some years. Links between learning and skills and resettlement had improved but there was too much emphasis on just filling places rather than ensuring individuals were appropriately placed. Despite this approach, the education and training capacity was substantially under-used.

1.28 Access to the library had significantly improved and a pro-active librarian had made the library a vibrant centre in education, with a good range of activities to promote literacy including a book club. There was an increased range of non-fiction texts and a good stock of DVDs and CDs to borrow but no regular supply of up-to-date newspapers and magazines.

1.29 There was insufficient purposeful work to occupy young people and many of them were involved just in domestic tasks on the landing. There was too little skills training to help employability. It still took too long for many young men and children to be assessed and allocated to work, during which time they were mostly locked in their cells.

1.30 Physical education facilities remained good and had improved with the addition of an astroturf pitch but this and the other outdoor pitches were under-used. Security restrictions meant only a limited amount of outdoor and adventurous activities had been run.

1.31 The activities provided still failed to match the needs of young people at Hydebank Wood YOC and on the basis of this short follow-up inspection, we considered that very little progress had been made in this area.

## Resettlement

1.32 In 2007, we considered that the YOC was not performing sufficiently well against this healthy prison test. Out of 19 recommendation in this area, five had been achieved, five partially achieved and nine not achieved. We have made no further recommendations.

1.33 There was a detailed local resettlement strategy but it did not contain anything specific about life-sentenced prisoners. The strategy set out how services were to be delivered and needs were articulated within the context of background research, legislation, roles and responsibilities. The strategy referred to performance measurement but it contained no measurable targets or arrangements for review, which awaited the overall NIPS resettlement strategy.

1.34 The Offender Management Unit (OMU) was well established and increased resources received to implement the new Criminal Justice Order sentences had benefited resettlement work generally. All prisoners including those on remand were involved in the development of their resettlement plans and had their needs assessed. However, there was a disjunction between the work of the OMU and residential areas and more effective links needed to be forged through better communication. Those covered by Criminal Justice Orders received good attention. There was still a need to improve local strategic management of resettlement and ensure that resettlement plans were more meaningful and actively informed what prisoners did. There had been little change in the management arrangements for life-sentenced prisoners and those potentially facing life sentences were not identified and supported.

1.35 Sentence managers interviewed and identified resettlement needs for all new arrivals and made referrals to appropriate services as necessary. A good range of services was provided to help with accommodation, debt and other issues that would impact on effective resettlement. There were no scheduled pre-discharge health clinics but community GPs were informed when prisoners on medication were released and those identified as having mental health problems were referred to the SEHSCT prison health discharge liaison team or their GP.

1.36 The visitors' centre continued to offer good facilities. NIACRO staff identified and talked to all first-time visitors and offered a wide range of practical support. Visits could be booked in person and on the internet but some visitors said they found it difficult to book by telephone. Family support services continued to be very good with two-hour visits in the family room and pro-active family liaison officers who saw all new prisoners and visitors.

1.37 There was no up-to-date and comprehensive drug and alcohol strategy based on an assessment of the needs of young people. However, a good range of services was provided including solution-focused therapies and individual counselling. Pre-release work was also provided and there were some effective links to community services to enable treatment to continue after release.

1.38 On the basis of this short follow-up inspection, we considered that some reasonable progress had been made in the area of resettlement.

CHAPTER 2:

# Progress since the last report

*The paragraph reference number at the end of each recommendation below refers to its location in the previous inspection report from 2007.*

## Main recommendations
(from the previous report)

2.1 **The Northern Ireland Prison Service should either remove children under the age of 18 from Hydebank Wood YOC or provide appropriately resourced, dedicated accommodation with a regime capable of meeting the needs of this population. (HP50)**
**Not achieved.** Although it had been agreed that young women under the age of 18 would be sent to the JJC rather than Hydebank Wood, male juveniles continued to be held on two landings on Willow House and the operational capacity to hold children had increased from 19 to 28. On the first day of the inspection, 16 children were held on Willow House and 11 of these were on remand. In the previous six months, there had been 92 committals. Care of children in Hydebank Wood YOC had improved overall. The accommodation had been refurbished and staff demonstrated an awareness that they were dealing with children and were more confident in and willing to engage with them. Despite the improvements, we remained concerned that the complex needs of children were not being met in a number of areas.

They were as follows:

- while most of the children we spoke to said they felt safe and 90% of children in the recent survey said they had never felt unsafe, staff said keeping juveniles safe from each other within the constraints of the two small landings on Willow House was a constant challenge. Officers often resorted to locking children up at different times just to keep them apart;

- evening association was unpredictable and depended on staff numbers. Staff and children rarely knew until late in the day whether evening association would take place. There was no scheduled time outside and some children said they had got fresh air only when they went outside to empty the bins;

- while access to education and training had improved, the quality still fell far short of what was required. Children had better access to activities as, subject to risk assessment, they could now mix with young adults in certain settings. However, the risk assessments we looked at were superficial and relied mainly on obtaining parental consent to mix with young adult men rather than properly assessing the risk;

- standard disciplinary procedures were contrary to good childcare and a disproportionate response to adolescent behaviour. One child had been brought before an adjudicator for refusing to open his curtains. Punishments were also

extremely harsh; one child lost all association in one month having already lost over half his association entitlement in all of the previous three months. Children remained too long on the basic level of the progressive regimes and earned privileges (PREP) scheme. Reviews and case conferences for the most problematic children did not take place quickly or often enough.

- Hydebank Wood YOC, the JJC, the Probation Board for Northern Ireland (PBNI) and the Northern Ireland Courts and Tribunals Service (NICTS) had agreed to hold a case conference on all children committed to Hydebank Wood YOC within 14 days of arrival. The main objective was to establish an individual management plan to address risk, vulnerability, security and specific needs and to recommend whether the specific needs could be better addressed at the JJC. Case conferences were attended by representatives of different departments and, in most cases, by the child concerned. Parents and a range of external agencies were invited and attendance by professionals was very good. Minutes indicated good discussion of the child's needs but most meetings recommended that the child should stay at Hydebank Wood, a conclusion apparently based on the wishes of the child or the parents. There had been nine applications for transfer to the JJC in the previous year and all had been granted but this was too few given that Hydebank Wood YOC clearly did not, and was never likely to, have the resources to meet the children's needs.
  **We repeat the recommendation.**

2.2 **The Northern Ireland Prison Service should issue clear guidance on the implementation of a diversity strategy indicating areas to be prioritised and provide relevant staff training including in religious and cultural differences. (HP51)**
**Not achieved.** Diversity was still not seen as a priority or well promoted and the NIPS had not issued any guidance on the implementation of a diversity strategy. Only 30% of staff in the prison had received training in diversity and those we spoke to did not feel it had been relevant to the Northern Ireland setting.
**We repeat the recommendation.**

2.3 **The reception area should be redesigned and refurbished to provide an appropriate environment to meet the needs of children and young people arriving in custody. (HP45)**
**Achieved.** A re-designed and refurbished reception for children and young adults had opened about six months before the inspection and was spacious, clean, light and welcoming. Children and young adults had to mix in reception but every effort was made to keep them apart and they were always held in separate waiting rooms.

2.4 **First night procedures should be agreed so that all new arrivals receive consistent and supportive care on arrival, including private interviews to assess immediate needs, access to peer support and appropriate supervision. (HP46)**
**Partially achieved.** First night procedures were outlined in the April 2010 'induction policy document' and were well known to designated staff on the committal wing of Beech House where young adults spent their first night. Two officers were always allocated to the committal unit so that one could focus on interviewing each new arrival in private and completing the relevant sections of the committal and first night information booklet. This was a reasonable assessment tool but did not include a section where the officer could list specific action points arising from the assessment. The unit was relaxed and informal and young adults said they had been well treated and, while anxious, had been helped to be put at ease. In a recent survey conducted by Opportunity Youth, 75% of respondents said they had felt safe on their

first night. Limited peer support was provided by selected enhanced prisoners but they were not always available when requested and could not be called for late arrivals. Some of the orderlies permanently on the wing informally made new arrivals welcome.

2.5 Children under the age of 18 spent their first night on the juvenile wing on Willow House. The same first night procedures applied and initial vulnerability interviews were conducted using the same tools as for young adults. However, staff said sometimes only one member of staff was on duty and they were therefore unable to give the young person their full attention. The relevant sections of the committal and first night information booklet were completed but the booklet was not focused on the needs of children, which limited the effectiveness of the interview and assessment. No peer support was offered to children and young people under the age of 18.

**Further recommendation**

2.6 Appropriate and distinct first night procedures for children should be introduced, including specific age-appropriate questions on the immediate issues facing children and clear action points arising from assessments.

2.7 **A personal officer scheme should be established to support young people at Hydebank Wood YOC, liaise with families and encourage effective resettlement. (HP47)**
**Not achieved.** A residential liaison officer scheme had been piloted but withdrawn. Residential managers said they were confident that all residential staff knew the young people on their wings and this appeared to be the case. Residential staff took incoming calls from the families of the young people but saw the task of actually initiating contact as the responsibility of the OMU. Wing files indicated very little contact with offender managers about resettlement issues and reintegration was not co-ordinated between residential staff and the OMU.
**We repeat the recommendation.**

2.8 **An effective anti-bullying and violence reduction strategy should be developed to ensure that all alleged incidents of bullying are investigated and vulnerable young people protected. (HP48)**
**Not achieved.** The outdated and ineffective 2005 anti-bullying and violence reduction strategy was still being used, although there were plans to roll out the challenging anti-social behaviour strategy that was being piloted in Ash House. Investigations were often not pursued if victims refused to make statements but others we looked at were thorough. No-one was being monitored under the anti-bullying strategy during the inspection. The centre operated an integrated regime and it was not clear that sex offenders and other vulnerable prisoners were well protected.
**We repeat the recommendation.**

2.9 **The suicide and self-harm prevention policy should be revised to reflect the specific needs of children and young adults and to develop a more therapeutic response to support young people at risk at Hydebank Wood YOC. (HP49)**
**Not achieved.** The NIPS suicide and self-harm policy had been revised but did not reflect and differentiate the specific needs of children and young adults, with only one paragraph on self-harm and vulnerability among young offenders. Unlike for women in Ash House, the distinct needs of children and young adults were not reflected in other documents. The safeguarding children framework (March 2010) made a brief reference to self-harm as a potential indicator of abuse.
**We repeat the recommendation.**

2.10 **The transfer of responsibility for health services should be completed expeditiously so that health services can be planned, provided and quality assured through integrated working. (HP52)**
**Partially achieved.** Responsibility for health services had finally been transferred in April 2008 but the services provided were not planned or quality assured through integrated working. A separate governance structure for the management of health care in the NIPS had been developed. Since the transfer of health care services, significant resources had been allocated to Maghaberry Prison but there was little evidence that the same time and commitment to improvement had been focused on in Hydebank Wood YOC and Ash House. A service improvement board for Hydebank Wood had been established and had first met in January 2011. Its purpose was to lead and direct the development of work streams to provide a focus for continuous improvement to improve the health of prisoners.

**Further recommendation**

2.11 The service improvement board should ensure that the health needs of young adults and children at Hydebank Wood YOC are identified and met.

2.12 **An education and training policy for young people should be developed, including a coherent and distinct strategy for juveniles, that provides sufficient work and education places to keep all young people purposefully occupied. (HP53)**
**Not achieved.** There was no coherent learning and training strategy that distinguished needs according to sentence length or specific to different groups such as children under the age of 18. The curriculum was outdated and not matched to the needs of prisoners, employers or the local labour market. Not enough thought had been given to working in partnership with external providers, such as further education or work-based learning providers, and there was insufficient identification of learning needs to address barriers to learning. The needs of many prisoners with low literacy and numeracy levels were not being met. Quality assurance and review arrangements were weak and did not identify or address any of the under-achievement or inadequate teaching and learning. Too much emphasis was placed on filling education, vocational training and activity places rather than ensuring that individuals were appropriately placed according to their need.
**We repeat the recommendation.**

**Further recommendation**

2.13 Effective collaborative partnerships with external education and training providers, such as further education and/or work-based learning suppliers, should be established.

2.14 **All young people should have at least 10 hours out of their cells on weekdays including a daily scheduled period of one hour's exercise in the open air. (HP54)**
**Not achieved.** The weekday routine allowed a maximum of 9.5 hours out of cell per day. Evening association periods were sometimes cancelled at short notice due to staff shortages, although there had been fewer cancellations in recent months.
A rota ensured that association was rarely cancelled on two consecutive nights on the same unit. The core day did not include a scheduled period of exercise and most young men and children were not able to spend an hour in the open air each day.
**We repeat the recommendation.**

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

**specify roles and responsibilities, set SMART objectives, outline provision for specific groups such as juveniles and lifers, and include arrangements for regular review. (HP55)**
**Partially achieved.** There was a detailed local resettlement strategy for 2011–14. It was a major improvement in that the particular resettlement needs of young offenders and foreign nationals were now specified but there was nothing specific about life-sentenced prisoners. The strategy set out how services were to be delivered and needs were articulated within a context of background research, legislation, roles and responsibilities. While there were references to performance measurement, there were no SMART objectives or arrangements for review, which awaited the overall NIPS resettlement strategy. There were named personnel responsible for delivering all resettlement and offender management roles and the strategy cross-referred to the offender management practice manual.

