Report on an announced inspection of

HMP Chelmsford

9 –13 July 2007

by HM Chief Inspector of Prisons

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Introduction

Chelmsford is a medium-sized local prison, which suffers from all the problems of an overcrowded prison system. Prisoners, often from London, arrived late, stayed for relatively short periods, and had insufficient to occupy them. These problems had been exacerbated by the prison's recent expansion and staffing problems. As a consequence, this inspection revealed some serious underlying issues that managers needed urgently to tackle.

A high percentage — around 40% — of prisoners at Chelmsford said that they felt unsafe at the time of the inspection. We identified a number of contributory factors. First, the reception and induction arrangements did not provide sufficient protection or support for vulnerable prisoners. Second, there were deficiencies, some serious, in suicide and self-harm prevention arrangements and access to Listener peer supporters. Third, the use of force by staff was high, and did not always appear justified: extraordinarily, there had been four uses of the bodybelt in the six months before the inspection. Finally, and importantly, the relationships between staff and prisoners, particularly on the more volatile young adults' wings, were not sufficiently positive and did not support dynamic security within the prison. It was noticeable that only 32% of young adults surveyed, against a comparator[1] of 66% for young adult prisoners, said that most staff treated them with respect.

Accommodation in the prison varied considerably with good conditions on the newer units and much poorer ones on the older wings. Relationships tended to mirror conditions, and to be better on the newer wings. We were, however, very concerned by the lack of care that was evident in the fact that prisoners did not get regular changes of clothing and bedding, and that issues of basic hygiene and cleanliness were not always swiftly addressed.

Some good work was taking place in race relations and to support foreign nationals, but staff with responsibilities in these areas were unable to deal effectively with the volume of work; and more training for all staff in cultural awareness was needed. Healthcare was also mixed, with some good primary care services, but some worrying deficits in mental healthcare and the regime available for inpatients. It was of great concern that suicidal prisoners were routinely placed in strip conditions in the healthcare centre, watched on CCTV cameras in adjacent offices, and not engaged with directly.

Like many local prisons, Chelmsford had insufficient activity for all its prisoners. Nearly a third of the population were unemployed, and a further third were engaged in wing activities that provided no skills or qualifications. Resources had recently increased, but strategic management and quality were inadequate. Allocation to work or education did not take sufficient account of prisoners' needs, and many of the courses on offer were too long for prisoners to complete. The vocational training that existed was good and relevant, but there was too little of it. There was no separate strategy for the 187 young adults – a quarter of the population – many of whom were likely to leave prison as unskilled as when they entered it.

Resettlement work was developing well. Offender management had improved provision for the 71 prisoners in scope of the new arrangements, though it would have benefited from better links with residential staff. As in many prisons, those serving indeterminate public protection sentences were marking time for long periods, without being able to access the programmes they needed to reduce risk. Short-term prisoners did not have custody plans; however, there was some good work being done to meet their housing, employment and finance needs,

[1] The comparator figure is calculated by aggregating all survey responses together and so is not an average across establishments.

particularly by the Foundation Training Company. Drug and alcohol work was also developing strongly, and would be improved further by the planned introduction of the integrated drug treatment system (IDTS).

This is, in many ways, a disappointing report. Previous inspections had shown considerable improvement at Chelmsford, both in performance and culture. This inspection, however, showed that this had been unable to withstand the combination of population pressure, increased numbers, and staff shortages and turnover. Managers now need to grip the key issues of safety, decency and activity, in order to make the best use of the resources they have, and of the time that prisoners spend there.

Anne Owers — November 2007
HM Chief Inspector of Prisons

Fact page

Task of establishment
Category B male local prison.

Area organisation
Eastern

Number held
9 July 2007: 687

Certified normal accommodation
570

Operational capacity
695

Last inspection
Short unannounced: September 2004

Brief history
Built from 1830 onwards as the county jail, it has been used as a long-term category B prison, a young person's prison and a local prison since 1987. Two new house blocks were opened in 1996 and G wing in 2007.

Description of residential units

Wing	Description	Number held
A	Segregation unit and key workers	36
B	Unemployed wing	126
C	Sentenced young adults	126
D	Vulnerable prisoners	55
E	Induction and first night	126
F	Mixed status employed	106
G	Employed and enhanced	120

Healthy prison summary

Introduction

HP1 All inspection reports carry a summary of the conditions and treatment of prisoners, based on the four tests of a healthy prison that were first introduced in this inspectorate's thematic review *Suicide is everyone's concern*, published in 1999. The criteria are:

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

HP2 Under each test, we make an assessment of outcomes for prisoners and therefore of the establishment's overall performance against the test. In some cases, this performance will be affected by matters outside the establishment's direct control, which need to be addressed by the National Offender Management Service.

... performing well against this healthy prison test.
There is no evidence that outcomes for prisoners are being adversely affected in any significant areas.

... performing reasonably well against this healthy prison test.
There is evidence of adverse outcomes for prisoners in only a small number of areas. For the majority, there are no significant concerns.

... not performing sufficiently well against this healthy prison test.
There is evidence that outcomes for prisoners are being adversely affected in many areas or particularly in those areas of greatest importance to the well being of prisoners. Problems/concerns, if left unattended, are likely to become areas of serious concern.

... performing poorly against this healthy prison test.
There is evidence that the outcomes for prisoners are seriously affected by current practice. There is a failure to ensure even adequate treatment of and/or conditions for prisoners. Immediate remedial action is required.

Safety

HP3 Prisoners' arrival into custody and their induction at Chelmsford met requirements, although they had long delays in reception. There were serious concerns about the safety and wellbeing of vulnerable prisoners on the induction unit and later, as they were required to overspill on to other units because of lack of space on the main

vulnerable prisoner unit, D wing. Levels of bullying, particularly on C wing, and the number of assaults were high. Suicide and self-harm structures were satisfactory, but the quality of monitoring documentation was variable and access to Listeners inadequate. The absence of Listeners in reception was a significant concern. The prison had little focus on meeting the needs of young adults. The segregation unit was reasonably well run, but use of force was very high and not always necessary. Chelmsford was not performing sufficiently well against this healthy prison test.

HP4 The prison received prisoners from the Greater London and Essex areas and escorts often arrived after 8pm, which affected reception and first night procedures. Prisoners were also often held on vehicles for some time before they were admitted to the reception.

HP5 Reception procedures were efficient and prisoners were treated well. However, in our survey, both adult and young adult prisoners were negative about their treatment in reception. Prisoners were routinely delayed before they were transferred to the wings, and did not have easy access to free telephone calls and showers. We were concerned about the confidentiality and wellbeing of those in the vulnerable prisoner holding room. Listeners and Insiders (prisoner peer supporters) were still not available in reception, although this had been a recommendation of a previous inspection, and subsequently repeated by the Prisons and Probation Ombudsman following a death in custody

HP6 Insiders were, however, available on E wing, the first night and induction unit. First night officers provided effective continuity of care, and prisoners' risk factors were assessed properly. Newly arrived vulnerable prisoners were also located initially on E wing. We had concerns about the confidentiality of their management as well as their safety. Some vulnerable prisoners had been on the unit for several weeks.

HP7 Induction took place the day after arrival, normally lasted a day, and met prisoner needs. It also included assessment by a range of agencies and regime providers. Following induction, prisoners were normally moved to other wings expeditiously. In our survey, young adults claimed not to have attended induction in their first week, and significantly higher numbers than the comparator felt unsafe on their first night in Chelmsford. Indeed, despite a reasonable level of provision, prisoners were generally negative about their initial experiences at Chelmsford.

HP8 Structures to manage and prevent bullying and reduce violence were well established. There were effective systems to identify bullying incidents, which were well integrated with other information sources, such as the security department. However, the identification of incidents from wing observation books was underdeveloped. Significant numbers of both adults and young adults surveyed reported that they currently felt unsafe. Bullying was a particular problem on C wing, with its preponderance of young adults, and young adults also reported that their property was frequently stolen. Levels of assaults in the prison were high. The anti-bullying coordinator had held focus groups about bullying and had conducted a survey of prisoners, but the analysis had yet to be published. The timeliness and quality of investigations into bullying incidents were improving.

HP9 The prevention of suicide and self-harm was managed through the monthly safer custody committee. The prison had opened 199 assessment, care in custody and teamwork (ACCT) self-harm monitoring documents since the start of 2007, most in reception. The quality of ACCT documents was mixed. Some initial assessments

lacked detail, one file reviewed had no care plan, and staff entries often failed to show engagement with prisoners. We were concerned that prisoners in crisis were routinely placed in strip conditions in the healthcare centre, some supervised via CCTV. Each wing had access to a Samaritans telephone, as well as material to distract prisoners in crisis, but access to Listeners was poor. There was good work in the daycare centre to support prisoners on open ACCTs.

HP10 The prison had a large and well-run security department with developed links to the local police. Up to four police liaison officers were available to the prison, and this had helped confront imported gang culture. The prison processed a large number of security information reports efficiently. Some 32 prisoners were on closed visits, and a similar high number of visitors were banned. The governance of these arrangements was weak. The establishment's rules were well publicised, and there was little evidence that the application of security procedures or rules impeded the regime.

HP11 The segregation facility was clean and well run. Under a two-tier compliance regime, prisoners could earn additional privileges for good behaviour. Staff-prisoner relationships were respectful, and the basic core regime offered exercise and showers. We had some concerns about an overspill facility for vulnerable prisoners next to the segregation unit, though the prison was seeking to make best use of available accommodation. These cells were sometimes used to help reintegrate formerly segregated prisoners.

HP12 There had been 626 adjudications in the first half of 2007. Disciplinary procedures were conducted fairly. However, the prisons 'refusal to transfer' protocol imposed a limited regime for prisoners who refused to transfer, despite other sanctions that were available, and amounted to an unauthorised or secondary punishment.

HP13 Use of force levels were high. The rate for the year leading up to our inspection was higher than comparable prisons without any obvious explanation. Most incidents concerned staff-prisoner conflict, and nearly half of all recent incidents involved young adults. Documentation recording incidents of use of force were not completed to a high standard. We were not assured that there had been sufficient attempts at de-escalation in all incidents or that force was always used as a last resort.

HP14 Special accommodation had been used 20 times in the first half of 2007, which was high, although a small number of prisoners had accounted for a number of incidents. The body belt had also been applied four times in this period, which was a very high figure. Record keeping for the authorisation of these interventions was also not of a high quality. On some occasions, prisoners were kept in special accommodation for some time after they had become compliant.

HP15 The positive rate for random drug testing was 4.8%, against a target of 9.4%. Detoxification was offered to drug and alcohol misusers. However, substance misuse detoxification did not begin until the day after reception, and the only regime available was not suitable for those who were severely dependent. The prison had no methadone maintenance options, even for those maintained in the community, but psychosocial support was improving. Detoxification arrangements were due to develop with the imminent introduction of the integrated drug treatment system. Links with drug intervention programmes (DIPs) were good.

HP16 The regime for vulnerable prisoners, mainly held on D wing, was reasonable. Work and education were provided, and staff-prisoner relationships were good. Prisoners there felt safe, although the wing was used as a thoroughfare for other prisoners. This impacted on the D wing regime, and was potentially intimidating for vulnerable prisoners. The overspill arrangements to hold vulnerable prisoners on A and E wings meant they had a poor regime, and those on E wing also experienced regular verbal intimidation.

HP17 There were approximately 180 young adults, about half concentrated on C wing. There was little formal recognition or provision for this group, despite their disproportionate experience of bullying, use of force, ACCT and adjudications. Young adults expressed negative perceptions about their treatment compared to adults across a range of issues. The needs of younger prisoners were overlooked, and the establishment needed to consider them more actively in its strategies.

Respect

HP18 The good quality accommodation and environment in the newer parts of the prison contrasted with poor quality accommodation elsewhere, in particular on B and C wings. The provision of clothing and bedding were poor. Staff-prisoner relationships were also poorer on these wings, as were young adult prisoners' perceptions of relationships with staff. A new personal officer scheme was not yet embedded into practice. There was some good work on race and diversity and in support of foreign nationals, but these needed further development. The management of prisoner complaints required substantial improvement. Healthcare provision was generally satisfactory, although the quality of regime for inpatients was limited and mental health provision lacked effectiveness. Overall, the prison was not performing sufficiently well against the healthy prison test.

HP19 There was a clear disparity in the quality of accommodation. B and C wings in particular had poor facilities, with mould in some cells, showers that often did not work, and limited screening of toilets in some shared cells. Accommodation on E, F and G wings, the newer parts of the prison, and to a certain extent D wing, was better. These had larger, cleaner cells on brighter, cleaner units. Prisoners had opportunities to wear their own clothes, but arrangements for the issue of prison kit were very poor. At the time of our inspection, many prisoners had not had clean bedding and clothes for three weeks. There were sufficient telephones on each wing to meet prisoner needs, although, in the main, availability was limited to association periods, and prisoners complained about lack of access.

HP20 The incentives and earned privileges (IEP) scheme was well publicised and offered meaningful incentives. It was based on a system of 'red entries' or warnings in wing files. A set number triggered an IEP review. In our view, many red entries were petty. The removal of in-cell power and all association for prisoners on basic regime was also punitive. In our survey, young adults were extremely negative about the fairness of the IEP scheme. Only 5% of young adults were on enhanced level compared to 22.5% of adults.

HP21 There were also disparities in the quality of relationships between staff and prisoners. In our survey, only 32% of young adults on C wing said they were treated with respect, significantly lower than the comparator of 68%. There were similar significant

disparities between those on B and C wings and those elsewhere. We observed that relationships on E, F and G wings, and also D wing, were constructive and respectful. Staff often referred to prisoners in stereotypical terms, expressing low expectations of young adults in particular. This did not encourage positive engagement.

HP22 A new personal officer policy had been introduced in June 2007 and had not yet become embedded in practice. Many staff entries in wing files were limited to issues of compliance rather than a rounded appreciation of individuals, although the quality was better on D and G wings. There were no links between the personal officer scheme and sentence planning.

HP23 The prison's kitchen was clean and well ordered, although flooring in the food preparation area needed repair. The pre-select menu suggested that meals were healthy, varied and balanced. However, the quality of food was affected because it remained in heated trolleys, often for up to three hours, before it was served to prisoners. Food comment books recorded many complaints, many of which had not been replied to. However, in our survey, more respondents than the comparator thought the food at Chelmsford was good.

HP24 The prison shop was provided in-house and a bagging system was used to deliver orders. Prisoners could use the shop service the day after their arrival. In our survey, however, only 29% of respondents thought the shop sold a wide enough range of products, significantly lower than the comparator of 43%.

HP25 Approximately 30% of Chelmsford's population were from black or minority ethnic backgrounds. Race equality structures were stretched. The race equality officer was only part-time, which meant that the diversity manager was routinely drawn into day-to-day issues. The structures were also not underpinned by a strategy to oversee delivery. Prisoner representatives were effective, but there was no effective consultation forum for black and minority ethnic prisoners. There were concerns about a lack of cultural awareness by some staff. The investigation of racist incident complaints was mostly satisfactory, although some needed to be completed more expeditiously.

HP26 Chelmsford held 150 foreign national prisoners. Nine were held solely on detention orders after their sentences had expired. One foreign nationals clerk managed a huge caseload, which restricted proactive and one-to-one work. Prisoner representatives and consultative forums were underdeveloped. However, some prisoners received legal advice from the Refugee Legal Centre, and there had been considerable effort to provide translation through appropriate software in laptop computers in key areas. However, there was no underpinning strategy to promote or coordinate these services.

HP27 Prisoners surveyed had poor perceptions and little confidence in the way applications and complaints were dealt with. Our own observations indicated that, while administrative procedures to manage complaints were satisfactory, many complaints, particularly on complex issues, were not completed properly or were delayed. Some answers to complaints were also poor, some unacceptably so. Prisoner complaints related to staff were not investigated thoroughly, and were not monitored by senior managers.

HP28 The full-time coordinating chaplain was a recently appointed Muslim chaplain supported by part-time and sessional chaplains from other faiths. All faith services

took place in the multi-faith room, which was a small and poor facility. The chaplaincy was well integrated into the life of the prison and contributed through a variety of faith-based courses and support services.

HP29 Health services were provided from an excellent new facility. Staff were working hard to provide a decent standard of care. Access to a GP was satisfactory and dental services were good. However, opportunities to provide health promotion advice were missed. Prisoner perceptions of health services were poor, and significantly worse than those from similar establishments. Prisoners with severe mental illness were not offered integrated and multidisciplinary treatment and care. We were particularly concerned about the paucity of routine and general interaction, and the lack of therapeutic input for inpatients, together with inappropriate use of strip clothing and CCTV for patients under constant observation.

Purposeful activity

HP30 There had been a significant increase in resources for learning and skills, but improvement in the quality of service had been slow. Coordination and planning of learning, as well as quality improvement initiatives, were underdeveloped. The teaching observed in classes was mainly satisfactory, but some was inadequate. While levels of achievement in literacy and numeracy were satisfactory, other education courses were often too long for prisoners to complete before they left the prison. Prisoners acquired good practical skills in most workshops, but there were very few opportunities to gain accreditation for them. A significant proportion of prisoners were involved in wing activities with little or no training element. Overall, far too many prisoners – almost a third of the population – were unemployed. The library was poorly stocked, and prisoner access poor. The quality of physical education was good, and the amount of time prisoners spent out of their cells was reasonable. The prison was not performing sufficiently well against this healthy prison test.

HP31 Resources for learning and skills had increased, with a rise in provision from 167 hours to 432 hours a week over the last two years. However, development had been slow, not helped by difficulties in the recruitment of qualified staff. There was poor collation and use of data in planning provision to meet prisoners' needs. For example, there had been no readily available data on learner achievement before the new contractor, Milton Keynes College, took over responsibility for learning and skills in August 2006. Quality improvement was underdeveloped. There was routine over-allocation of prisoners to some classes. Prisoners were allocated to activity without sufficient consideration of their needs, and learning provision lacked cohesion.

HP32 There had been some satisfactory levels of achievement in literacy and numeracy, and personal and social development programmes. These programmes catered for around 100 prisoners, but take-up of some classes was very low. The quality of teaching was generally satisfactory, but in some cases inadequate. There were good initiatives to support prisoners with specific learning difficulties and to promote diversity to learners. The resources and facilities for learning were satisfactory, with a newly built education and vocational workshop block.

HP33 There was good development of learners' practical skills in vocational training and workshops. There was some systematic training and practical learning, but the development of accredited employability training had been slow. Around 100

prisoners participated in these activities, but few had the opportunity for their practical skills to be accredited. Nearly 200 prisoners were involved in wing or similar activities with little or no training element. Significantly, over 200 prisoners, 31% of the population, were unemployed.

HP34 The library failed to meet the needs of the prison effectively. Stock was insufficient, and prisoner access was poor. Links to the learning and skills provider were also weak.

HP35 The gym offered a very good range of recreational PE and accredited programmes and was performing well, despite the disruption of some building work to extend the facilities. Prisoners could typically access the gym at least twice a week. The PE department had good and supportive links with healthcare staff.

HP36 There were transparent arrangements to record prisoners' time out of cell, with a reported outturn of about nine hours per day per prisoner. However, a qualitative analysis during our inspection indicated that a typical prisoner was more likely to spend between 3.5 and 7.5 hours out of cell, although this varied greatly between individuals. There was variation in each wing's own core routine, from which individual wings deviated routinely. This was a particular issue on B and C wings. The prison also had regular difficulty in reconciling its roll checks, which also affected time out of cell. Most prisoners had daily access to exercise and association, which was rarely cancelled.

Resettlement

HP37 The prison had good structures and governance arrangements to manage resettlement, but its resettlement strategy did not reflect much of the good work taking place. The coordination of, and outcomes from, the seven resettlement pathways were good, as was the provision of offender management. There was no formal custody planning for remand or short-term prisoners, but the 'custody passport' initiative ensured that all prisoners received some constructive engagement and were directed to support services. Chelmsford was performing reasonably well against this healthy prison test.

HP38 The prison's resettlement strategy document had been recently reviewed and republished. However, while it represented the establishment's intent, it did not reflect current initiatives or good practice. The strategy made little mention of interfaces with offender management or the work on pathways or with partner agencies. Nevertheless, prisoners were provided with a good service informed by a comprehensive annual needs analysis and managed by a resettlement committee that was focused on strategy and monitoring outcomes.

HP39 There was a separate offender management unit with a group of full-time offender supervisors. Seventy-one prisoners were in scope of national offender management arrangements. Links between offender management and the wings needed further development. Sentence planning boards were held regularly and prisoners were consulted about their plans and targets. There had been an increase in the number of completed offender assessment system (OASys) reports in the previous 12 months. The quality of these reports was generally very good and included consultation with prisoners. The basic needs of short-term and unconvicted prisoners were addressed

through a 'custody passport' system that sought to connect prisoners with support for their immediate resettlement needs. There was, however, no formal custody planning for short-term prisoners.

HP40 The prison held 19 life-sentenced prisoners and 27 serving indeterminate sentences for public protection (IPP). Some lifers had been held at Chelmsford for a considerable time, and a number of IPP prisoners were approaching, and in one case had exceeded, their tariff. The prison did what it could to support lifers pending their allocation to lifer centres, and there were trained officers on each wing. Monthly lifer meetings had been established and there was a quarterly newsletter. Assessments and all lifer documentation and administration were managed satisfactorily.

