Report on an unannounced short follow-up inspection of

HMP Swinfen Hall

15–17 April 2008

by HM Chief Inspector of Prisons

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Introduction

Swinfen Hall takes young adults, aged 18-20, and adults, aged 21-25, serving lengthy sentences up to life. It has almost doubled in size in recent years and has also effectively integrated the two age ranges. On our last visit, while commending much of what we found, we were concerned that insufficient purposeful activity had been put in place to meet this growth. On our return, for this short unannounced follow-up inspection, we were pleased to find Swinfen Hall remained a safe, respectful place, focused on resettlement, and that much progress had been made in the provision of purposeful activity.

Early days in custody were generally well managed, although we were unhappy with the quality of some safer cells used for new arrivals. Suicide prevention arrangements were good, but more needed to be done to deal effectively with bullies. Nevertheless, drugs were not a significant problem and vulnerable prisoners were safely managed on normal location. Segregation staff worked well with some difficult prisoners, although paperwork was poor and use of special cells and strip clothing needed tightening up.

It was of concern that incidents of violence and hostage taking had increased recently, with a consequential increase in use of force by staff. Managers believed the problems stemmed largely from a rapid influx of large numbers of prisoners on indeterminate sentences for public protection, many of whom had not understood the implications of their sentence and were frustrated by the lack of adequate national planning and resources to progress them appropriately through the system. Fortunately, it appeared that tensions had begun to subside.

The quality of accommodation was mixed, although the newer wings were impressive. Access to showers and telephones was adequate, but depended on staff discretion. Staff-prisoner relations remained very good, supported by a sound personal officer scheme and a meaningful incentives and earned privileges system. While race issues were well managed, provision for foreign national prisoners remained underdeveloped. Health services had improved.

Our previous concerns about a lack of sufficient purposeful activity had largely been allayed. Time out of cell remained adequate and almost all prisoners could now be usefully occupied. There was good access to learning and skills opportunities, although these tended to be low level and some work was menial. Library services, while good quality, struggled to keep pace with the expanded population, but physical education opportunities had increased appropriately.

There was an impressive, if nascent, strategic focus on resettlement, but implementation of the offender management model had been patchy. Initially, personal officers had been expected to act as offender supervisors, but this had proved unsuccessful with little contact with outside probation staff, a backlog in assessments and poor case management. Managers now intended to introduce a more traditional approach.

Work on all the resettlement pathways was generally good and there was an extensive range of offending behaviour programmes. However, we remained concerned about the management of visits, and considered that some of the arrangements for combating the threat of drug smuggling were disproportionate.

Swinfen Hall has, uniquely in the young offender estate, combined young adults aged 18-20 with adults aged 21-25. Integration of the regime has been accomplished with relatively few problems and separation only remained on some residential units. This integration had been aided by Swinfen Hall's ability, as an establishment for long-term prisoners, to progress its own

young adults on to adult wings. Whether this model would be as effective in a short-term or remand environment was less clear, and the Inspectorate would want to be assured that the needs of the respective age groups were properly catered for In any future exercises of this kind.

Swinfen Hall had seen the doubling of its population, some turbulence arising from the rapid influx of large numbers of prisoners serving indeterminate sentences of public protection and the need to integrate different age ranges effectively. Nevertheless, it had been able to sustain the generally safe and respectful atmosphere, focused on resettlement, that we have previously applauded. Commendably, it had also addressed the deficits we identified on our last visit in the provision of purposeful activity. It is, once again, a very impressive prison.

Anne Owers July 2008
HM Chief Inspector of Prisons

Fact page

Task of the establishment
Young adult male long-term training establishment.

Area organisation
West Midlands

Number held
611

Certified normal accommodation
600

Operational capacity
624

Last inspection
September 2005

Brief history
Swinfen Hall opened as a borstal in 1963 and, following a short period as a youth custody centre, in 1988-89, became a long-term closed young offender institution (YOI). Two new wings were built in 1998, increasing the capacity to 320 places. The establishment continued to take young men aged between 18 and 21 serving 3.5 years up to and including life. The establishment has gone through a major expansion programme that has increased prisoner places to 620. Over the last 24 months, Swinfen Hall has changed status from a YOI to a young adult establishment now receiving prisoners aged 18-25. Swinfen Hall currently provides over 340 prisoner places on accredited offending behaviour and drug treatment programmes.

Description of residential units

A, B & C wings	– 180 young adults (18-20)
D & E wings	– 128 young adults (18-20) and lifers/IPP
F & G wings	– 180 adults (21-25)
I & J wings	– 132 young adults (18-20) and adults (21-25), living on separate floors

Section 1: Healthy prison assessment

Introduction

HP1 The purpose of this inspection was to follow up the recommendations made in our last full inspection of 2005 and examine progress achieved. We have commented where we have found significant improvements and where we believe little or no progress has been made and work remained to be done. All inspection reports include a summary of an establishment's performance against the model of a healthy prison. The four criteria of a healthy prison are:

Safety	prisoners, even the most vulnerable, are held safely
Respect	prisoners are treated with respect for their human dignity
Purposeful activity	prisoners are able, and expected, to engage in activity that is likely to benefit them
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.

HP3 This Inspectorate conducts unannounced follow-up inspections to assess progress against recommendations made in the previous full inspection. Follow-up inspections are proportionate to risk. Short follow-up inspections are conducted where the previous full inspection and our intelligence systems suggest that there are comparatively fewer concerns. Sufficient inspector time is allocated to enable

inspection of progress and, where necessary, to note additional areas of concern observed by inspectors. Inspectors draw up a brief healthy prison summary setting out the progress of the establishment in the areas inspected. From the evidence available they also concluded whether this progress confirmed or required amendment of the healthy prison assessment held by the Inspectorate on all establishments but only published since early 2004.

Safety

HP4 In 2005, we assessed the prison as performing reasonably well against this healthy prison test and made 23 recommendations for further improvement. In this short follow-up inspection, we found that the prison had implemented 14 of our recommendations in full, two in part, one was no longer applicable, and six had not been implemented.

HP5 The quality and cleanliness of cellular vehicles had improved with the acquisition of new vehicles. The new reception was a huge improvement, and the environment was much more welcoming than in most prisons. Reception processes were generally good, although prisoners were often sent on to the wings for lunch before they had been fully processed, only to return in the afternoon. This was unnecessary, given that the number of new receptions was low and that most arrived in the late morning.

HP6 First night arrangements were similar to last time for young adults, but had improved for the adult site, so that all new arrivals received equitable treatment. The four safer cells with camera cover on B wing (the first night wing for young adults) were, inappropriately, on the establishment's certified normal accommodation and, therefore, were often used for new arrivals when the jail operated at full capacity. Although suitable for short-term occupancy by prisoners in crisis, the environment of these cells was poor, and they were not suitable for new arrivals' first days.

HP7 The induction process was reasonable. The induction programme was combined for young adults and adult prisoners, and the content was adequate. However, the programme started on Monday, which meant that new arrivals could spend their first few days locked in their cells rather than joining in on a rolling induction.

HP8 The governance of safer custody was good, with an improved strategic focus, and this area was well resourced and managed. Given the nature of the population, bullying was evident, but the establishment was well focused on its prisoners and their propensity for violence. However, there were still no key interventions for bullies, and victim support was underdeveloped. The establishment had not carried out a survey of prisoners about bullying for some time, despite our previous recommendation, so the current strategy was not informed by the views of the prisoners, although a survey was due.

HP9 Suicide prevention was well managed. There had been no deaths at the establishment since the previous inspection. Open self-harm monitoring documentation demonstrated a high degree of care for prisoners' welfare. Recorded observations by staff had also improved. There was much better attendance at the safer custody policy group.

HP10 The security department was well managed. However, the number of violent incidents, including assaults, fights and hostage events, had recently been high. This

was partly due to the general prison population, exacerbated by a sudden and destabilising influx in the last 12 months of prisoners on indeterminate sentences for public protection (IPP), many with short tariffs. Although the situation had settled down, we shared the governor's concern that a continuing increase in IPP prisoners could lead to a re-emergence of problems.

HP11 Use of force had increased significantly since the last inspection, in part due to a number of violent incidents that followed the rapid influx of IPP prisoners. However, the number of incidents appeared to have peaked, and there had been a downward trend over the past three quarters. Governance arrangements were good, and we were assured that staff used force appropriately and as a last resort. Procedures for using the special cell had generally improved, although some prisoners had remained in this accommodation for unnecessarily long periods, and the use of strip clothing needed tighter control – particularly for prisoners on open assessment, care in custody and teamwork (ACCT) forms.

HP12 Adjudication procedures were generally sound. The segregation unit and its regime were little changed. Although staff interacted well with the prisoners in the unit and successfully managed many difficult prisoners back on to normal location, this was not reflected in written documentation, there was little or no evidence of individual care planning, and the quality of ongoing good order reviews for longer term residents was poor.

HP13 The year-to-date positive mandatory drug testing rate was 5.64%. Although above the target of 4%, this was still relatively low, and feedback from prisoners and other indicators suggested that drugs were not widespread in the establishment. A protocol for a secondary detoxification service was required as a safeguard.

HP14 There was a policy of integrating vulnerable prisoners with the general population, which worked well. Staff were attuned to the risks involved with this strategy, and had a good knowledge of vulnerable prisoners on their wings. This was well managed, and vulnerable prisoners said that they felt secure and well supported by staff.

HP15 There had been some progress in this area, and the establishment managed safety issues well. However, the level of violent incidents and use of force had recently been high and, although both were decreasing, we were not yet sufficiently assured that this downward trend would be sustained. The establishment was still performing reasonably well against this healthy prison test.

Respect

HP16 In 2005, we assessed the prison as performing reasonably well against this healthy prison test and made 51 recommendations for further improvement. In this short follow-up inspection, we found that the prison had implemented 25 of our recommendations in full, seven in part, one was no longer applicable, and 18 had not been implemented.

HP17 The environment was similar to last time, with generally good standards of cleanliness in outside and communal areas. Cells were of mixed standards, but some were poor. The new units looked much cleaner than A, B and C wings. New telephones had been installed on some wings and the showers had also been

refurbished. However, although most prisoners did get daily access to showers and telephones, this was partly due to staff discretion and was not guaranteed.

HP18 The incentives and earned privileges (IEP) scheme worked reasonably well, and prisoners were generally engaged with it and keen to achieve enhanced status. There were meaningful differentials between regime levels, although only enhanced level prisoners on I and J wings got access to the full range of enhanced privileges, such as extra association and an open-door policy at mealtimes.

HP19 Staff-prisoner relationships were very positive, as at the last inspection, although this was not reflected in the most recent measuring the quality of prison life (MQPL) survey. Relationships were helped by the long-term and relatively static population, but the culture of the establishment was very positive. There was a good personal officer scheme, which built on the good relationships between staff and prisoners.

HP20 Catering had benefited from a new kitchen. However, we observed meals served early and outside the core day schedule, and there were missed opportunities for prisoners to dine in association, rather than in their cells. Breakfast packs were issued one week in advance, and usually eaten long before they were due. The prison shop had not changed significantly, and new arrivals could still experience long delays in accessing it.

HP21 Oversight of race equality was reasonable, as at the last inspection, but had not made any significant advance. Although around 38% of the population were from black and minority ethnic backgrounds, the establishment had no full-time race equality officer. Racist incident complaints were taken seriously, and the quality of investigations was reasonable. Some prisoner race equality representatives had received diversity training alongside staff, but others had not received any training or fully understood their role. There was also a staff assistant race equality officer on each wing, but this role was only nominal. The oversight of other aspects of diversity was embryonic and had mainly focused on staffing issues.

HP22 The number of foreign national prisoners had increased slightly, but the arrangements for their management had not made any significant progress. Although foreign national prisoners could make free monthly telephone calls if they had no visits, they had no access to immigration advisory services and the prison had less contact with the immigration services. There was no strategic oversight of this area, which needed development as a priority.

HP23 Prisoner complaints were well managed and the quality of replies had improved. However, there were still some unacceptable delays in responses to routine complaints.

HP24 Health services had improved since the last inspection, notably with the addition of an impressive new healthcare centre. Staffing levels had also improved, with a positive impact on delivery of services. Primary care remained good, and the practice of allocating nurses working in pairs on each wing worked well and benefited continuity of care. Our previous concerns about the collection of medication by prisoners had been resolved, as had the problems of getting prisoners to medical appointments. There was evidence of good collaboration between residential and nursing staff. Mental health provision remained good. A new service level agreement for pharmacy services had been agreed, but had not yet been implemented.

HP25 Overall, despite improvements in some areas, there had been insufficient progress to raise our previous assessment. The establishment was still performing reasonably well against this healthy prison test.

Purposeful activity

HP26 In 2005, we assessed the prison as not performing sufficiently well against this healthy prison test and made 11 recommendations for further improvement. In this short follow-up inspection we found that the prison had implemented seven of our recommendations in full and four in part.

