Criminal Justice Inspection Northern Ireland
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AN ANNOUNCED INSPECTION OF

WOODLANDS JUVENILE JUSTICE CENTRE

22-28 JANUARY 2022

SEPTEMBER 2022

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national preventive mechanism

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by Criminal Justice Inspection Northern Ireland; the Regulation and Quality Improvement Authority; and the Education and Training Inspectorate.

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.

SEPTEMBER 2022

eti
The Education and Training Inspectorate
Promoting Improvement

The **Regulation** and **Quality Improvement** Authority

CONTENTS

LIST OF ABBREVIATIONS

ACE(s)	Adverse Childhood Experience(s)
ADHD	Attention Deficit Hyperactivity Disorder
Belfast HSCT	Belfast Health and Social Care Trust
CAMHS	Child and Adolescent Mental Health Service
CHAT	Comprehensive Health Assessment Tool
CJI	Criminal Justice Inspection Northern Ireland
CLC	Children's Law Centre
CSE	Child Sexual Exploitation
DoH	Department of Health
DoJ	Department of Justice
EA	Education Authority
EI	Early Intervention
EOTAS	Education Other Than At School
ETI	Education and Training Inspectorate
GP	General Practice/Practitioner
HSCT	Health and Social Care Trust
HBW	Hydebank Wood Secure College and Ash House Women's Prison
ICT	Information, Communication and Technology
JJC	Juvenile Justice Centre (Woodlands)
MMPR	Minimising and Managing Physical Restraint
NI	Northern Ireland
NIAO	Northern Ireland Audit Office
NIECR	Northern Ireland Electronic Care Record
NPM	National Preventive Mechanism
OBA	Outcomes Based Accountability
OPCAT	Optional Protocol to the United Nations Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment

PACE	Police and Criminal Evidence (Northern Ireland) Order 1989
PCR	Polymerase Chain Reaction
PECCS	Prisoner Escorting and Court Custody Service
PfG	Programme for Government
PSNI	Police Service of Northern Ireland
RQIA	Regulation and Quality Improvement Authority
SBNI	Safeguarding Board for Northern Ireland
SEHSCT	South Eastern Health and Social Care Trust
SMT	Senior Management Team
SOP(s)	Standard Operating Procedure(s)
UK	United Kingdom
VOYPIC	Voice of Young People in Care
Woodlands/Woodlands JJC	Woodlands Juvenile Justice Centre
YJA	Youth Justice Agency

CHIEF INSPECTOR'S FOREWORD

A very small number of children in our community need to be detained in the secure custodial care setting of Woodlands Juvenile Justice Centre. Many of them are in the care of social services or are known to them. Sometimes they are in custody because there is nowhere else for them to go. Most of them have complex needs that the criminal justice system cannot address alone. Often they only stay a few days and they may be in and out of custody frequently. While low in number, these children require intensive support and interventions to keep them safe and out of the criminal justice system in the future.

Woodlands Juvenile Justice Centre (Woodlands) is still being used too often as a place of safety because there are no available alternatives and children remain in custody because a suitable bail address isn't available. I was told that some children were breaking bail conditions or reoffending because they would rather be in Woodlands than at home or in the community; this is clearly a concerning issue that needs to be explored further.

This inspection found that the Woodlands team had maintained a child centered approach and children in their care were held safely, were well cared for and had a positive relationship with staff. The improvements in education provision since the last inspection are particularly welcome and need to be sustained.

Effective detention services for a reduced and potentially further reducing small number of children are needed, however, the current operating costs and model are difficult to justify. An opportunity to lead the way and demonstrate an optimum partnership between the Department of Justice and Department of Health through merging Woodlands and Lakewood Secure Care Centre (Lakewood) to create a regional care and justice campus with joint governance and management will not go ahead now and instead shared services will be progressed. This is very disappointing, particularly given the uncertainty over budgets and pressures on social worker resources. What is now proposed appears to fall well short of the ambitious joint service model options originally consulted on.

This inspection identified opportunities for greater collaboration between Woodlands and Lakewood in a range of areas that would make better use of the collective infrastructure and staff resources. Continuity of care, relationships with key workers and cohesive care plans could help achieve better outcomes for 'care' and 'justice' children moving between Lakewood and Woodlands.

Leadership and decision making at the next stage will need the ambition and energy to develop child centered shared services that deliver the benefits and outcomes needed and I hope, move closer towards delivering the optimum service model envisaged for Northern Ireland's most challenging children. The dedicated and experienced leaders and staff in the Youth Justice Agency and Woodlands could make that happen and deliver for children who need help to stop offending and fulfill their potential.

I am grateful to the Inspection Team led by Maureen Erne supported by Dr Roisin Devlin and Rachel Lindsay and to the Regulation and Quality Improvement Authority and Education and Training Inspectorate Inspectors for their work on this inspection, particularly the additional planning and safety measures required for on-site evidence gathering.

I am also very grateful to the Woodlands Juvenile Justice Centre staff and the children in their care who contributed to and supported this inspection. We appreciate all the Woodlands team have done to keep children and each other safe, especially during the height of the COVID-19 pandemic.

Jacqui Durkin
Chief Inspector of Criminal Justice
in Northern Ireland

September 2022

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ABOUT WOODLANDS JUVENILE JUSTICE CENTRE

Task of Woodlands Juvenile Justice Centre (Woodlands)

Woodlands is the only custodial facility for children in Northern Ireland. It holds boys and girls aged from 10 to 17.

Capacity		
Children held at the time of inspection:	Total capacity:	Staffed places:
10	**48**	**36**

Profile of the children

There were 10 young people (nine boys and one girl) held at Woodlands at the commencement of fieldwork on 22 January 2022. All but one was held on remand and most had been granted bail but a suitable address had not been approved. There were three additional Police and Criminal Evidence (Northern Ireland) Order 1989 (PACE) admissions and three discharges over the course of the week.

Of the 10 young people in custody on 22 January 2022:

- all were Roman Catholic;
- they ranged in age from 13 to 17 years with four aged 17;
- one had been in the isolation unit for six days, three had been in custody on remand for around two weeks and had just moved to open Units from 'step down'[1] and the remainder had been at Woodlands on average for three and a half months ranging from two months to five months;
- one was a foreign national;
- social services had previously been involved or were involved with eight young people;
- seven had previous involvement with the Youth Justice Agency;
- seven had previously been involved with the Child and Adolescent Mental Health Service or were currently involved with the in-reach service;
- there were concerns that one young person had been at risk of Child Sexual Exploitation; and
- for three young people this was their first time in custody.

1 A Unit used to accommodate children after their initial isolation period and pending the result of a second COVID-19 test. After a second negative test, children were moved to open Units.

Key service providers

- Health care services are led by a Nurse Manager, seconded from the Belfast Health and Social Care Trust. Day-to-day nursing care was provided by a small number of regular Agency nurses.
- The South Eastern Health and Social Care Trust Child and Adolescent Mental Health Service provided a dedicated Step 3 CAMHS service to Woodlands for young people referred for emotional, mental health or difficulties associated with neurodiversity.
- Since 2017 the Education Authority has managed the delivery of education within Woodlands as part of its Education Other Than At School provision.

Department

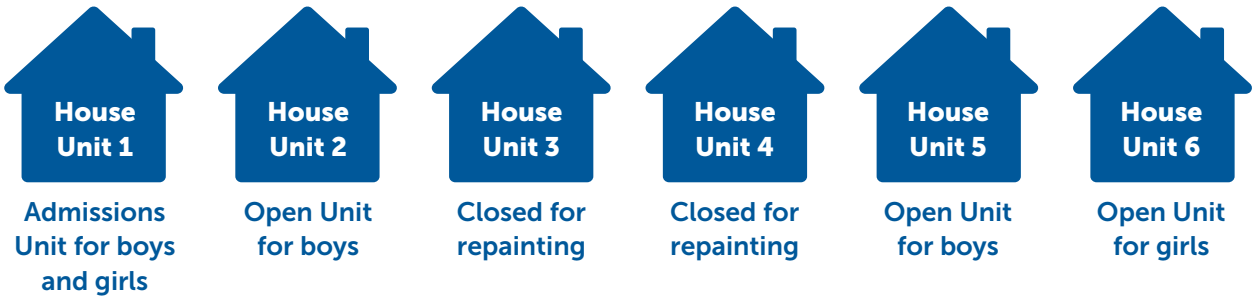
Woodlands is the custodial directorate of the Youth Justice Agency. The Youth Justice Agency is an Executive Agency of the Department of Justice and provides youth justice services under the Criminal Justice (Children) (Northern Ireland) Order 1998 and Justice (Northern Ireland) Act 2002.

Brief history

Woodlands opened in January 2007 and was a purpose-built facility which comprised six self-contained living Units clustered around an education area.

Short description of residential Units

The role of each Unit at the time of the inspection is outlined below.



Staffing

- At 31 December 2021 the total number of staff in post was 97 which excluded staff employed by the Education Authority, health care and private contractors.
- There were 55 care workers and 12 Team Leaders in post of which 20 were professionally qualified social workers.

Name of the Director

Paul McStravick, Acting Director Custodial Services, Youth Justice Agency.

Date of last inspection

November 2017 (report published June 2018).

EXECUTIVE SUMMARY

This inspection of Woodlands Juvenile Justice Centre formed part of Criminal Justice Inspection Northern Ireland's regular programme of inspection of places of detention, in accordance with its remit as part of the United Kingdom's National Preventive Mechanism and was conducted in partnership with the Regulation and Quality Improvement Authority and the Education and Training Inspectorate.[2] Our last inspection report of Woodlands Juvenile Justice Centre was published in June 2018. We inspected Woodlands Juvenile Justice Centre against *Expectations;* criteria adapted for use in Northern Ireland to assess the treatment of children and conditions in which they were held.

Strategy and governance

We were very conscious that we were not seeing Woodlands Juvenile Justice Centre in its normal operating context during this inspection. Like many other places of detention, leaders and staff had faced significant challenges with the onset of the COVID-19 pandemic to keep children, staff and visitors safe. For the most part a regime had been maintained, however the impact of the restrictions in place to mitigate against the risk of the spread of the virus was evident throughout life at Woodlands Juvenile Justice Centre, and was adversely impacting on children in custody. This was not unique to Woodlands Juvenile Justice Centre. As restrictions ease we encourage leaders to safely restore and develop the regime and also to review the learning from the last two years and build this into future contingency plans.

Very small numbers of young people were being committed to custody although the numbers had started to increase again slightly. The cost per place remained high. Woodlands Juvenile Justice Centre was staffed for 36 places and, at the time fieldwork was being conducted for this inspection, the facility was being maintained in its present state pending the creation of a regional care and justice campus which proposed Woodlands Juvenile Justice Centre's integration with Lakewood Regional Secure Care Centre. A strong child centred ethos was demonstrated by the leaders and staff we met during the inspection. However, we felt that if the integration of the two facilities was to be successful, there should be greater collaboration between the operational staff of Woodlands Juvenile Justice Centre and Lakewood Regional Secure Care Centre to aide their understanding of their respective environments and learn from each other.

2 As formal inspections across all education and training phases were paused, ETI conducted a formal monitoring visit rather than its usual full inspection.

In March 2022, the Ministers of Justice and Health decided that both facilities would continue to operate independently but develop shared support services. In light of this we recommend that a critical review is undertaken of the current operating model at Woodlands Juvenile Justice Centre that takes account of the implementation of the Ministers' decision.

There was a culture of continuous improvement and good progress had been made against the recommendations since the last inspection. Woodlands Juvenile Justice Centre had identified a number of areas for improvement in the self-assessment completed in preparation for this inspection. We supported this work and made recommendations to further embed improvements to: staff training – to ensure that all staff have training commensurate with their role; and the collection and use of data – to better understand the needs of children, inform service delivery and measure the progress young people make during the time they spend in custody.

Safety

We found children were held safely at Woodlands Juvenile Justice Centre. There were good admission and induction procedures and robust measures in place to safeguard young people and to support those at risk of self-harm. Child sexual exploitation screening was well-embedded. Child safeguarding training needed to be monitored more robustly. The behavioural management approach created a safe, controlled environment. The use of force had reduced since the last inspection and there was good governance of its use. We recommended improvements to a number of aspects of use of force record keeping to provide enhanced clarity and to ensure that post incident support was followed up and evaluated. The use of single separation presented as high and evidence extracted from the records we viewed did not provide robust assessment of the necessity and proportionality of the use of single separation. There was no robust evidence that each single separation inspected was effective and achieved improved outcomes for the young people. We recommended that the governance and rationale for use and delivery of single separation is improved.

Care

We found children were well cared for by staff and that young people felt cared for. Relationships between staff and young people were positive and particularly good with assigned key workers. Young people were encouraged to participate in life at Woodlands Juvenile Justice Centre and take responsibility for their behaviour. Formal engagement forums had been suspended for a period during the COVID-19 pandemic but had resumed in a different format. Every child had their own bedroom and they reported feeling safe in their room and communal areas. Some facilities were showing signs of wear and needed to be replaced, and more could be done to personalise bedrooms and communal spaces. The quality and quantity of food was generally good. Young people made few complaints; the Independent Reviewer of complaints continued to provide positive feedback on the management of complaints.

Children from a Catholic background continued to be overrepresented in custody. The Youth Justice Agency had commissioned external research to better understand the reasons for this.

Support for young people from Section 75[3] categories was provided on an individual basis. More could be done to champion and monitor equality and diversity within Woodlands Juvenile Justice Centre. Guidance was needed to support the management of non-binary young people in custody.

Generally the standard of health services was good and was child centred. The needs of young people were assessed on admission with appropriate referrals made during custody and on release. The in-reach Child and Adolescent Mental Health Service approach was very therapeutic and responsive and there were opportunities for this team to provide wider support to staff caring for children. Mostly satisfactory systems were in place for medicines management. Improvements were necessary in the management of controlled drugs, the governance and auditing systems, and the availability of newly prescribed medicines.

Purposeful activity

Children spent a large part of their day out of their bedrooms. For most, their day revolved around the school day and there were activities scheduled after school, in the evenings and at weekends. Young people had access to a well-equipped library and other excellent facilities to support learning, physical education and fitness. Due to current restrictions and low numbers of children in custody, optimal use was not being made of these facilities.

There had been an improvement in the planning and delivery of education, learning and skills since the last inspection. Recent service improvements were making a difference and needed to be sustained.

Resettlement

While face to face visits had been restricted at times during the COVID-19 pandemic, family contact was maintained through telephone calls and virtual visits. There was good work being done to support families and keep them involved and informed about their child's progress in custody. A new Integrated Care Planning process had been introduced for all children, excluding Police And Criminal Evidence (Northern Ireland) Order 1989 admissions, but more work was needed to ensure that all plans were individualised, contained specific, measureable, achievable, realistic, time-bound (SMART) objectives, adequately reflected the child's voice and recorded what progress had been achieved. In-reach Child and Adolescent Mental Health Service formulation meetings were good but these did not include the whole team nor were they completed for every child. Resettlement and reintegration planning, including interventions work, was often undermined by the relatively short time young people remained in custody.

Appropriate arrangements were in place to support the transfer of young people from Woodlands Juvenile Justice Centre to adult custody but the protocol needed to be updated.

The report makes one strategic recommendation, 11 operational recommendations and identifies five areas for improvement. Quality improvement plans identified by Woodlands Juvenile Justice Centre are also noted in the body of the report.

3 Section 75 of the Northern Ireland Act 1998 places a statutory obligation on public authorities to carry out their functions with due regard to the need to promote equality of opportunity and good relations in respect of religious belief, political opinion, gender, race, disability, age, marital status, dependants and sexual orientation.

RECOMMENDATIONS

STRATEGIC RECOMMENDATION

STRATEGIC RECOMMENDATION **1**

Within 12 months of publication of this report, the Youth Justice Agency should critically review the current operating model at Woodlands Juvenile Justice Centre that takes account of the impact of implementing the March 2022 decision by the Ministers of Health and Justice on the future of the regional care and justice campus programme. The review should include assurance that Woodlands Juvenile Justice Centre resources are deployed efficiently and effectively while maintaining a focus on delivering good outcomes for children.

In support of this, within three months of report publication, the Acting Director should identify and agree opportunities for the Woodlands Juvenile Justice Centre team to collaborate more closely with their counterparts in Lakewood Regional Secure Care Centre to discuss and better understand their respective operational environments and care approach. This will be essential for the successful implementation of any new shared services model.

Paragraph 2.42

OPERATIONAL RECOMMENDATIONS

OPERATIONAL RECOMMENDATION **1**

The Acting Director should introduce a regular staff training needs assessment with a clear plan for children's rights, child protection and child safeguarding training; this requires ongoing monitoring and exploration of opportunities tailored to staff roles in the Woodlands Juvenile Justice Centre to maximise their ability to identify and respond to concerns and young people's needs. This should be commenced within 12 months of publication of this report.

Paragraph 2.24

OPERATIONAL RECOMMENDATION **2**

Within 12 months of publication of this report, the Acting Director should develop and implement an effective mechanism to capture, monitor and analyse data which helps assess the outcomes for children in custody and informs the commissioning of services to address their risks and needs.

Paragraph 2.32

OPERATIONAL RECOMMENDATION **3**

Within six months of publication of this report, the leadership team at Woodlands Juvenile Justice Centre, in conjunction with the relevant authorities, should review its approach in response to the COVID-19 pandemic to identify learning and inform future response planning.

Paragraph 2.47

OPERATIONAL RECOMMENDATION **4**

The Acting Director should review the Minimising and Managing Physical Restraint policies and procedures within six months of publication of this report to address the following areas for improvement:

- the documenting of evidence to ensure that all instances of restraint, including use for serious damage to property, is limited to when there is an immediate risk to the safety of the child or others;
- that there are clear records that a child's family has been informed when Minimising and Managing Physical Restraint has been applied and that a child has had the opportunity to speak to someone impartial after the incident; and
- that post incident support is fully documented, followed-up and evaluated.

Paragraph 3.42

OPERATIONAL RECOMMENDATION **5**

Within six months of publication of this report, the Acting Director should review and improve the governance and delivery of single separation to provide assurance and evidence that its use is proportionate; it is only used as a last resort after other alternatives have been considered, and for the shortest time possible. This should include effective monitoring during the period of single separation and an audit process post single separation to extract learning by managers. Behaviour management processes should be monitored on a more holistic basis to demonstrate outcomes for young people.

Paragraph 3.58

OPERATIONAL RECOMMENDATION **6**

Within six months of publication of this report, the Acting Director, in conjunction with Youth Justice Agency leaders, should put in place effective arrangements to champion Equality and Diversity and ensure there are processes in place for effective equality monitoring. Guidance and training for staff should be provided on the management of transsexual and intersex children.

Paragraph 4.33

OPERATIONAL RECOMMENDATION **7**

The Acting Director and Nurse Manager should ensure that Standard Operating Procedures for the management of controlled drugs are further developed and implemented. The administration of controlled drugs should be witnessed by a second member of staff and records accurately maintained.

Paragraph 4.61

OPERATIONAL RECOMMENDATION **8**

The Acting Director and Nurse Manager should ensure that medicines are available for administration as prescribed. Any delays in availability should be investigated and action taken to ensure that effective ordering systems are in place.