HP41 Prisoners had good access to specialist housing and accommodation services, mainly through Nacro or the De Paul Trust (for those under 25). Services were well promoted, and there were regular housing clinics. Comparatively few prisoners were discharged from Chelmsford without accommodation.

HP42 Support for prisoners with finance, benefits and debt problems was reasonable. New arrivals were assisted in closing down agreements to prevent debt accumulation, and specialist advice was available from Nacro and Jobcentre Plus. The Foundation Training Company also provided money management modules on its resettlement programme, and there were plans to introduce a debt management course.

HP43 On the education, training and employment pathway, good pre-release employability training was provided by the Foundation Training Company, which was well structured and helped meet individual needs. There were also initiatives to refer prisoners to specialist agencies on release. The pre-release resettlement clinic for prisoners provided some help in this area. Construction training had been recently introduced, in line with skills shortages in the region.

HP44 There was little work to advise prisoners generally how to access health services upon release. However, where a specific health-related resettlement need was identified, there was effective liaison between healthcare and other departments supporting resettlement. Links between the mental health team and local community teams were satisfactory.

HP45 The prison had a comprehensive drug and alcohol strategy, but needed to update its drugs needs analysis. Staff had a high degree of commitment to the imminent implementation of the integrated drug treatment system (IDTS). This would integrate health services more effectively with the counselling, assessment, referral, advice and throughcare (CARAT) service, and develop much-needed expertise in dual-diagnosis for substance misusers. CARATs had already introduced some IDTS groupwork modules and managed an active caseload of 289, including 75 young adults. The prison had good links to the local drug intervention programme. The prison–addressing substance related offending (P-ASRO) drug intervention programme was also provided successfully. Voluntary drug testing was available for all prisoners regardless of their location.

HP46 The recently opened visitor centre and visits room facilities had improved visits. The visitor centre was managed well by an independent charity. Improved IT had speeded up the visits booking process. The visits room also included a crèche staffed by volunteers, but this was only open on Saturdays. Initiatives to support families

included parenting courses, children's visits and, creatively, a homework club for children and fathers.

HP47 There was a range of interventions to address prisoners' attitudes and behaviour, including the accredited enhanced thinking skills (ETS) and P-ASRO programmes. There was also work with sex offenders to prepare them for sex offender treatment programme (SOTP) referral, as well as pre-assessments for controlling anger and learning to manage it (CALM).

Main recommendations

HP48 Reception and induction arrangements should ensure that vulnerable prisoners are held safely, and have equal access to support and services.

HP49 Trained Listeners and Insiders should be available in reception.

HP50 Strip conditions and CCTV coverage should only be used in exceptional circumstances to manage prisoners at serious risk of self-harm, and only when other methods of direct and constant engagement and support have been tried, and failed.

HP51 The prison should introduce strategies to reduce bullying and fighting, in particular among young adults.

HP52 Force should be used by staff against prisoners only as a last resort, when all other courses of action have been explored and ruled out.

HP53 The provision of kit for prisoners should be improved with access to kit exchange for all at least once a week.

HP54 Complaints should be fully investigated and resolved appropriately and within agreed timescales.

HP55 The prison should increase the amount of appropriate activity, particularly accredited activity.

HP56 There should be a full needs assessment of the young adult population, and the results of this should inform local policies, regimes and the delivery of interventions. Young adult prisoners should be involved in this process.

HP57 Patients with mental health problems should receive the full range of appropriate multidisciplinary treatment and care as set out in National Institute for Health and Clinical Excellence (NICE) guidelines.

Section 1: Arrival in custody

Courts, escorts and transfers

Expected outcomes:
Prisoners travel in safe, decent conditions to and from court and between prisons. During movement prisoners' individual needs are recognised and given proper attention.

1.1 There was a significant number of prisoner movements through the prison each day. The escort vans were clean and in good condition, and escort staff treated prisoners with respect. Late arrivals affected reception and first night procedures.

1.2 Chelmsford received prisoners from a wide catchment area, which included 19 courts in Greater London and Essex. As a consequence, there was a significant number of prisoner movements through the prison each day. SERCO was the contracted escort company. The vans we inspected were approximately three years old and were clean and in good condition. In our survey, 64% of adult respondents said they had felt safe on journeys in escort vans, and 71% that escort staff treated them well, but respective responses from young adults were only 42% and 50%. The escort staff we observed treated prisoners with respect.

1.3 Arrivals after 8pm were common, and this affected reception and first night procedures. Prisoners were only allowed to disembark from the van one at a time when the relevant paperwork and computer entries had been completed. This meant a further delay for prisoners who had already spent a considerable time waiting to be transported from court and then travelling to the prison. Prisoners found this frustrating and we heard some shouting and kicking at the doors of the van while they waited to get off. When several vans arrived at the same time, SERCO staff waited in reception. This made the area crowded and affected confidentiality.

1.4 The prison had an impressive new video facility with two court links and four additional booths for contact with legal advisers, lawyers and other agencies. On average, there were approximately 25 video court appearances a week and a similar number of interviews with external agencies. The capacity increased court appearances and there were efforts to increase take-up from court users and reduce movements through reception.

Recommendations

1.5 Prisoners should arrive at the prison before 7pm to ensure that appropriate induction and first night processes can take place.

1.6 Prisoners should be allowed to disembark from cellular vehicles and wait in holding rooms before they are processed.

1.7 Escort staff should wait with prisoners in vans rather than in reception.

First days in custody

Expected outcomes:
Prisoners feel safe on their reception into prison and for the first few days. Their individual needs, both during and after custody, are identified and plans developed to provide help. During a prisoner's induction into the prison he/she is made aware of prison routines, how to access available services and how to cope with imprisonment.

1.8 Reception facilities had improved since our last inspection and were generally efficient, but there were no Listeners in the area and Listeners were not available to new arrivals after 8.30pm. Assessment was good and included input from healthcare staff. Prisoners were often delayed in their location to wings. All new arrivals spent their first night on a dedicated first night wing. Induction lasted only one day, but appeared efficient and appropriate. Vulnerable prisoners experienced inferior and potentially unsafe induction arrangements.

Reception

1.9 Reception facilities had improved since our last inspection. There was a large reception area, which was bright, clean and suitable for prisoners who used wheelchairs or had mobility difficulties.

1.10 Reception processes were efficient. Staff treated prisoners with consideration. They photographed and digitally fingerprinted them and gave them an identity card and a rub down search. New arrivals were asked if they had been to prison before. There were six holding rooms, which enabled adults, young adults and vulnerable prisoners to be held separately. However, the holding cell for vulnerable prisoners was in view of other prisoners collecting meals from the servery in reception. There were TVs in the holding rooms, but the only reading material was the induction pack. The prison had recently invested in laptop facilities to translate text into a range of languages to assist prisoners whose first language was not English. Staff also used a telephone translation service to communicate with prisoners.

1.11 Reception was busy and averaged 60 movements a day plus 10 new receptions. Processes were well organised. After they had waited in a holding room, prisoners were strip searched by two staff in cubicles that were screened off. A shower was available, but was not routinely offered to prisoners. Prisoners were issued with prison clothing and a kit pack if they were new to the prison, and a smoker's or non-smoker's pack. They saw a nurse, reception staff and a first night officer, and staff completed a cell sharing risk assessment and an assessment of prisoners' emotional wellbeing. Induction booklets, available in 10 languages, were also distributed. There was a servery in reception and prisoners could get a hot meal on arrival and their breakfast pack for the following day. However, after the necessary paperwork had been completed, prisoners often had to wait for some time in the holding rooms for staff to take them to the wings.

1.12 There were no Insiders or Listeners in the reception area to support prisoners, despite a previous recommendation in a death in custody report about this (see paragraph 3.26).

1.13 Although prisoners were given a personal identification telephone number (PIN) in reception, these were not activated until the following morning and they were often unable to contact their family and friends when they arrived. In our survey, 42% of adults said they had had problems contacting their family when they first arrived, against the comparator of 30%, and only 31%

had been able to have a free telephone call, against 52%. The response from young adults on a free call was 21% against a comparator of 71%. These difficulties were further compounded for prisoners subject to security restrictions, whose PIN was not activated until their security clearance check had been completed.

1.14 Prisoners who went to court ate their breakfast pack on the wing. They had no difficulty in accessing their stored clothing, which could be washed in advance.

First night

1.15 Under an induction policy, signed off in early 2007, all new arrivals spent their first night on E wing. E wing had good facilities, cells were clean and comfortable, and staff were welcoming. However, there was no contingency when location on E wing was not possible. On one night during the inspection, several staff told us that a new arrival had to be located on G wing instead, due to occupancy issues and staff inexperience. This was a concern given that first night resources were concentrated on E wing.

1.16 There were six trained first night officers who interviewed prisoners on reception and were detailed to E wing from Monday to Saturday. This provided continuity for new arrivals. E wing had two Insiders, who gave new arrivals a hot drink and an induction pack while they waited to be located in a cell. There was a new induction waiting room where new arrivals could meet Insiders and watch an informative DVD. The Insiders were currently not available after 8.30pm, but new arrivals could use a Samaritans telephone and were encouraged by first night staff to ring their cell bell if they felt vulnerable. Despite these arrangements, in our survey, only 33% of adult respondents said they had received support for managing feelings of depression or suicide on their day of arrival, against a comparator of 42%.

1.17 If prisoners arrived after 8pm, they were not usually offered a shower until the following day. Only 11% of adult survey respondents, against the comparator of 34%, and only 13% of young adults, against a comparator of 41%, said they were able to have a shower on their day of arrival.

1.18 Vulnerable prisoners were also located on E wing on their first night. While this arrangement provided consistency for the first night and induction experience, it failed to ensure the safety of vulnerable prisoners. We overheard verbal abuse and also spoke with one vulnerable prisoner who had been verbally intimidated on his arrival and during the night.

Induction

1.19 The induction programme took only one day to complete. In the morning, there were group sessions from E wing staff about prison rules, regimes, work and education opportunities, visits and the incentives and earned privileges scheme. Prisoners could ask questions, and the content was relevant and appropriate. In the afternoon, prisoners got individual advice from various agencies, including Nacro, Jobcentre Plus, and prison-based staff from departments such as probation, legal services, Insiders, the chaplaincy and counselling, assessment, referral, advice and throughcare (CARAT) service. This took place in an informal setting. During this process, an induction passport was completed, which recorded any areas that needed to be addressed while the prisoner was in custody.

1.20 Vulnerable prisoners were inducted separately from mainstream prisoners. Overall, their induction was inferior, and they often spent long periods locked up on the day following their arrival, due to the fact that they could not mix with other prisoners.

1.21 Following completion of the induction programme, prisoners were usually allocated to a wing within 48 hours of their arrival.

Recommendations

1.22 Insiders should be available to speak to new arrivals on the first night wing after 8.30pm.

1.23 Prisoners should be able to make a free telephone call on their day of arrival.

1.24 Prisoners should be able to have a shower on their day of arrival.

1.25 There should be clear contingency arrangements to cover the location of new arrivals when E wing spaces are unavailable.

1.26 The induction policy should include induction for vulnerable prisoners.

Section 2: Environment and relationships

Residential units

Expected outcomes:
Prisoners live in a safe, clean and decent environment within which they are encouraged to take personal responsibility for themselves and their possessions.

2.1 The residential units, including shower and toilet facilities, in the older part of the prison were poor, but the newer wings were of a higher standard. Prisoners did not have the option to dine in association. Kit issue had been poorly managed for several months and shortages were common. Prisoner consultative arrangements were effective.

Accommodation and facilities

2.2 Accommodation was provided in A-D wings in the older part of the prison and in more modern facilities in E, F and G wings. G wing had been operational for only six months and was in excellent condition. A wing housed the segregation unit, some key workers and was also an overspill for the vulnerable prisoner wing. B wing was largely for unemployed and remand prisoners. C wing accommodated young adults. Vulnerable prisoners were accommodated on D wing. E wing was the first night and induction centre and held prisoners on voluntary drug testing, and adult workers were located on F and G wings.

2.3 All cells had a notice board, bed or double bunk, locker and in-cell sanitation. The provision of tables and chairs was inconsistent. Prisoners on standard and enhanced regimes could have a television in cell. Although kettles were provided they were not available in all cells due to a shortage. The quality of the general fabric was poor. Cupboards could not be locked and were often in a poor state. Toilets in shared cells were not appropriately screened or sited in a separate area. We also saw an example where a prisoner's toilet had been blocked for 48 hours. There was curtain screening in some cells, but this was not sufficient to safeguard prisoners' dignity. Some cells in the older wings were dark, had damp and mould or required redecoration and refurbishment. Cells on the newer E, F and G wings were brighter, in better condition and of a higher standard. G wing had facilities for disabled prisoners, including modified cells and showers.

2.4 Prisoners could not dine in association and ate meals in their cells. Cell bells were tested regularly and wing logs evidenced this. We observed that cell bells were responded to quickly, although in our survey only 9% of young adult respondents said their cell bell was answered within five minutes, against a comparator of 43%.

2.5 Telephones were available on all wings, with a ratio of one telephone to 22 prisoners on the larger wings, which was close to our expectation of one to 20. The ratio was higher on F and G wings.

2.6 Recreation facilities such as table football, pool, table tennis and board games were available on all wings, although some equipment needed repair or replacement.

2.7 A governor's order on the display of offensive material had been published in May 2007. The policy was adhered to in the cells we inspected.

2.8 Each wing had its own core day regime that reflected its specific population. Wings had a period for showers, telephone calls and cell cleaning before core day activities commenced. Periods for association and exercise were generally adhered to, although could be affected by late roll reconciliation (see also paragraph 5.40).

2.9 Communication between prisoners and the establishment was effective. Prisoner consultative groups were held monthly and were well attended by prisoner representatives from each wing. The governor or deputy governor chaired the meeting and prisoners were able to air their concerns. All wings had recently been fitted with large notice boards, which enabled a considerable amount of material to be displayed effectively.

Clothing and possessions

2.10 There had been problems with kit management, and staff and prisoners confirmed that there had been no kit changes in the three weeks before our inspection. In our survey, only 63% of adult respondents said they were able to receive clean sheets every week, against the comparator of 84%, and only 45% said they received sufficient clean clothes for the week, against 53%. (See main recommendation HP53.)

2.11 In June 2007, the prison had decided that all prisoners could wear their own clothes, but there had been some difficulties with clothes handed in on visits and the benefits of this decision had yet to be realised. There were washing machines and driers on F and G wings, and additional equipment was due to be installed.

Hygiene

2.12 Communal areas on all wings were clean and prisoners reported no problems in accessing cleaning materials, which were readily available. Shower facilities in the newer wings were reasonable, although only G wing had showers that were individually screened. Shower provision was poor on the older wings, with poor water flow, cold water and lack of privacy screening. In our survey, 85% of adult respondents said they could shower every day, against the comparator of 74%.

Recommendations

2.13 There should be new shower facilities on B, C and D wings.

2.14 Cells with toilets not in a separate area should not be used for double occupancy.

2.15 Toilets in shared cells should have fixed privacy screening and should be kept in good repair.

2.16 Prisoners should be able to have kettles or flasks in their cells.

2.17 Furniture in cells should be fit for purpose and a locked cupboard should be provided.

2.18 Cells should be well maintained and in a good state of repair.

2.19 The prison should ensure that prisoners and visitors are clear about the processes for handing in changes of clothing.

2.20 Recreational facilities for prisoners should be maintained and replaced when required.

2.21 Prisoners should be able to dine in association.

Staff-prisoner relationships

Expected outcomes:
Prisoners are treated respectfully by all staff, throughout the duration of their custodial sentence, and are encouraged to take responsibility for their own actions and decisions. Healthy prisons should demonstrate a well-ordered environment in which the requirements of security, control and justice are balanced and in which all members of the prison community are safe and treated with fairness.

2.22 Staff-prisoner relationships varied between different parts of the prison and between adults and young adults. Relationships were positive and respectful in the newer parts, but less so on B and C wings. Staff had low expectations of young adults, which did not encourage better relationships.

2.23 Staff-prisoner relationships at Chelmsford were complex. They varied between the two principal prisoner groups – adults and young adults – and in the different parts of the establishment, the older and the newly built wings. In our survey, 78% of adult respondents said that staff treated them with respect, which was higher than the comparator of 68%. However, only 55% of respondents on B and C wings felt that staff treated them with respect. Similarly, 69% said they knew a member of staff they could turn to if they had a problem, which was also higher than the 63% comparator. However, the young adult response to the question on respectful staff treatment was only 32%, significantly below the young adult comparator of 68%, and only 32%, against the comparator of 69%, said there was a member of staff they could turn to for help. Under-21s had significantly worse perceptions of staff-prisoner relationships, particularly victimisation by staff.

2.24 Prisoners' views in our discussion groups were mixed. In one comprised of prisoners from E, F and G wings, prisoners spoke positively about staff when pressed, but some were also keen to report previous negative experiences on B wing. Other groups were more ambivalent and remarked on perceived staff inconsistency, unreliability and laziness, for example in dealing with applications or complaints. These mixed findings were generally consistent with those of a recent measuring the quality of prison life (MQPL) survey of February 2007, in which the prison scored poorly and prisoners were negative about staff-prisoner relationships.

2.25 Our observations were that staff-prisoner relationships were good in the newer parts of the prison (E, F and G wings) and also on D wing and in the segregation unit. Here relationships were positive, constructive and respectful, and were better than on B and C wings. However, although respectful, relationships on these wings were generally formal. We rarely saw staff in wing offices, but casual friendly engagement was also infrequent. For example, staff stood apart from prisoners on association or when they supervised exercise.

2.26 Staff often expressed stereotypical views about prisoners, and there were low expectations of prisoners in general, but young adult prisoners in particular. This did not encourage pro-social behaviour.

Recommendations

2.27 The prison should develop a programme of regular discussion forums and surveys to obtain a more informed view of prisoner opinion.

2.28 There should be training to improve staff work with young people.

2.29 Managers should monitor staff-prisoner relationships in all wings, as evidenced in documentation and interactions, in order to ensure consistency and best practice.

Personal officers

Expected outcomes:
Prisoners' relationships with their personal officers are based on mutual respect, high expectations and support.

2.30 The personal officer scheme had recently been relaunched, but had not yet become embedded into practice. Wing history sheets reflected varied engagement across the prison. Many entries focused on prisoners' compliance and behaviour and had yet to make links with sentence planning arrangements.

2.31 A new personal officer policy had recently been relaunched, and a comprehensive pocket guide for staff had also been developed and distributed. However, the new policy had not yet had the opportunity to become embedded into practice. Nevertheless, in our survey, 38% of adult respondents said their personal officer was helpful, against a comparator of 21%.

2.32 Personal officers were assigned a number of cells with a named back-up personal officer. There was some inconsistency about whether the name of the prisoner's personal officer was indicated outside their cell.

2.33 Under the new scheme, quality entries were expected to be made on the prisoner's wing history sheet every two weeks. Personal officer entries in the wing files we inspected were inconsistent on most wings. Most entries reflected a distance between staff and prisoners, and comments largely related to behaviour or compliance with the prison regime. There was little awareness of prisoners' circumstances or their sentence plans for those covered by offender management. Entries on files in D and G wings were more substantive, which reflected better quality staff-prisoner relationships. Wing managers generally undertook management checks, and in several files noted the lack of information or frequency of entries. (See also paragraph 3.6 on bullying.)

Recommendation

2.34 The new personal officer scheme should be supported by staff briefings about the requirements of the new policy to ensure personal officers are aware of their role and responsibilities.

Section 3: Duty of care

Bullying and violence reduction

Expected outcomes:
Everyone feels safe from bullying and victimisation (which includes verbal and racial abuse, theft, threats of violence and assault). Active and fair systems to prevent and respond to violence and intimidation are known to staff, prisoners and visitors, and inform all aspects of the regime.

3.1 A significant number of prisoners felt unsafe at Chelmsford. Bullying was a serious problem among the young adult population. The recently appointed anti-bullying coordinator had improved procedures for identifying bullying and the standard of investigations, but there was still some under-reporting of incidents. Improvement targets for bullies were weak, relevant information had not been cross-referred into wing history files, and arrangements for victims were poor. Valuable property was not routinely security marked.

3.2 There was a published violence reduction and anti-bullying policy. This area was the responsibility of the safer custody team (SCT), which met monthly (see paragraph 3.20). There was a full-time violence reduction and anti-bullying coordinator, who was a prison officer. He had been in post for just over three months, and had adequate cover arrangements. The coordinator provided detailed information to the SCT on fights, assaults and use of force incidents, but this was not in a format that could be easily used to identify emerging trends.

3.3 The coordinator had recently held a prisoner forum, which had generated some useful findings, and undertaken a survey, which was waiting analysis. Violence reduction was also an agenda item at senior management team meetings. The SCT had recognised a particular problem with prisoners being bullied into ordering specific items from the prison shop for others. As a result, it had changed the way order forms were issued to reduce opportunities for such bullying. Our survey findings indicated that bullying for canteen was a serious problem among young adults – 17% of young adult respondents, against the comparator of just 5%, reported that other prisoners at Chelmsford had taken canteen or property from them.

3.4 Although our survey findings relating to safety were mixed, it was a concern that 43% of adult and 39% of young adult respondents said that they currently felt unsafe in the establishment. These figures were significantly worse that the comparators of 20% for both groups.

