Thematic report by HM Inspectorate of Prisons

Separation of children in young offender institutions

A thematic review

by HM Inspectorate of Prisons

January 2020

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Introduction

This inspection investigated outcomes for children separated from their peers in the five young offender institutions (YOIs) in England and Wales. There are a variety of words used to describe situations where children are unable to mix with their peers or attend activities in the normal way. For the sake of clarity, we have used the term 'separation' to cover all of these throughout the report.

We understand that there are occasions when it is in a child's best interests to be separated from others either because they pose a risk to their peers or need protecting from them. In these cases, we expect managers to place separated children in a unit where they can gain access to the equivalent daily activity, including education, as the children they are separated from. We also expect staff to work with children to address the reasons for their separation and plan for their return to a normal regime.

During the course of this inspection we carried out 85 interviews with separated children and the staff responsible for their care. We also looked in detail at the cases of 57 separated children. The findings are a cause for significant concern.

We found that children's experience of separation differed dramatically depending on the establishment they were held in and even between different units in the same YOI. In such a small estate holding just 606 children, it was inexplicable that there were so many different models of separation.

The regime that was offered to most separated children was inadequate. While it tended to be better on designated segregation units, nearly all separated children spent long periods of time in their cell without any meaningful human interaction. We found children who were unable to access the very basics of everyday life, including a daily shower and telephone call. In the worst cases children left their cells for just 15 minutes a day.

We found significant failures of oversight both locally and nationally. This meant that leaders and managers did not have the basic information needed to identify these problems and address them. The current system of daily checks by managers, nurses and chaplains gave an illusion of oversight. However, these checks were cursory, often took place though a locked door and sometimes did not happen at all. This was compounded by weak or non-existent reintegration planning which meant that some children were separated for far too long.

This report does identify some areas of better practice, particularly at HMYOI Parc, where reintegration planning took place swiftly and children were separated for shorter periods of time. However, we have found multiple and widespread failings. As a consequence of these failings most separated children experienced a regime that amounted to the widely accepted definition of solitary confinement (see paragraph 2.6). For some of these children, their solitary confinement was prolonged in nature.

The weaknesses of current practice and oversight are of such a magnitude that we recommend an entirely new approach, and that current practice be replaced. A new model of separation should be implemented that enables managers to use separation to protect children from harm and prevents separated children being subjected to impoverished regimes.

Peter Clarke CVO OBE QPM October 2019
HM Chief Inspector of Prisons

Section 1. Summary

1.1 Prison Service rules allow managers in young offender institutions (YOIs) to separate children from their peers as a method of maintaining good order and discipline, or for their own best interests. This separation can take place in a designated separate segregation unit, on a specialist residential unit or on normal location.

1.2 In 2017, the Prison Service was found to be in breach of its own rules regarding separation of children in a court judgment involving a child who spent more than 100 days separated from his peers and who was deprived of adequate education. The child, identified in court documents as AB, was locked in his cell for over 22 hours a day, sometimes for more than 15 consecutive days. The court accepted that during some periods, when he had no education provision at all, 'the lack of mental and physical activity contributed to his frustration and so to his disruptive behaviour'.[1]

1.3 In response to this judgment, HM Prison and Probation Service (HMPPS) extended rule 49 'removal from association' (good order or discipline) oversight arrangements (see paragraph 2.3) to all children spending more than 22 hours a day in their cell. The aim was that management oversight would improve the regime that these children received.

1.4 This inspection has found that the approach has been unsuccessful. At the time of our inspection in spring 2019 around 10% of children in YOIs were separated from their peers under rule 49. Several other children were informally separated and spent more than 22 hours locked in their cell without any management oversight.

1.5 Many of the safeguards under rule 49 were not consistently implemented, and where they were they had not had any meaningful impact on the time that separated children spent out of their cells or the amount of education provided to them.

1.6 It is current HMPPS policy to prohibit the use of separation as a form of punishment and not to subject children to a regime that amounts to solitary confinement.

1.7 Our review of the separation of children in YOIs – based on analysis of surveys conducted in 2018–19 and fieldwork that took place in spring 2019 – has found that separation was used as a punishment, both implicitly in the case of many children separated on rule 49 and explicitly for children given losses of association or demoted to the basic regime in response to poor behaviour. We have found that most separated children experienced a regime that amounts to the widely accepted definition of solitary confinement (see paragraph 2.6). For a minority of separated children, solitary confinement had been prolonged in nature.

1.8 The experience of children separated on normal residential units – two-thirds of separated children at the time of this inspection – was particularly grim. Mainstream residential units were simply unable to provide children with their basic entitlements of a daily shower, telephone call and exercise. We met several children living on these units who received only 15 minutes out of their cell each day during the weekend.

1.9 The key finding of this review is that the current oversight arrangements and model of delivery of separation have failed to improve the day-to-day life of separated children across the estate. Daily visits to separated children by managers, chaplains and nurses, and weekly visits by governing governors, did not always take place. Reviews of separation did not focus

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1 See <https://howardleague.org/news/felthamsolitaryconfinementhighcourtjudgment/> accessed 24 October 2019.

on providing a credible plan to improve the regime for each child. Designated units for separated children were not organised well enough to provide them with an acceptable regime, including education and meaningful interaction with staff and peers. Senior management oversight at a national level lacked challenge, and we were surprised that in 2018–19 every one of the 346 requests to keep children separated for longer than 21 days was granted by the prison group director.

1.10 A basic requirement of leadership and management of separation is to understand what is being delivered on the ground, and to support staff in improving outcomes for separated children. This was undermined by a lack of accurate information locally and nationally; no accurate data were collated on how many children were separated, where they were separated, for how long, and how long they spent in their cell. This made it impossible for national leaders to monitor trends and act to improve practice. The lack of data also meant it was not possible to monitor disproportionality across any of the protected characteristics.[2]

1.11 We found many children in YOIs who were subject to unacceptably impoverished regimes. There was too little appreciation among staff at all levels of the negative effects of spending long periods locked in a cell without meaningful human interaction. As a consequence, too little was done too late to reintegrate children into a normal regime. The planning that did take place was undermined by poor delivery, particularly on normal residential units.

1.12 Many staff, managers and national leaders accepted the minimum entitlement of a regime for children – less than an hour out of their cell a day – despite this leaving little time for interaction with staff and peers, outside exercise, showering or phone calls. The current system of daily and weekly visits by managers, nurses and chaplains created an illusion of meaningful interaction and oversight, but in reality these checks were cursory and often did not happen at all. More importantly, despite significant investment of time and resources, the current system of rule 49 reviews, checks and safeguards had failed to prevent children receiving a harmful regime.

1.13 The current system of separation, with its roots in the adult estate, is unsuited to meeting the needs of children. We found there were fundamental flaws in leadership at a local and national level. There was no shared understanding of the aims of separation, how often it occurred and what support separated children should receive for the intervention to achieve these aims. Key safeguards, including health care, chaplaincy and prison group director authorisations, did not always take place, and most separated children did not have any opportunity for meaningful interaction with staff or other children.

Key concern and recommendation to the Secretary of State for Justice

1.14 Key concern: The current arrangements for separating children in YOIs do not safeguard children's well-being. Local and national leaders and managers have failed to prevent children from being subject to harmful regimes for extended periods of time. Oversight arrangements do not enable managers to know how many children are separated or for how long, or what interactions, education or health care input they have received. Safeguards for separated children involve a large number of cursory checks rather than meaningful and dynamic management.

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2 The grounds upon which discrimination is unlawful (Equality and Human Rights Commission, 2010).

Recommendation: The current models of separating children in young offender institutions should be replaced with a new system that ensures a regime that is equivalent to their non-separated peers.

Recommendations to HM Prison and Probation Service/Youth Custody Service

1.15 Reintegration planning should start from the day a child is separated and contain practical, timebound targets that are focused on enabling the child to return to a normal regime at the first opportunity.

1.16 Separated children should have access to an equivalent education day to their non-separated peers. This should include meaningful face-to-face interaction with teachers.

1.17 Separated children should be able to and encouraged to spend time out of their cell interacting with staff and peers.

1.18 Separated children should be able to spend an hour exercising in the open air every day.

1.19 Separated children should be able to have a shower and a phone call every day.

1.20 Oversight arrangements should enable national managers to monitor how many children have been separated and for how long, and the regime that these children receive. This information should be published.

1.21 Safeguards for separated children should involve regular meaningful contact with a manager who has the authority to make changes to the child's situation.

Recommendations to NHS England and NHS Wales

1.22 Children who require a mental health assessment should receive one without delay.

1.23 Children assessed as needing a mental health bed should be transferred within two weeks, in line with national NHS guidelines.

Section 2. Background to the report

2.1 Across the children's estate, children in YOIs can be separated in various locations, either in a designated separate segregation unit, on a specialist residential unit or on normal location. The table below sets out these locations at each of the five YOIs in England and Wales.

2.2 The Prison Service and others use a variety of definitions to describe situations where children are unable to mix with their peers. These can include segregation under a specific YOI rule (see below), a child's decision to self-isolate from their peers, the impact of a punishment limiting their access to association and confining them to their cell for long periods, and the effect of a prison running a limited or restricted regime which means that a child is unable to leave their cell. All of these situations can become solitary confinement if a child spends more than 22 hours locked in a cell without any meaningful human interaction (see paragraph 2.6). In this report we use the term 'separation' to describe all situations where children are not able to mix with their peers or attend activities in the normal way.

Table 1: Where children are separated in YOIs in England and Wales

HMYOI Cookham Wood	- segregation unit (Phoenix) - the Bridge unit (intended to support separated children to return to a normal regime) - on normal location
HMYOI Feltham A	- enhanced support unit (Albatross) - on normal location
HMYOI Parc	- T6 segregation unit (intensive support unit) - on normal location
HMYOI Werrington	- segregation unit ('welfare and development enhancement unit', WADE) - on normal location
HMYOI Wetherby and Keppel	- segregation unit (Anson) - on normal location

Separation policy

2.3 The authority to separate children in YOIs comes from the *Young Offender Institution Rules 2000*,[3] specifically rules 49 and 58.

Rule 49: Removal from association

1) Where it appears desirable, for the maintenance of good order or discipline [GOOD] or in his own interests, that an inmate should not associate with other inmates, either generally or for particular purposes, the governor may arrange for the inmate's removal from association accordingly.

2) An inmate shall not be removed under this rule for a period of more than three days without the authority of a member of the board of visitors or of the Secretary of State.[4] An authority given under this paragraph shall in the case of a female inmate aged 21 years or over, be for a period not exceeding one month and, in the case of any other inmate, be for a period not exceeding 14 days, but may be renewed from time to time for a like period.