HP27 The activity places under construction at the last inspection had been opened and, with over 600 places, the establishment could occupy just about all prisoners, which was a significant improvement on what we found previously. There was a new education provider and good quality assurance system, which was not in place last time. There was positive engagement generally between staff and prisoners in the education department.

HP28 There were good opportunities for prisoners to learn and achieve qualifications, but mainly at lower levels, and there were no meaningful learning opportunities in the kitchen. There was a lack of provision at level two and beyond for the more able prisoners, and limited progression opportunities.

HP29 The library was well promoted and access was reasonable. However, its stock had not increased in line with the expansion in population and fell about 25% short of the quantity needed.

HP30 Work activities were generally reasonable and varied, with learning embedded. However, work in the pallet shop was patchy and menial. During the inspection, no work was available in this workshop, and prisoners hung around with nothing to do. The overall ethos of this workshop was not consistent with the largely positive culture identified across the majority of the establishment's other activity places.

HP31 Physical education provision remained good, and facilities had improved with the construction of a new gymnasium.

HP32 Time out of cell was similar to the last inspection. Prisoners on standard level mostly only received evening association every other night and this was due to reduce further with the introduction of the new national core day. This was insufficient and was further compounded because evening association was regularly cancelled due to staff shortages.

HP33 There had been considerable progress in the quantity and quality of provision and facilities in this area, which merited raising our previous assessment. The establishment was now performing reasonably well against this healthy prison test.

Resettlement

HP34 In 2005, we assessed the prison as performing reasonably well against this healthy prison test and made 22 recommendations for further improvement. In this short follow-up inspection we found that the prison had implemented 15 of our recommendations in full, five in part, and two had not been implemented.

HP35 There was a detailed reducing reoffending strategy, although it was based on an out of date needs analysis. A 'road to resettlement' document had also recently been prepared, which was given to new arrivals to chart their progress through their sentence. While this document was impressive, it was too early to judge its effectiveness, and it had not yet been evaluated.

HP36 Offender management and planning was mixed and not always satisfactory. There were 300 prisoners in scope for phases two and three of the NOMS offender management model. These prisoners received a patchy service. The establishment had not fully created a central offender management unit (OMU), and personal officers carried out the tasks of offender supervisors. This approach was not working adequately, and the establishment planned to move to a more traditional offender management model. Strategic links with external probation services were not evident, and a considerable number of in-scope prisoners had no up to date offender assessment system (OASys) assessment, and some had not had their OASys assessment reviewed for over two years. This high risk group of prisoners were not adequately case-managed. By contrast, lower risk prisoners, not in-scope for offender management, received a slightly better service. Although there was a small backlog of outstanding assessments, this was reducing.

HP37 Public protection arrangements had improved. There was a large number of multi-agency public protection arrangements (MAPPA) and potential MAPPA cases at the establishment and, overall, we were satisfied that the establishment balanced decency and control.

HP38 There were 132 prisoners serving indeterminate sentences for public protection (IPP), who were new to the establishment since the last inspection. Many were from out of area. A significant number had not fully understood the consequences of their sentence and expected to be released automatically on their tariff dates, which created some unrest when the true position was explained to them. There were slightly more mainstream lifer-sentenced prisoners than previously. Provision for their management remained good.

HP39 Services across the range of resettlement pathways were generally adequate. Prisoners' access to interventions was good, and they had the opportunity for a much wider range of programmes than we usually find.

HP40 The use of closed visits had reduced. However, the policies of strip-searching all prisoners after a visit, and only offering closed visits to entire groups of visitors (following a drug dog indication on an individual) remained in place. These were disproportionate and contrary to Prison Service guidelines, and it was not clear that they made any meaningful difference in the reduction of supply.

HP41 Overall, there had been progress in some areas, but given our concerns – in particular about the weaknesses in the case-management arrangements for in-scope prisoners – this was insufficient to raise our previous assessment. The establishment was still performing reasonably well against this healthy prison test.

Section 2: Progress since the last report

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

Main recommendations (from the previous report)

2.1 There should be a new and purpose built reception facility. (HP48)

Achieved. The new reception was in a separate building within a secure compound linked to the main prison by a secure corridor. The area was spacious and clean, and communal corridors were well decorated. Holding rooms were appropriate and equipped with televisions, adequate seating and up to date information notices. New arrivals were seen by trained officers in a large open area close to the reception entrance. They sat with officers at a low round table for an initial interview. This informal and relaxed approach was welcoming and positive for new prisoners.

2.2 The first night procedures used on B wing should be extended to all newly arrived prisoners. (HP49)

Achieved. Most new arrivals were young adults between 18 and 21, who were located on the first night and induction centre on B wing. Those between 21 and 25 went into ordinary cells on F or G wings, depending on the availability of accommodation. Regardless of location, all new arrivals were interviewed by a wing senior officer and given an information leaflet explaining what to expect in their first days. They were also seen by a trained Insider within 24 hours. These contacts were recorded in the prisoner's induction document and on his personal history file. There were no designated first night cells, but written handover notes were left for the night patrol.

2.3 There should be full recording of the use of special cells. (HP50)

Achieved. The establishment no longer used the special cell to process all new arrivals to the segregation unit, and we were satisfied that use of special accommodation was recorded appropriately.

2.4 A review of all behavioural modification strategies should be carried out to ensure consistency, clarity and age-appropriateness, and proper linkages made to other relevant strategies. (HP51)

Partially achieved. The incentives and earned privileges (IEP) policy document had been comprehensively reviewed. The published scheme demonstrated links with offending behaviour interventions to encourage and motivate prisoners to engage with the regime and progress through the IEP levels. Ten-week reviews and additional IEP case conferences drew on information about progress towards sentence planning targets, post-programme reports and comments from activity supervisors. However, IEP-focused entries about young adults in wing history sheets still mainly related to the infringement of wing-based rules, with little evidence that a balance of information was used to inform decisions about the suitability of their IEP level.

Further recommendation

2.5 Incentives and earned privileges (IEP) reviews and decisions should not be based solely on the prisoner's adherence to wing rules, but should consistently consider their progress towards sentence planning targets and participation in regime activities.

2.6 There should be an end to doubling on D and E wings. (HP52)

Not achieved. There had been no change since the last inspection. Four cells on D and E wings designed for single occupation were still used to accommodate two prisoners.
We repeat the recommendation.

2.7 The arrangements for foreign national prisoners outlined in the establishment's foreign national strategy document should be implemented as a priority. This document should be effectively publicised to both staff and prisoners. (HP53)

Not achieved. A foreign nationals policy had been drawn up in 2006, but was not widely publicised. Some foreign national prisoners were unaware that they could have a free international telephone card if they had no domestic visits, and the role of the foreign nationals liaison officer was not publicised on the wings. On several wings, staff were unaware who the foreign national prisoners were.
We repeat the recommendation.

2.8 The quantity of purposeful activity needed to be expanded urgently to meet the needs of the increased population. (HP54)

Achieved. There were 610 activity places, of which 476 (78%) were filled. However, the number of participants in the pallet repair workshop was due to be reduced, and the 24-place industrial cleaning course had not been offered due to staffing changes. New provision due to start included music technology and radio technician programmes with a maximum of 28 places, an extra 24 places in the virtual campus and Learn Direct, and 10 motor vehicle places. Activity allocation was fair and equitable, but there were long waiting lists for building trades, catering, computer, repair, horticulture and motor mechanic training, as well as entry to the gym. There was insufficient work in the pallet repair workshop to guarantee adequate purposeful activity for all participants. Even when work was available in this workshop, the quality was poor and prisoners gained no meaningful skills. Most of the other workshops, including the ones about to open, had learning embedded, and the pallet workshop sat uncomfortably alongside them.

Further recommendation

2.9 The pallet repair workshop should be replaced with work of a genuinely purposeful nature.

2.10 The backlog of sentence plans should be reduced as a priority. (HP55)

Partially achieved. There had been considerable efforts to address the outstanding backlog of sentence plans. There had been an increase in the cases dealt with internally within the proper timescale and, although some reviews were still overdue, there was a plan to eliminate the remaining backlog (see paragraph 2.200)

Recommendations

Courts, escorts and transfers

2.11 Graffiti should be removed from cellular vehicles and arrangements put in place to prevent reoccurrence. (1.6)

Achieved. The escort contractor, Global Solutions, had recently introduced a new fleet of vans for inter-prison transfers. Those we inspected were clean, free from graffiti and had comfortable seating.

First days in custody

2.12 The local information booklet issued in reception should be available in languages other than English. (1.25)

Not achieved. Although we were told that the information booklet had been translated into eight languages, we found no evidence of this, nor that it was issued to foreign national prisoners. There were no copies in reception or on any of the wings (see paragraph 2.77). We repeat the recommendation.

2.13 The induction programme should start on the first full working day following reception. (1.26)

Not achieved. The five-day induction programme started on the Monday following the prisoner's arrival. Most new arrivals remained unoccupied, usually locked in their cells, during most of the core day until their formal induction programme began (see paragraph 2.20). We repeat the recommendation.

2.14 Reception staff should not routinely be redeployed to other duties. (1.27)

Achieved. Reception staff were not routinely redeployed to other duties during reception opening times (see also paragraph 2.17).

Additional information

2.15 The prison received an average of five new prisoners a week. These were all planned transfers, mostly from HMP Brinsford, about 14 miles away.

2.16 Procedures to welcome and process new arrivals were generally good. Reception officers were respectful, clearly focused on the potential risks, and ensured that individual safety needs were addressed. Risk assessments were carried out effectively, and all new arrivals had first night interviews by trained staff in private. The environment was welcoming and prisoners were treated with appropriate levels of care. They were all offered a free telephone call and a shower, and searching procedures were carried out sensitively in a screened area.

2.17 Reception was open from 7.30am to noon and 1.30pm to 5pm on weekdays. New arrivals sometimes arrived outside these times, although they were still accepted. However, many arrived just before reception closed at lunch time, and were only partially processed initially – they were interviewed briefly by reception officers to check whether they had any immediate

needs, seen by healthcare staff for an initial health screening, and then located on to the residential units (usually B wing) until reception reopened at 1.30pm. They were often located in cells before a full assessment of risk, not offered a telephone call on arrival, and not formally interviewed by wing staff to explain what to expect from the reception processes until later that afternoon. This was unnecessarily disruptive and confusing for prisoners. All of the seven new arrivals during the week of our inspection had arrived at 11.30am, were located on B wing over the lunch period and received a meal, and not returned to reception until 2pm.

2.18 After completion of reception processes, new arrivals went to their allocated wing (usually B wing) where they were met by wing staff and prisoner Insiders. They were given a tour of the wing and usually allocated a clean and well prepared cell. Local rules were explained, and they were given written information about what they could expect from their stay and how to get help if needed during their first night.

2.19 As at the last inspection, there were no designated first night cells, but handover procedures to night staff were effective and written instructions were in place. However, four safer cells on B wing, designed to accommodate prisoners in crisis, were sometimes used for ordinary prisoners on their first night, as they were on the establishment's certified normal accommodation. Conditions in these cells were inappropriate for first night prisoners. They were poorly furnished, had no space for property and CCTV cameras were in constant operation.

2.20 Trained induction officers still delivered a five-day induction programme from a large and well-equipped Portakabin. The environment was comfortable and welcoming, and it was well furnished, clean and bright. The induction officers saw prisoners individually to explain the induction pack, and gave them a copy of the induction schedule. Further assessments of need were recorded in induction and assessment documents, and progress through the programme was monitored. New arrivals saw relevant staff during their first week, including the chaplain, education advisers, counselling, assessment, referral, advice and throughcare service (CARATs) workers and resettlement staff. Induction sessions were rarely cancelled.

2.21 Prisoners were offered an induction family visit as part of their induction programme. The prison's aim was to establish initial links with families and involve them in aspects of the prisoner's sentence. Induction staff met families, who also had the opportunity to speak with key personnel involved in the care and management of their relative, and were given a tour of the prison, including the wings. Visitors and prisoners appreciated these visits, which helped relationships between families, the prison and prisoners.

Further recommendations

2.22 Reception should remain open if it is known that new prisoners are due to arrive outside the scheduled opening times.

2.23 New arrivals should be fully and promptly processed in reception and not located on to residential units for several hours halfway through the process.

2.24 All cells used for prisoners' first night should be properly furnished and have appropriate levels of privacy.

2.25 The safer cells, designed as a short-term intervention for prisoners in crisis, should not be used as normal accommodation.

Good practice

2.26 *Family induction visits helped to develop relationships between families, the prison and prisoners.*

Residential units

2.27 The in-cell furniture on A, B and C wings should be redesigned to allow space for a table and chair. (2.20)

Achieved. Folding tables and chairs had been put in cells on A, B and C wings.

2.28 An additional telephone should be provided on both D and E wings. (2.21)

Achieved. Additional telephones had been provided.

2.29 All prisoners should have daily access to telephones. (3.82)

Achieved. Prisoners reported no difficulty in using the telephones each day. The ratio of telephones to prisoners was high, and staff usually permitted their use during the day if prisoners were on the wings Demand for telephones was highest on Thursdays when prisoners received their telephone credits, which caused some delays in access to them.