Paragraph 4.64

OPERATIONAL RECOMMENDATION **9**

The Acting Director and Nurse Manager should ensure that governance and auditing systems are put in place to cover all aspects of the management of medicines identified in this report. Action plans to address any shortfalls should be implemented and addressed.

Paragraph 4.65

OPERATIONAL RECOMMENDATION **10**

The Acting Director should ensure that the planned review of Integrated Care Plans takes account of learning identified in this report. Care plans should be informed by an assessment of a young person's needs and a robust system to audit care plans should be put in place to ensure those needs are being met. Managers should ensure that all staff fully understand their role in the process and are clear how they best contribute to supporting case management teams.

Paragraph 6.10

OPERATIONAL RECOMMENDATION **11**
The Youth Justice Agency, Woodlands Juvenile Justice Centre, Hydebank Wood Secure College and Ash House Women's Prison should update the transition protocol within nine months of publication of this report to reflect how practice had evolved and incorporate learning and best practice from their respective experiences. This should include consideration of work to help parents of young people adjust to the transition from youth to adult custodial services.
Paragraph 6.28

Areas for improvement identified by Inspectors during this inspection are included within the report.

CHAPTER 1: INTRODUCTION

WHY INSPECT?

1.1 Woodlands Juvenile Justice Centre (Woodlands/Woodlands JJC) was inspected by Criminal Justice Inspection Northern Ireland (CJI) as part of its regular programme of inspections of places of detention.

1.2 The inspection was conducted in partnership with the Regulation and Quality Improvement Authority (RQIA) and the Education and Training Inspectorate (ETI). While formal inspections across all education and training phases continued to be paused, ETI conducted a formal monitoring visit rather than its usual full inspection (see paragraph 5.10 for further details).

1.3 All inspections carried out by CJI in partnership with the RQIA contribute to the United Kingdom's (UK) response to its international obligations under the Optional Protocol to the United Nations Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). The OPCAT requires that all places of detention are visited regularly by independent bodies collectively known as the National Preventive Mechanism (NPM) in order to monitor the treatment of and conditions for detainees.

Legislation and policy framework

1.4 The Criminal Justice (Children) (Northern Ireland) Order 1998 ('the Order') provides the legislative basis for the operation of Woodlands. The Order and supporting Juvenile Justice Centre Rules (Northern Ireland) 2008 ('the Rules') are modelled on the United Nations Convention on the Rights of the Child.

1.5 Underpinning the Rules were Standard Operational Procedures (SOPs) which had been reviewed and updated during 2020. The SOPs provided guidance and instructions to staff on safer custody, case management, social care, security, safety and welfare, support services, programmes and regimes and health care.

Background to this inspection

1.6 Woodlands was inspected against *Expectations for Children in Custody*.[4] The joint framework set out the criteria used by the Inspection Team to assess the treatment of children and the conditions at Woodlands.

4 *CJI, Expectations, Criteria for assessing the treatment of children and conditions in the Juvenile Justice Centre, Adapted for use from HM Inspectorate of Prison's Expectations for children in custody, Version 1, November 2021*, available at **http://www.cjini.org/getdoc/e4b25a40-5950-487e-9202-e430d6987584/JJC-Expectations-November-2021-(002).aspx**

1.7 HM Inspectorate of Prisons drew up the *Expectations* after extensive consultation and they were based on and referenced against international and regional human rights standards. The *Expectations* were based on four tests: Safety, Care, Purposeful Activity and Resettlement.

1.8 The joint inspection framework set out in the *Expectations* incorporated the ETI's *Inspection and Self Evaluation Framework* (ISEF): *Effective Practice and Self Evaluation Questions for Education Other Than at School* (EOTAS) and was used in conjunction with the RQIA's *Quality Standards for Health and Social Care, Supporting good governance and practice in the Health and Personal Social Services* (March 2006).

The 2022 inspection

1.9 The terms of reference for the inspection (see Appendix 1) were published in November 2021 and on-site fieldwork at Woodlands JJC was undertaken during January 2022.

1.10 Full details of the methodology for the inspection can be found at Appendix 2 and a glossary is at Appendix 3.

1.11 Fieldwork was conducted at a time when there were concerns about the risk posed by COVID-19 and the new Omicron variant in particular. Care was taken to reduce the Inspection Team's footprint during fieldwork to reduce any risk of transmission to children and staff at Woodlands while maintaining the integrity of the inspection. This resulted in adjustments to how we conducted ourselves but not what we examined.

1.12 Stakeholders from 11 external partner agencies and community and voluntary organisations were consulted at an early stage in the inspection. These discussions helped inform the focus of the inspection.

1.13 Woodlands completed a detailed self-assessment against the *Expectations* and provided supporting data and documentation to evidence their assessment. In completing the self-assessment, leaders at Woodlands identified 15 areas of improvement and these are referred to within the body of this report.

1.14 As the number of young people in custody at the time of the inspection was very small, all were given the opportunity to speak individually to Inspectors and their views are reflected throughout this report. Eight young people spoke to us. We also spoke to four young people at Hydebank Wood Secure College and Ash House Women's Prison (HBW) who had previous experience of being held at Woodlands or who had transferred from Woodlands JJC to HBW on their 18th birthday.

1.15 During fieldwork we:

- examined the facilities at Woodlands, observed how children were treated, how services were being delivered, and attended a number of case reviews and other regular meetings;
- held meetings with senior managers and staff at Woodlands and with representatives of partner organisations delivering services to children; and
- examined a range of documents to assess outcomes for children in a number of areas including the use of force, application of single separation, care planning and resettlement.

Previous inspection recommendations

1.16 The 2018 inspection report made one strategic recommendation and 34 operational recommendations for improvement. We assessed that Woodlands had achieved or partially achieved the majority of these recommendations. Where issues arising from previous recommendations continued to be unresolved, these are included in the relevant section of this report.

CHAPTER 2: STRATEGY AND GOVERNANCE

2.1 In this Chapter the strategy and governance arrangements pertaining to the operation of Woodlands are examined. In its self-assessment, leaders at Woodlands were asked to consider their performance against four areas which are set out below. The wider strategic issues impacting on the operation of Woodlands are also considered in this Chapter.

Leaders work collaboratively with staff, key partners, stakeholders and children to set and communicate strategic priorities that will improve outcomes for children.

2.2 The Northern Ireland Assembly adopted an Outcomes Based Accountability (OBA) approach to develop the 2016-2021 Programme for Government (PfG). The Department of Justice (DoJ) led on PfG Outcome 7 which is '*We have a safe community where we respect the law, and each other.*' The Youth Justice Agency (YJA) also contributed to PfG Outcome 12, which is '*We give our children and young people the best start in life.*'

2.3 The work of the YJA contributed across five priority areas as set out in the DoJ Corporate Plan 2019-22 and Business Plan 2021-22.[5] The DoJ Business Plan included an objective to put in place arrangements for the care of children in a safe, secure, therapeutic environment supported by a youth justice policy and legislative framework with a coherent approach to early intervention. The actions arising from this objective included work:

- to co-ordinate an approach to helping children avoid entry into the formal justice system;
- to develop an implementation plan for the establishment of a care and justice campus for approval by Ministers; and
- to develop a strategic framework for youth justice.

2.4 A Strategic Framework for Youth Justice 2022-2027[6] was published in March 2022 by the DoJ Youth Justice Agency (YJA). It set out the vision and work which will be delivered under the framework, as well as its underpinning principles.

5 *DoJ Corporate Plan 2019-22 & Business Plan 2021-222* available at **Corporate Plan 2019-2022 and Business Plan 2021-2022 (justice-ni.gov.uk)**

6 *DoJ Youth Justice Agency, Strategic Framework for Youth Justice 2022-2027*, March 2022, available at **https://www.justice-ni.gov.uk/sites/default/files/publications/justice/strategic%20framework%20for%20youth%20justice.pdf**

The Framework aligned with the PfG draft Outcomes framework and identified four outcomes against which delivery will be measured:

- children are exited from the criminal justice system at the earliest point, with appropriate support;
- positive outcomes for children, families, victims and communities affected by offending;
- children will only ever be placed in custody as a last resort; and
- working in partnership to deliver wider, systemic change to improve the lives of children.

2.5 Work had commenced to develop a new three year Corporate Plan setting out the YJA's strategic priorities and focused work was planned with key partners, stakeholders and staff.

2.6 Service level agreements were in place with the Education Authority (EA) for the provision of learning and skills, People 1st (vocational training)[7], the South Eastern Health and Social Care Trust (SEHSCT) (provision of an in-reach Child and Adolescent Mental Health Service, (CAMHS)), the Prisoner Escorting and Court Custody Service (PECCS) (transport of children to and from court), Probation Board for Northern Ireland (supervision of young people leaving custody) and Hydebank Wood Secure College and Ash House Women's Prison (regarding arrangements for the transfer of young people once they were aged 18).

2.7 Custodial Services leaders were represented on multiple steering groups/multi agency groups representing the interests of young people in custody. Stakeholders consulted during the inspection reported good collaborative relationships with leaders at Woodlands. There was strong partnership working between Woodlands and the EA and in-reach CAMHS teams which had resulted in improved outcomes (see Chapters 4 and 6).

Leaders provide the necessary resources to enable good outcomes for children in custody.

2.8 Woodlands had excellent resources both in terms of its staffing and facilities. The facilities at Woodlands will be discussed further in Chapter 3 (Purposeful Activity) and Chapter 4 (under Daily Life).

2.9 Despite the number of young people being admitted to custody dropping very significantly in recent years, Woodlands continued to be staffed for 36 places.

7 The People 1st service is contracted directly by Woodlands and does not come under the governance of the EA.

2.10 Total admissions peaked in 2013-14 but have since declined. The total number of children admitted in 2020-21 (269[8]) was the lowest number of admissions to custody in the last 10 years. The number of individual children admitted to custody also fell over the same time period from 214 in 2010-11 to 108 in 2020-21. The latter was the lowest number of young people to be admitted since Woodlands opened. As of 31 December 2021, the number of total admissions stood at 156 for 85 children. A profile of children held in custody during 2020-21 is at Appendix 4.

2.11 Although the number of admissions was already declining, the impact of the COVID-19 pandemic had also had an impact on the number of young people entering custody. In March 2021 the average daily population had dropped to four but it had started to rise again and at the time of the inspection had increased to 10. Leaders attributed the decline in the population to changes within the youth justice system aimed at reducing the number of admissions to custody and in particular, Early Intervention (EI) work although we were not provided with data to evidence the role of EI on admissions to Woodlands. If the number of admissions remained at the same rate, the overall admissions for the current financial year will be less than last year although more individual children will have been admitted.

2.12 Like other organisations in the criminal justice system, Woodlands was impacted by staff absences due to people either contracting the COVID-19 virus or having to self-isolate. The very small numbers of young people entering custody during this period was fortuitous. Woodlands response to the COVID-19 pandemic will be discussed further at paragraphs 2.43-2.47.

2.13 The current number of staff in post was 97 excluding staff employed by the EA, heath care and private contractors. As of 31 December 2021, there were 55 care workers and 12 Team Leaders in post of which 20 were professionally qualified social workers. At the time of the last inspection Woodlands had experienced a significant upheaval in its staffing as a result of a voluntary early retirement scheme. Staffing was more settled, at the time of the current inspection, with a comparatively small number of staff leaving and joining. The headcount had reduced by three since the last inspection due to three positions being suppressed or reclassified.

2.14 A number of key management and Team Leader positions were being filled on a temporary basis pending decisions being made about the future staffing requirements of a proposed regional care and justice campus. This, however, was not impacting the running of Woodlands. Staff reported leaders had an open door approach and were approachable and that they generally felt supported by managers.

8 *Unless otherwise stated all figures have been taken from the Northern Ireland Statistics and Research Agency, Northern Ireland Youth Justice Agency Annual Workload Statistics 2020-21* available from: **https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1023563/YJA_Workload_Stats_Bulletin_2020_21.pdf**

2.15 A local consultative committee was in place and met twice a year. This provided a forum for representatives of three staff associations to meet the Senior Management Team (SMT) and raise and discuss issues impacting their members. At the December 2021 meeting, SMT members were told that staff morale was at an all-time low and it was agreed that representatives would provide more specific information about this. Overall, we did not find morale among the staff members and managers we spoke was low; although there were understandable worries about the future given the ongoing plans for repurposing Woodlands and concerns about the COVID-19 pandemic.

2.16 The cost of holding a young person in custody remained high. Woodlands annual budget accounted for 49% of the YJA budget in 2020-21. With the small number of admissions and no change in the number of staffed places, the cost of holding a young person in custody during 2020-21 was £190,206 (expressed as the cost per place including corporate overheads)[9] or £829,988 when expressed as the cost per occupant. This has been reasonably consistent since the last inspection.

2.17 In its 2018 inspection report CJI recommended that the YJA should benchmark its custody quality and costs against other regions and similar services in other jurisdictions and standardise its counting rules (Operational recommendation 2). The YJA undertook a number of study visits and the report, produced by the then Director of Woodlands, was shared with Inspectors. Although the report contributed to an understanding of how other facilities costed their places and the services they each provided, it did not appear to reach any conclusions around standardising counting rules. In December 2020 the Northern Ireland Audit Office (NIAO) published a follow-up review[10] to its *Managing Children who Offend* report published in 2017. The NIAO found that, while the DoJ and the YJA had made progress in managing and delivering an effective reform programme of youth justice, the work did not meet the strategic needs identified in 2017, including around measuring and reporting on the impact of its work with young people and understanding of costs throughout the youth justice system.

2.18 As identified in previous reports, Woodlands had remained consistently under occupied and fixed costs were high. Woodlands was being maintained in its current state pending the outcome of the planned repurposing programme which aimed to integrate Woodlands with Lakewood Regional Secure Care Centre (Lakewood) to create a regional care and justice campus. This had impacted on capital investment at Woodlands. It is understood that the working assumption was that the costs of a new regional campus would be cost neutral and would not incur additional expense. However, see paragraphs 2.37-2.42 for further discussion about the proposed regional facilities.

9 *YJA, Extracted from data provided by Custodial Services as part of the data requested for the inspection. Unpublished.*

10 *NIAO, Managing Children who Offend: follow-up review, Report by the Comptroller and Auditor General, December 2020 available at:* **https://www.niauditoffice.gov.uk/sites/niao/files/media-files/244345%20Managing%20children%20who%20offend-%20follow%20up%20review%20Report_%28Cmbnd%20Final%29.pdf**

2.19 As with other criminal justice organisations, at the time of the inspection, the YJA was facing a flat cash budget in the 2022-23 financial year and was concerned about the impact of budget reductions on its ability to further develop its staff and services. The YJA was meeting in February 2022 to plan for future years in light of the reduced budget.

Staff training and supervision

2.20 During the previous inspection gaps in the Woodland's training plan were identified in relation to understanding the effects of trauma on children, as well as specialist needs for example, learning disability and Attention Deficit Hyperactivity Disorder (ADHD). Inspectors recommended that a review of additional staff training needs should be undertaken (Operational recommendation 1, 2018 inspection report).

2.21 A one-off needs analysis exercise was conducted when care workers were asked to identify additional training requirements. Two examples completed by care workers were provided and although these showed what training the individual staff felt they needed, it was not evident that this had been provided.

2.22 Despite training having been curtailed as a result of the COVID-19 pandemic, the Woodlands 2021-22 training priorities plan indicated that 70 residential staff had undertaken a half day training course on Adverse Childhood Experiences (ACEs), 42 staff had completed a half day safeguarding training programme (Note of concern awareness raising) and 15 staff had attended training delivered by the CAMHS. Five Team Leaders had completed external training on vicarious trauma. Minimising and Managing Physical Restraint (MMPR) refresher training had been maintained.

2.23 Training needs were identified during supervision and submitted through the personal development planning process. Inspectors were told that limited suggestions for training came through this route and training priorities were also identified by leaders. A number of staff members felt that there were opportunities for learning from colleagues within the YJA, which would enhance current provision.

2.24 The YJA was in the process of procuring a safeguarding training package which was undertaken on a three year cycle. The information provided during the inspection did not satisfy us that there was a rolling matrix that provided assurance that all staff had children's rights, child protection or safeguarding training on an annual basis commensurate with their role. Child safeguarding training needs and delivery needed better monitoring to demonstrate that training took place more than once every three years; the aim should be to conduct a refresher training activity annually. This was essential if staff were to be equipped to identify and respond to concerns of children entering custody.

OPERATIONAL RECOMMENDATION 1

The Acting Director should introduce a regular staff training needs assessment with a clear plan for children's rights, child protection and child safeguarding training; this requires ongoing monitoring and exploration of opportunities tailored to staff roles in the Woodlands Juvenile Justice Centre to maximise their ability to identify and respond to concerns and young people's needs. This should be commenced within 12 months of publication of this report.

2.25 Arrangements were in place to provide supervision although most staff, including Team Leaders, told us they relied heavily on support from their peers. A number of staff felt that supervision amounted to a tick box exercise and could be more meaningful.

2.26 Leaders had identified a need to better evaluate the effectiveness of training as an area for improvement in their self-assessment. This would entail assessing how staff applied the training in their day-to-day interactions with and in the care of young people. This would be a useful mechanism to help inform the identification of effective training and needs assessment.

Continuous improvement - Data is used to support good outcomes for children and procedures are in place to implement recommendations and learning arising from CJI and other inspections and incidents.

2.27 There was evidence of a continuous improvement culture among leaders and staff at Woodlands JJC. A mechanism was in place to support and monitor the implementation of inspection report and other recommendations and a number of tools were being developed to gather information from young people about their experiences including a pre-release questionnaire and satisfaction survey. The findings from recent surveys had been collated, examined and discussed by senior management.

2.28 The YJA's first *Performance Impact Report*, covering the business year 2020-2021, was published in December 2021.[11] The report was structured around four of the five strategic outcomes from the Agency's annual Business Plan and aimed to provide a clear picture of who the YJA was, what it did and what impact the work of the YJA had on children. This needed to be further developed to better evidence outcomes for young people in custody.

11 *Youth Justice Agency Performance Impact Report 2020-21* available at: https://www.justice-ni.gov.uk/publications/yja-performance-impact-report-2020-21

2.29 There were gaps in audit and the collection and monitoring of data to support good outcomes for young people across a range of areas and these will be discussed in the body of the report. Leaders acknowledged that the process of conducting the self–assessment for this inspection had also identified gaps in the collation of some data which, while held on an individual case by case basis, were not routinely gathered for wider analysis.

2.30 Leaders and staff articulated very well the needs and concerns for individual children in their care, however, the commissioning of services was not yet fully informed by a comprehensive analysis of the needs of young people in custody. There were a range of tools which gathered information on risk and needs including the YJA Assessment, quality improvement reports and a recently developed tracker to track progress in education, but these and the findings from the breadth of assessments undertaken by Woodlands staff, were not brought together to profile the needs of young people entering and leaving custody. A comprehensive profile should be in place to provide assurance that the support and services provided at Woodlands were reflective of and responsive to the needs of children there.

2.31 A theme raised by stakeholders was the absence of data to evidence the progress made by young people while in custody. At the last inspection the '*Justice Outcomes Star*' had been introduced to assist with this. *Outcomes Star* was an internationally accredited measurement tool to track children's progress. While the pilot had been deemed successful it had not been rolled out and was not being used at the time of the inspection. Plans were being made to relaunch the *Outcomes Star*. Data from this tool could assist with providing more meaningful data for performance impact monitoring.