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3 Available at <http://www.legislation.gov.uk/uksi/2000/3371/made> accessed 24 October 2019.

4 Amendments to Prison Service Instruction 1700 now designate this authority to the governor/director.

3) *The governor may arrange at his discretion for such an inmate to resume association with other inmates, and shall do so if in any case the medical officer or a medical practitioner such as is mentioned in rule 27(3) so advises on medical grounds.*

2.4 Where a child has committed an offence in breach of the YOI rules they will face an adjudication where the charge is laid before them. Before an adjudication takes place, rule 58 authorises that the child can be kept apart from other children pending that adjudication.

Rule 58: Disciplinary charges

1) *Where an inmate is to be charged with an offence against discipline, the charge shall be laid as soon as possible and, save in exceptional circumstances, within 48 hours of the discovery of the offence.*
2) *Every charge shall be inquired into by the governor.*
3) *Every charge shall be first inquired into not later, save in exceptional circumstances, than the next day, not being a Sunday or public holiday, after it is laid.*
4) *An inmate who is to be charged with an offence against discipline may be kept apart from other inmates pending the governor's first inquiry.*

2.5 PSI 1700 *Segregation*[5] provides detailed instructions for managing prisoners under rule 49, including the roles and responsibilities of various staff when children are separated.

PSI 1700 *Segregation* (2007)

Health care visits: health visits and assessments take place regularly to ensure there is no reason why prisoners should be removed from segregation on physical or mental health grounds.

A doctor or registered nurse must complete the Initial Segregation Health Screen within two hours of the child being segregated. This screen must be completed for all children held in:

- the segregation unit
- special accommodation (including any located within health care)
- any other segregated environment within the prison.

It must also be completed for any child placed in segregation to await adjudication for longer than four hours.

- A member of health care staff must attend and contribute to the segregation review board (this authorises the continuation of segregation for children held under rule 49). Health care staff are expected to comment on and assess the physical, emotional and mental well-being of the child, and whether there are any apparent clinical reasons to advise against the continuation of segregation. Recordings must reflect this ongoing assessment.

Children: guidance on providing the opportunity for a child to make representations is as below.

- When considering whether to segregate a child under rule 49, governors must consider whether the child can be given the opportunity to make representations against segregation before a decision to segregate is made.
- In deciding whether the opportunity to make representations can be provided, governors must take account of all the circumstances, including the risk to the child and others, the availability

5 PSI 1700 (2006). *Segregation and special accommodation*, available at <https://www.justice.gov.uk/offenders/psos> accessed 24 October 2019.

of staff, and the behaviour and competence of the children to make representations at that moment in time.

- If the governor decides that the child can be given the opportunity to make representations, that opportunity must be given.
- The governor must also consider the help that advocacy services can give to a child when making representations.
- If the governor decides that representations should not be allowed, this should be recorded defensibly to allow for challenge at a later stage.
- The child should be given the opportunity to make representations after being segregated.

Special (unfurnished) accommodation: special accommodation is only used to hold, for the shortest time necessary, a violent or refractory prisoner to prevent that prisoner injuring themselves or others. Special accommodation should not be used as a punishment. Additional precautionary measures are in place to care for prisoners at risk of suicide and self-harm who are located in special accommodation.

- When children are located in special accommodation in the segregation unit, staff must consider allowing them to make representations against segregation.
- Establishments should make contact with the head of placements (Youth Justice Board in the PSI, now Youth Custody Service) and the named youth offending team (YOT) whenever a child is located in special accommodation. The establishment's social worker should also be contacted to visit the child.
- In 2007 the 'young people's group' was working with the Youth Justice Board (YJB) to develop a central policy on 'calm-down' rooms. If a child is locked in accommodation for behavioural reasons, and that accommodation has had any one of the standard accommodation furniture, bedding and sanitation items removed in the interests of safety, then the procedures for special accommodation must apply.

2.6 Additional guidance to YOIs is provided in the joint Ministry of Justice, NHS England, HMPPS and YCS policy document *Building Bridges: A Positive Behaviour Framework for the Children and Young People Secure Estate*, which was published in March 2019.[6] The document provides additional guidance for the separation of children.

***Building Bridges: A Positive Behaviour Framework for the Children and Young People Secure Estate* (2019)**

5.20 Removing children and young people from their normal location, or separating them from their peers, should only be used as a last resort and where this is the best approach to meeting the needs of that young person and/or to managing risks posed to other children, young people and staff. It should:

- *be proportionate to the child or young person's needs and risks;*
- *be authorised by a senior member of staff;*
- *be reviewed frequently to ensure they are still justified;*
- *be followed by efforts to help the young person understand why the action was taken;*
- *be followed by a plan for reintegration, which should take place as soon as possible;*
- *continue to provide access to regime activities, particularly education;*

[6] MOJ, NHS England, HMPPS and YCS (2019). *Building Bridges: A Positive Behaviour Framework for the Children and Young People Secure Estate*. Available at <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/789861/building-bridges-positive-behaviour-framework.pdf> accessed 24 October 2019.

- *Note: There are some differences in the rules around removal from association across YOIs, STCs [secure training centres] and SCHs [secure children's homes]. Establishments must ensure they comply with the relevant legislation and guidance for the sector.*

Solitary confinement

Human rights standards prohibit the solitary confinement of children. This is reflected in our own *Expectations* criteria for assessing the treatment of children in detention.[7] Any of the current methods of separating children from their peers has the potential to become solitary confinement if the child experiences a regime that meets the following criteria.

Definition of solitary confinement

'The confinement of prisoners for 22 hours or more a day without meaningful human contact.' Rule 44 of *The United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules).*[8]

This is the definition used by HMI Prisons in our *Expectations* for children and throughout this report.

Meaningful human contact
A panel of experts convened by the University of Essex and Penal Reform International provided the following guidance on what constitutes meaningful human contact. [9]

The term [meaningful human contact] has been used to describe the amount and quality of social interaction and psychological stimulation which human beings require for their mental health and well-being. Such interaction requires the human contact to be face to face and direct (without physical barriers) and more than fleeting or incidental, enabling empathetic interpersonal communication. Contact must not be limited to those interactions determined by prison routines, the course of (criminal) investigations or medical necessity.

… it does not constitute 'meaningful human contact' if prison staff deliver a food tray, mail or medication to the cell door or if prisoners are able to shout at each other through cell walls or vents. In order for the rationale of the Rule to be met, the contact needs to provide the stimuli necessary for human well-being, which implies an empathetic exchange and sustained, social interaction. Meaningful human contact is direct rather than mediated, continuous rather than abrupt, and must involve genuine dialogue. It could be provided by prison or external staff, individual prisoners, family, friends or others – or by a combination of these.

Inspection findings on the use of separation

2.7 HMI Prisons has long reported concerns about the conditions that children are held in when managed on segregation units, and the regimes on offer to separated children.

Extent of use

2.8 Findings from HMI Prisons inspection surveys show that separation is widely used across the children's estate to manage children's behaviour. In surveys from our inspections published between 1 April 2018 and 31 March 2019, over half of children in YOIs (58%) reported that

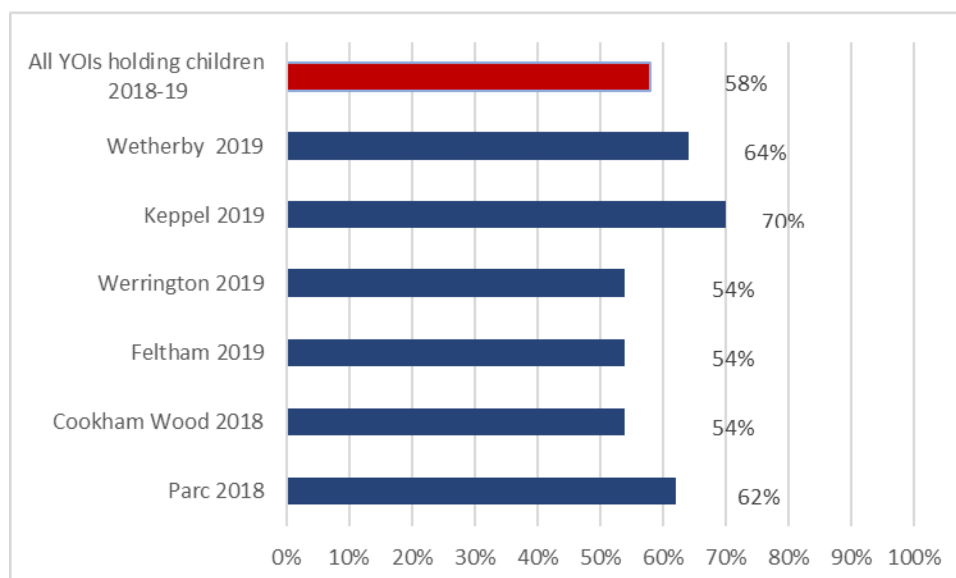
[7] *Expectations. Criteria for assessing the treatment of children and conditions in prisons*, available at <https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2018/11/Childrens-Expectations-FINAL-261118-2.pdf> accessed 24 October 2019.

[8] Available at <https://www.unodc.org/documents/justice-and-prison-reform/GA-RESOLUTION/E_ebook.pdf> accessed 24 October 2019.

[9] Available at <https://cdn.penalreform.org/wp-content/uploads/2016/10/Essex-3-paper.pdf> accessed 24 October 2019.

they had been kept locked up and stopped from mixing with other young people as a punishment, including time spent in a segregation unit or in their own room. This figure was highest at Keppel (70%) and lowest at Cookham Wood, Feltham and Werrington, where 54% of children had experienced some form of separation.

Figure 1: The proportion of children reporting that they had been kept locked up and stopped from mixing with other young people as a punishment, including time spent in a segregation unit or in their own room.[10]



Conditions

2.10 We have previously highlighted poor living conditions in designated segregation units in YOIs. At Cookham Wood, we reported poor conditions in the segregation unit in 2016, 2017 and 2018 with no improvement over that time. Communal corridors remained dark, the exercise yard was stark, cells were small, often dirty and poorly ventilated, walls and windows had graffiti, and many toilets were dirty and stained. At our latest inspection, conditions on the segregation unit were still not suitable for children; it was dark and oppressive, and cells remained dirty, covered in graffiti and in need of refurbishment. In contrast, we found that conditions on the segregation unit at Wetherby, which was previously dirty with offensive graffiti, had improved by our more recent inspection; most cells were clean and reasonably furnished, and they had also been freshly painted and were free of graffiti.