2.30 Additional showers should be installed on A, B and C wings to enable all prisoners to have daily access to showers. (2.22)

Achieved. Additional showers had been installed. They were clean, in good condition and screening was appropriate. Access was good, and most prisoners could have a shower every day.

2.31 The levels of in-possession property should be controlled through volumetric control checks. (2.23)

Achieved. There were procedures to control the volume of prisoners' property, which was monitored by residential staff during cell searches. The cells we saw had no excess property, and we saw no evidence of the hoarding of toiletries that we found last time. A facilities list outlined the range of items that prisoners could hold in possession, which was linked to the IEP system. This list was known to prisoners and adhered to.

2.32 Prisoners should be able to access items from their stored property within 48 hours of making an application. (2.24)

Achieved. Applications concerning access to property were processed on Saturday morning and prisoners usually received approved property within 48 hours.

2.33 Staff should not use prisoners to respond to emergency cell bells. (2.25)

Achieved. There was no evidence that prisoners were used to respond to cell bells, and records showed that officers answered them within three minutes.

2.34 Stained mattresses should be replaced. (2.26)

Achieved. Stained mattresses had been replaced, and the bedding we saw was in an acceptable condition.

Additional information

2.35 The accommodation was the same as at our last inspection, and wings were clean and adequately maintained. Cells were generally in good order, although those in the older part of the prison were small and some needed redecoration. All cells had in-cell electricity, a television and kettle. Information published on wing notice boards was up to date and relevant.

2.36 Although the narrow corridors, particularly on A,B and C wings, made observation difficult, staff regularly patrolled landings and supervision was at a good level.

2.37 All prisoners could wear their own clothes. Lists of approved items were published and prisoners knew the required standards. There were good supplies of prison clothing, which was of good quality. Prisoners could have their clothes cleaned once a week in a central laundry. There were weekly kit changes, which included clean sheets and bedding.

Staff-prisoner relationships

2.38 Prisoners should be addressed by their preferred name and certainly not be given a disrespectful 'pet' name by staff. (2.35)

Partially achieved. We observed more use of prisoners' first name than at the previous inspection, and written reports often referred to them by their first name. However, not all staff used prisoners' preferred names, although we did not hear them use disrespectful nicknames.

Further recommendation

2.39 All staff should be encouraged to address prisoners by their preferred name.

Additional information

2.40 Relationships between staff and prisoners were still very positive, and staff were generally good role models. The active approach to communicating and consulting with prisoners reported at our previous inspection was still evident. However, in the latest measuring the quality of prison life survey (MQPL) survey, in 2007, the least favourable responses from prisoners were on relationships with staff and feelings of inclusion. The establishment had raised these negative findings in consultation forums with prisoners, but had drawn no conclusions. Prisoners we spoke to during the inspection did not reflect the MQPL findings, and most were reasonably positive about staff.

Personal officers

2.41 Traditionally, personal officer work had been strong, and staff gave prisoners good welfare support. However, with the inception of the offender management model, personal officers had been given the role of offender supervisors, and were now required to organise and convene sentence planning reviews .This meant that they had less time for wing-based welfare

duties. A plan to appoint six specially trained offender supervisors would give personal officers more time for welfare work, but was contingent on the introduction of the new staff profile (see further recommendation 2.207).

Bullying and violence reduction

2.42 The anti-bullying team should regularly check all wing observation books for any reported bullying behaviour that might not have been reported through normal channels. (3.12)

Achieved. Nominated and trained anti-bullying staff checked all wing observation books and samples of prisoner wing files for indications of any bullying behaviour. Incidents were recorded and reported to the violence reduction coordinator. All incidents were noted, and the violence reduction committee reviewed reports of actual and suspected bullying each month.

2.43 All unexplained injuries should be followed up by the anti-bullying team. (3.13)

Achieved. Anti-bullying staff checked injury report forms routinely, and unexplained injuries were investigated and followed up as necessary. All were recorded and discussed at the violence reduction committee.

2.44 All prisoners found guilty of assaulting another prisoner should be placed on the anti-bullying scheme. (3.14)

Achieved. The violence reduction committee examined records of adjudications. Individual cases were investigated by anti-bullying staff, and some prisoners had been referred for anti-bullying measures.

2.45 The decision to place a prisoner on level two of the anti-bullying scheme should be made at principal officer level or above. (3.15)

Achieved. The decision to place a prisoner on formal anti-bullying procedures was made at principal offer level, and ratified by the violence reduction committee.

2.46 Prisoner representatives should be invited to join the quarterly anti-bullying committee. (3.16)

Not achieved. Prisoner representatives were not invited to the anti-bullying committee meetings (see paragraph 2.52) or to the violence reduction committee meetings.
We repeat the recommendation.

2.47 A programme for victims of bullying should be introduced. (3.17)

Partially achieved. A formal victim support system had been introduced, based on assessment of individual support requirements. Residential staff were unaware of many of the formal systems. However, staff were appropriately focused on prisoner safety, and good relationships and a functional personal officer scheme ensured that individual prisoners were supported. Entries in prisoner files showed that staff were aware of relevant issues and had insight into the support needs of their prisoners.

Further recommendation

2.48 The programme to support the victims of bullying should be reviewed and publicised to all staff.

2.49 The anti-bullying policy should be updated to include reference to the November 2004 survey results and establish stronger links with other relevant strategies such as that for the incentives and earned privileges scheme. (3.18)

No longer relevant. See paragraph 2.54.

Additional information

2.50 As at the last inspection, anti-bullying and violence reduction were high priorities. There was an anti-bullying policy document, available on all wings, which explained in simple language the procedures for staff to follow when dealing with suspected bullies. The policy was connected to the overarching violence reduction strategy, which set out the prison's strategic focus and commitment to the reduction of violence.

2.51 A multidisciplinary violence reduction team (the safer custody policy group) monitored levels of violence and ensured that policies were implemented properly. The committee met monthly, chaired by the head of residence, and was well attended by managers and relevant staff. Minutes of meetings showed that all violence-related issues, such as incidents of violence, fights, adjudications and assaults, were examined to identify trends or patterns. Action was taken appropriately and monitored.

2.52 A full-time violence reduction coordinator had been appointed and managed the day-to-day implementation of the strategy. A group of six residential officers had been nominated as anti-bullying staff to monitor suspected bullying activity on the wings. Two of the team were on duty every weekday to investigate all actual and suspected incidents of bullying identified in incident reports. As at the last inspection, they met formally each quarter to review performance and to identify any emerging issues concerning bullying, and made reports to the safer custody policy group for further analysis.

2.53 Since the last inspection, the prison had introduced a conflict resolution protocol to deal with low level disputes between prisoners. Trained officers saw the prisoners together to deal with minor problems before they escalated. Records were kept to monitor outcomes, and results were communicated to the safer custody policy group and the senior management team.

2.54 Although there were strong systems to combat bullying, the prison had not conducted a prisoner survey to inform its policy since the last inspection. Prisoners told us that, although staff took positive action to deal with bullies, they still found it difficult to report incidents.

Further recommendation

2.55 There should be a prisoner survey to inform a review of the anti-bullying policy.

Good practice

2.56 *Conflict resolution by trained officers was used to deal with low level disputes between prisoners.*

Self-harm and suicide

2.57 There should be wider senior management team representation at the safer custody meeting. (3.28)

Achieved. Representation at the monthly safer custody policy group meetings was wide and included senior managers, assessment, care in custody and teamwork (ACCT) assessors, residential officers, the chaplaincy and health staff.

2.58 More proactive use of prisoners' families should be explored as a resource for managing those at risk of suicide or self-harm. (3.29)

Not achieved. The use of prisoner's families as a resource for managing at-risk prisoners had not been fully explored.
We repeat the recommendation.

Additional information

2.59 There were still good procedures to manage prisoners at risk of self-harm and suicide. The safer custody policy group monitored the overall implementation of a comprehensive prevention policy, and a well-attended monthly suicide prevention meeting discussed all individual cases.

2.60 ACCT self-harm monitoring procedures had been in place since 2005. There were 12 open ACCT documents at the time of our inspection. The quality of entries was particularly good, demonstrating an in-depth understanding of the individual prisoner's circumstances and feelings. There was regular involvement from personal officers, and detailed support plans were prepared in consultation with the prisoner. Case managers had been appointed and held high quality reviews on time and with the prisoner.

Diversity

No recommendations were made under this heading at the last inspection.

Additional information

2.61 The responsibility for diversity had recently been transferred to the human resources and business planning manager, and an initial committee meeting had recently established terms of reference and membership. A diversity policy had been developed, but focused mainly on staff need.

Further recommendations

2.62 A diversity strategy based on the needs of prisoners at Swinfen Hall should be drawn up.

2.63 Prisoner representatives should be invited to attend the diversity committee.

Race equality

2.64 The race relations liaison officer/diversity manager post should be made full-time. (3.45)

Not achieved. The race equality officer (REO) had received a nominal increase in hours for race relations work, but in the previous three months had been able to devote only 42% of the allocated time to this role as she had been redeployed or unavailable to carry out her duties. Given the high number of black and minority ethnic prisoners in Swinfen Hall (38% of the population) this was insufficient. Some residential staff had been identified as assistant REOs, but these roles were only nominal and the staff were not given any time to support to the REO or act as a first point of contact for race issues on their wings.

Further recommendations

2.65 The race equality officer post should be full-time, and the postholder should not be redeployed to other work.

2.66 Assistant race equality officers should be given meaningful job descriptions and sufficient time to allow them to support the REO and carry out their range of duties.

2.67 Black and minority ethnic prisoners should have the opportunity to meet formally each month with prisoner representatives of the race relations management team and the race relations liaison officer. (3.46)

Not achieved. There had been no regular forum for black and minority ethnic prisoners to meet with wing representatives or the race equality officer. We were told that the current arrangements were informal and relied on prisoner representatives as a central contact for black and minority ethnic prisoners on wings and to relay information back to the race equality officer, who currently had little time for consultation with black and minority ethnic prisoners (see above).

Further recommendation

2.68 Black and minority ethnic prisoners should have the opportunity to meet formally each month with prisoner representatives of the race equality action team and the race equality officer.

2.69 A survey should be conducted of black and minority ethnic prisoners concerning their perceptions about how they are treated in the areas of respect and safety in the prison. (3.47)

Achieved. The psychology department had surveyed black and minority ethnic prisoners in May 2007, and this had resulted in an action plan based on the findings. Areas for improvement had included: better links with catering staff to review the quality of minority ethnic meals; a review of the shop list to ensure that a full range of black and minority ethnic goods was available; developing confidence in the complaints system; and enhancing staff's cultural awareness. Most of these actions had been completed.

Additional information

2.70 The race equality action team (REAT) met monthly and was well attended by staff and race equality prisoner representatives. The meeting focused on a range of relevant issue. Prisoner representatives attended a pre-meeting with the race equality officer, and prisoners' issues were a standing agenda item. A comprehensive race equality action plan had been developed and was monitored through the REAT.

2.71 In 2007, 110 racist incident forms had been submitted, and there had been 28 in 2008 to date. Replies were generally appropriate and respectful in tone and were usually completed in a timely manner, although this had been more problematic recently. REAT meetings reviewed all forms submitted in the previous month, and prisoners were invited to contribute to discussions about the management of investigations and responses.

2.72 Race equality prisoner representatives wore identifying T-shirts and jumpers and were visible on the wings. Some of them had received full diversity training, alongside staff, although others more recently selected had yet to receive any training, and were less clear about their role. There was a good range of publicity material promoting race equality around the prison.

Further recommendation

2.73 All prisoner diversity representatives should be trained and given clear guidance on their role and expected duties.

Foreign national prisoners

2.74 A multidisciplinary committee should be in place and meet regularly to ensure that the foreign nationals strategy is fully implemented. (3.60)

Not achieved. There was no multidisciplinary committee to focus on the needs of foreign national prisoners and oversee delivery of the foreign nationals strategy.
We repeat the recommendation.

2.75 Adequate time should be allocated to the foreign nationals liaison officer to ensure that the specified duties are carried out effectively. (3.61)

Not achieved. A principal officer had lead responsibility for foreign nationals, and was supported by a senior officer, but also had a range of other operational responsibilities and had limited time for this area. Foreign national liaison officers had also been designated on each wing, but several told us they had not received appropriate briefing or training about the needs of foreign national prisoners, such as how to access appropriate legal advice.
We repeat the recommendation.

Further recommendation

2.76 Wing-based foreign national liaison officers should be appropriately trained on the specific needs of foreign national prisoners.

2.77 An information and advice book for foreign national prisoners should routinely be issued to them at reception and should be available in languages other than English. (3.62)

Not achieved. Although the national prisoner handbook for foreign nationals was available in over 21 languages at reception, the local information and advice handbook for new arrivals had not been translated into other languages. The only resource to support foreign national prisoners with little or no English was the Big Word translation service.
We repeat the recommendation.

