Report on an unannounced short follow-up inspection of

# HMP & YOI Elmley

28–30 April 2009

by HM Chief Inspector of Prisons

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# Contents

# Introduction

Elmley is a local prison for adult and young adult male prisoners on the Isle of Sheppey. It is managed as part of a cluster with the two other prisons on the Isle. When we last inspected we described it as well managed, but struggling with the consequences of an overcrowded system. On our return for this unannounced short follow-up inspection, we found a slightly less pressurised prison that had improved or sustained performance in a number of areas, but still lacked sufficient purposeful activity.

Elmley had made progress on many of our recommendations to improve safety. Early days in custody were generally well managed, with good use of prisoner orderlies and an increase in the use of video links that had reduced the need for some escorts. However, the holding cells in reception remained grubby, and first night processes needed further tightening. There had been some improvements in violence reduction and anti-bullying arrangements, although more remained to be done. There had also been a reduction in the use of force and of the segregation unit. There were now fewer vulnerable prisoners who were housed in more appropriate accommodation. Improved drug treatment services were available.

Tragically, there had been three deaths in custody since our last visit, but we nevertheless identified some improvements in suicide prevention procedures. However, we remained very concerned by the inadequate governance and monitoring of those in such extreme distress that the prison felt it necessary to keep them in special accommodation, sometimes in strip clothing in healthcare. We believe that such a response to those at risk of suicide or self-harm is very rarely justified, and the lack of adequate management oversight was unacceptable.

The quality and cleanliness of accommodation varied, and house block 5 remained overcrowded and unpleasant. Staff-prisoner relations continued to be good, although not supported by a functioning personal officer scheme or effective incentives and privileges (IEP) scheme. Work on diversity issues required further development, particularly at a strategic level to broaden the agenda and build on the positive elements that had been put in place. The chaplaincy continued to provide a good service, and health services had improved.

There had been very little progress in expanding purposeful activity. Time out of cell for most prisoners remained poor. It was depressing to find that there were now fewer activity places than at the last inspection, with sufficient to meet the needs of only about half the population. The quality and quantity of education were satisfactory. The library was little used, but physical education provision was excellent.

Resettlement and offender management work was delivered on a cluster basis and, while there had been some progress, attention to the particular needs of prisoners at Elmley appeared limited. For example, there were no Elmley-specific policies, needs analyses or action plans to address the prison's largely short-term or remand population. The quality of provision along the resettlement pathways varied.

Elmley is a busy local prison and its transient population presents a wide array of risks and needs. There had been some progress since our last inspection and the prison was slightly less crowded, except for one house block. Aspects of work to ensure safety had improved, although we remained very concerned by the arrangements to manage prisoners at risk of suicide or self-harm. Some of the strengths that we had previously identified had been

sustained, for example the good staff-prisoner relationships. However, there was still far too little purposeful activity, and the prison appeared to gain little benefit from the clustering of resettlement arrangements with its neighbouring prisons.

Anne Owers June 2009
HM Chief Inspector of Prisons

# Fact page

Task of the establishment
Core local prison for adult and young adult male prisoners.

Area organisation
Kent and Sussex

Number held
942

Certified normal accommodation
753

Operational capacity
985

Last inspection
Full inspection: December 2006

Brief history
Elmley is a purpose-built local prison serving all courts in the county of Kent. The establishment opened in 1992 and includes a category C unit for up to 240 prisoners built in 1997. Elmley is the largest of the three prisons in the Sheppey cluster.

Description of residential units
Five house blocks hold between 183 and 240 prisoners each in single, double and treble cells. A sixth house block with single and double cell accommodation is under construction.

# 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 2006 and examine progress achieved. We have commented where we have found significant improvements and where we believe little or no progress has been made and work remained to be done. All inspection reports include a summary of an establishment's performance against the model of a healthy prison. The four criteria of a healthy prison are:

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

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

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

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

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

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

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

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

## Safety

HP4 In 2006, we judged Elmley to be not performing sufficiently well against this healthy prison test and made 50 recommendations. At this short follow-up inspection we found that 20 of the recommendations had been achieved, 15 partially achieved and 14 not achieved; one was no longer relevant.

HP5 Working relationships between the prison staff and contracted escort staff were good, and prisoner escort records were completed properly and legibly. Late arrivals from court were rare, and police cells were no longer used to accommodate prisoners overnight. Improved use of the video link had reduced the need for some escorts.

HP6 Reception was welcoming, with facilities to interview new arrivals in private, and prisoners were processed without undue delay. Although the condition of most holding rooms had improved, some remained stark, dirty and poorly equipped.

HP7 All new arrivals, including vulnerable prisoners, were located on the first night centre on house block 1. As at the last inspection, there were no dedicated first night cells, and handovers to night staff did not routinely include information on the location of new prisoners. There was an effective peer support scheme with trained prisoner Insiders who gave advice and support to all new arrivals on the day of their arrival.

HP8 The five-day induction programme addressed relevant issues, including information on how to access prison services and how to get help if required, and made good use of peer supporters. Trained prisoners helped deliver many of the induction modules, and supported individual prisoners during their first week. The atmosphere on the induction unit was constructive, although prisoners spent significant periods in their cell between sessions.

HP9 A violence reduction coordinator had recently been appointed. Thirteen staff had been trained as violence reduction liaison officers for the house blocks, and there were nine violence reduction prisoner representatives. The violence reduction policy required revision. There was good attendance at the monthly violence reduction meetings, which included prisoner representation. However, the committee's links with the security department, and analysis of data and trends, were underdeveloped. . Application of the three-stage anti-bullying procedure was limited. About 33 threatening or violent incidents, including assaults, were recorded each month, although the general atmosphere in the prison was settled and relaxed.

HP10 A comprehensive suicide prevention and self-harm management policy document had been reissued in September 2008 and monthly suicide prevention meetings took place. Assessment, care in custody and teamwork (ACCT) self-harm monitoring documents varied in quality, but there were post-closure reviews and prisoners received a questionnaire about their treatment under ACCT at its conclusion. There were no interventions for prisoners in crisis, although there was a large number of

Listeners and a crisis suite on one of the house blocks. We remained concerned that some prisoners in a self-harm crisis were held in special accommodation and/or in strip conditions in health services. As we found last time, there was no proper recording or governance of this arrangement, although there was no evidence that it occurred routinely. There had been three deaths in custody in the last two years, but no interim action plans had been developed.

HP11 Security systems and procedures were applied in a balanced and proportionate manner. The security department was intelligence-led with effective systems to process and analyse information. Dynamic security was in place, underpinned by good staff-prisoner relationships. There was a large numbers of security information reports (1,610 in 2009 to date), which were processed quickly with timely and appropriate action taken. Searching targets were met, but there were delays in intelligence-led searches and suspicion drug testing.

HP12 The number of formal adjudications was proportionate, procedures were properly conducted and fair, and charges were correctly explained to individuals. Adjudication standardisation meetings took place quarterly. Punishment tariffs had been published and were used consistently at formal hearings.