Regime

2.11 We frequently find that the regime for separated children, whether on a designated segregation unit or on a residential unit, is poor. Children often spend an excessive time locked in cells with very little to occupy them. At Cookham Wood, the daily regime for children on the Phoenix segregation unit was limited to a telephone call, 30 minutes in the open air and a shower; they had no access to gym equipment. There was a similar regime in the prison's Bridge unit – used as a progressive alternative to the segregation unit to manage children on rule 49 – for those unlocked singly, although children could receive an additional 30 minutes 'enrichment' time with an officer every three days if staff were available, as well as gym once a week. At Werrington, some children on the welfare and development

10 Survey data from Cookham Wood, Feltham, Parc, Werrington, Wetherby and Keppel inspection reports, available at <https://www.justiceinspectorates.gov.uk/hmiprisons/inspections/> accessed 9 December 2019.

enhancement unit (WADE) – a designated segregation unit – were held in separation conditions (on rule 49) with no access to education or gym, while others had more, albeit irregular, access to the regime. There was no plausible explanation for this discrepancy. At Wetherby, segregated children received daily outreach education and a weekly PE session supervised by gym staff.

2.12 Education provision for separated children also varied between units. In some units, education staff were able to run sessions for separated children but this was not always offered consistently as it depended on demand. For example, the segregation unit at Cookham Wood offered education every weekday morning but the frequency was determined by the numbers segregated, as education staff could only accommodate three children at each session. The prison's Bridge unit ran education in groups where possible, although this was not available for children who were singly separated. Kinetic Youth (a youth work charity commissioned by the youth custody service) visited both units daily providing support and activity for the children, including activity packs and one-to-one sessions with those who requested it.

Reviews and reintegration

2.13 We also found mixed practice on reviews and reintegration planning for separated children. At Feltham, regular review boards for separated children were better attended than we usually see, but targets set for children to reintegrate were often perfunctory and not adequately communicated to residential staff, who should have been instrumental in the reintegration of the children in their care. Cookham Wood held regular multi-agency rule 49 reviews for each child on the segregation unit, which were also well attended. We observed appropriate interactions with the children during reviews and all attendees were working to help them achieve their individual targets. The same was true for children separated on the Bridge unit, and conflict resolution staff also took part in the assessments to determine membership of the individual groups. At Wetherby, an excellent multidisciplinary meeting was well attended by key prison staff and managers to help direct and monitor reintegration work for all segregated children. This included those separated on normal location, for whom oversight had improved since the previous inspection. Individual management plans were raised for every child, and it was evident that staff supported individuals and addressed the issues that had led to their segregation. Multidisciplinary reviews were held for children separated under rule 49 and were well attended. However, plans for the child were not always agreed and documented at the review.

Concerns about the use of separation

2.14 The Joint Committee on Human Rights published its report on solitary confinement and restraint in youth detention in April 2019.[11] The report, citing evidence from the British Medical Association (BMA), stated that separation causes psychological harm with symptoms increasing with the length of confinement. The harmful effects include: 'anxiety; depression; hostility, rage and aggression; cognitive disturbances; hypersensitivity to environmental stimulation; paranoia; and in the most extreme cases, hallucinations and psychosis.' It also noted that children who are isolated even for short durations can experience 'paranoia, anxiety and depression', and that those isolated for extended durations 'are more likely to attempt or commit suicide'.

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[11] Joint Committee on Human Rights (2019). *Youth detention: solitary confinement and restraint*. Available at <https://publications.parliament.uk/pa/jt201719/jtselect/jtrights/994/99402.htm> accessed 24 October 2019.

2.15 Separation can also reinforce existing mental health problems. Evidence in the report from the Royal College of Psychiatrists (RCP) looking at child and adolescent mental health services (CAMHS) and custody explained that:

'*When a young person with mental health and/or emotional difficulties is denied two hours of meaningful contact and so enters a state of solitary confinement, their mental health problems and/or emotional difficulties are likely to be significantly exacerbated'*.[12]

The RCP stated that this risk is particularly acute due to the high prevalence of pre-existing issues for young people in secure settings.

2.16 Finally, the Joint Committee's report described how separation can in itself undermine the aims of detention. For example, children in YOIs who are separated from others will miss out on the usual routines, such as the weekly planned 30 hours of education and two hours of physical exercise. The Children's Commissioner's evidence to the report noted that isolation can contribute to reoffending:

'*Children often come to the secure estate establishments from very complex backgrounds, which means that they have previously lacked structure and guidance in their lives and that emotional regulation is difficult for them to grasp. Prolonged or frequent isolation can often serve to worsen these problems as the children fail to learn the important lessons of social order and interaction which they will need when they leave the establishment. In that sense, isolation can have a long-term negative impact on a vulnerable child and can contribute to the perpetual vicious cycle of release and re-offending. This would also explain an earlier finding of this study, that the children who were isolated once are likely to be isolated again*.'[13]

2.17 The BMA had previously recognised the profound impact that solitary confinement can have on children in its guidance for doctors working in the youth justice system. The guidance reiterates the key role played by doctors when children are separated.

BMA Guidance for doctors working in the youth justice system[14]

- *Doctors working in the youth justice system are bound by the same principles of medical ethics as they would be in the community*
- *Doctors should not be involved, either formally or informally, in certifying a child or young person as 'fit' for solitary confinement*
- *Doctors should raise concerns where they believe solitary confinement will be particularly damaging for a child or young person*
- *Doctors should visit children and young people in solitary confinement regularly, and raise any concerns they might have about any deterioration in health and wellbeing*
- *Doctors also have a more general duty to raise concerns about conditions which put patient safety at risk, or about practices which are abusive or negligent*
- *Children and young people in solitary confinement retain the same rights as other patients to privacy and confidentiality, but these rights are not absolute. They must be balanced against the risk of danger to the doctors involved in their care, and the need to share information in order to safeguard children and young people*

[12] Ibid. <https://publications.parliament.uk/pa/jt201719/jtselect/jtrights/994/99402.htm>

[13] Ibid. <https://publications.parliament.uk/pa/jt201719/jtselect/jtrights/994/99402.htm>

[14] British Medical Association (2018). *The medical role in solitary confinement: Guidance for doctors working in the youth justice system*. Available at <https://www.bma.org.uk/collective-voice/policy-and-research/equality/the-medical-role-in-solitary-confinement> accessed 9 December 2019.

- *Children and young people at risk of suicide or self-harm should not be accommodated in segregation units, other than in exceptional circumstances where psychiatric or psychological assessment indicates that it will reduce that risk. If it is unavoidable, doctors working in these settings should seek to ensure regular interaction with the patient and raise concerns where they feel health is deteriorating.*

Section 3. Aims and methodology

3.1 This inspection examined the separation of children in prisons in England and Wales. The key aims of the review were to:

- further investigate treatment and conditions in segregation units, including the number of children segregated, for how long and if they are reintegrated effectively
- better understand the experiences of children who are separated (both in segregation units and on other units they might be separated)
- make recommendations on the treatment and conditions of children who are separated.

3.2 In acknowledgment of the fact that children can be separated in many locations within a YOI, the following areas or locations were included in this inspection:

- designated segregation units
- other separation units, such as the Bridge unit at Cookham Wood and the enhanced support unit (ESU) at Feltham A
- segregation on normal location
- segregation conditions in other areas (such as health care).

Methodology

3.3 This report draws on in-depth inspections in spring 2019 focusing on the separation of children in all five YOIs that hold children in England and Wales. Additional analysis of HMI Prisons survey data was conducted to give a national picture.

HMI Prisons survey data analysis

3.4 We analysed HMI Prisons survey data for children in YOIs for the 2018–19 annual reporting year. These surveys were undertaken as part of our planned inspection programme, during which all children in YOIs were offered a questionnaire to complete. We also carried out an analysis of all children who were separated at the time of the survey, either in a designated segregation unit or specific separation unit (Bridge unit at Cookham Wood and the ESU at Feltham A). It was not possible to include children who were separated on normal location in this analysis.

Primary data collection

3.5 In May and June 2019, we carried out primary fieldwork in all five YOIs that hold children in England and Wales:

- HMYOI Cookham Wood
- HMYOI Feltham A
- HMYOI Parc
- HMYOI Werrington
- HMYOI Wetherby and Keppel

3.6 The fieldwork included the following activities:

- individual interviews with children who had experienced separation in the establishment
- individual interviews with operational and professional staff involved in the supervision and care of separated children

- a review of the separation documents for children who had been separated
- a review of the YOI's separation policies and procedures
- a review of the use of separation in the 12 months before the inspection.

Table 2: Interviews and case files review at inspections

	Interviews with children	Interviews with member of staff	Review of case files
HMYOI Cookham Wood	12	1	11
HMYOI Feltham A	10	7	14
HMYOI Parc	7	6	11
HMYOI Werrington	7	10	10
HMYOI Wetherby and Keppel	12	13	11

3.7 We conducted semi-structured interviews with 48 children who had been separated. The interviews covered their experience of being separated within the establishment – including the circumstances that led to their separation, their conditions while separated, their daily regime, treatment by staff, and experience of reviews and reintegration planning.

3.8 We conducted semi-structured interviews with 37 operational and professional staff involved in the supervision and care of separated children. These included unit managers, operational staff, health care staff and managers, Barnardo's case workers, Kinetics (education outreach) staff, Independent Monitoring Board (IMB), education staff and managers, prison chaplains and psychology staff. The interviews were aimed at understanding the experiences of staff in supporting and caring for children who had been separated.

3.9 We analysed the case files for each of the young people interviewed to investigate the processes for the separation to be authorised, what contact children had with professionals, separation reviews and reintegration planning.

3.10 We also examined individual establishment policies governing the use of separation, and analysed monitoring data on the use of separation for the 12 months before the inspection.

3.11 All data from interviews with prisoners and staff were summarised in a spreadsheet and coded. Judgements were then made about how the establishment performed against the expectations that we had developed for this review (see below and Appendix II). To avoid identifying individuals quoted in this report, we have not ascribed their establishments.

Expectations

3.12 For our core inspection programme, HMI Prisons inspects against independent human rights-based criteria known as *Expectations*.[15] Our expectations describe the standards of treatment

[15] HMI Prisons (2018). *Expectations: Criteria for assessing the treatment of children and conditions in prisons.* London: HMI Prisons. Available at <http://www.justiceinspectorates.gov.uk/hmiprisons/our-expectations/children-and-young-people-expectations/> accessed 24 October 2019.

and conditions we expect an establishment to achieve. Each expectation is underpinned by 'indicators' which suggest evidence that may indicate whether the expectation has been achieved. The list of indicators is not exhaustive and they do not exclude an establishment demonstrating that it has met the expectation in other ways. Separation of children is assessed under the healthy prison area of 'safety' (see Appendix I).

3.13 For the purposes of this thematic inspection, we developed more detailed separation expectations and indicators (see Appendix II). We used these expectations as the basis for the review, and they form the structure of this report.