## Recommendations

### Courts, escorts and transfers

2.16 **Young men, juveniles and women prisoners should be transported separately. (1.8)**
**Not achieved.** Young men, juveniles and women prisoners often travelled together. Records kept by reception officers in Ash House showed that male and female prisoners had travelled together at least 25 times since the beginning of 2011.
**We repeat the recommendation.**

2.17 **Young people should not routinely be handcuffed in vans or to and from reception without the need for this being determined through individual security risk assessment. (1.9)**
**Not achieved.** Young men and children were still handcuffed in vans and to and from reception without an individual risk assessment.
**We repeat the recommendation.**

2.18 **Staffing should be arranged so that young people do not wait unnecessarily on vans because reception is closed. (1.10)**
**Achieved.** Reception was staffed during the lunch and afternoon periods and young people were not kept waiting outside.

2.19 **Young people should arrive before 7pm. (1.11)**
**Not achieved.** In a recent six-month period, 14 young men and children had arrived after 7pm, including five after 8pm, two after 8.30pm and one after 9pm.
**We repeat the recommendation.**

2.20 **Young people should be escorted in vehicles that are safe, clean and comfortable. (1.12)**
**Not achieved.** The vans we examined were uncomfortable, did not contain seat belts and some were dirty and covered in graffiti.
**We repeat the recommendation.**

2.21 **Property and private cash should accompany unsentenced young people to court. (1.13)**
**Not achieved.** Property and private cash did not accompany unsentenced young men and children to court.
**We repeat the recommendation.**

2.22 **Young people should be given the information leaflet about Hydebank Wood YOC at court by NIPS escort staff. (1.14)**
**Not achieved.** Young people were not given the information leaflet at courts.
**We repeat the recommendation.**

2.23 **Young people should not be asked about their treatment by escort staff in the presence of these staff. (1.15)**
**Achieved.** Young people were not asked about their treatment in front of escort staff.

*First days in custody*

## Reception and first night

2.24 **Reception procedures should be less intimidating with young people greeted courteously by staff and permitted to sit at a table with an appropriate degree of privacy for initial procedures to be carried out. (1.39)**
**Achieved.** The reception area was relaxed and informal and some staff used the young person's first name. We saw one very vulnerable young person treated with particular care. Reception staff ensured that handcuffs were removed quickly before interviewing young men and children in private. This interview included notes on the family arrangements and any immediate concerns or anxieties. Those we observed were conducted sensitively and gave the young person a good opportunity to express any fears. The whole reception process lasted about 30 minutes. New arrivals were then taken to health care before going to the first night wing on Beech House, or Willow House if they were children. Young people we spoke to said they had been treated well by reception staff.

2.25 **Full information should be available to reception and first night staff to inform initial assessments. (1.40)**
**Not achieved.** Little information about young people was available either in advance or on arrival. At most, there was the court warrant containing only factual information or possibly details of a Police and Criminal Evidence Act (PACE) interview at a police station where the young person had given cause for concern. Reception and first night staff understood the potential risks to young people presented by this lack of information. It was particularly unacceptable that the JJC did not send information in advance of a young person aged 18 or under being transferred.
**We repeat the recommendation.**

2.26 **Juveniles should not be routinely strip searched. (1.41)**
**Not achieved.** Children under the age of 18 were still strip searched on arrival.
**We repeat the recommendation.**

2.27 **Strip searches should always be conducted by two officers. (1.42)**
**Achieved.** All young people were strip searched in private and had a shower immediately afterwards. The process was quick and young people we spoke to said it had been conducted sensitively and with two officers present. Reception staff said two officers were always present and understood the safeguarding implications for all concerned if that did not happen.

2.28 **Other young prisoners should not be used to interpret for new committals charged with serious offences or in circumstances where personal information is divulged. (1.43)**
**Achieved.** Reception and first night officers said they rarely received young people who needed an interpreter but understood that other young people should not be used to interpret when personal information was likely to be disclosed. A professional telephone interpreting service was used but the records did not identify which departments had used it so it was not possible to verify this from the records.

2.29 **All new committals should be able to make a free telephone call in private in reception or on their first night location. (1.44)**
**Achieved.** All new arrivals could make a free telephone call in private once on the first night wing and were often able to make several such calls over their first few days. Young people on remand said they had been able to make a free private call to a legal adviser.

2.30 **All new committals should be given a meal on their first night. (1.45)**
**Achieved.** All young people were given a meal on their first night.

2.31 **Reception waiting areas should be decent and contain relevant information in a range of formats so that it is accessible to all. (1.46)**
**Partially achieved.** Reception contained seven small waiting areas and two interview rooms, all of which were clean and private and in sight of the reception desk. All had a cushioned bench, a digital monitor showing the 'life' channel and up-to-date magazines and newspapers. There was some information on substance misuse services for young people but no other information about prison life. None of the materials were available in a format other than the written word, even though many new arrivals had problems with literacy.

2.32 **Insiders should be available in reception and for all new committals on their first night. (1.47)**
**Partially achieved.** Three peer supporters were available to give advice to young adults on the committal wing but only on request. There were no peer supporters for children.

2.33 **The first night guide for new committals should be revised and produced in a range of formats to contain only essential information to enable young people to cope with their first 24 hours. (1.48)**
**Achieved.** A new first night booklet for young people was written in an accessible style and contained all relevant information. Young people could also watch an information DVD in their cells.

## Induction

2.34 **All new arrivals, including juveniles, should receive appropriate and consistent induction. (1.49)**
**Partially achieved.** Young adults were moved from the committal wing to a dedicated induction wing about one week after arrival. A five-day comprehensive rolling induction programme was delivered to groups in a classroom setting and included an introduction to education and training, an individual education assessment and the opportunity to meet representatives of key departments. A register was kept to ensure that everyone participated in it. Young adults we spoke to said they had found the programme helpful, although they still spent too much time in their cells when not attending induction sessions.

2.35 Induction on the juvenile wing was not formalised and we were told it was delivered individually by wing staff. This was not recorded and wing files did not indicate that juveniles had received induction, although some behavioural compacts had been signed and children said they knew the rules and regulations. They spent a long time in their cells and some had to wait over 28 days before they could take part in education and training. Apart from cleaning jobs on the wing, there was little to occupy children in their first days and weeks at Hydebank Wood YOC.

## Accommodation and facilities

2.36 **Cells designed for one should not be used for two people. (2.14)**
**Achieved.** Young people no longer shared cells apart from three young adults in a small dormitory on Elm House who had chosen to do so to have company when locked up. The dormitory was a comfortable size and had a large adjoining bathroom.

2.37 **All cells should be regularly checked and kept in good condition. (2.15)**
**Achieved.** Cells on Beech and Cedar Houses were in good condition and those on the enhanced Cedar 5 landing were exceptional. Cells on Elm and Willow were in need of refurbishment. Young people said their cells were warm and well ventilated and that they were content with the standard of furniture. They were provided with adequate materials to keep their rooms clean and said any necessary repairs

were carried out quickly. Each unit had a weekly cell inspection.

2.38 **Toilets in shared cells should be adequately screened. (2.16)**
**Achieved.** Only one small dormitory was shared (see paragraph 2.36) and all other cells had either a permanent screen or the means to hang a curtain around the toilet.

2.39 **Some cells should be adapted for young people with disabilities. (2.17)**
**Achieved.** Two cells now had wheelchair access and one of these had an adapted shower. However, neither was on the ground floor. There were no adapted cells with hearing loops.

2.40 **Soiled mattresses and pillows should be replaced promptly. (2.18)**
**Achieved.** There was a good stock of mattresses and pillows and those in cells we examined were satisfactory. Young people said they were satisfied with what was provided.

2.41 **All young people should be provided with flasks. (2.19)**
**Achieved.** All young people were given a flask on arrival.

2.42 **Young people should be provided with at least two clean towels each week. (2.20)**
**Achieved.** Each wing had a good stock of clean towels available to young people as required.

2.43 **The offensive display policy should be uniformly applied. (2.21)**
**Not achieved.** The guidelines about offensive materials were not sufficiently clear and left staff to define what they considered to be offensive and what to do about it. Officers were clear about the rules as they were applied on their own houses but there was no consistency across the establishment. Material that was allowed on open display on one house was allowed only inside locker doors on others. Some staff allowed young people to display material during the week, take it down for the cell inspection and put it back up again afterwards.
**We repeat the recommendation.**

2.44 **Young people should be able to use microwaves for products from the tuck shop. (2.22)**
**Achieved.** Microwaves were available for young people to heat products from the tuck shop.

2.45 **The policy on the type of clothes young people can wear should be less restrictive. (2.23)**
**Achieved.** Young people could wear their own clothes, although items such as football shirts or those associated with combat which were potentially intimidating were banned. There was a reasonable upper limit on the value of clothing young people were allowed to wear.

2.46 **Access to the telephones should be improved. (3.101)**
**Achieved.** There was good access to telephones.

2.47 **Telephones should be enclosed in booths to allow privacy. (3.102)**
**Not achieved.** Most telephones were not in booths and could not be used in private.
**We repeat the recommendation.**

2.48 **There should be no unnecessary delays in prisoners receiving their mail. (3.103)**
**Partially achieved.** A standard operating procedure for mail had been introduced. Records of incoming and outgoing post were kept on all wings and prisoners signed on receipt of their mail. Despite this, young people on several landings said they were dissatisfied with the post arrangements, although the reason was unclear. In a recent survey by Opportunity Youth, 40% of children and young men said they had experienced problems with mail.

### Further recommendation

2.49 Managers should discuss prisoner dissatisfaction with the mail at prisoner consultation meetings and take action to address any identified shortfalls.

### Additional information

2.50 The communal shower and washing facilities on Elm and Willow Houses were in poor condition, with paint peeling from the ceilings, tiles that had come away from the walls and significant ingrained dirt throughout. Many showers did not have curtains. There had been recent attempts to paint over the cracks but the facilities were desperately in need of refurbishment.

### Further recommendation

2.51 The communal shower and washing facilities on Elm and Willow Houses should be refurbished and redecorated.

### Staff-prisoner relationships

2.52 **A prisoners' council should be established to allow senior managers to consult with the young men about routines and facilities and include discussions about how to improve relationships, with regular feedback to all staff and prisoners on action taken. (2.28)**
**Partially achieved.** A bi-monthly prisoners' council had been established and most meetings had good representation from all units. Representatives were not elected by their peers but were volunteers. The deputy governor and some residential senior officers attended consistently but attendance by other departments was erratic and some, particularly health care, education and offender management, did not attend. The meetings discussed a wide range of practical topics and issues raised by prisoners were usually dealt with constructively but the minutes did not include evidence of any ongoing discussion about improving relationships between staff and prisoners. The minutes were comprehensive but did not clearly identify the decisions made and how matters carried forward from previous meetings were resolved. Minutes were not displayed on unit notice boards.

2.53 **Managers should ensure that officers make active efforts to engage positively with prisoners and make regular recorded checks that this is happening. (2.29)**
**Not achieved.** Residential managers met with unit officers only twice a year for a routine appraisal and we were told there were no other formal arrangements to allow a more detailed discussion. The 'introducing positive role modelling' course had last been delivered in 2009 and only very few officers had completed it. Managers reviewed wing files weekly but focused on the young person's needs rather than the officer's contribution. Comments were mostly negative. One officer explained that he expected certain young people to do well and therefore did not feel the need to comment on it when they did. Many staff engaged positively with young people but did not have the required understanding of complex behaviours or training to intervene effectively with those who were most damaged. Responses to difficult situations were therefore intuitive rather than planned.

### Further recommendation

2.54 All staff should have training to help them understand, engage with and intervene effectively with young people in custody.