HP13 Use of force did not appear to be excessive for the size of the population, with 58 incidents in the first quarter of 2009. There had been a significant reduction in the number of incidents compared with the same period in 2008. The use of force committee met monthly to analyse information about all incidents. Trends and problem areas were identified, but links with the overarching violence reduction strategy were not well developed. There had been a marked reduction in the use of special cells in the segregation unit and governance arrangements had improved. However, we were not assured that that the use of the high-dependency cells in the health services department – where some prisoners had been placed in strip conditions during self-harm crises – was always properly authorised or monitored, or that staff were aware of the protocols for their use.

HP14 Conditions in the segregation unit were reasonable. However, the two special cells had only a concrete plinth and no mattress, as well as strip clothing and blankets. There had been a reduction in the number of prisoners segregated, particularly for their own protection, since our last inspection. Young adult vulnerable prisoners were no longer held routinely in segregation. However, the reintegration of prisoners segregated under good order or discipline to normal prison location was underdeveloped. Written observations in personal files had improved, and staff-prisoner relationships were good. The segregation regime remained limited, with no guarantee of daily access to basic amenities such as showers.

HP15 The prison reported an annual figure of 10.8% for positive mandatory drug tests against a target of 11.5%. A considerable number of suspicion drug tests were completed, but 56 had been missed in the previous six months. The integrated drug treatment system (IDTS) was now well established, and more than 130 prisoners were on maintenance programmes.

HP16 Vulnerable prisoners were now located on two spurs of house block 1, rather than in one whole house block, as at the last inspection. We were told that this now reflected the number of vulnerable prisoners at Elmley, following the transfer of many to nearby Maidstone prison. Young adult vulnerable prisoners were held on these spurs, but did

not share cells with adults and were subject to risk assessment. Vulnerable prisoners had a generally equitable access to regime, and appeared to feel safe.

HP17 At the conclusion of this short follow-up inspection, we noted measurable improvements to IDTS, some improvement to the management of vulnerable prisoners as well as other indicators to suggest Elmley was a reasonably safe prison. On that basis, we assessed that Elmley was now performing reasonably well against this healthy prison test.

## Respect

HP18 In 2006, we judged Elmley to be performing reasonably well against this healthy prison test. We made 54 recommendations, 28 of which had been achieved, 10 partially achieved and 16 not achieved.

HP19 With the exception of house block 5, communal areas on the residential units were reasonable. Many cells were clean and properly furnished but some, particularly the multi-occupied cells on house blocks 1 to 4, were dirty and had only a single table and chair. The toilets were filthy, and there was graffiti on walls and ceilings. The offensive display policy was not enforced effectively. As at the last inspection, living conditions on house block 5 were poor. Communal areas were grubby and all cells were doubled. The furnishing in these cells and the screening of toilets were inadequate. Although some areas of the prison grounds were well kept, many outside areas near to cells were littered with rubbish and had large amounts of bird droppings.

HP20 The majority of prisoners were on the standard regime of the incentives and earned privileges (IEP) scheme. Just under a fifth were enhanced status, and eight prisoners were on basic regime. Quality assurance of the IEP scheme was limited, and we were not assured that it was applied consistently or was a useful motivational tool.

HP21 The quality of relationships between staff and prisoners was good, as at our last inspection. Prisoners spoke positively about staff, and staff had a generally positive approach toward prisoners. The personal officer scheme was limited, with little in place. Records in prisoner wing files were of limited value, and most entries were merely about warnings given.

HP22 The kitchen was clean and well ordered. Meals were varied and included healthy options. Prisoner consultation meetings took place every month, and there were prisoner food representatives on all house blocks. A biannual survey was used to inform changes to the three-week menu cycle. There were food comments forms on the wing serveries, and the catering manager made individual replies.

HP23 The contract for the prison shop had been taken over by DHL Booker in February 2009. It was too early to ascertain the effectiveness of the new contract, although there seemed to be some inflexibility in allowing new prisoners to make orders if they arrived after the weekly deadline for these, or if a prisoner had been out at a court appearance on the day. There had been no shop survey for some time, although there was a regular shop meeting with wing-based prisoner shop representatives. The number of goods available had risen slightly since our last inspection.

HP24 The diversity policy encompassed race equality but was not strategic, and failed to address sexuality or age adequately. As a consequence, work on these aspects of diversity was limited. There was a bi-monthly diversity and race equality action team meeting, chaired by the governor, supplemented by separate meetings with prisoner diversity representatives.

HP25 Peer supporters completed basic disability assessment questionnaires for all new arrivals, and passed on relevant concerns to staff or the diversity officer to be progressed. About 100 prisoners had a self-declared disability. There was a register of these prisoners, which highlighted the requirement for periodic case review if necessary.

HP26 Approximately 23% of Elmley's population was from a black and minority ethnic background. The race equality aspect of the diversity policy was limited. One member of staff was the diversity manager, although he was supported by a network of about 15 prisoner diversity representatives. The management of racist complaints was generally good, with effective follow-up arrangements with prisoners and meaningful quality assurance structures. There was also some evidence that the prison took the concerns and perceptions of black and minority ethnic prisoners seriously, such as producing figures on equality of access to work in the prison.

HP27 The foreign nationals policy was thorough but out of date, and there was currently no coordinator to address the needs of foreign national prisoners. A large number of foreign national prisoners had been moved to house block 4 to improve peer support, but staff had not been well prepared for this. Links with the UK Border Agency had faltered, although two immigration surgeries had been planned. There was a register of foreign language speakers, and a handbook in different languages offered some written information about the prison to non-English speakers. A weekly foreign national peer support meeting continued to be held in the chapel.

HP28 Applications were managed through a simple logbook combined with a large range of application forms for different purposes. Although applications could be recorded, there was no follow up or tracking. There had been about 3,000 formal complaints in 2008. Quality assurance arrangements for complaints were inadequate, and a significant number of responses were unsatisfactory in tone or content. The prison had a full-time legal services officer as well as a bail information officer.

HP29 There was an active chaplaincy, which supported religious needs and the wider work of the establishment, such as suicide and self-harm prevention. There was a range of services and faith-based groups and attendance was good. For example, a large number of prisoners attended weekly Islamic teaching, which was also open to non-Muslims.

HP30 Health services were much improved since our last inspection. Primary care included two GP clinics daily, health promotion and access to a variety of specialist clinics. Reception procedures and the health screening of new arrivals were good, but secondary health screening was often carried out without the prisoner's complete clinical record. Primary mental health provision was more limited, but prisoners with an enduring condition received a reasonable service. Pharmacy services had improved. Staffing levels and skill mix were good, despite a reliance on agency staff. Inpatient arrangements were reasonable, and their time out of cell was satisfactory, but patients needed more activity.

HP31 At this short follow-up inspection, we concluded that Elmley continued to perform reasonably well against this healthy prison test.