Section 4. Outcomes for children

4.1 At the time of our inspection, managers in all five YOIs had records of 64 children who were subject to separation under rule 49. This was more than one in 10 of the 606 children held in a YOI during the inspection. Across the estate, the number of days that these children had spent separated ranged from one to 89. There were 42 children separated on normal location and 22 who were separated on dedicated units. This figure is an underestimate as managers were not aware of all children who were separated.

4.2 Our inspection looked at outcomes for children who had experienced separation assessed against the specific detailed expectations that we developed for this review (see Appendix II).

1. Safe outcomes for separated children are supported by effective leadership and management

4.3 We found that national and local leaders did not share a consistent view of the purposes of using separation and how separation achieved those purposes, which was a fundamental failing. In the absence of a consistent purpose of separation, a variety of specialist units and models of separation have been developed.

4.4 The rationale for separating children in different types of locations (an enhanced support unit, a segregation unit, on normal location or within a designated landing on normal location) was not clear to us. Different establishments had differing models of separation which used some or all of these locations in different ways. None of the models currently delivered met our expectations, and the variety of different methods of separation had become unmanageable and led to poor implementation across all sites.

4.5 We found a lack of leadership at both national and local levels, such that it was not possible to ensure that children were only separated for appropriate reasons, and that when separated they received a decent regime, including education and meaningful human contact with staff. In addition, with the exception of Parc, local managers did not plan effectively for children to reintegrate to a more normal regime.

4.6 While separation of children in designated units was always authorised, we found that several children were separated by frontline residential staff without management authorisation. This happened when staff failed to tell managers about children who were separated pending an adjudication, or when they did not recognise the cumulative impact of different punishments implemented at the same time as separation (for example loss of association or being on the lowest level of the incentives scheme while not attending education). As local managers were not aware of what was happening to these children, they were unable to ensure they received what they were entitled to.

4.7 The children's estate has a significant number of management safeguards designed to protect children in separation. However, we found that adherence to these safeguards had all too often become cursory and that they were not fulfilling their stated role. Daily and weekly checks of separated children by managers, doctors, nurses, chaplains and governing governors did not always take place, and chaplains and nurses often did not insist on the cell door being opened during their visits, which impeded contact with the child and observations of their condition. Area manager authorisations of separation were often not returned to the establishments on time, and in some cases were completely absent. However, our main concern was that in most cases we could not find evidence that these safeguards improved the regime separated children received.

Oversight of trends

4.8 Local and national data collection was poor. It was not possible for local managers to report accurately how many children had been subject to separation. This lack of accurate data meant that senior managers in the Youth Custody Service (YCS) were unable to effectively monitor its use or address any disproportionality.

4.9 The lack of data collected by establishments meant that it was not possible for us to comment definitively on trends in the use of separation. However, our own data collected during this inspection and our survey results indicated that separation was used frequently across all establishments holding children. Around one in 10 children were separated at the time of this inspection, and 58% of children who responded to our survey in 2018–19 reported that they had been kept locked up and stopped from mixing with other young people as a punishment, including time spent in a segregation unit or in their own room.

2. Children are only separated from others or removed from their normal location with the proper authorisation

4.10 Children should only be separated on the authority of a senior manager, irrespective of where in the establishment they are held. All YOIs use the same authorising paperwork and have the same timescales for completion and review.

4.11 There are two rules that allow prison managers to separate children (see paragraphs 2.3 and 2.4).

4.12 There must be a health care assessment of children once these rules are applied. A registered nurse or doctor should use a safety screening tool within two hours of separation commencing for rule 49, and within four hours for rule 58. A health care professional must see a child subject to these rules every day and a doctor should see them every third day as a minimum. Health care staff must complete a new safety screen in line with the review schedule for rule 49.

Authorisation

4.13 We did not find any children separated under prison rule 49 and 58 in specialist units without the required authorisation. However, children separated under these rules on residential wings were not always authorised. Feltham operated a policy in which a child placed on report was locked up until their adjudication was first heard – which could be for up to three days depending on the day they were initially placed on report. The decision to do this was made by an officer, not a senior manager. This policy was contradictory to HMPPS's rules governing the use of separation, including under rule 58, which state:

'It must not be used as an automatic measure but only where there is real need, such as the risk of collusion or intimidation relating to the alleged offence which segregation of the accused might prevent'.[16]

The absence of proper authorisation also meant that these children did not have access to safeguards, including a health care assessment, or systems of redress.

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16 Prison Service Instruction 47-2011: annex. Available at: <https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=2ahUKEwjQx6eUg7rkAhUOhlwKHc_SDGwQFjAAegQIARAE&url=https%3A%2F%2Fassets.publishing.service.gov.uk%2Fgovernment%2Fuploads%2Fsystem%2Fuploads%2Fattachment_data%2Ffile%2F319638%2Fprison-service-instruction-47-2011-annex.doc&usg=AOvVaw0YB0spRsG6wnmxiFo4LVDx> accessed 24 October 2019.

4.14 In addition, across the estate we found several children who were informally separated without management oversight. This was typically due to the imposition of aspects of the local behaviour management schemes. In particular, when a child lost association at an adjudication or was placed on the lowest level of the incentives scheme[17] while they were also receiving outreach education,[18] they were effectively separated but without the same level of oversight or safeguards.

4.15 At Werrington, most children held on rule 58 were moved to the designated segregation unit (WADE) where correct authorisations always took place. However, the separation of those who remained on the wings was not always authorised and they were not always seen by a health care professional. Staff were confused about what should happen when children were separated on the wing. We found that officers and supervising officers were effectively authorising separation of children due to their behaviour. This separation could last for an extended period as the decision to continue it was taken daily, depending on the child's behaviour at the point of unlock.

4.16 Rule 49 was also used to manage children who self-isolated, those who kept themselves away from other children and disengaged from the regime and education. In most cases we found this occurred within 72 hours of their isolation being noticed.

4.17 In all the YOIs we found examples of cursory reasons for separation, such as 'for your safety' or 'staff assault'. In some cases, the reason was not completed and managers assumed the previous authorising paperwork would suffice.

4.18 When a health care professional does not agree with the proposed separation or continued separation at a subsequent review (see paragraph 4.12), the authorising manager must complete a decision log and inform the governor if separation is to commence or continue. We found that medical risk assessments were only completed if the separation was authorised; we came across no instances where a health care professional concluded that separation was unsafe.

4.19 After 21 days, the authorisation to continue the separation of a child moves outside the establishment and must be made by the prison group director (PGD), the manager responsible for several establishments. In cases of extended separation, the PGD needs to give authorisation for each subsequent 21-day period. We found that there were occasions where this authorisation had not been acquired and children continued to be separated without it. In one case at Feltham, a child had been separated for 54 days at the point of our inspection, but this had not been approved by the PGD since the second 21-day point; this meant that he had been segregated for 12 days with no authorisation.

4.20 On several occasions the PGD returned the 21-day authorisation late, which meant that some children spent a considerable time separated without authorisation. This was a significant failure of a high-level safeguard.

4.21 Between 1 May 2018 and 30 April 2019, local managers had asked the PGD for 21-day authorisations on 346 occasions. This figure includes children who needed further authorisations at 42, 63 and 84 days. The only YOI not to have requested authorisation to separate a child for longer than 21 days was Parc. None of the 346 requests to separate a child for longer than 21 days had been rejected.

4.22 These PGD authorisations appeared to have become routine and did not provide the high-level oversight required to safeguard children from the harm of prolonged separation. As

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17 As a result of poor behaviour; the incentives scheme is a progression method to reward good behaviour.
18 Education provided to individuals or small groups of children on the wing rather than in education classrooms.

stated above, authorisation for continued separation was given in every single case, and in those we reviewed no recommendations were given to the establishment about how to manage the child or reintegrate them to a normal regime.

Reviews

4.23 The separation of children is supposed to be reviewed regularly. The review is to ensure that it is safe for the child to continue to be separated and that the reasons for separation are still valid. Reviews should act to protect a child from a harmful regime or one that amounts to solitary confinement. We found reviews of separation were generally held on time and were well attended for children who were separated on designated units, but less so for those on normal location. Regardless of their location, children told us that they did not always know the people present at their review. They were often duty workers rather than the child's specific caseworker, named officer or mental health nurse. For those separated on normal location, reviews were less likely to be well attended or detailed in nature.

4.24 One of the key functions of reviews is to protect children from the deterioration in well-being and mental health caused by spending long periods locked in their cells. It is therefore important that reviews consider and plan how to reintegrate a child back to a normal location. Except for Parc, which planned for reintegration from the 72-hour review and sometimes earlier, reintegration planning was almost always initiated too late, lacked specific time-bound actions and was poorly implemented.

Unfurnished accommodation

4.25 Unfurnished accommodation (also known as special accommodation) consists of cells with all or some of their furniture and fittings removed. HMPPS policy states this should only be used if there is a well-identified risk preventing a child from being placed in a furnished cell. Unfurnished accommodation requires authorisation by an operational manager and a subsequent risk assessment by a health care professional. The frequency of observations of those held in such accommodation is mandated as part of the assessment, and is always a minimum of five times an hour at irregular intervals.

4.26 It was difficult for us to quantify how often unfurnished accommodation was used across the estate as record keeping was poor and establishments were not always sure what constituted unfurnished accommodation. Although Cookham Wood declared no use of unfurnished accommodation, we found evidence that it had been used and authorised twice in the 12 months before our visit. Feltham had completed the required authorisations and safety screens but the use of this type of accommodation was very high, with 77 recorded uses in the year to 30 April 2019. In contrast, over the same period Cookham Wood had used it twice, Werrington once and Wetherby and Parc had not used unfurnished accommodation at all.

4.27 We found children isolated in special accommodation solely because they had self-harmed and were not compliant with staff, so were subsequently restrained. This was contrary to the HMPPS rules governing special accommodation. We also saw examples where operational managers had reduced the frequency of observation to below the minimum of five an hour. The conditions some children were held in were poor. For example, at Feltham one child was on a constant watch, which meant he was always in the direct sight of an officer. This child, who was in crisis, was left to lie on a mattress on the floor of a filthy cell for more than 22 hours a day with no meaningful contact.

Children at risk of suicide or self-harm

4.28 If a child is at risk of self-harm or suicide and subject to assessment, care in custody and teamwork (ACCT)[19] casework monitoring at the point of separation, or is placed on an ACCT during a period of separation, this must be recorded and the exceptional circumstances for the separation must be clearly set out in a decision log completed by the authorising manager. The health care professional who completes the risk assessment must note the ACCT and complete the assessment accordingly.