2.32 Woodlands had identified the need to enhance its data capture as an area for improvement. While we appreciate the difficulty with such small numbers of children entering custody, we recommend that Woodlands should develop an effective mechanism to capture, monitor and analyse data, which helps assess the outcomes for children in custody and informs the commissioning of services to address their risks and needs.[12]

OPERATIONAL RECOMMENDATION 2

Within 12 months of publication of this report, the Acting Director should develop and implement an effective mechanism to capture, monitor and analyse data which helps assess the outcomes for children in custody and informs the commissioning of services to address their risks and needs.

12 *See also the broader recommendation from CJI's inspection relating to the treatment of females in conflict with the law that the YJA complete an action plan for the development of a comprehensive profile of children engaged with it to enable personalised and gender-responsive services for all. CJI, An Inspection of How the Criminal Justice System Treats Females in Conflict with the Law, November 2021, Operational Recommendation 4*, available at **http://cjini.org/TheInspections/Inspection-Reports/2021/October-December/Females-in-Conflict-with-the-Law.**

Governance is based on clear, transparent processes and structures. Governance arrangements are monitored and reported on.

2.33 The Acting Director of Woodlands was a member of the YJA Board and led the SMT, which oversaw the day-to-day governance of Woodlands JJC. Business owners were responsible for reporting on performance to the SMT and they chaired monthly meetings for their respective areas of responsibility. All SOPs had been reviewed and updated during 2020. Inspectors observed a number of monthly meetings and daily handover meetings.

2.34 Communication was generally effective and particularly strong around discussions/ staff handovers about the needs of individual children but there were opportunities for a number of meetings to have a more outcomes focused approach. The operation of three separate staff teams limited opportunities for Team Leaders and staff to have time to debrief and learn collectively from each other and the opportunities to do this had been further impacted during the COVID-19 pandemic. As this eased Inspectors were told that opportunities for development could be scheduled as needed.

2.35 Gaps in governance arrangements in specific areas will be addressed in the body of the report (see paragraphs 3.42, 3.52 and 4.64).

2.36 Monthly monitoring visits were conducted by an Independent Monitor appointed by the YJA Management Board. Overall the Independent Monitor was positive about the operation of Woodlands and reported that he found relationships between staff and children to be mutually respectful and that a child centred ethos was evident. Areas for development were reported to the Acting Director on a monthly basis and a mechanism was in place to consider and review these reports.

Wider strategic issues

Proposal for a regional care and justice campus

2.37 The 2018 inspection report of Woodlands included a strategic recommendation that the YJA and the DoJ should collaborate with other Government Departments to more closely align the two facilities. The *Review of Regional Facilities for Children and Young People*[13] was published in March 2018 and recommended that the Lakewood and Woodlands facilities should be re-configured and replaced with a new integrated and more aligned model of provision. From October 2020 to January 2021 the DoJ and Department of Health (DoH) consulted on proposals to establish a regional care and justice campus for children and young people. A report[14] summarising the two Departments' joint response to the consultation and plans for next steps was published in June 2021.

13 *DoH, Review of Regional Facilities for children and Young people – Review Report, March 2018* available at: **https://www.health-ni.gov.uk/sites/default/files/publications/health/review-of-regional-facilities-for-children-young-people.pdf**

14 *DoH and DoJ, Establishment of a Regional Care and Justice Campus, Consultation Analysis Report, June 2021* available at: **https://www.health-ni.gov.uk/sites/default/files/consultations/health/doh-rcj-campus-analysis-report.pdf**

2.38 At the time of inspection fieldwork the operating and staffing model for a new proposed regional care and justice campus was still being developed which created uncertainty for staff at Woodlands and they were understandably concerned about this. There had been efforts to communicate with staff but some felt that communication could have been more meaningful.

2.39 Leaders from Woodlands were properly and actively involved in programme work streams to develop a regional care and justice campus. While this inspection did not seek to compare Woodlands and Lakewood, in the course of our work we found there was currently a significant difference in culture and care approaches between the two which should be addressed if the future integrated service model is to be successful. This was particularly evident in the approaches to behavioural management (see Chapter 3) and assessment and care planning (see Chapter 6). We identified that there was an opportunity for Woodlands and Lakewood to collaborate more closely at an operational level to discuss and better understand their respective operational environments and care approach.

2.40 During fieldwork for this inspection we were advised that Ministers would shortly make a decision on the governance arrangements for a regional care and justice campus. A third option, not previously consulted on, and which proposed integration of services such as education and health care rather than a full integration of the health and justice campuses had been developed. Subsequently, in March 2022 the Ministers of Health and Justice (Ministers) agreed that both facilities would continue to operate independently but develop shared support services. The Northern Ireland Framework for Integrated Therapeutic Care would be rolled out across both sites. Shared service provision would operate under a formal partnership agreement, supported by a jointly managed Partnership Board.

2.41 Without further information, it is less clear how the position now agreed fully meets the needs of children and young people requiring secure care as envisaged under the original proposals for a regional care and justice campus.

2.42 Given the recent decision by Ministers, a critical review of Woodlands current operating model (see paragraphs 2.16-2.19), and impact of the implementation of the Ministers' decision will be required. Maintaining the current facilities, staff and other resources at Woodlands under a new shared services model for a small and potentially reduced number of children, becomes less sustainable. It would be important, however, not to compromise the care provided to young people who must be detained at Woodlands.

STRATEGIC RECOMMENDATION **1**

In light of the decision of Ministers to develop a shared services model we recommend that within 12 months of publication of this report, the Youth Justice Agency should critically review the current operating model at Woodlands Juvenile Justice Centre that takes account of the impact of implementing the March 2022 decision by the Ministers of Health and Justice on the future of the regional care and justice campus programme. The review should include assurance that Woodlands Juvenile Justice Centre resources are deployed efficiently and effectively while maintaining a focus on delivering good outcomes for children.

In support of this, within three months of report publication, the Acting Director should identify and agree opportunities for the Woodlands Juvenile Justice Centre team to collaborate more closely with their counterparts in Lakewood Regional Secure Care Centre to discuss and better understand their respective operational environments and care approach. This will be essential for the successful implementation of any new shared services model.

COVID-19 restrictions and impact on children in custody

2.43 Leaders operated in accordance with internal operational guidance developed in conjunction with the Public Health Agency and informed by Public Health England guidance for prescribed places of detention. This entailed steps to test and isolate all new admissions, bubbling of young people based on their allocated House Unit, a routine testing service and contact tracing service for staff, and enhanced infection prevention and control measures.

2.44 The YJA had developed a Business Recovery Plan, which included custodial services at Woodlands, but this had not been updated since June 2020.

2.45 Leaders and staff at Woodlands had largely been successful at maintaining routines for children and minimising the spread of COVID-19 within the JJC, although in the early stages of the COVID-19 pandemic there was little for children to do as the education provision was suspended for a period. Children had, however, been able to spend lengthy times out of their rooms unlike other youth justice facilities in England. At that stage CJI reported that Woodlands had struck an effective balance between managing the requirement to isolate and the wellbeing of young people.[15] The impact on the normal day-to-day running of Woodlands, however, had been significant and Inspectors acknowledged that we were not seeing Woodlands as it would normally operate.

15 *National Preventive Mechanism Monitoring of Places of Detention during Covid-19, 12th Annual Report of the United Kingdom's National Preventive mechanism 2020-2021*, available at **https://s3-eu-west-2.amazonaws.com/npm-prod-storage-19n0nag2nk8xk/uploads/2022/02/6.7499_NPM_AnnualReport_2020_21_WEB.pdf**

2.46 While restrictions had eased in the community, a range of measures including isolation on committal and house bubbling continued to be in place at the time of the inspection and we found those to be adversely impacting the wellbeing of young people at Woodlands and their learning. This was evidenced in care arrangements, plans and other records. Leaders explained that at different times they had sought to adjust the measures, through discussions with the Public Health Agency, to mitigate the adverse outcomes for young people but they had not been successful in getting approval to make easements in their approach.

2.47 It was important that Woodlands JJC critically reviewed its operational response to the COVID-19 pandemic and current measures to mitigate the impact of isolation on the vulnerable young people admitted to Woodlands. A more agile, child centred response to the risks presented by the COVID-19 pandemic at any given point in time, and one which is reflective of the unique operating environment at Woodlands JJC should be considered in conjunction with the relevant authorities. This should help inform future response planning.

OPERATIONAL RECOMMENDATION 3

Within six months of publication of this report, the leadership team at Woodlands Juvenile Justice Centre, in conjunction with the relevant authorities, should review its approach in response to the COVID-19 pandemic to identify learning and inform future response planning.

Woodlands JJC as a place of safety and bail

2.48 Woodlands continued to be used as a place of safety under Police and Criminal Evidence (Northern Ireland) Order 1989 (PACE) regulations. The speed of work to realise improvements in outcomes for children was frustratingly slow. YJA workload statistics for 2020-21 showed that 77% of all admissions were under PACE compared with 22.7% remand and 0.7% sentenced. The PACE conversion rate, the number of PACE admissions subsequently remanded by court or sentenced to custody, remained consistent at 50%. Successive reviews and reports[16] and stakeholders consulted as part of this inspection continued to highlight concerns about the use of Woodlands as a place of safety, the number of children who continued to enter custody because they had no suitable bail address and the low numbers of children who received a custodial sentence after spending periods on remand.

16 *N Carr & S McAlister, Tracing the Review, Developments in Youth Justice in Northern Ireland 2011-2021, May 2021,* available at https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&cad=rja&uact=8&ved=2ahUKEwiOpffjuuv2AhWeQUEAHYrXCOAQFnoECAIQAQ&url=https%3A%2F%2Fwww.voypic.org%2Fwp-content%2Fuploads%2F2021%2F11%2FTracing-the-Review-2021.pdf&usg=AOvVaw21Dt2S7gsyxFzIQpJJMKTP; *Northern Ireland Law Commission, Report Bail in Criminal Proceedings, NILC 14(2012), available at* https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&cad=rja&uact=8&ved=2ahUKEwiY7c3Cu-v2AhXKPsAKHfeRACoQFnoECAIQAQ&url=http%3A%2F%2Fwww.nilawcommission.gov.uk%2F32432_-_bail_report_nilc14__2012_.pdf&usg=AOvVaw2TZyJRaQIvXgrAjSVq0XKE; *CJI, Police Custody: The Detention of Persons in Police Custody in Northern Ireland, September 2020, available at* https://www.cjini.org/getattachment/259c4dab-ec93-479e-8f5b-ce8bd70c88d6/report.aspx

2.49 In the last Northern Ireland Assembly mandate, the Justice (Miscellaneous) Provisions) Bill 2021 was to introduce a number of proposed changes to bail and remand legislation to strengthen rights to bail and introduce specific conditions which must be met before a child could be remanded but these proposals were withdrawn in July 2021. The *Strategic Framework for Youth Justice*[17], published in March 2022 included amending legislation to improve arrangements for bail and remand for children among a number of measures for change aimed at the use of custody as a last resort. This also included raising the age of criminal responsibility from 10 to 14 years, addressing delays in the Youth Court system and working in partnership with the DoH to implement a new regional care and justice campus.

2.50 As with previous inspections care experienced children continued to account for a significant proportion of all admissions to Woodlands.[18] Although the number of admissions and individual children had dropped since the time of the last inspection, this remained a concern. The *Strategic Framework for Youth Justice* recognised this and pointed to actions to implement a new regional care and justice campus as working to address this issue.

17 *DoJ YJA Strategic Framework for Youth Justice 2022-2027*, March 2022, available at **https://www.justice-ni.gov.uk/sites/default/files/publications/justice/strategic%20framework%20for%20youth%20justice.pdf**

18 *YJA workload statistics 2020-21 showed that in 2020-21 the percentage of admissions of care experienced children was 46.5% compared with 47.9% in 2016-17 and involved 54 and 38 children respectively.*

CHAPTER 3: SAFETY

Children, particularly the most vulnerable, are held safely.

EARLY DAYS IN CUSTODY

Expected outcomes: Children transferring to and from custody are safe and treated decently. On arrival children are safe and treated with respect. Their individual needs are identified and addressed, and they feel supported on their first night. Induction is comprehensive.

3.1 During the COVID-19 pandemic fewer children were being admitted to Woodlands and no children were being brought to court to attend hearings in person (see Appendix 4). The Police Service of Northern Ireland (PSNI) was responsible for escorting young people being held under PACE to Woodlands and escorting children to Woodlands after their first court appearance. There was a good, detailed Memorandum of Understanding between Woodlands and the PECCS who were responsible for escorting children to and from court after their first appearance. Recent inspections by CJI of Police[19] and Court Custody[20] found that arrangements for the transfer of children to Woodlands were good.

3.2 When notified of a potential PACE admission, Woodlands staff worked through a checklist to establish that custody was being used only as a place of last resort although in reality all acknowledged that it was the least worst option for a young person to spend the night at Woodlands than remain in a police custody cell overnight.

3.3 Although the working practice was that there would not be admissions from police custody after 9.30pm, in 19 cases reviewed by Inspectors seven young people were admitted at or after this time. Two of these admissions were around midnight. This was not ideal especially when health care and day staff were no longer available to conduct initial assessments and for the child to settle into their new surroundings, especially if they were being admitted to custody for the first time. A check of police records showed there were no undue delays in processing young people or arranging for them to be brought to Woodlands.

19 *CJI, Police Custody, The Detention of Persons in Police Custody in Northern Ireland, September 2020*, available at http://www.cjini.org/getattachment/259c4dab-ec93-479e-8f5b-ce8bd70c88d6/report.aspx

20 *CJI, Court Custody, The Detention of Persons in the Custody of the Courts in Northern Ireland*, available at http://www.cjini.org/TheInspections/Inspection-Reports/2022/Jan-Mar/Court-Custody-2022

When aware of a late admission, Woodlands could make arrangements for staff to remain to complete the first night admission process or night staff would manage immediate needs until a full admissions process could be completed the following day.

3.4 It was important that PSNI Custody Sergeants, detention and escorting Police Officers understood the operating procedures when a young person was admitted to custody as this could have an impact on how well they settled on their first night. In one instance a young person who had not been in custody before explained that Custody Detention Officers had provided assurance about what Woodlands was like and that they would be well looked after there but there were others examples where Police Officers had mistakenly told young people that they could have phones or would be able to have a smoke when they arrived and, when this wasn't permitted, their behaviour deteriorated. **Area for improvement: Given the potential for police custody and escorting staff to influence how well young people settled on their first night, the leadership team at Woodlands should continue to maintain regular communication with the police and bring any issues to the attention of police custody leads.**

3.5 All young people were admitted to House Unit 1. They had a Polymerase Chain Reaction (PCR) test done on their first night in custody and they remained in their rooms until the result of the test was received. They were managed under the single separation procedures.[21] If the result was negative and they displayed no COVID-19 symptoms, the young person moved to a 'step down' unit. There were separate 'step down' Units designated for girls and boys. A second PCR test was done on Day Five and, if this was negative, children moved to an open unit. During the inspection both 'step down' Units were being renovated and young people remained in House Unit 1 for the duration of their isolation period.

3.6 There was a comprehensive admissions and induction process to identify the immediate needs of young people arriving in custody. Woodlands JJC staff aimed to obtain as much information as possible before a child was admitted to help address their immediate and ongoing needs. They liaised closely with police, social workers, youth justice services, previous places of residence and families (where appropriate). Information was used to complete an initial Woodlands JJC risk assessment and a health care screen was completed on arrival. From the case files we looked at, admissions data and in discussions with staff, it appeared that there was an increased number of admissions of children not previously known to the YJA or social services, which made undertaking the initial risk assessment challenging.

21 *SOP 3.7 sets out the procedures associated with the Use of Single Separation. Single Separation was defined in the procedures as any time a young person was placed or locked in a room on their own, usually their bedroom, other than at their normal bedtime. Single Separation could be used as part of a behavioural management strategy to prevent serious disorder or injury to others. When young people were in their bedrooms they had to be checked at intervals no greater than 15 minutes. These checks were recorded on a separation log. The log contained written details of observations and contacts with the young person throughout the period they were separated.*

In one example only the child's mum's telephone number was available and she could not be contacted within the first 24 hours. A manual handling plan, and screening for risks of Child Sexual Exploitation (CSE) (see paragraph 3.14) was undertaken for each child within three days of admission. An assessment was also made of any conflicts a child might have with other children already at Woodlands.

3.7 There was no routine body searching of young people on their arrival. Children were allocated an individual room which had an en suite. Information booklets, bedding and some toiletries were made available in each room. Children could be provided with a TV/radio on their first night. All children were checked by staff at least every 15 minutes during the night or more frequently depending on the level of required observations.

Photograph 1
Bedroom in the Admissions Unit

Photograph 2
Communal area in the Admissions Unit

3.8 Children reported having very little to do while being isolated from other young people after their admission. Once negative COVID-19 tests were received they were allowed to go to the games room and go outside to the courtyard. While waiting on test results or following a positive test result, meals were eaten in rooms and there was limited evidence in separation logs of encouragement for some young people to leave their rooms and access fresh air. Telephones were brought to room doors rather than young people accessing facilities in communal areas. They were not enrolled in education until they had moved to open Units which, given the short time many young people stayed at Woodlands, was a missed opportunity to engage them in meaningful activity.

"I felt scared and alienated when I first came in because I was not with my family. I didn't get to do anything in the isolation unit and mainly played Xbox. The COVID rules were explained to me. It helped when I moved to an open unit and was able to get to the gym."

"For the first couple of hours I had no TV. I was given a booklet and staff sat down and talked to me and explained how long I was to be here. Staff explained everything and I had all the information I needed."

3.9 The usual induction process had been disrupted due to the requirement for children to be tested and isolate on arrival. The wider induction programme did not now commence until around 10 days after arrival. This had also created some issues for maintaining continuity of key workers.

3.10 Most children were familiar with the JJC's routines and how to access services including health care, legal representation and maintaining contact with families. All children who spoke with Inspectors said that they felt safe at Woodlands both in their rooms and in communal areas. Most attributed this to staff. A child who had previous experience of being in Lakewood said they felt more secure at Woodlands.

> *"If something kicks off staff would be straight over."*

> *"You can't get out so no-one can come for you."*

> *"Staff are good. At the moment we are not mixing with others... I know most people anyway as I used to run about with them."*

> *"Staff make you feel safe. They talk to you like a normal person."*

SAFEGUARDING OF CHILDREN

Expected outcomes: The Centre promotes the welfare of children, particularly those most at risk, and protects them from all kinds of harm and neglect.

3.11 There were good safeguarding policies in place and a strong child protection ethos was evident in discussions with leaders and staff. Oversight arrangements were good. The YJA was a member of the Regional Safeguarding Partnership and Woodlands was represented on the Safeguarding Board for Northern Ireland (SBNI) committees. The YJA Safeguarding procedures (2019) encompassed Woodlands and there was a specific operating procedure for Safeguarding - Child Protection in place setting out the legal obligations of staff and what procedures staff were to follow. The Acting Director and Deputy Directors of Woodlands represented Woodlands at six monthly YJA Safeguarding Group meetings where policy and practice developments, and learning arising from case management reviews and serious incidents were discussed. Two Team Leaders were designated CSE Champions.

3.12 There was evidence of Understanding the Needs of Children in Northern Ireland forms on file, timely CSE screening assessments and child protection referrals, which was good.