## Purposeful activity

HP32 At our previous inspection, we judged that Elmley was not performing sufficiently well against this healthy prison test and made 10 recommendations. Four of those recommendations were achieved, one partially achieved and five were not achieved.

HP33 Education was provided by A4E, but there was no separate contractor for the provision of information, advice and guidance (IAG). There was no education centre and learning took place in classes on the house blocks. Punctuality had improved since our last inspection. The curriculum had also broadened and was based on an analysis of prisoner need. Classroom provision was complemented by some outreach work in to the gym and workshops, and some open and distance learning was also available. There were the full-time equivalent of 90 education places, but as most of these were part-time, the number of prisoners who took part was much greater. Teaching, learning and achievement were all judged to be satisfactory.

HP34 There was a good quality library, but it was little used. As at our last inspection, only about 10% of the population used the library, and even those who managed to get there were not able to stay for long.

HP35 There were sufficient activity places, excluding offending behaviour programmes, to meet the needs of just over half the population. Most employment opportunities were mundane, and the quantity and quality of most accredited and vocational training were very limited.

HP36 There were excellent PE facilities, with places in sports activity for up to 200 prisoners a day. Prisoner access was reasonably equitable, and there was some accredited learning in addition to recreational activity. The gym also had links with education.

HP37 For the few prisoners fully engaged with the regime, time out of cell exceeded nine hours a day. For those not engaged, it was likely to be between four and seven hours. Association was provided every evening, although there was evidence of cancellations. The provision of exercise appeared to vary across the wings, but prisoners had domestic time during the day when they could access amenities.

HP38 On the basis of this short follow-up inspection, we considered that Elmley was still not performing sufficiently well against this healthy prison test.

## Resettlement

HP39 In 2006, we concluded that Elmley was performing reasonably well against this healthy prison test but made 25 recommendations. At this short follow-up inspection, we found that seven recommendations had been achieved, six partially achieved and 11 were not achieved. One recommendation was no longer relevant.

HP40 Resettlement work was incorporated into the wider Sheppey prison cluster reducing reoffending model. Strategic leads for the cluster met monthly, but there was currently no specific Elmley policy, action plan or needs analysis. The prison operated to a comprehensive, but now out-of-date cluster service level agreement (SLA). There

was no mechanism or planning arrangement for Elmley to ensure the integration of resettlement services for its prisoners.

HP41 The development of resettlement pathway work varied and some required development and better coordination. All prisoners were seen at induction and had a basic analysis of their needs against the pathways. How this information was used, however, varied greatly. There was no custody planning for prisoners on remand or sentences of less than 12 months, the majority of prisoners in the establishment.

HP42 The mechanism and model for offender management were reasonable. All prisoners serving over 12 months were subject to offender assessment system (OASys) assessment and were allocated an offender supervisor. For those in scope of formal offender management, about 195 prisoners, levels of recorded contact was good. A sentence plan was constructed for prisoners out of scope of offender management, but their contact with the offender management unit (OMU) was then limited to specific requests on application. Links with offender managers in the community were reasonable, and public protection procedures were effective.

HP43 The prison held more than 50 life-sentenced prisoners and just under 40 prisoners on indeterminate sentences for public protection (IPPs). IPPs and lifers were allocated to offender supervisors, although this had only recently been introduced. Provision for lifers was limited, but they were prioritised for offending behaviour programmes where necessary. There were no longer any lifer groups or lifer representatives on the wings. Since August 2008, 27 mandatory lifers had been allocated to training prisons.

HP44 All new arrivals were offered a basic initial housing assessment, sometimes undertaken by trained peer supporters. Where appropriate, and requested, further advice and support was offered with reasonable access to a range of accommodation providers, mostly within the area. In the last six months, 99% of prisoners released had an address to go to. Initial assessments by peer supporters during induction addressed finance and debt issues, but services were underdeveloped. There was no specialist support other than some limited signposting to services outside the prison.

HP45 Jobcentre Plus staff offered a job search facility through the cluster IAG department. The library had a computer resource to support CV and letter writing, and a member of the education staff provided additional support to assist access to training on release. Prisoners could attend a 'transit to work' course before release to develop job application skills, and there was a 'starting a business venture' course for those seeking self-employment.

HP46 The prison had effective arrangements with community-based mental health teams to ensure support for relevant prisoners on release. All released prisoners were helped to access GP services, and supplied with necessary medications if required.

HP47 The counselling, assessment, referral, advice and throughcare (CARAT) service had a caseload of 474 and provided a range of one-to-one and groupwork interventions. Partnership working with IDTS was effective, but support for prisoners with alcohol issues was less well developed. A large number of prisoners had completed the short duration drug (SDP) and P-ASRO (prison addressing substance related offending) programmes.

HP48 There was an excellent visits facility, supported by a welcoming visitors' centre. Visits were available daily and booking arrangements were good. There was some limited

work with Relate in support of families and relationships, but in other respects, work on the families and children pathway was limited.

HP49 Programmes were provided and managed centrally in the cluster. Provision included enhanced thinking skills (ETS), cognitive skills booster and CALM (controlling anger and learning to manage it). A non-accredited programme on victim work, designed for IPPs, was scheduled to run in May 2009.

HP50 On the basis of this short follow-up inspection, we considered that Elmley continued to perform reasonably well against this healthy prison test.

# Section 2: Progress since the last report

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

## Main recommendations (from the previous report)

2.1 The violence reduction strategy should be fully implemented, and the violence reduction committee should oversee the implementation. (HP48)

Partially achieved. There was some staff awareness of the violence reduction strategy and its sanctions to manage bullying and intimidation. Basic data indicated that the strategy was deployed and that prisoners were managed through its three stages. The violence reduction committee meetings had not paid sufficient attention to the content, development and level of awareness of the strategy. The strategy's approach to anti-bullying seemed limited, and the scheme was not supported by sufficiently detailed recording of anti-bullying management or quality assurance.

Further recommendation

2.2 The violence reduction strategy should be updated and relaunched, and the violence reduction committee should oversee its implementation.

2.3 Unfurnished accommodation should not be used to manage suicidal or self-harming behaviour. (HP49)

Not achieved. Unfurnished accommodation in the healthcare centre was still sometimes used to manage prisoners in crisis and at risk of suicide or self-harm. Prisoners in crisis were also sometimes put in strip clothing in unfurnished accommodation. There was no log in the health services department to indicate how frequently this occurred (see recommendation 2.170), and there was a lack of governance in this area. The safer custody coordinator reported that she was not always advised when prisoners were placed in strip clothing or unfurnished accommodation.

Further recommendations

2.4 Unfurnished accommodation should only be used to manage prisoners who are self-harming in the most exceptional circumstances.

2.5 The safer custody coordinator should always be advised when prisoners subject to assessment, care in custody and teamwork (ACCT) self-harm monitoring are placed in unfurnished accommodation or strip clothing.