2.78 Foreign national prisoners should be able to meet at least monthly in order to establish a self-help support group. (3.63)

Not achieved. There was no forum for foreign national prisoners to meet and develop a self-help group. As a result, some were misinformed about their rights. Some foreign national prisoners told us they would welcome the opportunity to meet regularly and share experiences with other foreign nationals.
We repeat the recommendation.

2.79 Routine consultation of the foreign national prisoner population should be undertaken and any significant issues raised acted on. (3.64)

Not achieved. The wing foreign national liaison officers were responsible for holding wing meetings for foreign national prisoners. Efforts to arrange such meetings had lacked strategic direction, foreign national prisoners had not been given information about the purpose and context of these meetings, and those that had taken place had been poorly attended.

Further recommendation

2.80 Foreign national prisoners should be encouraged to attend regular wing meetings held to consult them, and significant issues that they raise there should be acted on.

2.81 Ongoing contact should be maintained with local accredited immigration advice and support agencies. (3.65)

Not achieved. Links with such local agencies were underdeveloped. Several foreign national prisoners complained of difficulties in obtaining access to lawyers with specialist knowledge, and believed this had impeded progress with appeals. The Border and Immigration Agency (now the UK Border Agency) had visited the prison periodically, but had not attended in 2008 to date.
We repeat the recommendation.

Further recommendation

2.82 The establishment should liaise with the UK Border Agency to ensure more regular visits to foreign national prisoners subject to immigration control.

2.83 Accurate records should be kept of staff and prisoners who are able to speak languages other than English. (3.66)

Partially achieved. A list had recently been collated of staff who spoke foreign languages and their self-assessed level of proficiency. Prisoners had also been canvassed to find those who spoke other languages and were prepared to assist other prisoners, but this information had not yet been collated and published.
We repeat the recommendation.

Additional information

2.84 There were 50 prisoners recorded as foreign nationals. Five prisoners were detained under single administrative powers. One prisoner was seven months past his sentence expiry date and had applied for the facilitated return scheme on several occasions, but did not know if his application had been accepted.

Applications and complaints

2.85 Complaints should be responded to within seven days. (3.94)

Partially achieved. The complaints clerk had developed systems to follow up complaints not returned on time. We examined complaints submitted in the first three months of 2008 and found that most were responded to within specified timescales, but this was not always the case.

Further recommendation

2.86 Complaints should be responded to within three days or up to 10 days in exceptional circumstances.

2.87 All responses to formal requests and complaints should be respectful and address the issues raised. (3.95)

Achieved. We examined a number of complaints submitted during the previous three months. Replies were respectful and responded in full to the issues raised. In some cases it was apparent that the issues had been discussed in person with the prisoner, and the reply on the complaint form was a formal record of that meeting. For quality assurance, the head of performance unit checked the log and a random sample of replies each month.

Additional information

2.88 Information about the complaints procedures was included in the information booklet issued on reception, and the complaints clerk attended the induction programme. Prisoner cell cards carried information about the Independent Monitoring Board, including how to complain to it.

2.89 All wings had a readily accessible supply of complaint forms, and the complaints clerk was responsible for emptying complaint boxes. There had been 258 complaints submitted between December 2007 and February 2008, a reduction from the previous three months. The number of complaints and identified trends were discussed at the monthly safer custody policy group. The main areas of complaint in January and February 2008 were property and cash. The complaints clerk also attended the monthly prisoner council meetings.

Substance use

2.90 An appropriate testing suite, including a dry holding room, should be developed for mandatory drug testing as a matter of urgency. (8.82)

Achieved. The mandatory drug testing (MDT) suite was in a new building and consisted of a testing area, a toilet with a stable door for privacy, and two holding areas where a prisoner could be kept for up to three hours if they could not produce a sample. The suite was generally clean and tidy, although the toilet was very dirty.

Further recommendation

2.91 The toilet in the mandatory drug testing suite should be kept clean.

Additional information

2.92 The year-to-date positive MDT rate was 5.64% against a target of 4%. Only one prisoner had undergone a methadone detoxification programme in the last six years. However, there were no protocols on how to manage such prisoners, should any present with these needs. This was all the more relevant as, although there was currently no integrated drug treatment system (IDTS) due to the negligible need, funding for this programme was being considered.

Further recommendation

2.93 A secondary detoxification protocol should be introduced.

Vulnerable prisoners

No recommendations were made under this heading at the last inspection.

Additional information

2.94 As at the last inspection, the prison's policy was to integrate sex offenders and other vulnerable prisoners with the general population. Protocols set out the general principles and guidance for staff on managing vulnerable prisoners. Most vulnerable prisoners we spoke to said they felt safe, despite some fears about mixing with other prisoners.

2.95 There was evidence that this policy was successful. This difficult and diverse population was managed in conditions of safety and support, based on positive staff-prisoner relations and good personal officer support. The segregation unit was not used as a place of sanctuary for vulnerable prisoners, and assault levels had not risen since the last inspection. The safer custody policy group monitored levels of violence, bullying and self-harm by area, and each reported case was investigated.

Health services

2.96 The head of healthcare should be a member of the senior management team and the primary care trust/prison partnership board. (4.60)

Achieved. The healthcare manager was a band 7 registered general nurse (RGN) with extensive prison health experience. Her line manager was a clinical prison health manager who represented the prison at the primary care trust (PCT) and prison partnership board meetings. The healthcare manager was a member of the prison senior management team.

2.97 Algorithm-based nurse triage and more nurse-led clinics should be introduced. (4.61)

Partially achieved. Nurses assessed all prisoners who requested appointments and used a red, amber and green system to prioritise appointments. There was no formal algorithm-based nurse triage to ensure consistency and continuity of care and advice to prisoners. There were several nurse-led clinics run by qualified nursing staff, including asthma, smoking cessation, sexual health, vaccinations and health promotion. Prisoners with lifelong conditions were seen by the GP regularly, but there was no computerised register to manage and monitor prisoners with lifelong conditions.

Further recommendations

2.98 Algorithm-based nurse triage should be introduced.

2.99 There should be a computerised register to manage and monitor prisoners with lifelong conditions.

2.100 A full skill mix review of all healthcare staff should be undertaken to determine the requirement for nursing and nursing support staff as well as administrative support. (4.62)

Achieved. A full skill mix review of all healthcare staff was completed by the South Staffordshire PCT in June 2007. The healthcare team consisted of 9.5 nursing staff (5.5 RGNs and four registered mental health nurses, RMNs), three part-time administrative assistants, one part-time healthcare assistant, three full-time operational support grades and one instruction officer attached to the healthy living centre. Staff training needs were highlighted on their personal professional development plan. Mandatory training included basic life support, defibrillator and anaphylaxis training.

2.101 A system for implementing clinical supervision for nurses should be identified urgently and should include training. (4.63)

Achieved. Clinical supervision provided by the PCT was built into the healthcare routine for all nursing grades, who had protected time to access this monthly if required. The head of healthcare was a trained clinical supervisor. Clinical supervision was also discussed at clinical governance meetings

2.102 Alarm bells should be installed in the reception Portakabin. (4.64)

No longer relevant. There was a new reception, which was equipped with alarm bells.

2.103 The service level agreement between West Midlands Area Pharmacy and the primary care trust should be reviewed to determine the required level of input from the pharmacist, how often the pharmacist should visit the prison and provide pharmacist-led clinics, and to introduce clinical audit and medication review. (4.65)

Partially achieved. The South Staffordshire PCT had awarded the pharmacy contract to a new private pharmacy provider in August 2007. The new service level agreement (SLA) included greater pharmacist involvement and the provision of pharmacist-run clinics. However, the implementation of the new contract had been delayed due to staffing issues. We were told that the PCT hope to resolve this by June 2008.

Further recommendation

2.104 The new pharmacy contract should become operational as soon as possible.

2.105 The pharmacist should be a member of the medicines management committee. (4.66)

Achieved. The PCT head of pharmacy attended the quarterly medicine management committee meetings.

2.106 The pharmacy should reconcile stock medicines with prescriptions. (4.67)

Not achieved. This was covered by the new pharmacy SLA, which had not yet been implemented (see paragraph 2.103).
We repeat the recommendation.

2.107 Nurses should annotate prescription records when supplying in-possession medications. (4.68)

Achieved. Nurses now annotated prescription records when they supplied in-possession medication. Most prisoners had their medication in possession for up to 28 days. Supervised medication was administered by nursing staff at 8.15am and 4.45pm, and nurses took medication to prisoners who had to take it more frequently.

2.108 The special sick policy should be reviewed to include a formulary of simple medicines to be supplied by nurses. (4.69)

Achieved. The special sick policy had been reviewed in May 2007, and patient group directions (PGDs) had been developed to allow nurses to prescribe a list of approved medications. The PCT had also ratified a list of homely remedies, which allowed nurses to issue simple medications and creams.

2.109 A system should be introduced whereby simple medicines can be provided to prisoners by wing staff when the healthcare department is closed. (4.70)

Not achieved. Medicines were only issued by qualified nursing staff, and prisoners could not access simple medication, such as paracetamol, when the healthcare department was closed between 8.15pm and 7.45am.
We repeat the recommendation.

2.110 A system should be developed to ensure that clinical time is not wasted due to prisoners arriving late for or missing appointments. (4.71)

Achieved. Under a SLA with the PCT, the prison provided three operational support grade staff to escort prisoners to and from healthcare. This ensured that clinic time was not wasted, and allowed prisoners to continue their activity or programme while they waited to be escorted.

2.111 Counselling services should be introduced to provide better support for prisoners. (4.72)

Achieved. Following the nursing skill mix review in 2007, the nursing staff had been trained in areas such as motivational interviewing, aspects of cognitive behavioural therapy, and the National Institute for Health and Clinical Excellence (NICE) stepped care model for mental health. In addition, two nurses (RGN and RMN) were assigned to each wing for an average of two hours per day to offer additional support and continuity of care for issues such as sleep problems, anxiety, relaxation, anger, and low self-esteem. Wing staff told us they also felt well supported by the nurses.

2.112 Discipline staff should supervise medication times to ensure no more than one prisoner is receiving medicines at the collection point. (4.73)

Achieved. A discipline officer supervised medication times and ensured prisoners were seen one at a time. We observed this process, which was safe, orderly and confidential.

2.113 Certification, documentation and written policies on the provision of dental care detailed in the regulations and British Dental Association advice sheets should be held in the dental surgery. (4.74)

Achieved. All documentation for the provision of dental services was clearly labelled and available in the dental surgery.

Additional information

2.114 A new healthcare centre had been built since the previous inspection. It was bright and welcoming, and a huge improvement on previous facilities. All the consulting rooms radiated from a large, centrally located waiting room where there were sofas and a large coffee table. There was a large amount of health promotion material for prisoners to browse through, as well as a television that showed health promotion videos.

2.115 Prisoners generally had good access to health services. GP cover was very good, and prisoners benefited from a wide range of nurse-led clinics and visiting clinical specialists. Dental services were good, with a waiting time of four weeks for a routine appointment. Mental health support was good, with evidence of joint work between primary and secondary providers.

2.116 The healthy living unit, a daycare facility opened in September 2006, offered additional support to prisoners with needs such as confidence building, stress management, mild anxiety and depressive symptoms, cognitive behaviour therapy, nutrition, aromatherapy and personal hygiene. The unit had received the World Health Organisation best practice award 2007. Referrals to the unit were through the chaplaincy, wing officers, primary mental health nurses, GP or self-referral.

Good practice

2.117 *The healthy living unit offered daycare support to prisoners with a range of needs.*

Learning and skills and work activities

2.118 Individual learning plans should be kept up to date and used more effectively to plan and monitor individual learning. (5.14)

Partially achieved. The documentation and process for completion of individual learning plans (ILPs) had been recently revised and introduced, supported by appropriate staff development. The ILP was completed at a suitable point in the learner's programme. It was too early to judge the impact of this and other initiatives. Monitoring to ensure that ILPs were kept up to date and were effective in planning individual learning had started to be implemented. Currently, not all ILPs were completed to a satisfactory standard, and some were incomplete or did not include relevant targets. Actions stated in ILPs did not always support prisoners' achievement of their sentence plan. A planned personal tutor system to support prisoners had yet to be introduced. Derby College, the education provider, had plans for a quarterly audit of ILPs, but this had yet to be implemented.

Further recommendations

2.119 The links between individual learning plans (ILPs) and sentence planning should be improved.

2.120 The planned personal tutor system should be introduced as soon as possible.

2.121 Prisoners should be provided with regular opportunities to review their full learning plan and gain a clear understanding of what they have achieved and what they need to do. (5.15)

Achieved. Prisoners could review their progress at an appropriate point in their programme, and could clarify their level of achievement and action needed for improvement. However, they did not routinely receive a copy of their ILP, and not all progress reviews included enough detail to make them meaningful to learners or support effective monitoring.