3.5 Since the start of 2007, 150 anti-bullying documents had been opened, 95 on young adults. This was a disproportionately high number for this population. All of the 15 anti-bullying documents open at the time of inspection concerned young adults. Staff on C wing, which had the largest population of young adults, told us that bullying was a serious problem among this age group. This was confirmed by our own observations and conversations with prisoner groups, although findings in our safety surveys were inconclusive. We also looked at the number of alarm bells activated in the first five months of 2007. This totalled 179, of which 23.5% were on C wing. The level of assaults, however, was more reflective of the population split – of the 73 prisoners charged with assault since the start of 2007, 46 were adults and 27 young adults.

3.6 The coordinator had worked hard to implement good systems for identifying possible bullying incidents from security information reports (SIRs), injury to inmate forms (F213s), adjudications and complaint forms. However, arrangements to identify relevant information from wing observation books were underdeveloped. We found several bullying incidents that had not been reported to the coordinator. Alleged bullying incidents had previously been investigated by wing senior officers, and the quality and timeliness of these investigations had been variable. The coordinator had taken over responsibility for completing investigations, which had brought about consistency and improvement.

3.7 Information about the anti-bullying strategy and violence reduction was explained in the induction programme and included in the guide issued to all new arrivals. Relevant information was also well publicised in all wings through standard notices.

3.8 The anti-bullying strategy was based on three levels. Under stage one, the suspected bully was advised that he would be monitored for 14 days. A move to another landing was considered, and a review set at the end of the monitoring period. On stage two, a proven bully was placed on basic regime for 28 days and subject to further monitoring. There was a further review of his location, and a seven-day review was scheduled. Persistent bullies were placed on stage three, which meant a period in the segregation unit. Stage three bullies were reviewed after 72 hours. All prisoners subject to anti-bullying monitoring were set improvement targets, although some of these were meaningless. We saw examples where suspected bullies were set just one target, such as 'not to bully or tax other individuals'.

3.9 Information from anti-bullying incidents was not routinely cross-referenced into wing history files. There was little evidence that victim support plans were devised, as outlined in the policy. There were also no interventions for persistent bullies other than one-to-one work with psychology staff, although we saw no evidence that this was routinely considered. Valuable items, such as CD players, were not routinely security marked. This would have assisted staff searching cells to know that the occupants possessed only their own property.

Recommendations

3.10 The data provided to the safer custody team should enable emerging trends to be easily identified.

3.11 The establishment should investigate the reasons for the significant number of prisoners reporting that they feel unsafe at Chelmsford, and put in place arrangements to improve this.

3.12 All alleged incidents of bullying should be reported and investigated, and entries in wing observation books should be regularly checked for any indications of bullying.

3.13 Improvement targets set in anti-bullying monitoring should be better quality and relevant to the prisoner.

3.14 Persistent bullies should be referred to the psychology department for one-to-one intervention, and the establishment should also seek to establish other types of interventions for bullies.

3.15 Information relating to bullies and victims should be cross-referenced into wing history files.

3.16 There should be support plans for victims of bullying.

Housekeeping point

3.17 Valuable items, such as radios and CD players, should be security marked.

Self-harm and suicide

Expected outcomes:
Prisons work to reduce the risks of self-harm and suicide through a whole-prison approach. Prisoners at risk of self-harm or suicide are identified at an early stage, and a care and support plan is drawn up, implemented and monitored. Prisoners who have been identified as vulnerable are encouraged to participate in all purposeful activity. All staff are aware of and alert to vulnerability issues, are appropriately trained and have access to proper equipment and support.

3.18 Despite previous recommendations, Listeners and Insiders were not available in reception, although this was rectified during the inspection. Overall access to Listeners was generally poor. Initial self-harm monitoring assessor reports lacked detail, and there were insufficient monitoring entries that demonstrated positive engagement by staff. There was, however, evidence of a multidisciplinary approach to the management of prisoners on open documents. Prisoners in healthcare were placed in strip clothing solely to prevent acts of self-harm, and constantly supervised through in-cell CCTV, which were both inappropriate. The suicide prevention coordinator provided good monitoring data for the safer custody meetings, and the support group for prisoners on self-harm monitoring was good practice.

3.19 The establishment's suicide and self-harm policy had been last updated in September 2006. The policy document was comprehensive. It fully explained the responsibilities of staff and provided guidance on all areas relating to assessment, care in custody and teamwork (ACCT) self-harm monitoring documents and the monitoring of prisoners at risk. The policy explained the range of support available in individual cases. It also covered arrangements for notifying supervising officers of any prisoners subject to open ACCT documents before their release from custody.

3.20 All procedures relating to suicide and self-harm were managed through the safer custody team (SCT), which met monthly. Meetings of the SCT were chaired by a residential governor and were attended by staff from key departments, plus representatives from Insiders, Listeners and the local Samaritans.

3.21 A full-time suicide prevention coordinator (SPC), who was a senior officer, had been in post just over a year. There were adequate arrangements to cover her absence. The SPC provided the safer custody team with some good monitoring data, which enabled it to identify emerging trends relating to ACCT documents and self-harm incidents.

3.22 The establishment had introduced the ACCT system in April 2006, by when it had managed to train 100% of staff in the new procedures. New staff were trained in ACCT as part of their induction programme. Information about the role of Listeners and Samaritans was explained on induction, and well publicised around the establishment.

3.23 There were 32 ACCT documents open at the time of inspection, 11 of which related to young adults. A total of 199 ACCT documents had been opened since the start of 2007. Open ACCT documents were reviewed each Thursday, with some wings designated for morning reviews and others in the afternoon. This arrangement meant that staff from other departments could plan their time around any reviews that they needed to attend. Reviews that needed to be scheduled outside these times took place as required.

3.24 In the ACCT documents we reviewed, initial assessor reports generally lacked detail, one had no care map, even though it had allegedly been reviewed that day, and monitoring entries by staff did not always provide sufficient evidence of positive engagement. Although there were exceptions, there was generally a multidisciplinary approach to the management of prisoners at risk. Post-closure reviews were completed and records of these maintained.

3.25 At the time of inspection, there were nine Listeners, all adults. Holds were placed on Listeners wherever possible, and further training courses had been arranged. It was the establishment's policy that adult Listeners could, subject to risk assessment, be used to support young adults, but this was not widely understood by staff. Staff on C wing told us that they would not use an adult Listener, but would offer a Samaritans telephone. There had been ongoing problems with access to Listeners, which had been discussed at safer custody meetings for at least six months. Despite these discussions, the problem remained unresolved. We saw reported incidents where Listeners had not been provided in a timely fashion, particularly when requested during a patrol state. In one case, a Listener had been returned to his cell because it was a patrol period. We also saw an entry in an ACCT document where a prisoner who had requested a Listener had to wait over 2.5 hours, and had to repeat his initial request. Poor access to Listeners was confirmed in our survey, in which only 54% of adult and 35% of young adult respondents said that they were able to speak to a Listener at any time. These findings were significantly worse than the comparators of 63% and 51% respectively.

3.26 We were particularly concerned that Listeners and Insiders were not employed in reception to support new arrivals. This was a specific recommendation from our last report, which the establishment had rejected on the grounds that they were available on E wing, where all new arrivals went for their first night. However, this was not the case. In October 2006, a new prisoner had been placed directly on to C wing, due to population pressures in the establishment, and as a result bypassed many of the safety procedures on E wing. This included support from Insiders and Listeners. Tragically, this prisoner was found dead in his cell having apparently hung himself. Despite this, and another clear recommendation from the Ombudsman in his investigation report into the death that Insiders and Listeners should be available in reception, this was once again rejected by the establishment. The prison's death in custody action plan again stated that all new prisoners went on to E wing, although this was not always the case. We were told of an incident during the inspection where a prisoner on his first night was located directly on to G wing (see paragraph 1.15). The establishment only implemented our original recommendation during the inspection, after we had raised our concerns with them.

3.27 There had been three deaths in custody since the last inspection, and action plans were in place for each of the Ombudsman's investigations. With the exception of the example above, recommendations had been taken forward and there was good monitoring of progress.

3.28 In addition to Samaritans telephones, prisoners could ring the safer custody team free of charge and leave a message on its answer machine. This was a recently introduced initiative and had not yet been used. The safer custody telephone had been available to visitors for some time and was regularly used. There was an answerphone facility and all calls were registered and appropriate follow-up action taken.

3.29 Distraction packs were available to prisoners at risk of self-harm. These included colouring material and puzzles.

3.30 There were cells with reduced risk moulded fixtures and furniture in healthcare, the segregation unit and on G wing. Prisoners in healthcare were routinely placed in strip clothing solely to prevent acts of self-harm, which was inappropriate. We saw four prisoners in healthcare who were on constant observations. Two were closely supervised by a member of staff through the observation flap, with arrangements for a regular change of staff. The other two were monitored from the wing office through an in-cell CCTV system. We were told that the clinical psychiatrist had assessed these prisoners as too manipulative to be suitable for constant watch or engagement. It was apparent that constant monitoring via CCTV was a regular occurrence in healthcare. Such monitoring was inappropriate, as it failed to provide prisoners in crisis with required levels of engagement and support.

3.31 Night staff were aware of the location of prisoners subject to open ACCT forms. All night patrols carried an anti-ligature device in accordance with published instructions. They also carried cell keys in sealed packs and knew the correct action in the event of an attempted suicide.

3.32 The healthcare day centre ran a support group for prisoners on open ACCT documents or others identified as finding it difficult to cope. Referrals could be made through an ACCT review or by any member of staff. This was a valuable forum for prisoners to express their feelings and provide peer support. Relaxation techniques and one-to-one counselling were also available. The day centre also offered an eight-session IT interactive programme, 'beating the blues', designed for those who had anxiety or depression. Prisoners were seen individually after each session, and their responses to the programme were used as a guide to assess their likelihood of self-harm.

Recommendations

3.33 The quality of initial assessment, care in custody and teamwork (ACCT) assessor reports should be significantly improved and regularly monitored, and all ACCT documents should include a care map.

3.34 Staff monitoring entries in ACCT documents should demonstrate a high level of engagement with the prisoner.

3.35 Prisoners should have 24-hour access to Listeners.

3.36 CCTV should not be used as an alternative to observation of and engagement with prisoners at risk of self-harm, whereby staff are on hand to engage with the prisoner and offer individual support.

Good practice

3.37 *The support group for prisoners on open assessment, care in custody and teamwork documents was a valuable forum to discuss their feelings and receive support.*

Diversity

Expected outcomes: All prisoners should have equality of access to all prison facilities. All prisons should be aware of the specific needs of minority groups and implement distinct policies, which aim to represent their views, meet their needs and offer peer support.

3.38 A full-time diversity manager had recently been appointed, and all new arrivals were screened for disabilities. The prison had two adapted cells for those with disabilities.

3.39 A diversity statement had recently been published, backed up by equal opportunities and disabilities policy statements, which set out the aspirations of the establishment in terms of ensuring equality of opportunity and an absence of discrimination.

3.40 A full-time diversity manager had been appointed early in 2007. She was assisted by two disability liaison officers (one for staff and one for prisoners) and an equal opportunities officer.

3.41 Facilities had improved in recent months with the opening of G wing, which contained two cells suitable for disabled prisoners and accessible showers.

3.42 Disability assessments of new arrivals were carried out in reception. The liaison officer saw any prisoner who self-identified as disabled or in need of additional assistance, for example, older prisoners, for a full assessment of need. There was no specific provision for older prisoners, although the numbers over 60 were very low (only 11 at the time of the inspection). The education department undertook good work to identify prisoners with dyslexia (see paragraph 5.5), and the PE department had developed a range of programmes to attract under-represented groups into the gym.

Race equality

Expected outcomes:
All prisoners experience equality of opportunity in all aspects of prison life, are treated equally and are safe. Racial diversity is embraced, valued, promoted and respected.

3.43 Almost a third of the prisoner population were from black and minority ethnic backgrounds, but there were very few black and minority ethnic staff and staff training had not been adequate. There was no meaningful race equality strategy, although there were reasonable systems to oversee race equality. Resources, however, were stretched, which contributed in part to considerable delays in the investigation of racist incident complaints. Black and minority ethnic prisoners complained about a lack of awareness by some staff in contact roles.

Race equality

3.44 Around 30% of prisoners were from black and minority ethnic backgrounds. In contrast, there was only a handful of black and minority ethnic staff in contact roles with prisoners, despite the best efforts of the establishment to recruit staff from such backgrounds. The management support structures to oversee race equality were very stretched. There was a part-time race equality officer (REO), who spent up to three days a week on this work. She was assisted by

two assistant race equality officers. However, these staff only covered the REO's absences and their services could not be guaranteed, due to other staffing pressures. Consequently, the diversity manager was routinely drawn into day-to-day issues that could have been dealt with by other staff. There were no wing-based staff race equality assistants to ease the pressure on current resources.

3.45 There were prisoner diversity representatives around the establishment, whose role was well advertised. However, there was no formal consultation forum for black and minority ethnic prisoners. The race equality action team met monthly, chaired by the deputy governor. This meeting was well attended by all departments, as well as prisoners and community representatives. Despite these structures, there was no effective race equality strategy governing delivery.

3.46 Black and minority ethnic prisoners did not raise specific issues with us about direct discrimination or racist attitudes from staff or other prisoners. They did, however, express concern about some staff's lack of awareness of cultural issues. We saw some examples of this ourselves – for example, we observed an officer telling three black and minority ethnic prisoners sitting on a table to move, while ignoring three white prisoners also sitting on an adjacent table. On another occasion, we overheard racist banter between staff and prisoners during a sports event.

3.47 There had been only limited diversity training for staff in recent months, although a new integrated diversity training package had started to be delivered jointly to some groups of staff and prisoners, simultaneously.

3.48 Black and minority ethnic prisoners also complained about perceived imbalances in the number of successful applications for category D status compared to white prisoners. The establishment had done some work to alleviate concerns about this, although there was scope for further investigative work.

3.49 Our survey showed mixed responses from black and minority ethnic prisoners. In some areas they reported more favourably than white prisoners, for example in their treatment in reception, perceptions about fair treatment in the incentives and earned privileges scheme, and perceived fairness of the complaints systems. However, black and minority ethnic respondents were less favourable than white respondents on a range of issues, including feeling unsafe, use of force and staff victimisation. Nevertheless, 74% of black and minority ethnic respondents said that most staff treated them with respect, broadly in line with the white prisoners' response of 79%.

Managing racist incidents

3.50 Racist incident report forms were freely available in each wing. Most of these were managed appropriately. However, a significant number were not completed because prisoners had transferred or been discharged. Although this was sometimes inevitable, on some occasions there were long delays before the investigations started – often over two weeks – as the REO had been diverted on to other duties. In many cases where prisoners had transferred, although the paperwork had been forwarded to the new establishment, there was no evidence that the complaint had been followed up and investigated appropriately. One such case involved a serious complaint against a member of staff, which had not been investigated.

Race equality duty

3.51 Race impact assessments had been carried out across the required policies and functions. The diversity manager believed that these were variable in their standard, and there were plans to review these as well as provide some training for staff in completing impact assessments.

Recommendations

3.52 A race equality strategy should be developed.

3.53 The race equality officer post should be full-time.

3.54 Assistant race equality officers should be appointed on each wing to assist the race equality officer and act as a first point of contact on the wings on race-related issues. They should have a job description and facility time to carry out their duties.

3.55 Black and minority ethnic prisoner consultation forums should be initiated. Areas where black and minority ethnic prisoners have reported wide variations in perceptions compared with white prisoners should be explored further.

3.56 The race equality action team should monitor successful applications for category D status by ethnicity.

3.57 The innovative integrated diversity training package for staff and prisoners should be delivered to all staff, with priority to those in prisoner contact roles.

3.58 Delays in initiating racist complaints investigations should be reduced.

3.59 If a prisoner has transferred while their racist incident complaint is still outstanding, this should be followed up in all cases and final outcomes of investigations recorded on Chelmsford's racist incident report form log.

Foreign national prisoners

Expected outcomes:
Foreign national prisoners should have the same access to all prison facilities as other prisoners. All prisons are aware of the specific needs that foreign national prisoners have and implement a distinct strategy, which aims to represent their views and offer peer support.

3.60 There was a large number of foreign national prisoners. Some of the facilities and provision for them were good, but because there was no overarching strategy there were inconsistencies in delivery. Resources were extremely stretched.

3.61 There was a large numbers of foreign national prisoners at Chelmsford, with around 150 during the inspection and as many as 180 in recent months, which represented over a quarter of the population. Nine foreign nationals were detained beyond their sentence expiry dates, some for several months.

3.62 There was a foreign nationals coordinator, based in the custody office, who dealt with immigration issues. She had a huge caseload, which had restricted her ability to take an active approach to the role. As this workload had increased over the past 12 months, she had had to adapt her job specification to cope with the greater paperwork. Consequently, she now operated almost exclusively in a liaison role with the Border and Immigration Agency (BIA), with no prisoner contact. The diversity manager now did much of the daily interface work with prisoners. This current level of resources was insufficient, although we were told that additional resources had been approved for this work.

3.63 There was one foreign national prisoner representative, although this was an informal role and he had no formal job description or duties. There were no other identifiable peer supporters for foreign nationals. Many foreign national prisoners we spoke to said that they would welcome recognisable prisoner contacts on every wing. They also expressed a desire to meet their peers informally. The prison made good use of mentors, who were coordinated through the education department, and this role could be extended to include foreign nationals who did not understand English.

3.64 One positive initiative was that representatives from the Refugee Legal Centre (RLC) had recently started to visit Chelmsford to offer immigration advice to foreign national prisoners. They held general surgeries and also saw some prisoners on a one-to-one basis. However, no one from the BIA came to the establishment to meet foreign national prisoners.

3.65 There was no overall strategy to underpin services for foreign nationals or describe their delivery. There was only a brief mission statement. We found an overall lack of awareness by residential staff, as well as prisoners, about the entitlements of foreign national prisoners. For example, there was considerable confusion about the arrangements for foreign nationals to access monthly telephone credits, and not all prisoners entitled to this facility were aware of it or how to apply. We were told that this information was mentioned to foreign nationals during their induction. However, the induction booklet did not cover any provision for foreign nationals. None of the foreign national prisoners we spoke to remembered being told about their entitlements during induction.

3.66 The establishment had done much work to provide information for prisoners who spoke little English. There were touch-screen information points at various sites, including the library, with information in a range of languages. Staff also regularly used a professional telephone translation service. Laptop computers recently purchased for reception and induction staff had software that enabled staff to translate key information.

Recommendations

3.67 An analysis should be undertaken, in conjunction with prisoners, to determine the needs of foreign national prisoners at Chelmsford, and the resources required to deliver services effectively and consistently. This analysis should be the basis for an effective strategy for meeting the needs of foreign national prisoners.

3.68 There should be more resources for the provision of service for foreign national prisoners to enable a more proactive approach to this work.

3.69 Foreign national prisoner representatives should be appointed on every wing. They should have a formal job description and regularly meet the diversity manager and foreign nationals coordinator.

3.70 Prisoner mentors should be identified for prisoners who do not speak English.

3.71 There should be informal drop-in sessions for foreign national prisoners.

3.72 The Border and Immigration Agency should visit the establishment to meet foreign national prisoners and discuss their immigration cases.

3.73 There should be greater awareness among staff and prisoners of entitlements for foreign national prisoners and how to apply for them, and the induction booklet should contain information for foreign national prisoners.

Contact with the outside world

Expected outcomes:
Prisoners are encouraged to maintain contact with the outside world through regular access to mail, telephones and visits.

3.74 Arrangements for mail had recently improved. Access to telephones was poor and could not be guaranteed every day. Facilities for visits had improved considerably with a new visitor centre and visits complex. Staff in the visitor centre provided a good service, but visitors were often delayed by the lengthy search process. There had been no visitor survey. The main visit room was noisy, and the children's play area was usually closed. The number of prisoners on closed visits was high.

Mail

3.75 In our survey, 61% of adults and 78% of young adults said they had experienced problems with sending or receiving mail, significantly worse than the comparators of 44% and 37% respectively. We were told that prisoners' mail had been delayed earlier in 2007 as a result of staff shortages. Following staff reprofiling, there was now a discrete group of staff to improve continuity in the mail room, and at the time of inspection arrangements for processing incoming and outgoing mail were working well.

Telephones

3.76 Most wings had sufficient telephones on an acceptable ratio of one telephone to 20 prisoners. The other wings fell only just short of that ratio. Prisoners could use the telephone during a 30-minute domestic period and during association. Prisoners on B wing, however, did not have evening association routinely, and could only use the telephones at times that were more expensive and less convenient to family and friends. Telephone calls were cut off after eight minutes, and prisoners could not use them again for a set period.

3.77 In our groups, prisoners complained they were not guaranteed daily access to telephones, due to demand. In our survey, 65% of young adult respondents said they had problems in getting access to telephones, which was significantly worse than the comparator of 30%.

Visits

3.78 Visits took place each weekday between 2pm and 4pm, and at weekends between 9.30am and 11.30am and 2.45pm and 4.15pm. During our inspection, the establishment had also introduced an evening visit on Thursdays between 6.30pm and 8pm.

3.79 All domestic and legal visits had to be booked through a telephone line, which was staffed during weekdays only. Scheduled evening and weekend opening times had not been staffed, due to staff shortages, but this had been addressed in the recent staff reprofiling. A new IT system had significantly speeded up the process of repeat bookings. A booking hotline recently installed in the visitor centre allowed visitors to book their next visit free of charge.