2.6 An operational instruction should be drawn up clarifying the occasions on which all the different types of unfurnished, or partially furnished, special accommodation in the segregation unit and healthcare centre can be used. The instruction should cover the level of authorisation and ongoing governance required to locate or retain a prisoner in one of these cells. (HP50)

Not achieved. Although we were told that an operational instruction had been issued in 2007 clarifying the occasions when the different types of special accommodation at Elmley could be used, it could not be produced during our inspection. We could not find copies of the document on any of the residential units, the health services department or the segregation unit. Although staff in the segregation unit were aware of the circumstances and general protocols for use of special accommodation (as detailed in Prison Service Order 1700 on segregation and use of special accommodation), staff elsewhere in the prison were not. As at the last inspection, the four designated high-dependency cells in the health services department had been used as strip cells for prisoners as part of a self-harm reduction strategy without the normal safeguards of authorisation and governance associated with the use of special accommodation. Although health services staff said that these occasions were rare, there were no records of use of these cells. We were not assured that proper authority was given or that occurrences were justified. Staff were clearly unaware of the Prison Service procedures for the use of special accommodation.

Further recommendation

2.7 Prison Service procedures for the use of special accommodation should be incorporated into an operational instruction, which also covers level of authorisation and governance of use. Staff should be trained in the procedures, which should be applied in line with the instruction.

2.8 The primary care trust (PCT), in partnership with the establishment, should undertake a thorough review of current clinical management arrangements for substance-dependent prisoners, to ensure the safety of both prisoners and staff. (HP51)

Partially achieved. The prison had made significant progress in accommodation and staffing to treat substance-dependent prisoners. However, the increase in the population meant that current facilities and staffing were under-resourced to meet the needs of these prisoners. Although the clinical management of prisoners was appropriate and safe, the facilities needed further improvement. Building work on further accommodation was in progress, rooms were being refurbished and electronic clinical information systems were being installed. House block 5 was clinically unsafe for the administration of medicines. Medicines were transported safely, but there was some risk in the administration of controlled drugs

Further recommendation

2.9 The administration of medicines in house block 5 should take place in a safe and appropriate environment.

2.10 Vulnerable young adults should not be held in the segregation unit. (HP 52)

Achieved. The segregation unit was not used to accommodate vulnerable young prisoners.

2.11 The staffing complement for the establishment should include nursing staff with qualifications, skills and competencies to be able to provide services that correspond to patient need. (HP53)

Achieved. The current workforce provided a range of skills and competencies, which largely met the needs of prisoners. Gaps, such as podiatry, were catered for through visiting health professionals and, where appropriate, prisoners were taken to external health providers for

specialist appointments. The current workforce plan was under constant review due to the ongoing changes and improvements in health provision for prisoners. A recruiting campaign had been relatively successful given the prison's geographical position, and there had been significant increases in nursing and support workers. The strategic lead healthcare manager for the Elmley cluster oversaw links with external stakeholders and delivery of a strategic healthcare service, and other leads included a head of cluster healthcare, head of professional development and a business manager. The current nursing team comprised 28 trained nurses, including 18 agency nurses, three healthcare assistants and four trainee healthcare officers undergoing national vocational qualification level three training. Professional qualifications included 10 registered general nurses (RGNs), including one hospital officer, 14 registered mental health nurses (RMNs) and four RGN/RMNs. Many of the nursing staff had additional qualifications, including the management of patients with diabetes, asthma, cardiac and sexual health conditions. Administrative staff included 3.5 whole-time equivalent full- and part-time workers.

2.12 More activity and work should be provided and include more education and accredited training. (HP54)

Not achieved. There were sufficient activity places, mostly full time, for approximately 600 prisoners, including those working in the workshops, key workers and workers on house blocks. The number of places had reduced due to refurbishment and relocation of some areas, including 50 places in education and work. Much of the work was repetitive and mundane, and still lacked employment-related training and accreditation. There were approximately 90 full-time equivalent education places, predominately part time, with learning opportunities for 160 prisoners. The range of education courses had increased since the last inspection and was clearly linked to a prisoner needs analysis. There were no evening education classes.
We repeat the recommendation.

2.13 There should be much greater integration of resettlement services across the range of pathways. A properly equipped facility should be found to enable everyone working on reintegration services to be brought together to provide effective and coordinated provision, easily accessible by all prisoners approaching release. (HP55)

Partially achieved. Four of the resettlement pathways had come under the wider management of the information, advice and guidance (IAG) department, which was headed by a principal officer and senior officer who worked across the cluster. The cluster group included two officers based at Elmley working primarily with the accommodation and finance, benefit and debt pathways, as well as two officers who covered the children and family pathway, an education, training and employment (ETE) worker and six prisoner peer advisers. Four peer advisers were allocated to induction assessments and two to support the pre-release ETE assessments. Despite this work, some provision, in particular that relating to the children and families and finance, benefit and debt pathways, remained underdeveloped. Custody and sentence planning remained limited for prisoners not subject to offender management support (see paragraph 2.247). There were few, if any, links to offending behaviour programmes for this group, drug and alcohol services continued to operate separately, and, other than a check on access to general practitioners on release, the mental and physical health pathway functioned alone. Elmley had no specific forum or strategy to integrate resettlement services effectively. (See also further recommendation 2.246.)
We repeat the recommendation.

# Recommendations

## Courts, escorts and transfer

2.14 Prisoners should arrive at the prison before 7pm; any prisoners arriving after that time should still receive full reception and first night procedures. (1.12)

Achieved. At the time of inspection, prisoners were not routinely held in police cells for long periods, as they had been at the previous inspection under operation safeguard. Prison records showed that late arrivals were rare and when they occurred – for extraordinary reasons such as vehicle breakdown – reception remained open to ensure that prisoners had full access to all the reception and first night procedures.

2.15 Prisoners should be held in court cells for the minimum possible period. (1.13)

Achieved. The monitoring data we examined showed that prisoners did not remain in court cells for extended periods, and were taken to the prison promptly. New arrivals told us that they had remained in court cells for a maximum of two hours following their court appearance, which was an improvement on the five hours reported at the previous inspection.

2.16 Prisoners on escort vehicles should be given comfort breaks at least every two and a half hours. (1.14)

Achieved. Most prisoners arrived from courts in the Kent area so journeys over two hours were rare, and we found no cases where journey times had exceeded this. Prisoners were given packed meals and toilet bags if journeys were anticipated to be longer than two hours. Escorting staff told us that long planned journeys included toilet stops.

2.17 Written information about the prison should be routinely issued to prisoners at court, before their transfer, in a language they understand. (1.15)

Not achieved. Although there was a range of information for new arrivals in reception, written information was not issued at court.
We repeat the recommendation.

2.18 Subject to clearly demonstrated security considerations, prisoners should be informed at least 24 hours before planned transfers. (1.16)

Achieved. Prisoners were routinely informed of their planned transfers and were given at least 24 hours notice in writing.