4.29 We found two instances at Werrington where no decision log had been completed when it was decided to separate the children in crisis, and this had not been picked up at the review 72 hours later. We found two further examples at Cookham Wood where the recordings were so poor they were meaningless. At Feltham, we found four children on ACCTs who were separated when we first arrived. We could not be assured that these children were seen daily by managers or health care staff as the daily logs were not completed or signed by anyone. In one case at Feltham, a child judged to be at such a risk of self-harm as to require constant supervision[20] in unfurnished accommodation with a severely restricted regime (see paragraph 4.27) had an out-of-date care plan and staff had not completed the last written actions that had been noted, which included providing some clothing and bedding as he was cold; it was indefensible that staff had not carried this out. At Cookham Wood, the paperwork for three children on ACCTs that had been opened while they were separated was so poorly completed that we could not be assured that adequate safeguards were in place from managers or health care staff.

Safeguards

4.30 When a child is separated a manager (normally the duty governor) and the chaplain should see the child every day. In addition, a health care professional must see a separated child daily and a doctor should visit the child every three days. The IMB and the governor must see all separated children every week. All of these visits should be recorded.

4.31 We found these visits regularly did not happen. Although the situation was generally better for children on designated units, even here many daily visits did not take place. Of the 57 log sheets for separated children that we reviewed across the five sites, only 15 children had seen health care and 33 had seen a manager daily. Feltham did not have records of any daily visits to some of the separated children it held. Many children at Parc and those on normal location at Cookham Wood did not receive these visits either.

4.32 At Parc, health care and chaplaincy staff were unaware of their obligation to see separated children every day. Documentation at Parc showed that these visits never occurred at the weekend. More concerningly, at one site we saw completed records of health care visits to a separated child but when we viewed the CCTV footage it was evident that the visit had not taken place at the recorded time, if at all. At all sites we found that nurses, chaplains and the IMB often carried out these welfare checks from outside locked cell doors, which fundamentally undermined these safeguards and put children at risk. Visits by the doctor did not happen at the required three-day intervals across all sites. Even at sites where the daily checks were more meaningful, they were undermined by the establishment's inability to identify effectively who was separated, and their irregularity eroded its ability to safeguard these children effectively.

4.33 Daily rounds by the duty governor did not always take place and most governing governors did not make weekly rounds of segregation units. Even where these did take place, the

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[19] Assessment, care in custody and teamwork case management of children at risk of suicide or self-harm.
[20] A child will be constantly supervised if they are deemed to be at the most risk of attempting suicide or self-harm.

governors did not always complete the appropriate paperwork, and they did not include children separated on normal location.

Communication with the child

4.34 Children were not always informed of the reasons for separation; we found no evidence that they were in 15 of the 57 cases we reviewed. On the other occasions it consisted of either a written form, generally with a superficial reason, or a verbal explanation as part of the 72-hour review.

4.35 There was little opportunity for children, their families or advocates to challenge the decision to separate them. At Werrington, children were issued with a form to challenge the decision but this was not considered until their next review, which could be seven days later. Where children at Werrington had made representations to challenge the decision to separate, there was no evidence of managers considering or rejecting them. In all the cases we reviewed in which a child had made representations, the separation had gone ahead. There was little evidence across the children's estate that managers had considered any form of internal or external advocacy at any stage of the process.

3. Separation is not used as a punishment

4.36 Most managers and staff who we interviewed were clear that separation should not, and in their view, was not, used as a punishment. They described separation as used to protect staff and other children, to give children the time out they needed from residential units, and to reduce the risk children posed to themselves and others. One interviewee at Feltham told us that separation had previously been used as a punishment but not since the YOI's segregation unit was closed. This showed a lack of appreciation that the impact of being kept apart from ongoing interaction with peers and staff did not depend on the existence of a specific location. A few interviewees thought differently. One manager told us that it was difficult to describe separation as anything other than a punishment, and other staff who worked with children saw separation as such.

4.37 Separation, and its consequences for regime access, was seen as punishment by some of the children interviewed. One described how it felt like he was being punished when he was separated after someone else made threats against him. Another child who was meant to be taking his GCSEs and could not mix with others for education said: 'they are basically setting you up to fail. I don't know why they use education as a punishment. It shouldn't be'.

4.38 In the YOIs with dedicated care and separation units (CSUs), children who were involved in assaults on staff were usually moved there for at least the early part of their period of separation. While the decision to do this was usually based on the risk they posed to others, the fact remained that those children completed their separation in far more stark surroundings than children who were separated on residential units and so in reality the separation amounted to a form of punishment. However, regime provision was more consistent on the CSU than for children separated elsewhere in those YOIs. When multiple officer unlock procedures were necessary, this could add to the impression that there was a punitive element to the separation, even if it was not the case, as well as further reducing the regime, opportunities for relationship building or proactive work by agencies to address risk and need.

4.39 We had concerns about the use of separation for children under YOI rule 58 waiting to attend adjudications for alleged breaches of YOI rules. Governance of rule 58 separation was weak across the estate. At Feltham A, all children who received notification of adjudication were automatically placed on rule 58 by residential staff, even though it should only be

instigated by a manager together with a health care professional. This amounted to an unofficial punishment and appeared to have become custom and practice.

4.40 We found a number of children who had not been formally separated but were separated in practice because of the impact of other punishments for poor behaviour, which were not taken into account. We met children who attended individual outreach education rather than classes with their peers who had been placed on the lowest level of the incentives scheme and/or been given loss of daily activities (such as association or eating with others) as an adjudication punishment. The combined impact of these punishments was to keep them separated from others with an impoverished regime that was similar to that experienced by children on rule 49, but without any authorisation or governance.

4.41 There were instances of unofficial punishments used against children who were separated. Staff notes on the electronic case management system recorded the withholding of a child's daily regime because of poor behaviour. At one YOI, several children told us that staff had turned off the electricity to their cells without explaining why; the case notes did not record that this had happened and there was an absence of oversight over these punishments.

4.42 Even where there was no intent to use separation as a form of punishment, many separated children experienced very restricted regimes that penalised many aspects of their daily life. They had minimal periods out of their cells and no interaction with their peers, apart from shouting out of windows and cell doors (see paragraphs 4.54-4.56). Regardless of published regimes, children were not getting the daily activity they were due. The result was that children, including those who had not been involved in any poor behaviour or who did not pose a risk to others, but simply felt unsafe and were reluctant to leave their cells, experienced what amounted to solitary confinement.

4. Children who are separated from others are located in a suitable environment

Cells and living units

4.43 Accommodation used to separate children varied greatly between establishments. Some, such as Wetherby, Cookham Wood and Werrington, had segregation units with certified accommodation specifically for separation.[21] Cookham Wood also had the Bridge unit[22] where ordinary accommodation on one landing was used to separate children from others. Feltham had an enhanced support unit (ESU) designed to hold separated children and provide intensive support while working towards reintegration (see paragraph 4.48). At Feltham we saw additional calm-down cells,[23] used to separate children until they were calm enough to return to their own cell. All establishments also applied prison rule 49 (see paragraph 4.11) to children who were separated from others but continued to remain in their own cells. While children separated on normal location could personalise their cells, and at Wetherby could retain the possessions consistent with their incentives level, those held on dedicated segregation units had to leave many of their possessions behind in their cell, making these cells more impersonal and austere. Getting access to their personal property was a problem for most of the children we spoke to in dedicated units.

4.44 The condition of cells used to separate children varied greatly between the sites we visited. At Feltham, most of the cells were dirty, mouldy, heavily graffitied and unwelcoming. Chairs

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[21] CSU cells are certified to hold children in separation conditions.

[22] Introduced to manage separated children in one place. They receive some psychological input through a short-term assessment of risk and needs (STARN).

[23] Prison cells on ordinary location left empty for use when a child needed to calm down.

were often missing, and we received a complaint about a sink that had been blocked for three days. At Cookham Wood, lighting in cells was poor and although there was a small air vent cells were stuffy and children reported that they were too hot in the summer.

4.45 There were very high noise levels on the Bridge unit at Cookham Wood during our visit, with children banging doors and shouting to each other between cells. This clearly hindered education sessions as well as sleep. In our survey of those living on designated units across the estate, only 30% said it was quiet enough to relax or sleep at night time.

4.46 There were considerable differences between the living conditions in designated segregation units. At Cookham Wood, the segregation cells were stark. Several cells had been destroyed, with little scope for non-essential repair work to take place in the remaining cells, and graffiti was evident on walls, windows and cell furniture. At Wetherby, accommodation on the Anson CSU was reasonably well maintained and graffiti-free but children were not permitted to have many of their personal possessions with them. The progression unit[24] above Anson offered similar accommodation but children could have televisions. The telephones for children to use on Anson offered privacy, which was positive; there was also a wide selection of books, and communal areas were reasonable and provided adequate space for education. We observed the cells at Wetherby as adequately furnished and reasonably clean, as we also found on the Keppel unit.[25]

4.47 Feltham had recently opened the Falcon unit, which was designed to hear adjudications and deal with problematic behaviour but not to operate as a segregation unit. Managers had refurbished cells on the ground level of Falcon into calm-down cells (to eventually replace the squalid ones on the other wings). The new cells were clean and bright but very sparse and it was troubling that these were used frequently as special accommodation (see paragraph 2.5) to calm children down and to manage those who had made attempts to self-harm.

4.48 Feltham had opened its ESU around 18 months before our inspection. This was intended to provide the support needed to run an adequate regime for children who could not mix with others on normal location. The aim was to establish a community-based caring approach for children with complex needs involving input from psychology, designated staff to work with the children and an operational manager to oversee its progression. We were concerned to find that the ESU was not delivering this so long after it its establishment, and that frontline staff were frustrated by the inability to realise its initial vision. At the time of the inspection, several cells did not have an observation glass panel, and we observed one child being served his meal with a senior officer plus six prison officers in full personal protective equipment.

4.49 Werrington primarily relied on the WADE (welfare and development enhancement) segregation unit[26] to locate separated children. The cells were clean although they had no electricity; there were current bids to rectify this and move forward with in-cell telephones, which was positive.

4.50 Overall, children were not consistently encouraged to keep their cells clean. When we checked the daily records for children subject to rule 49, we found that cleaning materials were not routinely offered or encouraged. These documents also recorded that the children did not have daily access to a shower.

4.51 In our survey, less than a third of children (30%) held in dedicated units reported that that the temperature of their cell was suitable, three-quarters (76%) could access a shower daily

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[24] A landing above the separation landing containing a small number of cells, designated as a step-down from separation to transition back to ordinary location.

[25] A stand-alone unit at Wetherby which is a national resource.

[26] Previously the CSU.

(some establishments had in-cell showers), only half (55%) had enough clean, suitable clothes for the week, and not all children (79%) were provided with clean sheets every week. Shower facilities at most sites were adequate but they were squalid at Feltham.