2.55 **Staff should routinely use first names or title and surname when speaking or referring to young men in their care. (2.30)**
**Partially achieved.** Most staff still addressed young men and children by their surnames, although the use of first names was becoming more widespread,

particularly in reception and on the committal, induction and juvenile wings. Staff and young adults on the enhanced wing, Cedar 5, called each other by their first names, reflecting the constructive relationships there.
**We repeat the recommendation.**

## Bullying and violence reduction

2.56 **A safer custody committee specifically for Hydebank Wood Young Offenders Centre should be established focusing on anti-bullying, the prevention of suicide and the reduction of self-harm. (3.14)**
**Not achieved.** A single safer custody steering group met monthly and covered women and young men and children. This was often chaired by the governor or senior manager and was reasonably well attended, although there was not always a representative from health care or security. Prisoner representatives did not attend. Basic data about bullying and anti-social behaviour, self-harm, SPAR procedures and the use of the observation cells had only recently been presented to the meeting in a systematic way. The meeting had only recently discussed how to give appropriate consideration to the two separate populations.
**We repeat the recommendation.**

2.57 **All potential indicators of bullying should be monitored and, where there are concerns that bullying may be involved, the incident should be investigated irrespective of whether the alleged victim has made a written statement. (3.15)**
**Not achieved.** Little data on potential indicators of bullying, such as number or location of fights, assaults or unexplained injuries or when force had been used, were presented to the safer custody steering group meeting. No comprehensive survey about safety had been completed in recent years. A survey of 30 young offenders had been undertaken in September 2010 using one-to-one interviews by staff from Opportunity Youth. It included two questions on safety but it was not sufficiently detailed or in-depth and had not been used to inform the development of the safer custody strategy. In the survey, 77% of respondents said they had never felt unsafe. There were relatively few investigations into allegations of bullying, with just 11 in 2010, five of which had been unsubstantiated. In the year to date, 16 bullying information reports had been submitted and 10 of these had been substantiated. Investigations were still often dropped when victims were not prepared to make a statement or withdrew allegations.
**We repeat the recommendation.**

2.58 **The profile of anti-bullying should be improved to create an environment where young people have faith in the anti-bullying strategy, including appointing safer custody liaison officers for each unit. (3.16)**
**Not achieved.** The psychology department delivered some challenging anti-social behaviour awareness sessions to new arrivals during induction. This new strategy was being piloted for women and there were plans to introduce it in the YOC. Young people were reluctant to report bullying for fear of reprisals and staff sometimes identified some who would leave their rooms only when they knew staff were close by. Not enough was done to challenge bullying, intimidation and other anti-social behaviour overtly and there were no safety custody liaison officers on each unit to champion a violence reduction approach.
**We repeat the recommendation.**

2.59 **Effective interventions to challenge bullies and support victims should be developed. (3.17)**
**Not achieved.** There were no effective interventions to support victims and challenge bullies to change their behaviour. The main response was to move the victim

or perpetrator to other landings or units.
**We repeat the recommendation.**

2.60 **All staff in direct contact with young people should receive training in the anti-bullying strategy. (3.18)**
**Not achieved.** Staff had not been trained in the existing anti-bullying strategy and concerns had been expressed at the lack of training in the challenging anti-social behaviour strategy that was due to be introduced (see paragraph 2.58).
**We repeat the recommendation.**

## Additional information

2.61 Although Hydebank Wood YOC appeared generally safe, this was less true for young men and children both charged with, or convicted of, sex offences. It was difficult to maintain anonymity in what was a small community. Vulnerable prisoners were integrated on the units, which caused tensions and problems for staff in keeping them safe and ensuring they did not isolate themselves. Other young prisoners known to the security department were 'kept apart' because of previous conflicts in the community.

## Self-harm and suicide

2.62 **There should be a suicide prevention co-ordinator (SPC) exclusively for the Young Offenders Centre with sufficient allocated time to carry out this role. (3.37)**
**Not achieved.** Two principal officers had until recently managed the areas of suicide prevention, violence reduction and child protection across Ash House and the Young Offender Centre. This had since been reduced to one full-time principal officer who had no administrative support.
**We repeat the recommendation.**

2.63 **Formal investigations should be conducted into serious or near-fatal incidents to establish what, if any, lessons could be learned. (3.38)**
**Partially achieved.** Useful investigations into serious incidents of self-harm were carried out by a member of staff from the operations branch at headquarters. However, identified learning points were not shared with relevant managers or incorporated into action plans to inform local practice and findings were not sent to the director of prison health at the SEHSCT.

### Further recommendation

2.64 Investigations, recommendations and learning points from serious or near-fatal incidents should be shared with relevant staff including the SEHSCT and incorporated into action plans monitored by the safer custody committee.

2.65 **Prisoner at risk (PAR 1) procedures should be improved. Reviews should be multi-disciplinary, but with less reliance on the role of healthcare staff, and care plans should reflect the individual needs identified. (3.39)**
**Partially achieved.** Following a revision of procedures to support prisoners at risk of self-harm, PAR 1s had been replaced by SPAR documents. Reviews were held on specific days so that representatives from various departments could plan ahead and attendance had subsequently improved, although the departments involved were not always recorded. The safer custody manager completed a comprehensive audit of closed SPAR documents and notified senior officers of areas for improvement. In a recent audit of 41 SPAR documents, health care had been present at 98% of discussions, psychology at 80%, Opportunity Youth at 76% and probation 71%. There was virtually no attendance by activities areas or the chaplaincy. The OMU had been represented at 56%. Safer custody review meetings were held weekly to discuss cases where there were particular concerns. These were well attended by staff including the art therapist, psychology, chaplaincy, probation and Opportunity

Youth, and some meaningful action plans for their care were developed. There was still a need to improve general care plans, some of which identified issues but did not specify what action was being take to address them.

2.66 **Trained senior officers should provide continuity in the management of cases. (3.40)**
**Not achieved.** Principal officers had been trained in the case management of SPAR but senior officers had not. Reviews were chaired by whichever senior officer was on duty at the time so there was not always continuity.
**We repeat the recommendation.**

2.67 **Managers should make regular checks on open PAR 1 forms and make written comments on the quality of care offered. (3.41)**
**Not achieved.** Each page of the SPAR document included space for a required management check. In nearly every case, the manager had simply signed to confirm they had completed the check and none included any comment on the quality of care provided.
**We repeat the recommendation.**

2.68 **Key workers should be identified to work alongside young people at risk of self-harm or suicide. Entries in the daily supervision record should be improved and follow-up interviews conducted following the closure of PAR 1 forms. (3.42)**
**Partially achieved.** No key workers were allocated to young people identified as at risk of self-harm but senior officers emailed particular actions required to other departments following a case review. The quality of entries varied. Some indicated good engagement with prisoners at risk while others were too regular and made at predictable times. Follow-up interviews were completed a week after a SPAR was closed.

2.69 **The length of time young people are placed in the observation rooms in health care and the Special Supervision Unit (SSU) should be monitored by the safer custody meeting. (3.43)**
**Not achieved.** Data produced for the safer custody steering group included how often observation rooms were used but not how long young people had been held in them. According to information available through the prison record and information system management (PRISM), observation rooms in health care and the SSU had been used 15 times between September 2010 and March 2011 involving 13 different young people. Most had been held there for a day or less, although one young adult had been held for five days and one for two days.
**We repeat the recommendation.**

2.70 **Alternative therapeutic responses to the use of observation rooms and strip clothing should be developed for those at risk of self-harm. (3.44)**
**Not achieved.** Between September 2010 and March 2011, 19 young people had been placed in observation rooms and in strip clothing and another 11 had been placed in observation rooms in their own clothes, which appeared to be the first response when young men and children were assessed as at risk of self-harm. The need for more therapeutic responses to prisoners at risk was sometimes discussed at the fortnightly safer custody reviews but there was no day care and too little psychological or psychiatric support.
**We repeat the recommendation.**

2.71 **Young people at risk of self-harm should be held in the SSU only in exceptional circumstances. (3.45)**
**Achieved.** PRISM indicated that seven young adults had been placed in the observation cell in the SSU between September 2010 and March 2011 but the reason why was not always clear. No-one had been held for more than two days. We found one case where a young person at

risk had been placed in the SSU with no recorded evidence that any alternatives had been considered. We were told the SSU was used only in exceptional circumstances and in this particular case, a memo was sent to remind staff of the restrictions on using the SSU for prisoners at risk of self-harm.

2.72 **Young people should be able to contact the Samaritans free of charge from landing telephones. (3.46)**
**Achieved.** A good range of free telephone help lines were advertised by landing telephones in an initiative introduced in recent weeks. The list included the Samaritans number and all help lines could be contacted using a published personal identification number linked to an account paid for by the prison.

2.73 **Peer support should be improved, with a clear programme of training and regular support meetings for Insiders. (3.47)**
**Partially achieved.** The Insider scheme had been re-launched as a pilot at the beginning of the year and was comprehensively described in guidance notes. Four category D Insiders lived on Cedar House and could move unescorted around the centre. They wore identifying T-shirts and used a checklist of information to give to new arrivals but had no formal training. They worked to a rota to ensure that all new arrivals on Beech House had the opportunity to speak to one of them.

2.74 **All staff in contact with young people should receive suicide awareness training. (3.48)**
**Not achieved.** Minutes of the safer custody steering group meeting of January 2011 indicated that 50% of staff had been trained in applied suicide intervention skills in March 2010 but only 3% since then.
**We repeat the recommendation.**

2.75 **A Listener scheme should be developed. (3.49)**
**Not achieved.** Attempts to establish a Listener scheme in Ash House had been abandoned and not extended to the rest of Hydebank Wood. Insiders offered a different type of support and had no requirement to maintain confidentiality but provided some good peer support.
**We repeat the recommendation.**

2.76 **All officers should carry ligature knives. (3.50)**
**Achieved.** Senior, principal, security and class officers were issued with a ligature knife and a comprehensive policy on their safe use had been published. Additional knives were located in break-glass boxes on residential units.

## Additional information

2.77 An apparent self-inflicted death in July 2010, the first for around 10 years, was being investigated by the Prisoner Ombudsman for Northern Ireland and tragically a further death occurred not long after the inspection was carried out. Recorded levels of self-harm were not high, with an average of four young people a month self-harming. Two young adults were on SPAR documents. Therapeutic responses to support prisoners included art therapy, Opportunity Youth, psychology and Cruse bereavement counselling. There was no day care, the availability of cognitive behaviour therapy had been reduced and there was only limited psychiatric support. A new initiative to reduce the potential use of cell door handles as ligature points had been introduced on Beech and Cedar Houses but not elsewhere.

## Child protection

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

**Not achieved.** An excellent revised safeguarding children framework and guidance document which included a safeguarding children protocol was established between each of the health and social care trusts and the NIPS. However, procedures outlined were not being followed correctly by the prison or the local Gateway team responsible for receiving child protection referrals. The framework and guidance had been produced by the NIPS but it was not clear that all parties involved had agreed to fulfil their listed responsibilities. There were significant procedural frailties in the application of the referral procedures by the prison. Record-keeping was very poor. The child protection records included two cases of alleged assault by staff against a child. One had been referred to the local Gateway team but there had been no response and this had not been followed up by the prison. The other case had not been referred to the Gateway team and it was not clear what action had been taken. Both files noted that the children had subsequently withdrawn their allegation, one unsurprisingly following an interview by two prison managers. The child protection co-ordinator said the local Gateway team rarely acknowledged a referral. The framework set out a clear model of governance that was not being followed and there was an apparent tacit acceptance of this lack of engagement at all levels.
**We repeat the recommendation.**

2.79 **A formal request should be made that the governor of Hydebank Wood YOC is granted membership of the area child protection committee (ACPC). (3.62)**
**Not achieved.** There had been organisational changes to the ACPCS and the new structures had brought together one regional child protection committee (RCPC) to replace the previous four ACPCs. The safeguarding children framework and guidance described the new structures as functioning in shadow form in 2010. The governor of Hydebank Wood YOC was not part of the designated membership of the RCPC. We were told that a representative from the NIPS participated in the new arrangements as required but the criteria for that requirement were not specified. We were not assured that safeguarding issues specific to Hydebank Wood YOC were highlighted for attention as required at regional level.
**We repeat the recommendation.**

2.80 **An appropriate forum for the strategic development of child protection should be established and should include input from the local health and social services trust. (3.63)**
**Partially achieved.** A quarterly child protection co-ordination group reported to the head of safer custody at the NIPS headquarters. The safeguarding children framework and guidance outlined reporting procedures at a number of levels but, as noted above, these were not being followed. The designated membership of the child protection co-ordination group included the child protection co-ordinator from Hydebank Wood YOC and a representative from the local health and social care trust. The meetings were chaired by the head of the safer custody group. The child protection co-ordination group provided an ideal forum for discussion and resolution of issues of concern, such as the local health and social care trust failure to respond to child protection referrals. However, minutes of the meetings indicated that, while there were ongoing and regular discussions about the risks posed by prisoners at Hydebank Wood YOC to child visitors, the long-standing problem relating to the management of child protection referrals had not been raised.

2.81 **Child protection referrals should be monitored and analysed for patterns or trends. (3.64)**
**Not achieved.** Child protection referrals were a standing agenda item at the monthly safer custody meetings but there was no monitoring of progress of individual

referrals and strategic issues were not highlighted for action. The extent of overall monitoring of child protection referrals was very limited and the format used at the safer custody meetings provided little more than a list of numbers with no breakdown by type and no ongoing trend analysis. The new policy required the child protection co-ordinator to report progress on all investigations at least fortnightly to all parties concerned but this was not being done. There was also a requirement to prepare a quarterly report on the number, nature and outcome of child protection referrals for the governor in charge to present to the NIPS management board. Such reports would have provided useful information for the RCPCs but were not being produced.
**We repeat the recommendation.**

2.82 **All staff who come into contact with children should have comprehensive inter-disciplinary child protection training. (3.65)**
**Not achieved.** Child protection training was delivered in-unit but with no input from the local health and social services board. Although staff in key areas of the prison, such as Willow House, reception, visits and Ash House, had been appropriately prioritised for child protection training, there remained some significant gaps, including duty governors and almost two-thirds of officers. All staff had been issued with a useful good practice guide handbook, but those we spoke to admitted that they were unfamiliar with it. Experienced Willow staff understood child protection issues but this was not the case with others who might be expected to identify or deal with them.
**We repeat the recommendation.**

2.83 **Urgent steps should be taken to ensure that all staff coming into contact with children have protection of children and vulnerable adults (POCVA) checks. (3.66)**
**Achieved.** Previous shortcomings in maintaining local records of staff POCVA checks had been remedied with the introduction of Access NI checks. Retrospective tests had been carried out and there was a robust system to ensure that other checks were up-to-date.