2.19 The establishment should explore all opportunities to increase court usage of the video link facility. (1.17)

Achieved. There was good use of the video-link facilities. The prison provided an average of six court sittings a day for crown and magistrate courts in its area, and the link was also used for daily legal visits, inter-prison visits and interview facilities for probation-based offender managers.

## Additional information

2.20 Relationships between escort and reception staff were good. Information about prisoners was shared systematically and reception staff used it appropriately in initial risk assessments. Prisoner escort records were completed properly and legible. Relationships between prisoners and escort staff were good, and staff were polite and respectful. The cellular vehicles we inspected were clean and had adequate space for prisoners' property.

## First days in custody

2.21 Strip-searches should always be conducted by two members of staff. (1.34)

Achieved. Operational instructions on the conduct of all searching had been issued. These covered strip searches and included the mandate that they were to be carried out by two officers of the same sex as the prisoner. Staff were aware of these procedures, carried out strip searches properly and treated prisoners with respect.

2.22 A trained Listener should be used in reception. (1.35)

Not achieved. Trained Listeners were not employed in reception at the time of inspection.
We repeat the recommendation.

2.23 New arrivals should routinely be allowed a free phone call and a shower before being locked up for the night. (1.36)

Achieved. All prisoners could have a free phone call and a shower on the first night and induction centre on house block 1, whatever time they arrived.

2.24 Cells used to house prisoners for their first night in custody should be clean and properly prepared and equipped. (1.37)

Partially achieved. Although most cells on house block 1 were clean, adequately decorated and reasonably furnished, some used to accommodate new arrivals were poorly decorated, had dirt and graffiti on some walls and were generally unwelcoming.

Further recommendation

2.25 All cells used to accommodate first night prisoners should be clean, properly equipped and well decorated.

2.26 Patrol staff should be aware of the cell locations of any prisoners who arrived on that day. (1.38)

Not achieved. There was no dedicated first night accommodation on the first night and induction unit; new arrivals were located in whatever cells were vacant. There were inadequate systems to identify the location of new arrivals, and there were no proper handover procedures to ensure that staff coming on duty, particularly night staff, were aware of the locations of new arrivals and any special needs.
We repeat the recommendation.

2.27 Vulnerable prisoners should have access to the same first night arrangements as mainstream prisoners. (1.39)

Achieved. The vulnerable prisoners unit had been relocated to two spurs on the induction unit on house block 1 (see paragraph 2.70). This meant that first night and induction officers based on the house block could ensure that all prisoners had access to the same induction arrangements (see additional information below). Records of vulnerable prisoners showed that they had received a full induction programme that included extensive first night interviews and needs assessment. Many vulnerable prisoners attended induction with other new arrivals, following a risk assessment, and those who could not were seen individually. All new arrivals were seen by prisoner peer support workers (Insiders), and appropriate referrals were made to resettlement service providers, such as counselling, assessment, referral, advice and throughcare service (CARATs) and housing advisers, as necessary.

2.28 Induction interviews should take place in private. (1.40)

Achieved. Trained first night officers based on house block 1 saw all new arrivals individually in a private room in reception. They started an induction portfolio document that indicated any immediate needs and recorded any action required before the formal induction the following morning. Cell sharing risk assessments were also completed. New arrivals had a further interview in private when they were admitted to the first night and induction unit before they were locked up for the night, and a record of this was kept in the induction portfolio. Identified needs were dealt with and initial progress was tracked. Entries in files showed that interviewing staff were aware of the importance of dealing with immediate risks and anxieties, and the possible risks associated with the first night in prison. They took time to ensure that prisoners understood how to access services if they needed help during their first night.

2.29 Induction arrangements on house block 4 should be properly resourced. (1.41)

No longer relevant.

2.30 Interviews in reception by health services and first night staff should take place in private. (1.42)

Achieved. First night and health services staff saw all new arrivals in reception in private well-equipped offices.

## Additional information

2.31 The reception area was busy and processed about 25 to 30 prisoners a day. It was open from 6am until 8.30pm Monday to Friday, and on Saturday morning until 12.30pm. The main area was well decorated, clean and generally welcoming.

2.32 All new arrivals were given a comprehensive information pack that set out what they could expect and how to access help. All were offered tea, and those arriving at meal times were offered hot food. Staff-prisoner relationships were good. Officers were respectful and addressed individual safety needs. Prisoners were processed quickly, usually within 90 minutes.

2.33 Conditions in the holding rooms were generally poor. They were grubby, with worn furniture and cracked flooring, and those at the back end were particularly dirty and poorly decorated.

2.34 All new arrivals were located on to the first night and induction centre on spur one of house block 1. Vulnerable prisoners were located on to one of the other three spurs on the same house block. There was a good overall focus on prisoner safety on the unit. There was a clear vulnerable prisoner strategy. The fears of prisoners who requested protection were taken seriously, and staff entries in personal files indicated that they supported prisoners appropriately.

2.35 Insiders saw all new arrivals in groups and individually to explain how to use prison systems to meet their initial needs and to access help. The Insiders also escorted them to their cell and showed them around the unit. The Insiders scheme was well supported by staff, and there was effective governance through regular meetings between officers and prisoners.

2.36 A five-day induction programme started the morning following arrival and consisted of a series of individual interviews and assessments with a range of staff and departments. The more sensitive interviews took place in private rooms. Group sessions and further individual interviews covered diversity issues, anti-bullying, education and legal services; these were rarely cancelled.

Further recommendation

2.37 Holding rooms in reception should be clean and adequately decorated.

## Residential units

2.38 Cells should hold only the number of prisoners they were designed for. (2.11)

Not achieved. Cells on house block 5 designed for one prisoner were still used to accommodate two. Conditions here continued to be cramped, cells were not adequately furnished, and toilets were inadequately screened with a thin cloth curtain. Double cells on house blocks 1 to 5 were used to accommodate three prisoners. As at the last inspection, they were generally dirty and poorly furnished, with a single table and chair, and the toilets were filthy.
We repeat the recommendation.

2.39 The offensive display policy should be enforced. (2.12)

Not achieved. An offensive policy document had been published, but there was no evidence that staff enforced it. Posters and pictures prohibited by the policy were clearly displayed in many cells.
We repeat the recommendation.

2.40 Communal areas on house block 5 should be decorated and maintained. (2.13)

Not achieved. Conditions on house block 5 had not improved since the last inspection. Communal areas were dirty, walls were stained, much of the flooring needed repair, and paint was flaking from the ceiling in the central corridor.
We repeat the recommendation.

2.41 All cells should be kept clean and free from graffiti. (2.14)

Not achieved. Although many cells were adequately clean and well maintained, many were

dirty and poorly decorated. There was graffiti on some cell walls, particularly in multi-occupied cells. Toilets were often filthy.
We repeat the recommendation.

2.42 Showers should be clean, screened, and properly maintained. (2.15)

Achieved. Communal showers were clean and working, and had adequate privacy screening.