Safety

4.52 Perceptions of safety among children living on designated units were also a concern; a fifth (22%) said that they felt unsafe at the time of the survey. This was not surprising given that almost half reported that they had been victims of threats or intimidation from other children. Alarmingly, less than a third (32%) reported that they felt they were able to report such matters to a member of staff.

4.53 For children deemed at risk of suicide or self-harm, we were told by managers that constant supervision was not used very often. However, local data was not available in all establishments for us to assess this. In all but one of the establishments we visited (Werrington), we judged constant supervision as a form of separation and it was concerning to see children on constant supervision prevented from mixing with other children, dining communally or attending education.[27] Staff nearly always conducted the observations through a locked door or gate covered with Perspex with very little engagement. The cells were institutional and not appropriate for caring for a child in crisis. However, at Werrington children on constant supervision attended education and this was managed sensitively; deeming teachers as competent to constantly supervise a child in class was good practice

5. Children who are separated have access to a regime that meets their needs including regular and meaningful contact with staff and their peers

4.54 The daily regime for separated children was poor – all children had an unpredictable and limited amount of time out of their cell. In most cases, children were regularly subject to a regime that constituted solitary confinement: locked up for more than 22 hours a day, without meaningful human contact. In our survey of children on designated segregation or specialist separation units, only 53% reported getting more than two hours out of their room on a weekday. This dropped substantially at weekends, when most separated children were subject to regimes that constituted solitary confinement: only 17% of these children reported getting more than two hours a day out of their room. Our consistent finding across all sites was that the regime for children separated on normal location (66% at the time of the inspection) was worse than for those on designated units. In nearly all cases, children separated on normal location had an impoverished regime of around 90 minutes a day out of their cell during the week and as little as 15 minutes at the weekend.

4.55 We also found that children separated under rule 58 pending adjudication were subject to regimes that constituted solitary confinement. Most of the children subject to rule 58 reported very minimal time out of their cells, accessing showers and telephones only. There was no other opportunity for meaningful human interaction. Others reported no time out of their cells at all. It was particularly concerning that some separation documentation was missing, incomplete or inaccurate.

4.56 We noted distinct differences for separated children in accessing a regime depending on their location in the prison. As table 3 shows, children in a dedicated segregation unit, while still subject to an unacceptable regime, were more likely to be able to access basic necessities, including a shower and exercise daily; recording practices evidencing this remained inadequate but were better than we saw on normal location. Children separated

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27 A child will be constantly supervised if they are deemed at the most risk of attempting suicide or self-harm.

but remaining on normal location had substantially worse access to a regime; poor recording practices and an absence of effective oversight to address these issues meant that there was no evidence that some children had received any time out of their cell for several consecutive days. Recording was so poor across the four English YOIs that it was not possible for managers to tell us or inspectors where to find accurate information on how long some children had been subject to solitary confinement conditions while in custody. However, in interviews children separated on normal location confirmed that there were often days when they did not receive contact with other people, a shower or exercise. There were many children across all sites and locations who did not receive daily education. One child told us:

The regime is better on the [dedicated segregation] unit. You are guaranteed your regime every day. On the wing at the moment I get nothing.
17-year-old child separated on normal location

Table 3: The regime of seven children separated in different locations at one YOI

Child	Location	Days separated	Number of days paperwork missing	Days exercise recorded	Days shower recorded	Days when no time out of cell recorded
A	Normal location	23	5	6	Shower in cell	5
B	Segregation unit	7	0	5	4	1
C	Segregation unit	9	0	7	5	0
E	Segregation unit	36	0	10	19	8
G	Segregation unit	3	0	1	1	0
H	Separation unit	87	9	40	Shower in cell	14
I	Normal location	7	1	1	Shower in cell	4

Children waiting for hospital transfers

4.57 At the time of our inspection, eight children currently separated were waiting to transfer to a secure hospital to be treated for mental health conditions. Together, these children had spent a total of 373 days subject to separation. One child held at Cookham Wood had been separated on the segregation unit for 89 days before moving to a hospital bed. Throughout large parts of this time he received a very basic daily regime of 30 minutes exercise, a shower and a telephone call. As his health deteriorated further he was assessed for a bed in a secure adolescent forensic unit in April. While he was suitable for the unit it did not have a bed available and he was eventually moved to a similar unit at the end of May, having spent another 29 days separated in a constant observation cell. Most staff across the YCS do not have the training to work with children with this degree of mental ill-health.

4.58 While these children were placed inappropriately in custody rather than hospital they were unable to access a therapeutic regime that met their health care needs. Some cases had been escalated to NHS England, but there was no effective way to ensure that these very vulnerable children received the health care to which they were entitled.

4.59 Delays in transfer were experienced when children were due to turn 18, and also because of a severe lack of beds nationally. These problems resulted in HMPPS having to manage acutely unwell children through separation, which in its current form was unable to meet their needs.

Meaningful contact with staff and peers

4.60 Children subject to separation did not have daily, meaningful conversations with a sufficient range of staff. We reviewed 57 cases of children who had experienced separation across the estate in the last year. In four cases, recording was so poor that we could not make a judgement. Over half of the remaining 53 children (28) received no daily contact with unit staff, only 13 saw a chaplain every day, and 33 were recorded as having seen a senior manager every day during separation.

4.61 Children who we spoke to reported very limited interactions with staff. They said that some staff came to see them because they were separated but their checks took place through the locked door, rather than a meaningful interaction. We frequently observed this happening in all sites. Too many of the conversations staff had with children were incidental, dictated by prison regimes and took place through the door. This was particularly inappropriate if conversations required a safe and confidential space. One child we interviewed stated that:

Some staff just forget about me and ignore me and then give me a yellow card for using my bell. Sometimes I just want to talk to them.
17-year-old child separated on normal location

4.62 Staff from other departments, such as casework, and Barnardo's advocates and Kinetics workers, sometimes visited children who were separated. However, this did not always happen on a daily basis and recordings of these interactions on rule 49 paperwork was poor. These conversations were subject to prison officers agreeing to unlock the door; competing priorities meant these often took place through the locked door. One member of staff who we interviewed said:

Meaningful contact isn't valued sufficiently. If we cannot access the child for a proper conversation it inhibits the meaningfulness of the conversation… contact through the door makes it difficult to build a relationship with the child.
YOI child and adolescent mental health service worker

4.63 Children we spoke to described the lack of meaningful contact while they were separated. One child stated:

I get mad bored, there's nothing to do. Staff literally open your door for two seconds to give you your food… its minimal interaction. I don't think that's right… it's basically seg, but they took away the seg block and just put me in my room seg'd instead – what's the point?
17-year-old child separated on normal location

4.64 Children subject to separation also did not have regular or sufficient opportunities for meaningful contact with their peers. While some children reported contact with other children, this was minimal and only occurred if they could mix in groups of two or three for exercise or education, which did not happen every day. Most separated children, especially those separated on normal location, could only speak to each other at night by shouting through their doors or windows. One child stated:

We try to just ride it out together by talking through our doors and playing I-spy. It makes the time pass, especially at night time. I have a behaviour target to stop shouting through my door to the other boys on the unit, which I think is really unfair 'cause it is literally my only chance to chat to

anyone. We're not arguing or anything, we're just chatting, having a joke and checking up on each other.
16-year-old child separated on normal location

Children have sufficient activities to occupy and stimulate them in their cells

4.65 Separated children were locked up for too long on restrictive regimes, and had little to stimulate them sufficiently in their cells. We found some children who had access to a radio and TV. In some establishments, staff gave children word searches or stress balls, in-cell workouts or a book to read, and some children were given activity packs by youth workers or education outreach. However, this was the minority of children. Provision of activities to occupy children was inconsistent, and even if a child received an activity pack from education it was sometimes unrelated to their individual educational pathway. Parc did not offer outreach education and most children we spoke to there said they received nothing to occupy them while they were locked up. Many children in other institutions separated pending adjudication under rule 58 did not have access to outreach education. One 17-year-old separated on normal location said: 'there should be more to occupy your mind.'

Access to activities

4.66 Children who experienced separation were not able to access equivalent activities to their non-separated peers, including time in the open air. In the 57 cases that we reviewed, 24 did not contain information about exercise; this included all 14 cases from Feltham. Of the remaining 33, only seven received daily exercise throughout their period of separation.

4.67 Outside exercise yards on dedicated segregation units were colourless and confined, providing no stimulation for children. As with the case of Child J below, we sometimes found that children were forced to decide between time in the fresh air and education, because there was insufficient provision or organisation to provide both on the same day.

4.68 In some establishments, there had been attempts to offer alternative planned activity sessions for separated children. However, this was also inhibited by the restrictions of the regime. In one case, a child was over 45 minutes late for an art therapy session and was then unable to leave until an hour afterwards, which compromised the therapeutic impact of the intervention.

4.69 The educational outreach provision for separated children was inadequate. It was infrequent, inconsistent and competed with other regime activities for priority. Data from education providers showed that they attempted to deliver around three to five hours of education per child in outreach per week. However, this did not include all children subject to separation and covered the time when the child was unable to attend for reasons outside the control of the education provider. The difficulties in delivering outreach education meant that access was inequitable; while some children (often those who were not separated) did get more access to education, this meant that many got far less.

4.70 To illustrate this disparity, we examined education provision in detail for four children subject to separation on normal location for a total of 86 days. Over the separation period, a total of four hours 55 minutes of education was delivered, or just less than four minutes per child per day. One child spent 34 days separated and received only two hours 20 minutes of education.

4.71 In many establishments, managers were unable to coordinate the different activities for separated children effectively. Separated children and the staff looking after them did not have a timetable of who would get what activities and, crucially, when. This meant that valuable resources were often wasted as teachers, youth workers and health care

professionals were turned away or had to wait before a child was brought to their appointment. We saw a teacher being turned away from a unit because a child was on a seven-minute telephone call. This meant that children on this unit lost three hours of education time. More frequently, time was wasted waiting for children to be unlocked. We observed teaching staff waiting for 75 minutes to deliver a session for a child who was separated. This delay then compromised the education schedule, and access to education was significantly reduced for all separated children. At another establishment, a consultant psychiatrist was prevented from seeing a child due to a lack of staff; he told us that he had been attempting to see this child for two weeks.

Child J, 17-years old
Separated under rule 49 for 23 days on normal location due to self-isolation and experiences of bullying. He was too scared to come out of his cell for fear of a group assault.