3.13 Prior to May 2020 child protection reports of concern were not gathered for analysis but were reported to the YJA Safeguarding meeting. Since then 36 reports of concern were raised; 20 of those were made from January to December 2021. The majority of concerns identified since May 2020 were of paramilitary or community threat.

3.14 From April 2020, when data was first available, to December 2020, 182 CSE screening assessments were completed (37 for females and 145 for male) and forwarded to the relevant Health and Social Care Trust (HSCT) lead for assessment and decision. During 2021, 179 CSE assessments had been completed (34 for females and 145 male). There was not always evidence of a decision/outcome from these screening assessments returned by the HSCT leads. Audits completed by Woodlands CSE Champions identified this as an area of focus, as well as, checking that assessments had been properly forwarded by staff. Screening for children admitted to Woodlands under PACE has been an important development as some of these children were often not known to social services and this helped pick up information about risks to those children. Relationships with HSCT CSE social worker leads was described as a strength and good information exchange was reported; an example was discussed where information provided by HSCTs had helped Woodlands manage placement and movements of children where there had been concerns about peer-on-peer exploitation.

3.15 Formal training in CSE had been provided to care workers and Team Leaders during 2018-19. COVID-19 protocols meant that only staff in the Admissions Unit had been undertaking CSE screening; and it was noted that refresher training for all staff would be important in advance of this changing. Child criminal exploitation was a developing area and required reflection within training and staff development plans. This had been noted at a recent YJA safeguarding group meeting. A total of 17 staff had attended a *'Signs of Safety'* workshop during 2019-20 but a number mentioned that the training was made available to staff at Woodlands only after it had been rolled out elsewhere (see paragraphs 2.23-2.25 and Operational Recommendation 1). Woodlands had identified an area of improvement to ensure that lessons learned by staff regarding safeguarding should be included in future training development plans.

3.16 Reports of relationships with field social workers were mixed. There was evidence of email communication with social workers within children's files, records of telephone conversations and children reported speaking to social workers by telephone. Attendance by field social workers at care plan reviews varied. Some staff reported that social work intervention in some instances was "*amazing*" with links having improved, however, Inspectors were told of other instances where considerable intervention had been required by case management teams to secure social work allocation and input. In one example where social services disputed the correct HSCT allocation it was only after Woodlands asked the Children's Law Centre (CLC) to intervene that a social worker was allocated and suitable accommodation identified.

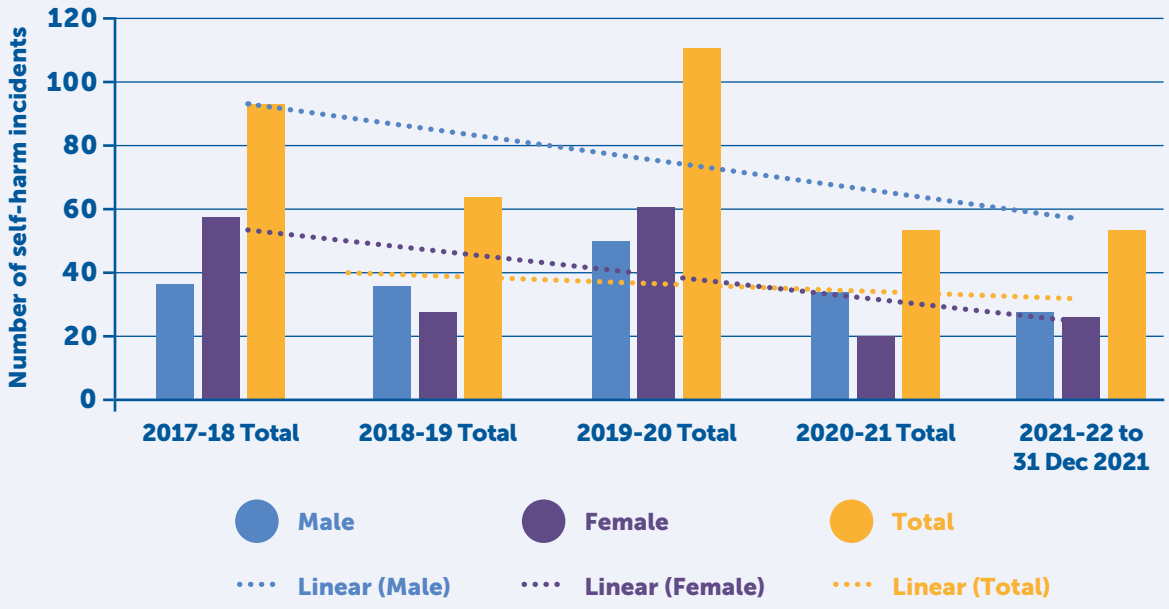
The young person had been in custody for three weeks. It was important that efforts continue to build relationships with field social workers. A single document to summarise social work input and outcomes would have been beneficial particularly to ensure continuity of care planning.

SUICIDE AND SELF-HARM PREVENTION

Expected outcomes: The Centre provides a safe and secure environment which reduces the risk of self-harm and suicide. Children at risk of self-harm are identified at an early stage and given the necessary support. All staff are aware of and alert to vulnerability issues, are appropriately trained and have access to proper equipment and support.

3.17 The number of self-harm incidents had decreased by over half from 2019-20 (111 relating to 19 young people) to 2020-21 (54 incidents relating to 21 individuals). Two girls accounted for 61 incidents in 2019-20, which resulted in a significant increase in the number of incidents in that period. The number of incidents to 31 December 2021 was comparable to that for the whole of the previous year. Overall the number of self-harm incidents had declined since the last inspection (see Chart 1). The rate of self-harm among girls was consistently much higher than for boys. Superficial cutting was the most prevalent form of self-harm incident.

Chart 1: Number of self-harm incidents by gender



3.18 Staff were alert to the risk of self-harm and were responsive to this risk. A multi-disciplinary care team managed young people in crisis. All bedrooms had been designed to be ligature free. Children were screened on arrival for risk of self-harm. Individual support plans and safety plans were in place for children who were at risk of self-harm. All children were closely monitored and where an elevated risk was identified, the frequency of observations was increased. Case management teams worked closely with the heath care and in-reach CAMHS teams to support children.

3.19 Data was monitored by gender, religion and nature of injury; scrutiny of this data was important in the understanding and development of appropriate support. The most recent minutes of the joint operational meeting between Woodlands and in-reach CAMHS team (December 2021) had identified a need to look beyond the statistics to focus more on the individuals who self-harmed so that improvements in practice could be identified. A Quality Improvement project had commenced to improve outcomes for young people at risk of self-harm and this was welcomed. We look forward to seeing the outcome of this work at a future inspection.

3.20 An incident of self-harm by a young person considered by Inspectors evidenced the need for continued learning in the provision of child and staff support following involvement in serious incidents. Current arrangements involved the in-reach CAMHS team providing support to the relevant case management team but the Woodlands leadership team saw an opportunity to develop this further to create a forum which would involve the wider staff group in House Units. This had been identified as an area for improvement that Inspectors supported.

SECURITY

Expected outcomes: Children are kept safe through attention to physical and procedural matters, including effective intelligence and positive relationships between staff and children.

3.21 We observed a safe and controlled environment and children reported that they felt safe (see paragraph 3.10). Security issues were assessed on admission and a MMPR handling plan was in place for each young person. This provided information on triggers to aggressive and challenging behaviour for the young person and listed the relevant de-escalation and behavioural management techniques which could be applied. Medical issues were also considered in this plan. The use of restraint is discussed at paragraphs 3.37-3.46.

3.22 Any matters relating to day-to-day risks presented by young people were discussed at handover meetings and staff briefed accordingly. This included information about relationships between young people and potential conflicts with anyone who had been admitted or was moving location. There was no evidence that the misuse of drugs was a significant issue at Woodlands.

3.23 The level of assaults on staff was low; seven incidents out of a total of nine in the last two years (2020-21 and April 2021-31 December 2021) were associated with use of restraint. Peer on peer assaults were also low with no incidents in the current year (2021-22 to February 2022) and an average of just over one incident in each of the years since the previous inspections.

3.24 SOP 4.3 set out the procedure for searching young people. The level of searching and results of searches was overseen at a monthly search audit and governance meeting and data was reported to SMT meetings. The level of targeted searches of young people and area searches varied. Some inconsistency in searching between House Units had been identified as an area for improvement. There was no evidence of routine use of searches involving the removal of clothing (Level 2 search) although the number of finds from targeted searches of young people was low. Area searches also yielded few finds. Staff had received training to search in a therapeutic environment in 2018-19. Consideration was being given to reviewing search procedures to take account of concerns about young people who presented a high risk of self-harm. This had been identified by Woodlands as an area for improvement.

3.25 The absence of a digital/electronic case management system resulted in staff spending a lot of time completing and duplicating appropriate governance records.

BEHAVIOUR MANAGEMENT

Expected outcomes: Children live in a safe, well-ordered and motivational environment where their good behaviour is promoted and rewarded. Unacceptable behaviour is dealt with in an objective, fair and consistent manner.

3.26 Woodlands operated a progressive regime which provided a range of privileges and incentives earned by the young people through positive engagement with their care plan. There were five levels of regime: Bronze, Silver, Gold, Platinum and Platinum Plus. All newly admitted young people began on Silver level.

3.27 Most children reported understanding the progressive regime and for the most part, staff and young people reported that the progressive regime was helpful. Children were engaged with the progressive regime.

3.28 Encouragement and motivation for those on Platinum Plus was an issue during the inspection, which had arisen as a result of COVID-19 protocols, for example, the Youth Club was no longer operating. Staff engaged with young people to devise different types of incentives during COVID-19 and there had been suggestions made at the Youth Forum to modernise computer consoles and review incentives within the various regime levels. Children we spoke to on Platinum Plus regime were pleased about reaching that level and were proud of their achievement.

3.29 Care workers completed daily behavioural logs and these were held in a file in House Units. Team Leaders reviewed each young persons' progressive regime level once per week which included considering the current regime level and the previous week's recorded behaviour. Young people were involved in this review. Inspectors observed a House Regime Meeting at which a staff member and children discussed their regime status and raised areas for improvement. The meeting was relaxed and open and young people were given the opportunity to suggest improvements to the regime.

3.30 Centralised data on the use of the progressive regime system was not available but the scheme was generally perceived to be fair although two of the young people we spoke to said they were not treated fairly by staff all the time. We were told that children were vocal if there was an issue with fairness and there were two examples where two children had contested their regime level. One had been due to move up a level and the other had been demoted to a lower regime level. When the cases were examined by a Team Leader, the children's assessment was upheld and they were moved to the correct level. Young people had recourse to an appeals process and complaints procedure (see paragraphs 4.20 to 4.21).

3.31 Where a young person's behaviour fell below the expected level, sanctions could be imposed. These were generally proportionate to the nature of the behaviour. The number of sanctions imposed dropped substantially during the COVID-19 pandemic consistent with the lower number of young people being admitted to custody; 113 sanctions during 2021-21 compared with 330 the previous year. As at the time of the last inspection, adverse reports accounted for the largest proportion of sanctions (62%, 113 of 183) followed by an early bed sanction (21%, 24 of 183).

3.32 There was evidence that staff worked with young people to achieve a proportionate response giving them opportunities to take corrective action before an adverse report was imposed. We saw and heard of instances when staff challenged inappropriate behaviour, for example, where there were developing issues between young people, use of inappropriate language and when rooms had been graffitied.

3.33 Sanctions for non-attendance at education was an issue and in one case where the young person was above compulsory school age and refused to attend, they were accumulating three adverse reports daily (due to non-attendance at three separate education sessions). The young person pointed out that an incident related to behaviour would have attracted one adverse report. This young person had to remain in his room and the single separation process (see paragraphs 3.47 to 3.57) was commenced during the school day. This situation had been continuing for some time and a creative way to engage with the young person and find a means to break the cycle of remaining on Bronze regime had not been found.

BULLYING AND VIOLENCE REDUCTION

Expected outcomes: Everyone feels safe from bullying and victimisation. Active and fair systems to prevent and response to bullying and violence are known to staff, children and visitors.

3.34 SOP 3.10 set out the procedures for preventing bullying and victimisation.

3.35 There had been no bullying incident reports since the last inspection and none of the young people we spoke to said that they had been bullied by another young person or by a member of staff. Managers and staff attributed this to their success in managing groups, behaviours and space.

3.36 At handover meetings accounts were given on a daily basis of each young person's behaviour and there was discussion about relationships between the young people in House Units. Events were closely monitored and action identified as required. We saw one example of an incident involving a conflict between two children which had the potential for bullying behaviour. There was evidence of an individual support plan for each young person, as well as, a joint support plan in place. There was currently no mechanism to gather feedback about bullying from visitors and this had been identified as an area for improvement.

USE OF FORCE

Expected outcomes: Force is only used as a last resort and if applied is used legitimately by trained staff. The use of force is minimised through preventative strategies and alternative approaches which are monitored through robust governance arrangements.

3.37 Woodlands used the nationally accredited system of physical restraint called Minimising and Managing Physical Restraint (MMPR). MMPR is an integrated behaviour management and restraint model of practice and had systems of governance and quality assurance to ensure that physical restraint was only used as a last resort. Monitoring and governance around use of MMPR was good. Monthly operational meetings reviewed incidents and learning and included discussion about how to better understand the lead up to incidents of restraint. All staff had been trained in MMPR and, although there were some challenges to maintain training during the COVID-19 pandemic, the required six monthly refresher training was back on course. Woodlands had nine in-house MMPR co-ordinators including a member of the Senior Management Team (SMT).

3.38 Data showed an overall reduction in the use of force incidents since the introduction of MMPR in 2017 from 44 in 2017-18 to 26 in 2020-21. From 1 April 2021 to 31 December 2021 there had been a total of 17 incidents. There had been no use of pain inducing techniques since January 2018 and most incidents in the last two years involved low level or 'figure of 4' holds.

3.39 MMPR could be used to prevent injury to self and/or others, escape, serious damage to property; serious disorder or incitement of others to do any of the aforementioned but only after all other reasonable efforts had been made to address the situation. In the majority of incidents MMPR was used to prevent the risk of harm to others followed by preventing harm to self. Internal Annual Review reports showed a significant reduction in the use of restraint to prevent self-harm since MMPR had been in use. Although the procedure permitted use for serious damage there had been no incident of MMPR for this reason alone. It would be important that MMPR policy/instructions were clear that in all instances, restraint techniques were only used where there was an immediate risk to the safety of the child or others.

3.40 Quality assurance documentation, video footage, and debrief paperwork for all incidents of MMPR were held in a secure location within the Centre. All incidents' paperwork was signed off by a senior manager.

3.41 Inspectors sampled five records relating to use of MMPR and found:

- a health care professional was present in two out of five (CJI's expectation is that they are present for all);
- time was between four and five minutes in four incidents and 29 minutes in one;
- there was not always an immediate debrief with the child due to it either being declined or behaviour not having returned to baseline;
- in two incidents there was minor injury with health care assessing only one of these; there was a warning sign (the young person said they couldn't breathe) in one; and
- in one instance MMPR was used to place the young person in safety clothing. In this instance a separate record was required from staff to document why continuous observations would not cover the risk to the young person.

3.42 It was important that the documentation included a record that the child's family had been informed about the use of restraint; that the young person had an opportunity to speak with someone impartial and this was clear in the record; and it was important to evidence support available for staff and young people after incidents of restraint to clearly demonstrate how this was made available, that there was a follow-up and how the support was evaluated (see also paragraph 3.20). In the sample records we examined the above information was lacking in some while in others there was no evidence of it being recorded.

OPERATIONAL RECOMMENDATION **4**

The Acting Director should review the Minimising and Managing Physical Restraint policies and procedures within six months of publication of this report to address the following areas for improvement:

- **the documenting of evidence to ensure that all instances of restraint, including use for serious damage to property, is limited to when there is an immediate risk to the safety of the child or others;**
- **that there are clear records that a child's family has been informed when Minimising and Managing Physical Restraint has been applied and that a child has had the opportunity to speak to someone impartial after the incident; and**
- **that post incident support is fully documented, followed-up and evaluated.**

3.43 All incidents of MMPR were reviewed by local MMPR co-ordinators along with staff statements, body worn camera and/or Closed-Circuit Television footage to assess the appropriateness of the intervention made and staff practice. Of a total of 144 incidents where MMPR was applied, 93 incidents were managed in three minutes or less, and 126 were managed in six minutes or less. Only four incidents lasted longer than 10 minutes.

3.44 An external investigation was required in all instances where there had been serious injury to staff or young people or where there had been warning signs of an injury. We considered one incident of MMPR which had been referred for external investigation. Due to COVID-19 pandemic restrictions and having to conduct the investigation remotely, it was not as timely as it otherwise would have been. It was noted that staff should be praised highly for the way they attempted to deal with the incident and preserve life and they '*... had the welfare and preservation of life at the heart of the use of force*.' The recommendations in this case were accepted by Woodlands.

3.45 Internal reviews had identified that female staff were less involved in use of force incidents. The gender of staff involved in using restraint was an important area to keep under review, and had been identified as part of learning following external investigation in relation to a particular incident of restraint.

3.46 Improvements were being developed to incident management during planned interventions and future training on a new behaviour management curriculum which was being piloted by the national MMPR team.

SEPARATION

Expected outcomes: Children are only separated from their peers with the proper authorisation, safely, in line with their individual needs, for appropriate reasons and not as a punishment.

3.47 Single separation was a behavioural management tool, which involved children being temporarily kept apart from other young people in their House Unit. Children usually spent this time in their bedrooms. Procedures for the governance and monitoring of single separation were set out in Woodlands SOP 3.7.

3.48 The use of single separation appeared high at 345 uses in 2020-21 and 236 from April to 31 December 2021. When calculated as a proportion of the number of admissions, the rate of use had increased by 38% from 2017-18 when the last inspection was conducted (93 per 100 admissions in 2017-18 to 151 per 100 admissions for April to December 2021). Part of the explanation for this could have been because a single separation log was opened for anyone having to isolate during the COVID-19 pandemic.

3.49 Data on the use of single separation was available by gender and religion, however, the duration and reason for the use of separation, although recorded in individual's files, was not centrally recorded or disaggregated and therefore not available for analysis of patterns and trends. This gap had already been identified by Woodlands as an area for improvement.

3.50 Inspectors sampled single separation records for the period July 2021 to December 2021. Single separation was used for a wide range of reasons which included:

- behaviour related, for example, verbal altercation and serious disorder with some following use of force;
- related to COVID-19 protocols (either on admission or due to being symptomatic);
- bail perfected and in room awaiting discharge;
- at the request of the child (for example, returned to room following morning rise and having completed chores);
- feeling unwell; and
- non-attendance at education - this was apparent across a number of records and a repeated occurrence for some children.

3.51 The duration ranged from 1 hour 10 minutes to just over 23 days. In a number of the files reviewed, there was evidence that children were offered opportunities to spend time out of rooms during periods of single separation. It was important that this was recorded consistently. Our examination of the records suggested there could be particular needs related to age and disability but there was no evidence in the case file to show how these needs were being met.

3.52 The records we viewed did not demonstrate sufficient investigation of the underlying causes of the behaviour resulting in the use of single separation nor the consistent development of individual support plans to chart a route out of it. It appeared that where single separation resulted from a particular incident, it could trigger the development of an individual management plan. For example, one young person in single separation for just over 10 days had a plan developed on Day Four. In contrast another young person who received multiple single separations every day due mostly to declining education, had no individual management plan.