3.80 The establishment had opened a new visitor centre and visits complex earlier in 2007. Facilities were excellent and in stark contrast to those reported at our last inspection. The centre was staffed by an independent charity with part-funding from the establishment. There was a centre manager, two other paid staff and a large group of volunteers. Staff in the visitor centre were friendly and helpful. The centre was clean and welcoming, relevant information was publicised, and a multi-media screen provided additional information for visitors. The centre also had a tea bar and children's play area.

3.81 Visitor centre staff explained all necessary arrangements to first-time visitors and gave them an information sheet, which included advice on the search procedure, complaints and sending in property or money. Plans for a visitor survey had been put on hold pending the move to the new facilities, and staff agreed that this was now needed. Staff told us that one frequent problem was that visitors turned up for a booked visit only to find that the prisoner was in court. This happened twice on the day we inspected the centre.

3.82 On arrival at the centre, visitors were checked in, had a biometric check of their thumbprint and were photographed. They were called through to the establishment in small groups based on their time of arrival, and were identified and searched. The search process often resulted in significant delays, which often reduced the length of visits. Drug dogs were regularly deployed to search visitors. A single indication by the drug dog resulted in a closed visit without any further supporting intelligence.

3.83 Unconvicted prisoners were entitled to a visit lasting at least an hour, every day. Convicted prisoners received a minimum of two one-hour visits every 28 days. Those on the standard level of the incentives and earned privilege scheme also had a privilege visit each month; enhanced level prisoners had two privilege visits.

3.84 The main visit room, which had 40 tables, was large and bright but very noisy. The establishment was aware of this problem and was looking at ways to reduce it. There was sufficient space between tables for an acceptable level of privacy. A refreshment bar staffed by volunteers offered drinks and basic snacks, and there were also vending machines. There was a children’s play area staffed by volunteers from the Mothers' Union, but this was only open on Saturdays.

3.85 Prisoners were escorted to visits, searched, placed in a sterile holding room and given a high-visibility vest. Vulnerable prisoners were escorted separately and put on designated tables that could be easily supervised. Visits staff appeared vigilant, were positioned at various points in the room and patrolled regularly. Visits lasted for the full session.

3.86 There was only one closed visit booth, but others were under construction. At the time of inspection, 32 prisoners were subject to closed visits, which was very high. Prisoners were placed on closed visits for three months initially, but reviewed monthly. We were told that the views of residential staff were requested and taken into account, but we were not satisfied that these arrangements took place routinely.

Recommendations

3.87 Prisoners should be able to use telephones on a daily basis, and have increased access during the evening period.

3.88 There should be a visitors' survey to assess their levels of satisfaction with the services.

3.89 Visitors should be notified when a prisoner is not available for a booked visit.

3.90 Entry arrangements should not result in unacceptable delays for visitors.

3.91 A positive indication by a drug dog should only result in a closed visit where there is other supporting intelligence.

3.92 The establishment should attempt to reduce the noise in the main visit room.

3.93 The children's play area in the main visit room should be staffed for all visit sessions.

3.94 Prisoners should be removed from closed visits at the earliest opportunity; reviews should routinely include formal contributions from residential staff.

Housekeeping point

3.95 Publicised opening times for the visits booking line should be adhered to.

Applications and complaints

Expected outcomes:
Effective application and complaint procedures are in place, are easy to access, easy to use and provide timely responses. Prisoners feel safe from repercussions when using these procedures and are aware of an appeal procedure.

3.96 We found that prisoners knew how to make applications and complaints, but believed that the processes were poor and that outcomes were unfair. There was no prisoner confidence that complaints against staff were fully investigated. Our observations revealed that the prison responded to complaints in accordance with targeted timescales, but at the expense of providing full responses to prisoners. Cursory interim responses were given to many complaints, which were than marked as closed.

3.97 Prisoners said it was easy to obtain application and complaints forms, and we found them readily available on all wings. Wing applications books were available and were completed daily. On one wing, we noted that several applications for the governor, some up to two weeks

old, had not been appropriately recorded or responded to and were still in the wing log. Following this up the next day, we noted that the applications had been removed, but the wing log had not been updated with the applications or responses. On another wing, we noted governor applications in the log that were five days old, and these too had not been logged or responded to.

3.98 In our survey, only 20% of adult respondents, against a comparator of 29%, believed their complaints were dealt with fairly. We found that a substantial proportion of complaints was not properly investigated or resolved appropriately. We saw many examples where complaints were referred to other individuals for further information or a response without specifying a date for a response. Complaints were not, therefore, closed down appropriately, which frustrated complainants. Although the timescale for the response was met, prisoners did not have appropriate responses to their complaints.

3.99 We saw several examples where confidential access complaints relating to staff treatment of prisoners were dealt with in a perfunctory manner and failed to address the issue raised. Several responses to complaints about staff behaviour encouraged the complainant to discuss the matter with wing managers who were, in fact, the subject of the complaint. During our inspection, prisoners were keen to make inspectors aware of their lack of confidence in the complaints process.

3.100 Prison records indicated that for the two months before the inspection most complaints related to employment, wages, the issuing of property and missing money. The complaints process was not sufficiently well publicised on residential units, and was not available in a range of languages.

Recommendations

3.101 Where complaints need to have additional information from a third party, staff should set a date for a final response and advise the prisoner of this process. Final responses and outcomes should always be filed with interim replies.

3.102 The complaints process, including appeals, should be clearly publicised for prisoners and be available in a range of languages.

3.103 Complaints relating to staff behaviour should be logged, dealt with by senior managers, and trends noted and acted upon.

Legal rights

Expected outcomes:
Prisoners are told about their legal rights during induction, and can freely exercise these rights while in prison.

3.104 Trained legal services information officers saw all new arrivals during their induction. Their role and contact details were advertised on all wings, and prisoners could see them quickly to deal with any changes to their circumstances.

3.105 Trained legal information officers saw all new arrivals during their induction programme. Needs were assessed and prisoners received good support.

3.106 The role and contact details of legal information officers were advertised on all wings and in the visit area. Prisoners could apply to see trained officers and probation staff on their wings if their circumstances changed. Applications were dealt with quickly, normally within two days.

3.107 Prisoners were given good quality legal advice leaflets that included information on bail applications, how to access solicitors and other legal services. Individual arrangements could be made for prisoners who chose to represent themselves in court, and there were no restrictions on the amount of legal correspondence that prisoners could send or receive.

3.108 Facilities for legal visits were good. The 12 rooms used to accommodate legal visits were clean, comfortably furnished and had good levels of privacy. Evening and weekend legal visits were permitted, and an efficient telephone booking system was in place.

Substance use

Expected outcomes:
Prisoners with substance-related needs, including alcohol, are identified at reception and receive effective treatment and support throughout their stay in custody. All prisoners are safe from exposure to and the effects of substance use while in prison.

3.109 First night clinical support for opiate users was inadequate, and detoxification was their only option. Substance misuse nurses and drug workers provided good psychosocial support, but they did not jointly coordinate prisoners' care. Dual-diagnosis expertise was lacking. However, the integrated drug treatment system was due to be implemented. The prison's mandatory drug testing rate was low for a local establishment, and comprehensive security measures were in place.

Clinical management

3.110 New arrivals received a healthcare screen. Any treatment required for alcohol dependency was started immediately, but opiate users were given only basic first night symptom relief. Following a comprehensive assessment by the substance misuse nurse and a GP appointment, they commenced a lofexidine detoxification regime the next day. Prisoners maintained on methadone in the community could not continue this treatment.

3.111 In the previous six months, 369 prisoners had undergone detoxification – 244 from opiates and 125 from alcohol. This included 11 young adults. Detoxification took place on E wing, where prisoners stayed for up to five days. They had daily contact with substance misuse nurses, who also provided wing support when prisoners were moved to a general location.

3.112 The lead GP, the substance misuse nurse team leader and the pharmacy manager had undertaken specialist substance misuse training, and appropriate clinical supervision arrangements were in place. An E grade and agency nurses had recently joined the team, and additional substance misuse nurses were being recruited.

3.113 Each prisoner had a care plan, but this was not jointly planned and coordinated with the counselling, assessment, referral, advice and throughcare (CARAT) service. A new joint working protocol between healthcare and CARATs was awaiting agreement. Prisoners with mental health and substance-related problems could be referred to the mental health in-reach team for groupwork and counselling, or to the primary healthcare team for wing support and

access to psychiatry input. However, none of the services specialised in treating dual-diagnosis clients.

3.114 The establishment was due to implement the integrated drug treatment system (IDTS) at the end of October 2007. A 58-space unit with single cell accommodation on E wing had been refurbished, and was due to come into use as the clinical stabilisation unit. It would be staffed by a group of dedicated officers. Plans for a second stage unit had not been finalised.

3.115 Medical cover was set to increase, allowing for treatment to commence in the evenings and at weekends, and recruitment for a G grade substance misuse team leader and additional nurses to provide 24-hour cover was underway. Treatment protocols, including methadone maintenance regimes, were being developed in consultation with national clinical advisers and the primary care trust.

3.116 The CARAT team had already expanded and had started to run IDTS groupwork modules on E wing; substance misuse nurses would also be trained to deliver these.

3.117 Good throughcare links ensured that prisoners could continue treatment post-release. We were impressed by the enthusiasm and commitment of all staff, both at strategic and operational level, to implement IDTS.

Drug testing

3.118 Reception tests, undertaken every four months, revealed that 60% of new arrivals had used drugs before custody. In our survey, only 16% of adult respondents said it was easy to get illegal drugs at the prison, against a comparator of 31%. No respondents reported drug-related victimisation by staff or other prisoners.

3.119 The establishment's random year-to-date mandatory drug testing (MDT) positive rate was 4.8%, against a target of 9.4%. Fewer than 20% of security information reports were drug-related; suspicion tests averaged only a 32% positive rate, which was low.

3.120 MDT was conducted by two dedicated officers from the operations group. Three other officers were trained in the procedure. The scheme was well managed, and testing took place in appropriate premises. Prisoners mainly tested positive for cannabis and benzodiazepines, followed by opiates. All positive tests resulted in a referral to the CARAT service.

3.121 Comprehensive security measures included five drug dogs, a search team, daily contact with police intelligence officers, and telephone monitoring. Finds included hooch (illegal alcohol). At the time of the inspection, 32 prisoners were on closed visits. In recent months, 160 visitors had also been banned following police and custody checks, which was high (see paragraph 6.6).

3.122 The head of security attended drug strategy meetings, and there was good communication between departments dealing with supply and demand reduction aspects of the strategy.

Recommendations

3.123 Opiate-dependent prisoners should be given appropriate first night clinical support.

3.124 Clinical treatment should be flexible, based on individual need and include the option of stabilisation/maintenance regimes.

3.125 Healthcare and counselling, assessment, referral, advice and throughcare (CARAT) services should work in an integrated way and coordinate prisoners' care jointly.

3.126 Healthcare providers' skill mix should include dual-diagnosis expertise.

Protection of vulnerable prisoners

3.127 Vulnerable prisoners who lived on the vulnerable prisoner unit had a reasonable regime and reported feeling safe. Overspill arrangements for those located elsewhere were less satisfactory.

3.128 Vulnerable prisoners were mainly located on D wing. They all, however, spent their first night on E wing (induction unit) and moved on to D wing once they had completed their induction and when a space became available (see paragraph 1.18). D wing could accommodate up to 55 prisoners. However, the number of prisoners seeking protection exceeded this number. Overspill prisoners were located on A2 landing, next to the segregation unit, and a number were also kept on E wing, following their induction, awaiting a space on D wing. Vulnerable young adults lived on D wing alongside adult prisoners. There were three young adults on D wing during the inspection. Staff we spoke to were not aware whether a formal risk assessment of those young prisoners had taken place.

3.129 Prisoners on D wing reported feeling reasonably safe and had an adequate, if basic, regime. Work was available in the laundry and vulnerable prisoners could also access a range of education classes (see paragraph 5.7). The environment on D wing was good. The wing was clean and reasonably bright, and relationships between staff and prisoners were generally good. However, mainstream prisoners had to pass through D wing at mass movement times en route to their activities. This disrupted D wing's routine, and it was reported that threats and abuse were not uncommon.

3.130 A more significant weakness in the overall arrangements for vulnerable prisoners was that D wing was not big enough. New arrivals and vulnerable prisoners returning from court were located on mainstream accommodation on E wing and A wing respectively, where they did not receive a full regime and were not able to be effectively protected. We were particularly concerned about arrangements for newly arrived vulnerable prisoners. In reception, we observed a member of staff disclosing the identities of vulnerable prisoners on E wing to a newly arrived prisoner, which could have had serious consequences. Once on E wing, vulnerable prisoners were subjected to verbal abuse through their cell doors from other prisoners and had to remain on this wing for many days, or even weeks, awaiting a space on D wing. One vulnerable prisoner reported feeling isolated and vulnerable on E wing and had not been able to contact his family for several days following his arrival; staff had not communicated with him about why he had not been moved to D wing. Vulnerable prisoners returning from court usually had to go on to A2 overspill landing until there was a free space on D wing. Although these prisoners were, in theory, allowed to go to D wing to participate in certain regime activities, such as association, this depended on staff availability and frequently did not happen.

Recommendations

3.131 There should be a risk assessment of the appropriateness of mixing vulnerable young adults with adult prisoners.

3.132 There should be an alternative route for mainstream prisoners during free-flow movement so that they do not have to pass through D wing.

3.133 Staff should not disclose the identities of vulnerable prisoners to other prisoners.

Young adult prisoners

3.134 Young adult prisoners fared badly compared with their adult counterparts. Chelmsford's regime was focused predominantly around adult prisoners, and none of its policies or strategies actively identified the distinct needs of this age group.

3.135 The number of young adult prisoners at Chelmsford was around 180 (a quarter of the population), representing a 20% increase since the last inspection. C wing was identified as a 'young adult' wing, although only around 80 young adults lived on this unit. This meant that more than half of Chelmsford's young adults were dispersed around the establishment. Young adults identified as vulnerable were located on D wing, alongside adult vulnerable prisoners.

3.136 We looked at the outcomes for young adult prisoners, which gave us some cause for concern. When we looked at, for example, use of force, segregation, anti-bullying, adjudications, open ACCT documents, and basic regime we found that young adults featured more prominently, pro rata, than their adult counterparts.

3.137 The perceptions of young adult prisoners about Chelmsford were also significantly worse than their adult counterparts. This was confirmed in our survey, where responses were more negative across a range of issues, notably incentives and earned privileges, use of force, and being segregated. Young adults also responded more negatively generally to a range of questions about relationships with staff and feeling safe. However, they responded more positively than adults to questions about their early days in custody, healthcare and the gym.

3.138 There was no formal recognition of this particular group of prisoners in any of Chelmsford's policies, which were all aimed at the adult population, and there was no strategic oversight of their management. We were concerned that the specific needs of this particular age group were being overlooked in what was a predominantly adult environment. There was considerable scope for more active consideration of the specific needs of young adults, which should inform local strategies and regime delivery wherever possible, particularly in education, vocational training and interventions.

Recommendation

3.139 An identifiable manager should be appointed with overall strategic responsibility for young adult prisoners at Chelmsford. A strategy should be developed for their overall management.

Section 4: Health services

Expected outcomes:
Prisoners should be cared for by a health service that assesses and meets their health needs while in prison and which promotes continuity of health and social care on release. The standard of health service provided is equivalent to that which prisoners could expect to receive in the community.

4.1 Staff worked hard to provide a decent standard of care and were committed to improvements. The health centre was an excellent environment for patient care. There had been a renewed focus on prison health from the local NHS since reorganisation, but progress had been slow. Clinical skills were not used to best effect, and some aspects of service delivery were not well organised – applications for appointments were not confidential and prisoners complained of delays and lost requests; pharmacy arrangements were inefficient; and there were long waits to see the dentist. Initial screening procedures were not adequate, and opportunities to promote and protect health were missed. A good daycare programme was available for prisoners with mild to moderate health problems, but the mental health in-reach team did not work with the psychiatrists, and prisoners with severe mental illness were cared for by the primary care team and did not have integrated, multidisciplinary treatment. There had been long delays in the transfer of some severely mentally ill patients to external specialist facilities. The levels of patient engagement on the inpatient unit were too low, their time out of cell was too short, and they had very poor access to therapeutic or rehabilitative daycare. The use of strip clothing and CCTV to monitor patients at risk of self-harm was of particular concern.

General

4.2 The last health needs assessment had been in 2002. The newly formed mid-Essex primary care trust (PCT) had stated that this would be updated in August 2007. Prison health partnership board meetings had been reconvened following NHS reorganisation and were well attended by senior representatives from the prison, healthcare and the PCT.

4.3 Healthcare was provided in a spacious and well-equipped two-storey building completed in 2004. A large daycare centre had a welcoming main area with comfortable seating, displays of prisoners' poetry and art, and interview and group rooms. The delivery of prison-addressing substance related offending (P-ASRO) had recently moved into the two largest group rooms and two offices.

4.4 There was an inpatient unit with 12 large individual cells, which were fitted with safe furniture, except for two cells that had hospital-type beds. Prisoners said that the cells were extremely hot in summer and cold in winter. Other areas of the building were stuffy and poorly ventilated. Two cells were fitted with CCTV. The inpatient unit had an interview room and a small day room. The two corridors had drinking fountains, hot water points and wall-mounted telephones, but the latter did not have hoods for privacy. The building had full disabled access, including a lift and toilet, and there were accessible bath and shower facilities in the inpatient unit

4.5 There were treatment rooms on E, F and G wings, but the one on F wing had no hatch so medicines were given out through the barred gate. The room on G was very small. B and C wings were served from the one area with a hatch into each wing. While cramped, these rooms were generally clean. There were two good-sized clinical rooms in reception where two staff could work when the department was busy.

4.6 Health promotion literature was available in the health centre and in the wing clinical rooms, but little information on health topics was displayed across the prison. Patients with long-term conditions could be referred to the gym for specific exercise programmes, and the prison had recently become smoke-free, but there was no prison-wide health promotion strategy.

Clinical governance

4.7 The head of healthcare attended the PCT clinical governance meeting. She also held clinical governance meetings in healthcare that were attended by all staff on duty, including discipline officers deployed to the unit. The level of staff involvement was positive, although there had not been any trend analysis of incidents and there was no programme of clinical audit. Many healthcare policies were under revision or had been recently ratified.

4.8 Senior healthcare staff attended the prisoner consultative committee where concerns about healthcare could be raised. In our survey, only 25% of adults and 28% of young adults said that healthcare was good or very good, against the comparators of 34% and 46% respectively. For foreign national respondents, this figure was 10% against a comparator of 28%. We identified some potential reasons for these views in our discussions with prisoners, but in the absence of a patient forum or other mechanism to assess their perceptions of healthcare (apart from complaints) these impressions could not be confirmed. Nursing staff had just started ethnic monitoring as part of the reception health screen, but they had not received training on how to do this and it was unclear why the information was not being accessed from elsewhere. Healthcare staff used the professional telephone translation service. A chronic disease register was maintained, but only for patients with diabetes.

4.9 The healthcare department used the main prison complaints system. This did not maintain confidentiality, but boxes had been ordered to set up a separate health complaints process. The healthcare manager responded directly in writing to prisoner complainants, unless the complaint was about clinical care, in which case the PCT investigated. Patients pursuing a complaint could get assistance from the Independent Complaints Advisory Service, whose number was on their PIN telephone cards. Notices advertising this service were displayed across the prison.

4.10 Primary care staff were employed by the prison. The head of healthcare, a senior nurse, reported directly to the governor. Four teams, totalling 14.2 whole-time equivalents (wte) nurses and five healthcare assistants (4.5 wte) covered primary care, inpatients, mental health and substance misuse. The two nurses (1.6 wte) in the primary care mental health team were mental health (RMN) trained, and others were general trained, including for inpatients. Two nurses worked permanent nights on the inpatient unit. It was not clear that staffing levels and current skill mix would be able to cover future service developments, such as dual-diagnosis work (mental health and substance misuse). The deputy head of healthcare and one of the mental health nurses had been seconded to set up the integrated drug treatment system (IDTS) prior to recruitment of permanent staff. Their roles were covered by acting up arrangements and agency staff. The department also had two full-time administrators and seven permanently allocated discipline staff.

4.11 Three GPs, employed by a private provider, amounted to 1.5 wte. The lead GP was full-time, but working temporarily for two days a week as the prison's regional adviser on IDTS. The other two worked sessions, one temporarily covering the lead GP's absence.

4.12 A full-time pharmacist, a senior technician who was pharmacy manager and three further pharmacy technicians worked in the pharmacy, which also provided a service to HMP

Bullwood Hall. All except the pharmacy manager were agency staff, although recruitment was in progress. A dentist had been in post for some years and was assisted by a trained dental nurse. A psychiatrist from the local mental health trust provided two sessions a week. In response to high demand, the head of healthcare had commissioned four additional sessions a week from another psychiatrist, although these were currently filled by a locum. A mental health in-reach team of three full-time RMNs and a qualified counsellor, also from the local mental health trust, ran the daycare unit. Its team administrator post was vacant.

4.13 Health staff had good access to prison and external training. Updated resuscitation skills training was due for most staff, but had not been offered to the dental team. All nurses had access to external supervision, and the healthcare assistants received group supervision from a district nurse in the community. The lead GP was appraised by the PCT, but learning and development time was not part of his contractual arrangements, as would be expected in a community setting. The mental health in-reach team received supervision from its trust.

