Report on an unannounced short follow-up inspection of

HMP Cardiff

28–30 June 2010

by HM Chief Inspector of Prisons

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1st Floor, Ashley House
Monck Street
London SW1P 2BQ
England

Contents

Introduction

HMP Cardiff is a large Victorian inner city local prison, which also has a training function. Like many prisons, it must manage a range of challenging issues, including overcrowding, an ageing infrastructure and a disparate and transient population of often needy – and sometimes challenging – prisoners. It is, therefore, commendable that this unannounced follow-up inspection was able to confirm that the prison remained an essentially safe purposeful place, appropriately focused on its resettlement role.

Despite a tragic spate of deaths in custody, Cardiff continued to provide an essentially safe environment. An appropriately heightened focus had been given to suicide prevention work and to learning lessons that might prevent future fatalities. Early days in custody were satisfactorily managed, although reception staff struggled to deal with the churn of prisoners that they faced. Anti-bullying work was sound and levels of assault were low.

Security was effective and generally proportionate. The establishment appeared to be on top of the drug problem that followed many prisoners into custody. However, there was still too little care planning for those who struggled to cope and other vulnerable prisoners. Moreover, overcrowding had led to some vulnerable prisoners being housed in the segregation unit and therefore receiving a minimal regime. The establishment awaited clarity from regional managers as to whether it would in future hold vulnerable prisoners, including sex offenders.

The quality and cleanliness of the living accommodation varied. Staff-prisoner relationships were generally good, but were not supported by a consistently effective personal officer scheme. Some aspects of the management of diversity were underdeveloped. Health care was much improved.

Time out of cell varied and there was an adequate range of work and education opportunities, to which prisoners had appropriate and equitable access. Learning was suitably modular in approach, thus addressing the needs of an often short-term population. The library and PE facilities were satisfactory.

There was a sound emphasis on resettlement. A well-resourced offender management unit ensured proper assessment of risk and need, and a range of reintegration services were available to prepare prisoners for release. Life- sentenced prisoners received basic levels of support. Visit facilities were poor but staff were polite and helpful to visitors.

This is a generally positive report which demonstrates that Cardiff has sustained much of the progress that we identified on our last visit, although we identify a number of areas for further improvement. This is commendable given the inherent challenges facing managers and staff, both in terms of the ageing, overcrowded environment of the prison, and the many risks and needs posed by the transient prisoner population.

Nigel Newcomen **September 2010**
HM Deputy Chief Inspector of Prisons

Fact page

Task of the establishment
HMP Cardiff is a large Victorian city centre-based local establishment, predominantly serving the Welsh courts and the south-west of England. The establishment holds adult convicted and remand prisoners and those awaiting sentence. It is designated to hold category B and C prisoners, including life-sentenced prisoners. The prison also holds vulnerable prisoners and sex offenders on a separate unit. In addition to its local function, Cardiff provides a training function, with workshop, education and offending behaviour programme provision.

Area organisation
NOMS Cymru

Number held
797

Certified normal accommodation
555

Operational capacity
824

Last inspection
7–11 January 2008

Brief history
The Marquis of Bute donated the current site at Cardiff in 1832 to take over the county gaol and to provide a larger new gaol and house of correction. The three Victorian blocks were built in 1870 and the three modern wings in 1996.

Description of residential units

A wing	Employed worker unit	172
A1 wing	Segregation and progression	25
B wing	Convicted prisoners	143
B1 wing	Vulnerable prisoners	34
C wing	Rule 45 prisoners	52
D wing	Enhanced prisoners	59
E wing	Lifer prisoners	98
F wing	Trials and remands	150
F1 wing	Induction unit	42
G wing	Detoxifying prisoners	27
Healthcare	Medical unit	2

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 2008 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.

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

- outcomes for prisoners are reasonably good 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. Procedures to safeguard outcomes are in place.

- outcomes for prisoners are not sufficiently good 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.

- outcomes for prisoners are poor 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 At our inspection in 2008, we found that in Cardiff, outcomes for prisoners were reasonably good against this healthy prison test. We made 20 recommendations in this area, of which five had been achieved, one partially achieved, 12 had not been achieved and one was no longer relevant. We have made a further 35 recommendations.

HP5 Prisoners reported a reasonable experience of transfer to the prison and the majority had travelled short distances. Insufficient use was made of the video-link facilities, primarily due to some reluctance by the courts.

HP6 The reception area environment met the needs of the number of prisoner movements through it. Not all prisoners were offered a shower but all were offered a free telephone call. Some prisoners spent too long in reception. First night procedures were good and essential information was obtained before location on the wings. First night accommodation was poor; the cells were dirty and some contained offensive graffiti and damaged furniture.

HP7 Most prisoners said that the induction was poor and did not tell them what they needed to know. Prisoners who were located on other wings for their first night were inducted by wing staff.

HP8 There had been seven deaths in custody since the previous inspection, five of which were self-inflicted. There had been a recent change in the coordination of suicide prevention and self-harm management. Senior officers were becoming more involved and were supported during the transition by the safer custody team. Only 43% of staff had received assessment, care in detention and teamwork (ACCT) refresher training in the previous three years. The quality of ACCT documents was mixed and the Listener scheme poorly coordinated.

HP9 Bullying and violence reduction arrangements were mostly reasonable. Detailed trend analysis had resumed only recently. The quality of entries in violence reduction booklets was poor. Levels of assaults were low.

HP10 Security arrangements were sound and the level of security intelligence was good. Regular security bulletins were provided to staff. Engagement at the security meeting was good and interdepartmental. Closed visits were imposed for illicit activity not always related to visits, and restrictions were imposed for up to three months without review.

HP11 The segregation unit was occasionally used as an overflow for C wing (vulnerable prisoner) new arrivals. Access to any regime was limited, particularly for those not

held there under punishment. Prisoners stayed on the unit for relatively short periods, and staff on the unit engaged well with them. Most segregated prisoners were subsequently reintegrated onto the wings. However, there was no formal reintegration planning for challenging prisoners located on the progression unit (A1 landing) or vulnerable prisoners on B1 landing.

HP12 Adjudications were of a good standard, although there were no quality assurance arrangements. The location for adjudications was inappropriate.

HP13 Levels of use of force had increased since the previous inspection but were still low and well documented. Planned removals were not video-recorded.

HP14 Mandatory drug testing was appropriately resourced and testing was unpredictable. There had been a 9.5% positive rate in the previous calendar year, against a target of 9%. Visits had become more susceptible to the smuggling of drugs with the loss of the drugs dog. Suspicion testing was generally carried out in time. There was no formal integrated drug treatment system (IDTS) programme. The counselling, assessment, referral, advice and throughcare (CARAT) service provided psychosocial support.

HP15 On the basis of this short follow-up inspection, we considered that outcomes for prisoners were still reasonably good against this healthy prison test.

Respect

HP16 At our previous inspection, we found that in Cardiff, outcomes for prisoners were reasonably good against this healthy prison test. We made 77 recommendations in this area, of which 25 had been achieved, 16 partially achieved, 35 had not been achieved and one was no longer relevant. We have made a further 35 recommendations.

HP17 Generally, the communal areas were clean and well maintained. Some cells contained graffiti, and the offensive display policy was not adhered to. Prisoners were only issued with one set of prison clothing, and there were inadequate laundry facilities on some of the wings. Although reasonable adjustments had been made for some prisoners with disabilities located on normal location, there were no adapted cells, and four prisoners using wheelchairs were located in the health care centre.

HP18 The incentives and earned privileges scheme was used as an effective behaviour management tool, with evidence of incremental incentives for those on the basic regime on the A1 landing. The incentives for being on the enhanced level of the scheme were insufficiently motivational, and enhanced prisoners who were not located on D wing (the enhanced unit) were unfairly disadvantaged in their access to association.

HP19 Staff–prisoner engagement was good, although not during exercise. On association, most staff were responsive to prisoners, but others observed supervision from the landings.

HP20 The level of engagement with the personal officer scheme varied. Some prisoners reported no contact with their personal officer, while others had good contact and

appreciated their efforts. The personal officer entries were better on the smaller units and reflected a good level of engagement with prisoners.

HP21 Catering arrangements were reasonably good. There were diverse meal choices and prisoners' dietary requirements were catered for. There were no opportunities for prisoners to dine in association. National Vocational Qualifications up to level 2 were available to prisoners working in the kitchen.

HP22 Shop provision was discussed at consultation meetings. New receptions could wait as long as 12 days after arrival to receive a shop order.

HP23 There was no overarching diversity strategy and poor provision for older, gay, bisexual and transgender prisoners. The diversity and race equality action team met monthly and were at the stage of identifying leads for each of the strands. Arrangements for prisoners with disabilities were underdeveloped. The disability liaison officer had insufficient time to undertake the work but held informal meetings with groups of prisoners with disabilities. There was no formal care planning or peer support for prisoners who required day-to-day support.

HP24 There was no race equality officer in post. Racist incidents were investigated by managers in the area concerned, and the diversity manager reviewed all investigations. A consultation meeting with black and minority ethnic prisoners had recently started. The number of racist incident report forms was low and the quality of investigations had improved since the previous inspection, but serious complaints were not pursued when complainants were discharged before completion of the investigations.

HP25 There was a basic foreign nationals policy. Consultation with foreign national prisoners had declined, as no meetings had taken place since March 2010 and the coordinator was on long-term sick leave. There were monthly surgeries with the UK Border Agency but no links with specialist independent advice and voluntary sector organisations. There were seven immigration detainees.

HP26 Staff dealt reasonably quickly with applications and complaints. Many complaints that we looked at had not been answered appropriately, with some receiving no response. Analysis of a comprehensive range of complaints data was undertaken every month.

HP27 Faith provision was good and well integrated across the establishment. The team was involved in resettlement work and provided reducing reoffending programmes.

HP28 Arrangements to support prisoners in legal matters were effective, and bail information staff offered a good service, including attending court. Prisoners had suitable access to Prison Service Orders and other legal documents in the library.

HP29 The new health care centre was a much improved environment but was underused, with GP and opticians' clinics held on the wings owing to a shortage of staff to escort prisoners to the centre. GP services were reasonable but there were long waiting lists for the dentist. There was some secondary dispensing, and evening medications were given too early. There were no pharmacy-led clinics. Inpatients with acute needs had no access to day care or activity. Primary mental health provision was fragile, with no designated staffing. The mental health in-reach team provided a good service to the small number of prisoners on their caseload. There was inadequate counselling provision. There was little evidence of promotion of exercise in relation to fitness.

HP30 On the basis of this short follow-up inspection, we considered that outcomes for prisoners were still reasonably good against this healthy prison test.

Purposeful activity

HP31 At our previous inspection, we found that in Cardiff, outcomes for prisoners were reasonably good against this healthy prison test. We made 10 recommendations in this area, of which nine had been achieved and one had not been achieved. We have made one further recommendation.

HP32 The prison recorded an average weekday time unlocked of 8.1 hours but this masked the disproportionately poor access of those located on the health care centre and the induction unit. Association and exercise were offered more reliably than at the time of the previous inspection.

HP33 The quantity of employment, education and training places for the population was similar to that at the time of the previous inspection: 660 activity places, including 75 in education classes. Work allocation was fair and informed by prisoners' basic skills. Opportunities for accredited training had improved, with a focus on employability skills. Some of the accreditation was basic but appropriate for the short-term needs of the population.

HP34 Learning support was good and based on a thorough needs analysis. All courses were modular, with each module being discrete and leading to the award of credit. The range of education programmes was closely matched to the job market. Most courses were at levels 1 and 2, as well as entry level. Higher levels of courses were available by distance learning.

HP35 Prisoners in full-time education had access to the library twice a week; others had weekly access. There was a limited stock of books available on the wings. Prisoners had poor access to daily local newspapers.

HP36 All prisoners had satisfactory access to the gym and facilities were good; about two-thirds used them regularly.

HP37 On the basis of this short follow-up inspection, we considered that outcomes for prisoners were still reasonably good against this healthy prison test.

Resettlement

HP38 At our previous inspection, we found that in Cardiff, outcomes for prisoners were reasonably good against this healthy prison test. We made 44 recommendations in this area, of which 23 had been achieved, four partially achieved, 15 had not been achieved and two were no longer relevant. We have made a further 15 recommendations.

HP39 There was an up-to-date resettlement strategy, based on a comprehensive needs analysis, and a focus on the reducing reoffending pathways. Governance arrangements had improved since the previous inspection and there was better attendance at the strategic meeting. Twice-yearly meetings were convened with the external voluntary and community agencies which contributed to the reducing reoffending agenda.

HP40 There was a well-resourced offender management unit. Ninety-four prisoners were in scope of offender management. There was a small number of offender assessment system (OASys) assessments outstanding. Custody planning for prisoners serving less than 12 months was good; their resettlement needs were identified and addressed by the resettlement team and other departments.

HP41 Indeterminate-sentenced prisoners had negative views about their time at the establishment. E wing was the designated lifer wing but there was no differentiation in the regime or facilities, and no lifer days. Parole dossiers were up to date. There were sound identification and assessment processes in relation to public protection.

HP42 Recategorisation boards were held regularly and prisoners were moved promptly to open conditions. There were some difficulties in moving prisoners to establishments for specific interventions. Release on temporary licence was rarely used, and weekly home detention curfew boards were convened but decisions sometimes made after prisoners' eligibility dates.

HP43 Prisoner orderlies completed prisoners' basic accommodation assessments but were not trained and did not receive accreditation. Pre-discharge boards ensured that prisoners' needs were checked before release.

HP44 Preparation for release was good. There was a range of finance, benefit and debt services available and prisoners had the opportunity to open a bank account. A preparation for release course offered prisoners the opportunity to complete job searches, prepare for interviews and write CVs, as well as access other resettlement services. Links with employers had improved.

HP45 Health care discharge planning was good and appointments and registrations were made for prisoners with GPs when needed. Patients under the care programme approach were put in contact with community mental health teams.

HP46 The drug strategy policy was under review and included alcohol services. CARAT case notes were detailed and assessments and care planning were good. There were links with drug intervention programmes, the Community Safety Partnership and GPs to provide ongoing support to prisoners on release.

HP47 The visitors centre was a poor environment and provided little more than a booking-in facility. The visits hall was noisy and institutionalised, especially for those on closed visits, where facilities were poor. Staff were polite and respectful to visitors and the atmosphere was relaxed. Visiting orders were only valid for 14 days for most prisoners. There were no family days. The chaplaincy team provided courses for fathers, and Storybook Dads was run by the library.

HP48 There was a range of offending behaviour programmes, which were appropriately prioritised based on risk and sentence length. The establishment was piloting the control of violence for angry impulsive drinkers (COVAID) programme, which had been identified as a gap in provision. The chaplaincy provided the restorative justice programme. The waiting lists for offender behaviour courses were manageable.

HP49 On the basis of this short follow-up inspection, we considered that outcomes for prisoners were still reasonably good 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 **The role of the progression unit should be clarified, and there should be clear and accountable management, including the selection and de-selection of prisoners. (HP53)**

Partially achieved. There was an undated policy for the progression unit, and the head of the specialist unit told us that this was out of date. It outlined the management structure and lines of accountability up to the governor. The policy gave a brief outline of the different ways in which prisoners could be allocated to the unit and the level of access to the regime. No behaviour or general targets were set for prisoners held on the unit, other than for those on the basic regime. There were plans to hold review boards similar to those in the segregation unit, so that decisions could be made about whether prisoners were ready to be moved to another wing, but at the time of the inspection there was no clear process for prisoners to be reintegrated back to normal location.

Further recommendations

2.2 The policy for the progression unit should be updated to reflect current practice and outline how prisoners are selected and de-selected from the unit.

2.3 There should be planning for prisoners' reintegration from the progression unit onto other wings and this should be reviewed regularly and include achievable behaviour targets.

2.4 **The establishment should set up effective communications with black and minority ethnic prisoners to establish the reasons for and reduce their perceptions of alienation. (HP54)**

Not achieved. The establishment had only recently instigated a diversity forum with the nominated diversity prisoner representatives. There had been no similar focus groups held with black and minority ethnic prisoners, or any other forum for enabling this group to communicate concerns or issues (see recommendation 2.136 and further recommendation 2.138).

2.5 **Night staffing arrangements should be overhauled to ensure that all staff deployed to night duty are fully trained and conversant with all key procedures. (HP55)**

Achieved. Night staffing arrangements had been reviewed and all night staff were trained and conversant with key procedures.

2.6 **The opening of the new health care centre should not be delayed, and patients and services should be transferred as a matter of urgency. (HP56)**

Achieved. There was a new, purpose-built health care centre, with good facilities for primary care services, but these were poorly utilised owing to a shortage of staff to escort prisoners,

and GP and opticians clinics were held on the wings. When prisoners attended the health care centre, they were escorted by registered nurses or health care support workers. The centre contained 22 cells, including 16 designated inpatients beds.

Further recommendations

2.7 The prison should provide officer escorts for prisoners to attend the health care centre and nursing staff should cease escorting prisoners.

2.8 GP clinics should be held in the main health care building, where records and clinical equipment can be accessed easily.