Further recommendation

2.122 ILPs should contain sufficient details to be meaningful, and prisoners should have better access to them.

2.123 Quality assurance procedures with effective monitoring arrangements should be fully implemented for all areas of learning. (5.16)

Partially achieved. The quality improvement group had recently been replaced with three teams that considered the three Ofsted inspectorate strands, as well as leadership and management. Team leaders were responsible for quality in the allocated strand. The head of learning and skills, who had a strategic overview of quality assurance, chaired all meetings. This approach had started to secure consistent quality assurance. Internal auditing had been improved to aid the monitoring of compliance, although Derby College had yet to complete the

process for the current academic year. All areas carried out programme reviews that also informed self-assessment, although these had been introduced only recently and it was too early to judge the effectiveness of monitoring arrangements overall.

2.124 Data should be used more effectively to set educational targets and monitor performance. (5.17)

Partially achieved. Relevant performance data was produced and had started to be monitored at quality strand meetings. Data was used more appropriately to identify areas for curriculum development. Appropriate targets had been set, although not all were communicated well enough to aid monitoring. The use of data for trend analysis had still to be effectively exploited across all education and training. Many arrangements to improve the use of data were relatively new and it was too early to assess their effectiveness.

Further recommendation

2.125 Education performance data should be used comprehensively to identify trends.

2.126 Additional support should be given to teachers to improve the quality of teaching and learning. (5.18)

Achieved. Derby College had taken over the education provision in July 2006 and introduced more robust processes to improve the quality of teaching and learning, including assessment through the observation of tutors. The outcomes of session observations were suitably recorded and graded, and the quality strand meetings reviewed the grades. Unsatisfactory performance by teachers was appropriately followed up and supported. There had been staff development to improve practice, and there were satisfactory opportunities to share good practice.

2.127 Arrangements should be in place to ensure that suitable resources are supplied in time. (5.19)

Achieved. Procurement was planned and implemented effectively, and learners had access to suitable resources to enable effective participation in learning.

2.128 The curriculum should be expanded based on a review of learning and skills involving all stakeholders. (5.20)

Achieved. There had been extra provision in literacy and numeracy, distance learning, cookery, carpentry and IT. Since the previous inspection, training programmes in tiling, plumbing, bricklaying, carpentry, painting and decorating had also been introduced.

2.129 The library should improve its stock by undertaking a needs analysis that involves relevant stakeholders. (5.21)

Achieved. There had been two needs analyses since 2005, with a further one due to be undertaken. There had also been a survey in June 2007 of prisoners whose first language was not English to ascertain their needs, and seven main languages were identified – Afrikaans, Polish, Punjabi, Urdu, Arabic, Kurdish and Somali. There had been appropriate action to improve the library stock in response to these analyses. However, the target of 10 books per person had not been achieved (the stock was currently 4,576 books, which fell about 25%

short of the number needed), and a proposed increase to the budget to replace books had been refused.

Further recommendation

2.130 The range and quantity of library stock should be significantly increased.

2.131 The library should improve the way it promotes its service to prisoners. (5.22)

Achieved. Notice boards on each wing were used effectively to promote the library service. The library's links with the education department and workshops had improved. An induction process was subcontracted to Carter and Carter, and their weekly induction in the library included an introduction to the library service. Initiatives to encourage interest in literacy had been introduced, including creative writing sessions offered in conjunction with the National Research and Development Agency, story telling and writing projects via the Paul Hamlyn Foundation, and the national six-book challenge scheme to encourage book-reading. Prisoners with children could participate in the production of storybooks and books for memory scheme for their children.

2.132 Suitable qualifications at level 2 should be introduced in the workshops and qualification opportunities should be introduced in catering. (5.30)

Partially achieved. Since the previous inspection, new qualifications, some at level two, had been introduced. However, some significant areas of work did not offer qualifications up to level two (including catering, industrial cleaning, waste management, motor vehicle, horticulture and land-based provision). Prisoners working in the kitchen were not able to undertake appropriate qualifications at NVQ levels one or two.

Further recommendations

2.133 Appropriate level two qualifications should be available for prisoners working in industrial cleaning, waste management, motor vehicle, horticulture and land-based provision.

2.134 Prisoners working in the kitchen should be able to work towards level one and level two NVQs.

Additional information

2.135 Since the previous inspection, education and skills training had been delivered mainly by Derby College, with a few programmes also provided by South Birmingham College. Effective action to secure progress on many of our previous recommendations had been relatively recent. Expansion of provision had been good, but there was still a need to develop progression opportunities up to level two in some areas. Quality assurance was satisfactory overall, but many of the processes required further embedding and review to evaluate their effectiveness.

Physical education and health promotion

No recommendations were made under this heading at the last inspection.

Additional information

2.136 The PE department was very well equipped and had modern, well-maintained premises, including a new gymnasium. Outdoor facilities were also good. Access to equipment was well-managed. Sixty-two per cent of the prison population took part in recreational PE, and an additional 10% were on accredited PE programmes. Staff had responded positively to meeting prisoners' needs, such as introducing cricket, which was popular with prisoners, particularly those from the Asian community. The relationships between gym staff and prisoners were mutually respectful.

Faith and religious activity

2.137 Every effort should be made to ensure that there is no slippage in the scheduled date for the completion of the new chapel and mosque. (5.44)

Achieved. The new chapel and mosque were both completed on time.

Additional information

2.138 The chaplaincy team continued to provide a comprehensive level of spiritual and pastoral care. Members of the team were well integrated into the running of the establishment and attended safer custody, public protection and drug strategy meetings. The new chapel and mosque had excellent conditions for worship. The full-time Muslim chaplain played a significant role in the prison and was respected by staff and prisoners across all faiths.

Time out of cell

No recommendations were made under this heading at the last inspection.

Additional information

2.139 Most prisoners were unlocked for reasonable periods during the core day. However, evening association only took place every other evening for standard regime prisoners on D and E wings, and all prisoners on A, B and C wings. This was inadequate for a training establishment. Evening association was also subject to regular cancellation due to staff shortages caused, in part, by delays in implementing the new national core day arrangements. We also observed some slippage in regime times, with lunch served early, resulting in prisoners being locked up before the scheduled time. When this was pointed out, steps were taken to address this.

Further recommendations

2.140 There should be more weekday evening association for all prisoners.

2.141 Managers should ensure that published regime times are adhered to.

Security and rules

2.142 Security staff should not wear the dedicated search team uniform, certainly not when carrying out non-searching duties and preferably not at all. (6.10)

Achieved. Alternative, appropriate protective clothing was worn by staff carrying out searches. The shirts did not show their names, but names or numbers were due to be displayed on new shirts that were due. We observed staff wearing this uniform only to carry out searching.

2.143 Reviews of prisoners' categorisation should take place at least annually and prisoners should have the opportunity to contribute to the process. (6.11)

Partially achieved. The prison had improved categorisation procedures and had recently introduced six-monthly categorisation reviews for adult prisoners. Initial categorisation and review dates were held on a central database. Case administrators were responsible for checking the database and forwarding review paperwork to wings at the review date. Wing senior officers carried out initial categorisations and reviews, with the knowledge of the prisoners. Prisoners could provide written submissions and contribute to the review process. A few review dates had been missed, but most prisoners had their categorisation reviewed at least annually.

Further recommendation

2.144 Categorisation review dates should be adhered to and should take place at least annually.

Additional information

2.145 The security department was well managed, and attendance at the security committee meeting was good. The department had received 474 security information reports in the first three months of 2008. These were processed in a timely manner and followed up appropriately. A monthly security bulletin circulated to all staff provided a comprehensive overview of security information reports received, reported incidents and any identified trends, and details of prisoners serving sentences for arson or racially aggravated offences or identified as gang members. There had been 65 reportable incidents since January 2008 - mainly prisoner-on-prisoner assaults, and incidents of self-harm.

2.146 Prisoners on closed visits and visitors subject to bans were reviewed monthly by the security senior officer. Two dog handlers operated two passive and two active dogs. The police liaison officer was shared with a number of prisons in the area, and the prison reported effective working arrangements.

2.147 A comprehensive explanation of rules was included in the induction information booklet and prisoner compacts, and was published on wing notice boards.

2.148 Categorisation arrangements were managed through the offender management unit, although there were plans to bring these under the control of the security department. Young adult prisoners could apply to be considered for open conditions, and these requests were dealt with by residential governors; one young adult was due to be transferred to open conditions in the week following our inspection. An appeal process was in place.

Discipline

2.149 All charges should be fully investigated by adjudicators, regardless of plea. (6.29)

Partially achieved. We reviewed a large sample of completed adjudication records. Most were fully investigated, but a few were still insufficiently recorded following a guilty plea. The establishment had recognised this. The governor now personally quality checked all completed adjudications, and had pointed out to adjudicating governors that some of the completed records, usually following a guilty plea, needed better evidence of investigation. The more recent examples that we sampled were better. However, in one case the adjudicating governor had applied the wrong burden of proof when considering whether a charge was proven or not. This may have been a simple recording error, but required clarification.

Further recommendation

2.150 The correct burden of proof should be applied in all adjudications.

2.151 Prisoners should not be subject to unofficial punishments without going through the adjudication process. (6.30)

Achieved. We found no evidence that staff bypassed the adjudications process.

2.152 A duty manager's written authorisation should be given every time a prisoner is deprived of normal clothing, even if this is for only a short period of time on initial location in the segregation unit. (6.31)

Not achieved. It was not always clear from the special accommodation paperwork whether or not a prisoner had been deprived of his normal clothing when located in the special cell. Although there was a protocol covering the use of strip clothing (see paragraph 2.157), in some cases we reviewed, prisoners had been put into strip clothing with no obvious reason for this decision or comments from the authorising manager to explain this. Although there was no evidence that prisoners were placed in strip clothing as a punishment, neither were there always reassurances to the contrary. On a few occasions, prisoners on open assessment, care in custody and teamwork (ACCT) documents who had to be located in the special cell because they were violent and non-compliant were also deprived of their clothing, again without proper explanation; this was inappropriate.

Further recommendations

2.153 Duty managers should abide by the criteria for placing a prisoner in strip clothing in the special cell, and should fully justify this decision in the accompanying paperwork.

2.154 Prisoners on open ACCT documents should not be deprived of their normal clothing if they have to be located in the special cell.

2.155 An operational instruction should be produced for the use of special accommodation, particularly regarding when it is used as a reception facility in the segregation unit. This should include clarification on the authorisation for and use of strip-clothing. (6.32)

Achieved. An operational instruction had been produced and updated in June 2007. This set

out clearly the criteria for when the special cell could be used and the authorisation requirements. It also spelt out the circumstances when strip clothing could be used, although it was not evident that managers always followed the guidance (see above). There was little mention in the operational instruction of the need for extra consideration when locating a prisoner on an open ACCT into special accommodation.

Further recommendation

2.156 The operational instruction governing the use of the special cell should, in consultation with the safer custody policy group, be amended to cover circumstances when prisoners on open ACCT documents have to be located there.

2.157 Senior managers should ensure that prisoners are only strip-searched on arrival in the segregation unit following an assessment of risk and not as a matter of routine. (6.33)

Achieved. The segregation unit's operating instructions were clear that prisoners should not automatically be strip searched on arrival there. Staff also confirmed that prisoners sometimes received a rub-down search, although strip searching was more common.

2.158 Toiletries specifically for black and minority ethnic prisoners should be provided in the segregation unit. (6.34)

Not achieved. This recommendation had been accepted and included in the prison's action plan. However, staff confirmed that prisoners located in the segregation unit were given only prison-issue toiletries. The unit's own rules also stated that prisoners could only have prison-issue toiletries unless specified otherwise in their individual care plans. However, care plans no longer existed (see paragraph 2.164).
We repeat the recommendation.

Additional information

2.159 Use of force had risen significantly since the last inspection, mainly because of the large increase in prisoners on indeterminate sentences for public protection (IPP), especially during 2007. This had had a significant de-stabilising effect, reflected in the number of incidents, fights, adjudications etc. There had been 285 use of force incidents in 2007, an increase of more than 50% since the last inspection. IPP prisoners had accounted for 86% of all use of force incidents between January and March 2008. There had also been 1,599 adjudications in 2007, an increase of nearly 40%. Since the start of 2008, however, the situation appeared to have settled and the trends were starting to go down.

2.160 There were good governance arrangements for use of force. A use of force committee met quarterly and reviewed individual incidents, as well as trends and patterns. The figures showed that the number of incidents had decreased continuously over the previous three quarters, with only 49 incidents in the last quarter.

2.161 We reviewed all the use of force incidents for 2008. In general, staff statements provided a reasonable picture of the events that led up to the deployment of force. The biggest single cause was staff intervening to separate two prisoners fighting. We were assured that staff used force proportionately and as a last resort, and that management oversight was good.

2.162 Arrangements for the use of special accommodation had changed. Of the two special cells in the segregation unit, only one was now used and the other was used as a store room. The cell in use was completely bare and also dirty. Paperwork was now completed every time the special cell was used. Most prisoners spent very little time there and were removed to furnished accommodation after a few minutes. On a few occasions, however, prisoners located in the special cell during the evening spent the whole night there, even if they had calmed down.