## Additional information

2.43 There was accommodation for up to 960 prisoners in five main residential house blocks. House blocks 1 to 4 were identical in design, with three spurs separated by lockable gates over three floors. House block 5 was a quick-build unit with two floors, in a separate area from the other units. House block 1 housed the first night and induction centre and vulnerable prisoners, house blocks 2, 3 and 4 held a mix of convicted and unconvicted adult prisoners, and house block 5 held category C convicted adult prisoners. Young prisoners were located on house blocks 2 and 3 in separate cells from adult prisoners.

2.44 Communal areas on house blocks 1 to 4 were generally clean and well maintained. Offices, interview rooms and classrooms on all blocks were well equipped and fit for purpose. Association took place on landings, which had pool and table tennis tables. These areas were of an adequate size and had good sight lines for supervision. Residential units were calm and quiet during the night. Observation panels in cell doors were free from obstruction, and all prisoners had access to an in-cell call bell.

2.45 Although many areas in the prison grounds were maintained, some areas, particularly beneath cells, were littered with rubbish and waste food. There were pigeon faeces on outside walls and walkways. The area between house blocks 1 and 5 were particularly affected, and we saw rats in outside areas near to prisoners' cells.

2.46 Prisoners were regularly consulted about the routines and facilities of residential units. A prisoners' consultation group met each month, and was attended regularly by prisoner representatives and staff from all house blocks. Minutes of these meetings showed that the prison had responded to reasonable requests from prisoners.

2.47 All prisoners were permitted to wear their own clothes, including those on the basic level of the incentives and earned privileges (IEP) scheme, and there were supplies of adequate prison clothing for those requiring it. Prisoners had at least weekly access to well-equipped laundries on each house block. Lists of approved items were published, and prisoners were aware of the required standards. Clean bedding was provided each week, or as requested, and mattresses were replaced as required. Prisoners had access to showers during association and at other times during the day through a simple request to residential staff.

Further recommendation

2.48 The prison grounds should be clean and without food and animal waste, and should be free from vermin.

## Staff-prisoner relationships

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

## Additional information

2.49 The relationships between staff and prisoners appeared to be reasonably good. The interaction we observed with friendly, usually purposeful and normally respectful. However, in the prison's most recent measuring the quality of prison life (MQPL) survey in 2008, prisoners said that they found it difficult to get help from staff, and two-thirds believed staff ignored them. The majority felt that they were treated fairly, but that they were not valued as individuals.

## Personal officers

2.50 Personal officers should make regular, meaningful contact with their prisoners, rather than simply recording behavioural observations about them in history sheets. (2.26)

Partially achieved. The personal officer scheme policy referred to the importance of regular contact and wing file entries, but (as with the incentives and earned privileges (IEP) scheme) wing file entries varied considerably in quality and frequency. While some files had regular personal officer entries that indicated good knowledge of the prisoner, others had few if any entries and referred primarily to IEP issues and/or were observational. We saw no reference in files to the resettlement needs of prisoners and, for those subject to offender management contact, there was no reference to sentence planning targets.

2.51 Prisoners should not have to change personal officer when they change cell location within the same house block. (2.27)

Not achieved. Personal officers were still allocated to specific cells rather than individuals. If prisoners changed cells but stayed on the same house block, they also changed personal officer.
We repeat the recommendation.

2.52 The new personal officer scheme should be delivered in full. There should be regular management checks to ensure consistency of delivery. (2.28)

Partially achieved. The personal officer scheme had been updated in December 2007 and was due to be reviewed in December 2009. Although all prisoners were allocated a personal officer, the quality of entries and engagement with prisoners varied considerably. There was no quality assurance or regular management checks. Some staff had a good understanding of their prisoners, which was not reflected in files, but there was no system to encourage or support a consistent approach.

Further recommendation

2.53 There should be regular management checks and quality assurance to ensure consistent delivery of the personal officer scheme.

## Bullying and violence reduction

2.54 The role of anti-violence wing liaison officers should be more actively promoted, and they should regularly attend violence reduction committee meetings. (3.12)

Partially achieved. There were 13 anti-violence wing liaison officers and nine violence reduction prisoner representatives across all the house blocks and in the health services department and the segregation unit. A few of these staff had attended the violence reduction committee meeting over the past six months, but not all could attend due to shift patterns. The newly appointed violence reduction coordinator planned to meet these staff regularly.

Further recommendation

2.55 The violence reduction coordinator should have regular meetings with anti-violence wing liaison officers.

2.56 A full-time violence reduction coordinator (VRC) should be appointed. (3.13)

Achieved. A full-time violence reduction coordinator had started work in March 2009. He had not yet had specialist training or mentoring in his new role.

Further recommendation

2.57 The violence reduction coordinator should receive appropriate training and support.

2.58 The collection and analysis of data on bullying and intimidation should be improved. Patterns and trends should be identified and submitted to the violence reduction committee for scrutiny. (3.14)

Not achieved. A range of basic information was gathered and presented each month, but this was not analysed over time to assist the effective management of bullying and intimidation. We repeat the recommendation.

2.59 All complaints concerning bullying or intimidation should be passed to the VRC and investigated. (3.15)

Partially achieved. The violence reduction coordinator received complaints from the request complaints clerk that inferred bullying or intimidation, but he did not always receive reports of unexplained injuries from the health services department.

Further recommendation

2.60 Health services staff should pass on details of all unexplained injuries to the violence reduction coordinator.

2.61 There should be regular victimisation surveys, and their results should be analysed and used to inform the violence reduction strategy. (3.16)

Not achieved. There had been no surveys on victimisation for over three years. The experience of prisoners, therefore, was not used to inform the development of work in this area.
We repeat the recommendation.

2.62 There should be appropriate interventions in place for bullies and victims of bullying. (3.17)

Not achieved. There were no interventions for bullies and no structured support for victims. Bullies were managed through the three stages of sanctions, but this did not include any opportunities to address their behaviour in a supported environment.
We repeat the recommendation.

## Additional information

2.63 The prison had recently invested additional resources in this area with a full-time post dedicated to violence reduction. There was a three-stage anti-bullying approach, which consisted of staff monitoring, downgrade to basic regime and discipline through good order. There had been 83 bullying incidents recorded in the previous six months. Investigations were carried out by wing-based staff but these appeared limited and required more detailed attention. The supporting paperwork for the anti-bullying approach was limited, and it was difficult to ascertain how victims were supported. Violence reduction meetings reported regular delays in the timeliness of investigations, and there was no quality assurance system to oversee the content and quality of investigations. Where force was used, the violence reduction coordinator held post-restraint interviews. There was a helpline for family and friends to report concerns about bullying, but this was rarely used.

2.64 Violence reduction meetings were monthly were reasonably well attended and included prisoner representatives, although security representatives were not always present and links between the two departments were underdeveloped. Links with the offender management unit (OMU) were good, and the two departments shared key information to assist sentence planning.

2.65 The last violence reduction training had taken place in late 2008. There had been 164 recorded violent incidents In the previous five months, with 66 assaults on prisoners in the previous six months.