During the 23 days of separation, this child received time in the fresh air on six days and education for a total of 70 minutes. On some days he was forced to decide between time in the fresh air and education, as the regime did not allow him to access both. There were no records for five days of this child's separation period, so it was unclear whether he had any time out of his cell or meaningful contact during that time. He had requested a transfer to another establishment simply so he could access a regime and talk to others. The reality of his daily existence was that he was behind his door all day with no meaningful human interaction.

When asked his views on separation this child commented: 'When I'm separated it's like I'm suddenly invisible.'

Children can shower and use the telephone daily

4.72 In our survey, 76% of children who were separated on designated units said they could shower every day and 81% that they were able to use a telephone every day. Of the 57 cases we looked at in detail, including children on designated units and normal location, only 18 recorded that children received a daily shower and 19 that the child received a daily telephone call. With the exception of Parc, where practice was better, these children were more likely to receive a daily shower and telephone call if they were separated on a designated unit. We also found evidence of children being refused daily access to showers or telephone calls due to poor behaviour, such as the following case.

Child K, 17-years old
Separated under rule 49 for 12 days on normal location due to being unable to mix with other children on his wing.

During the 12 days of separation, this child had exercise time recorded on only two days, and a shower and telephone call recorded on just five days. In 12 days of separation this totalled only two hours 20 mins out of his cell. This child received no education outreach or activity pack while separated on the wing. Sometimes, his access to showers and telephone was refused as a punishment. This child wished to attend his rule 49 review. This was not facilitated and instead he received an update at his door.

When asked his views on separation this child commented: 'I'm getting less than 20 minutes out of my cell a day. I have to remind them to unlock me or I am just banged up all day long.'

6. Children are separated for the shortest possible period before being reintegrated to a normal regime.

4.73 We found no examples where required reviews did not take place for the children identified as being on rule 49. Those for children in designated units were often multiagency, including a mental health care professional, and focused on the child's ability to cope with separation. The quality of reviews attended during the site visits was often better than the records suggested. However, reviews for children separated on normal location were less well developed. Generally, children attended the review process, but we found several examples where the child was not invited and the outcome of the review was communicated to him through a locked door.

4.74 Most establishments commissioned a short-term assessment of risk and need (STARN) through the review process, which aimed to give residential staff advice on how to manage separated children on their units. However, there was a wide variation across the estate about when these were undertaken, from 72 hours to two weeks after the initial separation.

4.75 In some establishments, casework officers attended reviews, plans were focused on getting the child out of separation, and issues from other plans that were influencing the separation were included. However, this level of planning and involvement from casework was not universal, leading to many perfunctory and vague plans.

4.76 Every child was given several targets at each review. Most of these were behaviour-related. The quality of these targets was inconsistent across establishments and their aims varied. Some establishments focused on behaviour, and this was the driving factor in determining whether a child would remain in separation; others looked at the reasons for the behaviours and tried to engage the child in resolving them with more detailed plans.

4.77 The regime that applied to children while separated was linked to their behaviour and formed a large part of the planning process. The aim of most plans centred on the child behaving well and stopping the behaviours that had led to separation. However, for most children we found their time out of cell was so restricted they were not given an opportunity to show that their behaviour had improved or their risk reduced. Some establishments provided children with a copy of their plan but this was not done everywhere.

4.78 We saw no examples of input from outside the establishment (such as families or local authorities) into the separation review process. Children were often encouraged to give some input and we witnessed some good engagement, especially at initial reviews. This initial engagement presented a window of opportunity for managers that was too often missed, and the longer the separation the less inclined the child was to engage.

4.79 Health care staff were always in attendance and we also regularly saw psychology input. As the review was the decision-making process for continued separation, the attending health care professional completed the safety screening at this point.

4.80 A key part of the review process is to address any signs of declining emotional and mental well-being; however, we found no evidence that children had been removed from separation or returned to normal location because of a decline in their mental health. Managers did try to identify risk through increased observations or relaxing a part of the regime, but implementation of these changes was too often poor.

4.81 For most children reintegration planning was poor. In the 57 cases we reviewed only 11 had plans to enable the child to reintegrate to a normal regime. Practice in this area was significantly better at Werrington, where nine of the 10 cases we reviewed had a

reintegration plan. At Parc reintegration planning started at the 72-hour review, where managers routinely put into place a plan that, if successful, would end the separation before the seven-day review. In all but three cases in the previous 12 months, this approach had been successful within seven days. This included cases where children had committed serious acts of violence against other children and staff. The key characteristic of the plans at Parc was the provision of education and other activity at specific times to ensure that both staff and children knew what to expect.

4.82 Reintegration into the normal regime differed greatly between the establishments. In Parc we saw children who had been involved in a serious violent incident being reintegrated back into education after three or four days, and a return to normal regime within a week. Those found guilty of an offence at an adjudication were similarly returned to a normal location and regime within the same timescale, but without access to the items that had been removed by the adjudicator.

4.83 In the remaining YOIs, reintegration planning was absent, late or not specific. In most establishments, separation was overly driven by process and lacked flexibility. Apart from at Parc very few children were removed from separation in between reviews. This lack of flexibility in the process and inconsistent reintegration planning for the majority of separated children was a fundamental failure and resulted in prolonged periods of separation, further exposing children to the risks of declining mental health and well-being.

4.84 At Werrington there was some good work on the WADE segregation unit with some children who faced particular challenges. One child who regularly seriously self-harmed and had been self-isolating was associating as part of a small group, regularly attended education and was engaged with the chaplaincy, visiting the chapel regularly. However, he still often spent more than 22 hours a day locked in his cell. The perceived predictability of the regime on the WADE unit caused additional issues as children who were separated on normal location, and so had an impoverished regime, sometimes carried out acts of violence or arson to get placed on the unit with its improved regime.

4.85 It was clear that establishments wanted to reduce the amount of separation. However, we found that a lack of an acceptable regime or interventions for separated children, combined with an absence of reintegration planning, meant that separation continued for longer than was necessary in many cases.

4.86 Establishments collected data on the reasons for separation and there was some effective collation and review of these reasons. This was especially so at Wetherby where a good quality, well-attended meeting generated sound actions to reduce the amount of separation. Although we saw such meetings in other prisons, they were not as well developed as at Wetherby.

4.87 Separating disruptive or vulnerable children increases managers' ability to run the mainstream regime and gives staff and other children some respite from the issues that had led to separation. However, it was not clear how the separation we saw could address or improve a child's behaviour. On the contrary, we found that, in its current form, where children are locked up for up to 23 hours 45 minutes a day without meaningful interaction, intervention or reintegration planning, separation was likely to make the underlying behaviour issues worse.

7. Relationships between children and staff are warm, compassionate and helpful but staff maintain appropriate boundaries

4.88 In our survey, only a third of children who had been separated on a designated unit said they felt cared for by staff. In interviews, children who had experienced separation held mixed views about staff: some thought they were treated differently when separated while others thought there was no difference, depending on their relationship with staff. Staff entries in electronic case notes and rule 49 logs often focused on the practicalities of the daily regime that children had received rather than demonstrating good quality interaction with them through the day, or an understanding of their background, needs and targets and the staff role in helping the child to progress. There was little evidence that staff worked with children towards ending their separation. However, staff did sometimes acknowledge good behaviour. Examples included: 'had an exceptional day', 'did well enough to earn himself some merits. Well done', 'displayed good behaviour throughout the day', 'has behaved all week and worked extremely hard in his outreach sessions', 'has asked to come out to clean the landing and help staff', 'Green card issued - Encouraging another YP to come down and helping to de-escalate a situation'.

4.89 Operational staff (prison officers) often appeared more focused on keeping the regime running than on the individual needs of separated children for regular, consistent interaction and activity. This was a particular issue when children were separated on normal residential units, with little staff appreciation of the frustration for children held in a small cell for most of the day. One entry on the electronic case records for a child who was separated and also being managed through ACCT illustrated this:

X continues to tell us he's bored but has had what he has been entitled to.

The *minimum* regime provision of between 30 and 90 minutes a day out of cell was seen as the target to achieve, and there was little understanding of any child's need for stimulus and interaction with other human beings. Staff on the wings placed more importance on meeting the daily requirements of the rule 49 separation process than understanding and addressing the issues that had led to children being separated. The latter was usually undertaken by specialist teams (such as conflict resolution, psychology or interventions staff) rather than staff on residential units, so children did not benefit from the valuable input that residential staff could have made.

4.90 Staff were often too busy to do more than facilitate a basic separation regime of daily exercise, shower and a telephone call, and possibly some outreach education. This limited their ability to spend time with and develop relationships with children. Children talked about this in their interviews. One said he appreciated that staff were busy but he only needed basic communication. Another said that while he could ask for cleaning materials every other day busy staff might not be able to facilitate this. One child said he saw outreach education for only around 10 minutes every few days and he would have liked more education but he knew staff were busy seeing other children. None of these were unreasonable requests, but the children's perceptions were that staff did not have time to do them. Our observations during the site visits confirmed this. We saw some residential unit staff struggling to keep on top of all the tasks that needed to be done during core activity periods. At one site, staff appeared overwhelmed with the sheer number of children who were kept apart from others because of an unresolved conflict (often referred to as 'keep-aparts') and one-to-one regimes they had to facilitate each day for separated children. Many staff wanted to do more but were unable to deliver even the basics of everyday life.

4.91 Across the sites we were told that children who were the most demanding got more staff attention to the detriment of others who were separated. We observed this during site visits, where we saw some staff giving time to responding to those who were loudest and

most extreme in their demands for attention, while other separated children had to wait for their limited time out of cell. There was a risk that staff could easily overlook the wider needs of quieter children once they had been offered their exercise, shower and time on the telephone. More staff entries in files and logs concerned the more disruptive children or poor behaviour.

4.92 Children said that staff on some specialist units treated them better than staff on general residential units, which was consistent with what we saw during our site visits. The number of children on the specialist units was typically much lower than on the main residential units and operational staff there had far more time to give to each child. Children on the WADE segregation unit at Werrington acknowledged this in their interviews, telling us 'Staff are nicer to you when you're on the block', and that WADE unit staff were 'more chilled and understanding'.

4.93 Almost two-thirds (65%) of children who had been separated on designated separation or segregation units said there was a member of staff they could turn to for help with a problem. Children interviewed mentioned their caseworkers and Barnardo's advocates as people they would turn to. Their thoughts about reporting poor staff behaviour varied; only 53% of children said they would report it if they were bullied or victimised by staff. They told us that they knew how they could do this – through speaking to a manager or Barnardo's advocate or putting in a written complaint – but some did not see the point in raising poor staff behaviour. One child explained that as they had to live with staff it was important to 'keep it calm with staff in the jail'.