## Applications and complaints

2.84 **The complaints procedure should be promoted more effectively through notices on houseblocks, individual interviews and induction programmes to ensure that young people know they have a right to complain and how to go about it. (3.118)**
**Achieved.** The number of complaints made in the three months before the inspection had risen significantly compared to the same period in the previous year, which suggested that more prisoners understood how to use the system. The induction programme included a comprehensive session on the right to complain and how to do so. Children on Willow House said they understood the complaints procedure. A new information booklet included an easy to follow section about making complaints and there were clear notices about the complaints procedure next to all complaints boxes on the wings. A number of the complaints we looked at showed that a member of staff had helped the young person make the complaint. Young people we spoke to said they understood how to make a complaint but continued to have little faith in the system. In the recent Opportunity Youth survey, 90% of respondents said they knew how to make a complaint.

2.85 **Young people should be able to access and submit complaint forms confidentially. (3.119)**
**Achieved.** There were complaints boxes on all houses situated away from landing offices and desks. The boxes could only be opened by a member of staff with the authority to do so. All complaints boxes had complaints forms by them. The detail of each complaint was entered on a

database and access to this was now restricted to a senior officer or above.

2.86 **Young people should not be required to make a formal request for a telephone call or a shower or other routine matters. (3.120)**
**Partially achieved.** Although there was still a formal requirement for young people to make requests for telephone calls and showers, in practice they were able to have these without making requests.

2.87 **There should be a formal system of quality assurance of complaints to ensure that they are fully investigated and that replies are courteous and directly and clearly address the nature of the complaint. (3.121)**
**Not achieved.** A nominal quality assurance system only covered timescales and did not examine the quality of the investigations or responses. Complaints we looked at often did not explain how matters had been investigated, particularly when complaints were about a member of staff. Not all investigations came to a clear conclusion. Many responses were not addressed to the young person concerned and simply detailed the final decision. When formal written complaints were resolved at the initial interview stage, the young person was not given a written explanation. None of the responses addressed the young person by name and most were curt rather than polite and explanatory.
**We repeat the recommendation.**

2.88 **Requests and complaints should be routinely analysed to identify patterns or trends. (3.122)**
**Not achieved.** There was still no system to analyse requests and complaints.
**We repeat the recommendation.**

## Faith and religious activity

2.89 **Chaplains should be formally invited to all prisoner at risk (PAR 1) reviews. (5.35)**
**Partially achieved.** Chaplains were not routinely notified of or invited to all SPAR reviews. However, they did attend weekly safer custody meetings where case discussions took place on prisoners causing concern, some of whom were subject to SPAR procedures.

## Additional information

2.90 The chaplains had a high profile, worked well as a team and were easily accessible to prisoners. The spiritual and pastoral needs of prisoners continued to be well met. Chaplains also played an active role in the equality and diversity committee.

## Substance use

2.91 **All those who require first night treatment/symptomatic relief following screening and testing should have it prescribed and administered. (3.129)**
**Partially achieved.** Drug testing was not carried out on arrival. Assessments were used at the discretion of the nurse on duty rather than routinely. There was no evidence that they were audited to monitor compliance. If deemed appropriate by the duty nurse, the prison GP was contacted and a verbal instruction was obtained for the administration of symptomatic relief. This was recorded on EMIS and a prescription generated within a maximum of 72 hours, although this was not always signed by the prescriber in line with National Medical Council guidelines.
**We repeat the recommendation.**

2.92 **Specialist staff should complete a comprehensive assessment of need to determine suitable stabilisation, maintenance or detoxification regimes. (3.130)**
**Not achieved.** One young man who required first night treatment and symptomatic relief for a benzodiazepine addiction remained in the inpatient unit only overnight before being transferred to the

main prison and was not referred to the addictions team. This was clearly the normal approach and the addictions team had no young men or children on its caseload and few had ever been referred. Health services staff said they rarely saw the need to refer anyone to the addictions team. This was an indication of the need for such decisions to be made by specialist staff rather than general health services staff.
**We repeat the recommendation.**

2.93 **Prescribing regimes should be flexible and meet individual need. (3.131)**
**Not achieved.** As young people were not referred to the addictions team, we were not assured that prescribing regimes were flexible to meet individual need or that GPs tailored detoxification protocols individually.
**We repeat the recommendation.**

2.94 **Young people should receive effective support during and post clinical intervention. (3.132)**
**Partially achieved.** As noted, young people did not receive the support of the specialist addictions team. Ad:ept provided one-to-one counselling as well as solution-focused therapy and a pre-release course. Young people were also encouraged to undertake an OCN level 1 drug and alcohol awareness course.

### Further recommendation

2.95 Young people should benefit from the support of the specialist addictions team.

### Diversity

2.96 **The equality and diversity committee should meet regularly, with all designated members or representatives attending, to consider and take action on any identified or potential areas of discrimination. (3.80)**
**Not achieved.** The equality and diversity committee did not meet regularly and attendance was often poor. Areas of actual or potential discrimination were sometimes identified but no action was then taken.
**We repeat the recommendation.**

2.97 **A system of monitoring that identifies and highlights areas of under and over-representation should be introduced and monitoring data should distinguish between male and female prisoners. (3.81)**
**Partially achieved.** A new system of monitoring data capable of identifying 'discrepancies' was being introduced but had not yet been implemented. The existing system was able to differentiate between male and female prisoners but the process was complicated and comparative data based on sex were not used to discern patterns and trends.
**We repeat the recommendation.**

### Additional information

2.98 A draft policy on diversity was more a statement of intent than a working tool and did not adequately reflect the distinctive features of Hydebank Wood YOC. A separate equality and diversity action plan was not being monitored because the equality and diversity committee did not function effectively. Apart from the work carried out by a few specialist staff, particularly the equality and diversity officer, there was little evidence that diversity was positively promoted. A specialist adviser had made some useful contributions to the equality and diversity committee in the past year but this had not been sustained.

### Race equality

2.99 **The equality and diversity officers should receive specialist training and should be allocated dedicated time to carry out their additional duties. (3.82)**
**Not achieved.** The equality and diversity officer had still not received any specialist training. He spent between half and one

day a week trying to deal with all aspects of diversity in addition to his core duties as a generic officer. He was also covering this area of work in Ash House following the resignation of the equality officer there. He sometimes worked on his rest day to ensure the diversity work was carried out on time, was clearly overloaded and did not receive enough time or support to carry out the role properly.
**We repeat the recommendation.**

2.100 **Links with Irish Traveller support groups should be strengthened and consolidated. (3.83)**
**Partially achieved.** Attempts to strengthen links with the Irish Traveller organisation, An Munia Tober, had resulted in this group running an awareness-raising event for prison staff in November 2010. The group had since regularly been invited to visit but it was proving difficult to keep the link active.
**We repeat the recommendation.**

2.101 **A separate system for investigating racist complaints should be introduced and staff appropriately trained. (3.84)**
**Not achieved.** There was still no separate system for investigating racist complaints and no additional training had been introduced. Prisoners making complaints about racism were dealt with through the generic complaints system, which did not allow sufficient scrutiny or analysis.
**We repeat the recommendation.**

### Additional information

2.102 The population was predominantly white. There were small numbers of Irish Travellers and some young people of mixed heritage. Race relations did not appear to be an area of conflict, although Irish Travellers we spoke to said staff did not understand or respect their cultures and that they were treated more punitively than other prisoners.

### Religion

*No separate recommendations were made against this heading in the 2007 report, which were covered under diversity.*

### Additional information

2.103 A total of 55% of prisoners said they were Roman Catholic and 34% Protestant. The remainder followed different minority faiths or no faith. There was no obvious religious discrimination or sectarianism and we received no complaints from prisoners about this, although Roman Catholics still appeared to be over-represented in adjudications and on the basic regime level. Prisoners could be identified by their religion on wing charts but most staff did not appear to consider this a significant characteristic. There was, however, no reliable way of analysing data relating to religion so it was not clear whether any discrimination was actually taking place and this was a significant failure. Funding had just been obtained for a research project across all three Northern Ireland prisons to examine this more closely.

### Foreign nationals

2.104 **The Border and Immigration Agency should be asked to supply a named liaison person so that the prison can help foreign national prisoners prepare for their release or removal. (3.85)**
**Achieved.** The UK Border Agency (UKBA) had nominated a named liaison person. This had improved communication between the prison and the immigration authorities and meant foreign national cases were better administered before release.

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

**Not achieved.** Professional interpreting services were little used and staff relied instead on using other prisoners to interpret.
**We repeat the recommendation.**

### Additional information

2.106 Work with foreign national prisoners was given more prominence than other areas of diversity. There were two prisoners from a foreign national background and both had received some support from the equality and diversity officer. One of the young men we spoke to said he felt quite well supported. The other young man, who could speak very little English, had been the subject of a serious bullying incident that appeared to have been badly handled initially until the equality and diversity officer had became involved and resolved the situation satisfactorily.

### Prisoners with disabilities and older prisoners

*No recommendations were made against this heading in the 2007 report.*

### Additional information

2.107 A disability liaison officer (DLO) had recently been appointed. He had not received any training but had a background in fire safety so was familiar with some aspects of the role. There were no personal evacuation plans, although at least one young man had a severe disability affecting his mobility. The manager responsible for diversity had recently carried out a brief disability audit, the results of which clearly indicated that the number of prisoners with some form of disability had been significantly under-identified.

## Health services

### General

2.108 **The health needs assessment of the young people at Hydebank Wood YOC should be reviewed and services to meet their specific needs should be commissioned and provided. (4.34)**
**Partially achieved.** A baseline health needs assessment had been carried out in 2009 by combining the results of the previous needs assessments with prevalence data for the Northern Ireland population. The latter were adjusted where UK prison data showed an increased prevalence of a particular condition. An annual health needs assessment was carried out for the commissioners, Health and Social Care Board. However, this relied on counting the number of referrals to specific services, such as mental health and addictions services, which were not always made as such services were not available in sufficient quantities. The assessment method was therefore flawed and resulted in an under-identification of needs. There were no specific child and adolescent mental health services (CAMHS) and primary care services were not well developed.
**We repeat the recommendation.**

2.109 **All pharmacy polices should be formally reviewed and adopted via the medicines and therapeutic committee. (4.41)**
**Achieved.** Pharmacy policies were formally reviewed and adopted by the medicines and therapeutics committee, which met three times a year. As policies were reviewed and updated, they were rewritten in the standard operating procedure format.

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

**Not achieved.** There was no information-sharing policy. Patients' consent to share information was obtained but there was little evidence that information was shared with relevant staff, such as drugs and alcohol workers, to enhance prisoner care. **We repeat the recommendation.**

## Clinical governance

2.111 **All emergency equipment should be checked regularly to ensure that it is in date and fit for purpose; documented evidence of such checks should be kept. (4.35)**
**Not achieved.** There was a large and heavy emergency response bag, a separate bag containing oxygen and a suction machine that was not plugged in to charge. Some of the equipment was inappropriate and there were no emergency drugs. There were supposed to be weekly checks but records showed these did not always take place. Defibrillators had recently been placed at strategic locations but not all discipline staff had been trained in their use. **We repeat the recommendation.**

2.112 **All health services staff, including allied health professionals, should have annual training in resuscitation and child protection. (4.36)**
**Not achieved.** Not all the health services staff had received child protection or annual resuscitation training.
**We repeat the recommendation.**

2.113 **Clinical supervision should be available to all health services staff. (4.37)**
**Partially achieved.** There were two trained clinical supervisors but staff we spoke to did not take advantage of clinical supervision and there was no protected time for it.
**We repeat the recommendation.**

2.114 **There should be formal arrangements for the loan of occupational therapy equipment and specialist advice to ensure that patients are able to access mobility and health aids if required. (4.38)**
**Achieved.** Following the transfer of health services to the SEHSCT, health services staff could now access occupational therapy equipment. Specialist nurses could also be asked to see patients when required.

## Primary care

2.115 **Following a reception screening, a further health assessment should be carried out by trained staff no later than 72 hours after the young person's arrival in custody. (4.43)**
**Achieved.** There were templates on EMIS for both an initial reception screen and a further screen within 72 hours of a young person's arrival.

2.116 **The rapid vaccination course for Hepatitis B should be adopted. (4.44)**
**Achieved.** The rapid vaccination course had been adopted but had subsequently stopped due to a perceived stock supply problem. We raised this with managers and the course was restarted.