2.9 **There should be more routine and robust management checks of the quality and clarity of entries in the assessment, care, custody and teamwork (ACCT) documents. These checks should be recorded, along with details of any action taken. (HP57)**

Achieved. There had been a recent change in the quality checking process of ACCT documents. From the beginning of June 2010, the safer custody team had handed over responsibility for the management of open ACCT documents to residential unit managers. The wing managers and senior managers were responsible for the quality-checking process, using a comprehensive aide-memoir document to help them to maintain a high standard of quality assurance. Wing staff had readily accepted this responsibility and were quickly becoming competent in completing the ACCT documents.

2.10 **All prisoners should be able to engage in purposeful activity. (HP58)**

Partially achieved. The quantity of employment, education and training places for the population was similar to that at the time of the previous inspection, with 660 activity places. There had been a small increase in the percentage of prisoners engaged in purposeful activity through some new jobs, for example in recycling waste and the introduction of part-time employment. There were well-developed plans to extend training places in areas where employers were wiling to employ former prisoners (see paragraph 2.207).

2.11 **The strategy for E wing as a lifer unit should be clarified and implemented, and there should be accountable management of all life-sentenced and indeterminate-sentenced prisoners held in the establishment. (HP59)**

Not achieved. All the life-sentenced prisoners were accommodated on E wing but there were only minor differences between the regime on E wing and that on other residential units. There was no specific strategy for running the wing as a lifer unit and prisoners did not feel that their specific needs were being met. There was accountable management for casework through a dedicated governor for indeterminate-sentenced prisoners. The residential aspects were managed by the residential governor.
We repeat the recommendation.

Recommendations

Courts, escorts and transfers

2.12 **Management should seek to increase the use of the video link suite. (1.6)**

Not achieved. Despite there being capacity for a maximum of 40 sessions a day, only six booked video links were used for court sessions scheduled for the first day of the inspection and eight for the second day. There were no inter-prison visits booked and the booths were not used for reviews for prisoners serving indeterminate sentences for public protection (IPP) or lifers, or for parole hearings. The quarterly meetings with court service managers that had previously been a vehicle to encourage the court services to increase the use of video link had ceased in December 2009. Managers told us that there was little engagement from local magistrates and that they were aware that the suite remained largely underutilised. The courts that engaged with the system only booked one day in advance.
We repeat the recommendation

Additional information

2.13 Most prisoners in our groups had travelled short distances from courts in the south-west of England and Wales and reported a reasonable experience of the transfer process. Reception was mainly clean, with light and reasonably sized holding rooms, but these and parts of the reception area contained a small amount of graffiti. All holding rooms contained working televisions and a range of information relevant to the establishment, although this was only in English. There were two areas where strip-searching took place; one was a series of booths, which were well screened and provided an appropriate level of decency, and the other was in an area where there was no screening, so prisoners could be seen by anyone working in the reception office, the property store or just walking through. Prisoners were handcuffed routinely when embarking and disembarking from cellular vehicles, regardless of levels of security intelligence. Cell sharing risk assessments and first night interviews were conducted in private by induction staff.

2.14 Not all prisoners were offered a shower in reception but all were offered a free telephone call. Some prisoners spent too long in reception. First night procedures were good, and essential information was obtained before location on the wings

2.15 As there was no prisoner movement across the prison between 4pm and 6pm, there were occasions when prisoners were kept in reception for long periods, waiting to be moved to the wings. During the inspection, it took over five hours to move new arrivals onto the F1 induction landing.

Further recommendations

2.16 The use of the 'open' strip-search area should cease.

2.17 Prisoners should not routinely be handcuffed when embarking and disembarking from cellular vehicles.

2.18 All prisoners should be offered a shower in reception.

2.19 Prisoners should spend as short a period as possible in reception.

First days in custody

2.20 **New receptions should be able to purchase a smokers' pack and PIN telephone credit. (1.22)**

Achieved. New receptions had a £3 PIN telephone allowance and could purchase smokers' or non smokers' grocery packs. It was not possible to purchase both packs. For prisoners with no private cash on reception, there were facilities for an advance of pay to be credited, which would then be retrieved from earnings/private cash. There was no facility to offer transferred-in prisoners any advance of monies, as their accounts were automatically transferred under the P-NOMIS system.

2.21 **All new receptions who opt to complete the induction programme, and all those new to custody, should be located on the F1 landing. (1.23)**

Not achieved. Some new prisoners were still located on wings other than F1. Those requiring detoxification services were located on G wing and others were located wherever there was a space. There was no strategic overview of accommodation usage, with individual wings managing the population independently, often resulting in prisoners remaining on these other wings, waiting for spaces on the induction wing that were being blocked by prisoners who had completed induction but were in turn waiting for spaces elsewhere.
We repeat the recommendation.

2.22 **The induction policy should specify the length of stay on the induction landing and this should be implemented. (1.24)**

Not achieved. The policy did not identify a specific induction period. Records we checked showed that some prisoners stayed on the induction landing for longer than seven days, and during the inspection there was one prisoner on F1 who had been there for over seven weeks. Thirteen of the 23 prisoners on the unit at the time of the inspection had completed induction and were waiting for spaces elsewhere. There was no timetable for induction and all of the prisoners we spoke to were unaware of what they would be doing on each day of the programme.
We repeat the recommendation.

Housekeeping point

2.23 The induction programme should have a clear timetable.

2.24 **The full range of induction material and information should be available in languages other than English. (1.25)**

Not achieved. There was some information available in languages other than English, although this was produced centrally and was not specific to the establishment. The induction booklet for prisoners, where available, was in English only, and the copy we received contained some out-of-date material. The induction video/DVD that had been in use at the time of the previous inspection had been replaced by a long PowerPoint presentation; this was also in English only. Prisoners located on G wing did not receive the induction given to other prisoners; they were given only an oral presentation by staff, based on the induction record. The prisoners we spoke to on the induction landing had received almost no written information, with the exception of counselling, assessment, referral, advice and throughcare (CARAT) and some educational material.

Further recommendations

2.25 The induction process should provide prisoners with sufficient up to date information and the information booklet should be available in an appropriate range of languages.

2.26 Prisoners located on G wing should receive the same induction as that given to other prisoners.

Additional information

2.27 The cells on the F1 induction landing were dirty, ill equipped and in a poor decorative state. There was a considerable amount of offensive graffiti in most of the cells we saw. There were no screens around toilets and, where there was cell furniture, it was of a poor quality and often broken. One of the prisoners we spoke to had been on the unit for over a week and had no pillow or toiletries. When questioned, he had no idea how to request these and did not know even basic information about the prison, even though he had completed induction. Although we brought this to the attention of staff on the Monday evening, he did not receive a pillow or toiletries until we raised it with staff again on the Wednesday morning.

Further recommendation

2.28 Cells should be cleaned, decorated and suitably equipped for new arrivals.

Residential units

2.29 **There should be one telephone available for every 20 prisoners. (2.17)**

Not achieved. There was one telephone to 22 prisoners on most of the wings, except on A wing, where there was only five telephones for 200 prisoners.
We repeat the recommendation.

2.30 **Cells designed for one prisoner should not be used for two. (2.18)**

Not achieved. Cells designed for one prisoner continued to be occupied by two prisoners.
We repeat the recommendation.

2.31 **The offensive display policy should be applied consistently. (2.19)**

Not achieved. There was an offensive display policy which outlined what prisoners were permitted to display and where. Although the policy stated that soft pornography was not appropriate, we saw many pictures displayed that contravened the policy. Not all staff were clear about what was permissible, so the policy was not enforced consistently.
We repeat the recommendation.

2.32 **Laundering arrangements should operate effectively. (2.20)**

Partially achieved. Prison clothing continued to be laundered at HMP Leyhill. The laundry arrangements for prisoners' clothes had improved but did not operate effectively on all wings. Laundry facilities were supposed to be available on all the wings, but on B1 they had not yet been installed and on C wing the washing machine was too large to fit into the room, so

prisoners had to use the facilities on other wings or wash their clothing in their cells. Staff on these wings told us that they had been waiting a few weeks for the issues to be addressed.

Further recommendation

2.33 There should be laundry facilities on each of the wings and they should be in good working order.

2.34 **Arrangements for the selection and de-selection of prisoners onto and off B1 landing should be set out and applied consistently. (2.21)**

Not achieved. A policy was being drafted during the inspection to outline the function of the B1 landing and criteria for selection and de-selection, as well as how prisoners would be reintegrated to other units.
We repeat the recommendation.

2.35 **A programme to support prisoners on the B1 landing should be reintroduced. (2.22)**

Not achieved. Prisoners were provided with individual support as and when required. Work and basic education was provided on the unit for those who required it, and psychologists and a health care assistant also visited. There were no day care facilities for prisoners located on this landing. The head of specialist units had met with the area psychology team to discuss providing meaningful interventions to prisoners located on B1 and the progression unit, to equip them with the necessary skills to go onto normal location. This was still in the planning stages.
We repeat the recommendation.

2.36 **'Lodgers' should not be held on the B1 landing, and this accommodation should be removed from the establishment's certified normal accommodation. (2.23)**

Partially achieved. 'Lodgers' were no longer held on the B1 landing but, due to population pressures, the accommodation remained as certified normal accommodation.

Additional information

2.37 The accommodation remained the same as at the previous inspection but the function of some of the wings had changed. C wing had been designated as a vulnerable prisoners unit since December 2009. This was a short-term plan, with a view to transferring this group of prisoners to HMP Parc in October 2010. There were plans for C wing then to be transformed into a more suitable first night and induction wing, to accommodate the larger number of remand prisoners anticipated at the establishment. E wing continued to house life-sentenced prisoners but, again, there were plans for this group of prisoners to be transferred to HMP Parc. G wing, which had previously housed the health care centre, was now the detoxification unit.

2.38 C wing accommodated up to 60 prisoners but, due to the fluctuating number of prisoners seeking Rule 45 (segregation for own protection) status, there was sometimes insufficient space on the unit, so such prisoners had been housed in the health care centre and the segregation unit, sometimes on their first night. Prisoners told us that they were well looked after by staff on this wing and were aware that their location on this wing was a temporary measure. Activities for prisoners on this wing were limited to mundane tasks, although prisoners told us that they were content to engage in such activities, as it meant that they were

unlocked throughout the day. The small number of prisoners who were unemployed on this wing (eight, at the time of the inspection) received association on alternate days; it was unclear why all of the prisoners could not be unlocked for evening association. They had equitable access to the gym and library provision.

2.39 Prisoners located on B1 had the opportunity to go off the unit to work or education if they so wished but some of the prisoners we spoke to said that they preferred to remain on the unit. Staff on B1 interviewed prospective prisoners before their location there, to ensure that they had genuine concerns about remaining on normal location and that they needed additional support. Education was delivered on the unit and basic employment was provided. Staff on the unit described their role as providing support to prisoners and working with them to improve their confidence, and they demonstrated a good knowledge of the prisoners in their charge.

2.40 B1 was used as a thoroughfare for main movements to work. We were told that this caused minimal disruption to prisoners on B1, as they were already locked behind their doors at these times (11.30am and 4.30pm). (See also section on time out of cell.)

2.41 The communal areas were generally clean and well maintained and there were painting groups across the establishment who ensured that areas were refreshed. During the inspection, prisoners' cells were generally well maintained, except on F1, where the throughput of prisoners was high and the maintenance of the first night accommodation was poor (see section on reception and first night). There were no adapted cells on normal location. The health care department conducted risk assessments for prisoners with disabilities, to see if it was appropriate for them to be located on normal location. Some prisoners with disabilities were located on normal location, and minor reasonable adjustments had been made for them, but no formal support was offered to these groups to clean cells or access meals. At the time of the inspection, four prisoners using a wheelchair were located in the health care centre, as it was the only available accommodation that met their needs.

2.42 Cell observation panels were generally kept clear, and during the inspection prisoners told us that staff responded promptly to cell call bells. Prisoners were clear about the sanctions that would be imposed if call bells were misused. Notices were displayed across the wings, but only in English. Prisoner consultation meetings were held regularly but there was no representation from prisoners on C wing. A range of issues was discussed and there was evidence that action was taken to address some of them. At one of the meetings, in February 2010, prisoners had raised their concerns about insufficient kit being issued, as they received only one set of prison clothing. The head of special units was trying to address this situation at the time of the inspection.

2.43 While additional telephones had been installed since the previous inspection, there were still insufficient for the number of prisoners, particularly on A wing (see recommendation 2.29), and we observed queues on this wing. A wing prisoners on afternoon association were unable to contact their families in the evenings.

2.44 Mail was delivered to the prison each morning, except Sundays. It was sorted by a team of officer support grades and delivered to the wings later in the morning. Outgoing mail was collected at this time and sent out on the same day, except at weekends.

2.45 Recorded delivery mail was issued on the day it arrived and monies received for prisoners were dealt with swiftly. We observed that postal orders had been left unsecured on a desk while a member of staff took a break from duties.

2.46 Staff had an up-to-date list of prisoners whose mail was monitored, and this was updated weekly by the public protection team. Rule 39 letters (legal and confidential access correspondence) were not opened by staff.

Further recommendations

2.47 Rule 45 prisoners should not 'lodge' in the health care centre or segregation unit.

2.48 All prisoners located on C wing should have evening association.

2.49 The B1 landing should not be used as a thoroughfare for prisoner movements.

2.50 There should be formal support arrangements for prisoners with disabilities who require support.

2.51 There should be adapted accommodation available on normal location.

2.52 Prisoners should be issued with more than one set of prison kit.

Housekeeping points

2.53 Notices should be available in languages relevant to the population.

2.54 Prisoner representatives from all wings should attend the consultation meetings.

2.55 Monies, cheques and postal orders received in prisoners' mail should be kept secure at all times.

Progression unit (A1 landing)

2.56 **A full regime, including purposeful activity, exercise and daily association, should be offered to all prisoners. (2.35)**

Partially achieved. Prisoners could go off the unit to education or work where appropriate. Those on a basic regime received association once a week, which could increase with improved behaviour. During the inspection, a range of prisoners was located on the wing: six on the basic regime, some who had progressed from the segregation unit, and 17 from the F1 (first night and induction) landing who were waiting for transfer to another wing. Prisoners located on this wing who were not employed received association on alternate evenings and had a restricted regime, particularly those waiting to move to other wings. All others had access to daily weekday outdoor exercise (except prisoners on the basic regime), the library and the gym.
We repeat the recommendation.

Further recommendation

2.57 'Lodgers' should not be held on the A1 landing.

2.58 **Formal plans for all prisoners on the progression unit for the delivery of care and its purpose should be developed. (2.36)**

Not achieved. There was no formal planning for prisoners on the progression unit. This was further complicated by the large number of prisoners who were located there owing to a lack of space on other units.
We repeat the recommendation.

2.59 **Clear admission criteria for the progression unit should be developed and published. (2.37)**

Partially achieved. The policy document needed to be updated and published (see paragraph 2.1).

2.60 **A multidisciplinary approach should be adopted to improve the planning and implementation of care for prisoners on the progression unit. (2.38)**

Not achieved. See recommendation 2.58.

2.61 **There should be an officer dedicated exclusively to the segregation unit during the night. (2.39)**

Achieved. There was a member of staff dedicated to the segregation unit during the night.

Staff–prisoner relationships

2.62 **Staff should be encouraged to refer to and about prisoners by their preferred name. (2.43)**

Not achieved. Senior managers acknowledged that most staff referred to prisoners by their surname, and we observed this to be the case. On the smaller units, staff referred to prisoners by their preferred names.
We repeat the recommendation.

Additional information

2.63 Staff–prisoner engagement was good, although not during exercise (see section on time out of cell). In our groups, prisoners described a relaxed atmosphere and were reasonably positive about staff and their interactions with them on a general level. Some described staff as not being proactive in dealing with their concerns or queries. The interactions we observed were positive and professional, and staff responded to prisoners' requests. During association, some staff were approachable, with notably good and relaxed interactions on the discrete units (A1, B1). Prisoners on D wing (the enhanced wing) said that staff engaged with them on a day-to-day basis and also about their sentence plans, and took an interest in their progress toward achieving their targets. Staff on E and F wings supervised association from the landings.

2.64 Prisoners told us that staff were clear about the boundaries of acceptable and unacceptable behaviour. Staff used informal warnings and the sanctions available to them when behaviour was inappropriate and this was recorded in prisoners' records. They also used incentives to encourage better behaviour.

Personal officers

2.65 **Training should be provided to all staff in regular contact with prisoners to increase their understanding of prisoners' resettlement needs and associated interventions. (2.50)**

Achieved. Two-thirds of staff had received programmes and resettlement awareness training since the previous inspection. In addition, a few had received thinking skills programme and control of violence for angry impulsive drinkers (COVAID) awareness. At the time of the inspection, 40% of staff had attended a workshop led by representatives from Citizen's Advice about the services they provided. The deputy governor had also tasked a residential governor to identify a training package relevant to the personal officer's role and to a new personal officer policy that was being drafted.