3.53 Observations at times recorded children having received a phone call or had spoken with a health professional but most entries were standard in nature. There should be better records of what the goals are when single separation is imposed, what interventions are required, what progress is being made and how the young person is responding, which are linked to any other plans involving the child. Where single separation continued for a period beyond three hours, evidence of timely review and planning for moving out of single separation was required. Letters of authorisation from the Acting Director stated that staff would continue to encourage the young person to come out of their rooms but did not include an assessment of what that encouragement entailed. These letters were mostly standard and not tailored to the child. Similar issues had been identified during the last inspection when a recommendation was made to improve the recording of decision-making, justification for continued separation and that audits of compliance should be undertaken by management (Operational recommendation 4, 2018 inspection report).

3.54 Learning styles and other forms of support suited to particular needs including disability would have been beneficial for children declining education and separated as a result. More creative thinking around how to engage young people in purposeful activity and interventions so that they are separated for the shortest time possible was required. In addition, plans needed to demonstrate that children separated from others had been encouraged and supported to go outdoors to get fresh air.

3.55 The absence of disaggregated data on single separation meant it was not possible for Inspectors to give an overall assessment of the proportionality or necessity of its use.

3.56 Staff considered single separation to be an important part of the behaviour management approach and one which reduced the need for restraint. They described it as a last resort, particularly after an incident had occurred because young people could experience a depressive phase. The SOP for single separation stated that it would only be used where it was necessary in the best interests of a child or as part of an overall behavioural strategy to prevent injury to self/others or serious disorder. Records reviewed by Inspectors suggested that for some uses single separation was the conventional response and not a last resort, for example non-attendance at education, COVID-19 protocols and prior to discharge or transfer.

3.57 Better links between the use of, and management plans related to, restraint and single separation was required. Where use of MMPR had preceded or followed a single separation, the record for each was in a separate file even though the incidents were connected. For example, in one case where MMPR had been used the young person was separated for 48 days following the incident and in another case the young person was separated for 10 days after MMPR had been applied. Monitoring needed to be undertaken on a more holistic basis.

3.58 The governance, rationale for use and delivery of single separation was a concern and needed to be improved. Behaviour management should be monitored on a more holistic basis.

OPERATIONAL RECOMMENDATION **5**

Within six months of publication of this report, the Acting Director should review and improve the governance and delivery of single separation to provide assurance and evidence that its use is proportionate; it is only used as a last resort after other alternatives have been considered, and for the shortest time possible. This should include effective monitoring during the period of single separation and an audit process post single separation to extract learning by managers. Behaviour management processes should be monitored on a more holistic basis to demonstrate outcomes for young people.

CHAPTER 4: CARE

Children are cared for by staff and they are treated with respect for their human dignity.

RELATIONSHIPS BETWEEN STAFF AND CHILDREN

Expected outcomes: Children are treated with care by all staff, and are expected, encouraged and enabled to take responsibility for their own actions and decisions. Staff set clear and fair boundaries. Staff have high expectations of all children and help them to achieve their potential.

4.1 A case management team was in place for each child. The team comprised a:

- case manager - a Team Leader (who was usually a qualified social worker) and oversaw the management of the case;
- a key worker - a care worker who was usually professionally qualified (although not necessarily) and who undertook induction, assessments and interventions, regular key work sessions and were available for support; and
- co-workers - care workers with a range of experience and skills and who supported delivery of the plan.

4.2 Mostly key workers worked in the same House Unit where the young people they were responsible for lived. At the time of the inspection key workers had a caseload of one to two children. Case management and care planning are discussed further in Chapter 6.

4.3 Children reported positive relationships with staff especially key workers and we saw ample evidence of good respectful relationships between staff and children throughout the week of the inspection and in case files. Stakeholders too found relationships and the care children received was generally good.

"90% of staff are good to me."

"Yes, staff care. They are keen to play board games."

"Some of them just have a power/control thing. Get locked up for the stupidest thing. There are staff I get on really well with. Yes, I feel cared for by the staff."

"...they [key worker] don't treat me like a lesser person or criminal."

4.4 Staff were regularly engaged with young people when in the House Units and during activities and the staff and young people ate their meals together. The strength of relationships with young people and a commitment to help make a difference to their young lives was most often cited by staff as the most positive aspect of their role at Woodlands. Many talked about the relationship they had with young people as being probably one of the most stable relationships the young people had had and this was evidenced by continued contact with children after they had left Woodlands. This was echoed by young people we spoke to at Hydebank Wood Secure College who had been transferred from Woodlands or had previous experience of being there.

4.5 A couple of children reported issues with individual members of staff but all said that there was a member of staff they could talk to if they had a problem. The network of support extended beyond case management staff and care workers in Units to teaching, health care and the in-reach CAMHS team.

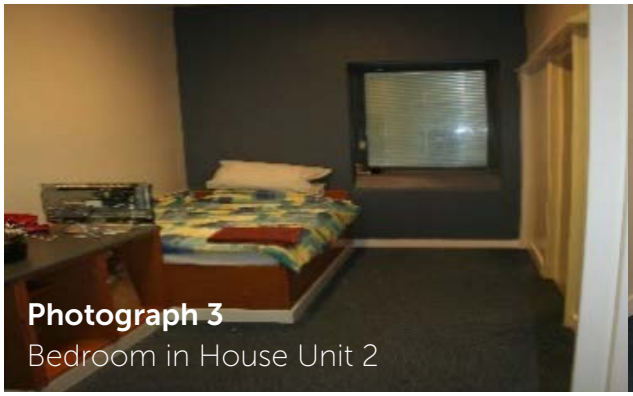
DAILY LIFE

Expected outcomes: Children live in a clean and decent environment and are aware of the rules and routines of the Centre. They are provided with essential basic services, are consulted regularly and can apply for additional services and assistance. The complaints and redress processes are efficient and fair.

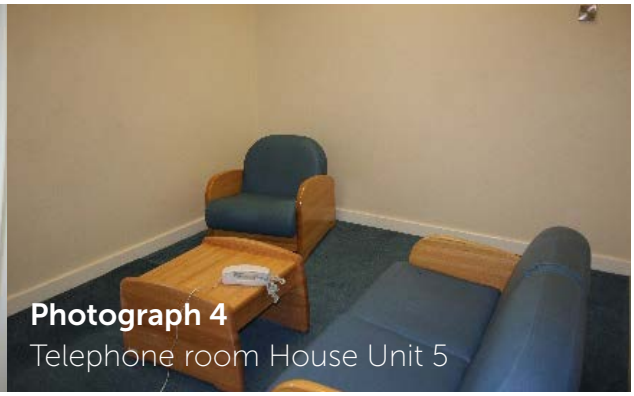
Living conditions

4.6 There were six House Units which could hold up to a maximum of eight young people. Children had their own bedrooms with en suite bathroom and they reported being able to shower every day.

4.7 There was a communal recreation/dining area at the entrance to the House Unit and a number of smaller games/TV rooms, laundry, health care and private telephone rooms. There was access to good outdoor space either in a courtyard or to the front of the Unit. The designation of each House Unit at the time of the inspection is set out in the *About Woodlands* JJC section.



Photograph 3
Bedroom in House Unit 2



Photograph 4
Telephone room House Unit 5

Photograph 5
Dining area House Unit 5

Photograph 6
Outdoor space House Unit 2

4.8 There was limited personalisation of bedrooms. Those on Platinum Plus regime had more items in their rooms in accordance with their regime level. There were no boards on walls to put up pictures/photographs or pieces of their own art with young people instead putting photographs on the control panels or windows. There was mixed feedback from staff as to what was permitted. Although some rooms had a desk and some cupboard space others did not. Where there was a desk, no seating was provided. We were told this was in the interests of safety and also to encourage young people to interact in communal areas rather than be managed under the single separation procedures. If a child wanted to read, draw or do homework in their bedroom they had to sit on their bed. The same blanket approach applied to everyone regardless of their regime level. There was an opportunity to risk assess what could be provided on a case-by-case basis. This had already been identified by Woodlands and should be progressed.

4.9 House Units were generally clean but some areas and fittings were worn and needed to be replaced or were in need of a deeper clean. To reduce the number of people entering House Units during the COVID-19 pandemic the in-house cleaning team were no longer routinely attending houses unless asked to address a specific problem. Bathroom floors and sanitary ware were stained and we were told this was likely because the floor surface was breaking down due to its age. Some carpets in bedrooms were also stained. In some instances these had been replaced with a hard surface covering which some of the young people preferred as they could keep it clean. A programme of painting was ongoing at the time of the inspection. Plans to refurbish the bathrooms were included within the current accommodation strategy.

4.10 Children were expected to engage in domestic chores including tidying their rooms and shared chores in the communal areas of the House Units. Staff supported young people to develop independent living skills and maintain personal hygiene. Daily routine checks were undertaken of bedrooms and staff followed up with young people if something wasn't in order. Young people were not permitted in each other's rooms. There was limited evidence of graffiti in rooms and where it was found, it had been carved into bed mounts, doors and walls.

4.11 Young people wore their own clothes and clothing was supplemented by Woodlands as required, for example underwear, sports clothing, footwear and outdoor waterproofs. Staff had access to a supply of clothing to address the needs of any young person particularly after admission. Family and friends could bring clothing to Woodlands and young people could also purchase their own clothes. A new process to improve the process of young people buying their own clothes had been identified by Woodlands as an area for improvement.

4.12 Some personal property could be kept in bedrooms; otherwise it was stored in a locked cupboard adjacent to the child's bedroom. Children could access property from their cupboard at any time during the day by asking a member of staff. Any items that young people were not permitted to have or were in excess of allowances were stored securely and returned to the young person when they were leaving.

Residential

4.13 The in-house catering department provided meals on a six-week menu. The range and size of meals appeared appropriate for adolescents. Menus reflected the preferences of young people, especially considering some may experience poor nutrition when in the community, but also introduced healthy options, for example salads and vegetables. Pre-COVID-19 a café had opened to provide a canteen style service and it was hoped this could be re-introduced once public health guidance allowed.

4.14 The health care team advised about those who had religious, cultural or special dietary requirements (for example, allergies) and menus were adapted to cater for their needs.

4.15 Children were asked to complete feedback forms after every lunch and dinner and most reviewed were rated positive, although some children told Inspectors food was "just ok" or "not good." The Catering Manager had periodically attended the Youth Forum to discuss food/meal choices.

4.16 Young people could order items from a shop. The list of available items included a range of confectionery, greetings cards, seasonal items and branded toiletries and laundry products that young people could purchase, over and above what was provided by Woodlands. A number of children reported that the shop mainly listed unhealthy snacks and they would prefer alterative options. There was a mechanism through the Youth Forum to suggest alternative products and, as we observed, children could also add comments to the bottom of their 'tuck sheet.'

Consultation, requests and redress

4.17 Children were encouraged to have a 'voice' in various aspects of life at Woodlands, for example, through the Youth Forum, involvement in House Unit regime meetings, completing catering feedback forms and attending meetings related to their case management.

4.18 The Youth Forum was a good initiative but had been suspended from March 2020 to October 2021. Prior to March 2020 young people from different House Units had come together to meet senior managers to discuss service provision. Their suggestions were tracked on an action plan and there was evidence that their feedback had influenced a range of services. In the interim period feedback from young people was channelled through house based weekly regime meetings and individually with staff members. Forum meetings resumed in November 2021 but in a different format to maintain House Unit 'bubbling'. One of the recurring issues raised by young people was when the Youth Club would resume. There was no current action plan but the intention was to restart this work with the resumption of regular meetings.

4.19 There was evidence that staff and children were encouraged to resolve issues informally and of help being given to children to raise matters formally. In case files we saw examples where key workers encouraged children to avoid conflict with other young people and proposals to adopt restorative approaches to repair relationships between key workers and young people were they were difficult or had broken down. Children said that they would raise issues with their key workers.

Complaints

4.20 Most children we spoke to said they were aware they could complain but had no reason to do so or said they wouldn't. The level of complaints raised by children remained low with only three complaints raised during 2020-21 and five in the period from April 2021 to October 2021. Two of these related to complaints about the way staff had spoken to the young person, and the remaining three concerned the issuing of an adverse report, a young person not being permitted to play Xbox and another who did not agree he should remain in his room. A complaints register was maintained but this did not record whether the young person was satisfied with the outcome of the complaint. There was evidence that parents were updated about the outcome of complaints. Complaints forms were not freely available in House Units. There was a complaints box located in the education building to allow young people to lodge a complaint where they did not want to go through a particular member of staff. The leaflet explaining the complaints process appeared complicated to Inspectors and this could be looked at as part of ongoing work to review literature for young people. **Area for improvement: Complaints forms should be made freely available, the complaints register should record if the young person is satisfied with the outcome of the complaint and the information provided to young people should be reviewed with them to check that it is accessible.**

4.21 All the complaints we looked at had been resolved internally; none were referred to the Independent Complaints Reviewer. The most recent *Annual Report of the Independent Complaints Reviewer* (2020-21) stated that the YJA, including Woodlands, continued to meet high standards in terms of its complaints procedure and implementation. The report included a recommendation that the YJA took steps in the coming year to ensure that previous staff training was reinforced by a follow-up reminder of the importance of recording complaints.

Legal rights

4.22 Children were informed about their legal rights and they were well supported by staff at Woodlands and a number of external advocacy services. Most children reported being able to access their solicitor by telephone and advocacy services were provided by the Children's Law Centre (CLC) and Voice of Young People in Care (VOYPIC). These services had been maintained through telephone contact during the COVID-19 pandemic when access to Woodlands was restricted although all agreed that the quality of this work had been impacted slightly as a result of the change in format. Organisations reported positive, collaborative relationships with the Woodlands leadership team and staff. Most children that we spoke to were not aware of the CLC. This could have been because CLC representatives did not currently have a physical presence. Solicitors raised concerns about not being able to meet children face-to-face at Woodlands although arrangements could be made for video consultations. When young people were being isolated on admission they did not attend court hearings but the records demonstrated that the outcome of proceedings were explained to them. It was important that as soon as it is safe to do so that access to face-to-face legal advice services were restored.

4.23 Children were informed about and understood their sentence or remand in custody. We saw examples where staff explained to young people about their status in the Centre, especially in the early days and concerning issues around bail (especially where the availability of a bail address was a challenge) as well as providing emotional support around applications for bail and discussing the possibility depending on the outcome, for example, of transfer to HBW (see paragraphs 6.21- 6.29).

EQUALITY AND DIVERSITY

Expected outcomes: The Centre demonstrates a clear and co-ordinated approach to eliminating discrimination, promoting equitable outcomes and fostering good relations, and ensures that no child is unfairly disadvantaged. This is underpinned by effective processes to identify and resolve any inequality. The diverse needs of each child are recognised and addressed.

4.24 Woodlands had a strong ethos of dealing with every child as an individual and working on a multi-disciplinary basis to support their needs. Equality and diversity matters were largely considered in this context. There was some monitoring by Section 75 categories of admissions, restraint and self-harm across gender and community background. Work was ongoing to produce longitudinal equality monitoring data based on quarterly reports submitted to the Acting Director on gender, age and religion but this was not available during the course of inspection fieldwork.

4.25 Admissions forms recorded Section 75 characteristics relating to gender, age, religion/community background, nationality, ethnicity and disability. We saw no reference to data being collected on sexual orientation. In the body of one file we reviewed we saw reference to the young person having a child but whether the young person had any dependents was not captured as part of admission data gathering.

4.26 Consistently the proportion of Catholic children admitted to Woodlands was higher than the proportion of Protestant children or those from other religions. Although the proportion admissions of Catholic children had reduced from the last inspection (from 74% to 66%), this remained a matter of concern. The YJA had commissioned Queen's University Belfast to undertake research to better understand the over-representation of particular groups in the Youth Justice System, to include an analysis of Section 75 and related data. The report was not yet completed and was not available during the inspection.

4.27 A pastoral team regularly visited Woodlands from Presbyterian, Elim and Catholic faiths to provide support to children albeit this had been restricted during the COVID-19 pandemic. The pastoral team could access Ministers/leaders from different faiths where required. Religious services and events were arranged to celebrate certain events and festivals. Bibles and other religious texts were not provided as standard but could be made available on request.

4.28 There were some examples in files of children being challenged by staff about inappropriate language/comments about staff or other children. In the records we reviewed we saw no complaints from children relating to discrimination or children who had committed hate crimes.

4.29 There was no Equality and Diversity Champion or designated equality representatives among young people or a specific equality focus through the range of consultation fora with children.

4.30 Access to interpreting services were in place to facilitate communication with foreign national children on formal matters but an issue had been identified around conversations concerning daily living and this had been identified by Woodlands as an area for improvement. Young people had access to support through the CLC and the Deputy Director was a member of the Regional Practice Network for Separated and Unaccompanied Children and could draw on this network to support individual children.

4.31 Two trans/non-binary children had been admitted in recent months and Inspectors were told this was now happening more frequently than before. While the needs of these young people were being met, they had been released before progressing beyond the isolation unit when decisions would have been required about their house placement and ongoing management. Staff felt, and we agreed, that this was an area where they would benefit from additional guidance and training.

4.32 Many young people admitted to Woodlands had mental health issues which could be considered as disabilities including ADHD, Autism Spectrum Disorder, as well as cognitive/processing impairments. Each child was assessed on their arrival by health care and their needs were explored during initial assessments. Mental health needs were more fully explored by the in-reach CAMHS team (see paragraphs 4.45-4.52).

4.33 Although we recognised that the needs of individual children were being met on a case by case basis, the absence of formal arrangements to champion Equality and Diversity and a specific equality focus at consultation events with young people, meant there was limited evidence of broader considerations around the needs of Section 75 groups and the promotion of equitable outcomes and good relations for and between children. While some outcomes for young people were monitored, this needed to be developed further to ensure there were effective processes in place to promote equality of opportunity and identify and resolve any inequality. There was a need to develop clear guidance on how Woodlands would manage transsexual and intersex children and train staff and children.

OPERATIONAL RECOMMENDATION **6**

Within six months of publication of this report, the Acting Director, in conjunction with Youth Justice Agency leaders, should put in place effective arrangements to champion Equality and Diversity and ensure there are processes in place for effective equality monitoring. Guidance and training for staff should be provided on the management of transsexual and intersex children.

HEALTH SERVICES

Expected outcomes: Children are cared for by services that assess and meet their health, social care and substance use needs and promote continuity of health and social care on release. The standard of health service provided is equivalent to that which children could expect to receive elsewhere in the community.

4.34 As at the previous inspection health care services continued to be provided and funded by Woodlands rather than a HSCT. The current arrangement was temporary pending the creation of a regional care and justice campus when it was envisaged that a HSCT would assume responsibility for both Woodlands and Lakewood.

4.35 Generally the standard of health services provided to young people was good and was child-centred. The needs of young people were assessed by the health care team on admission with appropriate referrals being made to provide continuity of care on release.

4.36 Nursing care was provided by four regular agency nurses from a range of specialisms and the team was led by a Nurse Manager seconded from the Belfast Health and Social Care Trust (Belfast HSCT). They were supported by an Occupational Therapist who was seconded from the SEHSCT. There was nursing cover every day from 8am to 9pm.