4.94 Staff on specialist units like WADE at Werrington and the ESU at Feltham had more time to devote to the children in their care than officers on main residential units. We saw some good examples of staff listening to and helping children, and children clearly appreciated staff who were able to make time for them. One child said, 'just listening is enough to make me feel like they care'. However, there was often a big gap between what children would have liked to happen, what staff wanted to happen and what was possible. The multiple officer unlock arrangements for some children did not help interactions as they were pre-planned and privacy was impossible. We also observed that it could be difficult for staff from agencies such as health care, education and youth workers who wanted to spend time with children to get them unlocked. This hindered both the provision of required support and the development of appropriate relationships between children and these professionals.

4.95 Despite this, we saw good examples of individual care. One remanded child who was struggling to get to grips with life in custody was given a book by a member of staff who had talked with him about his hobbies and interests and thought the subject would engage and distract him. A child at Feltham A described the efforts of a Kinetics worker who:

… actually sat with me and chatted and tried to help… made an effort… got me out of my room.

There were also instances of staff showing age-appropriate tolerance in response to poor behaviour. For example, a child who had graffitied his cell was given the chance to remove it rather than be put under a formal process to punish him. A member of staff noticed that a child was not eating much food and put monitoring and support in place.

4.96 In their interviews, children said they were only sometimes asked about their mental well-being and how they were feeling while separated. Not all the daily welfare checks that should have been carried out by different agencies took place, and many were held through locked doors, which clearly prevented private or meaningful conversation and informed assessments of well-being. (See also paragraphs 4.53 and 4.61–4.62.) During site visits we saw some health care professionals being told they had to speak to children through their locked doors, particularly for children separated on their residential unit. During interviews it was noticeable how well children remembered those staff who had opened their doors or had a

proper conversation with them while they were separated. One said of a particular governor, 'he is my favourite, he's helpful… he listens'.

4.97 One child told us:

It's just the little things, when you're locked up 23 hours a day, the little things can make you crazy.

Another said he had an 'emotional breakdown' some days previously because he became really bored on rule 49 as there was nothing to do all day. He described how a custodial manager from another residential unit spoke to him and was 'really helpful and nice', and said since that attitudes of other wing staff towards him had improved. Another child made a direct link between spending time out of cell and well-being, saying it would improve the experiences of separated children like him by giving more time out of cell 'for my mental health'.

4.98 Several of the children interviewed described sleeping most of the day when separated and then staying awake at night talking to other children or playing games like I-Spy. One child on a specialist unit said he tried to sleep all day to make the time go faster. None of this promoted good mental or physical well-being and was not being addressed by staff or managers. However, at the Cookham Wood Phoenix unit, children were expected to be awake and dressed at morning unlock to collect their breakfast and request any applications for a shower, telephone call or exercise they wanted during the day. This at least established the time they were expected to be awake and engaging with staff at the start of the day.

4.99 Unsurprisingly, separated children were often not receptive to morning visits from health care professionals, chaplains or caseworkers to check on their welfare, telling us they got annoyed when staff tried to talk to them in in morning. One was explicit that this was because he was always tired after staying up all night.

Appendix I: Inspection team

Angus Mulready-Jones	Team leader
David Foot	Inspector
Angela Johnson	Inspector
Esra Sari	Inspector
Rebecca Stanbury	Inspector
Sharlene Andrew	Researcher
Helen Ranns	Researcher
Claudia Vince	Researcher

Appendix II: HMI Prisons expectations for separation/removal from normal location[28]

19. Children are only separated from others or removed from their normal location with the proper authorisation and are located for appropriate reasons. Separation is not used as a punishment.

The following indicators describe evidence that may show this expectation being met, but do not exclude other ways of achieving it.

- *There is a clear strategy in place for the use of all forms of separation.*
- *The use of separation and segregation on normal location and in specialist units is appropriately authorised, monitored by senior staff and analysed for patterns and trends.*
- *Health care staff promptly assess all separated and segregated children and contribute to care planning.*
- *Segregation and separation is used only as a last resort after other alternatives have been considered. It is used for the shortest time possible.*
- *Children at risk of suicide or self-harm are only segregated in clearly documented, exceptional circumstances.*
- *Children are not separated as a punishment and the decision to separate them is for justifiable reasons, authorised properly and recorded.*
- *Children are given the reasons for their separation in a format and language they understand.*
- *Children and their parents, carers or outside workers can make representations to a senior manager before they are separated in specialist units or on normal location.*

20. Children whose behaviour requires them to be temporarily separated from others are located in a suitable environment where their individual needs are fully met.

The following indicators describe evidence that may show this expectation being met, but do not exclude other ways of achieving it.

- *Children temporarily separated from normal location have regular and meaningful contact with staff. They are able to have meals and continue their education and other activities outside their cell, within the restrictions of their temporary environment.*
- *Children are never subjected to a regime that amounts to solitary confinement.*[29]
- *Children separated in specialist units or on normal location have a plan which ensures that their time is spent addressing their problematic behaviour. The contents of plans are always properly linked to any other existing plans involving that child.*
- *Specialist units are decent, clean and meet the needs of children.*
- *Staff are vigilant in detecting signs of decline in emotional and mental well-being.*
- *Children have meaningful conversations with a range of staff every day, including the opportunity to speak in confidence with a senior manager, a health care professional and a chaplain.*
- *Those who are temporarily removed from mainstream activities can access equivalent activity to their non-segregated peers, including time in the open air.*
- *Children have sufficient activities to occupy and stimulate them in their cells.*
- *Children relocated to specialist units are not strip-searched unless there is sufficient specific*

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[28] *Expectations. Criteria for assessing the treatment of children and conditions in prisons*. Available at: <https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2018/11/Childrens-Expectations-FINAL-261118-2.pdf> accessed 24 October 2019.

[29] The United Nations Standard Minimum Rules for the treatment of prisoners define solitary confinement as confinement 'for 22 hours or more a day without meaningful human contact'.

intelligence and proper authorisation.
- *Children are separated for the shortest possible period before being reintegrated to a normal regime.*
- *Reviews are held regularly and involve the child and all relevant staff.*
- *Parents/carers and relevant professionals, including social workers, youth offending team (YOT) workers and advocates, are engaged where appropriate.*
- *Data is used effectively to identify and minimise risks to the safety of children and staff.*

Appendix III: HMI Prisons expectations for this thematic inspection

HMI Prisons inspection of separation expectations

1. Safe outcomes for separated children are supported by effective leadership and management.

- *National and local leaders have a clear understanding of what separation is for and how it achieves these aims.*
- *There is an effective strategy at a national and local level that informs the use of all forms of separation.*
- *The use of separation reduces over time*
- *Leaders and managers are aware of all children who are separated and ensure they are provided with a constructive regime that meets their needs.*
- *Disproportionality in the use of separation is identified and addressed.*
- *Children are not placed in unfurnished accommodation.*

2. Children are only separated from others or removed from their normal location with the proper authorisation and are located for appropriate reasons.

- *The use of separation on normal location and in specialist units is appropriately authorised, monitored by senior staff and analysed for patterns and trends.*
- *Separation is used only as a last resort after other alternatives have been considered and tried. It is used for the shortest time possible.*
- *Health care staff promptly assess all separated children and contribute to care planning.*
- *Children at risk of suicide or self-harm are only separated in clearly documented, exceptional circumstances.*
- *Children are given the reasons for their separation in a format and language they understand.*
- *Children and their parents, carers or outside workers are told about the decision to separate and the reasons for separation. They can make representations to a senior manager before children are separated in specialist units or on normal location.*
- *Professionals from the community are invited to reviews of separation.*

3. Separation is not used as a punishment.

- *Children are not separated as a punishment and the decision to separate them is for justifiable reasons including their safety and the safety of others.*

4. Children who are separated from others are located in a suitable environment.

- *Cells and communal areas are light, well decorated and suitable for children.*
- *Children have their own bed, chair and lockable cupboard and provision for the storage of personal belongings is adequate.*
- *Children are allowed to personalise their cells.*
- *Children have access to drinking water, a toilet and washing facilities at all times.*
- *Children feel and are safe in their cells and communal areas.*
- *Children can raise the alarm in an emergency.*
- *Communal areas meet the needs of the population and are supervised effectively by staff.*
- *Units are as calm and quiet as possible to avoid incidents and to enable rest and sleep*
- *Children have access to necessary supplies of their own personal hygiene items. Basic hygiene items are provided free of charge.*
- *Freshly laundered bedding and towels are provided on at least a weekly basis.*
- *Children have access to sufficient cleaning materials to keep their cells and communal areas clean and are encouraged to use them.*
- *Children have a varied, healthy and balanced diet which meets their individual needs.*

5. **Children who are separated have access to a regime that meets their needs including regular and meaningful contact with staff and their peers.**
   - *Children are never subjected to a regime that amounts to solitary confinement.*[30]
   - *Children have meaningful conversations with a range of staff every day, including the opportunity to speak in confidence with a senior manager, a health care professional and a chaplain.*
   - *Children have regular opportunities for meaningful contact with their peers.*
   - *Children have sufficient activities to occupy and stimulate them in their cells.*
   - *Those who are temporarily removed from mainstream activities can access equivalent activity to their non-segregated peers, including time in the open air. Areas for association, education and exercise are properly equipped.*
   - *Children are not subject to punitive security measures.*
   - *Children can shower and use the telephone daily.*

6. **Children are separated for the shortest possible period before being reintegrated to a normal regime.**
   - *Children who are separated have a plan which ensures that their time is spent addressing their needs. The contents of plans are always properly linked to any other existing plans involving that child.*
   - *Reviews are held regularly and involve the child. Parents/carers and relevant professionals, including health care, social workers, youth offending team (YOT) workers and advocates, are engaged where appropriate.*
   - *Reviews identify and take action to address signs of declining emotional and mental well-being.*
   - *Children have access to appropriate independent advocacy and advice. They are supported to contribute fully and to challenge decisions made regarding their care.*
   - *The Independent Monitoring Board (IMB) is informed of all reviews. Children can easily speak to members of the IMB in confidence.*
   - *Children have access to advocates, health care, social workers and legal advice.*

7. **Relationships between children and staff are warm, compassionate and helpful but staff maintain appropriate boundaries.**
   - *Staff behave in a fair and consistent way, care for children as individuals and respond to their needs.*
   - *Staff understand the impact of life experiences, such as trauma, abuse and mental illness, on behaviour.*
   - *Staff are vigilant in detecting signs of decline in emotional and mental well-being.*
   - *Staff show a genuine interest in children and listen to them, giving their time freely.*
   - *All children have someone to turn to if they have a problem.*
   - *Staff know how to raise concerns about colleagues' behaviour or interactions with children and do so without repercussion.*

[30] The United Nations Standard Minimum Rules for the treatment of prisoners define solitary confinement as confinement 'for 22 hours or more a day without meaningful human contact'.