2.66 **Management checks should include monitoring the quality and the frequency of entries in wing files. (2.51)**

Partially achieved. Management checks were plentiful in prisoners' history records, but they commented mainly on the quantity rather than quality of the entries. Even when there was an inappropriate reference to a prisoner, this was not addressed.
We repeat the recommendation.

2.67 **Personal officers should be aware of the particular needs and risks associated with the prisoners in their charge, and this should be reflected in records of their contact with prisoners. (2.52)**

Partially achieved. Personal officer entries on wing history sheets were particularly good on the smaller units, including the segregation unit. Staff on these units clearly had a good understanding of prisoners' needs and risks, and engaged with them about their offending behaviour and support needs. On the larger wings, most personal officers made weekly entries but they were observational and did not reflect any significant interactions with prisoners, and there were few comments about prisoners' family and personal relationships and whether they maintained links with them.
We repeat the recommendation.

Additional information

2.68 Some prisoners reported no contact with their personal officer, while others had good contact and appreciated their efforts. Most prisoners told us that they were aware of who their personal officer was, although most had not been formally introduced to them or met them regularly. In the foreign national prisoner group we held, only two prisoners said that they had a personal officer.

2.69 There was an undated personal officer policy which outlined the role of personal officers, including their involvement in sentence planning and important assessments; however, few personal officers engaged with this.

Further recommendation

2.70 Personal officers should be actively involved in prisoners' sentence planning and support resettlement objectives.

Bullying and violence reduction

2.71 **All staff, particularly those in prisoner contact roles, should receive anti-bullying training and refresher training at regular intervals. (3.9)**

Not achieved. There had been no anti-bullying or violence reduction training since the previous inspection. A trainer had been identified and trained and was due to start a series of training events in the near future.
We repeat the recommendation.

2.72 **Prisoners subject to anti-bullying procedures should have access to appropriate interventions aimed at achieving sustained and agreed changes in behaviour. (3.10)**

Not achieved. There were no interventions linked directly to the violence reduction or anti-bullying strategy. Prisoners placed on stage 2 or 3 of the anti-bullying procedures could normally expect to be located on the A1 landing or segregation unit, although some remained on their residential units, where (according to the policy document) interventions into anti-social behaviour would be made. The controlling anger and learning to manage it (CALM) and thinking skills courses were available but were offence- rather than behaviour linked, and we could find no evidence of any prisoners attending the courses as a direct result of referral following bullying incidents.
We repeat the recommendation.

2.73 **The safer custody committee should monitor patterns of violence and intimidation so that any new trends or developments likely to threaten prisoners' safety or feelings of safety are identified and responded to quickly. (3.11)**

Partially achieved. A comprehensive monitoring tool had been introduced in May 2010 which included a range of data to enable the prison to monitor trends and areas of repeated incidents. The minutes and monthly statistics did not offer any evidence of analysis of incidents before the introduction of this tool.
We repeat the recommendation.

Additional information

2.74 There was an undated violence reduction policy which concentrated primarily on bullying and the management of perpetrators and victims. Most entries in the closed bullying observation booklets included the comment, 'no further bullying activity noted'.

2.75 There had been 18 prisoners subject to violence reduction monitoring in 2009 and six between January and the end of June 2010, indicating a projected reduction. To date, there had been investigations into 116 reported violent incidents in 2010.

2.76 There had been no violence reduction survey completed in 2010; the most recent survey we were able to obtain had been conducted in January 2009.

Further recommendation

2.77 A violence reduction survey should be carried out and the findings analysed and acted on.

Housekeeping point

2.78 Staff should give full written details of all interactions with prisoners in anti-bullying booklets.

Self-harm and suicide

2.79 **The family liaison officer should have access to a confidential telephone service to speak to bereaved family members. (3.25)**

Achieved. There was a dedicated telephone line in the safer custody office for staff acting as a family liaison officer (FLO) to use to contact the families of prisoners. This telephone was in a quiet area, away from the main office, affording the FLO an appropriate amount of privacy. One of the safer custody team had been the FLO in five of the recent death in custody cases. He had received no formal Prison Service training for the role but was a qualified bereavement counsellor.

Further recommendation

2.80 Staff acting as the family liaison officer should be fully trained for the role.

2.81 **All staff, particularly night duty staff, should receive assessment, care in custody and teamwork (ACCT) foundation training. (3.26)**

Not achieved. There had been little ACCT training since the previous inspection, and the percentage of staff who were either in date from their initial training or had had refresher training had fallen to 43%, from a high of 72%.
We repeat the recommendation.

2.82 **The support group for prisoners subject to ACCT monitoring should resume as soon as the health care day centre facilities are available. (3.27)**

No longer relevant. Funding for day care services in the health care department had been removed.

2.83 **Staff should be provided with feedback on ACCT entries, commending good practice and highlighting inadequate or poor practice. Additional guidance and training should be provided for those staff who require it. (3.28)**

Not achieved. There was no system for managers to communicate directly to staff any shortfalls or good practice in relation to the quality of ACCT entries. There were limited comments in ACCT documents and they generally comprised general remarks on the preceding day's entries (see also paragraph 2.9).
We repeat the recommendation.

2.84 **A protocol should be introduced for the use of safer cells and the Listeners' suite on A wing; the safer custody committee should monitor the use of these facilities. (3.29)**

Not achieved. There were no care suites, with Listeners' cells being used instead. One of the cells was also occupied by one of the wing cleaners, who remained in the cell if the support session took place during the night. The use of safer cells and Listeners' cells was included in the overall self-harm and suicide policy document but there was no protocol governing their use. A new protocol for the use of constant observation had been drawn up recently by the safer custody manager. The safer custody team did not monitor the use of Listeners or support cells, beyond receiving a copy of Listeners' records.
We repeat the recommendation.

Further recommendations

2.85 Care suites should be available for use in all residential areas.

2.86 Listener support sessions during the night should be undertaken with due regard to confidentiality.

2.87 **First-aid boxes and suicide response kits should be available in all wing offices; they should be secure and replenished following use. (3.30)**

Not achieved. There were no first-aid boxes in four of the wing offices we visited. Where there were first-aid boxes, they were not sealed and staff were unclear who would replace any items used from them. There was a suicide response kit at the centre of the main residential block; although this was checked regularly, we found some items listed on the contents sheet to be missing.
We repeat the recommendation.

Additional information

2.88 The safer custody manager had been in post for only three months and was striving to effect the change from a centrally coordinated safer custody team to the devolvement of daily management to wing managers (see paragraph 2.9).

2.89 There had been seven deaths in custody since the previous inspection, five of which may have been self-inflicted. The prison had received reports on three of these and agreed the action plans. The action plans were reviewed at safer custody meetings, and actions formed part of a comprehensive safer custody assurance framework document, along with recommendations from previous HMIP reports, self- and peer audits and their continuous improvement plans. There had been two near-death incidents in recent months, which had been appropriately investigated.

2.90 There were 11 Listeners at the time of the inspection. Listeners and the Samaritans coordinator told us that it was difficult to retain Listeners owing to the need to transfer prisoners to other prisons because of population pressures. There was a Listener in reception and also on the induction wing but they had no specific contact roles and had already worked in these areas before training as Listeners. The Listeners met the Samaritans coordinator fortnightly for supervision and ongoing training. There was no rota for Listeners and it was usual to call out a Listener who was located on the nearest wing. There were safer cells on each wing and three constant observation cells in the new health care unit. There had been one constant watch in 2010 to date, for a period of seven days, in one of the health care cells.

2.91 There had been 81 acts of self-harm and a total of 193 ACCT documents opened in 2009, and 28 acts of self-harm and 97 ACCT documents opened in 2010 to date, projecting a similar number to that of the previous year. There were 16 ACCT documents open at the time of the inspection.

2.92 ACCT entries were of reasonable quality during the day but were often repetitive and predictable during the night. Reviews were conducted on time and were well attended by an appropriate range of staff. Care plans were mostly appropriate but objectives were not time bound. Post-closure reviews were inconsistent, with a system of a review each day following closure, for seven days in some cases, with minimal entries; similarly, the final reviews were generally inadequately detailed. Of the last 10 ACCT documents closed, four had inadequate post-closure entries, mainly citing 'no concerns'.

2.93 We noted a prisoner on the induction landing who had been on the unit for a week; he was on an open ACCT document, with boredom cited as a trigger for self-harm. Despite bringing this to the attention of staff and managers, he was still on the unit, with a very limited regime, at the end of the inspection.

2.94 There was a helpline for families, which we rang on the first day of the inspection, leaving a message for someone to contact the inspection team; we did not receive an acknowledgement.

Further recommendations

2.95 The roles of the reception and induction Listeners should be developed and integrated into the induction policy.

2.96 There should be a uniform system of post-closure review, with qualitative entries made by the case manager.

2.97 The helpline should be monitored daily.

Housekeeping point

2.98 Care plan objectives should be time bound.

Applications and complaints

2.99 **Application forms to see a governor before submitting a complaints form should be available on the wings. (3.95)**

Achieved. A range of application forms was available on all wings on request; applications to governors were made using general application forms. Checks of the data available from the complaints clerk showed that the appropriate application forms were used.

Housekeeping point

2.100 Application forms should be freely available on all residential units.

2.101 **The quality of replies to complaints should be monitored. (3.96)**

Achieved. The audit and compliance team manager reviewed a 10% sample of replies each month. There was no evidence of any senior management involvement in the quality assurance process. All complaints were scanned before being returned to the prisoner. Of the 10 we looked at, six had not been answered appropriately, including two no-responses (possibly a scanning error), and one, in which staff bullying was mentioned in the complaint but not in the reply, had not been followed up, with just a standard response to the prisoner from the health care department saying that the doctor had written directly to the prisoner.

Further recommendation

2.102 There should be senior management involvement in the quality assurance process for complaints.

2.103 **Data collated on complaints should be analysed to identify any trends, and these should be addressed by management. (3.97)**

Achieved. A comprehensive range of complaints data was collated and analysed each month at the performance meeting. Actions were identified and allocated to managers to investigate, with outcomes reported at the next performance meeting.

Additional information

2.104 Not all wings recorded the submission of applications and none had records of the outcomes or dates of replies. Complaint forms were widely available and complaints were collected every weekday by the complaints clerk. There had been 650 complaints in 2010 to date, which suggested a significant rise on the 2009 figure. Wing, medical and property issues made up the highest proportion of complaints. Complaint forms were available in English only.

2.105 There was an average of 70 applications to the Independent Monitoring Board each month, with the highest proportion being in relation to long waiting times for medical attention.

Housekeeping point

2.106 Complaint forms should be available in a range of appropriate languages.

Legal rights

2.107 **All legal services staff should receive legal services training and refresher courses. (3.104)**

Achieved. Two of the legal services staff had been trained and the third was due to go on a course.

Additional information

2.108 The legal services office was staffed by one full-time and two part-time members of staff. They provided a comprehensive service which included meeting all new receptions on the next

working day after their arrival. Legal services also included access to solicitors' directories and to a list of immigration specialist solicitors. Legal services staff contacted solicitors on behalf of prisoners when required and saw prisoners by application. Advice and support was offered to prisoners wishing to represent themselves in court and those undergoing legal proceedings.

2.109 A bail service was provided under a new contract with Stonham Housing. In the previous two months, five prisoners had secured housing through this route. The part-time members of staff also attended the local magistrates' court every morning and dealt with bail applications there, to prevent some offenders having to come to prison.

2.110 There were 10 legal visits rooms next to the main visits hall. Legal visits took place from Monday to Friday, between 9.15am and 11.30am, and 2pm and 4.15pm.

Faith and religious activity

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

Additional information

2.111 A full-time Church of Wales chaplain acted as coordinating chaplain, supported by a range of part-time and sessional chaplains, a psychology assistant and an administrative officer. The team was well integrated across the establishment, providing regular Anglican, Roman Catholic, Muslim, Buddhist and Sikh services, as well as a range of classes, including Bible studies, Koran studies and a Sikh class. They coordinated a number of reoffending courses: family man, fathers inside, supporting offenders through restoration inside and Christianity explored. The team was also responsible for ensuring that Cymru Support Training and Referral Tool (CSTART) interviews were carried out for all new arrivals, with a 100% return since the tool had been launched in April 2010.

2.112 Specific bereavement support was available from an accredited Quaker counsellor and the team had recently initiated a Muslim-based community chaplaincy support scheme – Faith in the Future – whereby three community Imams assisted in the resettlement of four Muslim prisoners.

2.113 The chapel was a good resource and the multi-faith room was appropriate in size and décor for its purpose.

Substance use

2.114 **Prescribing regimens for opiate-dependent prisoners should be flexible and based on individual need. (3.120)**

Not achieved. The clinical prescribing protocols remained largely inflexible to individual prisoner need and did not conform to national clinical guidelines. Prisoners who were on existing prescribed opiate maintenance doses through their GP or external addiction agency and serving less than three months, continued with their maintenance dose. Prisoners not on prescribed programmes before they came to Cardiff, could not access stabilisation, substitution-detoxification and were provided with acute detoxification. Prisoners on longer sentences were put on standard reducing regimes which were not flexible to previous individual opiate usage. There was a review of clinical protocols being undertaken at the time of our visit. Prisoners requiring acute drug detoxification were admitted to the inpatients unit. **We repeat the recommendation.**

2.115 **The establishment should clarify clinical leadership of the detoxification unit. (3.121)**

Partially achieved. The drug strategy manager was the designated lead for the detoxification unit and substance use team. The unusual dual responsibility of leading the substance use team alongside wider drug strategy manager responsibilities could have compromised the strategic and whole-prison approach to drugs and alcohol.

Further recommendation

2.116 The prison should provide a designated clinical lead for the substance use team, to enable both clinical management and drug strategy work to be achieved effectively.

2.117 **Individual care plans and reviews should be developed which demonstrate patient involvement. (3.122)**

Achieved. There were care plans and evidence of reviews which reflected prisoner engagement and agreement.

2.118 **The mental health in-reach team's skill mix should include dual diagnosis expertise. (3.123)**

Not achieved. There was no designated dual diagnosis expertise in the in-reach team. **We repeat the recommendation.**

2.119 **The regime on the detoxification unit should be developed to include more structured psychosocial support. (3.124)**

Achieved. Prisoners on G wing were able to access psychosocial support from group sessions, run by CARAT workers as an integrated drug treatment system (IDTS) psychosocial support programme, with all the constituent components except the 'healthy living' element, which was in the process of being developed with the gym as a 'tackling drugs through physical education' programme.

Additional information

2.120 There was an ongoing review of health services which also included the potential for acute detoxification beds in the health care department, and the manager of the substance use team to become part of the health services team.

2.121 At the time of the inspection, there were 47 prisoners on methadone and seven on buprenorphine regimes. Under compact-based drug testing, in May 2010, 10 out of a total of 16 positive tests (62.5%) were related to buprenorphine, which was a rise from the four positive tests in April.

2.122 Prisoners with alcohol problems were able to access Alcoholics Anonymous weekly. Seven or eight prisoners attended these sessions, which were held in the C wing group room, and prisoners were escorted to the wing by CARAT workers.

2.123 Mandatory drug testing was appropriately resourced and testing was unpredictable. There had been a positive test rate of 9.5% in the year January to December 2009, against a target of

9%. Visits were more susceptible to the smuggling of drugs with the loss of the drug dog. Suspicion testing was generally done in time. There was no formal funded IDTS programme.

Diversity

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

Additional information

2.124 Work in the diversity strands, apart from race equality and foreign nationals, was underdeveloped. There was no overarching diversity strategy and no specific policies relating to age, disability and sexuality. The prison was at the stage of identifying leads for each of the strands.

2.125 One of the part-time members of the chaplaincy team had been appointed as the disability liaison officer but he had little time to carry out the role. There appeared to be good consultation, with separate monthly focus groups held for mainstream and vulnerable prisoners and for inpatients, but these were not minuted so it was unclear what actions had been taken subsequently. While all prisoners declaring a disability on reception were interviewed, there was no formal care plan process or a formal database identifying all prisoners with disabilities.

2.126 The coordinating chaplain had been appointed as the liaison officer for older prisoners but there were few formal measures for supporting this group of prisoners. Older prisoners who were retired were unlocked during the day.

Further recommendations

2.127 There should be an overarching diversity policy that sets out how the diverse needs of all prisoners will be met.

2.128 The disability focus groups should be minuted formally and issues raised should generate action points that are followed up at subsequent meetings until completed.

2.129 A database should be maintained of all prisoners with disabilities, and care plans raised and regularly reviewed for all such prisoners.

Race equality

2.130 **All reported racist incidents should be properly investigated by trained staff. (3.50)**

Not achieved. Reported racist incidents were investigated by managers within the area concerned, more often than not a senior officer on one of the residential units, none of whom had received specific training for such investigations. These were then checked and monitored by the diversity manager, who was trained in investigations.
We repeat the recommendation.

2.131 **An effective quality assurance system should be developed to ensure that the investigations are conducted properly and that evidence has been fully explored. (3.51)**

Achieved. The diversity manager, a full-time post occupied by a 'developing Prison Service

manager' (DPSM, formerly the principal officer grade), reviewed all investigations carried out following the submission of a racist incident report form (RIRF), to ensure that the issues raised had been addressed and all relevant individuals had been interviewed.