4.37 All children were initially screened on admission by a nurse and a Comprehensive Health Assessment Tool (CHAT) was completed. CHAT assessments were in-depth, though complex. Nursing staff said that they explained the complexities to each young person undergoing assessment in a manner which they understood. The CHAT system was audited and these audits highlighted that the timeframe for completion was not always met. A system should be in place to address this.

4.38 Nurses did not have direct access to the Northern Ireland Electronic Care Record (NIECR) which should be addressed. Alternative arrangements were in place but these were not appropriate. This is potentially an area that could be addressed under the regional facilities programme.

4.39 Relationships between staff and the young people were very good. The nursing staff spoke passionately about the care they delivered. The young people were observed to have good lines of communication with the health care team and young people spoken with were aware of how to access health care.

4.40 The nursing staff displayed a professional and dedicated approach to their work, which was person-centred. They had developed initiatives to work in partnership with the young person and there was evidence of the young person being involved in their health care planning.

4.41 A joint initiative had been introduced by the health care staff and CAMHS in-reach team to provide a six-week health promotion programme but this had been postponed because of the impact of the COVID-19 pandemic.

4.42 Woodlands used the services of a local general medical practice. Due to COVID-19 restrictions the weekly General Practitioner (GP) clinic was held remotely; nursing staff provided details of all young people for review. The GP also reviewed images remotely and any treatment plans were well documented. A weekly clinic was held by a psychiatrist. In addition to these clinics, nurses could consult with the GP by telephone each day and out-of-hours GP services were also available. In an emergency young people could be taken to an Emergency Department. Arrangements were in place with a local pharmacy for daily delivery of medicines.

4.43 Access to a COVID-19 vaccination and other routine immunisations were not available at Woodlands. In one instance, plans were being made for a young person to attend a vaccination clinic during a future period of temporary release.

We consider the absence of arrangements to support vaccinations was a missed opportunity to promote the general health and wellbeing of this vulnerable group of young people. In relation to COVID-19, the vaccine status of an individual was the biggest mitigation in respect of isolation after a close contact and following admission. Improved access to vaccinations could have enabled different responses to reduce the time children spent isolated.

4.44 The infection prevention and control policy had been reviewed in July 2020 but had not been updated to reflect the ongoing COVID-19 pandemic.

Mental health

4.45 Woodlands continued to partly fund a CAMHS in-reach service, which was seconded from the SEHSCT. The team was available from 9am to 5pm Monday to Friday. There was no emergency/on-call provision as part of the Service Level Agreement. The team comprised: a Consultant Forensic Psychiatrist (0.5 whole time equivalent), Specialist Clinical Psychologist, a Band 6 CAMHS Nurse (from November 2021) and administrative support. Members of the team had been redeployed during the COVID-19 pandemic. A specialist Forensic Psychologist position (one whole time equivalent) was vacant.

4.46 The approach of the CAMHS in-reach team was observed as therapeutic and responsive but not all children admitted to Woodlands were referred or remained long enough to see the in-reach team. Recommendations made during the previous inspection had largely been met and the CAMHS team was much better integrated.

4.47 Young people were referred to the service as a result of screening on admission, if they were experiencing mental health issues or if they were currently open to a community CAMHS team. From April - September 2021, 39 young people were referred to in-reach CAMHS of which 13 were released without being seen. This figure is concerning particularly when coupled with the in-reach team not being able to have contact with young people for 10 days due to the requirement for them to isolate on their admission. Of the remaining 26 referrals, the majority (22) were currently open to community CAMHS teams. Most of the young people referred to the service in this period were male (34), aged 16 and above (31), white (35) and Catholic (23), mostly reflecting the profile of young people admitted to Woodlands. Children living in the Southern and Belfast HSCT areas accounted for the highest number of referrals (16, 12). Most young people (24) had been living with their birth family and five had been in residential care and were not under the care of Social Services.

4.48 The majority of mental health presentations related to depression (20) and anxiety and general anxiety disorder (16); three related to psychosis. Chart 2 shows the additional needs:

Chart 2: Presentation of young people referred to in-reach CAMHS

Neuro disability 23 young people had a history of ADHD		
85% had traumatic and Adverse Childhood Experiences (ACEs)	87% were engaged in poly-substance misuse	One young person had a diagnosis of Autism Spectrum Disorder (ASD)
	One young person had an acquired brain injury	

Source: Extract from in-reach CAMHS Quality improvement report April-September 2021

4.49 The in-reach CAMHS team conducted in-depth mental health assessments and provided ongoing interventions to help resolve a young person's mental health problems. We saw examples of case psychological formulations and integrated health care plans and attended the weekly multi-disciplinary team meeting at which every young person's case was reviewed. Although young people did not attend this meeting, there was evidence in the case files that they were involved in discussions about their care and treatment which was supported by members of the CAMHS in-reach team and key workers.

4.50 The in-reach team produced six monthly quality improvement reports, a monthly operational meeting had been introduced and Woodlands and SEHSCT met to review service provision.

4.51 The young people we spoke to were very positive about their engagement with the CAMHS team and of the support they provided. It was evident in the service's improvement reports that there was a gap in gathering formal service user experience. This would be important information to reflect on work being taken forward by Woodlands to evidence the progress made by young people while they are in custody (see Operational Recommendation 2).

4.52 Leaders at Woodlands saw opportunities for the in-reach team to provide a greater supervisory and consultative role to staff, including outside of normal business hours, so that their skills and knowledge could be disseminated more widely, and the CAMHS team wanted to do more. Based on the number of referrals/ assessments and interventions completed they potentially had the scope to do more of this type of work. This should be taken forward under the arrangements in place to review service provision as set out in the Service Level Agreement.

Ophthalmology and dental services

4.53 Ophthalmology had been unavailable from the beginning of the COVID-19 pandemic. Nursing staff asked young people about sight problems on admission and at the time of the inspection no problems had been identified. We were advised there was a process in place to attend ophthalmology if required.

4.54 A dental team visited once every two weeks. Dental emergencies outside of this were not always managed in a timely manner. At the time of the inspection one young person was receiving regular paracetamol for a number of days before a dental assessment was undertaken.

Medicines optimisation and pharmacy services

4.55 There was evidence that mostly satisfactory systems were in place for the management of medicines. Improvements were necessary in the management of controlled drugs, the governance and auditing systems, and the availability of newly prescribed medicines.

4.56 Medicines were managed and administered by nurses who advised that they had received appropriate training and had regular supervision with the Nurse Manager. Team Leaders received annual update training and competency assessment on the administration of prescribed medicines and discretionary list medicines to ensure that medicines could be administered safely when nurses were not on duty.

4.57 Arrangements were in place for the safe management of medicines during admission and discharge. As nurses did not have access to the NIECR, details of pre-admission medicines were obtained from various sources on admission including the young person's GP, the CAMHS team, children's home or parents depending on circumstance. Systems were in place to ensure that young people had a continuous supply of their medicines at discharge; discharge summaries were provided to relevant health care professionals when necessary.

4.58 Personal medication records were in place for all young people who were prescribed medicines. In line with safe practice, a second member of staff should verify and sign the personal medication records when they were written and updated to ensure accuracy of transcribing. As identified at the last inspection (Operational recommendation 31) when the dose of a currently prescribed medicine was changed, a new label was requested from the community pharmacist. This practice was unsafe as there is a chance that the label could be placed on the incorrect medicine. Further guidance on the safe management of dosage changes was provided during the inspection.

4.59 A review of the medication administration records indicated that the majority of medicines were being administered as prescribed. However, there had been a delay in obtaining supplies of two recently prescribed medicines. Robust systems should be in place to ensure that medicines are available for administration as prescribed. Records of administration had been pre-signed for one medicine; records of administration must be signed when the nurse has witnessed the administration. As identified at the last inspection, a divider should be placed between each young person's records to ensure that staff do not refer to an incorrect record and administer a medicine in error.

4.60 Adherence to medication regimens was monitored and young people were promptly reviewed when adherence was poor and/or diversion to other young people was suspected. Nurses were reminded that refused medicines should be disposed of promptly to reduce the risk of an error occurring.

4.61 Controlled drugs were safely and securely stored in controlled drugs cupboards in the treatment room in each house. A review of the controlled drug record books indicated that the administration of controlled drugs was not witnessed by a second member of staff. A number of missed signatures for administration were observed and there was evidence that stock balances had not been accurately recorded on a number of days. Staff advised that reconciliation checks were carried out daily; but the records of these checks did not facilitate a clear audit trail. Woodland's controlled drug policy stated that two members of staff should be involved in the administration of controlled drugs and that both staff should sign the records of administration. SOP for controlled drugs should be further developed and implemented; regular audits on the management of controlled drugs should be completed to ensure compliance.

OPERATIONAL RECOMMENDATION **7**

The Acting Director and Nurse Manager should ensure that Standard Operating Procedures for the management of controlled drugs are further developed and implemented. The administration of controlled drugs should be witnessed by a second member of staff and records accurately maintained.

4.62 Medicines were stored safely and securely in medicine cupboards in each treatment room. The temperature range of the medicine refrigerator in the treatment room was monitored each day. Staff advised that systems were in place to ensure the temperature of medicine rooms were appropriately maintained.

4.63 Discretionary list medicines and medicines awaiting disposal were stored in the health centre treatment room. Nurses were reminded that external medicines are for single person use only. A small number of out of date medicines were removed for disposal. Running balances of discretionary list medicines, such as paracetamol, were maintained and staff advised that frequent use was referred to the prescriber for review. Records for the disposal of medicines, including controlled drugs, were maintained.

4.64 Staff advised that there had been no medication related incidents. Nurses were reminded that delays in the administration of prescribed medicines had the potential to affect the health and wellbeing of young people. Any non-administration of medicines due to stock supply issues should be investigated and the learning shared with all relevant staff to ensure that effective ordering systems are in place.

OPERATIONAL RECOMMENDATION **8**

The Acting Director and Nurse Manager should ensure that medicines are available for administration as prescribed. Any delays in availability should be investigated and action taken to ensure that effective ordering systems are in place.

4.65 Woodlands' auditing system should be further developed to cover all aspects of the management and administration of medicines, including those highlighted at this inspection. Action plans to address any shortfalls identified should be implemented and addressed.

OPERATIONAL RECOMMENDATION **9**

The Acting Director and Nurse Manager should ensure that governance and auditing systems are put in place to cover all aspects of the management of medicines identified in this report. Action plans to address any shortfalls should be implemented and addressed.

CHAPTER 5: PURPOSEFUL ACTIVITY

Children are able, and expected, to engage in education and other activity that is likely to benefit them.

TIME OUT OF ROOM

Expected outcomes: Children spend most of their time out of their room, engaged in activities such as education, leisure and cultural pursuits, seven days a week.

5.1 Generally children spent most of the day out of their rooms and engaged in activities. The core day at Woodlands revolved around the school day (9.15am – 3.30pm) and most children engaged with the timetable. A range of after school and evening recreation activities were offered. At weekends there were a range of activities and an opportunity to meet key workers.

5.2 Young people said that they were offered the opportunity to spend time outdoors and said that staff would go for walks with them. There were excellent outdoor facilities, a gym, fitness room and swimming pool that young people could access. Plans were well advanced to develop an outdoor space for Duke of Edinburgh Award activities.

5.3 At the time of the inspection, due to bubbling, activities between Units were not now taking place. This and the small number of young people in custody meant that optimal use could not be made of the available facilities. It is timely that Woodlands reviewed its dynamic risk assessment to enable the pupils access the full range of facilities on offer.

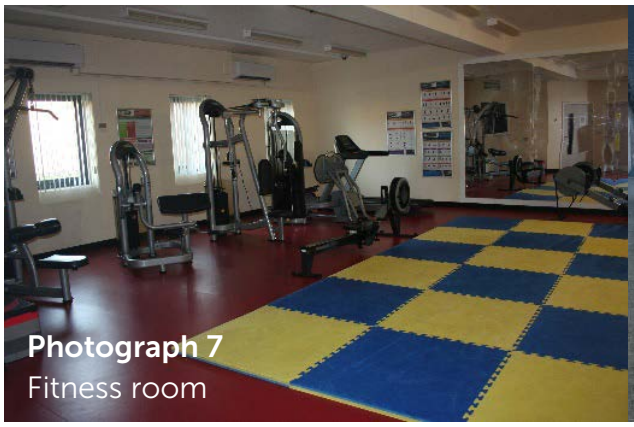
5.4 Those who were being managed under the single separation procedures, including those who were isolating, spent limited time out of their rooms (see paragraph 3.51).

5.5 Pupils had access to a well-equipped library during the day. They were encouraged to borrow fiction and non-fiction books and reading materials were presented creatively to engage and motivate the pupils with reading in line with their ability. The frequency of use was not tracked currently and pupils would benefit from regular access to the library outside formal hours. Each House Unit also held a small number of books if children asked for reading material.

There was a strategic plan to enable access to C2K[22] in House Units to expand the potential for learning outside of school and Woodlands had identified this as an area of improvement. **Area for improvement: In taking this forward provision needs to be made for Woodlands staff to be trained in its use to ensure effective and successful implementation.**

5.6 Pupils developed their skills in physical education through personalised programmes tailored to their needs and interests. They worked well with determination and applied their skills following effective guidance. Importantly, they evaluated their learning and performance to identify next steps for improvement, including the use of digital technology. In addition, they had good access to opportunities to develop their personal fitness supported by staff, 21 of whom were accredited Personal Fitness Trainers. We saw an example where a pupil was encouraged to provide guidance and support to a peer; this gave the young person the opportunity to demonstrate the learning they had acquired. Leaders had appropriately identified the need to provide the pupils with opportunities for accredited courses in physical education.

5.7 Pupils understood the importance of healthy living and personal fitness. They applied their understanding through practical learning experiences in personal fitness sessions and catering. The pupils would benefit from an enhanced nurture breakfast[23] to ensure all pupils made healthy eating choices in starting the day. A coffee shop was being refurbished as part of a business enterprise project which would provide opportunities for the promotion of independent healthy eating choices. **Area for improvement: there needed to be a greater focus on healthy eating which could be explicitly modelled and reinforced throughout the day both in the residential areas and EOTAS centre.**



Photograph 7
Fitness room

Photograph 8
Outdoor recreational facility

22 A Northern Ireland wide information and communication network operated on behalf of the EA, providing internet and supporting applications and services to pupils at school and home.

23 The aim of nurture breakfast is to support pupils to have a positive start to their day. It is a time where child-to-child and child-to-adult relationships are positively fostered and reinforced. A healthy and well-balanced meal is provided, which class groups prepare and enjoy together. This is a time to prepare pupils mentally and emotionally for the day ahead.

5.8 The curriculum provision had widened to include catering, art, horticulture and music, which engaged the pupils in their learning, promoted wellbeing and helped them develop skills for transition. Importantly, the Key Stage 3 curriculum was aligned better to the statements of minimum requirement for progression in literacy, numeracy and wider skills development. In addition, a small number of pupils attained well in a national art competition. The provision for Information, Communication and Technology (ICT) and Learning for Life and Work required further development.

5.9 Current isolation rules were restricting the pupils' personal and social development in readiness for transition to the community.

EDUCATION, SKILLS AND WORK ACTIVITIES

Expected outcomes: All children are expected and enabled to engage in education, skills or work activities that increase their employability on release. There are sufficient, suitable education, skills and work places to meet the needs of the population and provision is of a good standard.

5.10 The ETI monitoring visit focused on the EOTAS Centre's view of improvements effected prior to the COVID-19 pandemic and any impact of COVID-19 on the curriculum, including practical work, learning experiences, and the quality of learning and teaching. The visit was intended to support the EOTAS Centre at Woodlands to reflect on the strengths of their current provision with a view to being well prepared for a follow-up inspection when that can take place.

5.11 The important areas for improvement identified in the inspection of June 2018[24] were to:

- provide an intensive support programme to engage pupils more effectively to become literate and numerate;
- develop fully individual education plans and update baseline assessments to record pupils' progress to inform planning for learning and teaching;
- provide opportunities for all pupils to complete courses they started after transitioning from Woodlands and individualised transition experiences for all pupils;
- enable pupils to access a wider range of subjects including personal and social education, employability and a therapeutic programme;
- establish robust and objective quality assurance systems of the curriculum provision, learning and teaching to prioritise staff professional learning to better meet the needs of the pupils; and
- improve the effectiveness of governance.

24 http://www.cjini.org/TheInspections/Inspection-Reports/2018/April-June/JJC

Photograph 9
Literacy room

Photograph 10
Library

Photograph 11
Art room

Photograph 12
Hairdressing salon

5.12 In the interim, the key changes to the EOTAS Centre's context, including those relating to the COVID-19 pandemic are summarised below:

- the appointment of a new senior leader, and the appointment of teachers of art and design and mathematics to permanent posts;
- the clarification of strategic leadership roles and responsibilities to support centre improvement targeted on leading learning and teaching, and developing further the effectiveness of the relationships with the staff of Woodlands;
- the creation of a 'leading learning' team, which comprised a lead tutor for vocational education and a nurture champion;
- the improved access to ICT facilities for vocational education tutors;
- the refurbishment of the coffee shop to facilitate business enterprise education; and
- the review and adaptation of the school development plan and associated action plans to take account of the impact of the COVID-19 pandemic. Staff maximised the safe use of accommodation, circulation areas, resources and communication technology in line with guidance from the Public Health Agency and the Department of Education to facilitate learning and teaching, including practical work in specialist accommodation.

5.13 Since the 2018 inspection, the following key actions were implemented by the EOTAS Centre with EA support:

- the creation and implementation of a strategic development plan, with a learning and teaching action plan targeted at improving the pupils' learning experiences and their outcomes;
- the review of the Key Stage 3 curriculum in order to meet the minimum statutory requirements in levels of progression in two of the three cross-curricular skills, namely communication and using mathematics;
- the widening of the curriculum offered to include ICT, physical education, horticulture, music and personal development;
- the introduction of personal learning plans that identify specific learning strategies to meet the pupils' complex needs;
- staff engaged in a wide range of professional learning including improving: the special educational needs provision; trauma-informed, restorative and nurture practice; the tracking system; literacy strategies; and curriculum planning;
- the senior leader attended child protection training in January 2022; child protection policies have been updated with the development of a comprehensive Relationships and Sexuality Education policy;
- the recently-introduced electronic baseline tracking system to record pupils' progress in literacy, numeracy, ICT, vocational education and the pupils' personal, social and emotional development;
- the design of key stage curriculum pathways for pupils with a non-determined length of attendance; this will make use of the baseline data to inform planning to meet each pupil's interests, ability and transition needs; and
- the monthly reporting system to Woodlands management and the termly reports to referring schools/centres.

5.14 The impact of the actions taken by the EOTAS Centre is summarised below:

- the EOTAS Centre had identified through its recently-introduced OBA reporting that the majority of pupils make steady progress from the baseline assessment sat on entry to Woodlands;
- the effective practice in the lessons observed was characterised by staff engaging the pupils positively in their learning through contexts reflecting the pupils' interests. Staff modelled, guided and supported pupils in learning independently, encouraging them to self-evaluate and review their learning with peers. They used effective questioning to extend the pupils' learning, promoted extended responses and motivated pupils well through consistent positive reinforcement;
- in the lessons observed, the pupils used appropriately and confidently subject specific terms. In following instructions they completed tasks with attention to detail and perseverance. They worked with increasing independence, including undertaking research and handling equipment. They asked questions readily reflecting their interest in their learning and they could apply their skills in real life contexts and across the curriculum;

- the analysis of data to identify the baseline position of pupils to enable staff to plan individualised learning programmes to motivate and engage the pupils;
- the development of the literacy support programme through the *Engage Programme* to help pupils analyse text for deduction and inference; and
- the personalised transition programme for pupils when the time comes for the pupils to leave Woodlands.