2.117 **Barrier protection (condoms and lubricants) should be freely available. (4.45)**
**Not achieved.** Young people could not get condoms and lubricants while in prison or when leaving.
**We repeat the recommendation.**

2.118 **Health services staff should liaise with the physical education department to ensure that young people can take full advantage of the physiotherapy services offered. (4.46)**
**Achieved.** The sports therapist confirmed that health services staff liaised and appropriately referred young people to the physical education department.

## Additional information

2.119 Nurses undertook a triage system for referral to the GP. There was no internal appointment system, which occasionally created problems for officers on the wings and heightened tensions as young people were not always seen on the day of request. Some young people we spoke to said it was difficult to get past the nurses to see a doctor.

## Pharmacy

2.120 **The special sick policy should be reviewed regularly by the medicines and therapeutic committee to ensure that all appropriate medicines can be supplied. (4.40)**
**Achieved.** The special sick policy had been reviewed and a range of medicines made available for health services staff to administer without the need for a prescription. These were recorded on the prescription chart of each individual patient.

2.121 **All pre-packs should be dual-labelled. When the pre-pack is dispensed against a prescription, one label should be removed and attached to the prescription chart, which should then be faxed to the pharmacy provider so that the pharmacist can satisfy him/herself that the prescription was appropriate and that the correct item has been supplied. (4.47)**
**No longer relevant.** There were no pre-packs. Prisoners received their individual named supply when prescribed. Any stock medicines used were issued on a dose-by-dose basis.

2.122 **Patient information leaflets should be supplied wherever possible. A notice should be displayed to advise patients of the availability of leaflets on request. (4.48)**
**Achieved.** A patient information leaflet (PIL) was provided with all dispensed medicines and, when medicines were issued daily or weekly, was given with the first supply. Notices advising patients that leaflets were available on request were put up during the inspection.

2.123 **Decisions about daily, weekly or monthly in possession medications should be clearly documented. (4.49)**
**Not achieved.** The in possession policy published in November 2010 was not being adhered to. The up-to-date risk assessment for decision-making was not in use and the recommended number of random monitoring checks was not being achieved. An obsolete risk assessment document was used but nurses said the decision was usually subjective. Documentation was often incomplete and there was little evidence of review.
**We repeat the recommendation.**

2.124 **There should be patient group directions (PGDs) for all vaccinations. (4.50)**
**Not achieved.** There were PGDs for some vaccinations but a complete range of vaccinations, such as Meningitis C, was not available. Not all the PGDs were in date and appropriately signed.
**We repeat the recommendation.**

### Further recommendation

2.125 All patient group directions should be in date and signed in accordance with SEHSCT policy.

2.126 **Over-the-counter medicines should be available for young people to buy from the tuck shop. (4.51)**
**Not achieved.** Over-the-counter medicines were not available. However, a number of general sales list medicines for treating minor ailments were available following a consultation with a member of the health services team.
**We repeat the recommendation.**

2.127 **Young people who arrive with ongoing dependence on prescription medications should be carefully assessed and monitored before any detoxification regime is commenced. (4.52)**
**Not achieved.** Young people were not referred to the addictions team (see section on substance use) and the protocols for comprehensive assessment of drug use were not followed.
**We repeat the recommendation.**

## Dentistry

2.128 **Dental staff should have access to young people's clinical records and complete medical history sheets for each patient. (4.39)**
**Achieved.** Dental staff had access to young people's clinical records on EMIS and completed the relevant medical records for each patient.

## In-patient care

2.129 **The in-patient beds should not form part of the prison's certified normal accommodation. (4.54)**
**Not achieved.** The in-patient bed provision had reduced from nine to six but they remained part of the prison's certified normal accommodation.
**We repeat the recommendation.**

2.130 **Admission to the in-patient unit should be decided on clinical need. (4.55)**
**Partially achieved.** Admission to the in-patient unit was based on clinical need but staff appeared reluctant to admit patients to health care, particularly in relation to self-harm and detoxification. One woman in Ash House who was self-harming quite severely was not admitted to the unit despite requests from Ash House staff.
**We repeat the recommendation.**

## Further recommendation

2.131 All prisoners requiring a clinical alcohol detoxification should be admitted to the in-patient unit.

2.132 **Day services should be available for those less able to cope with prison life. (4.56)**
**Not achieved.** There were no services for those less able to cope with life on the wings and no links between health services and education staff. Before the transfer of services to the SEHSCT, prisoners had received input from three cognitive behaviour therapy (CBT) nurses but there was now only one CBT nurse available for half a day a week. The regime of the prison meant the CBT nurse could not offer any enhanced services, such as 'mindfulness' or dialectical behaviour therapy.
**We repeat the recommendation.**

## Additional information

2.133 The reorganisation and refurbishment of the health care unit had provided four beds for males and two for females. However, the layout did not promote privacy or dignity as male and female patients were cared for in one area, creating difficulties with personal hygiene and free association. During the inspection, one young man was accommodated as an in-patient for the whole week and another stayed for one night but the week before had seen two males and one female accommodated on what had been designed as the male side of the health care unit.

2.134 The health care unit had two holding areas where patients waited to be seen by the nurse or doctor. Both rooms were converted cells with only partly screened toilets and, while basins were provided, there was no soap or paper towel dispenser to allow patients to wash their hands.

### Further recommendation

2.135 All health services accommodation should be fit for purpose, with appropriate provision for male and female patients to be held separately.

### Secondary care

2.136 **Arrangements for attendance at outside hospital appointments, including waiting times and cancellations, should be subject to audit. (4.53)**
**Not achieved.** We were told that a record was kept of cancellations of outside hospital appointments but no evidence of this was provided. Minutes of the prison health care partnership board indicated ongoing problems in this area.
**We repeat the recommendation.**

### Mental health

2.137 **Psychiatric services should be reviewed to ensure that there are sufficient resources to meet the needs of young people, including child and adolescent services. (4.57)**
**Not achieved.** There was less psychiatric input from specialist services for young people. The psychiatric consultant post was vacant. A staff grade doctor covered one session a week and there was some input from a forensic psychiatric consultant. The Trust was considering the appointment of a permanent forensic psychiatric consultant. A CAMHS consultant could be requested but there was no regular service. Staffing levels meant Registered Mental Nurses (RMNS) were not always on duty when the psychiatric physicians were on site, so there were few opportunities for multi-disciplinary meetings to ensure continuity of care and develop strategies for the care of patients.
**We repeat the recommendation.**

### Additional information

2.138 A recent incident highlighted the need for a more cohesive response to serious adverse incidents. A RMN was on night duty alone when a young person was psychotic and disturbed. The RMN was concerned about the medication prescribed by the GP and made a professional judgement to call the consultant psychiatric at home for guidance. We regarded this as a serious adverse incident as it highlighted gaps in the provision of care, such as the training needs of the GP and the need to have a protocol in place. The incident was not recorded as an adverse incident. There seemed to be two systems running parallel in relation to serious adverse incidents, with investigations carried out by both the Trust and the Prison Service.

### Further recommendation

2.139 Clear guidance on reporting serious adverse incidents should be issued and these incidents should be investigated in a co-ordinated fashion to ensure lessons learnt are implemented effectively.

### Time out of cell

2.140 **Unlock and lock-up should take place at the published times. (5.41)**
**Not achieved.** Prisoners were still often locked up at least 15 minutes early in the evenings. The core day indicated that prisoners should be locked up at 7.45pm and staff were off duty at 8pm. However, we saw most prisoners locked up by 7.30pm, with some staff already waiting at the gate to leave at that time. There was also some slippage in unlock times in the morning and after lunch.
**We repeat the recommendation.**

2.141 **Staffing ratios should be reviewed to ensure they are appropriate to the risk posed by prisoners. (5.42)**
**Not achieved.** Staffing ratios were unchanged and unlock restrictions were still

imposed on one or more landings if the houses were not regarded as fully staffed. **We repeat the recommendation.**

### Learning and skills and work activities

2.142 **The use of existing education and training capacity should be improved. (5.17)**
**Not achieved.** The capacity in education, vocational training and work remained under-utilised. Too few learning and skills classes were full, with only 42% of available vocational training and work activities utilised. The number of vocational training places was limited. Many young men and children still took too long to be assessed and allocated to work, during which time they were mostly locked in their cells. **We repeat the recommendation.**

2.143 **Links between education and training provision and resettlement planning should be improved. (5.18)**
**Partially achieved.** Communication links between learning and skills and the Offender Management Unit had started to improve through representation on the resettlement board and could be further developed through sharing information on prisoners' achievements, progression pathways and learning support needs.

2.144 **Young people should have improved access to the library. Access to the ICT facilities in the library should be improved. (5.19)**
**Partially achieved.** Access to the library had significantly improved and a pro-active librarian had made it a vibrant centre in education with a good range of activities to promote literacy. Some additional computers were available but no internet access and ongoing ICT technical issues prevented the effective use of this resource. Prisoners did not have access to the library in the evenings or at weekends.

### Physical education and health promotion

2.145 **The range of vocational courses leading to qualifications should be developed further to meet the needs and interests of all young people, particularly those who do not attend the gym regularly. (5.26)**
**Not achieved.** The range of vocational programmes was outdated and did not meet prisoners' needs and this was not just restricted to those offered in physical education. For example, about half the vocational training places were construction-related for which there was little manifest demand and the programmes provided were at levels below employer requirements. The ICT provision was unsatisfactory. Prisoners' employability skills were not enhanced sufficiently and links with employers were under-developed. **We repeat the recommendation.**

2.146 **The range of outdoor and adventurous activities available should be developed further subject to suitable risk assessments. (5.27)**
**Partially achieved.** The facilities for physical education were good and had improved with the addition of the astroturf pitch but this and the other outdoor pitches were under-used. Some outdoor adventure activities had been run but these were limited by security restrictions.

### Security and rules

2.147 **Procedures governing closed visits should be reviewed to enable pro-active decisions to be made based on firm intelligence. (6.11)**
**Achieved.** When there was sufficient intelligence, the governor could now authorise a closed visit at short notice rather than having to wait for written authorisation from NIPS headquarters. Good joint work had also begun with the police, who would assist in entry searching procedures when intelligence indicated a visit was going to be used to try to traffic

illicit articles. So far, 100% of such targeted searches had resulted in such items being recovered.

2.148 **The number of routine cell searches should be reduced and the searching strategy should be reviewed to find more efficient and effective ways of tackling supply reduction. (6.12)**
**Not achieved.** The frequency with which every cell was searched had increased from every 14 to every eight days but had since reverted to once a fortnight. Managers said that reducing the level to every 28 days was being considered but this was still too high given that only 4% of all searches, random and target, resulted in any find. Searching data were not monitored for patterns and trends and the searching strategy had not been reviewed.
**We repeat the recommendation.**

2.149 **Dynamic security should continue to be promoted and clear job descriptions drawn up for the security liaison officers. (6.13)**
**Partially achieved.** Staff-prisoner relationships had improved and security managers and staff tried to ensure that staff understood their responsibilities in reporting what they saw and heard. More security information reports were submitted, although some staff were still reluctant to use them. Clear job descriptions had not been drawn up for security liaison officers.

2.150 **Opportunities for more free movement around the Young Offenders Centre should be increased. (6.14)**
**Not achieved.** While staff no longer escorted small numbers of prisoners around in a regimented way, only a select few prisoners working on gardens were allowed free movement. The security manager was developing a new system where prisoners would be allowed to move unescorted outside general movement times but this had yet to be introduced.
**We repeat the recommendation.**

2.151 **The role of the security liaison officers should be reinforced by residential managers and staff should be encouraged to submit security information based on their own observations. (6.15)**
**Partially achieved.** All wings now had officers assigned the role of security liaison officers who maintained good links with the security department and attended all security committee meetings. More staff now submitted security information but security managers said some still preferred to pass on information by telephone rather than committing it to paper.

2.152 **Security bulletins should be posted on the prison intranet for staff information and guidance. (6.16)**
**Achieved.** A monthly security briefing provided staff with general security information specific to Ash House and Hydebank Wood YOC. It was available in hard copy and on the prison intranet.

2.153 **The security committee should include representatives for education, workshops and other departments that have direct dealings with prisoners. (6.17)**
**Partially achieved.** Minutes from the monthly security committee meeting indicated that the education manager attended but there was no other functional attendance other than security and residential.