2.163 The segregation unit had been slightly extended since the last inspection, with the addition of four cells and a new adjudication room. Despite the extension, the unit still seemed dated and was shabby. Some of the cells were also grubby and needed refurbishment.

2.164 The staff group had been specially selected to work in the unit, and we observed good staff interactions with prisoners. Staff worked hard to encourage prisoners to return to normal location. Record keeping was disappointing, however, and did not reflect the good work of the staff. At the last inspection, we reported favourably on the recent introduction of prisoner care plans, which were completed after 24 hours. These had since disappeared and, although prisoners were successfully returned to normal location, there was no evidence that this was a planned or systematic process. Prisoners' records were now located in the new adjudications room, well away from the staff office, which did not facilitate regular entries – records showed staff entries only every couple of days. Similarly, the completed good order reviews that we inspected showed no strategic planning to get a prisoner out of segregated conditions. Targets were simplistic and superficial, and typically involved nothing more than being polite to staff and conforming to unit rules.

2.165 The daily regime in the segregation unit remained basic, but adequate. Prisoners were still allowed off the unit to take part in activities such as education and programmes, subject to risk assessment. We were told that personal officers still visited prisoners on the unit, but there was little evidence of this. The published unit rules and regime document was out of date, and had inaccurate information. There was scope to improve the overall regime of the segregation unit and introduce behavioural incentives, such as access to privileges and punishment mitigation.

Further recommendations

2.166 Prisoners should be removed from unfurnished accommodation at the earliest opportunity, once they have calmed down and are compliant.

2.167 The segregation unit cells should be redecorated and maintained in a suitable condition.

2.168 The segregation unit rules and regime document should be revised and updated.

2.169 All prisoners in segregation should be allocated a member of the unit staff as a key worker within 24 hours of arrival who should make daily records of their prisoner's behaviour on their history sheets. There should also be regular liaison with the prisoner's wing staff to facilitate their return to normal location.

2.170 Individual support and behaviour plans should be drawn up for all segregated prisoners within 48 hours of segregation, targeting their return to normal location. If segregation continues beyond 20 days, a care plan should be put in place to prevent psychological deterioration.

2.171 The overall regime of the segregation unit should be modernised through the introduction of behavioural incentives.

Incentives and earned privileges

2.172 The privileges stated in the incentives and earned privileges (IEP) policy document should be revised to reflect actual practice. (6.47)

Not achieved. A revised facilities list linked to the IEP scheme had been published in April 2008. Prisoners on the enhanced level were entitled to wing-based association five nights a week. However, as A, B and C wings operated a rota system for evening association, enhanced level prisoners on these wings failed to receive this entitlement routinely.

Further recommendation

2.173 All prisoners should receive the full range of privileges specified in the published incentives and earned privileges (IEP) policy document.

Additional information

2.174 The IEP scheme was communicated to staff and prisoners in a policy document, which had been reviewed in January 2008. Most prisoners joined the scheme at the standard level, but those transferring in from other establishments were allowed to retain enhanced status.

2.175 A prisoner's incentive level was reviewed every 10 weeks. Some wings published review dates on wing notice boards. Additional case conferences could be held earlier as a result of a series of negative entries in wing history sheet. Prisoners could also apply to be considered for enhancement within the assessment period if they had received positive entries. Activities staff, such as education or workshop instructors, usually made entries in wing history sheets. Prisoners were able to attend reviews or make written representations, and records of case conferences showed that this happened. An appeals process was in place.

2.176 The safer custody policy group monitored snapshot data of the number of prisoners at each level on a monthly basis. In March 2008, 17 prisoners were on basic, 248 on standard and 352 on enhanced. The IEP scheme was also monitored at wing level through principal officer discussions with senior officers. IEP had recently been added as a standing agenda item on prisoner council meetings. The prison had responded to feedback at this forum about the lack of differential between standard and enhanced levels by introducing an exceptional spends scheme only available to enhanced level prisoners. Prisoners were paid according to their IEP status, which meant that prisoners doing the same job were paid at different rates.

Further recommendation

2.177 Prisoners doing the same job should not receive different levels of pay.

Catering

2.178 All prisoners should have access to a shower after work in the kitchen. (7.11)

Achieved. Prisoners who worked in the kitchen confirmed that they could receive showers on the wings when they returned from work. Staff also told us that groups of designated workers were given priority access to showers on returning from work. There was also a shower for prisoner use in the kitchen area if prisoners needed this in advance of an afternoon visit, and this was often used.

2.179 Breakfast packs should be issued on the morning they are meant to be eaten. (7.12)

Not achieved. Packs of breakfast cereal were given to prisoners for the following week, and they were expected to apportion these daily and store them in their cell. Milk cartons were issued the night before and kept in cells unrefrigerated. Bread rolls were provided by the kitchen, and prisoners could buy jams and spreads through the prison shop. There were no facilities to make toast.
We repeat the recommendation.

2.180 Systems should be in place to ensure that prisoners can dine in association. (7.13)

Not achieved. Prisoners still ate their meals in cell on most wings. The establishment claimed that prisoners did not wish to dine in association. However, the enhanced wings had an open door policy, whereby prisoners were allowed into each others' cells to eat their meals and were not locked in at this time. We saw small groups of prisoners on these wings eating together in cells, although the absence of proper facilities meant that they had to stand while they ate. This suggested that there was some demand for communal eating facilities, and there was certainly scope to offer this more widely.

Further recommendation

2.181 Prisoners should be given greater opportunities to dine communally.

2.182 Utensils used to serve Halal food should be kept separate. (7.14)

Achieved. Separate cabinets had been installed in each kitchen to store halal utensils, which were easily distinguishable by different coloured handles.

2.183 Food trolleys should be adequately cleaned after each use. (7.15)

Achieved. We inspected a number of food trolleys and all were clean. Each wing was responsible for ensuring that their trolley was cleaned after each meal, and they were inspected by kitchen staff before food was loaded. If they were not properly clean, trolleys were sent back to the wing for cleaning.

2.184 Entries in the food comments books should demonstrate that catering staff are responding to individual comments and that prisoners are informed of any action taken. (7.16)

Partially achieved. Food comments books were available on each wing and were used to

record both compliments and complaints about the food. Catering staff responded to some, but not all, of the comments. Food comments books were countersigned by kitchen staff, but invariably entries read that 'comments were noted' instead of a more comprehensive reply to the specific issue. There was better staff engagement with prisoners about the food at prisoner council meetings and at catering committee meetings. These processes had resulted in changes to menus, and appeared to be more effective.

Further recommendation

2.185 Catering staff should provide more comprehensive responses to written comments from prisoners.

Additional information

2.186 Since the last inspection, a new kitchen had become operational. This was large, clean and bright, with well-designated areas for food preparation and storage. Menus operated over a four-week cycle, were well balanced and catered for a wide range of dietary needs.

2.187 We noted that some food, including rice and vegetables, was placed on heated food trolleys from 3pm, which contravened the Prison Service requirement to store food on heated trolleys for only 45 minutes before it was served. Lunch meals were collected from the kitchen from 11.15am and were served on wings from 11.30am. Evening meals were also collected from 4.15pm. Wing serveries were generally clean and wing servery workers were appropriately dressed.

Further recommendations

2.188 Food should not be stored on trolleys beyond the period specified by the Prison Service.

2.189 Lunch should not be served before noon and evening meals before 5pm.

Prison shop

2.190 Prisoners should be able to buy items from the prison shop within 24 hours of arrival. (7.22)

Not achieved. New arrivals could still not buy items from the shop within 24 hours. In some cases they had to wait up to nine days to get their order.
We repeat the recommendation.

2.191 The cost of products on offer should be comparable to those of a high street shop. (7.23)

Not achieved. The price of goods on sale remained in line with the expensive nationally negotiated contract prices.
We repeat the recommendation.

2.192 The value of the smoker's and non-smoker's packs should be increased. (7.24)

Not achieved. The value of the packs remained little changed, with a smoker's pack at £3.27

and a non-smoker's pack at £3.03.
We repeat the recommendation.

Strategic management of resettlement

No recommendations were made under this heading at the last inspection.

Additional information

2.193 Some high quality documents had been produced – the reducing reoffending strategy and the road to resettlement personal handbook. The strategy was detailed and comprehensive, and based on the most recent survey, carried out in 2006. The findings were already becoming out of date, however, and an annual needs analysis was needed to keep the strategy up to date.

2.194 The handbook was a recent initiative. It was well designed and professional, and resembled a Filofax. It was intended to be used by prisoners to keep a record of their sentence and help them to serve their time constructively. While potentially a useful tool, we saw little evidence yet of its practical application, although it was too early to judge its usefulness. Plans to monitor the effectiveness of the personal manuals would ensure they were going to the right people and that they would get the correct help to use them properly.

Further recommendations

2.195 The reducing reoffending strategy should be based on an up to date needs analysis.

2.196 Provision of the road to resettlement handbook should be monitored and evaluated carefully to ensure that best use is made of this resource.

Offender management and planning

2.197 The establishment should review the resources allocated to the offender assessment system (OASys) department. (8.13)

Achieved. The manager of the OASys department had been upgraded from senior to principal officer. This had resulted in greater priority to this area, and progress was now made more quickly.

2.198 A protocol should be introduced to ensure uniformity in the quality checking of OASys assessments. (8.14)

Achieved. OASys assessments were checked regularly by the visiting senior probation officer, who used the nationally prescribed format for this work. Feedback was given to the principal officer responsible for OASys who dealt with any emerging practice issues.

2.199 Home probation officers should be encouraged to attend sentence planning/resettlement boards. (8.15)

Partially achieved. In cases where reviews were out of date, this was highlighted on a database and home-based probation officers were contacted to request that they attend reviews. Overall, however, the responses still tended to be poor.

Additional information

2.200 There had been significant improvements in the administration of OASys, and a great deal of work to reduce backlogs. The NOMS offender management model had been introduced since the previous inspection, and 300 prisoners currently came under the scope of phase two or three. This group had a backlog of 77 cases who had not had an OASys assessment in the previous 12 months. A smaller number had been waiting for over two years for a review, and a further six prisoners had had no OASys assessment at all.

2.201 There were 313 cases outside the scope of offender management model and that were dealt with internally. Of these, 20 had had no assessment at all, and there was a backlog of a further 49 cases with no OASys assessment in the last 12 months. There was an action plan to deal with all the outstanding out of scope work within the following two months.

2.202 We were surprised to find that the normal model for offender management had not been fully established. Internal offender supervisors had not yet been appointed, and the sentence planning work they would have done was carried out instead by personal officers. Although this was meant to enhance the role of personal officers, in practice, this was difficult for them, given the competing pressures on the wings, and the work did not always take place. OASys assessments carried out within the prison for prisoners not in scope for offender management were currently completed by two trained assessors. Prisoners in phases two and three, many of whom were higher risk than those who were out of scope, were not being effectively case-managed at the time of the inspection. In addition to the internal shortcomings, resource pressures meant that external offender managers seldom visited the establishment or completed assessments on time, and there were no staff in the prison who could progress this work.

2.203 The establishment had recognised some of the shortcomings with the delivery of offender management, and planned to create a dedicated offender management unit. Six officers had been selected as offender supervisors and specially trained. The plan was for them to take on responsibility for the sentences of out-of-scope prisoners, and act as the liaison between in-scope prisoners and offender managers. However, their introduction was contingent on new staffing profiles, which could not be implemented until the new national core day commenced. External probation services also needed to invest more in taking responsibility for and managing the sentences of in-scope prisoners, but there was no indication that such improvement was likely in the short-term.

2.204 The chaplaincy continued to send families a document requesting them to contribute towards setting behaviour targets within the sentence planning process. This initiative encouraged family members to come to meetings, where their attendance approached 40% of cases.

Further recommendations

2.205 All prisoners should be given the opportunity to participate in sentence planning.

2.206 The backlog of outstanding assessments and reviews should be cleared.

2.207 The prison should create a dedicated offender management unit, staffed by identified offender supervisors, at the earliest opportunity, in order to implement fully the NOMS offender management model.

2.208 Offender managers based in the community should play a full and active part in sentence planning of in-scope prisoners.

Indeterminate-sentenced prisoners

2.209 A lifer liaison officer job specification outlining all aspects of the work should be produced. (8.24)

Achieved. A job specification had been produced which included the necessary links between lifer work and OASys, as well as relevant aspects of work with prisoners serving an indeterminate sentence for public protection (IPP).

2.210 The confidential supplementary dossiers should be stored more securely and access to them controlled. (8.25)

Achieved. All dossiers were held securely in the OMU. Access was strictly controlled, and files could only be removed following receipt of a signature.

Additional information

2.211 Lifers continued to be located on D wing. The number had risen from 42 at the last inspection to 52. A new feature was the IPP population, which was rising. There were 132 IPP prisoners at the time of our inspection, located throughout the establishment. The centrally located lifers continued to be well supported by trained staff. Because of the nature of their sentences, the IPP population tended to be resource-intensive. If the number of IPP prisoners kept rising, additional resources would be needed to meet their needs. It was also difficult to resource these cases within externally imposed timescales, despite the active management by the head of programmes to provide relevant services.