2.132 **All investigation reports should be approved for action by the governor or her representative. (3.52)**

Achieved. The governor reviewed and signed off all investigation reports/RIRFs.

2.133 **Victim support plans to ensure that prisoners are helped to deal with issues resulting from investigations should be introduced. (3.53)**

Not achieved. Although there had been no major incidents resulting in victims requiring specific support over the previous 12 months, there were no formal processes for ensuring that the necessary support was identified when needed, and implemented via a support plan.
We repeat the recommendation.

2.134 **Prisoner representatives should be appointed on all residential units. (3.54)**

Partially achieved. There were appointed prisoner representatives on all units, with the exception of the vulnerable prisoner unit, primarily because the representatives on the other units had objected to the presence of a representative from this unit at the prisoners' diversity meeting. This had not been challenged by the establishment. Although senior managers said that it was a temporary issue, as the vulnerable prisoner unit was due to be moved to HMP Parc, the prison had effectively reinforced the unacceptable attitudes of the prisoner representatives by acquiescing to their wish to boycott representation from the unit.

Further recommendation

2.135 Prisoner representatives should be appointed from all residential units. Consideration should be given to the suitability of any representative refusing to engage with other representatives because of their own prejudices.

2.136 **Arrangements should be made to enable groups of black and minority ethnic prisoners to meet to discuss the issues important to them. (3.55)**

Not achieved. No arrangements had been made to enable groups of black and minority ethnic prisoners to discuss issues important to them.
We repeat the recommendation.

2.137 **The REO should ensure that formal consultation meetings with black and minority ethnic prisoners regularly take place, and that prison managers attend. (3.56)**

Partially achieved. A monthly diversity focus group had recently been formed, where the appointed diversity representatives met the diversity manager to discuss all diversity-related issues. While the representatives could raise any such issues brought to them by black and minority ethnic prisoners, there was no forum to facilitate direct engagement by prison managers with black and minority ethnic prisoners.

Further recommendation

2.138 A forum specifically for black and minority ethnic prisoners, distinct from the diversity representatives meeting, should meet regularly to discuss pertinent issues with prison managers.

Additional information

2.139 There had been 41 RIRFs submitted in the first six months of 2010. Most incidents had been low level and not found to be of a racist nature, and, while the quality of investigations had improved, they were often conducted by managers within the area of the complaint. When more serious complaints had been made and the complainants had been discharged before completion of the investigations, they were not followed up but left unresolved. There was no evidence that prisoners received a written response once their complaint had been investigated.

2.140 Ethnic monitoring took place at the monthly diversity and race equality action team (DREAT) meeting, but minutes indicated only where ethnic groups were out of range, with no indication of whether this had generated discussion or the subsequent action points to resolve issues when they had occurred consistently.

Further recommendations

2.141 All racist complaints should be investigated as thoroughly as possible and not left unresolved because a prisoner has been discharged.

2.142 All prisoners should receive a written response to any submitted racist incident report form (RIRF) once it has been investigated.

2.143 When ethnic monitoring data indicate that an ethnic group is consistently over- or under-represented within a specific area (for example, employment or adjudications), appropriate investigations and, where necessary, action to address the issue should be undertaken.

Foreign national prisoners

2.144 **Foreign national prisoner representatives should be appointed. (3.65)**

Not achieved. No foreign national prisoner representatives had been appointed.
We repeat the recommendation.

2.145 **Consultation meetings with staff and foreign national prisoners should take place regularly. (3.66)**

Partially achieved. A foreign nationals forum had been set up, which was scheduled to meet bi-monthly. However, the officer carrying out the role of foreign nationals coordinator was on long-term sick leave and no replacement had been identified, so no meeting had taken place since March 2010. Minutes indicated that a range of prison-related issues had been discussed, but attendance had been inconsistent, with sometimes as many as 13 prisoners attending, but often as few as three.

Further recommendations

2.146 A replacement foreign nationals coordinator should be appointed, either temporarily or permanently, in the continued absence of the current post holder.

2.147 The foreign nationals forum should take place as scheduled and not be dependent on the availability of the foreign nationals coordinator.

2.148 **A multidisciplinary committee should be assembled to ensure that protocols stated in the policy document are fully implemented. (3.67)**

Achieved. The DREAT meeting included foreign national issues as a standing agenda item. Minutes indicated that the meeting was consistently well attended, with all appropriate functions represented.

2.149 **Local policies, routines and rules should be translated into languages other than English. (3.68)**

Partially achieved. A copy of basic rules and routines was available in a number of languages, but policies had not been translated. Managers said that if a specific document or policy was requested in a prisoner's first language, this could be facilitated, but there was no promotion of this facility, in English or other languages.

Further recommendation

2.150 The facility to translate policies and other official documents should be promoted to all foreign national prisoners, in a language they understand.

Additional information

2.151 In the ongoing absence of the foreign nationals coordinator, there was little engagement with the foreign national population, which had comprised up to 80 prisoners in the previous six months, and stood at 59 at the time of the inspection. This was highlighted by the fact that information relating to foreign national work (for example, the database of prisoners whose first language was not English and records for each foreign national, detailing immigration issues), could not be provided for us during the inspection.

2.152 There were seven detainees held. There was no independent legal advisory service available for foreign national prisoners with deportation issues. The UK Border Agency (UKBA) held a monthly surgery for such prisoners, but many foreign national prisoners told us that these provided little useful information. For example, one prisoner's sentence had expired in February 2009 and he had been told each month since then that there was no space available for him in the immigration removal estate.

2.153 Telephone interpreting services were used rarely, with invoices indicating one or two calls per month, of short duration. We were told that a prisoner on D wing was often used as an interpreter for Vietnamese prisoners. In the absence of the foreign nationals coordinator, we were unable to ascertain if a list was kept of staff and prisoners who could translate when necessary.

Further recommendation

2.154 Foreign national prisoners should be assisted to access accredited, independent immigration advice and support when necessary.

Housekeeping point

2.155 Accurate records of staff and prisoners able to speak languages other than English should be kept and published to all staff.

Health services

2.156 **Inpatient beds should not form part of the certified normal accommodation. (4.68)**

Not achieved. All 22 cells in the health care department were part of the certified normal accommodation. There were 16 inpatient beds commissioned by the Cardiff and the Vale University Health Board.
We repeat the recommendation.

2.157 **Prisoners should not be admitted to the inpatient unit unless there is an identified clinical need. (4.69)**

Not achieved. At the time of the inspection, there were 11 patients on the inpatient unit with varying degrees of mental health needs, most of whom had complex and significant problems. Five patients were waiting for assessment and/or a secure mental health placement, including two who were also receiving alcohol detoxification. In the remaining 11 cells, there was one wing cleaner and nine prisoners on Rule 45, including four with disabilities who were located there only because they could not be located appropriately on residential wings. There was a 'health care for inpatients' policy. This did not specify admission criteria and we understood that prisoners were routinely admitted for non-clinical reasons and that there was pressure from the prison to do so. A report on the use of the inpatient unit between January and March 2010 showed a regular pattern of approximately a half to a third of all cells being used for non-clinical reasons.
We repeat the recommendation.

2.158 **An electronic patient management system should be introduced as soon as possible. (4.70)**

Not achieved. Enabling work for an electronic patient management system had been completed and staff training initiated. We were told that the system was projected to go live in early 2011. Paper clinical records continued to be used. Current clinical records were housed in a back office in the health care centre; records for prisoners on C wing were kept in the wing treatment room, and inpatient clinical records were kept in the nursing office in the inpatients department. The quality of record keeping was variable and it was not always clear who had made the entry.
We repeat the recommendation

2.159 **Published day care programmes should be implemented as soon as possible. (4.71)**

Not achieved. There was no day care available for inpatients or vulnerable prisoners. Inpatients had a maximum of one hour out of their cells because of the complex mix of

prisoners on the unit and a shortage of discipline staff to enable this. There was one 'payment plus' officer during the day and on the night shift. The expert patient programme (a self-management programme for prisoners with chronic diseases) had been introduced in February and there had been some smoking cessation sessions.
We repeat the recommendation.

2.160 **Facilities should be provided so that prisoners are able to dine out of cell. (4.72)**

Not achieved. There were facilities available but due to the shortage of discipline staff and nursing staff capacity, this did not happen.
We repeat the recommendation.

2.161 **The head of health services should have a separate office. (4.73)**

Achieved. The head of health services had a separate office in the new health care facility.

2.162 **Ambulance response times should be monitored by health services staff. (4.74)**

No longer relevant. We were told that there was no longer a delay in ambulance response times. There was a 'first responder' scheme (including basic life support and use of a defibrillator), with eight prison staff trained by the Welsh Ambulance Service, but this was not sufficient to cover the 24-hour period consistently.

2.163 **The F wing treatment room should have a stable door to improve the administration of medicines to prisoners, and a privacy hood should be provided. (4.75)**

Not achieved. There was a perspex covered gate with a small aperture, through which prisoners received their medicines. There was no privacy hood but the yellow line had been moved to ensure that prisoners stood further back from the gate. Nurses told us that it was sometimes difficult to hear what prisoners were saying through the hatch.
We repeat the recommendation.

2.164 **The health care room in reception should be provided with proper office furniture and reconfigured to ensure optimum security for health services staff. (4.76)**

Achieved. The reception health care room was located near to the reception desk and was appropriately furnished. Staff had access to a panic button.

2.165 **The mental health in-reach team should be co-located with general health services staff to improve communication. (4.77)**

Achieved. The mental health in-reach team was based on the first floor of the new health care centre.

2.166 **Primary mental health staff should be employed predominantly on mental health duties and should attend all mental health referral meetings. (4.78)**

Not achieved. There was an interim arrangement in place pending the recruitment and appointment of new posts for primary mental health services. Registered mental health nurses in the general health care team responded to primary mental health needs. There was no designated time for primary mental health clinics and there was a waiting list of 60 patients and an average waiting time of up to six weeks for appointments, with some working prisoners waiting up to 12 weeks. Mental health services had been reviewed and integrated services

were planned, but recruitment to the designated posts had been a slow process.
We repeat the recommendation.

2.167 **Mental health awareness training should be a regular programme for all prison staff. (4.79)**

Not achieved. Few staff had received mental health awareness training. None of the segregation staff had been trained. Staff at HMP Swansea had offered some spaces on their training programme, due to take place in August 2010, and health services, safer custody and detoxification wing staff were scheduled to attend.
We repeat the recommendation.

2.168 **Written entries into clinical records should be legible and a method for identifying the writer and their designation introduced. Entries should be respectful. (4.80)**

Not achieved. The quality of written entries was variable. The role and status of the signatory was not always clear. The entries we saw were respectful.

Further recommendation

2.169 Audits of clinical record keeping should be carried out and training made available to remind all health services staff of their professional accountabilities in respect of record keeping.

2.170 **Health services staff should use the record tracer card system to enable administrative staff to know where clinical records are at all times. (4.81)**

Not achieved. There was a record tracer system but the location of records was still a regular problem. We were told that there were occasions when the GP would have to see patients without their clinical record. There was also a problem with keeping up to date with the filing of test results.
We repeat the recommendation.

Further recommendation

2.171 A system should be developed to ensure that all diagnostic test results are logged on receipt, screened by the GP and then filed promptly into the clinical record.

2.172 **The head of health services should introduce prisoner health care forums to improve communication between the health care department and prisoners. The specific concerns of black and minority ethnic prisoners should be investigated. (4.82)**

Achieved. There was a health care prisoner forum, chaired by the practice manager, and we were told that there was liaison with the diversity and disability managers to ensure representation from black and minority ethnic prisoners and those with disabilities. A prisoner focus group had been held in February 2010, chaired jointly by the practice manager and disability liaison lead, to inform the health care needs analysis; there had been representation by black and minority ethnic prisoners at this meeting. There had also been black and ethnic minority representation at a previous patient user forum meeting held in June 2009.

2.173 **A health services worker should be nominated to assist with the compilation of chronic disease management records. (4.83)**

Achieved. The lead GP was in charge of chronic disease management. There was an electronic register, held in the form of a Microsoft Excel spreadsheet updated by health services staff. There were designated clinics for asthma and coronary heart disease.

2.174 **Secondary screening should be mandatory unless specifically refused. (4.84)**

Not achieved. We were told that secondary screening was offered to all prisoners. However, there were no designated clinics for secondary screening, and the section in the reception screening template which asked prisoners whether they wanted secondary screening had not been completed in the records we reviewed. A GP attended reception and saw all prisoners on admission, which enabled early appropriate prescribing and referrals, but not all prisoners would declare their health needs on arrival.
We repeat the recommendation.

2.175 **Clinical records should be transported to wings in secure wheeled cabinets. (4.85)**

Achieved. Nurses transported clinical records to the wings in sealed rucksacks, sometimes making more than one journey in order to adhere to health and safety risk requirements related to carried weight; because of the presence of stairs, wheeled trolleys would not be suitable.

2.176 **Triage algorithms should be developed to ensure consistency of advice and treatment to all prisoners. (4.86)**

Achieved. A triage template had been introduced which had been reviewed and approved by the NHS commissioners. All patients requesting to see the GP or other primary care practitioners were triaged by practice nurses, except when it was immediately clear that the referral to the particular primary care service was appropriate or the prisoner declined to give further information.

2.177 **A senior health services worker should be nominated to lead on the development of a health promotion strategy, which should include the management of chronic disease. (4.87)**

Achieved. A practice nurse was the designated lead for health promotion. A 'healthy lifestyle promotion strategy', with associated meetings, had been developed, based on a whole-prison approach to health-promoting behaviour; this forum was chaired by the deputy governor. There had been two meetings in the previous six months. Early priorities had been identified but implementation of the planned programme had not started.

2.178 **The optician's waiting list should be scrutinised to ensure that all prisoners needing spectacles are seen as soon as possible. (4.88)**

Partially achieved. There were two sessions a month, with an average of eight patients seen at each session, which represented an increase since the previous inspection. At the time of the inspection, there were 44 prisoners waiting for routine appointments and three for urgent appointments. The average waiting time for a routine appointment was three months and urgent appointments were prioritised. It was not clear how prisoners who needed a simple spectacle prescription were identified.
We repeat the recommendation.

Housekeeping point

2.179 The prison should assess the need for making 'ready specs' available for prisoners.

2.180 **Secondary dispensing should not be undertaken. (4.89)**

Not achieved. Nurses decanted small quantities of medication from named patient packs to transport to the segregation wing and B1 landing. We were told that, due to the high turnover in the segregation unit, it was difficult to transport large quantities of medication to and from this location. However, this practice constituted secondary dispensing. When a prisoner or a medication was not suitable for 'in possession', the latter was put into Henley bags labelled by the nurses.
We repeat the recommendation.

2.181 **Medication should only be given 'in-possession' if properly dispensed in a suitable container. (4.90)**

Not achieved. There were instances, such as for night sedation, where nurses decanted medication using part-blister packs and/or decanted small quantities into bottles which they labelled with the patient's details.
We repeat the recommendation.

2.182 **The timing of medication rounds should be reviewed to ensure that patients get the best treatment possible. (4.91)**

Not achieved. There were two medication rounds a day, at 7.45am and 4pm. This meant that medication required outside these times but not able to be in possession was sometimes administered to patients on an individual basis or, more commonly, was given to the patient in a labelled bag, to be taken later. Supervised night sedation was given at 4pm, which was inappropriate.
We repeat the recommendation.

2.183 **The pharmacist should introduce pharmacy-led clinics. (4.92)**

Not achieved. There had been a pharmacy-led clinic but this had been discontinued owing to staffing capacity. We were told that a business case had been submitted for further pharmacy sessions.
We repeat the recommendation.

2.184 **The in-possession policy should be reviewed and include a documented risk assessment of each drug and patient. A formal risk assessment tool should be made available for staff to use. (4.93)**

Partially achieved. The policy had been reviewed and there was a risk assessment tool available, although it was only used with prisoners being considered for in-possession medication.

Further recommendation

2.185 All prisoners should be risk assessed for in-possession medication on arrival or as soon as practicable. The risk assessment should be repeated when circumstances change.

2.186 **The 'special sick' policy should be reviewed on a regular basis by the medicines and therapeutics committee (MTC) to ensure that all appropriate medicines can be supplied. (4.94)**

Achieved. The special sick policy had been reviewed and reissued in April 2010 and approved through the medicines management meeting

2.187 **Supplies of 'special sick' medication should always be recorded on prescription and administration charts. Its use should be monitored. (4.95)**

Not achieved. Medicines administered under the special sick policy were not consistently recorded on medication administration charts. There were no audits of medicines administered under this policy.
We repeat the recommendation.

2.188 **The local health board (LHB) and the pharmacist should develop a drug formulary, and prescribers should be encouraged to adhere to it. (4.96)**

Not achieved. There was no locally agreed primary care formulary. Regular health board prescribing advice newsletters were circulated to the GPs and independent nurse and pharmacist prescribers.
We repeat the recommendation.