5.15 Based on the evidence available at the time of the monitoring visit, ways to improve included:

- prioritising the collation of data from referring schools/EOTAS centres, including an escalation system to ensure a response;
- ensuring pupils develop more systematically their literacy, numeracy and ICT skills in their vocational education through rigorous monitoring and evaluation by People 1st;
- evaluating the impact of teachers' feedback to pupils and the evaluation of the learning to inform planning for pupils to attain the best possible outcomes;
- developing the curriculum for ICT and Learning for Life and Work, including an emphasis on healthy eating;
- demonstrating the sustained impact of teacher professional learning on the pupils' ability to self-regulate their behaviour and take responsibility for their emotional health and wellbeing;
- formalising the exceptional teaching arrangements for pupils with medical and other needs who are unable to attend the EOTAS Centre;
- evaluating the effectiveness of the transition process on pupils' longer term outcomes; and
- establishing independent governance, including for safeguarding arrangements.

Accommodation

5.16 The pupils do not have access to facilities for technology and design.

5.17 The District Inspector will continue to monitor the EOTAS Centre's provision. A formal follow-up inspection will be conducted when inspection resumes.

CASE EXAMPLE 1

A 16-year-old child was attending the EOTAS Centre. They had been in their last year of school in the community before coming into Woodlands. They were working towards vocational qualifications and mathematics and English. They had taken part in a video conference meeting with a careers adviser and help was being provided to support the young person transfer to a regional college and to gain relevant work experience. The young person and their family were very positive about a monthly school report which they were now receiving which told them how they were doing and what level they had progressed to.

CHAPTER 6: RESETTLEMENT

Children are effectively helped to prepare for their release back into the community and effectively helped to reduce the likelihood of reoffending.

CHILDREN, FAMILIES AND CONTACT WITH THE OUTSIDE WORLD

Expected outcomes: Managers support children in establishing and maintaining contact with families, including corporate parents, and other sources of support in the community. Community partners drive sentence and remand planning and families are involved in all major decisions about detained children.

6.1 Young people were supported to maintain/restore regular contact with families/carers through visits and telephone calls when that was appropriate. Where parents or young people did not consent to contact, care workers maintained regular contact. The frequency and duration of visits and suitability of contacts were decided at initial planning meetings.

6.2 Data was not centrally recorded on the involvement of families in care planning but there was extensive evidence in case files of contact between case management teams and parents, of parents including corporate parents being invited to care planning meetings, and of families being updated on the outcome of complaints, use of restraint and single separation.

6.3 Following admission all families were contacted by a Family Link Worker who provided excellent support that was well received by families who participated. Monthly family group meetings had been impacted during the COVID-19 pandemic but two face-to-face group meetings had resumed in November 2021. These had been well attended and families were very positive about the support they had received. A number of participants commented that it would have been helpful to have had similar training before their child had offended which illustrated the value of EI work. Woodlands wanted to expand the family link role to other areas of Northern Ireland.

6.4 Data on the number of family visits was not recorded other than in individual case files so it was not possible to make an assessment of their uptake. We were told that uptake of virtual visits introduced when face-to-face visits had been suspended was low and this seemed to be partly due to young people and/or their parents not liking or being comfortable with this format. This was in contrast to the uptake of virtual visits in adult prisons. It would be worth exploring with young people and their families why this was the case.

Video technology was being used to good effect to support families to attend care planning meetings especially when they would have had to travel long distances to attend in person.

6.5 Visits rooms were clean and while work had been done to brighten the rooms, they were small and had limited facilities. No physical contact was currently permitted between parents and children during visits. While face-to-face family visits had been restricted at times during the pandemic, family contact was maintained through telephone calls and virtual visits. We were told that it can be uncomfortable for families and young people to meet for an extended period in the confined space of the visiting rooms depending on individual circumstances. Woodlands recognised this and on a number of occasions (mostly pre-pandemic but also at times during it) had taken a more creative approach to support young people develop and restore family relationships through doing activities together like fitness, swimming, art, woodwork and cooking. There was impressive overnight family accommodation to support extended visits for young people in custody. This had not been used since the COVID-19 pandemic and data was not available on the use of this facility prior to this. As restrictions eased, there should be a continued focus on opportunities to make optimal use of the good facilities to support and promote family engagement.

Photograph 13
Artwork – family visit room

Photograph 14
Family visit room

6.6 Young people could make regular telephone calls to family members and friends after numbers had been screened. The rooms used to make calls in were in poor condition and should be improved as part of the accommodation strategy.

PRE-RELEASE AND RESETTLEMENT

Expected outcomes: Planning for a child's release or transfer starts on their arrival at the Centre. Resettlement underpins the work of the whole Centre, supported by partnerships in the community and informed by assessment of children's risk and need. Ongoing planning ensures a seamless transition into the community.

Sentence planning and remand management (care planning)

All children have a sentence or remand management plan, which is based on an individual assessment of risk and need. Relevant staff work collaboratively with children and their parents or carers in drawing up and reviewing their plans. The plans are reviewed regularly and implemented throughout and after children's time in custody to ensure a smooth transition to the community.

6.7 SOPs set out the key stages in the care planning process, which aimed to support young people from their arrival until their discharge from custody. The flowchart at Appendix 5 summarises the key stages and timescales. The process was well embedded, it applied to both young people who were remanded or sentenced, there was evidence of good multi-disciplinary working and children and their families were involved at every stage except where they had declined to attend. A number of young people we spoke to said they were not aware of the goals they were expected to achieve.

6.8 The challenge was that many children were seldom in custody long enough[25] to benefit fully from what Woodlands had to offer, and as the majority of children were there on remand, their release dates were unpredictable. We examined nine cases to assess resettlement outcomes. In six instances the young person was released on bail before the initial planning meeting was due to take place (within seven to 10 days of admission). Of the remaining three cases only one remained long enough for a follow-up care plan review to take place. We were satisfied, however, that immediate resettlement needs were being met but offending risk and needs could not be met in this timescale.

25 Source YJA: The average length of stay by status for 2021-22 was: PACE 1 day; Remand 20.7 days; and Sentenced 25.3 days when calculated as a proportion of the total number of movements for each category. During 2021 the average number of days in custody for those on remand was 46 days and it was five months for those who were sentenced.

CASE EXAMPLE 2

A 17-year-old non-binary child (who preferred 'he' pronouns) was first admitted under PACE and then remanded on charges including common assault against his parents. On his admission his family were contacted to gather background information on his risk and needs. His parents did not wish to have any direct contact with the child but requested that they were kept updated. He had previously been living at home with his parents. The initial assessment identified that he had ADHD, anxiety and other physical and mental health needs. Medication was not provided on the first night in custody as no nurse was on duty. He was granted bail after five days to a hostel with a plan to move to other accommodation arranged by social services. During this time he had one meeting with a key worker at which they discussed plans for release/bail and his relationship with his parents. The YJA assessment of his risk of offending was not completed in the time available. There was no initial planning meeting as the young person was released prior to this taking place. The key worker ensured that social services were aware of a risk of CSE and of a domestic violence disclosure made during their meeting. A medical discharge summary was issued by CAMHS prior to the young person's release. The young person indicated that he wanted to return to school on release but there was no engagement with education due to the short stay in custody. There was no time to engage in the usual care planning process but immediate risks assessments were completed and immediate safeguarding needs identified and shared.

6.9 Following recommendations made at the last inspection (Operational recommendations 10, 21 and 22) care planning had continued to evolve. A new Integrated Care Planning process had launched in November 2021. The aim was to draw together the young person's needs in one place, including their health and education needs, and devise a single plan of work which was child centred rather than service focussed. The same plan was also to cover the initial supervision period after discharge.

6.10 The new process was not well embedded. More work was needed to ensure all plans were individualised, contained specific, measurable, achievable, realistic and time-bound (SMART) objectives, adequately reflected the child's voice and recorded what progress had been achieved against set goals. Greater input and involvement from field social workers was required. There was a need to ensure the whole staff care team understood their role in the new process and how to effectively contribute to it.

OPERATIONAL RECOMMENDATION **10**

The Acting Director should ensure that the planned review of Integrated Care Plans takes account of learning identified in this report. Care plans should be informed by an assessment of a young person's needs and a robust system to audit care plans should be put in place to ensure those needs are being met. Managers should ensure that all staff fully understand their role in the process and are clear how they best contribute to supporting case management teams.

6.11 Robust audit arrangements of care plans was also needed. Leaders recognised that there was still work to do and the process was due to be reviewed in March 2022. The review should take account of the issues identified in paragraph 6.10.

6.12 Some staff felt that young people were now better listened to even if they didn't have the confidence to attend care plan review meetings. They said that previously reviews tended to be negative and focussed on risk but now there was more positivity and person-centred planning to meet the young person's needs. We attended two review meetings and agreed that the discussion focussed on the child's needs and opportunities were given to the children to ask questions and talk about how they were feeling.

6.13 Care plans were informed by a range of risk assessments, which could be voluminous. It was difficult to piece together all of the information these assessments contained to support care planning and inform the whole care team working with a young person of their particular risk and needs.

6.14 These assessments and reviews did not appear to connect behaviours with individual needs which for example may be associated with ACEs and meant emerging risks may be missed.

6.15 The YJA Assessment was being updated to introduce a more needs based approach and this presented an opportunity to reflect ACEs and a trauma informed approach, which could underpin the Integrated Care Planning process. The SMT were advised to contact their counterparts in Lakewood to consider how the regional development and implementation of the therapeutic care plan compared with their own Integrated Care Planning process.

6.16 A number of good assessments were completed by young people including a 'What do you think' questionnaire and a Crime Pics survey assessing their attitude to offending, but it was not evident that the outcome of these was fully reflected when care plans were being developed. The aim was to repeat these assessments to chart changes in attitudes but we saw few updated assessments in files because the young person had been released.

6.17 The CAMHS formulation meetings were a very good way of analysing the Antecedent-Behaviour-Consequence (ABC) of individual behaviours and a young person's presentation, staff concerns and agreeing a plan for staff supporting young people, however these did not include the whole care team working with the young person nor were they done for every child. There was an opportunity to introduce reflective practice work, supported by CAMHS, for the whole care team. Linkages could also be made with behavioural management plans.

6.18 Key workers had a caseload of one or two children. Most key workers were experienced social workers who were supported by co-workers (see paragraph 4.1 for description of roles). It was important that Woodlands maintained suitably qualified staff to lead care planning work – there were now nine care workers who were qualified social workers and 11 social work qualified case managers. Three student social worker placements commenced during the week of the inspection and a scheme was available for staff to apply to undertake social work training.

6.19 Timely multi-disciplinary review meetings were taking place and children and their families were supported to participate in these meetings although many young people were released before initial planning meetings and review meetings took place.

6.20 Key worker sessions with young people were regularly recorded and there was evidence of good engagement. Records should include a clear programme of the work being undertaken, an analysis of whether goals were being worked towards effectively and if not, what was preventing this.

Children transferring to the adult estate

6.21 A protocol[26] was in place and good arrangements had evolved over time between Woodlands and HBW to manage the transfer of young people to an adult facility. The protocol was outdated and should be updated to reflect how the current arrangements have evolved and to incorporate learning and best practice.

6.22 HBW were notified of a potential transfer and at least one pre-transfer meeting took place, attended by HBW staff including a representative of HBW's Mental Health Team and the Safer Custody Team. Following assessment young people could remain on the safer custody caseload at HBW depending on their needs.

6.23 On average seven young people had transferred in the years since the last inspection; four young people had been moved in the current business year to 30 December 2021.

26 *Protocol between the Youth Justice Agency (YJA), Woodlands Juvenile Justice Centre (JJC) and Hydebank Wood Young Offenders Centre (YOC) re: Transition of young people into Adult Custodial Services, 2014. Unpublished.*

6.24 Evidence from a review of six randomly selected cases showed that appropriate information was shared and practical arrangements for transfer including awards/certificates, property and money were put in place. All but one of the six young people had transferred on the day of their 18th birthday and all six were being held on remand. HBW acknowledged that post transfer meetings had not taken place in all recent cases. It was important for these to be resume and learning reflected in practice.

6.25 In three of the six cases we examined, either the young person or a staff member had highlighted anxiety/low mood preceding transfer and there had been 'outbursts' before transfers were effected. It was good, therefore, that HBW's Safer Custody Team were involved in the process. We spoke to two of the six young people that were still at HBW, both reported they had settled in well. All of the young men we spoke to at HBW said they had outgrown Woodlands in one way or another and were ready to move. They spoke very highly of key workers and other staff members at Woodlands and in some instances planned to contact them in future.

6.26 In terms of outcomes for the young people in our sample, two of the six were subsequently released on bail from HBW, two were sentenced, one person was discharged at court after 47 days at HBW and another young person was transferred under a Transfer Direction Order to a medium secure mental health unit 63 days after they were transferred.

6.27 It was not always evident in Woodland's records at what stage initial conversations around transfer had taken place. We recognised this could be fluid depending on the availability of bail addresses, pending court dates and the young person's needs/circumstances. **As an area for improvement Woodlands staff should consider and document the potential for transfer to HBW at the earliest opportunity, ideally at the Initial Planning Meeting, to allow adequate time to prepare the young person and their family for this transition.**

6.28 Staff at HBW identified that transition from youth to adult custody had been difficult for some parents of young people and this was an area where respective family links workers might collaborate. Although Woodlands staff had produced an information booklet for families, a particular issue was identified around communication and information.

OPERATIONAL RECOMMENDATION **11**

The Youth Justice Agency, Woodlands Juvenile Justice Centre, Hydebank Wood Secure College and Ash House Women's Prison should update the transition protocol within nine months of publication of this report to reflect how practice had evolved and incorporate learning and best practice from their respective experiences. This should include consideration of work to help parents of young people adjust to the transition from youth to adult custodial services.

6.29 We also attended a case review meeting for a young person who was being transferred to a specialist facility outside of Northern Ireland. Given the significance of this move, steps were taken to help the young person and their family prepare for this transition. These included providing a virtual tour of the new facility and arranging for the young person to attend a house meeting so that they could meet some of the other residents. The young person had the opportunity to ask questions of the receiving facility and was clearly very well supported by their key worker and other members of the multi-disciplinary care team.

REINTEGRATION PLANNING

Expected outcomes: Children's resettlement needs are addressed prior to release. An effective multi-agency response is used to meet the specific needs of each individual child to maximise the likelihood of successful reintegration into the community.

INTERVENTIONS

Expected outcomes: Children can access interventions designed to promote successful rehabilitation.

6.30 Resettlement needs formed a key element of the care planning process. As well as challenges resulting from young people staying a very short time at Woodlands, for others the time held in custody presented a different challenge. Staff recognised that young people at Woodlands lived in a highly controlled environment and yet they were often released without recourse to the same 24-hour support network. We attended one meeting during the inspection where it was noted that the young person had become very dependent on key members of staff and services. One of the difficulties being addressed was how to prepare that young person for release and transition to support services in the community. Mobility leave (periods of temporary release) was being considered to help the young person adapt to noise and everyday living experiences which they had been sheltered from while at Woodlands. The expertise of the various participants at the meeting was being drawn upon to inform discussions about pre-release planning with the young person and in anticipation of their next care planning review meeting.

6.31 Practical resettlement help was provided by care and education staff. Young people were assisted to prepare for independent living. Timely onward referrals to maintain continuity of physical and mental health were made and in one case in our sample a first appointment with a community service had been made. In three cases, plans were in place to continue their education; in the other cases the young person had not engaged with education at the time of their admission or they hadn't been able to engage due to the limited time they had been in custody. There was good communication with Youth Justice Service staff. The Family Link worker offered and provided support to families to help them prepare for the young person returning home.

CASE EXAMPLE 3

A 15-year-old male child was admitted under PACE and remanded the following day. No suitable address was available for bail. Six weeks after admission he received a six-month Juvenile Justice Centre Order. In total he spent 90 days in custody – half of the time on remand and half sentenced. A Care Order was in place and there had been a long history of social work involvement with his family. There was a history of violence and concerning behaviour in children's homes and secure care/ custody. His first court finding of guilt was at age 11 and he had more than eight previous sanctions. He had a history of polysubstance misuse and had been expelled from school and attended EOTAS in the community. There was good multi-agency attendance at the Initial Planning Meeting including by field social workers but the young person declined to attend. CSE and Child Criminal Exploitation risks were considered at the Initial Planning Meeting. A referral to in-reach CAMHS was not made as he had previously refused to engage with this service. At the next care plan review, progress against the goals identified at the Initial Planning Meeting was noted. The young person had weekly meetings with their key worker and was known to them from previous meetings. Their meetings covered progress on the regime, employment at Woodlands, money management, family engagement, dealing with conflict and how his court case was progressing. Key worker sessions also noted plans for release and of engagement between the field social worker and key worker. The young person and their key worker seemed to have a positive relationship and there were instances noted where the key worker had praised the young person for improvements in his behaviour and being able to maintain composure. At discharge the young person had plans to attend an EOTAS Centre and a first CAMHS appointment was arranged in the community.

Interventions

6.32 Delivery of interventions for many children was hindered by the short time they stayed at Woodlands. There was evidence of individual work being undertaken with key workers and with other service providers.

6.33 It would be impossible to undo ACEs, neglect and disruptive upbringings in a matter of days and difficult for good habits developed in Woodlands to be sustained.

6.34 The reality was that there was limited opportunity in most cases to address behaviours in the time available and to meaningfully contribute to reducing offending. This was either because of the very short time a young person spent in custody or due to the time taken for their case to be dealt with[27], they spent a very short time in sentenced custody.

27 The median time taken for charge cases at Youth Magistrates' Court was 187 days, which was an increase of 59.8%. Summons cases increased by 34.7% to 326 days. Source: NISRA: 2020-21 Case processing times for criminal cases dealt with at Courts in Northern Ireland 2020-21.

The reoffending statistics for the 2018-19 cohort bore this out with 19 of the 22 young people released from Woodlands reoffending within one year of their release.[28] Data on risk profile showed most admissions to Woodlands were assessed as presenting a medium risk of reoffending.

6.35 A persistent difficulty and one which was highlighted during discussions with stakeholders was around securing appropriate accommodation for young people. The *Expectation* that children had suitable, sustainable and safe accommodation arranged 14 days prior to their release was not feasible in most cases. In the small sample of cases we looked at, young people were being released soon after a suitable address had been approved which in some instances was the day before their release.

"I can't go back to a children's home, I can't get my own place. Staff have spoken to me about what the options are."

"...can't find anywhere, so don't know how long I'll be here."

"My social worker is trying to find an address and my solicitor has been on to most of my family to try and get an address. The issue with going home is my drug use."

6.36 In the nine cases in our resettlement sample, four of the young people had been charged with offences against their parent(s). Prior to admission eight of the young people had been living at a parental home; four were released to a parental home.