Further recommendations

2.66 Bullying investigations should be carried out to a high standard and completed within the designated timescales.

2.67 A representative from the security department should attend the violence reduction committee meeting.

2.68 Victim support logs should be introduced to give evidence of support for victims.

2.69 There should be a quality assurance scheme to oversee the management of bullying investigations.

## Vulnerable prisoners

2.70 The prison should reduce the number of spaces for vulnerable prisoners so that provision more accurately reflects the needs of the population. (3.27)

Achieved. In December 2008, vulnerable prisoners were moved from house block 4 to two spurs of house block 1, which more accurately reflected the number of prisoners who requested protection. Staff regarded the new accommodation as generally safer, and since the move only one prisoner in the vulnerable population had been subject to anti-bullying arrangements. There were still six prisoners on the two identified spurs who were not classed as vulnerable, but were orderlies who had agreed to stay following the change. At the time of the inspection, there were 103 vulnerable prisoners on house block 1, of whom six were young adults. There was a risk assessment policy for this small group, and all young adults were assessed before coming on the unit. Young adults did not share with adults. The regime for vulnerable prisoners was generally consistent with that available for normal location prisoners, but we were concerned about the quality of workshop available for them (see paragraph 2.181 and further recommendation 2.184).

2.71 Plans should be introduced to support the active reintegration of suitable prisoners to normal location. (3.28)

Not achieved. The ratio of sex offenders to non-sex offenders in the vulnerable prisoner accommodation was unclear, although staff estimated it was approximately 60:40. There was no clear policy to encourage vulnerable prisoners to return to main location, regardless of the nature of their offences. There were no individual plans, and any discussions tended to centre on incentives and earned privileges (IEP) reviews or annual sentence plans.
We repeat the recommendation.

## Self-harm and suicide

2.72 All appropriate departments and the escort contractor should be represented at safer custody committee meetings. (3.41)

Partially achieved. Attendance at the monthly safer custody meetings was reasonable, but health services representatives were frequently absent. A representative from the escort contractor attended some meetings.

Further recommendation

2.73 Health services staff should be represented at all safer custody meetings.

2.74 Ongoing analysis should be carried out by the safer custody committee to monitor and follow up trends detected in the data produced by the safer custody officer. (3.42)

Not achieved. A reasonable range of data was collected and presented to meetings each month, but this information was not analysed over time to detect trends and assist the development of work in this area.
We repeat the recommendation.

2.75 All staff should be assessment, care in custody and teamwork (ACCT) trained. (3.43)

Partially achieved. The training department for the cluster maintained a database of staff who had received foundation, assessor and case manager training in ACCT self-harm monitoring procedures. It was possible to identify staff from Elmley who had received assessor and case manager training, but not those who had received foundation training, as this data was for all staff in the cluster. There was evidence of frequent and ongoing training for prison staff, but not all agency staff in the health services department had been trained in ACCT procedures.

Further recommendation

2.76 Agency nurses should complete assessment, care in custody and teamwork (ACCT) training.

2.77 The quality assurance system should emphasise the quality of work rather than the process. (3.44)

Not achieved. The key focus of quality assurance in safer custody notes was the correct completion of paperwork. There was virtually no account of the quality of relationships between staff and prisoners subject to ACCT.
We repeat the recommendation.

2.78 Listeners should be permitted to conduct follow-up visits. A passport system should be introduced so that they are able to make visits while retaining a degree of confidentiality. (3.45)

Achieved. Listeners had a passport card to enable them to move about the prison. They were able to make follow-up visits to prisoners without compromising confidentiality.

2.79 There should be free telephone access to the Samaritans. (3.46)

Achieved. Samaritans phones were available on all wings and prisoners could request access at any time. Prisoners could also contact the Samaritans through the PIN (personal identification number) phone system.

2.80 Crisis suites should be available. (3.47)

Achieved. There was a crisis suite on house block 1, which was occupied by a Listener. The suite was appropriately furnished and a pleasant environment. However, it was also designated as one of two adapted cells for prisoners with disabilities and could potentially be withdrawn from use as a crisis suite.

Further recommendation

2.81 A permanent crisis suite should be available at all times.

## Additional information

2.82 A full-time safer custody coordinator had been in post since January 2009 and played an active role in ACCT reviews, but had not yet received any specific training. There were 27 open ACCTs at the time of inspection, and the gate lodge held a full list of these prisoners,

updated daily. There were no distractions or activities for prisoners in crisis, and no therapeutic interventions to increase the self-esteem and self-confidence of prisoners who felt vulnerable.

2.83 There was a comprehensive safer custody policy, which had been updated in 2008. Safer custody meetings took place monthly, and were regularly attended by prisoner representatives. There were 15 designated Listeners, and efforts to ensure a large enough pool was recruited and trained regularly. Prisoners had good access to Listeners, who were well supported by Samaritans representatives, who attended the prison for a fortnightly meeting and debrief session. The Samaritans also attended safer custody meetings.

2.84 There had been two self-inflicted deaths at Elmley in 2008 and one in 2009. There had been debriefs, but the establishment had not drawn up interim action plans to address issues as it was still waiting for advice from the Prisons and Probation Ombudsman.

Further recommendations

2.85 The safer custody coordinator should receive appropriate training and support.

2.86 The prison should introduce activities and therapeutic interventions for prisoners in crisis.

2.87 Interim action plans should be developed following a death in custody to identify immediate improvements.

## Diversity

2.88 Older prisoners should have access to a regime that fully meets their needs and provides a range of age-appropriate activities. (3.56)

Not achieved. There was no specific provision to meet the needs of older prisoners, such as age-appropriate recreational activities. The needs of older prisoners were not covered in the diversity policy, and there had been no needs analysis of this group.
We repeat the recommendation.

Further recommendation

2.89 The diversity strategy should address the needs of older prisoners.

2.90 All retired prisoners should receive retirement pay of £2.75 in addition to the basic rate of £2.50 a week. (3.57)

Not achieved. Since the last inspection, there had been an annual review of prisoners' pay. For the past two years, retired prisoners had received a weekly rate of £3.25 but no additional money, although this was included in the prison's action plan. Retired prisoners could work if they were able, but those who were not had a limited income.

Further recommendation

2.91 Retired prisoners should receive the additional retirement payment outlined in the prison's action plan, and the level of this should be subject to annual review.

## Additional information

2.92 There was a full-time diversity and race equality officer. A diversity policy, including race equality, had been published and was supplemented with a range of additional instructions, including the management of disability for staff and prisoners, and racist incident reporting. The policy document was not strategic and needed to be refreshed.

2.93 New arrivals completed a disability questionnaire and had more detailed assessments if required. A disability register identified prisoners requiring additional support or personal evacuation plans, and highlighted prisoners who required periodic case assessment.. Disabilities had been self-disclosed by 102 prisoners.