4.14 First aid kits were available on the wings, and lists of qualified first aiders were displayed. Resuscitation and emergency equipment was kept in wing treatment rooms and in the health centre. Not all records of equipment checks were complete. Maximum and minimum temperatures of fridges in the dispensary and other clinical areas were recorded daily and were within an acceptable range. However, we saw no records for the fridge in reception. External contractors handled waste disposal. There had been an infection control audit of healthcare in November 2005 and most recommendations had been implemented. Some of the non-clinical areas were cleaned by the inpatient orderlies, but unless the orderlies could be supervised, clinical staff had to clean the secure clinical areas. A cleaner was due to start work.

4.15 Paper-based clinical records were used in all departments. There was computer hardware for an electronic clinical record system, but not all staff had been trained in this. All clinical records of current and released prisoners were securely stored. The entries in notes we examined, especially from the GPs, psychiatrists and mental health nursing team, were of a good standard, although signatures were not always legible. Clinical entries in dental records were of a high standard, but there was no routine entry in the main clinical notes that the dentist had seen a patient. The mental health in-reach team kept its own notes, but had only recently agreed to make an entry into the main clinical record when a patient used its services. Notes made by the genitourinary physician were kept separate, in line with legislation. With the patient's permission, he occasionally made a note in the main clinical record. Prescriptions were correctly written on standard prison prescription forms. The records we saw were correct, except on the inpatient unit where several forms had boxes with a cross in them or left blank with no reason given.

Primary care

4.16 A nurse saw all new arrivals in reception, including on Saturdays. The standard prison reception screen was used, or a shorter in-house screen if the prisoner had transferred from another prison. No compacts or consents were signed. Staff were alert and sympathetic to the needs of prisoners, but the screening interview was inconsistent. The healthcare department had chosen not to contribute to induction on the basis that prisoners were already given too much information. However, many prisoners did not take up a recently introduced secondary health screen, so opportunities were missed to offer health promotion advice and identify health needs. New arrivals who wished to see a doctor, including for detoxification, could do so the following day, including at weekends. Prescriptions could be obtained out of hours and medicines were issued from pharmacy stock.

4.17 Access to healthcare was by written application. Prisoners were encouraged to give their request to healthcare staff, but forms also came via the general applications process. This was not confidential, and prisoners complained to us that forms got lost or were delayed. Nurses did simple triage, except for the dentist or the optician where the next available appointment was offered. A triage policy was in place, but no clinical algorithms were used and staff had not had specific training. There was no nurse prescribing. One patient group directive was in use, for hepatitis B vaccination.

4.18 Patients were informed of their appointment on the day, which was too short notice. Waiting times for nurse triage were one or two days and for the GP about one week or sooner, if urgent. Urgent requests could also be telephoned through from the wings or prisoners could present themselves at medicines administration times. The lead GP was available from 8am to 6pm, including by telephone if not in the prison. Although the local out of hours GP service was used, by informal arrangement the GP preferred to be called if the patient was already known to the healthcare department.

4.19 An optician visited monthly and saw 20 patients, but waiting times were up to three months. A consultant in genitourinary medicine attended for two sessions a week and saw six to eight patients a session, of whom about half were new. The full range of acute and chronic conditions were seen and treated. He also visited the wings if needed. The waiting time for a routine appointment had been three weeks in the previous month, but urgent cases could be seen at the next clinic. A nurse also held a clinic for sexual health advice. Condoms were available, but only by request from this clinic.

4.20 Other nurse-led work included smoking cessation, diabetes management, blood pressure measurement, tissue viability (such as leg ulcer dressings), and seasonal flu immunisation. The only formal chronic disease management, including access to external specialist input, was for diabetes. Support for these patients was good, but there was not enough provision for other long-term conditions. Nevertheless, a few prisoners known to have particular health problems were seen regularly (often because they were on 'see to take' medication) and had care plans. The PCT had provided equipment when needed.

Pharmacy

4.21 The pharmacy service was provided by the prison. Out of hours, including at weekends, nurses could obtain dispensed medicines from a locked cupboard in the healthcare treatment room. Dispensed individually labelled medicines were also stored in the treatment room. Appropriate stock control and labelling systems were in use, including for controlled drugs. Patient medication records were maintained for all prisoners.

4.22 Pharmacy technicians held daily medicines administration sessions on wings B to G and were able to advise prisoners about their medication. Nurses administered medicines to individual prisoners on A wing (the segregation unit). On D wing, medicines were administered from the wing office, which was not confidential. This was also the case across the prison, as medicines were given out from hatches or through a barred gate where other prisoners queued for medicines. There was inadequate attention to assuring a prisoner's identity before medication was given out. A list of medicines that did not need prescription could be given out at these times, but records were kept in a separate book at each hatch rather than on the prisoner's prescription chart. These records were not reviewed and no reason was recorded for their administration, so it was not possible to assess potential overuse. Staff had not been trained on the use of these medicines. Prisoners could make a separate appointment to see the

pharmacist or a technician. Notices outside the treatment rooms stated that patient information leaflets were available.

4.23 Pharmacy staff were extremely busy yet most prisoners had their medication issued daily in Henley bags, which was time-consuming. The prison medicines management committee had recommended that prescriptions be issued for up to 28 days, subject to a formal risk assessment and a compact signed by the prisoner. However, the in-possession policy did not reflect this, and prison management had concerns about security risks that had not been resolved.

4.24 The medicines management committee met four or five times a year and was well attended. The pharmacist did not routinely provide aggregated information to the committee, which had not reviewed prescribing patterns. However, prescribing of codeine or opiate-based analgesia and night sedation was notably low, minimising risk of their potential misuse in the prison. The local PCT formulary was used.

Dentistry

4.25 Dental treatments were of a high standard and appropriate to the needs of prisoners. The dentist attended two days a week for four clinical sessions. About 40 patients a week were given a routine dental appointment. Urgent cases were seen at the following session and appropriate analgesia or antibiotics were prescribed in the interim. About 40 patients were receiving follow-up treatment at any one time. Dental trauma cases were referred to the local hospital.

4.26 Despite this good access to care, about 40% of patients failed to attend for their appointment. This was an important factor in the large waiting list of about 120, and waiting times of up to two months. Neither healthcare staff nor the prison had taken steps to resolve the problem, which led to a significant waste of clinical time and prisoner frustration.

4.27 The dental reference service conducted inspections and had found that equipment, record keeping and procedures were satisfactory, except that an amalgam separator had yet to be fitted to the dental unit. No routine summary or returns were made of numbers of patients seen and treatment provided by the dentist, so it was not possible to assess levels of dental health need.

Inpatients

4.28 The inpatient unit was not part of the certified normal accommodation of the prison. A policy governed admission, and admissions on non-health grounds were rare. The unit accepted prisoners from other prisons in the area without inpatient facilities, so it was usually full. At the time of our inspection, all but one patient had been admitted because of mental health problems and/or because they were considered at risk of self-harm. Three orderlies provided a good level of support; one was a trained Listener. They did general cleaning and served meals from a small servery. One nurse and one discipline officer were on duty at night, but this was not enough to provide safe trained staff cover in the event of an emergency.

4.29 Inpatients had no routine access to education or therapeutic activity, either individually or in small groups, until they were well enough to join mainstream activities. However, the mental health in-reach team had recently agreed to take inpatient referrals. There was a low level of general one-to-one interaction between patients and staff on the unit unless a patient was under constant observation. This was partly because the core day was far more restrictive than

in the main prison. There was no evening association, and a maximum of three hours out of cell. The timetabled two-hour afternoon exercise session had also been cancelled on 21 occasions in the five weeks before the inspection, and on several other occasions had been less than two hours. Although some of this was due to bad weather, no other indoor activities had been offered.

4.30 Four prisoners were on constant observation during the inspection, and another was admitted during the week for constant observation directly from reception. This person had committed acts of self-harm following three nights in police custody with no treatment for his drug addiction. Three of the five patients were observed directly by their own nurse, and in each case there was good interaction. However, two patients were observed through CCTV by one nurse in the office. This was in contravention of a Prison Service order, and provided no opportunity for staff to engage with prisoners, who were left on their own for large parts of the day. All patients under constant observation were in strip clothing and had little to occupy them in their cells. The CCTV observation and the strip clothing had been recommended by the psychiatrist. Following recent deaths in custody, health and discipline staff were on high alert about the potential for self-harm. In the previous month, up to eight people had been on constant observation.

4.31 The level of concern for prisoners' safety was positive, but the use of CCTV and strip clothing was not appropriate and the overall regime was unnecessarily restrictive. We were assured that decisions about care were made jointly, but it appeared that prisoners on constant observation were reviewed sequentially by ACCT assessors, nursing staff, the GP and the psychiatrist without these staff working as a team to share responsibility and risk.

Secondary care

4.32 A healthcare administrator managed outpatient appointments in conjunction with healthcare staff using a traffic light prioritising system. A maximum of two external appointments a day could be accommodated. This required substantial administrative effort to minimise cancellations and rearrangements. In the previous six months, there had been 223 referrals for external appointments; 52 (23%) were cancelled or rearranged, although only four were recorded as due to staff shortages. It was not possible to assess from the records the extent to which waiting times were within NHS targets.

Mental health

4.33 The primary care mental health nursing team saw and assessed all new arrivals referred from reception with a suspected mental health problem. Other prisoners who wished to be seen for a mental health problem and referrals from the wing were initially seen by the GP. The visiting psychiatrists advised the GP and the primary care mental health team. Acutely unwell patients were maintained on the nurses' caseload. Prisoners with stable or less severe problems were followed up by one of two healthcare assistants. Staff provided a mainly wing-based service and were extremely busy. In the first half of 2007, they had received about 50 new referrals a month, maintaining a caseload of up to 130 and assessing or reviewing between 42 and 87 patients monthly. They did not use the care programme approach (CPA) for patients with severe mental illness.

4.34 The mental health in-reach team ran therapeutic groups such as anger awareness, creative writing, alcohol relapse prevention, support for prisoners on open ACCT documents, and an afternoon with various options for vulnerable prisoners. Individual counselling was available, as was support for a computerised cognitive behavioural therapy programme. Referral could be

from anyone, including the prisoner. A prisoner had a mental health assessment before acceptance, but services were not restricted to those with diagnosed mental illness. Fifty to 60 people were seen weekly. This team did not run wing-based outreach nor provide input for acutely mentally ill patients. It did not have access to the psychiatrists. Only three of its clients were on long-term CPA.

4.35 Despite the dedication of both teams, their substantial expertise was not used to best effect. Neither severely ill patients nor those with mild to moderate problems got the most benefit from the combined resources. There was a substantial amount of consultant psychiatrist time, but there were gaps in provision, such as occupational and talking therapy. Communication between the two teams had started to improve since the secondment of a new in-reach team leader, the return of the head of healthcare from maternity leave, and the appointment of a new mental health commissioning manager at the PCT.

4.36 Mental health transfers to external hospitals were difficult, and some patients had experienced long waits. In one case during our inspection, an inpatient had waited nearly three months for an assessment five weeks previously, and there was no indication of when a bed would be available.

Recommendations

4.37 There should be a programme of clinical audit that covers topics appropriate to prison health.

4.38 Prisoners should have more opportunities to give feedback and make suggestions about health services.

4.39 There should be steps to identify and minimise any barriers to health services experienced by young adults, foreign nationals and other potentially excluded groups.

4.40 Prisoners who wish to make a complaint about healthcare should be able to do so in confidence direct to healthcare.

4.41 There should be a review of the skill mix and staff complement, including the need for dual-diagnosis (substance misuse and mental health problems) expertise and more multidisciplinary input to mental healthcare.

4.42 All health staff, including the dental team, should receive annual updates on resuscitation skills and use of the defibrillator.

4.43 GPs practising at the prison should have access to learning and development programmes in line with what is available for GPs working in the community.

4.44 Full and complete signed records of administration of medicines should be kept on prescription charts, including where patients refuse medication or fail to attend.

4.45 Failure to attend or refusal of medication should be followed up and appropriate action taken.

4.46 Healthcare staff should make full use of the opportunities provided during reception, induction and secondary screening procedures to ensure prisoners have maximum opportunity to benefit from health services.

4.47 Prisoners should be able to apply to be seen in healthcare using a confidential and dedicated procedure that is regularly reviewed to identify and remedy any delays.

4.48 Nursing staff should use clinical triage algorithms to ensure consistency of advice and treatment to prisoners.

4.49 Patient group directives should be developed to support a greater range of nurse-led treatment.

4.50 Patients attending healthcare should have reasonable notice of their appointment.

4.51 There should be more efficient use of the optician's sessions to reduce waiting times.

4.52 A wider programme of chronic disease management should be introduced.

4.53 Patients should be able to collect their medicines in privacy.

4.54 There should be appropriate identity checks of prisoners before medication is supplied.

4.55 Records of all medications supplied to a patient, whether prescribed or not, should be maintained on one record, together with a reason for the supply of any non-prescribed medicine.

4.56 Procedures should be used to identify and address overuse of non-prescribed medication.

4.57 All staff who give out non-prescribed medicines should receive training on their use.

4.58 There should be an agreed, transparent and documented risk assessment procedure, including regular multidisciplinary review, to determine whether a patient can have their medication in possession.

4.59 The medicines management committee should regularly review prescribing trends to guide policy development and check on implementation.

4.60 The healthcare department should work with the rest of the prison to minimise missed appointments, especially with the dentist.

4.61 The dentist should provide regular returns of the numbers of patients seen and treatment provided.

4.62 The number of trained health staff on night duty should be increased to provide safe cover of the inpatient unit and the wings.

4.63 Inpatients should have access to therapeutic daycare options, including education and work appropriate to their clinical condition and that contribute to their recovery.

4.64 Inpatients should have daily opportunities for exercise and association equivalent to the rest of the prison, as their clinical condition allows.

4.65 Healthcare and other prison staff should work jointly to manage and take responsibility for decisions about prisoners at risk of suicide and self-harm.

4.66 The care programme approach should be used for patients with severe mental illness.

4.67 Prisoners requiring specialist mental health inpatient care should be assessed within seven days and transferred expeditiously.

Housekeeping points

4.68 Condoms should be freely available to prisoners.

4.69 Hoods should be fitted over the telephones in the inpatients unit.

4.70 Regular checks on fridge temperatures and emergency equipment should be documented and any problems rectified promptly.

4.71 Entries into clinical notes should include a legible record of the name of the person making the note.

4.72 The dentist and the mental health in-reach team should note in the patient's main clinical record that they have seen a patient and provide summaries of treatment and care.

4.73 An amalgam separator should be fitted to the dental unit.

Section 5: Activities

Learning and skills and work activities

Expected outcomes:
Learning and skills provision meets the requirements of the specialist education inspectorate's Common Inspection Framework (separately inspected by specialist education inspectors). Prisoners are encouraged and enabled to learn both during and after sentence, as part of sentence planning; and have access to good library facilities. Sufficient purposeful activity is available for the total prisoner population.

5.1 The prison had improved its provision of learning and skills, particularly since new contractual arrangements had started in August 2006. However, learning, skills and work activities were inadequate overall, and too few prisoners were engaged in them. The prison did not offer sufficient vocational qualifications, and education courses were often too long for short-stay prisoners to complete. Nearly a third of the prison population were unemployed. Stock and prisoner access to the library were poor.

5.2 Initial assessment of prisoners' needs was timely. They routinely received appropriate literacy and numeracy assessments during their induction, based on a nationally recognised assessment tool. They were given appropriate guidance on how to make applications for work and learning and skills. However, information gathered at initial advice and guidance interviews was not subsequently used effectively across the prison.

5.3 Around 100 prisoners followed vocational training courses or other work activity with a strong training element. Structured vocational training was offered in construction trades, industrial cleaning, computing and barbering. Learners developed their practical skills well. Those involved in work activity in the recycling workshop and the kitchen improved their team working and other generic work skills. Many followed short health and safety programmes, sometimes leading to accreditation. Achievement of occupationally specific qualifications in physical education, such as national vocational qualifications (NVQs), was excellent, and at least satisfactory for those taking industrial cleaning qualifications. However, for most prisoners in work or vocational training there was no opportunity to gain substantial vocational qualifications. Few computing learners remained long enough at the prison to complete full qualifications. A sizeable number of prisoners, nearly 200, engaged in wing or similar work with little or no training element.

5.4 In education, the achievement of qualifications and standards of work were satisfactory. Between two-thirds and three-quarters of prisoners who completed their courses gained qualifications. However, significant numbers left the prison before they completed their courses, and progress for some who remained was too slow. Around 100 prisoners participated in education classes, most of which were part-time.

5.5 Some initiatives and projects were particularly good. The development of provision to identify and support prisoners with specific learning difficulties, such as dyslexia, was very good. A small group of prisoners worked with the writer in residence and significantly improved their personal and social skills. Pre-release training from the Foundation Training Company was good. A newly revised pay policy positively encouraged prisoners to engage in learning and skills activity.

5.6 Resources and facilities for learning included good classrooms in the newly built learning and skills block, and appropriately equipped workshops. Teaching and learning were mostly satisfactory, although inadequate in some literacy and numeracy classes. Planning of learning to meet individual needs in most education provision was weak. Assessment and recording of progress was poor.

5.7 The prison had secured a considerable increase in resources for learning and skills. The number of hours available each week had more than doubled, from 167 to 432, between 2005-06 and 2006-07, and the number of prisoners in education and training had increased. The volume of activity offered to vulnerable prisoners had increased and most were in work or education, although their choices were narrow. Recruitment of learning and skills staff, however, had been slow and some posts were unfilled, and a significant proportion of staff lacked experience and needed training. Despite the increase in provision, over 200 prisoners – 31% of the prison population – were unemployed.

5.8 Access to activity, including training, was poorly coordinated between the prison and education contractor. Criteria to decide prisoners' eligibility for learning, skills and work activity were not always clear. The practice of allocating too many prisoners to particular workshops or classes was common and impeded systematic learning. Prisoners were regularly turned away from workshops or classes or left in their cells, although they expected to participate. There was poor take-up on many of the programmes aimed at fostering personal development and social integration.

5.9 The development of employability training leading to accreditation was slow, and the strategy for its implementation not completed. Only one of the four new construction training workshops opened in April 2007 offered craft skill accreditation. Arrangements to recognise and record non-accredited learning in vocational and other areas were weak.

5.10 The collation and use of data in planning provision was poor. Data collection had improved since the current contractor, Milton Keynes College, had taken over in August 2006. However, much of the data collation had been targeted narrowly on compliance with performance targets rather than how to improve learning and skills provision. Data was not analysed to compare the achievement of different groups of prisoners, such as those in the prison for different lengths of time.

5.11 The prison had a detailed range of policies and procedures for managing learning and skills, but their implementation was ineffective. Monitoring of progress on development plans was not sufficiently thorough.

Library

5.12 The library was provided under a contract with Essex County Council and was staffed by two part-time senior library assistants. The post of the library development officer was vacant.

5.13 Library staff had developed some good initiatives to promote the library, such as themed displays, visits from established authors and activities centred on the writer in residence. A well-planned listening library had been developed with the county library services and was due to be in use from the end of July 2007.

5.14 The library did not meet the needs of the prison population effectively. It was too small for the number of prisoners using it and did not have an adequate stock. There was a satisfactory range of simplified books and other resources to support the development of literacy and

numeracy skills. Links with learning and skills providers were weak, and teaching staff did not make adequate use of the library to support learning and skills.

5.15 Library staff used prison records well to match the displays of books in foreign languages with the nationalities of the current prison population. However, overall there were too few books, newspapers and periodicals in foreign languages. The range of legal and reference books was also narrow.

5.16 Opportunities to use the library were poor. A rota enabled prisoners from each wing to visit the library once a week, but staff were not always available to escort them. Access for employed prisoners was particularly limited. The library was closed at weekends.

Recommendations

5.17 More prisoners in work or vocational training should have the opportunity to achieve substantial vocational qualifications.

5.18 Learning and skills programmes should be better matched to prisoners' length of stay.

5.19 Planning of learning to meet individual needs, assessment and recording of progress should be improved, and there should be better coordination of access to activity. The collation and use of data in planning provision should be improved.

5.20 There should not be routine over-allocation of prisoners to workshops or classes.

5.21 The library's stock of books, newspapers and periodicals in foreign languages and legal and reference books should be increased.

5.22 The library facility should be enlarged and improved to meet the needs of the prison population.

5.23 All prisoners, including employed prisoners, should have regular access to the library.

5.24 There should be appropriate links between the library and learning and skills providers to ensure the library contributes effectively to prisoners' learning and development.

Physical education and health promotion

Expected outcomes:
Physical education and PE facilities meet the requirements of the specialist education inspectorate's Common Inspection Framework (separately inspected by specialist education inspectors). Prisoners are also encouraged and enabled to take part in recreational PE, in safe and decent surroundings.

5.25 Physical education provision at Chelmsford was very good, and there was a high take-up by prisoners.

5.26 Prisoner access to physical education and health promotion was good. Health and fitness were promoted strongly, with promotional materials on the wings and elsewhere. Healthcare staff

regularly referred prisoners for remedial programmes of activity, which PE staff carried out effectively, and other prisoners self-referred.

5.27 Health services staff assessed all new arrivals for fitness and recorded the results on the local inmate database system (LIDS). This was supplemented by a useful health questionnaire at PE induction, available in several languages.