## Discipline

2.154 **A behaviour management strategy should be developed for Hydebank Wood YOC, incorporating recognised best practice in managing the behaviour of young people and in consultation with Opportunity Youth and other external youth agencies. (6.38)**
**Not achieved.** No behaviour management strategy had been developed and there was no evidence that practices other than the

PREP scheme, adjudications and minor reports were used formally to manage poor behaviour.
**We repeat the recommendation.**

2.155 **The adjudication room should be made a more age-appropriate environment for children. (6.39)**
**Not achieved.** No modifications had been made to the room. However, minor reports for children who were charged with a breach of prison rules were now used more often.
**We repeat the recommendation.**

2.156 **There should be a written record of adjudication hearings to ensure that managers are able to scrutinise and evaluate disciplinary procedures. (6.40)**
**Not achieved.** Adjudications were still recorded onto CD and recordings were not reviewed for quality assurance purposes.
**We repeat the recommendation.**

2.157 **The reasons for the disproportionate number of Roman Catholic prisoners placed on report should be investigated and appropriate action taken as necessary. (6.41)**
**Not achieved.** There had been no investigation into why a disproportionate number of Roman Catholic prisoners had been and continued to be placed on report.
**We repeat the recommendation.**

2.158 **A more robust system for ensuring that the advocacy service is made available to all children facing disciplinary charges should be introduced. (6.42)**
**Achieved.** Children facing disciplinary hearings were asked at the point the paperwork was issued whether they wanted an Opportunity Youth worker to advocate for them. A member of staff then contacted Opportunity Youth. Opportunity Youth also contacted the segregation unit every morning and had a daily presence on the children's unit. Opportunity Youth staff were confident that they were always informed when a child was subject to a disciplinary hearing.

2.159 **Guidance on appropriate levels of punishments should be updated to make punishments more commensurate with offences and should be subject to regular review through standardisation meetings. (6.43)**
**Not achieved.** A national tariff for all prisoners regardless of sex or age had been produced and took no account of the circumstances of young adults or children. A wide range of punishments could be applied for offences and the maximum punishment for most offences still exceeded what we would consider proportionate. Standardisation meetings were not held.
**We repeat the recommendation.**

2.160 **Adjudicating governors should not make punishments in excess of the published tariffs without providing a reason or justification. (6.44)**
**Achieved.** There were no examples of punishments in excess of the published tariff, although the tariff allowed for very high levels of punishments (see paragraph 2.159).

2.161 **Partial remission of punishments and other means of encouraging good behaviour should be considered for prisoners in the special supervision unit. (6.45)**
**Achieved.** Records indicated that it was not unusual for prisoners to return to their wing before completing their full period of cellular confinement.

2.162 **Prisoners should not be subject to informal or group punishments without the safeguard of going through a formal disciplinary process. (6.46)**
**Not achieved.** There were a number of examples where privileges had been informally withdrawn by staff. This included one young person whose television had been withdrawn as it had been damaged

when he set off the sprinkler system. He had been told he would get it back only when he had paid for a new one. There were also anecdotal accounts from prisoners, later confirmed by staff, that a whole side of a wing had remained locked up during association because one prisoner had been shouting out of a window.
**We repeat the recommendation.**

2.163 **All staff involved in an incident involving the use of force should complete the relevant paperwork on the same day. (6.47)**
**Achieved.** All use of force paperwork that we looked at covering the previous six months was complete and there was no indication that it had not been completed following the incident concerned.

2.164 **The use of force committee should be chaired by a senior manager, meet monthly and robustly analyse every use of force incident in order to satisfy members of the legitimacy of the intervention. (6.48)**
**Achieved.** While membership of the committee was limited, it was chaired by the deputy governor, met monthly and scrutinised records relating to all incidents involving use of force by staff in the previous month. The number of incidents by location was also monitored.

2.165 **All staff should be refreshed in control and restraint techniques every 12 months. (6.49)**
**Not achieved.** Just under half of staff had received control and restraint refresher training in the previous 12 months.
**We repeat the recommendation.**

2.166 **The practice of locking down the entire establishment whenever an alarm bell is activated should cease and more appropriate arrangements introduced. (6.50)**
**Not achieved.** The entire establishment was still locked down whenever an alarm bell was activated. This was disproportionate and unnecessary.
**We repeat the recommendation.**

2.167 **All unfurnished cells should be formally designated as special accommodation with a protocol specifying how they are to be used, with authorisation at an appropriately senior level, and the formal procedures for the use of special accommodation followed. (6.51)**
**Achieved.** All special accommodation was now designated as such and there was a policy stipulating under what circumstances it was to be used and that authorisation from the duty manager was required. Routine observations were required in line with the NIPS CRS operating procedures. Special accommodation had not been used in the previous six months.

2.168 **Young people should not be located for up to 48 hours in the segregation unit solely on the basis of an indication by the passive drug dog. (6.52)**
**Not achieved.** Young people were still located in the segregation unit following an indication from a passive drug dog after a visit. Managers said many returned to their unit well within 48 hours after either handing over drugs or a negative indication from the drug dog but they could not evidence this as no records were kept.
**We repeat the recommendation.**

2.169 **Special Supervision Unit staff should be selected to work there by the governor based on their commitment to work constructively with difficult and challenging young people and a willingness to move away from the customs, practices and terminologies of the past. (6.53)**
**Not achieved.** There were no formal selection criteria. Staff working in the segregation unit said they had either expressed an interest in working there or were told they would be.
**We repeat the recommendation.**

2.170 **Young people in the Special Supervision Unit should be allowed tobacco in possession. (6.54)**
**Achieved.** Young people could now keep tobacco in possession while in the Special Supervision Unit.

2.171 **All young people in the Special Supervision Unit should receive the minimum regime entitlements of a shower, telephone call and time in the fresh air every day, regardless of the number of adjudications scheduled. (6.55)**
**Achieved.** All young people we spoke to either currently or previously located in the Special Supervision Unit said they had received daily access to the telephones, showers and exercise yard.

## Progressive regimes and earned privileges scheme (PREPS)

2.172 **Visits and telephone allowances should not be part of the PREP Scheme. (6.67)**
**Achieved.** Visits were a part of the PREPS but appropriately so as the minimum entitlement was available on the basic level and additional visits on enhanced. Visits lasted the same amount of time regardless of a prisoner's PREPS level. Child-centred visits were available at all levels. Prisoners on the basic level were limited to spending £20 a week on telephone credit, those on standard to £24 and those on enhanced to £30. These levels were reasonable.

2.173 **There should be more sustained efforts to help those on the basic regime for lengthy periods to progress to standard. (6.68)**
**Not achieved.** There was too punitive an approach to the PREPS and too many young people remained too long on basic. On one day of the inspection, nine prisoners were on the basic level. Over a recent 12-month period, 32 prisoners had been on basic for between four and six weeks and 15 over eight weeks. Some plans of prisoners on basic had very general targets and did not indicate that enough was being done to help them progress.
**We repeat the recommendation.**

2.174 **The procedures for applying for special privileges status should be published, transparent and monitored. (6.69)**
**Not achieved.** Special privileges status had been removed for a short time but had been reintroduced through the OMU. A notice to staff set out the criteria for internal and external special privileges. Applications were considered by the home leave board. No information had been published for prisoners who did not know the criteria or how to apply for it.
**We repeat the recommendation.**

2.175 **PREPS should be routinely monitored by religion by the equality and diversity committee. (6.70)**
**Not achieved.** The diversity and equality committee looked at a snapshot of prisoners' PREPS levels by religion at bi-monthly meetings but there was no routine monitoring. According to data for the period from March 2010 to February 2011, Roman Catholics accounted for 75% of prisoners on basic for four to six weeks, 91% of those on basic for six to eight weeks and 67% of those on basic for over eight weeks. The average Roman Catholic population in the six months to February 2011 was 57.5%.
**We repeat the recommendation.**

2.176 **The operation of PREPS across all units should be monitored for fairness by a senior manager. (6.71)**
**Not achieved.** There was no formal monitoring of the operation of the PREPS Scheme across the different units. We were told that managers were aware that some staff had used the PREPS levels unfairly to move prisoners between units, particularly when prisoners were being demoted from the enhanced Cedar House.
**We repeat the recommendation.**

## Catering

2.177 **The standard of food should be improved. (7.7)**
**Not achieved.** We received numerous complaints about the standard of the food. Most prisoners we spoke to said the food was bland and unappetising and many said they bought items from the shop to supplement their diet.
**We repeat the recommendation.**

2.178 **All personnel responsible for handling food should be subject to a health check. (7.8)**
**Partially achieved.** Male prisoners no longer worked in the kitchen but all those working on serveries were subject to health checks. However, staff responsible for handling food were not subject to these checks and simply had to report any notifiable conditions.

### Further recommendation

2.179 All staff responsible for handling food should be subject to a health check.

2.180 **The consultation arrangements about food should be improved so that views expressed by prisoners are considered seriously and, when valid, acted on. (7.9)**
**Not achieved.** Consultation arrangements about the food were extremely poor and prisoners had no effective forum where they could express their views. No food survey had been carried out since February 2009, no food comment books were available and little attention was paid to any comments about food made at the general consultation forums.
**We repeat the recommendation.**

## Additional information

2.181 The food we sampled was bland and the menu lacked variety. Food was also kept in the heated trolleys for some time before being served so was often over-cooked and unappetising. Prisoners on C5 had some opportunities to cook food for themselves, which they preferred. Prisoners welcomed the cooked breakfast provided at weekends.

## Prison shop

2.182 **Young people in Hydebank Wood YOC should have the same spending allowances as women prisoners in Ash Unit. (7.17)**
**Achieved.** Spending allowances under the PREPS were identical for all prisoners in Northern Ireland.

## Strategic management of resettlement

2.183 **A resettlement team should be established along the lines of the teams that exist in the other two Northern Ireland prisons. (8.10)**
**Achieved.** A new OMU had been established in September 2009 in dedicated premises where prison officers, probation personnel, chaplains, psychologists and voluntary sector providers were co-located and worked well together. Sentence managers were mostly longstanding main grade prison officers who volunteered for these positions. Their job was essentially to ensure that all remanded and sentenced prisoners had a resettlement plan. The training provided was good. The reason for establishing the OMU was the introduction of new Criminal Justice Order (Northern Ireland) 2008 sentences requiring greater input by both prisoners and staff in advance of release. This population represented only 41 out of 203 men but resettlement work as a whole benefited as it was subsumed within the new arrangements. Unfortunately, some NIPS staff viewed the OMU as remote from their roles.

2.184 **The weekly operational and monthly strategic resettlement meetings should be reprioritised and should have clear terms of reference that clarify their distinct purposes. (8.11)**
**Not achieved.** Resettlement board

minutes from October 2008 to January 2011 showed that meetings had lapsed in early 2009 until September 2009. Subsequent minutes were available for February, August, November and December 2010 and January 2011, by which stage the meeting had been renamed as 'resettlement/inmate activities'. Representatives from health care, custody, the gym and kitchen were consistently absent. In November 2010, it was recorded that there were no terms of reference for the group but the situation began to clarify in December 2010, when it was minuted that the purpose of the meeting was 'to inform everyone of what programmes and interventions were taking place in the centre and to discuss new initiatives'. However, the non-attendance of key members precluded any further discussion. More recently, the managers' weekly performance meetings and the introduction of an intervention panel to oversee programme delivery had improved accountability.
**We repeat the recommendation.**

## Offender management and planning

2.185 **Prisoners should be invited to attend their resettlement meetings and meaningfully engaged in preparing for these meetings. (8.26)**
**Partially achieved.** All new committals, including those on remand, were expected to attend a resettlement board within four weeks and most did so. Some prisoners were confused about the purpose of the meeting and some said the activities and programmes suggested to them had not materialised several months later. Two internal reports completed in 2010 suggested there had been a significant improvement in elements of resettlement at Hydebank Wood but prisoners remained uncertain about the benefits. Most said they had copies of their sentence plans but several had thrown them away. The terminology was felt to be confusing and information overload was considered a problem. A new induction programme aimed to help improve prisoners' understanding of the process.

2.186 **Resettlement plans should actively inform allocation to activities and programmes and decisions about regime status. (8.27)**
**Not achieved.** Sentence plans had improved, particularly for prisoners on Criminal Justice Order sentences. However, neither prisoners nor staff believed the plans influenced allocation to activities or regime status, which depended more on security decisions, prisoner conduct and motivation. Everything also had to fit in with the increasingly limited regime. There were some examples where miscommunication had led to prisoners being withdrawn from activities without reference to themselves or key workers and others where prisoners were allocated to inappropriate programmes. The new resettlement strategy detailed the role of residential liaison officers (see section on main recommendations) who would 'provide an important link with sentence managers, case managers and other key support services'. While the residential liaison officer scheme never really got going within the YOC, it was positive that nearly all young male prisoners, including remandees, knew their sentence manager and understood their role.
**We repeat the recommendation.**

2.187 **Home leave and resettlement leave statistics should be disaggregated and separately reported. (8.28)**
**Achieved.** Separate data were now available. In the year to March 2011, 150 of 194 home leave applications had been approved and all eight resettlement leave applications had been successful. Staff understood the different purposes of resettlement and home leave.