28 *NISRA, S Browne & R Millar, Adult and Youth Reoffending in Northern Ireland (2018/19 Cohort), November 2021* available at https://www.justice-ni.gov.uk/publications/adult-and-youth-reoffending-northern-ireland-201819-cohort

APPENDIX 1: TERMS OF REFERENCE

AN INSPECTION OF WOODLANDS JUVENILE JUSTICE CENTRE

TERMS OF REFERENCE

Introduction

Criminal Justice Inspection Northern Ireland (CJI) proposes to undertake an announced inspection of Woodlands Juvenile Justice Centre (JJC/Centre) as part of its regular programme of inspections of places of detention. The last inspection report was published in June 2018.

This inspection will be conducted in partnership with the Regulation and Quality Improvement Authority (RQIA) and the Education and Training Inspectorate (ETI).

All inspections carried out by CJI in partnership with the RQIA contribute to the UK's response to its international obligations under the Optional Protocol to the United Nations Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT).[29] The OPCAT requires that all places of detention are visited regularly by independent bodies collectively known as the National Preventive Mechanism (NPM) in order to monitor the treatment of and conditions for detainees.

Context

The JJC is the custodial directorate of the Youth Justice Agency (YJA) and is the only custodial facility for children in Northern Ireland. The Criminal Justice (Children) (Northern Ireland) Order 1998[30] (the Order) provides the legislative basis for the JJC's operation. The Order and supporting JJC Rules are modelled on the United Nations Convention on the Rights of the Child.

Health care services at the JJC are led by a Nurse Manager who is seconded from the Belfast Health and Social Care Trust. The South Eastern Health and Social Care Trust Child and Adolescent Mental Health Service provide in-reach support to the Centre. Since 2017 the Education Authority has managed the delivery of education within the JJC as part of its Education Other Than At School (EOTAS) provision.

The last JJC inspection report included a strategic recommendation that the YJA and the Department of Justice should collaborate with other Government Departments

29 Available at **https://www.ohchr.org/EN/ProfessionalInterest/Pages/OPCAT.aspx**
30 The Criminal Justice (Children) (Northern Ireland) Order 1998 available at: **https://www.legislation.gov.uk/nisi/1998/1504/contents**

and agencies to implement the recommendations of the *Review of Secure Care and Regional Specialist Children's Services*, particularly in relation to closer alignment between the JJC and Lakewood Secure Care Centre (Lakewood). The *Review of Regional Facilities for Children and Young People*[31] was subsequently published in March 2018 and recommended that the Lakewood and Woodlands facilities should be re-configured and replaced with a new integrated and more aligned model of provision. Most recently the Departments of Justice and Health consulted on proposals to establish a regional care and justice campus for children and young people. A report[32] summarising the two Departments' joint response to the consultation and plans for next steps was published in June 2021.

While work progresses to establish a regional care and justice campus, Woodlands JJC continues to operate as a justice facility and comes under the inspection remit of CJI in accordance with Section 46 of the Justice (Northern Ireland) Act 2002.

The JJC will be inspected against *Expectations for Children in Custody* (see document attached) which have been customised for use in Northern Ireland. These incorporate the ETI's *Inspection and Self-Evaluation Framework* (ISEF): *Effective Practice and Self Evaluation Questions for EOTAS* and will be used in conjunction with the RQIA's *Quality Standards for Health and Social Care, Supporting good governance and practice in the Health and Personal Social Services* (March 2006). Developed by HM Inspectorate of Prisons specifically for assessing the treatment of children and conditions in which they are held, the *Expectations* are based on four tests: Safety, Care, Purposeful Activity and Resettlement and are referenced against international and regional human rights standards.

Aims of the inspection

The broad aims of the inspection are to examine:

- the profile of children held at the Centre and compare that with other jurisdictions, as appropriate;
- the governance, leadership, staffing and costs of the JJC;
- the outcomes for children against the four tests set out in the *Expectations* that is, Safety, Care, Purposeful Activity and Resettlement; and
- the implementation of previous inspection recommendations.

Other relevant significant matters arising during the inspection may also be considered.

31 *DoH, Review of Regional Facilities for children and Young people – Review Report, March 2018,* available at: **https://www.health-ni.gov.uk/sites/default/files/publications/health/review-of-regional-facilities-for-children-young-people.pdf**

32 *Departments of Health and Justice, Establishment of a Regional Care and Justice Campus, Consultation Analysis Report, June 2021,* available at **https://www.health-ni.gov.uk/sites/default/files/consultations/health/doh-rcj-campus-analysis-report.pdf**

Methodology

The *Expectations* will be used to assess the treatment of children and conditions in the JJC.

Section 2 of the *Expectations* incorporates health services which will be inspected by the RQIA. Education, skills and work activities contained in Section 3 will be inspected by the ETI. The Inspection Team will work collaboratively to test and agree their findings across each of the four tests to reach an overall assessment of the outcomes for children.

Design and Planning

Data and documentation such as policies, procedures and guidance documents will be reviewed prior to fieldwork.

Delivery

Stakeholder consultation

Stakeholders from external partner agencies and community and voluntary sector organisations will be consulted as part of the fieldwork. They will include:

- Commissioner for Children and Young People in Northern Ireland;
- Children's Law Centre;
- NIACRO;
- Include Youth;
- Voice of Young People in Care;
- Barnardo's NI;
- Northern Ireland Law Society;
- Independent Monitor Youth Justice Agency;
- Northern Ireland Guardian Ad Litem Agency;
- Northern Ireland Human Rights Commission;
- Probation Board for Northern Ireland;
- Police Service of Northern Ireland; and
- Prisoner Escort and Court Custody Service, Northern Ireland Prison Service.

As a number of inspections are running concurrently, Inspectors will endeavour to streamline meetings with stakeholders and cover both topics at one meeting, where appropriate.

Self-assessment

The JJC, Education Authority and health care providers will be asked to undertake a self-assessment based on the *Expectations for Children*, which will be reviewed by CJI, ETI and RQIA prior to the commencement of fieldwork.

Development of fieldwork plan

The fieldwork plan will include:

- on site fieldwork to examine the facilities at the JJC, observe how children are treated, how services are delivered, and review custody/care records;
- meetings with senior managers and staff at the Centre and with representatives of partner organisations delivering services to children;
- surveys; and
- case reviews.

The views of children held at the Centre will be sought through semi-structured interviews.

Care will be taken by Inspectors to develop age appropriate question sets and, given the small number of children held at the Centre, to ensure that children are not interviewed by multiple Inspectors.

In conducting the inspection, the Inspection Team will comply with Northern Ireland Assembly regulations and public health guidance to control the spread of COVID-19 as appropriate at the time of the on-site fieldwork. This may include wearing Personal Protective Equipment (PPE) such as facemask and gloves while in the Centre. JJC staff, partner agencies and children should be advised that Inspectors may be wearing PPE during the site visit.

Initial feedback to agency

On conclusion of the fieldwork the evidence will be analysed and emerging recommendations will be developed. The Inspection Team will present the findings to appropriate organisations.

Drafting of report

On completion of the inspection a draft report will be shared with the inspected bodies for factual accuracy check, which is to be completed in four weeks. The Chief Inspector will also invite the inspected bodies to complete an action plan within four weeks to address the recommendations and if the plan has been agreed and is available, it will be published as part of the final inspection report. The inspection report will be shared, under embargo, in advance of the publication date with the inspected bodies.

Publication and Closure

A report will be sent to the Minister of Justice for permission to publish. When permission is received the report will be finalised for publication. A press release will be drafted and shared with the YJA and JJC prior to publication and release. A publication date will be agreed and the report will be issued.

Indicative timetable

November/December 2021	Self-assessment/research
	Stakeholder consultation
January 2022	Review self-assessment
	Conduct fieldwork including surveys, interviews/focus groups, case reviews
April 2022	Draft report to YJA and JJC
May 2022	Factual accuracy feedback and draft action plan received
May/June 2022	Report design and publication

The above timetable may be impacted by a number of factors such as any change in COVID-19 health restrictions and/or Ministerial request for an urgent inspection. The inspected organisation will be kept advised of any significant changes to the indicative timescale.

APPENDIX 2: METHODOLOGY

DESKTOP RESEARCH AND DEVELOPMENT OF INSPECTION TERMS OF REFERENCE AND QUESTION AREAS

Reports, statistics and other documents (including previous inspection reports) relevant to Woodlands Juvenile Justice Centre and youth justice were reviewed. HM Inspectorate of Prisons *Expectations* for children in custody were adapted for use in Northern Ireland and Woodlands was consulted on their application. A Terms of Reference was developed and this document and a copy of the *Expectations* were published on the Criminal Justice Inspection web site.

Self-assessment and document review

Woodlands was asked to complete a self-assessment against the *Expectations* and provide supporting documents and data. The self-assessment materials were reviewed in advance of fieldwork and were used to inform the fieldwork plan and interview question sets.

Fieldwork

Fieldwork commenced on 22 January 2022 when all young people currently in custody were invited to speak with Inspectors. Each House Unit and other facilities at Woodlands were visited during the week and Inspectors observed a number of management meetings, classes, activities and case review meetings.

Files were inspected to build a profile of the young people currently in custody, to assess resettlement outcomes and examine other *Expectation* areas including care planning, use of force, separation and arrangements for transferring young people to Hydebank Wood.

One-to-one and focus groups interviews were conducted with a range of personnel within the relevant agencies. Staff at Woodlands were given the opportunity to meet with Inspectors individually.

Two surveys were developed: one aimed at families of young people in custody and the other at individuals who provided services to young people. Regrettably there was no uptake of either survey.

Discussions with young people in custody

As the number in children in custody was very small, each young person was invited to speak individually with Inspectors. A short leaflet explaining the background to the inspection and what the children would be asked was circulated in advance of meetings taking place.

The interview questions were drawn from the *Expectations* and centred around how safe young people felt, how well they felt they were cared for, how they spent their time and what help they were getting to prepare to leave Woodlands. Eight of the 10 children at Woodlands agreed to speak to Inspectors. Their views are reflected throughout the report. A number of informal discussions with young people also took place over the course of the week.

Stakeholder consultation

Stakeholders who had an interest in or provided services to those held at Woodlands were consulted at an early stage in the inspection.

CJI Inspectors met with representatives from the following organisations:

- Children's Law Centre;
- Include Youth;
- Independent Monitor, Youth Justice Agency;
- Law Society of Northern Ireland Criminal Solicitor's Committee;
- Northern Ireland Commissioner for Children and Young People;
- Northern Ireland Human Rights Commission;
- Police Service of Northern Ireland;
- Prisoner Escorting and Court Custody Service, Northern Ireland Prison Service;
- Prison Officers' Association;
- Probation Board for Northern Ireland; and
- Voice of Young People in Care.

APPENDIX 3: GLOSSARY

Children

Children aged from 10 to 17 who have been remanded or sentenced to custody can be held at Woodlands. Woodlands is also designated as an overnight place of safety under the Police and Criminal Evidence (Northern Ireland) Order 1989 (PACE). The terms children and young people are used interchangeably throughout this report when referring to those detained at Woodlands. The term pupil is used in the education and skills section.

Criminal Justice Inspection

Criminal Justice Inspection Northern Ireland (CJI) is an independent statutory Inspectorate, established under the Justice (Northern Ireland) Act 2002, constituted as a Non-Departmental Public Body (NDPB), a corporation sole, in the person of the Chief Inspector. CJI was established in accordance with Recommendation 263 of the Review of the Criminal Justice System in Northern Ireland of March 2000. CJI is a member of the UK NPM.

C2K

C2K (formerly known as Classroom 2000) is a Northern Ireland-wide information and communications network operated on behalf of the Education Authority (EA) in Northern Ireland. It provides the internet and supporting applications and services to pupils at school and home. Each pupil is provided with a C2K account and email address.

Education and Training Inspectorate for Northern Ireland

The Education and Training Inspectorate (ETI) is a unitary Inspectorate, and provides independent inspection services and information about the quality of education, youth provision and training in Northern Ireland. It also provides inspection services of the learning and skills provision within prisons, in line with an agreed annual memorandum of understanding and an associated service level agreement.

Education Authority

The Education Authority (EA) is responsible for ensuring that efficient and effective primary and secondary education services are available to meet the needs of children and young people, and support for the provision of efficient and effective youth services. The EA assumed responsibility for managing delivery of education at Woodlands in September 2017 as part of its Education Other Than At School (EOTAS) provision.

Education Other Than at School (EOTAS) Centre

Education Other than at School (EOTAS) is EA educational provision for children with social, behavioural, emotional wellbeing issues who, without its provision, cannot sustain access to suitable education. EOTAS allows young people who have been expelled from school, or have otherwise disengaged from their registered school, to participate in education until they: i) Achieve a new school place; ii) Are prepared for re-entry to an existing school place; or iii) Reach compulsory school leaving age. EOTAS is not a duplication of mainstream education. It is an educational provision to meet specific, identified pupil needs and is not a standalone alternative. The education provision at Woodlands is a dedicated EOTAS Centre.

Leader

In this report the term 'leader' refers to anyone with leadership or management responsibility in the youth justice agency or youth custodial services.

Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority (RQIA) is a NDPB responsible for monitoring and inspecting the quality, safety and availability of health and social care services across Northern Ireland. It also has the responsibility of encouraging improvements in those services. The functions of the RQIA are derived from the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003. RQIA is a member of the UK NPM.

Time out of room

Time out of room, in addition to formal 'purposeful activity', includes any time children are out of their bedrooms to associate or use communal facilities to take showers or make telephone calls.

Youth Justice Agency

The Youth Justice Agency (the Agency or YJA) was established on 1 April 2003 as an Executive Agency within the Northern Ireland Office following the recommendations of the Criminal Justice Review. On 12 April 2010, justice functions in Northern Ireland were devolved to the Northern Ireland Assembly and the Department of Justice (DoJ) came into existence as a new Northern Ireland Department. From that date, the Agency became an Executive Agency of the DoJ. The Agency sits within the DoJ's Reducing Offending Directorate (ROD).

APPENDIX 4: PROFILE OF YOUNG PEOPLE IN CUSTODY 2020-21

Unless otherwise stated all figures relate to 2020-21. Last inspection was 2017-18.

108 children admitted – *lowest number of children admitted in the last 10 years.*

50% PACE conversion rate – *remained consistent.*

0.6 per 1,000 – reduction from 0.8 at last inspection.

77% of all admissions were under PACE, **22.7%** remand and **0.7%** sentenced – *sentenced admissions decreased from 3.8%.*

1.4 per 1,000 individual admission rate from Derry & Strabane – the *highest number of individual children admissions continued to be from Belfast.*

30.1% of those who reoffended in the one year observational period (2018-19 cohort) were youths (Source: NISRA).

19 of 22 youths released from custody reoffended during the one year period (Source: NISRA).

66% Catholic children admitted – lower than last inspection 74% but remained consistently higher.

4 lowest daily population March 2021. *The average was 11 – reduction from 21 in 2017-18.*

7.7 months was average time spent by sentenced children, **24** days for remands and **1** day for PACE.

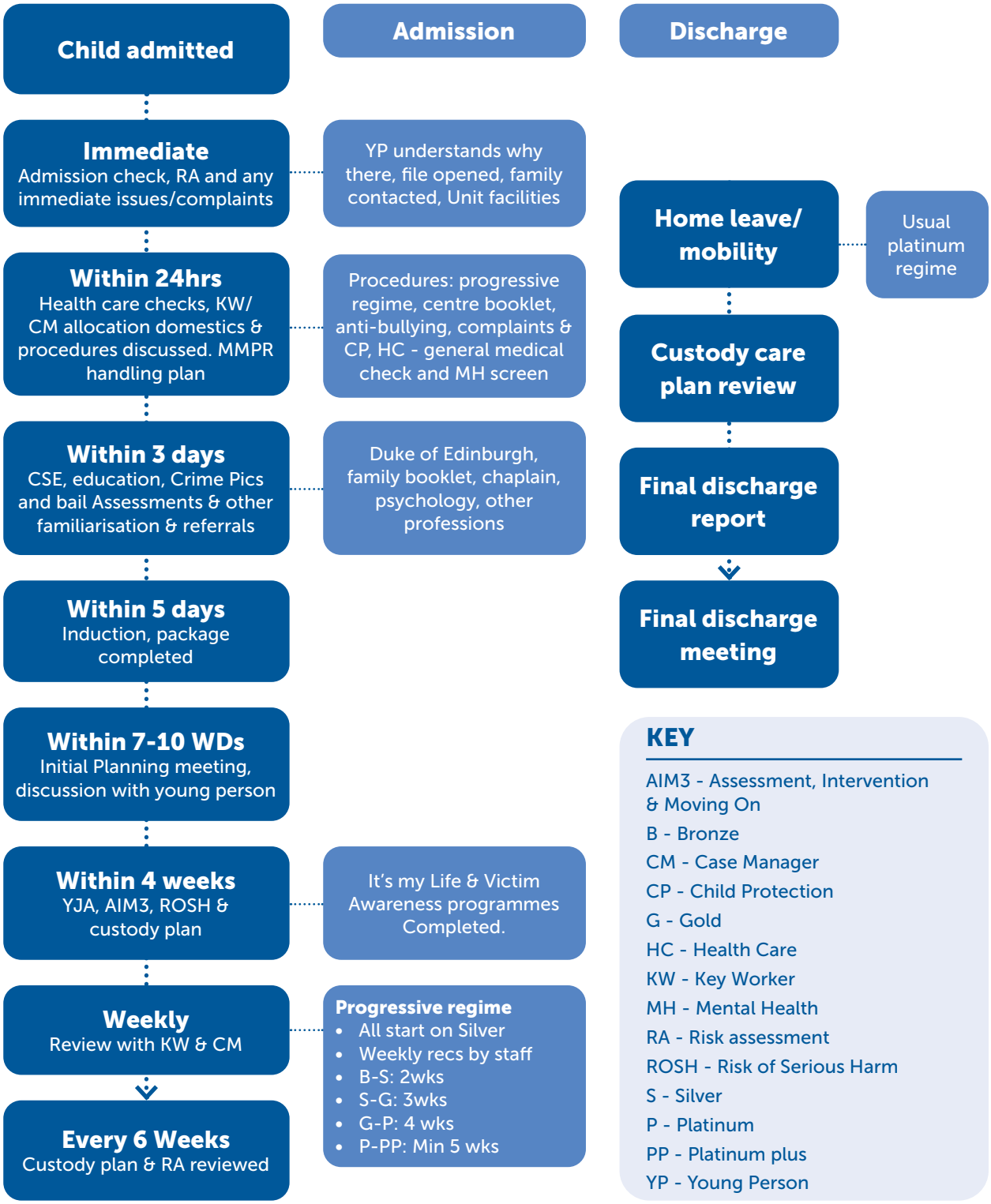
20% proportion of girls admitted – highest proportion of girls admitted in last 10 years. *Prior to that the proportion of girls admitted had been fairly consistent at 13% of all admissions.*

187 days median time taken for charge cases at Youth Court – *this was an increase of* **59.8%**. Summons cases increased by **34.7%** to **326** days (Source: NISRA).

46% of admissions were care experienced children.

9.3% proportion of 10-13 year old children admitted – *increased from 4.2% at last inspection. Also increase in proportion of 14 year olds but number of 15 year olds had reduced significantly.*

APPENDIX 5: SUMMARY OF CARE PLANNING PROCESS



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