2.189 **All pharmacy procedures and policies should be formally reviewed and adopted via the MTC. Once completed, all staff should read and sign the agreed adopted procedures. (4.97)**

Partially achieved. All significant policies with a wider application than just to pharmacy staff were reviewed and updated through the medicines management meetings. Local pharmacy standard operating procedures were reviewed and updated as required.

Further recommendation

2.190 An audit cycle should be developed to target policy compliance with specific reference to medication/pharmacy-related policies and procedures.

2.191 **The MTC, through the pharmacy team, should implement medication reviews for prisoners. (4.98)**

Partially achieved. Individual reviews of medication were conducted by GPs. There were no pharmacy-led reviews with patients.
We repeat the recommendation.

Additional information

2.192 Health services were commissioned by Cardiff and the Vale University Health Board, with which there was good engagement. There was an ongoing major review of health care, including services and structures, in order to develop proposals for the future delivery of services, including the potential to integrate detoxification services into the health care department. The health care environment had improved significantly since the previous inspection, with the opening of the new building (see paragraph 2.6).

2.193 A shortage of prisoner escorts and inappropriately located inpatients (see recommendation 2.157) had resulted in nursing staff time not being used to best clinical and therapeutic advantage. There was a 0.5 whole-time equivalent practice manager, who was also a Prison Service manager. The lead practice nurse was also an officer. Nurses who were prison officers, and the prison healthcare officers remained in prison officer uniform.

2.194 Although a 'healthy lifestyle promotion strategy' had been developed (see paragraph 2.177), there was little evidence of health promotion literature and no structured health promotion. There had been a well-man clinic but this had ceased owing to the withdrawal of health board support.

2.195 There were seven wing-based GP sessions a week, provided by a private health care provider (Serco), which included inpatients and administrative time. One GP worked almost full time in the prison and was also linked to a local practice. Prisoners told us that they sometimes waited for two weeks to see the GP. Prisoners on A and B wings could wait longer owing to the attendance schedule, and prisoners on C wing, who were often older and had more complex needs, could wait longer because of pressure on the sessions. Use of equipment such as ECG machines was sometimes delayed, as items were stored in the main health care department and could not be readily transported (see further recommendation 2.8).

2.196 Pharmacy staff had undertaken a prescribing/dispensing audit in May 2009 to identify the number of prisoners on in-possession medication by wing.

2.197 There were four dental sessions a week. At the end of June 2010, there had been 40 patients waiting for initial triage, 11 waiting for initial routine assessments, 11 waiting for initial routine treatments and 28 who had received emergency treatments and were waiting for routine follow-up care.

2.198 Between January and March 2010, of the 181 external hospital appointments scheduled, approximately 20% had been cancelled owing to security issues, with a small number of NHS cancellations.

2.199 The mental health in-reach team comprised one band seven team leader (a community psychiatric nurse), one band six community psychiatric nurse and a half-time occupational therapist. The team caseload was 26 at the time of the inspection. There were fortnightly psychiatrist-led primary care clinics; there were 23 patients on the caseload and urgent referrals were seen within two weeks and routine referrals or reviews within two months. There were strict criteria for referral to secondary mental health services. The psychiatrist was linked to a local low secure provision and provided seven sessions a month for secondary care. A counselling psychologist provided one session a week, which was restricted to complex problems. There was a weekly multidisciplinary mental health review meeting, which included primary and secondary mental health staff but no wider representation from the prison.

Further recommendations

2.200 Nurses should not be used to escort prisoners to and from the health care department.

2.201 Nurses and health care support staff should all wear an NHS-type uniform, irrespective of their employment status, to distinguish their role as health services staff from that of prison officer.

Housekeeping point

2.202 The number of external health care appointments cancelled unnecessarily should be monitored and reduced.

Good practice

2.203 *A review of in-possession prescribing by wing had enabled staff to look at how the proportion of prisoners on in-possession medication could be increased safely.*

Learning and skills and work activities

2.204 **Learner portfolios should always go with prisoners when they are transferred or released from custody. (5.27)**

Achieved. Prisoners were provided with a useful summary record of the outcomes of initial and post-instruction assessments of literacy and numeracy, as well as a record of courses and qualifications that they had successfully completed, including information on the level of course and the examination board. This information was emailed to other prisons on transfer, to prisoners' home addresses and to any other relevant agencies such as probation services.

2.205 **More use should be made of sentence planning information to inform learning plans. (5.28**)

Achieved. Information on sentence planning was now emailed routinely to the learning and skills department. The information was recorded and used appropriately to inform prisoners' individual learning plans.

2.206 **The Welsh language and culture should be promoted within the establishment. (5.29)**

Achieved. Bilingual posters and promotional materials were displayed in many areas. Prisoners were given opportunities to attend classes in conversational Welsh, and the prison radio station promoted Welsh rock music. Staff were also given opportunities to attend Welsh language classes.

2.207 **Better use should be made of labour market information to inform the development of provision. (5.30)**

Achieved. The workshops and the learning and skills provision had changed focus, so that the education, work and training were all orientated towards employability skills. This had led to the introduction of training and qualifications in areas such as painting and decorating, brickwork, cleaning, hospitality and catering. There were well-developed plans to establish training routes in car valeting, highway maintenance and computer repairing. More than a third of job roles led to qualifications, including National Vocational Qualifications (NVQs) in

performing manufacturing operations; laundry work; waste management and recycling; and construction. The prison had held a number of job fairs with local and regional employers, including some in the catering and hospitality, computing and construction industries. Two teachers had been trained to deliver training in the Deloitte employability skills scheme.

2.208 **National Vocational Qualification (NVQ) training should be provided for information, advice and guidance workers to improve the quality of this service. (5.31)**

Achieved. At the time of the inspection, six staff and eight prisoners had completed an information, advice and guidance (IAG) NVQ at level 3 through the St Giles Trust scheme. Four prisoners were working as peer advisers on the wings, including the remand wing, as well as in session-based IAG sessions. A further four staff and four prisoners were working towards the qualification. The IAG function played an integral role in the learning and skills provision.

2.209 **Procedures to transfer assessment results to workshop instructors and trainers should be improved. (5.32)**

Achieved. The labour board took account of prisoners' literacy and numeracy skills when determining the suitability of prisoners for jobs that they had applied for. All the information on learners' skills, qualifications and employment history was recorded routinely on a newly developed database (Meganexus) and made accessible to all trainers and instructors, who had used this information well.

2.210 **All staff should be aware of the learning and skills strategy, and the need for punctuality and attendance. (5.33)**

Achieved. Officers had become more aware of the importance of making sure that prisoners arrived on time for classes. Punctuality had improved and attendance at education sessions was 86%, against a target of 80%.

2.211 **The library Service Level Agreement should be updated to ensure that the service continues to develop. (5.34)**

Not achieved. A Service Level Agreement had been made with Cardiff City Council in the previous year. However this had not taken account of the changed needs of the prison library. The primary focus for the library and the learning and skills department was now on improving prisoners' employability skills.
We repeat the recommendation.

Additional information

All courses were modular, with each module being discrete and leading to the award of credit. The range of education programmes was closely matched to the job market. Most courses were at levels 1 and 2, as well as entry level. Higher levels of courses were available by distance learning.

2.212 The learning and skills programmes were good and improving. There was a clear sense of direction, with the head of education and skills also responsible for work and training. There were 75 full-time places but prisoners were able to attend on both a full- and part-time basis. A discrete learning support unit had been established since the previous inspection and worked well. Most prisoners who had attended learning support classes had made good progress in improving their reading and writing skills, often from a low base.

2.213 All classrooms were well equipped with computers, and all, including the classroom in the gym, had interactive whiteboards. The education department had started to build a virtual learning environment on their intranet.

2.214 There was a range of learning opportunities, including open and distance learning for higher levels of courses. All the education and training courses in the education department and the training workshops included essential skills, and all had an emphasis on employability skills. All courses were modular, and prisoners could join at any time when a place became available. Each module was discrete, was delivered in one week and led to the award of credit. Most courses were at levels 1 and 2, as well as entry level. The range and delivery of qualifications met the needs of prisoners well and were closely matched to the job market. Some of the accreditation was basic but appropriate for the short-term needs of the population. Learning support was good and based on a thorough needs analysis.

2.215 The education and training staff made good use of sentence planning information, as well as information from initial screening, when allocating prisoners to training places, work and education.

2.216 Prisoners in full-time education had access to the library twice a week; others had weekly access. The main library had a good range of books. Although the library on the wings had limited stock, prisoners were able to order books and other materials from the main library. Prisoners had suitable access to Prison Service Orders and other legal documents. Two library orderlies provided assistance to users. There was a small stock of books in minority languages. Prisoners had poor access to daily local newspapers. The main library had eight computers for private study. Two prisoners had completed a relevant NVQ at level 1 and worked well as prisoner orderlies.

Further recommendation

2.217 The stock of books in foreign languages should be increased to meet the needs of the foreign national population.

Physical education and health promotion

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

Additional information

2.218 All prisoners had good access to the gym and other PE facilities, and about two-thirds used them regularly. Most scheduled sessions comprised football, basketball and use of fitness equipment, including weights. Gym sessions were scheduled throughout the week, including evenings and weekends. The gym staff provided support for prisoners on fitness regimes. Since the previous inspection, the gym had started two sessions a week of bowls for the over-50s, but uptake was poor.

Time out of cell

2.219 **The reasons for cancellation of association should be addressed. (5.54)**

Achieved. The number of cancellations of association had reduced significantly. A snapshot

survey of two months in 2010 showed fewer than four cancellations a month (with the exception of staff training days).

Additional information

2.220 The prison was recording an average weekday time unlocked of 8.1 hours. However, this could only be achieved by prisoners who were in full-time education or employment and were located on D wing, where workers were offered association every weekday evening. Prisoners on F1 and C wings and also those on the basic regime or stage 2 of the violence reduction strategy on the A1 landing could achieve as little as two hours unlocked if they were unemployed. The regime in the health care unit was particularly poor, despite the presence of a discipline officer; such prisoners regularly received only one hour out of cell per day and there was no day care activity. Staff told us that they routinely observed exercise periods from outside the enclosed yards.

2.221 There was no published core day for prisoners on B1, but the core day for B wing suggested that prisoners were locked up at 12.30pm after lunch and at 4.45pm before teatime, so prisoners on B1 had some of their time unlocked curtailed.

Further recommendation

2.222 Staff should supervise exercise within the security fence and should use this time to interact with prisoners.

Housekeeping point

2.223 There should be a published core day for the B1 landing.

Security and rules

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

Additional information

2.224 The security committee met monthly and was attended by a police liaison officer, prison managers and staff from all areas of the establishment. The meetings were chaired by an operational governor grade. A wide range of topics was discussed, including a synopsis of intelligence received from security information reports (SIRs), security objectives and the current priorities of reducing the smuggling of drugs and mobile telephones. There were effective links between the security department, the safer custody team and the race equality officer, when in post (see section on race equality). A member of the safer custody team attended the security department every day to check security information about bullying and other violent incidents from the previous day.

2.225 The security department was managed effectively by the head of security (a governor grade). Its day-to-day operation was the responsibility of two senior officers. There had been 753 SIRs submitted, by staff of all grades, in the six months before the inspection. These were processed and categorised by a security analyst. Information was communicated to staff in all areas of the establishment through monthly bulletins. Suspicion drug testing as a result of

information submitted by staff was carried out within a reasonable timeframe but we were unable to ascertain if target searching was carried out.

2.226 Supervised prisoner movement was permitted at the beginning and end of planned regime activities and prisoners were able to walk freely within supervised areas. Individual risk assessments for prisoners accessing activities were over-cautious, with security staff considering security information dating back at least two years, and in some cases longer.

2.227 There were seven prisoners subject to closed visits. Some of these were as a result of illicit activity unrelated to visits, such as possession of mobile telephones. The security manager imposed the restriction for between one and three months initially and the first review took place at the end of this period. Two visitors had been banned following incidents during entry to visits.

2.228 Three prisoners had been subject to escape list procedures. One had been reviewed shortly before the inspection and the restrictions removed. He had been on this list for seven months, despite monthly reviews showing that no further information had come to light. The remaining two prisoners had had the restrictions imposed following incidents outside of prison custody.

2.229 Prisoners were advised of the establishment's rules during induction and by way of a behaviour compact, which they signed. Some rules were over-restrictive; for example, prisoners were not allowed to purchase bananas or oranges or have them served at mealtimes. Staff told us that this was to prevent the brewing of hooch.

Further recommendations

2.230 Target searching should be carried out within a reasonable timeframe and records kept of this.

2.231 Prisoner access to activities should not be impeded by consideration of security information dating back more than six months.

2.232 Prisoners should only be placed on closed visits as a result of intelligence or incidents related to visits.

2.233 Prisoners should be removed from the escape list if no further intelligence comes to light that suggests that they pose an escape risk.

2.234 Prisoners should be able to have bananas and oranges.

Discipline

2.235 **The punishment tariff should be made known to prisoners before adjudication. (6.35)**

Not achieved. The information folder supplied to prisoners before adjudications did not contain the punishment tariff and it was not made available to prisoners anywhere else. **We repeat the recommendation.**

2.236 **Planned use of force interventions should be video-recorded. (6.36)**

Not achieved. A video camera was available but planned use of force interventions were not

video-recorded.
We repeat the recommendation.

2.237 **The regime for longer-stay prisoners in the segregation unit should be improved to include some out-of-cell purposeful activity. (6.37)**

Not achieved. The regime for longer-stay prisoners in the segregation unit had not improved. There was no out-of-cell activity and prisoners remained locked behind their doors for long periods of time.
We repeat the recommendation.

Additional information

2.238 There had been 386 adjudications between January and June 2010, which represented a slight reduction from the previous year's total of 816 but an increase since the previous inspection. The main charges were mandatory drug testing failures, possession of unauthorised articles and disobedience. The independent adjudicator attended every 28 days to hear the more serious charges. Charges were appropriately laid and the records we examined showed that charges heard by Prison Service adjudicators were fully investigated and recorded. Records from the independent adjudicator did not always show that a full enquiry into the circumstances had been carried out.

2.239 A punishment tariff was in place and adjudicators recorded when they went outside of the guidelines. We found one instance where a prisoner had been awarded 100% loss of earnings, so he might have been unable to purchase telephone PIN credit to stay in contact with his family.

2.240 Adjudications were carried out in the office on the segregation unit, which was an unsuitable location. The adjudications we observed were disrupted by prisoners looking at closed-circuit television (CCTV) images. A computer was in use by staff during adjudications and in view of the prisoners, and confidential information was on display in the room. The independent adjudicator carried out adjudications in a separate, more suitable location.

2.241 There were no quality checks on adjudication documents and there was no monitoring or analysis of statistics relating to adjudications. Managers had recognised this and a committee had been formed to examine and discuss aspects of adjudications.

2.242 There was little use of force, with 100 incidents in 2009 and 68 in the year to date; however, this represented a year-on-year increase since the previous inspection. The documentation we examined showed that force had been used as a last resort and that staff had attempted to de-escalate situations before using force. Incidents had been well recorded and gave a full account of events, although most had been certified by the person authorising the use of force. No management checks of use of force documentation were carried out and there was no monitoring or analysis of statistics relating to the use of force.

2.243 The special accommodation had been used twice in 2010. Both uses had been for less than one hour and had been correctly authorised.

2.244 The segregation unit was based on A wing. The unit was generally clean, although some cells were in a poor state of decoration. The safer custody and dirty protest cells were in particularly poor condition, with graffiti on the walls. All cells had in-cell electricity and CCTV camera coverage.

2.245 The unit had a dedicated staff group, all of whom had been authorised by the governor to work there. All had undertaken training in mental health awareness, as well as in adjudication procedures, ACCT procedures, and control and restraint. The relationship between staff and prisoners was courteous, although prisoners were mostly called by their surnames.

2.246 There were four prisoners on the unit at the time of the inspection. Two of these were serving punishments of cellular confinement following adjudications and two were segregated for reasons of good order. All had been authorised correctly and a mental health safety screening had been completed by health services staff. Three of the prisoners were returned to normal accommodation during the inspection.

2.247 The segregation records we examined showed that prisoners did not generally spend long periods on the unit and that most returned to normal location. Records for the previous three months showed that the average occupancy in the unit was five prisoners daily, up to a maximum of 10 when it was used as an overflow facility for C wing.

2.248 Reviews of segregation were carried out within the prescribed timescales and there was evidence of meaningful behaviour targets being set for some individuals. Daily records were mainly observational, with more detailed entries on wing history sheets and P-NOMIS. There was no formal care planning for segregated prisoners or formal reintegration protocols.

2.249 Prisoners on the unit had daily access to telephones, showers and outdoor exercise. Some in-cell work and education was provided for those who were not under punishment (see also paragraph 2.239). Those on the unit were visited by health services and chaplaincy staff, a governor grade and a representative from the Independent Monitoring Board daily.