## Indeterminate-sentenced prisoners

2.188 **Lifer liaison officers should fulfil the role of personal officers for lifers and keep in regular touch with them about their progress. (8.38)**
**Not achieved.** There were no lifer officers for young men. While they had sentence managers who dealt with local regime planning, the Maghaberry lifer management unit oversaw case progression. Reports for their annual reviews often had to be completed by staff who were not acquainted with them. Maghaberry Lifer Management Unit had provided relevant documentation but it was not on the lifers' Hydebank OMU files. Consideration was being given to integrating the Lifer Management Unit with OMUs in each prison, which would redress this deficiency.
**We repeat the recommendation.**

2.189 **A fundamental review of the lifer regime should be undertaken to recognise their specific needs and to allow them more responsibility, including the possibility of earning special privileges status. (8.39)**
**Not achieved.** No review had been undertaken and lifers were still integrated with other remand and sentenced prisoners. They could not even progress to Cedar 5 landing. There were seven young male lifers, all of whom would transfer to Maghaberry by the age of 24 and could then expect to go to the Braid lifer unit rather than into the main prison.
**We repeat the recommendation.**

2.190 **A formal process should be agreed to identify and support potential lifers. (8.40)**
**Not achieved.** No process had been agreed and several staff were unaware of potential lifers on their landings.
**We repeat the recommendation.**

## Resettlement Pathways

### Finance, benefit and debt

2.191 **Advice on finances should be provided to all young people who need it. (8.54)**
**Achieved.** A NIACRO benefits advice worker based in the OMU was available to see the prisoners each week. We were told that good work was being delivered in relation to housing and benefits advice and 'fewer people were slipping through the net'.

### Drugs and alcohol

2.192 **The drug and alcohol strategy should be informed by a comprehensive needs assessment and any identified gaps in service provided. (8.59)**
**Not achieved.** There was no up-to-date drug and alcohol strategy. Drug strategy meetings were poorly attended and had only recently started again after several months.
**We repeat the recommendation.**

### Children and families of offenders

2.193 **There should be clear signposts to the prison, particularly at the entrance. (3.104)**
**Partially achieved.** There was a sign at the entrance but still no signposting to the prison from surrounding roads.

2.194 **All prisoners should be allowed visits of at least one hour. (3.105)**
**Achieved.** Visits lasted one hour.

2.195 **Visitors should be able to purchase hot meals or snacks either in the visitors' centre or in the visits hall. (3.106)**
**Achieved.** NIACRO had introduced a trolley refreshment service in the visits room that included a selection of sandwiches.

2.196 **Babies should be searched only when there is specific intelligence, agreed by a senior manager, that this is necessary. (3.107)**
**Not achieved.** All babies were still given a rub-down search without individual risk assessment.
**We repeat the recommendation.**

2.197 **Privacy screening should be introduced between the closed visit rooms and the general visits area. (3.108)**
**Not achieved.** The situation had not changed.
**We repeat the recommendation.**

2.198 **Guidance on closed visits should specify when decisions to impose restrictions should be reviewed. (3.109)**
**Not achieved.** An instruction to governors dated 31 March 2009 stated that the duration of a closed visit would be subject to 'periodic review' but not what this meant in practice.
**We repeat the recommendation.**

2.199 **Arrangements for consulting visitors about their experience should be improved. (3.110)**
**Partially achieved.** The visitors' comment book was no longer available. A suggestion box had been installed in the visitors' centre but no writing materials were provided. A monthly visitor forum involving visitors and prison managers had been introduced but minutes were not displayed in the visitors' centre and none were made available to us so we could not determine what had actually been discussed. There was no annual survey of visitors' experiences. NIACRO had undertaken a visitor survey in December 2010 but this had been limited to the booking provision. This showed that most visits took place on Saturday and were booked by telephone, a method that a quarter of respondents found difficult. The booking line was closed at lunchtimes and after 4pm but visits could also be booked in person and through the internet. The NIPS planned to introduce a centralised booking system for all Northern Ireland prisons.

## Additional information

2.200 The prison was reasonably well served by public transport. The visitors' centre was comfortable and well equipped and NIACRO staff ran a 'meet and greet' service for first time visitors as well as giving support and information to all visitors. The visits room was little changed and young men and juveniles continued to share it with women prisoners. Family liaison officers saw all new arrivals and their visitors to explain the support available. Family days were organised three or four times a year and the family room was still used for juveniles to enjoy a two-hour visit with their parents and for young men to have time with their children and children's carer.

## Attitudes, thinking and behaviour

2.201 **The NIPS should provide interventions for young people in denial about their current offence to address previous offending, the consequences of being imprisoned and future risks. (8.70)**
**Partially achieved.** A new 'safer lives' programme had been designed and introduced for young male sex offenders and a programme for arsonists was run in conjunction with the Northern Ireland Fire and Rescue Service. However, there was still no specific provision for prisoners who denied their offending. A range of programmes covering drugs and alcohol abuse, anger management, GOALS (a programme designed to tackle the psychology of social exclusion) and enhanced thinking skills addressed the consequences of imprisonment and future risks but were primarily for sentenced prisoners. The new resettlement strategy Pathways focused mainly on personal development issues that would contribute at least indirectly to addressing future risks.

CHAPTER 3:

# Summary of recommendations

*The following is a list of both repeated and further recommendations included in this report. The reference numbers in brackets refer to the paragraph location in the main report published in 2007.*

## Main recommendations

3.1 The Northern Ireland Prison Service (NIPS) should either remove children under the age of 18 from Hydebank Wood YOC or provide appropriately resourced, dedicated accommodation with a regime capable of meeting the needs of this population. (2.1)

3.2 The NIPS should issue clear guidance on the implementation of a diversity strategy indicating areas to be prioritised and provide relevant staff training including in religious and cultural differences. (2.2)

3.3 Appropriate and distinct first night procedures for children should be introduced, including specific age-appropriate questions on the immediate issues facing children and clear action points arising from assessments. (2.6)

3.4 A personal officer scheme should be established to support young people at Hydebank Wood YOC, liaise with families and encourage effective resettlement. (2.7)

3.5 An effective anti-bullying and violence reduction strategy should be developed to ensure that all alleged incidents of bullying are investigated and vulnerable young people protected. (2.8)

3.6 The suicide and self-harm prevention policy should be revised to reflect the specific needs of children and young adults and to develop a more therapeutic response to support young people at risk at Hydebank Wood YOC. (2.9)

3.7 The service improvement board should ensure that the health needs of young adults and children at Hydebank Wood YOC are identified and met. (2.11)

3.8 An education and training policy for young people should be developed, including a coherent and distinct strategy for juveniles, that provides sufficient work and education places to keep all young people purposefully occupied. (2.12)

3.9 Effective collaborative partnerships with external education and training providers, such as further education and/or work-based learning suppliers, should be established. (2.13)

3.10 All young people should have at least 10 hours out of their cells on weekdays including a daily scheduled period of one hour's exercise in the open air. (2.14)

## Recommendations

### Courts, escorts and transfers

3.11 Young men, juveniles and women prisoners should be transported separately. (2.16)

3.12 Young people should not routinely be handcuffed in vans or to and from reception without the need for this being determined through individual security risk assessment. (2.17)

3.13 Young people should arrive before 7pm. (2.19)

3.14 Young people should be escorted in vehicles that are safe, clean and comfortable. (2.20)

3.15 Property and private cash should accompany unsentenced young people to court. (2.21)

3.16 Young people should be given the information leaflet about Hydebank Wood YOC at court by NIPS escort staff. (2.22)

### First days in custody

3.17 Full information should be available to reception and first night staff to inform initial assessments. (2.25)

3.18 Juveniles should not be routinely strip searched. (2.26)

### Accommodation and facilities

3.19 The offensive display policy should be uniformly applied. (2.43)

3.20 Telephones should be enclosed in booths to allow privacy. (2.47)

3.21 Managers should discuss prisoner dissatisfaction with the mail at prisoner consultation meetings and take action to address any identified shortfalls. (2.49)

3.22 The communal shower and washing facilities on Elm and Willow Houses should be refurbished and redecorated. (2.51)

### Staff-prisoner relationships

3.23 All staff should have training to help them understand, engage with and intervene effectively with young people in custody. (2.54)

3.24 Staff should routinely use first names or title and surname when speaking or referring to young men in their care. (2.55)

### Bullying and violence reduction

3.25 A safer custody committee specifically for Hydebank Wood YOC should be established focusing on anti-bullying, the prevention of suicide and the reduction of self-harm. (2.56)

3.26 All potential indicators of bullying should be monitored and, where there are concerns that bullying may be involved, the incident should be investigated irrespective of whether the alleged victim has made a written statement. (2.57)

3.27 The profile of anti-bullying should be improved to create an environment where young people have faith in the anti-bullying strategy, including appointing safer custody liaison officers for each unit. (2.58)

3.28 Effective interventions to challenge bullies and support victims should be developed. (2.59)

3.29 All staff in direct contact with young people should receive training in the anti-bullying strategy. (2.60)

### Self-harm and suicide

3.30 There should be a suicide prevention co-ordinator (SPC) exclusively for Hydebank Wood YOC with sufficient allocated time to carry out this role. (2.62)

3.31 Investigations, recommendations and learning points from serious or near-fatal incidents should be shared with relevant staff including the SEHSCT and incorporated into action plans monitored by the safer custody committee. (2.64)

3.32 Trained senior officers should provide continuity in the management of cases. (2.66)

3.33 Managers should make regular checks on open PAR 1 forms and make written comments on the quality of care offered. (2.67)

3.34 The length of time young people are placed in the observation rooms in health care and the Special Supervision Unit (SSU) should be monitored by the safer custody meeting. (2.69)

3.35 Alternative therapeutic responses to the use of observation rooms and strip clothing should be developed for those at risk of self-harm. (2.70)

3.36 All staff in contact with young people should receive suicide awareness training. (2.74)

3.37 A Listener scheme should be developed. (2.75)

## Child protection

3.38 The agreement of the local area child protection committee (ACPC) with the revised child protection policy should be secured and a protocol agreed with the local health and social services trust to make the policy and related practices a reality. (2.78)

3.39 A formal request should be made that the governor of Hydebank Wood YOC is granted membership of the area child protection committee (ACPC). (2.79)

3.40 Child protection referrals should be monitored and analysed for patterns or trends. (2.81)

3.41 All staff who come into contact with children should have comprehensive inter-disciplinary child protection training. (2.82)

## Applications and complaints

3.42 There should be a formal system of quality assurance of complaints to ensure that they are fully investigated and that replies are courteous and directly and clearly address the nature of the complaint. (2.87)

3.43 Requests and complaints should be routinely analysed to identify patterns or trends. (2.88)

## Substance use

3.44 All those who require first night treatment/symptomatic relief following screening and testing should have it prescribed and administered. (2.91)

3.45 Specialist staff should complete a comprehensive assessment of need to determine suitable stabilisation, maintenance or detoxification regimes. (2.92)

3.46 Prescribing regimes should be flexible and meet individual need. (2.93)

3.47 Young people should benefit from the support of the specialist addictions team. (2.95)

## Diversity

3.48 The equality and diversity committee should meet regularly, with all designated members or representatives attending, to consider and take action on any identified or potential areas of discrimination. (2.96)

3.49 A system of monitoring that identifies and highlights areas of under and over-representation should be introduced and

monitoring data should distinguish between male and female prisoners. (2.97)

### Race equality

3.50 The equality and diversity officers should receive specialist training and should be allocated dedicated time to carry out their additional duties. (2.99)

3.51 Links with Irish Traveller support groups should be strengthened and consolidated. (2.100)

3.52 A separate system for investigating racist complaints should be introduced and staff appropriately trained. (2.101)

### Foreign nationals

3.53 Professional interpretation services should be used when legal matters or issues relating to vulnerability are discussed with young people with little or no English. (2.105)

### Health services

3.54 The health needs assessment of the young people at Hydebank Wood YOC should be reviewed and services to meet their specific needs should be commissioned and provided. (2.108)

3.55 There should be an information-sharing policy with appropriate agencies to ensure efficient sharing of relevant health and social care information. It should include the need to obtain a patient's consent when appropriate. (2.110)

3.56 All emergency equipment should be checked regularly to ensure that it is in date and fit for purpose; documented evidence of such checks should be kept. (2.111)

3.57 All health services staff, including allied health professionals, should have annual training in resuscitation and child protection. (2.112)

3.58 Clinical supervision should be available to all health services staff. (2.113)

3.59 Barrier protection (condoms and lubricants) should be freely available. (2.117)

3.60 Decisions about daily, weekly or monthly in possession medications should be clearly documented. (2.123)

3.61 There should be patient group directions (PGDs) for all vaccinations. (2.124)

3.62 All patient group directions should be in date and signed in accordance with Trust policy. (2.125)

3.63 Over-the-counter medicines should be available for young people to buy from the tuck shop. (2.126)

3.64 Young people who arrive with ongoing dependence on prescription medications should be carefully assessed and monitored before any detoxification regime is commenced. (2.127)

3.65 The in-patient beds should not form part of the prison's certified normal accommodation. (2.129)

3.66 Admission to the in-patient unit should be decided on clinical need. (2.130)

3.67 All prisoners requiring a clinical alcohol detoxification should be admitted to the in-patient unit. (2.131)

3.68 Day services should be available for those less able to cope with prison life. (2.132)

3.69 All health services accommodation should be fit for purpose, with appropriate provision for male and female patients to be held separately. (2.135)

3.70 Arrangements for attendance at outside hospital appointments, including waiting times and cancellations, should be subject to audit. (2.136)