2.212 We were told that some IPP prisoners had arrived at Swinfen Hall unclear of the consequences of their sentence, and with unrealistic expectations about progression and release. This had caused some unrest among this population initially, when these issues were clarified, but the situation had now calmed down.

Further recommendation

2.213 There should be sufficient resources to provide relevant programme work for prisoners serving an indeterminate sentence for public protection.

Public protection

2.214 The role and responsibilities of the risk management team should be explained to staff. (8.51)

Achieved. An information note to staff had been published explaining the role and function of the risk management team.

2.215 Staff should be notified about the background offences of prisoners subject to multi-agency public protection arrangements and any specific risk managed. (8.52)

Partially achieved. Monthly intelligence reports were circulated to all the wings and were kept in ring binders. These reports had a wide range of useful information, and it was clear that staff read them and were well briefed about security risks. Some staff were due to be trained on site about risk assessment for IPP prisoners. However, as many of the prisoners were high risk, general staff awareness about public protection issues needed to be raised.

Further recommendation

2.216 All staff who have individual contact with prisoners should be trained to be aware of any important public protection issues they present.

2.217 There should be a clear job description that outlines the responsibilities of the public protection co-ordinator. (8.53)

Achieved. A principal officer had been appointed as the public protection coordinator .He had been given a precise remit and was clear about his role.

Resettlement pathways

Reintegration planning

2.218 An alternative mentoring scheme to that provided until recently by SOVA should be introduced to the establishment. (8.41)

Achieved. A mentoring scheme run by the Newbridge charity had been introduced since the previous inspection (see below).

Accommodation

2.219 Prisoners received support from the full-time specialist on-site housing worker employed by the Newbridge charity. We found no evidence that any prisoner was discharged without accommodation to go to, and prisoners who faced particular difficulties were supported by mentors.

Education, training and employment

2.220 Prisoners had access to a visiting specialist from Jobcentre Plus on two days a week. They could also use job search facilities and support through Learndirect.

Mental and physical health

2.221 Resettlement provision for prisoners with general and mental health needs was good, and the prison had good communication with community primary care and mental health services. Healthcare staff attended the resettlement board meetings three months before the prisoner's release, where health needs were identified in ample time to arrange throughcare. The prisoner's named nurse saw him one week before release to ensure all appropriate arrangements had been made. The prisoner was given a GP letter with a summary of his care, a sexual health pack and one-week supply of any medication needed.

2.222 Prisoners with a severe and enduring mental health need were subject to the safeguards of the care programme approach (CPA). The in-reach nurse liaised with the community mental health team and made an appointment for the prisoner to have a mental health review within seven days of release.

Good practice

2.223 *Prisoners covered by the care programme approach were given an appointment for a mental health review in the community within seven days of release.*

Finance, benefit and debt

2.224 Staff who worked on the pre-release course reported that debt was a serious problem for prisoners, particularly the younger age group. A member of staff from Citizens Advice visited the establishment twice a week to provide guidance and support, but this was not sufficient to assist all prisoners who had debt-related problems.

Further recommendation

2.225 There should be increased finance, benefit and debt support to meet prisoner need.

Additional information

2.226 There were pre-release conferences on all prisoners shortly before they were released. We observed two of these. The meetings were well chaired with useful contributions from prison-based staff, as well as community-based probation officers. The meetings tended to focus on practical arrangements and were an effective way of ensuring that prisoners received help with accommodation, clothing or finance before their release.

2.227 All prisoners also had the opportunity to attend the two-week pre-release course, and around 75% took part in this. The focus was again on providing practical help prior to their release. There was an emphasis on confidence building to help prisoners cope with interviews and social situations.

2.228 All prisoners who were discharged were expected to be picked up by someone on release. This helped to ensure that they did not fall down at the first hurdle.

Drugs and alcohol

2.229 The P-ASRO (prison addressing substance related offending) referral target for CARATs (counselling, assessment, referral, advice and throughcare service) should be reviewed. (8.78)

Achieved. All P-ASRO referrals were subject to a comprehensive substance misuse assessment (CSMA) and a quality check by the P-ASRO treatment manager, who checked the CSMA, care plan and interviewed the prisoner to ascertain their level of motivation. This process had improved the suitability of the candidates for referral, and had reduced their number. There had been 129 referrals from CARATs to P-ASRO in the year to date, and the success rate of referrals was 62%. The P-ASRO key performance target was 80 starts per

year with 52 completions. Year-to-date figures achieved were better, at 80 starts and 66 completions.

2.230 A mechanism for evaluating CARAT-based treatment outcomes, including service-user feedback, should be developed. (8.79)

Achieved. Since May 2007, the drug strategy principal officer had submitted five user evaluation feedback forms monthly to the cluster manager. This information was obtained from prisoners following group and one-to-one work, and was used to aid service provision.

2.231 Recommendations from the 2004 drug survey (February 2005) should be incorporated into the annual action plan. (8.80)

Achieved. There had been a substance misuse survey in February 2008, which was used to inform the substance misuse strategy 2008-09. The survey highlighted the need for alcohol programmes, as 50% of respondents said their offence(s) were related to alcohol, and 16% had treatment needs solely for alcohol. These prisoners were outside the remit for CARAT or P-ASRO interventions, and support was limited to monthly Alcoholics Anonymous self-help meetings and alcohol awareness sessions run by a local provider. All new arrivals saw a member of the CARAT team at induction within their first 24 hours, whether or not they had an identified drug or alcohol problem, and could elect to opt in or out of the service.

Further recommendation

2.232 There should be services for prisoners with an alcohol misuse problem, including regular group sessions, one-to-one counselling, psychosocial support, and throughcare arrangements.

2.233 Substance of choice, as identified by CARAT clients, should be monitored to inform strategic and treatment development. (8.81)

Achieved. Substance of choice was recorded and monitored at the monthly drug strategy meetings, as was the use of other drugs and alcohol. This information was used to develop an individual care plan for the prisoner. There was a joint referral process between health services and CARATs, which was well supported by health services and the primary mental health nurses.

Additional information

2.234 CARAT services were provided by four full-time CARAT workers, a service worker, a senior practitioner, and a cluster manager (who covered three prisons). One full-time and one part-time administrative assistant supported the team. The CARAT team was the main gatekeeper for all referrals to the substance misuse services, and had a fully integrated role in the prison. The CARAT service was represented at a range of meetings, including drug strategy, sentence planning, resettlement, and healthy living, along with representatives from healthcare and the gym. The team was also represented on the induction/pre-release boards.

2.235 There were good measures to ensure a smooth transition into the community for prisoners who needed substance use support on release. The CARAT team had good links with local drug intervention programme (DIP) teams, who they contacted one month before the prisoner's release. DIP teams and probation staff were invited into the prison to discuss the

prisoner's release plans and to coordinate a joint approach to his management in preparation for release.

2.236 CARATs gave prisoners with alcohol problems an information pack before their release with the telephone numbers of local community agencies which could support them.

2.237 There were 150 voluntary drug testing (VDT) compacts with 1.5 tests per month; the year-to-date positive rate was 1.21%. There was a waiting list of 25 prisoners for the programme, which offered incentives for testing negative. For five negative tests the prisoner got a bronze certificate, and for 10 negative tests he got a silver certificate and a £2 telephone credit or an extra visit.

Children and families of offenders

2.238 A designated children's play area should be provided in the main visits room. (3.83)

Partially achieved. A play area had been constructed and was appropriate in size and location. However, the range of toys and games available was limited and did not cater for a wide range of ages. The play area could only be used by children who were supervised by an adult, and there were times when it was not available.

Further recommendations

2.239 The children's play area should have a sufficient range of resources for children of all ages.

2.240 A suitably qualified playworker should be employed in the children's play area during visits.

2.241 Closed visits should be authorised following consultation with the duty governor and only when there is a risk justified by security intelligence. (3.84)

Achieved. Duty governors were contacted when closed visits were sought following security intelligence or positive indications from the drug dog.

2.242 The practice of issuing closed visits to parties of visitors because the detection dog had indicated on one of them should cease. (3.85)

Not achieved. A positive indication from the drug dog on one visitor in a group still resulted in an offer of a closed visit to the whole group. This practice was disproportionate and there was little evidence that closed visits contributed significantly to supply reduction overall (see below). The governor recognised this and indicated a willingness to look at this policy again.
We repeat the recommendation.

2.243 A review of the nature of the high number of drug dog indications should be carried out. (3.86)

Achieved. Four new drug dogs had been allocated to the prison and had been trained to indicate individuals more specifically. As a consequence, the number of positive indications, and resultant closed visits, had dropped significantly to just eight a month in the previous six months, compared to 49 a month at the previous inspection. Notably, there had been no evidence of an increase in the amount of drugs within the establishment, despite the large reduction in the use of closed visits.

2.244 Strip-searching prisoners after visits should be based on risk assessment. (3.87)

Not achieved. All prisoners were still routinely strip searched following domestic visits, regardless of an assessment of risk. Several prisoners commented that they found the experience degrading. The prison believed that this approach was a deterrent to drug trafficking during visits, although there was limited evidence that the visits area was a significant route for drugs to enter the establishment, and the practice contradicted Prison Service searching policy.
We repeat the recommendation.

Additional information

2.245 There was a visitors' centre outside the prison. This had no facilities to provide hot drinks for visitors, some of whom had travelled long distances. Visits did not commence at the stated time, as visitors were slow in being taken to the prison.

2.246 There was a new visits hall since the last inspection, with space for 37 domestic visits and 10 closed visits. Visits took place on five days a week, excluding Mondays and Fridays. Legal visits generally took place in the visits hall in the morning or on the wings if they were in the afternoon. The visits hall had a tea bar staffed by volunteers from the Friends of Swinfen Hall Committee and a prisoner. It was self-financing and any profits were used to support the visits area. The range of refreshments was limited.

2.247 Monthly family visits took place on Mondays. They had originally been targeted at prisoners who had completed the Fathers Inside programme, but this no longer ran and other prisoners could take part. These visits were more relaxed with fewer restrictions than standard visits, and prisoners were encouraged to take part in active play with their children. Prisoners were positive about these visits. Storybook Dad was also run through the education department.

Further recommendations

2.248 Visitors should be able to obtain hot and cold drinks at the visitors' centre.

2.249 Visits should commence at the stated time.

2.250 A wider range of food should be available at the visits hall tea bar.

Attitudes, thinking and behaviour

2.251 The head of programmes should be fully supported by other managers to identify and encourage suitable officers to train as offending behaviour programme tutors. (8.33)

Achieved. All the officer vacancies on the programmes team had been filled, and senior staff had supported this process.

2.252 Existing rooms used for the delivery of accredited programmes should, where necessary, be refurbished and redecorated. (8.34)

Achieved. The accommodation for groups had been upgraded and was suitable for its purpose.

Additional information

2.253 There had been improvements in the staffing and accommodation for this area, and overall programmes work continued to be well managed .The programmes team was large and well integrated, and its work was generally supported by mainstream staff. The head of programmes worked hard to manage the available scarce resources effectively. He continued to allocate resources on the basis of assessed need rather than as a response to other external pressures, particularly in relation to the rising IPP population.