Further recommendations

2.250 All adjudication records should show a full investigation of the charges.

2.251 Prisoners should not be given 100% loss of earnings as a punishment.

2.252 Adjudication hearings should be conducted in a more suitable location.

2.253 Adjudication documents should be quality checked and adjudication statistics monitored and analysed.

2.254 The year-on-year increase in use of force should be investigated and action taken if required.

2.255 Use of force should be certified by a manager not involved in the incident.

2.256 Management checks of use of force documentation and monitoring and analysis of statistics should be carried out to identify and act upon trends.

2.257 Segregation unit cells should be cleaned of graffiti and redecorated.

2.258 Care planning and reintegration protocols should be developed and introduced on the segregation unit.

Incentives and earned privileges

2.259 **The incentives and earned privileges (IEP) scheme should be connected to sentence planning, and prisoners motivated to achieve agreed targets and objectives. (6.44)**

Not achieved. Although the policy linked IEP to sentence planning, there was little evidence in wing history sheets of personal officers making that connection through weekly reviews or offering motivation and encouragement to achieve targets and objectives, except for some prisoners on the basic regime on the A1 landing.
We repeat the recommendation.

Additional information

2.260 The IEP policy had been reviewed but some aspects had not been updated. The impact assessment for equal opportunities was out of date, having been completed in 2005. The policy set out a clear description of the scheme and how it should be applied. Prisoners were able to stay on the level of the scheme that they had been on at their previous establishment. There were the usual three levels of basic, standard and enhanced. The policy did not mention D wing, which staff considered to be a 'super-enhanced' wing. Application of the policy was inconsistent, with different recording methods and different documents in use across the residential units, and some prisoners on basic, who should have been located on the A1 landing, remaining on their wings. We found applications from prisoners for consideration for enhanced status, on one wing dating back to January 2010, that had not been completed.

2.261 There were 214 prisoners on the enhanced level, 563 on standard and nine on basic at the time of the inspection. Prisoners in our groups said, and our observations confirmed, that the differentials between the levels were insufficient to encourage them to aspire to enhanced status. Prisoners on the enhanced regime who were not located on D wing were disadvantaged in their access to association, receiving less than those on this wing.

2.262 Staff could issue warnings for poor behaviour which were filed in individual wing records. Prisoners were reviewed after receiving three warnings within a three-month period. The policy allowed for prisoners to be automatically downgraded from enhanced to basic for some offences, which was inappropriate when they had already received a punishment for a proven adjudication, although we did not find any instances where this had happened. Personal officers did not always complete monthly entries in wing history sheets to indicate whether or not prisoners' behaviour was consistent with their IEP level. Reviews were carried out by wing staff, and prisoners attended or could make written submissions to these boards and were given details of how to appeal the decisions made. Records for prisoners on the basic regime on the A1 landing showed that they were given incremental incentives to improve their behaviour.

Further recommendations

2.263 Prisoners on enhanced status should have the same access to association, irrespective of where they are located.

2.264 The IEP policy should be fully reviewed and updated, for example to ensure appropriate differentials, and applied consistently.

Catering

2.265 **The midday meal should not be served before noon. (7.7)**

Not achieved. We observed the lunchtime meal being served at approximately 11.45am on each day of the inspection, and staff and prisoners told us that this was the norm.
We repeat the recommendation.

2.266 **The reasons for the dissatisfaction with the catering should be examined. (7.8)**

Achieved. Bi-annual surveys were conducted by the catering department, and the catering manager attended the prisoner consultative committee, at which catering was a standing agenda item.

2.267 **There should be opportunity for the longer-term prisoners on E wing to prepare their own food. (7.9)**

Not achieved. Food preparation facilities for the longer-term prisoners on E wing were poor. There was a small refrigerator with a broken door, a microwave and a toaster with four grilling slots, only two of which worked.
We repeat the recommendation.

Additional information

2.268 Feedback from prisoners was mostly positive in relation to the quality of food, although there were consistent complaints about portion sizes. Complaints could be raised via a form, and each prisoner submitting a complaint received a written response from the catering manager.

2.269 The menu was based on a three-week cycle and was altered to reflect feedback from the bi-annual food survey (see paragraph 2.266), although the response rate was usually poor, with often no more than 10% of prisoners responding.

2.270 All prisoners employed in the kitchen were health screened and received an appropriate induction. Levels 1 and 2 NVQs in catering and British Institute of Cleaning Sciences (BICS) cleaning could be undertaken by prisoners, and two recently discharged prisoners had been found employment on release through links developed by the catering department.

Prison shop

2.271 **The shop should be an agenda item at all prisoner consultation meetings, and issues raised should be responded to by the appropriate manager at Charles Fellowes. (7.15)**

Achieved. Prison shop arrangements were a standing agenda item at the prisoner consultative committee meeting. The prison manager responsible for shop arrangements attended and liaised with the central contactor, DHL, about any issues raised.

2.272 **The results of prisoner surveys should be communicated to prisoners and should influence the range of products on the shop list. (7.16)**

Not achieved. The results of prisoner surveys were not communicated to prisoners and did

not influence the range of products on the shop list.
We repeat the recommendation.

2.273 **The range of black and minority ethnic products should be made available to all prisoners, regardless of incentives and earned privileges (IEP) status. (7.17)**

Achieved. All items on the prison shop list were available to all prisoners.

2.274 **The range of hobby items should be increased. (7.18)**

Achieved. Hobby brushes, matchstick cutters, model matches, wood glue, sandpaper and varnish had been added to the shop list since the previous inspection.

Additional information

2.275 The prison shop list provided a reasonable range of goods but prisoners in our groups complained of escalating prices against a backdrop of pay rates that had remained static.

2.276 After receiving their initial reception packs, prisoners could wait up to two weeks before being able to submit and receive a full shop order.

Further recommendation

2.277 Prisoners should be able to receive a full shop order within 24 hours of arrival.

Strategic management of resettlement

2.278 **The establishment should deliver a resettlement awareness session for all staff to inform them of the strategy and how it influences outcomes for prisoners. (8.6)**

Achieved. Resettlement training was provided as an addition to the programme awareness sessions attended by staff. The training informed residential staff of the resettlement services provided and how to refer prisoners. Officers we asked had attended the session and knew how to direct prisoners to resettlement services. Training records showed that 78% of staff had attended in the previous three years.

2.279 **The establishment should recruit a chartered psychologist to deliver the identified interventions. (8.7)**

A**chieved.** Psychology services were organised on an area basis, shared with the other Welsh prisons. In the team were four full-time and one part-time chartered forensic psychologists. They spent much of their time at Cardiff and undertook the role of treatment managers for accredited programmes. Delivery of interventions was by trained facilitators from operational and psychology backgrounds.

2.280 **There should be a gatekeeper responsible for each resettlement pathway. (8.8)**

Achieved. For each pathway, there was a designated lead member of staff and they all attended the resettlement committee meeting, except for the head of health care. This meant that the mental and physical health pathway was not considered alongside the development of the other pathways.

Housekeeping point

2.281 The lead for the mental and physical health pathway should attend resettlement committee meetings.

2.282 **Monitoring and evaluation of interventions should take place locally, and information gathered should be used to influence the resettlement strategy. (8.9)**

Achieved. Monitoring and evaluation of interventions were carried out by the psychology department and included in the needs analysis which informed the resettlement strategy.

2.283 **There should be a review into whether the psychology department is meeting the needs of determinate-sentenced prisoners; once completed, appropriate action should be taken. (8.10)**

Achieved. The psychology department had been reorganised on an area basis and services were provided for determinate- and indeterminate-sentenced prisoners (ISPs). Examples of work with determinate-sentenced prisoners included referrals from multi-agency public protection arrangements (MAPPA), safer custody assessments and individual programme work.

2.284 **Membership of the resettlement meetings should be increased to ensure that all stakeholders attend and that relevant statutory and non-statutory agencies contribute. Action points identified at these meetings should be time bound and not allowed to run over target dates. (8.11)**

Achieved. Attendance at the resettlement committee was reasonable, with the exception of health services staff (see paragraph 2.280). Non-statutory organisations met twice a year with the head of resettlement, who represented their views at the resettlement committee. Action points in the minutes were recorded and progress checked at the following meetings.

Housekeeping point

2.285 Agreed actions should have a completion date set and recorded in the minutes.

Additional information

2.286 The resettlement strategy had been recently updated and was based on a comprehensive needs analysis provided by the area psychology team. This reflected the characteristics and needs of the prison's population and was linked to the range of services provided under each pathway.

Offender management and planning

2.287 **Prisoners serving less than 12 months should have individual custody plans and a designated member of staff to work with, to ensure that assessed needs can be addressed during their sentence. (8.28)**

Achieved. In the previous three months, the electronic Cymru – Support, Training and Referral Tool, an area National Offender Management Service (NOMS) initiative, had been introduced.

All prisoners, both sentenced and remand, were interviewed by the chaplaincy team and their resettlement needs recorded. Referrals were generated to appropriate resettlement services and actions recorded to build up a casework record. The next phase of this project was to include preferred community-based providers so that support continued beyond the end of prisoners' sentences.

2.288 **Sentence planning templates should be revised to conform to National Offender Management Service requirements. (8.29)**

Achieved. Sentence plans were recorded on the templates provided with offender assessment system (OASys) documentation.

2.289 **The public protection policy should be revised to reflect the safeguarding children agenda and to clarify staff roles and responsibilities. (8.30)**

Achieved. The public protection policy had been revised and included a section on safeguarding children. The roles and responsibilities of specific staff, such as those supervising visits and telephone monitors, were carefully detailed and explained.

2.290 **Safeguarding children training should be provided for those staff who have regular contact with children. (8.31)**

Achieved. A programme of training for 31 staff with responsibility for children in visits had been delivered to a mixture of managers, officers and support staff. The training included public protection and family connections.

2.291 **Security staff should always be represented at the monthly public protection panel meetings. (8.32)**

Partially achieved. The public protection policy stated that a monthly meeting should be held but did not specify who should attend. Minutes showed security department representation at two or the previous three meetings.
We repeat the recommendation.

2.292 **The establishment should make greater use of the release on temporary licence facility to assist the resettlement of prisoners. (8.33)**

Not achieved. In the previous six months, there had been only two successful release on temporary licence (ROTL) applications. There was no structure for providing resettlement opportunities through the ROTL process. The head of resettlement considered that this would be difficult to achieve because the prison was required to recategorise lower-risk prisoners and transfer them as soon as possible to less restrictive conditions.
We repeat the recommendation.

2.293 **Monthly lifer meetings should be held to inform the population of the establishment's intentions, and a full-time lifer manager should be appointed. (8.34)**

Partially achieved. There were no monthly lifer meetings and this was reflected in the concerns that prisoners expressed to us. Issues that they raised had not been addressed with them and there was poor communication between lifer managers and prisoners. There was a full-time ISP manager, who had been in post for approximately three months. She was responsible for casework issues, and the head of residential was responsible for their living conditions.

Further recommendation

2.294 Residential and lifer casework managers should hold monthly consultation meetings with life-sentenced prisoners and those serving indeterminate sentences for public protection (IPP).

2.295 **The establishment should provide prisoners serving indeterminate sentences for public protection with factual information about their sentence. (8.35)**

Achieved. Each IPP prisoner was allocated to an offender supervisor, who interviewed him within five days of arrival at the establishment. The interview included an explanation of the sentence which was recorded on a form signed by the prisoner.

2.296 **All life-sentenced prisoners should be allocated a lifer-trained personal officer, and receive an information pack. (8.36)**

Not achieved. All life-sentenced prisoners were allocated a personal officer from among the dedicated E wing staff group, but only two officers had been trained to work with such prisoners. The establishment had applied for staff places on training courses but these had been cancelled. The next course was due in November 2010 and three officers were booked to attend. There were no information packs available.
We repeat the recommendation.

2.297 **The backlog in reports for life-sentenced prisoners should be addressed and a protocol introduced to ensure that reports are kept up to date. (8.37)**

Achieved. A dedicated ISP clerk had been appointed and she had established systems which ensured that outstanding reports were promptly followed up. At the time of the inspection, there was no backlog of dossiers due to be submitted to the parole board.

Additional information

2.298 At the time of the inspection, the prison held 497 sentenced and 300 unsentenced prisoners. Of the sentenced prisoners, 90 were lifers, 16 were IPP sentenced and came under phase 3 of offender management, 78 were in scope of phase 2 of offender management and 187 were sentenced to more than 12 months. This made a total of 371 prisoners requiring some input from the offender management team.

2.299 The offender management unit was well staffed, with six prison officers and four probation staff providing the service. There was a small backlog of 17 OASys assessments which had not been completed within the required timescale, and four prisoners had been transferred before their OASys assessment had been completed. During the inspection, we found one prisoner whose sentence plan had not been completed after five months at the prison. We were told that there had been problems in the allocation of work to offender supervisors; a further check found that this had been an isolated case.

2.300 The quality of assessments and sentence plans was checked by the senior probation officer and this was supplemented by a formal quality assessment system, which included a wider range of trained assessors. Evidence from the early stages of implementation of this system showed that it effectively and consistently identified practice that required attention and that it was driving staff improvement.

2.301 Home detention curfew (HDC) arrangements were robust, with prisoners being notified three months before their eligibility date and weekly boards held. Around 75% of applications for HDC were considered after their eligibility date. A sample of these showed that the reasons for the delay were outside the prison's control, usually because of short sentences following a period of remand, or transfer to the establishment without the process having been initiated. We also saw instances where late cases were processed in a short time.

2.302 Categorisation boards were held monthly and there was no backlog at the time of the inspection. Reviews were held every six months and after completion of an offending behaviour programme.

2.303 At the time of the inspection, the establishment held only two category D prisoners, which reflected its success in moving recategorised prisoners to open conditions, but it had more difficulty in finding appropriate places for the 150 category C prisoners it held who wanted to move out of the area. Arrangements for moving prisoners to category C prisons in the area worked well, but those requiring a place out of area for a specific intervention usually had to wait for a long time.

2.304 Facilities for life-sentenced and IPP prisoners were underdeveloped. There were no designated lifer days, and prisoners complained that maintaining contact with families who were located some distance away was difficult.

Further recommendation

2.305 All OASys assessments should be completed in the required timescale.

2.306 There should be a system to provide management oversight of all outstanding assessments and sentence plans.

2.307 Prisoners recategorised to category C should be transferred promptly to an establishment appropriate to the progression of their sentence plan.

2.308 Lifer days or family days should be provided for all prisoners at least twice a year.

Resettlement pathways

2.309 **The establishment should accredit the work of those prisoners carrying out the housing needs assessment and offering advice in reception. (8.42)**

Not achieved. Prisoner orderlies in reception completed a brief accommodation assessment of all prisoners arriving at the establishment. However, they were not trained and they told us that the work was not demanding and was not accredited.
We repeat the recommendation.

2.310 **Protocols for finding accommodation for prisoners outside Wales should be developed. (8.43)**

No longer relevant. The catchment area of the prison had changed since the previous inspection and prisoners were not received from courts outside Wales, so few prisoners required accommodation elsewhere on release. In the previous six months, one prisoner had been referred for accommodation outside Wales. Prisoners wishing to be accommodated in

south-west England were referred to the South-West Gateway and any other requests were dealt with by contacting prisons close to the requested area for advice.

2.311 **The establishment should ensure that it can find accommodation for prisoners with specific diverse needs. (8.44)**

Achieved. Gwalia Housing Association, representatives of which worked in the prison, had a directory of accommodation which provided for a range of prisoner needs, including substance use, mental health problems, disability and for older people. Assessments were made of prisoners' specific needs and they were matched to appropriate providers.

2.312 **Subject to risk assessment and identified need as part of a formal resettlement plan, all category C and D prisoners should have the opportunity to apply for work or education in the community during at least the final three months of their sentence. (8.50)**

Not achieved. The governor had rejected this recommendation, as most prisoners who were considered suitable for ROTL were transferred to open conditions.
We repeat the recommendation.

2.313 **All prisoners should undertake a pre-release resettlement course. (8.51)**

Achieved. All prisoners due for discharge were assessed by a pre-discharge board six weeks before release, if there was time. They were then directed to a five-day pre-release course, which dealt with post-custody supervision obligations, claiming benefits, job seeking and training opportunities, including preparation for interviews and writing CVs. The course was run every week, and in the previous six months more than 200 prisoners had attended.

2.314 **An assessment should be carried out to identify what financial assistance is needed by prisoners, and the necessary agencies and services should be introduced to meet this need.(8.54)**

Achieved. An assessment was made of prisoners' financial circumstances as part of the C-START assessment. Referrals were made to the appropriate services in the prison, including Citizens Advice, Morgan's Solicitors and Jobcentre Plus. Citizens Advice saw approximately eight prisoners on one morning a week and provided advice and support with basic financial matters. More in-depth debt advice and casework was provided by Morgan's Solicitors, which saw up to 10 prisoners one day a week. The services of Jobcentre Plus were available three days a week to set up benefit claims, advise on appropriate applications, including community care grants, and settle arrears of payments.