3.71 Psychiatric services should be reviewed to ensure that there are sufficient resources to meet the needs of young people, including child and adolescent services. (2.137)

3.72 Clear guidance on reporting serious adverse incidents should be issued and these incidents should be investigated in a co-ordinated fashion to ensure lessons learnt are implemented effectively. (2.139)

### Time out of cell

3.73 Unlock and lock-up should take place at the published times. (2.140)

3.74 Staffing ratios should be reviewed to ensure they are appropriate to the risk posed by prisoners. (2.141)

### Learning and skills and work activities

3.75 The use of existing education and training capacity should be improved. (2.142)

### Physical education and health promotion

3.76 The range of vocational courses leading to qualifications should be developed further to meet the needs and interests of all young people, particularly those who do not attend the gym regularly. (2.145)

### Security and rules

3.77 The number of routine cell searches should be reduced and the searching strategy should be reviewed to find more efficient and effective ways of tackling supply reduction. (2.148)

3.78 Opportunities for more free movement around the YOC should be increased. (2.150)

### Discipline

3.79 A behaviour management strategy should be developed for Hydebank Wood YOC, incorporating recognised best practice in managing the behaviour of young people in consultation with Opportunity Youth and other external youth agencies. (2.154)

3.80 The adjudication room should be made a more age-appropriate environment for children. (2.155)

3.81 There should be a written record of adjudication hearings to ensure that managers are able to scrutinise and evaluate disciplinary procedures. (2.156)

3.82 The reasons for the disproportionate number of Roman Catholic prisoners placed on report should be investigated and appropriate action taken as necessary. (2.157)

3.83 Guidance on appropriate levels of punishments should be updated to make punishments more commensurate with offences and should be subject to regular review through standardisation meetings. (2.159)

3.84 Prisoners should not be subject to informal or group punishments without the safeguard of going through a formal disciplinary process. (2.162)

3.85 All staff should be refreshed in control and restraint techniques every 12 months. (2.165)

3.86 The practice of locking down the entire establishment whenever an alarm bell is activated should cease and more appropriate arrangements introduced. (2.166)

3.87 Young people should not be located for up to 48 hours in the segregation unit solely on the basis of an indication by the passive drug dog. (2.168)

3.88 Special Supervision Unit staff should be selected to work there by the governor based on their commitment to work constructively with difficult and challenging

young people and a willingness to move away from the customs, practices and terminologies of the past. (2.169)

### Progressive regimes and earned privileges

3.89 There should be more sustained efforts to help those on the basic regime for lengthy periods to progress to standard. (2.173)

3.90 The procedures for applying for special privileges status should be published, transparent and monitored. (2.174)

3.91 PREPS should be routinely monitored by religion by the equality and diversity committee. (2.175)

3.92 The operation of PREPS across all units should be monitored for fairness by a senior manager. (2.176)

### Catering

3.93 The standard of food should be improved. (2.177)

3.94 All staff responsible for handling food should be subject to a health check. (2.179)

3.95 The consultation arrangements about food should be improved so that views expressed by prisoners are considered seriously and, when valid, acted on. (2.180)

### Strategic management of resettlement

3.96 The weekly operational and monthly strategic resettlement meetings should be reprioritised and should have clear terms of reference that clarify their distinct purposes. (2.184)

### Offender management and planning

3.97 Resettlement plans should actively inform allocation to activities and programmes and decisions about regime status. (2.186)

### Indeterminate-sentenced prisoners

3.98 Lifer liaison officers should fulfil the role of personal officers for lifers and keep in regular touch with them about their progress. (2.188)

3.99 A fundamental review of the lifer regime should be undertaken to recognise their specific needs and to allow them more responsibility, including the possibility of earning special privileges status. (2.189)

3.100 A formal process should be agreed to identify and support potential lifers. (2.190)

### Resettlement pathways

3.101 The drug and alcohol strategy should be informed by a comprehensive needs assessment and any identified gaps in service provided. (2.192)

3.102 Babies should be searched only when there is specific intelligence, agreed by a senior manager, that this is necessary. (2.196)

3.103 Privacy screening should be introduced between the closed visit rooms and the general visits area. (2.197)

3.104 Guidance on closed visits should specify when decisions to impose restrictions should be reviewed. (2.198)

Section 2

# Appendices

# Appendix 1: Inspection Team

| | |
|---|---|
| **Dr Michael Maguire** | Chief Inspector of Criminal Justice in Northern Ireland (CJI) |
| **Michael Loughlin** | Inspection Team Leader, Her Majesty's Inspectorate of Prisons (HMIP) |
| **Tom McGonigle** | Inspector, CJI |
| **Fay Deadman** | Inspector, HMIP |
| **Ian MacFadyen** | Inspector, HMIP |
| **Paul Fenning** | Inspector, HMIP |
| **Lucy Young** | Inspector, HMIP |
| **Ian Thomson** | Inspector, HMIP |
| **Elizabeth Tysoe** | Health Care Inspector, HMIP |
| **Elizabeth Colgan** | Lead Inspector, Regulation and Quality Improvement Authority (RQIA) |
| **Helen Daly** | Pharmacy Inspector, RQIA |
| **Paula Hendron** | Inspector, RQIA |
| **Gerry Colgan** | Inspector, RQIA |
| **Barry O'Rourke** | Lead Inspector, Education and Training Inspectorate (ETI) |
| **John Baird** | Inspector, ETI |
| **Deirdre Gillespie** | Inspector, ETI |
| **Jayne Walkingshaw** | Inspector ETI |

# Appendix 2: Prison population profile

*Please note: the following figures were supplied by the establishment and any errors are the establishment's own.*

**Population breakdown by:**

| (i) Status | No. of young adults | % |
|---|---|---|
| Sentenced/fined | 109 | – |
| Remand/awaiting trial | 80 | – |
| **Total** | **189** | **100** |

| (ii) Length of sentence | No. of Young Offenders | % |
|---|---|---|
| Less than 6 months | 25 | 30.5 |
| 6 months to less than 12 months | 16 | 19.51 |
| 12 to 18 months | 1 | 1.2 |
| 18 to 24 months | – | – |
| 24 to 36 months | 3 | 3.66 |
| 36 to 48 months | 1 | 1.2 |
| Over 48 months | 1 | 1.2 |
| Life/SOSP | 2 | 2.4 |
| ECS | 4 | 4.88 |
| DCS | 29 | 35.36 |
| ICS | – | – |
| **Total** | **82** | **100** |

| (ii) Length of sentence | No. of young adults | % |
|---|---|---|
| Less than 6 months | 1 | 3.7 |
| 6 months to less than 12 months | 2 | 7.4 |
| 12 to 18 months | 1 | 3.7 |
| 18 to 24 months | 1 | 3.7 |
| 24 to 36 months | – | – |
| 36 to 48 months | 3 | 11.1 |
| Over 48 months | 5 | 18.5 |
| Life/SOSP | 5 | 18.5 |
| ECS | 1 | 3.7 |
| DCS | 8 | 29.7 |
| ICS | – | – |
| **Total** | **27** | **100** |

| (iii) Length of time served for unsentenced men | No. of Young Offenders | % |
|---|---|---|
| Less than 1 month | 29 | 40.8 |
| 1 month to 3 months | 14 | 19.7 |
| 3 months to 6 months | 19 | 26.7 |
| 6 months to 1 year | 9 | 12.7 |
| **Total** | **71** | **100** |

| (iii) Length of time served for unsentenced men | No. of young adults | % |
|---|---|---|
| Less than 1 month | – | – |
| 1 month to 3 months | 5 | 55.6 |
| 3 months to 6 months | 2 | 22.2 |
| 6 months to 1 year | 1 | 1.1 |
| 1 to 2 years | 1 | 1.1 |
| **Total** | **9** | **100** |

| (iv) Main offence | No. of Young Offenders | % |
|---|---|---|
| Murder | 4 | 2.6 |
| Other offences against the person | 41 | 26.8 |
| Burglary/robbery/theft | 73 | 47.7 |
| Fraud and forgery | 1 | 0.7 |
| Drug offences | 8 | 5.2 |
| Other offences | 8 | 5.2 |
| Criminal damage | 8 | 5.2 |
| Motoring offences | 2 | 1.3 |
| Sex offences | 8 | 5.2 |
| **Total** | **153** | **100** |

| (iv) Main offence | No. of Young Offenders | % |
|---|---|---|
| Murder | 6 | 16.7 |
| Other offences against the person | 9 | 25 |
| Burglary/robbery/theft | 13 | 36.1 |
| Sex offences | 2 | 5.5 |
| Drug offences | 1 | 2.8 |
| Other offences | 4 | 11.1 |
| Criminal damage | 1 | 2.8 |
| **Total** | **36** | **100** |

| (v) Age | No. of males | % |
|---|---|---|
| 18 - 20 | 153 | 81 |
| 21 and Over | 36 | 19 |
| **Total** | **189** | **100** |

| (vi) Home address | No. of Young Offenders | % |
|---|---|---|
| Northern Ireland | 138 | 90.2 |
| Republic of Ireland | 1 | 0.6 |
| England | – | – |
| NFA | 10 | 6.6 |
| Unknown | 4 | 2.6 |
| **Total** | **153** | **100** |

| (vi) Home address | No. of young adults | % |
|---|---|---|
| Northern Ireland | 30 | 83.3 |
| Republic of Ireland | – | – |
| England | 1 | 2.8 |
| NFA | 5 | 13.9 |
| Unknown | – | – |
| **Total** | **36** | **100** |

| (vii) Location Breakdown | County | No. of Young Offenders | % |
|---|---|---|---|
| Northern Ireland | Antrim | 75 | 49 |
| | Armagh | 7 | 4.6 |
| | Down | 16 | 10.5 |
| | Fermanagh | 7 | 4.6 |
| | Londonderry | 18 | 11.8 |
| | Tyrone | 15 | 9.8 |
| Republic of Ireland | Dublin | 1 | 0.6 |
| NFA | | 14 | 9.2 |
| **Total** | | **153** | **100** |

| (vii) Location Breakdown | County | No. of young adults | % |
|---|---|---|---|
| Northern Ireland | Antrim | 12 | 33.3 |
| | Armagh | 1 | 2.8 |
| | Down | 9 | 25 |
| | Fermanagh | 3 | 8.3 |
| | Londonderry | 4 | 11.1 |
| | Tyrone | 1 | 2.8 |
| England | Bucks | 1 | 2.8 |
| NFA | | 5 | 13.9 |
| **Total** | | **36** | **100** |

| (viii) Nationality | No. of Young Offenders | % |
|---|---|---|
| British | 15 | 9.8 |
| British – England | 1 | 0.6 |
| British – Northern Ireland | 114 | 74.5 |
| Northern Irish | 8 | 5.2 |
| Irish | 12 | 7.8 |
| Lithuanian | 1 | 0.6 |
| Chinese | 2 | 1.3 |
| **Total** | **153** | **100** |

| (viii) Nationality | No. of young adults | % |
|---|---|---|
| British | 1 | 2.8 |
| British – England | 2 | 5.6 |
| British – Northern Ireland | 27 | 75 |
| Northern Irish | 3 | 8.3 |
| Irish | 3 | 8.3 |
| **Total** | **36** | **100** |

| (ix) Ethnic group | No. of Young Offenders | % |
|---|---|---|
| Black African | 1 | 0.6 |
| Chinese | 2 | 1.3 |
| Irish Traveller | 3 | 2 |
| White | 146 | 95.5 |
| Other Ethnic Group | 1 | 0.6 |
| **Total** | **153** | **100** |

| (ix) Ethnic group | No. of young adults | % |
|---|---|---|
| Black Caribbean | 1 | 2.8 |
| Irish Traveller | 2 | 5.6 |
| White | 33 | 91.6 |
| **Total** | **36** | **100** |

| (x) Religion | No. of Young Offenders | % |
|---|---|---|
| Church of England | 1 | 0.6 |
| Church of Ireland | 20 | 13.1 |
| Methodist | 1 | 0.6 |
| Baptist | 2 | 2 |
| Presbyterian | 23 | 15 |
| Roman Catholic | 85 | 55.5 |
| Other religion | 1 | 0.6 |
| Nil | 16 | 10.5 |
| Free Presbyterian | 3 | 2 |
| Jew | 1 | 0.6 |
| **Total** | **153** | **100** |

| (x) Religion | No. of young adults | % |
|---|---|---|
| Church of England | 1 | 2.8 |
| Church of Ireland | 2 | 5.6 |
| Methodist | 1 | 2.8 |
| Free Presbyterian | 2 | 5.6 |
| Presbyterian | 10 | 27.8 |
| Roman Catholic | 20 | 55.5 |
| **Total** | **36** | **100** |

First published in Northern Ireland in October 2011 by
CRIMINAL JUSTICE INSPECTION NORTHERN IRELAND
14 Great Victoria Street
Belfast BT2 7BA
www.cjini.org

**ISBN 978-1-905283-67-5**

Typeset in Gill Sans
Printed in Northern Ireland by Commercial Graphics Limited
Designed by Page Setup