5.28 Monitoring of participation in PE was thorough and take-up was high. Rotas were planned carefully to enable equal access to recreational PE for employed and unemployed prisoners. Access was twice a week for all prisoners, except those on basic regime. Prisoners on remedial health programmes attended three times a week.

5.29 Indoor and outdoor PE facilities were good and included an Astroturf pitch. Activities included cardiovascular routines, weight training, circuit training and outdoor activities such as football. Some activity was aimed at different groups of prisoners, including those over 35. A good range of vocational training courses was offered. Training was very well structured, and qualification achievement was excellent.

5.30 Prisoners received clean kit each time they attended the gym. The gym showers were closed temporarily due to building work on an extension to the PE facilities, but staff accompanied prisoners to their wings to supervise those taking showers after activity.

Faith and religious activity

Expected outcomes:
All prisoners are able to practise their religion fully and in safety. The chaplaincy plays a full part in prison life and contributes to prisoners' overall, care, support and resettlement.

5.31 The chaplaincy team was well integrated into the running of the establishment. Facilities had been significantly improved since the previous inspection and met the needs of the population. New arrivals were now seen by a chaplain within their first 24 hours. Prisoners had good access to religious artefacts.

5.32 The chaplaincy team was led by a full-time Muslim chaplain who had been in post for approximately three months. All other faiths were covered on a part-time or sessional basis. The team was also assisted by several volunteers. Chaplains were seen around the establishment and appeared to be well integrated. A representative from the team regularly attended key meetings and review boards for prisoners on open ACCT self-harm monitoring documents.

5.33 A multi-faith room had been provided since the last inspection and was used for all religious services. The room could hold up to 75 prisoners, which was sufficient to meet demand. Notice boards had been installed and posters celebrating the main faiths were displayed. Blinds were used to cover religious artefacts as necessary. There was a washing area next to the main room where Muslim prisoners could wash before Friday prayers. The new facilities were functional and an improvement on the previous arrangements.

5.34 The duty chaplain saw new arrivals individually on the day after their arrival as part of the induction programme. They were given a general leaflet about the chaplaincy at Chelmsford and, where appropriate, a specific leaflet about their religion. The previous induction

arrangements had been unpredictable. This was confirmed in our survey, in which only 41% of adult respondents said they had access to a chaplain within their first 24 hours, against a comparator of 47%. The previous problems in covering the post of duty chaplain had been addressed. We saw a planner for the forthcoming month in which all days were effectively covered.

5.35 The multi-faith room was accessed via the vulnerable prisoner unit, which was not ideal (see section on vulnerable prisoners). The establishment had recently introduced a joint service for mainstream and vulnerable prisoners, although there had been some opposition to this from staff and prisoners. Vulnerable prisoners were locked in their cells while mainstream prisoners moved through D wing to the multi-faith room. They were then unlocked and seated at the back of the room next to the staff and returned to their cells before the movement of mainstream prisoners began. These arrangements were satisfactory.

5.36 The approximate average attendance for each service was Anglican 40, Catholic 30, Muslim 60 and Sikh two. There were no significant clashes between scheduled services and other elements of the regime. Prisoners had to put their names down to attend a service and only those registered for that faith could attend. Prisoners registered as of no faith could explore any faith, by attending a service following an application. Prisoners were able to celebrate all major religious festivals. The facilities list identified a range of religious artefacts that could be posted in or accepted through visits. Prayer oils and incense sticks were available through the prison shop.

5.37 The chaplaincy contributed to the wider regime by presenting the Alpha course, a Bible study group and bereavement counselling.

Time out of cell

Expected outcomes:
All prisoners are actively encouraged to engage in out of cell activities, and the prison offers a timetable of regular and varied extra-mural activities.

5.38 Prisoners had reasonable levels of time out of cell, although just short of our expectation of 10 hours per day. There were deviations from the published core days on some wings, which were not always satisfactorily explained. Most prisoners generally had reasonable access to daily association and exercise.

5.39 The prison reported a time out of cell figure of nine hours a day against a target of 9.1 hours and had achieved this consistently over many months. Data collection methods were sophisticated, transparent and supported by information technology. However, our own assessment, based on a qualitative analysis of prisoner experiences, suggested that a full-time employed prisoner was typically out of cell for between nine hours 44 minutes and seven hours 46 minutes. For an unemployed prisoner, time out of cell was normally between two and five hours, dependent on the availability of regime elements.

5.40 Each wing had its own published core day which, although similar, had significant variations. The newer wings were more consistent in their application of the core day, but there was evidence of regular deviation from it on B and C wings. Difficulties in reconciling the prison roll appeared to impact regularly on time out of cell, and there was evidence that wing managers

exercised discretion in their interpretation of the core day, again to the detriment of time out of cell.

5.41 Most prisoners had daily access to association and exercise, and there was no evidence that either was routinely cancelled. In our survey, responses about access to basic daily regime elements, such as showers and association, were above the comparators. Unusually, there was no evening association on B wing. In addition to association, daily domestic periods were also available.

Recommendations

5.42 Wing routines should be followed in accordance with published core day timetables.

5.43 Time out of cell should be increased.

5.44 All wings should benefit from evening association.

Section 6: Good order

Security and rules

Expected outcomes:
Security and good order are maintained through positive staff-prisoner relationships based on mutual respect as well as attention to physical and procedural matters. Rules and routines are well-publicised, proportionate, fair and encourage responsible behaviour. Categorisation and allocation procedures are based on an assessment of a prisoner's risks and needs; and are clearly explained, fairly applied and routinely reviewed.

6.1 The prison had a substantial and sophisticated security department with well-developed intelligence management systems and strong links to the police. Most systems worked well, but governance of closed visits and banned visitor arrangements needed improvement. There was a generally balanced approach to the application of security and rules.

Security

6.2 The prison had a large and developed security department, which was part of a wider operations group and headed by a senior manager. The department included an intelligence cell, a dog group with three staff and six dogs, mandatory drug testing (MDT) and a 'security intelligence team', which was a small, dedicated search team. The department was also well supported administratively. A very well-attended security committee met monthly under the chairmanship of the deputy governor. The broad membership included departments such as psychology, resettlement and the chaplaincy. The committee was supported by comprehensive data and analysis in the form of a monthly security bulletin. Its minutes indicated that discussion covered the full range of relevant issues in reasonable depth.

6.3 Relationships with the local police were highly developed. Up to four police liaison officers were seconded to the prison, although at the time of the inspection this had temporarily reduced due to changes in personnel. The function of these officers ranged from traditional police liaison work to public protection issues and ongoing cooperation on intelligence matters which, in particular, had helped to confront imported gang culture.

6.4 The prison had received 3,300 security information reports (SIRs) in 2007 to date compared to a total of 4,500 in 2006. This was partly explained by the growth of the prison, but also by management initiative. Systems to manage intelligence flows were well developed, and SIRs were dealt with expeditiously. Records indicated that there was a preponderance of SIRs from B and C wings. Although many SIRs were classified as miscellaneous, a number focused on drugs and threats of violence in various forms.

6.5 The prison had large numbers of prisoners on closed visits – 32 at the time of the inspection. Reviews took place regularly, supported by computerised recording and diary software. Review data was, however, limited and communications with prisoners were formulaic and perfunctory. Reviews were also undertaken by just one person, normally the head of function.

6.6 At the time of the inspection, some 46 persons were banned from visiting serving prisoners. This was a very high figure, although we were given assurances that decisions were made on a case-by-case basis. We were not confident, however, that these decisions were regularly

reviewed or that governance of the banned visitor list was adequate. In our view, some criteria were excessive, in particular the potential banning of all visitors with drugs convictions in the previous five years.

6.7 Security requirements and the prison's rules were well publicised around the establishment. They were managed and applied in a way that did not needlessly interfere with the legitimate operation of the prison's regime. For example, main movement was managed in a relaxed but efficient manner with measured but unobtrusive supervision. An exception was the prison's repeated difficulties in reconciling its roll. Staff and prisoners told us that delays to roll reconciliation were regular and impacted on opportunity for time out of cell.

Categorisation

6.8 There were efficient systems for the categorisation of prisoners, and there were no unnecessary delays in the initial categorisation process. Prisoners could request the establishments they were transferred to. Their needs were taken into consideration wherever possible, although with population pressures it was not always possible to meet their preferences. For most prisoners, the availability of space rather than appropriate interventions or closeness to home determined their allocated establishment. Consequently, some prisoners, particularly young adults, refused to transfer to their allocated establishment when it was at considerable distance, such as Norwich or Glen Parva. The establishment had a protocol for managing prisoners who refused to transfer, which imposed restrictions on their regime at Chelmsford (see paragraph 6.20).

6.9 Given the short length of stay of most prisoners, there was virtually no demand for reviewing their categorisation levels.

Recommendations

6.10 Prisoners should receive fuller written explanations for decisions following closed visits reviews.

6.11 The quality of information and the range of contributions for closed visits reviews should be improved.

6.12 Decisions to ban visitors should be reviewed regularly.

6.13 The criteria for the banning of visitors should be reviewed and focus on clear and recent intelligence concerning current threats.

6.14 Processes to reconcile the prison's roll should be improved, and delays recorded and subject to management scrutiny.

Discipline

Expected outcomes:
Disciplinary procedures are applied fairly and for good reason. Prisoners understand why they are being disciplined and can appeal against any sanctions imposed on them.

6.15 Adjudication procedures were generally sound, although we found some evidence of unofficial punishments and considered that the implementation of the refusal to transfer policy acted as a secondary punishment. Use of force levels were high and out of proportion with comparable jails. Accompanying documentation failed to provide assurances that force was used legitimately and as a last resort on all occasions. The segregation unit was an unusual design, but reasonably well run.

Disciplinary procedures

6.16 There had been 626 adjudication charges during the first six months of 2007. Around 35% had been laid against young adults who accounted for only 25% of the population. There was no use of minor reports for young adults.

6.17 The adjudication room was small but adequate. The adjudications we observed were conducted well, and prisoners were fully involved with the process. Previous good conduct was taken into consideration as mitigation when making a punishment following a finding of guilt. A review of completed records also provided assurances about the thoroughness and overall fairness of procedures.

6.18 Punishment tariffs were in place and reviewed regularly through standardisation meetings. However, tariffs were not published on the wings.

6.19 We had some concerns about the use of unofficial punishments. We found examples in wing history sheets where prisoners had been banned from using the gym outside the formal process of an adjudication. There were also notices that said that TVs would be removed as a punishment if prisoners did not keep their cells adequately clean.

6.20 Chelmsford also operated a refusal to transfer policy, whereby prisoners who refused to transfer to another prison when required to do so were placed on basic regime. This protocol applied, regardless of former behaviour, for as long as the prisoner refused to transfer, without review. We considered that this acted as an unnecessary secondary punishment, given that prisoners were also placed on report following a refusal to transfer.

Use of force

6.21 Force had been used against prisoners on around 175 occasions in the first six months of 2007. The rate appeared to be increasing from 2006, even taking into account the increased prison roll at the start of 2007. If continued, the number would exceed 350 incidents by the end of 2007. This incidence was higher than comparable establishments, without obvious explanation.

6.22 An analysis of individual incidents showed that most occasions where force was deployed against prisoners had involved prisoner conflict with a member of staff. Comparatively few incidents involved staff separating prisoners fighting among themselves, or did not use control and restraint (C&R). Almost half all recent incidents, 47%, had involved young adults.

6.23 There was no use of force committee to oversee the governance of use of force, no formal quality assurance of completed paperwork, and no structured trend analysis. However, the safer custody meeting reported on individual incidents, and some data was collated in monthly performance reports. C wing and reception were the most common areas where force had

been used in recent months. The establishment had identified the high number of incidents in reception and had taken steps to address this, which had led to a reduction in the number of incidents in the month before the inspection.

6.24 We looked at a large sample of completed records. Many of the use of force forms were completed poorly and did not give particularly good quality information about the exact nature of the incident. Statements from officers were often perfunctory and reasons for the deployment of force were often vague and mechanistic, such as: 'no more force was used than necessary'. One form said force had been deployed because the prisoner was delaying reception procedures. In another case, force was used because a prisoner flicked an officer on the shoulder. On several occasions it was not clear that there had been sufficient attempts at de-escalation. Although there was no overall atmosphere of intimidation, we were not assured that force had been used as a last resort on all occasions.

6.25 Although operational managers should have attended planned removals, their attendance was not apparent from the completed paperwork, and they did not complete any paperwork following incidents. We also found some occasions where healthcare staff had not been present at planned removals.

6.26 Special accommodation had been used on 20 occasions in the first six months of 2007 (five of which involved young adults). Although this figure was also high, it was skewed slightly because a small number of prisoners accounted for disproportionate use. A body belt had also been used four times in the first six months of 2007, which was an exceptionally high figure.

6.27 The accompanying paperwork for use of special accommodation was also not always completed to a high and consistent standard. In some cases, prisoners appeared to have been kept in special accommodation for some time after calming down and becoming compliant. There were also lengthy gaps between written observations on some forms, and pages missing on some of the paperwork. In one case when a body belt had been applied to a prisoner, there was no clear reason as to why this was done. He had been quiet and compliant for some time in the special cell before staff entered, restrained him and applied a body belt, which stayed on for several hours.

6.28 We noted that the recent measuring the quality of prison life (MQPL) survey at Chelmsford contained some negative prisoner perceptions about alleged unfair staff use of C&R procedures. The report stated that: 'Prisoners expressed an opinion that some officers looked for any excuse to use C&R and certain officers tried to wind prisoners up in order to elicit an aggressive response, which would necessitate the use of C&R. Several prisoners claimed that they had experienced or witnessed the use of C&R in non-violent situations where officers had perhaps misinterpreted "hand gesturing" as physical aggression.' We were concerned that the prison did not appear to have done anything with this information.

Segregation unit

6.29 The segregation unit was an unusual design, covering one-and-a-half floors of A wing. The unit was clean and well maintained. The ground floor had six safer cells, two special cells and some waiting rooms. The first floor had a further six normal segregation unit cells on one side of a gate, plus a further five cells not designated as segregation unit cells, but used mainly to hold overspill vulnerable prisoners. The third floor of A wing had normal cells for key workers. Some cells in the segregation unit were temporarily out of use, following a recent incident. The standard of the remaining cells was reasonable.

6.30 The unit held an average of seven prisoners during the inspection. There were currently no long-term residents, although we were told that some prisoners had spent lengthy periods in segregation because they did not want to go on to normal location and tried to transfer out of Chelmsford via the segregation unit. A specially selected staff group on A wing interacted positively with segregated prisoners.

6.31 The regime in the segregation unit was basic but adequate. There was a two-tier, compliance-based regime. Prisoners could have additional privileges on stage two, such as access to education and the gym. Prisoners were considered for movement between the two levels at their good order reviews. These reviews were multidisciplinary and prisoners were fully involved. Prisoners in the segregation unit confirmed that they were usually offered a shower and exercise every day.

6.32 We had some initial concerns about the use of the five cells not classified as segregation cells. During the inspection, these cells were used to house vulnerable prisoners, a prisoner at the end of his period of segregation about to return to normal location, and a prisoner recently transferred in to Chelmsford who had not settled on normal location and who had only a few days left to serve. We recognised that the establishment was making constructive use of an unusual facility and that prisoners did not spend lengthy periods in this transient unit. However, the allocation criteria for these cells were not clear, and their residents did not receive a full regime.

Recommendations

6.33 The use of unofficial punishments should cease.

6.34 The refusal to transfer protocol should be discontinued.

6.35 The prison should establish a use of force committee, linked into the violence reduction committee, to monitor in detail use of force incidents. Any lessons learned or training needs identified should be acted on.

6.36 Paperwork for the use of force, special accommodation and body belts should always be completed to a high standard. Statements should be thorough and should make clear why the level of force deployed was necessary.

6.37 There should be formal allocation criteria for the non-segregation unit cells next to the segregation unit.

Housekeeping point

6.38 Punishment tariffs should be published on residential units.

Incentives and earned privileges

Expected outcomes:
Incentives and earned privilege schemes are well-publicised, designed to improve behaviour and are applied fairly, transparently and consistently within and between establishments, with regular reviews.

6.39 The differential between standard and enhanced levels of the incentives and earned privileges scheme was reasonable and motivated prisoners. However, young adults did not fare well in the scheme and had little confidence in it. Red entries were issued for very minor reasons, and the basic regime was unnecessarily punitive. Review boards did not take account of the views of activity supervisors.

6.40 The incentives and earned privileges (IEP) scheme was based on three levels – basic, standard and enhanced. The scheme was explained in a policy document and applied to both adult and young adult prisoners. A published facilities list outlined the range of items permitted in possession by prisoners on each level. At the time of our inspection, 22.5% of adults were on the enhanced level compared to just 5% of young adults, and only 1% of adults were on basic, against 7% of the young adult population.

6.41 Unsurprisingly, young adults were extremely negative about the IEP scheme. In our survey, no young adult respondents said they were on the enhanced level, against the comparator of 30%, and only 23% of respondents, against the comparator of 46%, felt they had been treated fairly in their experience of the scheme. The respective findings in the survey of adult prisoners were significantly above the comparators.

6.42 The IEP scheme was explained on induction, included in the booklet issued to all new arrivals, and well publicised around the establishment. Prisoners normally joined the scheme on standard level, but those transferred in from another prison where they had already achieved enhanced status could retain that level.

6.43 Staff made regular entries in prisoners' wing history files and those that reported negative behaviour were written in red. Two red entries in a 28-day period resulted in a written warning, and a further red entry in the next 28 days resulted in a referral to an IEP review board. The policy document also allowed for serious incidents to be automatically referred to a board. There were clear links with the anti-bullying policy, and known bullies on stage two of the strategy were placed automatically on basic.

6.44 Standard prisoners could be considered for enhanced status after three months, through self-referral or nomination by their personal officer. In order to qualify they had to conform fully to the rules and regime, sentence plan targets, attend work or education as required, and display excellent standards of behaviour. They also needed no proven adjudications against them in the previous three months, and to be drug-free and willing to participate in random and voluntary drug testing.

6.45 IEP boards were normally chaired by the wing senior officer and attended by at least two wing staff who knew the prisoner. The board tried, where possible, to get the prisoner's personal officer to attend, but this was not always possible. The prisoner was also permitted to attend and/or submit written representations. We found no evidence that supervisors from activity areas, such as education or work, routinely contributed to the IEP review process.

6.46 The differential in privileges available to enhanced level prisoners was reasonable. In addition to the usual increase in private cash and an extra monthly visit, they could retain a TV remote control, attend a weekly evening visit, and were considered for more trustworthy jobs in the establishment. Enhanced level prisoners could also have a range of additional items, including play station, game cube, quilts and quilt covers. The policy also allowed enhanced level prisoners to receive a higher sessional pay rate for their work, which was inappropriate.

6.47 We reviewed documentation of prisoners on the basic level. In all cases, basic appeared justified and based on a pattern of behaviour. However, many red entries had been issued for very minor misdemeanours, such as misuse of cell bell or being inappropriately dressed on the landing, without any previous warnings issued. We were told that these entries were normally only made after several verbal warnings. Prisoners on the basic level had daily access to showers and exercise, but received no association and had no in-cell power. This meant that they were deprived of their radio/CD player, which was unnecessarily punitive. Prisoners on the basic level were set improvement targets.

Recommendations

6.48 The establishment should investigate young adults' negative perceptions of the incentives and earned privileges scheme, and support more young adults to achieve enhanced status.

6.49 Activity supervisors should routinely contribute to incentives and earned privileges reviews.

6.50 Enhanced level prisoners should not receive a higher pay rate for the same work as those on standard or basic levels.

6.51 Basic level prisoners should receive some association and should not be deprived of their in-cell power supply.

6.52 Wing history files should show evidence that verbal warnings have been issued before red entries are made.

Section 7: Services

Catering

Expected outcomes:
Prisoners are offered varied meals to meet their individual requirements and food is prepared and served according to religious, cultural and prevailing food safety and hygiene regulations.

7.1 The kitchen was generally clean and well ordered, although needed some repair. The pre-select menus had healthy, varied and balanced meals. However, food remained on heated trolleys and wing hot plates for too long before it was served, sometimes up to three hours. Food comment books showed many complaints from prisoners about the quality of their meals, especially on B and C wings. They did not receive replies and prisoners felt that their views were not taken seriously.

7.2 The main kitchen was in a purpose-built building, and was generally clean and well ordered. However, some flooring around the deep fryers was stained, broken and needed repair. Food was stored in proper conditions, and regular stock control and quality checks were made and recorded. Religious and cultural dietary requirements were observed.

7.3 The atmosphere in the kitchen was relaxed and supportive, but appropriately controlled. Although prisoner kitchen workers were treated with respect and their contributions were encouraged and appreciated by catering staff, formal qualifications, such as national vocational qualifications, were not offered.

7.4 Pre-select menus for lunch and evening meals were offered over a four-week cycle. The selection was balanced with a wide range of choices, including a healthy option and a cooked breakfast at weekends. Fresh fruit was offered every day.

7.5 Meals were transported to serveries on the wings by heated trolleys. These were clean and in good working order. However, the hot meal served to prisoners between 5.30pm and 6.30pm was loaded on to the trolleys as early as 3.30pm, and remained there for up to three hours after it had been cooked. We found that the quality of food had deteriorated during this period, particularly on C wing where the evening meal could be served as late as 6.45pm. In our survey, only 17% of respondents on B and C wings said that the food was good or very good, which was significantly below the average of 30% for the other wings.