2.315 **A dedicated counselling, assessment, referral, advice and throughcare (CARAT) manager should be appointed to ensure quality control and service monitoring, and to address staff performance issues. All staff delivering CARAT services should be subject to appropriate case management review and supervision. (8.72)**

Partially achieved. A part-time CARAT manager had been appointed in April 2010. The post holder was a prison officer/DPSM. Due to required restrictions on recruitment, he did not have a background in drugs and alcohol. Work was ongoing to provide him with appropriate knowledge and skills and ensure that he had links with CARAT managers in other prisons.

Further recommendation

2.316 The post of CARAT manager should be made full time.

2.317 **The drug strategy committee should strengthen links with local community planning bodies. (8.73)**

Achieved. The drug strategy committee had strong links with all the local drug intervention programme (DIP) teams and regular representation on the Community Safety Partnership committee and GPs.

2.318 **A voluntary drug testing unit should be created to provide prisoners with post-detoxification support. (8.74)**

No longer relevant. The wing-based CARAT workers provided appropriate support for prisoners post-detoxification on all locations, including F wing for the remand prisoners. CARAT case notes were detailed and assessments and care planning were good. The introduction of compact-based drug testing and related motivational interviews had focused support effectively across the prison.

2.319 **Remand and short-term prisoners should have access to a structured intervention to meet their needs. (8.75)**

Achieved. Remand and short-sentenced prisoners had access to the same support as other prisoners (aside from the prison addressing substance related offending (P-ASRO) programme).

2.320 **The voluntary/compliance drug testing compact should be reviewed, and its purpose clarified. (8.76)**

Partially achieved. There were now two compacts, one for voluntary drug testing (VDT) and a second for incentive-based drug testing. Some officers appeared to be confused about the difference between them, and applied sanctions inappropriately. There had been a number of initiatives to ensure that prison staff were properly informed about the criteria for testing under the compacts, including notices to staff, face-to-face education by the VDT officers and information through the drug strategy meetings. There had been some instances of poor internal attendance at drug strategy meetings, notably by security staff, in the previous six months. A new compact-based drug testing policy, which provided detailed explanation, was in draft form and due to be ratified in July 2010.
We repeat the recommendation.

Housekeeping point

2.321 The drug strategy meeting should be chaired by the deputy governor or a delegated representative and there should be regular attendance by appropriate prison staff.

2.322 **There should be no upper limit set for the number of visits that remand prisoners can receive. (3.77)**

Not achieved. The visits allowance for remand prisoners had been reduced since the previous inspection.
We repeat the recommendation.

2.323 **There should be a properly functioning visitors centre. (3.78)**

Not achieved. The visitors centre provided little more than a booking-in facility. The centre was austere, dirty and there was little information available for visitors.
We repeat the recommendation.

2.324 **Visitors centre staff should be fully aware of the visits procedures, including visits entitlements. (3.79)**

Achieved. Visitors centre staff had written information about visits procedures and were fully aware of entitlements.

2.325 **The establishment should advertise the identity of the family liaison officer and how to contact her. (3.80)**

No longer relevant. The family liaison officer post for visitors now sat within the safer custody team with an advertised helpline.

2.326 **An alternative to the perspex divide in the visitors centre should be sought. (3.81)**

Not achieved. The perspex divide between staff and visitors remained in place, making it difficult for visitors and staff to hear one another.
We repeat the recommendation.

2.327 **Visitors should be searched in private, and staff should use prisoners' chosen names when calling visitors into the visits room. (3.82)**

Not achieved. All visitors, including children, were searched in the open entrance area in the gate, in full view of any visitors or callers to the prison. Staff used prisoners' surnames when calling visitors into the visits room.
We repeat the recommendation.

2.328 **Visitors should not be strip-searched, but offered a closed visit if there is reliable intelligence that security may be breached. (3.83)**

Not achieved. We found records that showed that visitors had been strip-searched in the month before the inspection.
We repeat the recommendation.

2.329 **The establishment should introduce family-friendly furniture to the visits room and the layout should be conducive to relaxed conversations. (3.84)**

Not achieved. The furniture in the visits room was the same as at the previous inspection. Prisoners complained that it was unsuitable, as the tables were low and the furniture fixed, so there was a large space between prisoners and their visitors, discouraging contact.
We repeat the recommendation.

2.330 **Facilities such as the children's play area and the canteen should be staffed and open at all times during visits periods. (3.85)**

Partially achieved. The children's play area was open regularly but the canteen was closed on Tuesdays.

Further recommendation

2.331 The canteen in the visits room should be open for every visits session.

2.332 **The closed visits facility should not be in full view of the main hall. (3.86)**

Not achieved. The closed visits facility remained in full view of the main hall.
We repeat the recommendation.

2.333 **Prisoners should not be required to wear bibs on visits. (3.87)**

Not achieved. Prisoners were required to wear coloured bibs for both domestic and legal visits.
We repeat the recommendation.

2.334 **The visits holding rooms should be decorated and some visual stimulation should be installed. Staff should enquire into the whereabouts of visitors who have not arrived 15 minutes after the session has started. (3.88)**

Not achieved. The visits holding rooms were in poor condition, particularly the one used for prisoners leaving visits, which was dirty and had graffiti on the walls. There was no information displayed for prisoners. Staff did not enquire about the whereabouts of visitors who had not arrived.
We repeat the recommendation.

2.335 **Both the 'family man' and 'fathers inside' courses should be more widely advertised, and personal officers should promote them when appropriate. (8.79)**

Achieved. Both courses were widely advertised and staff and prisoners were aware that they were available.

2.336 **Alternative interventions should be available for determinate-sentenced prisoners who are assessed as unsuitable for the existing programmes. (8.84)**

Not achieved. Apart from accredited programmes, there were few interventions available which addressed offending behaviour. For a small number of prisoners, individual sessions with psychologists were available and the chaplaincy provided a restorative justice programme.
We repeat the recommendation.

2.337 **The programme support provided to indeterminate-sentenced prisoners should be replicated for those on determinate sentences; a nominated person should be responsible for assisting the consolidation of learning and reinforcing prisoners' learning and progress. (8.85)**

Achieved. Each prisoner undertaking an accredited programme was assigned to a key member of the programme delivery team. This member of staff was responsible for providing support and advice during the programme and for liaising with the residential staff on the prisoner's wing.

2.338 **Prisoners should be able to have their suitability for other offending behaviour programmes assessed while still at the establishment. (8.86)**

Achieved. To assist with transfer to appropriate establishments, assessments were undertaken for programmes which were not available at Cardiff. The risk assessment of sex offenders was completed as a preliminary for transfer to establishments offering the sex offender treatment programme. Prisoners were also assessed for the healthy relationships and cognitive self-change programmes (see further recommendation 2.361).

Additional information

2.339 Resettlement services were clustered together in one unit, where offending behaviour programmes were also delivered, overseen by the programme manager for interventions, who was a senior officer. This arrangement allowed for good integration and access for prisoners.

2.340 The service provided by Gwalia Housing Association provided a link with community services in Wales and was complemented by transitional support services, which met released prisoners who required accompanying to accommodation.

2.341 Assessments of remand prisoners' accommodation needs were provided to court-based services, so that assistance could be provided to those released directly from court.

2.342 There had been good progress in improving the employability skills of prisoners as part of the preparation for resettlement. The range of employment opportunities that could lead to employment had been increased (see paragraph 2.207). All qualification routes included qualifications in literacy and communication.

2.343 A nurse routinely attended the pre-discharge board and recorded any matters needing resolution before discharge in the clinical record, but no discharge template was used. Prisoners without a GP were given advice about how to register. If necessary, for prisoners living in Wales, the nurse used a centralised health board telephone directory to arrange registration directly with the nearest GP, and this information was then included in a letter for the prisoner to take away. For prisoners returning to England, the nurse identified a local GP for them, using individual primary care trust information. NHS Direct cards were given to prisoners routinely.

2.344 Prisoners on prescribed medication attended the wing treatment hatch two to three days before release, to request take-home medication. A seven-day supply of take-home medication was then given in possession to the prisoner at the treatment hatch or when in reception.

2.345 Prisoners who were part of the care programme approach were put in contact with their local community mental health team.

2.346 In 2009, the P-ASRO programme had achieved 65 starts and 46 completions, against a target of 95 starts and 65 completions. In the year to date, one group had completed, with 12 starts and eight completions, and a second group of 12 had started. We were told that the long recruitment process for facilitators to run the programme had caused problems.

2.347 All prisoners being discharged with drug and alcohol problems were linked with their local drug and alcohol teams. Prisoners returning to Welsh addresses were put in contact with their local DIP link workers, some of whom visited such prisoners before release. For those returning to addresses in England, contact was made using the CARAT single point of access system to locate the appropriate local services.

2.348 Prisoners on methadone or buprenorphine received their daily dose on the wings before release. Information about prescriptions and release dose administration was faxed to the prisoner's local service. Prisoners with alcohol-only problems were signposted to transitional support services and could be put in contact with these services at Bridgend for local follow-up.

2.349 There was a project enabling prisoners to have naloxone to take away with them, with related education before release. To date Cardiff had delivered training to 110 prisoners and 33 had left the prison with a take home kit.

2.350 The prison had an arrangement with a local bank which enabled prisoners to open an account before they were released. The head of resettlement told us that this was a popular service but he did not have records of the number of accounts opened. A money management course was available in education.

2.351 The visitors centre was outside the main gate, staffed by officer support grades, and opened daily at 12.30pm. Visitors could wait there until they were called across to the visits hall. Visitors told us that staff were polite and friendly and were particularly helpful to those visiting for the first time. A biometric identification system was in use and, once visitors' details had been entered onto the system, identification was a quick process. There were toilets and lockers in this area but little else for visitors (see recommendation 2.323).

2.352 Visitors entered the prison through the main pedestrian gate up to quarter of an hour before visits started. Visits took place daily (except Sundays) over two sessions, between 1.45pm and 2.45pm and 3pm to 4pm. Further sessions were held on Saturdays between 9.45am and 11.15am and on Sundays between 1.50pm and 3.20pm.

2.353 The visits hall was large, bright and clean, with sufficient space for up to 45 visits, but was noisy and institutionalised. A tea bar was provided by the Samaritans. There was a formal play area for children, staffed by the visits play area coordinator and volunteers, who provided supervised play and activities. The atmosphere in visits was relaxed, and discipline staff who supervised the visits remained at a discreet distance.

2.354 The closed visits booths were poorly furnished and visitors and prisoners were required to sit on wooden boxes. There was insufficient space for more than one visitor to sit down and we observed one visitor having to stand for an hour during a closed visit.

2.355 Visits could be booked by telephone and by email. Visitors reported long waits and difficulties in getting through on the visits booking line; we were unable to get an answer when we called. Use of the email system was increasing. Visiting orders for all prisoners except those on the enhanced regime were valid for only 14 days.

2.356 There were no family visits or lifer days (see further recommendation 2.308). Other provision included Storybook Dads in the library. Family man and fathers inside courses were run by learning and skills with support from the chaplaincy (see also paragraph 2.335).

2.357 The range of accredited offending behaviour programmes provided was appropriate to some of the needs of the population, with 72 completions of the thinking skills programme and 28 completions of the controlling anger and learning to manage it (CALM) programme a year. Management of waiting lists was appropriate and prisoners were prioritised based on risk and sentence length. Risk levels, length of sentence and responsivity were taken into account. The range of programmes was developing, with the introduction of programmes for substance misuse. Some programmes that were required by the population were not provided, including the healthy relationships and cognitive self-change programmes, and it was difficult to find

places in prisons which provided these. The establishment was piloting the control of violence for angry impulsive drinkers (COVAID) programme, which had been identified as a gap in provision.

2.358 At the time of the inspection, individual work with psychologists was being undertaken with seven prisoners following parole board directions, and some MAPPA-registered prisoners. One prisoner was completing the cognitive self-change programme individually with a visiting psychologist.

Further recommendations

2.359 The wooden box seating in the closed visits booths should be replaced with conventional chairs, and sufficient chairs should be provided for visitors.

2.360 The telephone facility for booking visits should be improved.

2.361 The prison should provide offending behaviour programmes relevant to the population.

Housekeeping point

2.362 A discharge checklist/template should be developed.

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 Prisoners recategorised to category C should be transferred promptly to an establishment appropriate to the progression of their sentence plan. (2.307, see paragraph 2.303)

Recommendations **To the governor**

Courts, escorts and transfers

3.2 Management should seek to increase the use of the video link suite. (2.12)

3.3 The use of the 'open' strip-search area should cease. (2.16, see paragraph 2.13)

3.4 Prisoners should not routinely be handcuffed when embarking and disembarking from cellular vehicles. (2.17, see paragraph 2.13)

3.5 All prisoners should be offered a shower in reception. (2.18, see paragraph 2.14)

3.6 Prisoners should spend as short a period as possible in reception. (2.19, see paragraph 2.15)

First days in custody

3.7 All new receptions who opt to complete the induction programme, and all those new to custody, should be located on the F1 landing. (2.21)

3.8 The induction policy should specify the length of stay on the induction landing and this should be implemented. (2.22)

3.9 The induction process should provide prisoners with sufficient up to date information and the information booklet should be available in an appropriate range of languages. (2.25, see paragraph 2.26)

3.10 Prisoners located on G wing should receive the same induction as that given to other prisoners. (2.26)

3.11 Cells should be cleaned, decorated and suitably equipped for new arrivals. (2.28, see paragraph 2.26)

Residential units

3.12 There should be one telephone available for every 20 prisoners. (2.29)

3.13 Cells designed for one prisoner should not be used for two. (2.30)

3.14 The offensive display policy should be applied consistently. (2.31)

3.15 There should be laundry facilities on each of the wings and they should be in good working order. (2.33)

3.16 Arrangements for the selection and de-selection of prisoners onto and off B1 landing should be set out and applied consistently. (2.34)

3.17 A programme to support prisoners on the B1 landing should be reintroduced. (2.35)

3.18 Rule 45 prisoners should not 'lodge' in the health care centre or segregation unit. (2.47, see paragraph 2.38)

3.19 All prisoners located on C wing should have evening association. (2.48, see paragraph 2.38)

3.20 The B1 landing should not be used as a thoroughfare for prisoner movements. (2.49, see paragraph 2.40)

3.21 There should be formal support arrangements for prisoners with disabilities who require support. (2.50, see paragraph 2.41)

3.22 There should be adapted accommodation available on normal location. (2.51, see paragraph 2.41)

3.23 Prisoners should be issued with more than one set of prison kit. (2.52, see paragraph 2.42)

Progression unit (A1 landing)

3.24 The policy for the progression unit should be updated to reflect current practice and outline how prisoners are selected and de-selected from the unit. (2.2)

3.25 There should be planning for prisoners' reintegration from the progression unit onto other wings and this should be reviewed regularly and include achievable behaviour targets. (2.3)

3.26 A full regime, including purposeful activity, exercise and daily association, should be offered to all prisoners. (2.56)

3.27 'Lodgers' should not be held on the A1 landing. (2.57)

3.28 Formal plans for all prisoners on the progression unit for the delivery of care and its purpose should be developed. (2.58)

Staff-prisoner relationships

3.29 Staff should be encouraged to refer to and about prisoners by their preferred name. (2.62)

Personal officers

3.30 Management checks should include monitoring the quality and the frequency of entries in wing files. (2.66)

3.31 Personal officers should be aware of the particular needs and risks associated with the prisoners in their charge, and this should be reflected in records of their contact with prisoners. (2.67)

3.32 Personal officers should be actively involved in prisoners' sentence planning and support resettlement objectives. (2.70, see paragraph 2.69)

Bullying and violence reduction

3.33 All staff, particularly those in prisoner contact roles, should receive anti-bullying training and refresher training at regular intervals. (2.71)

3.34 Prisoners subject to anti-bullying procedures should have access to appropriate interventions aimed at achieving sustained and agreed changes in behaviour. (2.72)

3.35 The safer custody committee should monitor patterns of violence and intimidation so that any new trends or developments likely to threaten prisoners' safety or feelings of safety are identified and responded to quickly. (2.73)

3.36 A violence reduction survey should be carried out and the findings analysed and acted on. (2.77, see paragraph 2.76)

Self-harm and suicide

3.37 Staff acting as the family liaison officer should be fully trained for the role. (2.80)

3.38 All staff, particularly night duty staff, should receive assessment, care in custody and teamwork (ACCT) foundation training. (2.81)

3.39 Staff should be provided with feedback on ACCT entries, commending good practice and highlighting inadequate or poor practice. Additional guidance and training should be provided for those staff who require it. (2.83)

3.40 A protocol should be introduced for the use of safer cells and the Listeners' suite on A wing; the safer custody committee should monitor the use of these facilities. (2.84)

3.41 Care suites should be available for use in all residential areas. (2.85)

3.42 Listener support sessions during the night should be undertaken with due regard to confidentiality. (2.86)

3.43 First-aid boxes and suicide response kits should be available in all wing offices; they should be secure and replenished following use. (2.87)

3.44 The roles of the reception and induction Listeners should be developed and integrated into the induction policy. (2.95, see paragraph 2.90)

3.45 There should be a uniform system of post-closure review, with qualitative entries made by the case manager. (2.96, see paragraph 2.92)