Section 3: Summary of recommendations

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

Recommendation — To NOMS

3.1 There should be an end to doubling on D and E wings. (2.6)

Recommendations — To the governor

First days in custody

3.2 The local information booklet issued in reception should be available in languages other than English. (2.12)

3.3 The induction programme should start on the first full working day following reception. (2.13)

3.4 Reception should remain open if it is known that new prisoners are due to arrive outside the scheduled opening times. (2.22)

3.5 New arrivals should be fully and promptly processed in reception and not located on to residential units for several hours halfway through the process. (2.23)

3.6 All cells used for prisoners' first night should be properly furnished and have appropriate levels of privacy. (2.24)

3.7 The safer cells, designed as a short-term intervention for prisoners in crisis, should not be used as normal accommodation. (2.25)

Staff-prisoner relationships

3.8 All staff should be encouraged to address prisoners by their preferred name. (2.39)

Bullying and violence reduction

3.9 Prisoner representatives should be invited to join the quarterly anti-bullying committee. (2.46)

3.10 The programme to support the victims of bullying should be reviewed and publicised to all staff. (2.48)

3.11 There should be a prisoner survey to inform a review of the anti-bullying policy. (2.55)

Self-harm and suicide

3.12 More proactive use of prisoners' families should be explored as a resource for managing those at risk of suicide or self-harm. (2.58)

Diversity

3.13 A diversity strategy based on the needs of prisoners at Swinfen Hall should be drawn up. (2.62)

3.14 Prisoner representatives should be invited to attend the diversity committee. (2.63)

Race equality

3.15 The race equality officer post should be full-time, and the postholder should not be redeployed to other work. (2.65)

3.16 Assistant race equality officers should be given meaningful job descriptions and sufficient time to allow them to support the REO and carry out their range of duties. (2.66)

3.17 Black and minority ethnic prisoners should have the opportunity to meet formally each month with prisoner representatives of the race equality action team and the race equality officer. (2.68)

3.18 All prisoner diversity representatives should be trained and given clear guidance on their role and expected duties. (2.73)

Foreign national prisoners

3.19 The arrangements for foreign national prisoners outlined in the establishment's foreign national strategy document should be implemented as a priority. This document should be effectively publicised to both staff and prisoners. (2.7)

3.20 A multidisciplinary committee should be in place and meet regularly to ensure that the foreign nationals strategy is fully implemented. (2.74)

3.21 Adequate time should be allocated to the foreign nationals liaison officer to ensure that the specified duties are carried out effectively. (2.75)

3.22 Wing-based foreign national liaison officers should be appropriately trained on the specific needs of foreign national prisoners. (2.76)

3.23 An information and advice book for foreign national prisoners should routinely be issued to them at reception and should be available in languages other than English. (2.77)

3.24 Foreign national prisoners should be able to meet at least monthly in order to establish a self-help support group. (2.78)

3.25 Foreign national prisoners should be encouraged to attend regular wing meetings held to consult them, and significant issues that they raise there should be acted on. (2.80)

3.26 Ongoing contact should be maintained with local accredited immigration advice and support agencies. (2.81)

3.27 The establishment should liaise with the UK Border Agency to ensure more regular visits to foreign national prisoners subject to immigration control. (2.82)

3.28 Accurate records should be kept of staff and prisoners who are able to speak languages other than English. (2.83)

Applications and complaints

3.29 Complaints should be responded to within three days or up to 10 days in exceptional circumstances. (2.86)

Substance use

3.30 The toilet in the mandatory drug testing suite should be kept clean. (2.91)

3.31 A secondary detoxification protocol should be introduced. (2.93)

Health services

3.32 Algorithm-based nurse triage should be introduced. (2.98)

3.33 There should be a computerised register to manage and monitor prisoners with lifelong conditions. (2.99)

3.34 The new pharmacy contract should become operational as soon as possible. (2.104)

3.35 The pharmacy should reconcile stock medicines with prescriptions. (2.106)

3.36 A system should be introduced whereby simple medicines can be provided to prisoners by wing staff when the healthcare department is closed. (2.109)

Learning and skills and work activities

3.37 The pallet repair workshop should be replaced with work of a genuinely purposeful nature. (2.9)

3.38 The links between individual learning plans (ILPs) and sentence planning should be improved. (2.119)

3.39 The planned personal tutor system should be introduced as soon as possible. (2.120)

3.40 ILPs should contain sufficient details to be meaningful, and prisoners should have better access to them. (2.122)

3.41 Education performance data should be used comprehensively to identify trends. (2.125)

3.42 The range and quantity of library stock should be significantly increased. (2.130)

3.43 Appropriate level two qualifications should be available for prisoners working in industrial cleaning, waste management, motor vehicle, horticulture and land-based provision. (2.133)

3.44 Prisoners working in the kitchen should be able to work towards level one and level two NVQs. (2.134)

Time out of cell

3.45 There should be more weekday evening association for all prisoners. (2.140)

3.46 Managers should ensure that published regime times are adhered to. (2.141)

Security and rules

3.47 Categorisation review dates should be adhered to and should take place at least annually. (2.144)

3.48 The correct burden of proof should be applied in all adjudications. (2.150)

3.49 Duty managers should abide by the criteria for placing a prisoner in strip clothing in the special cell, and should fully justify this decision in the accompanying paperwork. (2.153)

3.50 Prisoners on open ACCT documents should not be deprived of their normal clothing if they have to be located in the special cell. (2.154)

3.51 The operational instruction governing the use of the special cell should, in consultation with the safer custody policy group, be amended to cover circumstances when prisoners on open ACCT documents have to be located there. (2.156)

3.52 Toiletries specifically for black and minority ethnic prisoners should be provided in the segregation unit. (2.158)

3.53 Prisoners should be removed from unfurnished accommodation at the earliest opportunity, once they have calmed down and are compliant. (2.166)

3.54 The segregation unit cells should be redecorated and maintained in a suitable condition. (2.167)

3.55 The segregation unit rules and regime document should be revised and updated. (2.168)

3.56 All prisoners in segregation should be allocated a member of the unit staff as a key worker within 24 hours of arrival who should make daily records of their prisoner's behaviour on their history sheets. There should also be regular liaison with the prisoner's wing staff to facilitate their return to normal location. (2.169)

3.57 Individual support and behaviour plans should be drawn up for all segregated prisoners within 48 hours of segregation, targeting their return to normal location. If segregation continues beyond 20 days, a care plan should be put in place to prevent psychological deterioration. (2.170)

3.58 The overall regime of the segregation unit should be modernised through the introduction of behavioural incentives. (2.171)

Incentives and earned privileges

3.59 Incentives and earned privileges (IEP) reviews and decisions should not be based solely on the prisoner's adherence to wing rules, but should consistently consider their progress towards sentence planning targets and participation in regime activities. (2.5)

3.60 All prisoners should receive the full range of privileges specified in the published incentives and earned privileges (IEP) policy document. (2.173)

3.61 Prisoners doing the same job should not receive different levels of pay. (2.177)

Catering

3.62 Breakfast packs should be issued on the morning they are meant to be eaten. (2.179)

3.63 Prisoners should be given greater opportunities to dine communally. (2.181)

3.64 Catering staff should provide more comprehensive responses to written comments from prisoners. (2.185)

3.65 Food should not be stored on trolleys beyond the period specified by the Prison Service. (2.188)

3.66 Lunch should not be served before noon and evening meals before 5pm. (2.189)

Prison shop

3.67 Prisoners should be able to buy items from the prison shop within 24 hours of arrival. (2.190)

3.68 The cost of products on offer should be comparable to those of a high street shop. (2.191)

3.69 The value of the smoker's and non-smoker's packs should be increased. (2.192)

Strategic management of resettlement

3.70 The reducing reoffending strategy should be based on an up to date needs analysis. (2.195)

3.71 Provision of the road to resettlement handbook should be monitored and evaluated carefully to ensure that best use is made of this resource. (2.196)

Offender management and planning

3.72 All prisoners should be given the opportunity to participate in sentence planning. (2.205)

3.73 The backlog of outstanding assessments and reviews should be cleared. (2.206)

3.74 The prison should create a dedicated offender management unit, staffed by identified offender supervisors, at the earliest opportunity, in order to implement fully the NOMS offender management model. (2.207)

3.75 Offender managers based in the community should play a full and active part in sentence planning of in-scope prisoners. (2.208)

3.76 There should be sufficient resources to provide relevant programme work for prisoners serving an indeterminate sentence for public protection. (2.213)

3.77 All staff who have individual contact with prisoners should be trained to be aware of any important public protection issues they present. (2.216)

Resettlement pathways

3.78 There should be increased finance, benefit and debt support to meet prisoner need. (2.225)

3.79 There should be services for prisoners with an alcohol misuse problem, including regular group sessions, one-to-one counselling, psychosocial support, and throughcare arrangements. (2.232)

3.80 The children's play area should have a sufficient range of resources for children of all ages. (2.239)

3.81 A suitably qualified playworker should be employed in the children's play area during visits. (2.240)

3.82 The practice of issuing closed visits to parties of visitors because the detection dog had indicated on one of them should cease. (2.242)

3.83 Strip-searching prisoners after visits should be based on risk assessment. (2.244)

3.84 Visitors should be able to obtain hot and cold drinks at the visitors' centre. (2.248)

3.85 Visits should commence at the stated time. (2.249)

3.86 A wider range of food should be available at the visits hall tea bar. (2.250)

Examples of good practice

3.87 Family induction visits helped to develop relationships between families, the prison and prisoners. (2.26)

3.88 Conflict resolution by trained officers was used to deal with low level disputes between prisoners. (2.56)

3.89 The healthy living unit offered daycare support to prisoners with a range of needs.(2.117)

3.90 Prisoners covered by the care programme approach were given an appointment for a mental health review in the community within seven days of release. (2.223)

Appendix I: Inspection team

Jonathan French	Team leader
Ian Macfadyen	Inspector
Marie Orrell	Inspector
Gordon Riach	Inspector
Andrea Walker	Inspector
Margot Nelson-Owen	Healthcare inspector
Nigel Bragg	Ofsted inspector

Appendix IIa: Prison population profile – adults*

(i) Status	Number of prisoners	%
Sentenced	126	*20.5*
Detainees (single power status)	1	*0.1*
Total	127	20.6

(ii) Sentence	Number of prisoners	%
2 years-less than 4 years	18	*3*
4 years-less than 10 years	93	*15*
10 years and over (not life)	3	*0.5*
Life	13	*2.1*
Total	127	20.6

(iii) Length of stay – *see Appendix IIb*

(iv) Main offence	Number of prisoners	%
Violence against the person	23	*3.7*
Sexual offences	31	*5*
Burglary	9	*1.5*
Robbery	35	*5.7*
Theft and handling	1	*0.1*
Drugs offences	11	*1.8*
Other offences	14	*2.3*
Offence not recorded/ holding warrant	3	*0.5*
Total	127	20.6

(v) Age	Number of prisoners	%
21 years to 29 years	127	*20.6*
Total	127	20.6

(vi) Home address – – *see Appendix IIb*

(vii) Nationality	Number of prisoners	%
British	111	*18*
Foreign nationals	16	*2.6*
Total	127	20.6

(viii) Ethnicity	Number of prisoners	%
White:		
British	77	*12.5*
Other White	2	*0.3*
Mixed:		
White and Black Caribbean	5	*0.8*
Asian or Asian British:		
Indian	4	*0.6*
Pakistani	4	*0.6*
Other Asian	6	*0.9*

* Percentages expressed as percentages of the whole population.

Black or Black British:		
Caribbean	10	*1.7*
African	10	*1.7*
Other Black	9	*1.5*
Total	127	20.6

(ix) Religion	Number of prisoners	%
Church of England	35	*5.7*
Roman Catholic	15	*2.5*
Other Christian denominations	3	*0.5*
Muslim	22	*3.6*
Sikh	1	*0.1*
Buddhist	1	*0.1*
Other	5	*0.8*
No religion	45	*7.3*
Total	127	20.6

Appendix IIb: Prison population profile – young adults*

(i) Status	Number of prisoners	%
Sentenced	486	*79.2*
Detainees (single power status)	1	*0.1*
Total	487	79.3

(ii) Sentence	Number of prisoners	%
2 years-less than 4 years	42	*6.8*
4 years-less than 10 years	256	*41.7*
10 years and over (not life)	19	*3*
Life	170	*27.8*
Total	487	79.3

(iii) Length of stay**	Number of prisoners	%
6 months to 1 year	20	*3.2*
1 year to 2 years	154	*24.9*
2 years to 4 years	234	*37.8*
4 years or more	211	*34.1*
Total	619	100

(iv) Main offence	Number of prisoners	%
Violence against the person	148	*24*
Sexual offences	109	*18*
Burglary	20	*3*
Robbery	110	*18*
Theft and handling	2	*0.3*
Drugs offences	34	*5.5*
Other offences	55	*9*
Offence not recorded/holding warrant	9	*1.5*
Total	487	79.3

(v) Age	Number of prisoners	%
18 years	42	*6.8*
19 years	127	*20.7*
20 years	167	*27.2*
21 years	151	*24.6*
Total	487	79.3

(vi) Home address**	Number of prisoners	%
Within 50 miles of the prison	403	*65.2*
Between 50 and 100 miles of the prison	98	*15.8*
Over 100 miles from the prison	116	*18.7*
No fixed address	2	*0.3*
Total	619	100

* Percentages expressed as percentages of the whole population.

** Adults and young adults combined.

** Adults and young adults combined.

(vii) Nationality	Number of prisoners	%
British	465	*75.7*
Foreign nationals	22	*3.6*
Total	487	79.3

(viii) Ethnicity	Number of prisoners	%
White:		
British	294	*48*
Irish	3	*0.5*
Other White	4	*0.6*
Mixed:		
White and Black Caribbean	31	*5.1*
White and Black African	2	*0.3*
White and Asian	3	*0.5*
Other Mixed	11	*1.8*
Asian or Asian British:		
Indian	7	*1.1*
Pakistani	21	*3.4*
Bangladeshi	2	*0.3*
Other Asian	13	*2.1*
Black or Black British:		
Caribbean	62	*10.2*
African	15	*2.4*
Other Black	18	*2.9*
Chinese or other ethnic group:		
Other ethnic group	1	*0.1*
Total	487	79.3

(ix) Religion	Number of prisoners	%
Church of England	116	*19*
Roman Catholic	83	*13.5*
Other Christian denominations	6	*0.9*
Muslim	84	*13.7*
Sikh	2	*0.3*
Other	15	*2.4*
No religion	181	*29.5*
Total	487	79.3