7.6 Wing-based serveries were clean and well equipped. Servery workers wore protective clothing and the handling of food was appropriate. Although food comment books were available to prisoners at all serveries, complaints about the quality of food were not always answered by catering staff. The catering manager attended the monthly prisoner consultation meetings, but catering staff were not present on the wings when meals were served. Prisoners, particularly young adults on C wing, said they felt they had little opportunity to make meaningful comments about the food.

Recommendations

7.7 Hot food should be served to prisoners shortly after it has been cooked.

7.8 Catering staff should regularly attend wings at meal times to answer prisoner complaints and to check the quality of food served.

7.9 All comments from prisoners about the quality of prison food should be replied to.

Prison shop

Expected outcomes:
Prisoners can purchase a suitable range of goods at reasonable prices to meet their diverse needs, and can do so safely, from an effectively managed shop.

7.10 The in-house prison shop was well managed by enthusiastic staff. There was a good selection of items, including those that reflected the diverse needs of the prisoner population, with prices mainly in line with the high street. However, the range of goods was restricted because of a lack of space to store fresh food, especially fruit and vegetables.

7.11 The prison shop was run as an in-house operation with a full-time manager supported by two administration officers. The list of goods available for prisoners to buy was published and available on all wings.

7.12 Prisoners could order items every week and new arrivals were normally able to receive a full service the day after their arrival. New arrivals without private money were offered a £2 advance and a pack containing basic items, such as tobacco, snacks and basic toiletries.

7.13 Although the range of goods was generally adequate and reflected the diverse needs of the prisoner population, and prices were comparable with the high street, the available storage space was small, which meant that items such as fresh fruit and vegetables could not be stocked.

7.14 The pre-ordered, bagged and delivered service was efficient and sufficiently flexible to accommodate the needs of those about to leave or just arriving. Orders were delivered to prisoners on their wings, and staff supervision of this process was good. Prisoners could also order a range of items from catalogues.

Recommendation

7.15 A range of fresh food, including fruit and vegetables, should be available from the prison shop.

Section 8: Resettlement

Strategic management of resettlement

Expected outcomes:
Resettlement underpins the work of the whole establishment, supported by strategic partnerships in the community and informed by assessment of prisoner risk and need.

8.1 The resettlement of prisoners had been given a high priority. The area was well managed by a team of dedicated staff, and service providers could share information and contribute to developments. However, the published policy did not represent the prison's strategy to meet the resettlement needs of prisoners, and did not include many of the positive interventions recently introduced.

8.2 There had been improvements in prioritising and developing resettlement services for prisoners since the last inspection. A new offender management unit had begun to draw together the various strands of resettlement services, including sentence management, offender assessment system (OASys), release on temporary licence, public protection and home detention curfew. Other resettlement services were managed separately by a team of managers, officers and external community service providers, such as Nacro, Jobcentre Plus and the Foundation Training Company.

8.3 A senior governor grade had overarching managerial responsibility for all resettlement strands, including offender management, supported by a deputy and a designated resettlement manager.

8.4 The type and range of resettlement services was based on an annual prison-wide analysis of the needs of all prisoners. Results from the 2007 analysis had been published and had been used to inform and update provision.

8.5 A resettlement manager had been appointed in March 2007 to coordinate links with voluntary, community-based and statutory agencies and to ensure that staff worked in collaboration to achieve agreed results. There were regular meetings. The resettlement manager had introduced a single document, the custody passport, that was used by all resettlement agencies to monitor and record the immediate and longer term resettlement needs of prisoners (see paragraph 8.15).

8.6 A resettlement committee had been formed and met monthly to monitor the quality of resettlement outcomes and maintain the direction of services. It was chaired by the head of resettlement and attended by senior managers from appropriate areas in the prison, such as induction, healthcare, security and residential areas, as well as representatives from the external resettlement agencies. Managers had been appointed to each resettlement pathway. They had specific responsibilities to ensure that agreed outcomes were delivered in each area, and also attended all resettlement committee meetings. Minutes showed that managers were clear about their areas of responsibility and were actively involved in the planning and delivery of services. They presented formal reports, and agreed action was taken and monitored where necessary.

8.7 A resettlement strategy document had been reviewed and republished in 2007. Although it broadly described the establishment's intent and aspirations for the resettlement of prisoners, it did not present a strategic overview and did not include many of the recent positive interventions. There was little mention of the interface between offender management and the rest of the prison, and there was insufficient information about management systems, monitoring of outcomes or the prison's links with voluntary and community agencies. The type and range of services was not explicit in the document. Residential staff we spoke to were generally unaware of their responsibilities in prisoner resettlement.

Recommendations

8.8 There should be a resettlement strategy document that represents the prison's strategic overview of resettlement and intervention structures, and apportions responsibilities.

8.9 The resettlement strategy document should be widely advertised to all staff, particularly officers working on the wings.

Offender management and planning

Expected outcomes:
All prisoners have a sentence or custody plan based upon an individual assessment of risk and need, which is regularly reviewed and implemented throughout and after their time in custody. Prisoners, together with all relevant staff, are involved with drawing up and reviewing plans.

8.10 An offender management unit had been set up and full-time offender supervisors appointed. The unit was well managed and developing its role. High risk prisoners had been prioritised, and in-scope cases for national offender management procedures were dealt with effectively. Links between the unit and the wings were not yet adequately established. The number and quality of completed offender assessment system (OASys) assessments for prisoners serving 12 months and over had improved. However, formal custody planning for remanded prisoners and convicted prisoners serving less than 12 months required further development. There were unacceptably long delays in the transfer of life- and indeterminate-sentenced prisoners from Chelmsford to dedicated lifer centres. The establishment was not equipped to meet the needs of this population on a long-term basis.

8.11 A dedicated offender management unit (OMU) had been established and three full-time offender supervisors had been appointed. The multidisciplinary team was made up of seconded probation officers, prison officers and administration grades. It was responsible for offender assessment system (OASys), public protection, sentence planning and offender management.

8.12 The unit was managed overall by the head of resettlement and was effectively integrated into the prison's resettlement strategy through staff attendance at resettlement committee meetings. However the role of the unit was poorly advertised and not adequately described in the prison's resettlement strategy document (see paragraph 8.7).

8.13 High risk prisoners had been prioritised for case management, and all of the 71 in-scope cases were managed through the NOMS offender management model. In these cases, there was a high level of integration between sentence planning and other functions in the prison, including public protection, the psychology department and the resettlement team. Sentence planning

boards were held and targets for improvement were made through consultation with the prisoner. Links between the OMU and wings had begun to develop, but were not adequately established. Although we saw some entries in wing files from offender supervisors that recorded some progress against sentence plan targets, residential staff and personal officers in particular, were uninvolved in the process. Residential staff we spoke to said that they were unaware of their particular responsibilities for sentence management. Although most were aware of the role of the OMU, they were unsure how it linked with their own.

8.14 There had been an increase in the number of completed OASys assessments for prisoners serving 12 months and over. At the time of inspection, of the 194 prisoners eligible for OASys, 91 were complete, 58 were in process and 45 had not yet been allocated. The quality of completed assessments was good. There was regular consultation with prisoners, and risk factors were identified and targets set that directly related to those that were relevant.

8.15 Formal custody planning for remanded prisoners and convicted prisoners serving less than 12 months was underdeveloped. Although prisoners' individual risk and resettlement needs were assessed during their induction, those on remand or serving less than 12 months did not have a formal plan that tracked progress, including post-custodial needs. However, the prison had developed a custody passport, drawn up during induction, that recorded the immediate and mid-term needs of all prisoners. This gave assurance that the basic resettlement needs of shorter term prisoners were being addressed. This computer-generated form was used by all agencies to record required action on housing, finance and offending behaviour needs. Progress was monitored by the resettlement manager, and prisoners were invited to attend a discharge clinic four to six weeks before their release to deal with any changes to their circumstances.

8.16 The Foundation Training Company offered a four-week pre-discharge course to prepare prisoners for release. The course was accredited by the Open College Network and allowed prisoners to obtain recognised qualifications in communications, numeracy and basic information technology. Other modules included preparation for work, personal development and money management.

8.17 Prisoners subject to public protection measures were informed in writing of the arrangements to manage their risk by the nominated public protection manager. There were effective systems to identify all high risk prisoners. Daily lists of new receptions were generated by an OMU administration officer and passed to the public protection manager that day. Restrictions on prisoners subject to measures were authorised by a governor and relevant agencies/departments informed. All those subject to any monitoring were seen by the public protection manager who explained how the restrictions affected them.

8.18 Release on temporary licence (ROTL) was not used effectively for resettlement and suitable prisoners were not identified. Prisoners told us they were unaware of how to access the system. Only six prisoners had been released on resettlement licence since January 2007.

Indeterminate-sentenced prisoners

8.19 The post of lifer manager was covered by one of the residential principal officers. He was supported by at least one trained lifer officer on each wing. At the time of inspection, the establishment had 19 lifers and 27 prisoners serving indeterminate sentences for public protection (IPPs). This was a significant increase. The lifer committee met monthly, chaired by the lifer manager. Attendance at these meetings was good. However, there was no forum for lifers to meet staff and their peers.

8.20 The main problem for lifers and IPP prisoners at Chelmsford was the lack of onward movement into first stage lifer centres or training prisons. Delays were most acute among the lifer population, as IPPs were often prioritised for moves due to their shorter tariffs. At the time of inspection, some lifers had already been waiting to be transferred for over 18 months from their date of sentence, and one prisoner had been waiting for three years. The situation was also poor for IPPs, as some were already approaching their tariff date and at least one had already reached it. The lack of movement on to first stage centres or training prisons had caused significant frustration for staff and prisoners. Despite the best efforts of staff, the establishment was not able to offer the range of services or programmes to meet the needs of these prisoners.

8.21 Potential lifers were identified on reception and interviewed by the lifer manager. Relevant information was issued and they were allocated a lifer trained member of staff as their personal officer. Most multi-agency lifer risk assessment panels (MALRAPs) took place within the four-month target. A few were overdue, but this was being addressed. OASys plans for lifers and IPPs were up to date. There was a quarterly newsletter for interested individuals with useful information, including outlining the range of services available at specific first stage establishments.

Recommendations

8.22 Links between the offender management unit and the wings should be developed. Residential staff should be more involved in supporting prisoners to achieve sentence planning targets.

8.23 Prisoners suitable for release on temporary licence should be considered and encouraged to apply.

8.24 All prisoners should have a written plan that specifies how their specific needs are to be met during and post custody

8.25 Life- and indeterminate-sentenced prisoners should be transferred to an appropriate establishment at the earliest opportunity.

8.26 All lifers should get the opportunity to participate in regular group meetings with a lifer manager.

Resettlement pathways

Expected outcomes:
Prisoners' resettlement needs are met under the seven pathways outlined in the Reducing Reoffending National Action Plan. An effective multi-agency response is used to meet the specific needs of each individual offender in order to maximise the likelihood of successful reintegration into the community.

8.27 Reintegration services were generally effective. Services to help prisoners find accommodation after release were well developed, as was the pre-release employability training provided by the Foundation Training Company. There were also plenty of sources of advice on finance, benefits and debt. Prisoners with identified health needs were seen before release, but there was no systematic process to pick up all prisoners before their final discharge. The drug

strategy was going through considerable change with the imminent onset of the integrated drug treatment system, but there was no counselling, assessment, referral, advice and throughcare service (CARATs) specialism to meet the needs of young adults. There were some useful initiatives, including an innovative weekly homework club, to support links to children and families, and the accredited programmes provided were appropriate for a local prison population.

Accommodation

8.28 There were well-developed services to help prisoners find accommodation after release. Prisoners had good access to these services, mainly through the De Paul Trust for prisoners aged 25 and under and Nacro for those over 25. All prisoners were seen by housing officers during their induction programme. Needs were assessed, recorded and tracked on the prisoner custody passport (see paragraph 8.15). At the end of their sentence, prisoners were invited to attend a housing clinic six weeks before their release date to reassess their needs and respond to any changes in circumstances.

8.29 These services were effective in maintaining prisoners' existing housing and in finding new accommodation for those with none on release. From April to June 2007, only 21 of 209 prisoners released had no prearranged accommodation to go to.

8.30 Services were well advertised on all wings, and prisoners could contact housing officers through application. Further housing needs clinics were held each Wednesday, which prisoners could attend for advice.

Education, training and employment

8.31 Pre-release employability training was good. The Foundation Training Company provided a well-established programme for prisoners approaching release. Two-day short courses and a longer programme met the needs of long- and short-term prisoners effectively. Programmes concentrated on developing prisoners' employability, job search and ICT skills. Access to a range of other providers of advice, guidance and support was carefully integrated to help prisoners into jobs and to meet their other practical needs. Prisoners' attainment was carefully monitored and their progress clearly recorded.

8.32 The Next Step contractor, Anglia Guidance, offered pre-release information, advice and guidance on request. It referred prisoners to agencies inside and outside the prison that could help them secure employment. It took part with other agencies, such as Jobcentre Plus, in a useful resettlement event offered to prisoners three weeks before their release.

8.33 Vocational training included some useful accredited health and safety training. Newly developed training in construction was an appropriate response to skills shortages in London and the South East. However, too little of the prison's employability training or other learning and skills provision was clearly aimed at meeting resettlement needs.

Finance, benefit and debt

8.34 The prison offered a good service overall. The financial situation of new arrivals was assessed during their induction programme. Nacro and the De Paul Trust provided assistance where necessary to close down rental and housing agreements to prevent accrual of rent arrears.

Jobcentre Plus provided advice on benefit entitlement. Specialist staff also saw prisoners at a resettlement discharge clinic six weeks before their discharge.

8.35 The prison had plans, in conjunction with Citizens Advice, to introduce a course in debt and bank account management, but these had not yet been implemented. The Foundation Training Company offered money management modules in its resettlement course (see paragraph 8.31).

Recommendation

8.36 The planned course in debt and bank account management should be introduced.

Mental and physical health

8.37 Health staff liaised with housing, probation and OASys in connection with prisoners with health problems likely to affect their resettlement. Prisoners due for release were prescribed any medication they were on, and given a standard letter for their GP stating that a medical report could be provided on request. Prisoners without a GP were given advice on how to register.

8.38 There was no systematic population-based work to ensure all prisoners due for discharge were given advice on accessing health services, health promotion and illness prevention. Condoms were not issued. A previous resettlement 'clinic' where prisoners due for release could ask for advice from a number of services, including healthcare, no longer ran.

8.39 The primary care mental health and the mental health in-reach teams attempted to link with external organisations to prepare for the release of prisoners with mental health problems. This generally worked well for the local mental health teams in Essex, but had been more difficult where patients were released to other areas.

Recommendations

8.40 All prisoners should receive information in preparation for release on health protection and access to health services.

8.41 Mental health services in the prison should work actively with a prisoner's local mental health team to prepare for their release.

Drugs and alcohol

8.42 The drug strategy was headed by the offender management unit's governor. A dedicated principal officer managed and coordinated the different strands of the strategy. Monthly multidisciplinary meetings were well attended by relevant departments, service providers and representatives from the local drug intervention programme (DIP). There were excellent strategic and operational links with community partnerships.

8.43 The drug strategy document had recently been reviewed. It was in line with the Prison Service Eastern area drug strategy, contained a local action plan, and incorporated the integrated drug treatment system (IDTS), which was due to be implemented. A comprehensive alcohol policy was also in place. However, there had been no detailed population needs analysis to inform the drug and alcohol strategy for two years.

8.44 Counselling, assessment, referral, advice and throughcare (CARAT) services were provided by a manager, a deputy and nine workers from ADAPT (Alcohol and Drug Addiction Prevention and Treatment), as well as two officers. A third officer post was vacant. The team had increased to allow for the roll-out of IDTS groupwork modules. Appropriate management and supervision arrangements were in place, and all staff had access to training. The officers had, until recently, been diverted to other duties, which was not acceptable. The service was accommodated in well-refurbished offices on E wing. Under the IDTS initiative, the team's work would extend to Saturday mornings and evenings.

8.45 Prisoners received daily induction input, and the initial triage assessment was completed within the first two or three days of their arrival. Substance misuse nurses had recently started to undertake the first part of this assessment for prisoners requiring detoxification. The service was on target to meet the key performance target of 1,060 initial assessments, as well as local targets for comprehensive assessments, care plans, groupwork and one-to-one sessions.

8.46 In July 2007, the team's active caseload stood at 289 clients, 75 of whom were young adults. The service was divided into three teams, and each shared a caseload. This system ensured good client access to workers, but young adults were not prioritised and no one specialised in working with the younger age group. In our survey, 25% of young adult respondents said they had a drug problem on arrival, against a comparator of 13%; only 24%, against 46%, knew who to contact in the prison to get help with external drug/alcohol problems; and 28%, against 14%, thought they would have a problem with drugs when they left.

8.47 CARAT clients' care plans were detailed and of a high standard. Structured one-to-one work was supplemented with in-cell work packs. The service had introduced three two-hour IDTS groupwork modules in June 2007 – motivation to change, alcohol awareness and relapse prevention. Additional modules, such as drug and cocaine/crack awareness, were due to be rolled out. Two dedicated groupwork rooms were available on E wing.

8.48 Substance misuse nurses and CARAT workers did not currently provide an integrated service, but were due to do so under the IDTS. Nurses were not yet in post to run health awareness sessions. There were no regular meetings between the services to jointly plan and review prisoners' care.

8.49 Prisoners with primary alcohol problems were given an in-cell pack, but the CARATs contract excluded ongoing one-to-one work with primary alcohol users. In practice, the service was flexible. Other services for problem alcohol users included a 10-week alcohol awareness group run by the mental health in-reach team at the day centre, and weekly Alcoholics Anonymous meetings facilitated by CARAT officers and the voluntary drug testing (VDT) coordinator separately for vulnerable prisoners, young adults and the general population.

8.50 The CARAT service was well integrated into the prison, and represented at relevant multidisciplinary meetings. Clients who required counselling were referred to the mental health in-reach team. Joint work on dual-diagnosis clients had not been formalised with the primary or secondary mental health service.

8.51 Excellent links had been established with the local DIP service to facilitate prisoners' throughcare. Two part-time DIP prison link workers, a sessional drug and alcohol counsellor, and volunteer mentors were available to focus on release planning. A dedicated DIP housing officer was also due to provide regular input to prisoners. In our survey, only 8% of adult respondents thought they would have a problem contacting drug/alcohol agencies on release, against a comparator of 22%. However, 35% of young adults thought this would be

problematic, against a comparator of 18%. DIP and CARAT workers reported a lack of appropriate community services to support young adults post-release.

8.52 Prisoners with at least three months left to serve could undertake the prison-addressing substance related offending (P-ASRO) programme. In 2006, 96 started and 81 completed the course, exceeding the completion target of 62. P-ASRO could also be accessed by young adults, with a maximum of two participating in a course. In our survey, 40% of adult respondents thought the alcohol/drug programme would help them on release, significantly above the comparator of 24%.

8.53 P-ASRO had run since 2004, was well managed and well established, valued by the prison, and had achieved an audit score of 100%. The team consisted of a treatment manager, deputy, psychology assistant and two officers, with another officer post vacant. All were directly employed by the prison. The CARAT deputy manager was the continuity/resettlement officer, and the drug strategy coordinator was the programme manager. There was a good level of joint work with the CARAT team. The team was piloting a revised P-ASRO manual, which put more emphasis on harm reduction and relapse prevention, but the course was still abstinence-based. It was, therefore, unlikely that prisoners maintained on methadone under the IDTS would be able to access this programme.

8.54 Voluntary drug testing (VDT) was available to prisoners whatever their location. Two hundred and twenty prisoners had signed VDT compacts, against a target of 200, and the required testing frequency was achieved. A dedicated officer coordinated the scheme, and approximately 50 staff were trained in the procedure. VDT positive rates were low and mainly for cannabis, followed by benzodiazepines.

8.55 A separate compact had been devised for enhanced level prisoners on G wing, the VDT unit, but testing was still described as 'voluntary' rather than as compliance testing.

Recommendations

8.56 There should be a detailed population needs analysis to inform the drug and alcohol strategy.

8.57 Dedicated counselling, assessment, referral, advice and throughcare (CARAT) officers should not be diverted to other duties.

8.58 The drug strategy team should ensure that services meet the needs of young adults, and the CARAT team should develop specialised work with this age group.

8.59 CARAT and healthcare services should work together in a more integrated way to plan and coordinate prisoners' care.

8.60 P-ASRO programme staff should develop a peer support scheme.

8.61 The area drug coordinator and the prison should assess the need for an additional drug/alcohol programme suitable for prisoners in the integrated drug treatment system who are not on maintenance programmes.

8.62 There should be a clear distinction between voluntary and compliance drug testing in prisoners' compacts.

Good practice

8.63 *The establishment had developed excellent strategic and operational links with community partnerships. The local drug intervention programme provided a range of prison-link services to help prisoners plan for their release.*

Children and families

8.64 Contact details for a range of prison visitor support groups and the assisted prison visits scheme were well publicised in the visitor centre. Details were also included in various leaflets that were freely available. A CARAT worker attended the visitor centre each Thursday to hand out leaflets to visitors and explain the range of services. Visitors could discuss any concerns with centre staff after their visit or report them on the safer custody helpline. The safer custody team kept a diary of calls received and any follow-up action. They routinely consulted with family members and gave them feedback.