3.46 The helpline should be monitored daily. (2.97, see paragraph 2.94)

Applications and complaints

3.47 There should be senior management involvement in the quality assurance process for complaints. (2.102)

Substance use

3.48 Prescribing regimens for opiate-dependent prisoners should be flexible and based on individual need. (2.114)

3.49 The prison should provide a designated clinical lead for the substance use team, to enable both clinical management and drug strategy work to be achieved effectively. (2.116)

3.50 The mental health in-reach team's skill mix should include dual diagnosis expertise. (2.118)

Diversity

3.51 There should be an overarching diversity policy that sets out how the diverse needs of all prisoners will be met. (2.127, see paragraph 2.124)

3.52 The disability focus groups should be minuted formally and issues raised should generate action points that are followed up at subsequent meetings until completed. (2.128, see paragraph 2.125)

3.53 A database should be maintained of all prisoners with disabilities, and care plans raised and regularly reviewed for all such prisoners. (2.129, see paragraph 2.125)

Race equality

3.54 All reported racist incidents should be properly investigated by trained staff. (2.130)

3.55 Victim support plans to ensure that prisoners are helped to deal with issues resulting from investigations should be introduced. (2.133)

3.56 Prisoner representatives should be appointed from all residential units. Consideration should be given to the suitability of any representative refusing to engage with other representatives because of their own prejudices. (2.135)

3.57 Arrangements should be made to enable groups of black and minority ethnic prisoners to meet to discuss the issues important to them. (2.136)

3.58 A forum specifically for black and minority ethnic prisoners, distinct from the diversity representatives meeting, should meet regularly to discuss pertinent issues with prison managers. (2.138)

3.59 All racist complaints should be investigated as thoroughly as possible and not left unresolved because a prisoner has been discharged. (2.141, see paragraph 2.139)

3.60 All prisoners should receive a written response to any submitted racist incident report form (RIRF) once it has been investigated. (2.142, see paragraph 2.139)

3.61 When ethnic monitoring data indicate that an ethnic group is consistently over- or under-represented within a specific area (for example, employment or adjudications), appropriate investigations and, where necessary, action to address the issue should be undertaken. (2.143, see paragraph 2.140)

Foreign national prisoners

3.62 Foreign national prisoner representatives should be appointed. (2.144)

3.63 A replacement foreign nationals coordinator should be appointed, either temporarily or permanently, in the continued absence of the current post holder. (2.146)

3.64 The foreign nationals forum should take place as scheduled and not be dependent on the availability of the foreign nationals coordinator. (2.147)

3.65 The facility to translate policies and other official documents should be promoted to all foreign national prisoners, in a language they understand. (2.150)

3.66 Foreign national prisoners should be assisted to access accredited, independent immigration advice and support when necessary. (2.154, see paragraph 2.152)

Health services

3.67 The prison should provide officer escorts for prisoners to attend the health care centre and nursing staff should cease escorting prisoners. (2.7)

3.68 GP clinics should be held in the main health care building, where records and clinical equipment can be accessed easily. (2.8)

3.69 Inpatient beds should not form part of the certified normal accommodation. (2.156)

3.70 Prisoners should not be admitted to the inpatient unit unless there is an identified clinical need. (2.157)

3.71 An electronic patient management system should be introduced as soon as possible. (2.158)

3.72 Published day care programmes should be implemented as soon as possible. (2.159)

3.73 Facilities should be provided so that prisoners are able to dine out of cell. (2.160)

3.74 The F wing treatment room should have a stable door to improve the administration of medicines to prisoners, and a privacy hood should be provided. (2.163)

3.75 Primary mental health staff should be employed predominantly on mental health duties and should attend all mental health referral meetings. (2.166)

3.76 Mental health awareness training should be a regular programme for all prison staff. (2.167)

3.77 Audits of clinical record keeping should be carried out and training made available to remind all health services staff of their professional accountabilities in respect of record keeping. (2.169)

3.78 Health services staff should use the record tracer card system to enable administrative staff to know where clinical records are at all times. (2.170)

3.79 A system should be developed to ensure that all diagnostic test results are logged on receipt, screened by the GP and then filed promptly into the clinical record. (2.171)

3.80 Secondary screening should be mandatory unless specifically refused. (2.174)

3.81 The optician's waiting list should be scrutinised to ensure that all prisoners needing spectacles are seen as soon as possible. (2.178)

3.82 Secondary dispensing should not be undertaken. (2.180)

3.83 Medication should only be given 'in-possession' if properly dispensed in a suitable container. (2.181)

3.84 The timing of medication rounds should be reviewed to ensure that patients get the best treatment possible. (2.182)

3.85 The pharmacist should introduce pharmacy-led clinics. (2.183)

3.86 All prisoners should be risk assessed for in-possession medication on arrival or as soon as practicable. The risk assessment should be repeated when circumstances change. (2.185)

3.87 Supplies of 'special sick' medication should always be recorded on prescription and administration charts. Its use should be monitored. (2.187)

3.88 The local health board (LHB) and the pharmacist should develop a drug formulary, and prescribers should be encouraged to adhere to it. (2.188)

3.89 An audit cycle should be developed to target policy compliance with specific reference to medication/pharmacy-related policies and procedures. (2.190)

3.90 The MTC, through the pharmacy team, should implement medication reviews for prisoners. (2.191)

3.91 Nurses should not be used to escort prisoners to and from the health care department. (2.200, see paragraph 2.193)

3.92 Nurses and health care support staff should all wear an NHS-type uniform, irrespective of their employment status, to distinguish their role as health services staff from that of prison officer. (2.201, see paragraph 2.193)

Learning and skills and work activities

3.93 The library Service Level Agreement should be updated to ensure that the service continues to develop. (2.211)

3.94 The stock of books in foreign languages should be increased to meet the needs of the foreign national population. (2.217, see paragraph 2.216)

Time out of cell

3.95 Staff should supervise exercise within the security fence and should use this time to interact with prisoners. (2.222, see paragraph 2.220)

Security and rules

3.96 Target searching should be carried out within a reasonable timeframe and records kept of this. (2.230, see paragraph 2.225)

3.97 Prisoner access to activities should not be impeded by consideration of security information dating back more than six months. (2.231, see paragraph 2.226)

3.98 Prisoners should only be placed on closed visits as a result of intelligence or incidents related to visits. (2.232, see paragraph 2.227)

3.99 Prisoners should be removed from the escape list if no further intelligence comes to light that suggests that they pose an escape risk. (2.233, see paragraph 2.228)

3.100 Prisoners should be able to have bananas and oranges. (2.234, see paragraph 2.229)

Discipline

3.101 The punishment tariff should be made known to prisoners before adjudication. (2.235)

3.102 Planned use of force interventions should be video-recorded. (2.236)

3.103 The regime for longer-stay prisoners in the segregation unit should be improved to include some out-of-cell purposeful activity. (2.237)

3.104 All adjudication records should show a full investigation of the charges. (2.250, see paragraph 2.238)

3.105 Prisoners should not be given 100% loss of earnings as a punishment. (2.251, see paragraph 2.239)

3.106 Adjudication hearings should be conducted in a more suitable location. (2.252, see paragraph 2.240)

3.107 Adjudication documents should be quality checked and adjudication statistics monitored and analysed. (2.253, see paragraph 2.241)

3.108 The year-on-year increase in use of force should be investigated and action taken if required. (2.254, see paragraph 2.242)

3.109 Use of force should be certified by a manager not involved in the incident. (2.255, see paragraph 2.242)

3.110 Management checks of use of force documentation and monitoring and analysis of statistics should be carried out to identify and act upon trends. (2.256, see paragraph 2.242)

3.111 Segregation unit cells should be cleaned of graffiti and redecorated. (2.257, see paragraph 2.244)

3.112 Care planning and reintegration protocols should be developed and introduced on the segregation unit. (2.258, see paragraph 2.248)

Incentives and earned privileges

3.113 The incentives and earned privileges (IEP) scheme should be connected to sentence planning, and prisoners motivated to achieve agreed targets and objectives. (2.259)

3.114 Prisoners on enhanced status should have the same access to association, irrespective of where they are located. (2.263, see paragraph 2.261)

3.115 The IEP policy should be fully reviewed and updated, for example to ensure appropriate differentials, and applied consistently. (2.264, see paragraph 2.260)

Catering

3.116 The midday meal should not be served before noon. (2.265)

3.117 There should be opportunity for the longer-term prisoners on E wing to prepare their own food. (2.267)

Prison shop

3.118 The results of prisoner surveys should be communicated to prisoners and should influence the range of products on the shop list. (2.272)

3.119 Prisoners should be able to receive a full shop order within 24 hours of arrival. (2.277)

Offender management and planning

3.120 The strategy for E wing as a lifer unit should be clarified and implemented, and there should be accountable management of all life-sentenced and indeterminate-sentenced prisoners held in the establishment. (2.11)

3.121 Security staff should always be represented at the monthly public protection panel meetings. (2.291)

3.122 The establishment should make greater use of the release on temporary licence facility to assist the resettlement of prisoners. (2.292)

3.123 Residential and lifer casework managers should hold monthly consultation meetings with life-sentenced prisoners and those serving indeterminate sentences for public protection (IPP). (2.294)

3.124 All life-sentenced prisoners should be allocated a lifer-trained personal officer, and receive an information pack. (2.296)

3.125 All OASys assessments should be completed in the required timescale. (2.305, see paragraph 2.299)

3.126 There should be a system to provide management oversight of all outstanding assessments and sentence plans. (2.306, see paragraph 2.299)

3.127 Lifer days or family days should be provided for all prisoners at least twice a year. (2.308, see paragraph 2.304)

Resettlement pathways

3.128 The establishment should accredit the work of those prisoners carrying out the housing needs assessment and offering advice in reception. (2.309)

3.129 Subject to risk assessment and identified need as part of a formal resettlement plan, all category C and D prisoners should have the opportunity to apply for work or education in the community during at least the final three months of their sentence. (2.312)

3.130 The post of CARAT manager should be made full time. (2.316)

3.131 The voluntary/compliance drug testing compact should be reviewed, and its purpose clarified. (2.320)

3.132 There should be no upper limit set for the number of visits that remand prisoners can receive. (3.322)

3.133 There should be a properly functioning visitors centre. (3.323)

3.134 An alternative to the perspex divide in the visitors centre should be sought. (3.326)

3.135 Visitors should be searched in private, and staff should use prisoners' chosen names when calling visitors into the visits room. (3.327)

3.136 Visitors should not be strip-searched, but offered a closed visit if there is reliable intelligence that security may be breached. (3.328)

3.137 The establishment should introduce family-friendly furniture to the visits room and the layout should be conducive to relaxed conversations. (3.329)

3.138 The canteen in the visits room should be open for every visits session. (3.331)

3.139 The closed visits facility should not be in full view of the main hall. (2.332)

3.140 Prisoners should not be required to wear bibs on visits. (2.333)

3.141 The visits holding rooms should be decorated and some visual stimulation should be installed. Staff should enquire into the whereabouts of visitors who have not arrived 15 minutes after the session has started. (2.334)

3.142 Alternative interventions should be available for determinate-sentenced prisoners who are assessed as unsuitable for the existing programmes. (2.336)

3.143 The wooden box seating in the closed visits booths should be replaced with conventional chairs, and sufficient chairs should be provided for visitors. (2.359, see paragraph 2.354)

3.144 The telephone facility for booking visits should be improved. (2.360, see paragraph 2.355)

3.145 The prison should provide offending behaviour programmes relevant to the population. (2.361, see paragraph 2.357)

Housekeeping points

First days in custody

3.146 The induction programme should have a clear timetable. (2.23)

Residential units

3.147 Notices should be available in languages relevant to the population. (2.53, see paragraph 2.42)

3.148 Prisoner representatives from all wings should attend the consultation meetings. (2.54, see paragraph 2.42)

3.149 Monies, cheques and postal orders received in prisoners' mail should be kept secure at all times. (2.55, see paragraph 2.45)

Bullying and violence reduction

3.150 Staff should give full written details of all interactions with prisoners in anti-bullying booklets. (2.78, see paragraph 2.74)

Self-harm and suicide

3.151 Care plan objectives should be time bound. (2.98, see paragraph 2.92)

Applications and complaints

3.152 Application forms should be freely available on all residential units. (2.100)

3.153 Complaint forms should be available in a range of appropriate languages. (2.106, see paragraph 2.104)

Foreign national prisoners

3.154 Accurate records of staff and prisoners able to speak languages other than English should be kept and published to all staff. (2.155, see paragraph 2.153)

Health services

3.155 The prison should assess the need for making 'ready specs' available for prisoners. (2.179)

3.156 The number of external health care appointments cancelled unnecessarily should be monitored and reduced. (2.202, see paragraph 2.198)

Time out of cell

3.157 There should be a published core day for the B1 landing. (2.223, see paragraph 2.221)

Strategic management of resettlement

3.158 The lead for the mental and physical health pathway should attend resettlement committee meetings. (2.281)

3.159 Agreed actions should have a completion date set and recorded in the minutes. (2.285)

Resettlement pathways

3.160 The drug strategy meeting should be chaired by the deputy governor or a delegated representative and there should be regular attendance by appropriate prison staff. (2.321)

3.161 A discharge checklist/template should be developed. (2.362, see paragraph 2.343)

Good practice

Health services

3.162 A review of in-possession prescribing by wing had enabled staff to look at how the proportion of prisoners on in-possession medication could be increased safely. (2.203, see paragraph 2.196)

Appendix I: Inspection team

Vinnett Pearcy	Team leader
Karen Dillon	Inspector
Martin Owens	Inspector
Paul Rowlands	Inspector
Andrew Rooke	Inspector
Nicola Rabjohns	Health care inspector
Eleanor Davies	ESTYN inspector

Appendix II: Prison population profile

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

Status	21 and over	%
Sentenced	497	62
Recall	3	0.4
Convicted unsentenced	128	16.4
Remand	136	17
Civil prisoners	3	0.4
Detainees	8	1
Total	**797**	**100**

Sentence	21 and over	%
Unsentenced	259	32.5
Less than 6 months	77	9.5
6 months to less than 12 months	43	5.4
12 months to less than 2 years	83	10.4
2 years to less than 4 years	121	15
4 years to less than 10 years	99	12.8
10 years and over (not life)	9	1.1
ISPP		
Life	106	13.3
Total	**797**	**100**

Age	Number of prisoners	%
Please state minimum age	21	
Under 21 years		
21 years to 29 years	343	43.1
30 years to 39 years	271	34.1
40 years to 49 years	117	14.7
50 years to 59 years	34	4.1
60 years to 69 years	23	2.89
70 plus years	9	1.13
Please state maximum age	83	
Total	**797**	**100**

Nationality	21 and over	%
British	700	87.8
Foreign nationals	59	7.4
Total	**797**	**100**

Security category	21 and over	%
Uncategorised unsentenced	0	
Uncategorised sentenced	1	0.15
Category A	0	
Category B	52	6.5
Category C	150	18.7
Cat D	2	0.25
Other	592	74.3
Total	**797**	**100**

Ethnicity	21 and over	%
White		
British	637	79.9
Irish	2	0.25
Other white	19	2.38
Mixed		
White and black Caribbean	28	3.51
White and black African	7	0.88
White and Asian	1	0.13
Other mixed	7	0.88
Asian or Asian British		
Indian	11	1.38
Pakistani	8	1
Bangladeshi	1	0.13
Other Asian	8	1
Black or black British		
Caribbean	18	2.26
African	15	1.88
Other black	9	1.13
Chinese or other ethnic group		
Chinese	2	0.25
Other ethnic group	5	0.63
Not stated	17	2.13
Refused	2	0.25
Total	**797**	**100**

Religion	21 and over	%
Baptist	2	0.25
Church of England	64	8.12
Roman Catholic	81	10.23
Other Christian denominations	256	32.5
Muslim	79	10.03
Sikh	1	0.13
Hindu	3	0.38
Buddhist	11	1.4
Jewish	0	0
Other	13	1.65
No religion	287	36
Total	**797**	**100**

Sentenced prisoners only

Length of stay	21 and over	
	Number	%
Less than 1 month	86	15
1 month to 3 months	222	39
3 months to 6 months	136	24
6 months to 1 year	75	13

1 year to 2 years	34	6
2 years to 4 years	8	1.4
4 years or more	4	0.7
Total	**565**	**100**

Unsentenced prisoners only

Length of stay	21 and over	
	Number	**%**
Less than 1 month	103	44.4
1 month to 3 months	113	48.71
3 months to 6 months	14	6.03
6 months to 1 year	2	0.86
1 year to 2 years	0	0
2 years to 4 years	0	0
4 years or more	0	0
Total	**232**	**100**

Main offence	21 and over	%
Violence against the person	255	32.4
Sexual offences	103	13
Burglary	125	15.5
Robbery	48	6
Theft and handling	54	6.7
Fraud and forgery	13	1.6
Drugs offences	44	5.5
Other offences	133	16.5
Civil offences	3	0.34
Offence not recorded/holding warrant	19	2.4
Total	**797**	**100**