8.65 The Ormiston Trust presented an Open College Network-accredited parenting course four times a year. It also arranged monthly children's visits, which were well established. To qualify for these visits prisoners had to pass a risk assessment, which included at least one month clear of any positive drug tests. The establishment had also planned a family day to coincide with national play day on 1 August 2007. Relationship counselling was available through the DIP programme.

8.66 The establishment held a homework club every other Tuesday evening. Run by some staff and volunteers, the club was well publicised to staff and prisoners. Prisoners were subject to careful risk assessment to be selected to take part. All staff involved had been screened and received an enhanced Criminal Records Bureau disclosure. Children were collected from their mother or legal guardian outside the main gate and taken into the prison for their father to assist with their homework. If the child was too young to be given homework, age-appropriate activities were provided by staff from the education department. Meals for the children were donated by Sainsburys. Although these arrangements benefited only a few prisoners, they had a significant impact on those involved.

8.67 Evening visits had just been introduced for enhanced level prisoners. Accumulated visits were available, and the qualifying criteria were explained in a published policy document.

Good practice

8.68 *The homework club assisted carefully selected prisoners to maintain a special bond with their children.*

Attitudes, thinking and behaviour

8.69 The provision of interventions to deal with offending behaviour was appropriate and well managed. A prisoner needs analysis carried out in 2007 had been used to inform the provision.

8.70 The prison offered two offending behaviour programmes that had been accredited by the Prison Service. Enhanced thinking skills (ETS) and prison-addressing substance related offending (P-ASRO) (see paragraphs 8.52-53) were delivered by a dedicated programmes group with trained staff, including prison officers, psychologists and psychology assistants.

8.71 Appropriate referral and assessment systems were in place and were managed effectively by a nominated programmes manager, supported by the head of the psychology department. There were strong links with the OMU and resettlement team. Referrals were made by offender supervisors for case managed offenders (see paragraph 8.13) according to prisoner need identified through OASys. Other prisoners were referred from residential staff, induction officers and prisoners themselves.

8.72 ETS was delivered by trained staff from the programmes group. The standard of delivery was high with an implementation quality rate (IQR) of 100%. The prison could offer 50 places on courses per year. Attendance lists were well managed and all prisoners who had been assessed as suitable for ETS had been scheduled on to a course. Separate courses were run for prisoners from the vulnerable prisoner unit. Classrooms were properly equipped, of adequate size and well decorated.

8.73 Prisoners were motivated to participate in interventions, and there was also work to prepare sex offenders for the sex offender treatment programme (SOTP) and controlling anger and learning to manage it (CALM) course offered at other prisons on transfer.

Section 9: Recommendations, housekeeping points and good practice

The following is a listing of recommendations and examples of good practice included in this report. The reference numbers at the end of each refer to the paragraph location in the main report.

Main recommendations to the governor

9.1 Reception and induction arrangements should ensure that vulnerable prisoners are held safely, and have equal access to support and services. (HP48)

9.2 Trained Listeners and Insiders should be available in reception. (HP49)

9.3 Strip conditions and CCTV coverage should only be used in exceptional circumstances to manage prisoners at serious risk of self-harm, and only when other methods of direct and constant engagement and support have been tried, and failed. (HP50)

9.4 The prison should introduce strategies to reduce bullying and fighting, in particular among young adults. (HP51)

9.5 Force should be used by staff against prisoners only as a last resort, when all other courses of action have been explored and ruled out. (HP52)

9.6 The provision of kit for prisoners should be improved with access to kit exchange for all at least once a week. (HP53)

9.7 Complaints should be fully investigated and resolved appropriately and within agreed timescales. (HP54)

9.8 The prison should increase the amount of appropriate activity, particularly accredited activity. (HP55)

9.9 There should be a full needs assessment of the young adult population, and the results of this should inform local policies, regimes and the delivery of interventions. Young adult prisoners should be involved in this process. (HP56)

9.10 Patients with mental health problems should receive the full range of appropriate multidisciplinary treatment and care as set out in National Institute for Health and Clinical Excellence (NICE) guidelines. (HP57)

Recommendations to NOMS

9.11 Prisoners should arrive at the prison before 7pm to ensure that appropriate induction and first night processes can take place. (1.5)

9.12 Life- and indeterminate-sentenced prisoners should be transferred to an appropriate establishment at the earliest opportunity. (8.25)

Recommendation to Border and Immigration Agency

9.13 The Border and Immigration Agency should visit the establishment to meet foreign national prisoners and discuss their immigration cases. (3.72)

Recommendations to the area manager

9.14 There should be new shower facilities on B, C and D wings. (2.13)

9.15 The area drug coordinator and the prison should assess the need for an additional drug/alcohol programme suitable for prisoners in the integrated drug treatment system who are not on maintenance programmes. (8.61)

Recommendations to the governor

Courts, escorts and transfers

9.16 Prisoners should be allowed to disembark from cellular vehicles and wait in holding rooms before they are processed. (1.6)

9.17 Escort staff should wait with prisoners in vans rather than in reception. (1.7)

First days in custody

9.18 Insiders should be available to speak to new arrivals on the first night wing after 8.30pm. (1.22)

9.19 Prisoners should be able to make a free telephone call on their day of arrival. (1.23)

9.20 Prisoners should be able to have a shower on their day of arrival. (1.24)

9.21 There should be clear contingency arrangements to cover the location of new arrivals when E wing spaces are unavailable. (1.25)

9.22 The induction policy should include induction for vulnerable prisoners. (1.26)

Residential units

9.23 Cells with toilets not in a separate area should not be used for double occupancy. (2.14)

9.24 Toilets in shared cells should have fixed privacy screening and should be kept in good repair. (2.15)

9.25 Prisoners should be able to have kettles or flasks in their cells. (2.16)

9.26 Furniture in cells should be fit for purpose and a locked cupboard should be provided. (2.17)

9.27 Cells should be well maintained and in a good state of repair. (2.18)

9.28 The prison should ensure that prisoners and visitors are clear about the processes for handing in changes of clothing. (2.19)

9.29 Recreational facilities for prisoners should be maintained and replaced when required. (2.20)

9.30 Prisoners should be able to dine in association. (2.21)

Staff-prisoner relationships

9.31 The prison should develop a programme of regular discussion forums and surveys to obtain a more informed view of prisoner opinion. (2.27)

9.32 There should be training to improve staff work with young people. (2.28)

9.33 Managers should monitor staff-prisoner relationships in all wings, as evidenced in documentation and interactions, in order to ensure consistency and best practice. (2.29)

Personal officers

9.34 The new personal officer scheme should be supported by staff briefings about the requirements of the new policy to ensure personal officers are aware of their role and responsibilities. (2.34)

Bullying and violence reduction

9.35 The data provided to the safer custody team should enable emerging trends to be easily identified. (3.10)

9.36 The establishment should investigate the reasons for the significant number of prisoners reporting that they feel unsafe at Chelmsford, and put in place arrangements to improve this. (3.11)

9.37 All alleged incidents of bullying should be reported and investigated, and entries in wing observation books should be regularly checked for any indications of bullying. (3.12)

9.38 Improvement targets set in anti-bullying monitoring should be better quality and relevant to the prisoner. (3.13)

9.39 Persistent bullies should be referred to the psychology department for one-to-one intervention, and the establishment should also seek to establish other types of interventions for bullies. (3.14)

9.40 Information relating to bullies and victims should be cross-referenced into wing history files. (3.15)

9.41 There should be support plans for victims of bullying. (3.16)

Self-harm and suicide

9.42 The quality of initial assessment, care in custody and teamwork (ACCT) assessor reports should be significantly improved and regularly monitored, and all ACCT documents should include a care map. (3.33)

9.43 Staff monitoring entries in ACCT documents should demonstrate a high level of engagement with the prisoner. (3.34)

9.44 Prisoners should have 24-hour access to Listeners. (3.35)

9.45 CCTV should not be used as an alternative to observation of and engagement with prisoners at risk of self-harm, whereby staff are on hand to engage with the prisoner and offer individual support. (3.36)

Race equality

9.46 A race equality strategy should be developed. (3.52)

9.47 The race equality officer post should be full-time. (3.53)

9.48 Assistant race equality officers should be appointed on each wing to assist the race equality officer and act as a first point of contact on the wings on race-related issues. They should have a job description and facility time to carry out their duties. (3.54)

9.49 Black and minority ethnic prisoner consultation forums should be initiated. Areas where black and minority ethnic prisoners have reported wide variations in perceptions compared with white prisoners should be explored further. (3.55)

9.50 The race equality action team should monitor successful applications for category D status by ethnicity. (3.56)

9.51 The innovative integrated diversity training package for staff and prisoners should be delivered to all staff, with priority to those in prisoner contact roles. (3.57)

9.52 Delays in initiating racist complaints investigations should be reduced. (3.58)

9.53 If a prisoner has transferred while their racist incident complaint is still outstanding, this should be followed up in all cases and final outcomes of investigations recorded on Chelmsford's racist incident report form log. (3.59)

Foreign national prisoners

9.54 An analysis should be undertaken, in conjunction with prisoners, to determine the needs of foreign national prisoners at Chelmsford, and the resources required to deliver services effectively and consistently. This analysis should be the basis for an effective strategy for meeting the needs of foreign national prisoners. (3.67)

9.55 There should be more resources for the provision of service for foreign national prisoners to enable a more proactive approach to this work. (3.68)

9.56 Foreign national prisoner representatives should be appointed on every wing. They should have a formal job description and regularly meet the diversity manager and foreign nationals coordinator. (3.69)

9.57 Prisoner mentors should be identified for prisoners who do not speak English. (3.70)

9.58 There should be informal drop-in sessions for foreign national prisoners. (3.71)

9.59 There should be greater awareness among staff and prisoners of entitlements for foreign national prisoners and how to apply for them, and the induction booklet should contain information for foreign national prisoners. (3.73)

Contact with the outside world

9.60 Prisoners should be able to use telephones on a daily basis, and have increased access during the evening period. (3.87)

9.61 There should be a visitors' survey to assess their levels of satisfaction with the services. (3.88)

9.62 Visitors should be notified when a prisoner is not available for a booked visit. (3.89)

9.63 Entry arrangements should not result in unacceptable delays for visitors. (3.90)

9.64 A positive indication by a drug dog should only result in a closed visit where there is other supporting intelligence. (3.91)

9.65 The establishment should attempt to reduce the noise in the main visit room. (3.92)

9.66 The children's play area in the main visit room should be staffed for all visit sessions. (3.93)

9.67 Prisoners should be removed from closed visits at the earliest opportunity; reviews should routinely include formal contributions from residential staff. (3.94)

Applications and complaints

9.68 Where complaints need to have additional information from a third party, staff should set a date for a final response and advise the prisoner of this process. Final responses and outcomes should always be filed with interim replies. (3.101)

9.69 The complaints process, including appeals, should be clearly publicised for prisoners and be available in a range of languages. (3.102)

9.70 Complaints relating to staff behaviour should be logged, dealt with by senior managers, and trends noted and acted upon. (3.103)

Substance use

9.71 Opiate-dependent prisoners should be given appropriate first night clinical support. (3.123)

9.72 Clinical treatment should be flexible, based on individual need and include the option of stabilisation/maintenance regimes. (3.124)

9.73 Healthcare and counselling, assessment, referral, advice and throughcare (CARAT) services should work in an integrated way and coordinate prisoners' care jointly. (3.125)

9.74 Healthcare providers' skill mix should include dual-diagnosis expertise. (3.126)

Vulnerable prisoners

9.75 There should be a risk assessment of the appropriateness of mixing vulnerable young adults with adult prisoners. (3.131)

9.76 There should be an alternative route for mainstream prisoners during free-flow movement so that they do not have to pass through D wing. (3.132)

9.77 Staff should not disclose the identities of vulnerable prisoners to other prisoners. (3.133)

Young adult prisoners

9.78 An identifiable manager should be appointed with overall strategic responsibility for young adult prisoners at Chelmsford. A strategy should be developed for their overall management. (3.139)

Health services

9.79 There should be a programme of clinical audit that covers topics appropriate to prison health. (4.37)

9.80 Prisoners should have more opportunities to give feedback and make suggestions about health services. (4.38)

9.81 There should be steps to identify and minimise any barriers to health services experienced by young adults, foreign nationals and other potentially excluded groups. (4.39)

9.82 Prisoners who wish to make a complaint about healthcare should be able to do so in confidence direct to healthcare. (4.40)

9.83 There should be a review of the skill mix and staff complement, including the need for dual-diagnosis (substance misuse and mental health problems) expertise and more multidisciplinary input to mental healthcare. (4.41)

9.84 All health staff, including the dental team, should receive annual updates on resuscitation skills and use of the defibrillator. (4.42)

9.85 GPs practising at the prison should have access to learning and development programmes in line with what is available for GPs working in the community. (4.43)

9.86 Full and complete signed records of administration of medicines should be kept on prescription charts, including where patients refuse medication or fail to attend. (4.44)

9.87 Failure to attend or refusal of medication should be followed up and appropriate action taken. (4.45)

9.88 Healthcare staff should make full use of the opportunities provided during reception, induction and secondary screening procedures to ensure prisoners have maximum opportunity to benefit from health services. (4.46)

9.89 Prisoners should be able to apply to be seen in healthcare using a confidential and dedicated procedure that is regularly reviewed to identify and remedy any delays. (4.47)

9.90 Nursing staff should use clinical triage algorithms to ensure consistency of advice and treatment to prisoners. (4.48)

9.91 Patient group directives should be developed to support a greater range of nurse-led treatment. (4.49)

9.92 Patients attending healthcare should have reasonable notice of their appointment. (4.50)

9.93 There should be more efficient use of the optician's sessions to reduce waiting times. (4.51)

9.94 A wider programme of chronic disease management should be introduced. (4.52)

9.95 Patients should be able to collect their medicines in privacy. (4.53)

9.96 There should be appropriate identity checks of prisoners before medication is supplied. (4.54)

9.97 Records of all medications supplied to a patient, whether prescribed or not, should be maintained on one record, together with a reason for the supply of any non-prescribed medicine. (4.55)

9.98 Procedures should be used to identify and address overuse of non-prescribed medication. (4.56)

9.99 All staff who give out non-prescribed medicines should receive training on their use. (4.57)

9.100 There should be an agreed, transparent and documented risk assessment procedure, including regular multidisciplinary review, to determine whether a patient can have their medication in possession. (4.58)

9.101 The medicines management committee should regularly review prescribing trends to guide policy development and check on implementation. (4.59)

9.102 The healthcare department should work with the rest of the prison to minimise missed appointments, especially with the dentist. (4.60)

9.103 The dentist should provide regular returns of the numbers of patients seen and treatment provided. (4.61)

9.104 The number of trained health staff on night duty should be increased to provide safe cover of the inpatient unit and the wings. (4.62)

9.105 Inpatients should have access to therapeutic daycare options, including education and work appropriate to their clinical condition and that contribute to their recovery. (4.63)

9.106 Inpatients should have daily opportunities for exercise and association equivalent to the rest of the prison, as their clinical condition allows. (4.64)

9.107 Healthcare and other prison staff should work jointly to manage and take responsibility for decisions about prisoners at risk of suicide and self-harm. (4.65)

9.108 The care programme approach should be used for patients with severe mental illness. (4.66)

9.109 Prisoners requiring specialist mental health inpatient care should be assessed within seven days and transferred expeditiously. (4.67)

Learning and skills and work activities

9.110 More prisoners in work or vocational training should have the opportunity to achieve substantial vocational qualifications. (5.17)

9.111 Learning and skills programmes should be better matched to prisoners' length of stay. (5.18)

9.112 Planning of learning to meet individual needs, assessment and recording of progress should be improved, and there should be better coordination of access to activity. The collation and use of data in planning provision should be improved. (5.19)

9.113 There should not be routine over-allocation of prisoners to workshops or classes. (5.20)

9.114 The library's stock of books, newspapers and periodicals in foreign languages and legal and reference books should be increased. (5.21)

9.115 The library facility should be enlarged and improved to meet the needs of the prison population. (5.22)

9.116 All prisoners, including employed prisoners, should have regular access to the library. (5.23)

9.117 There should be appropriate links between the library and learning and skills providers to ensure the library contributes effectively to prisoners' learning and development. (5.24)

Time out of cell

9.118 Wing routines should be followed in accordance with published core day timetables. (5.42)

9.119 Time out of cell should be increased. (5.43)

9.120 All wings should benefit from evening association. (5.44)

Security and rules

9.121 Prisoners should receive fuller written explanations for decisions following closed visits reviews. (6.10)

9.122 The quality of information and the range of contributions for closed visits reviews should be improved. (6.11)

9.123 Decisions to ban visitors should be reviewed regularly. (6.12)

9.124 The criteria for the banning of visitors should be reviewed and focus on clear and recent intelligence concerning current threats. (6.13)

9.125 Processes to reconcile the prison's roll should be improved, and delays recorded and subject to management scrutiny. (6.14)

Discipline

9.126 The use of unofficial punishments should cease. (6.33)

9.127 The refusal to transfer protocol should be discontinued. (6.34)

9.128 The prison should establish a use of force committee, linked into the violence reduction committee, to monitor in detail use of force incidents. Any lessons learned or training needs identified should be acted on. (6.35)

9.129 Paperwork for the use of force, special accommodation and body belts should always be completed to a high standard. Statements should be thorough and should make clear why the level of force deployed was necessary. (6.36)

9.130 There should be formal allocation criteria for the non-segregation unit cells next to the segregation unit. (6.37)

Incentives and earned privileges

9.131 The establishment should investigate young adults' negative perceptions of the incentives and earned privileges scheme, and support more young adults to achieve enhanced status. (6.48)

9.132 Activity supervisors should routinely contribute to incentives and earned privileges reviews. (6.49)

9.133 Enhanced level prisoners should not receive a higher pay rate for the same work as those on standard or basic levels. (6.50)

9.134 Basic level prisoners should receive some association and should not be deprived of their in-cell power supply. (6.51)

9.135 Wing history files should show evidence that verbal warnings have been issued before red entries are made. (6.52)

Catering

9.136 Hot food should be served to prisoners shortly after it has been cooked. (7.7)

9.137 Catering staff should regularly attend wings at meal times to answer prisoner complaints and to check the quality of food served. (7.8)

9.138 All comments from prisoners about the quality of prison food should be replied to. (7.9)

Prison shop

9.139 A range of fresh food, including fruit and vegetables, should be available from the prison shop. (7.15)

Strategic management of resettlement

9.140 There should be a resettlement strategy document that represents the prison's strategic overview of resettlement and intervention structures, and apportions responsibilities. (8.8)

9.141 The resettlement strategy document should be widely advertised to all staff, particularly officers working on the wings. (8.9)

Offender management and planning

9.142 Links between the offender management unit and the wings should be developed. Residential staff should be more involved in supporting prisoners to achieve sentence planning targets. (8.22)

9.143 Prisoners suitable for release on temporary licence should be considered and encouraged to apply. (8.23)

9.144 All prisoners should have a written plan that specifies how their specific needs are to be met during and post custody. (8.24)

9.145 All lifers should get the opportunity to participate in regular group meetings with a lifer manager. (8.26)

Resettlement pathways

9.146 The planned course in debt and bank account management should be introduced. (8.36)

9.147 All prisoners should receive information in preparation for release on health protection and access to health services. (8.40)

9.148 Mental health services in the prison should work actively with a prisoner's local mental health team to prepare for their release. (8.41)

9.149 There should be a detailed population needs analysis to inform the drug and alcohol strategy. (8.56)

9.150 Dedicated counselling, assessment, referral, advice and throughcare (CARAT) officers should not be diverted to other duties. (8.57)

9.151 The drug strategy team should ensure that services meet the needs of young adults, and the CARAT team should develop specialised work with this age group. (8.58)

9.152 CARAT and healthcare services should work together in a more integrated way to plan and coordinate prisoners' care. (8.59)

9.153 P-ASRO programme staff should develop a peer support scheme. (8.60)

9.154 There should be a clear distinction between voluntary and compliance drug testing in prisoners' compacts. (8.62)

Housekeeping points

Bullying and violence reduction

9.155 Valuable items, such as radios and CD players, should be security marked. (3.17)

Contact with the outside world

9.156 Publicised opening times for the visits booking line should be adhered to. (3.95)

Health services

9.157 Condoms should be freely available to prisoners. (4.68)

9.158 Hoods should be fitted over the telephones in the inpatients unit. (4.69)

9.159 Regular checks on fridge temperatures and emergency equipment should be documented and any problems rectified promptly. (4.70)

9.160 Entries into clinical notes should include a legible record of the name of the person making the note. (4.71)

9.161 The dentist and the mental health in-reach team should note in the patient's main clinical record that they have seen a patient and provide summaries of treatment and care. (4.72)

9.162 An amalgam separator should be fitted to the dental unit. (4.73)

Discipline

9.163 Punishment tariffs should be published on residential units. (6.38)

Examples of good practice

9.164 The support group for prisoners on open assessment, care in custody and teamwork documents was a valuable forum to discuss their feelings and receive support. (3.37)

9.165 The establishment had developed excellent strategic and operational links with community partnerships. The local drug intervention programme provided a range of prison-link services to help prisoners plan for their release. (8.63)

9.166 The homework club assisted carefully selected prisoners to maintain a special bond with their children. (8.68)