2.94 The key focus of diversity work had been on disability, but there had been little attention to issues of age or sexuality. The governor chaired a bi-monthly diversity and race equality meeting, and this was supplemented by separate meetings with prisoner representatives and the diversity and race equality officer. Diversity and race equality meetings were generally well attended. A range of monitoring information was presented to the meeting, but this was not analysed over a longer period to identify patterns and trends.

Further recommendations

2.95 The diversity policy should be revised and relaunched, and include specific sections on age and sexuality, as well as disability and race equality.

2.96 The diversity and race equality committee should receive quarterly information that highlights trends and patterns over time.

## Race equality

2.97 The diversity consultation meetings with prisoners should be used to explore further the wide variations in perceptions in many areas between black and minority ethnic and white prisoners. (3.66)

Partially achieved. The black and minority ethnic prisoner population was approximately 23%. The diversity and race equality officer was working with 15 prisoner representatives to review the allocation of work to black and minority ethnic prisoners. The findings of this project, which was in addition to the standard ethnic monitoring, were to be distributed to staff on house blocks to promote awareness of equality of opportunity.

Further recommendation

2.98 The prison should continue to explore black and minority ethnic prisoners' perceived differential access to the regime with prisoner representatives.

2.99 All complaints that have a racial aspect should be referred to the DREO [diversity and race equality officer] on racist incident report forms (RIRFs), and fully investigated. (3.67)

Achieved. The RIRFs that we inspected showed that complaints with a racial aspect had been

directed to the diversity and race equality officer for investigation. The officer reported good links with the request complaints clerk and was satisfied that he received all relevant complaints.

### Additional information

2.100 There had been 56 RIRFs submitted in the previous six months. Investigations into all RIRFs were substantial, and included a personal letter to the complainant. The complainant was also given a brief questionnaire at the end of the process to see if he was satisfied with the investigation and the outcome. However, the results of this were not aggregated and reported to the diversity and race equality action team. The timeliness of completing investigations had deteriorated recently as the diversity and race equality officer had been involved in planning a diversity event and there was no identified support to cover his absence. The prisoner diversity representatives believed that consultation at Elmley worked well.

Further recommendations

2.101 There should be staff back-up arrangements to cover the absence of the diversity and race equality officer.

2.102 The diversity and race equality committee should receive and analyse trend data from racist incident report forms.

### Foreign national prisoners

2.103 The foreign nationals coordinator should have the necessary time and resources to cover the responsibilities involved and to develop the role. (3.80)

Not achieved. There was currently no foreign nationals coordinator, and a temporary postholder had returned to other duties. Given the large number of foreign national prisoners, an identified and visible foreign national coordinator was needed.
We repeat the recommendation.

2.104 Eligible foreign national prisoners should be able to make a free five-minute international phone call each month. (3.81)

Achieved. Under a new system introduced in November 2008, foreign national prisoners could apply for a free monthly card to enable them to make a five-minute call to any destination regardless of cost. This had been publicised through a notice to prisoners and was also promoted by diversity representatives.

2.105 Effective arrangements should be put in place to cover absences of both the foreign nationals coordinator and the immigration clerk. (3.82)

Not achieved. At the time of the inspection, the administrative clerk with responsibility for foreign nationals was on long-term sick leave and her work was not covered consistently. The foreign nationals coordinator role was also not covered (see above) and there were no suitable back-up arrangements.
We repeat the recommendation.

2.106 The diversity consultation meetings with prisoners should be used to explore further the wide variations in perceptions in many areas between foreign and British prisoners. (3.83)

Not achieved. The diversity consultation meetings with prisoners appeared to pay limited attention to the specific needs of foreign national prisoners. There had been no survey of foreign national prisoners to gather their views on relevant issues.
We repeat the recommendation.

Further recommendation

2.107 There should be regular surveys of foreign national prisoners.

## Additional information

2.108 At the time of our inspection, there were 155 foreign national prisoners located throughout the prison. The prison reported that 24 prisoners were held beyond the end of their sentence. Foreign national prisoners had a specific induction input on relevant issues, including access to legal support and free monthly phone calls. One wing on house block 4 had recently been populated solely with foreign national prisoners, following the decanting of vulnerable prisoners to Maidstone. This move was generally popular with prisoners, although staff had not received any briefing on the specific needs of foreign national prisoners.

2.109 Foreign national prisoners we spoke with were happy with the amount of consultation with them, but commented that support from immigration officials had been poor. Staff had arranged for two immigration surgeries to take place in May 2009. There was no independent advice for foreign national prisoners.

2.110 The library had a reasonable range of foreign language books for prisoner, although demand was low. There were no foreign language newspapers or magazines. There was a list of prisoners who could speak foreign languages, and telephone interpreting services were used regularly.

Further recommendations

2.111 Staff should be briefed on the specific needs of foreign national prisoners.

2.112 The prison should approach the UK Border Agency to arrange regular surgeries with immigration officials.

2.113 The prison should establish access to independent immigration advice services for prisoners.

2.114 The library should provide foreign language newspapers and magazines.

## Applications and complaints

2.115 Complaints should not be filed away as dealt with until a substantive response has been produced. (3.110)

Not achieved. There were several examples of interim responses to complaints that were then

classified as a closed complaint. We also found several cases of complaints made through the confidential access system that were not deemed to be suitable and were returned to prisoners to resubmit on the standard complaint form. This was unhelpful and caused delays in ensuring complaints were answered appropriately.
We repeat the recommendation.

2.116 Complaints submitted to the area manager through confidential access that are not deemed suitable to be dealt with through this channel should be forwarded to and addressed by the relevant department. (3.111)

Not achieved. Confidential access complaints sent to the area manager that were assessed as unsuitable to be dealt with were returned to the prisoner with a letter inviting them to resubmit their complaint to the most appropriate department. This process did not ensure that complaints were managed in a timely manner.
We repeat the recommendation.

2.117 Formal complaints should always be answered by the most appropriate person, and responses should always deal thoroughly with the issue raised. (3.112)

Partially achieved. Complaints were usually answered by the most appropriate person. However, some responses did not deal with the original complaint thoroughly, and some were cursory.

Further recommendation

2.118 Responses to complaints should be respectful and deal thoroughly with the issue raised.

## Additional information

2.119 Wing applications were received by staff and recorded in a log book. However, there was no system to track responses to applications. Governor's applications were also managed through the same system.

2.120 Prisoners had made over 3,000 complaints in 2008. Basic statistics recorded the timeliness of response, but there was no analysis of complaints by type or location. Responses to complaints were varied: some were respectful and addressed the prisoner by name, but others were curt and failed to deal with the issue. There was no formal quality assurance system.

Further recommendations

2.121 The applications system should record when prisoners receive a response to their application.

2.122 Information on complaints should be analysed more thoroughly by type, location and resolution, and reported regularly to the senior management team.

2.123 Complaints should be quality assured on a regular basis.

## Legal rights

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

## Additional information

2.124 A full-time legal services officer was in post, but had not yet received formal training. All new arrivals received information on legal services during induction. The main legal services on offer were lodging of fines and advice on bankruptcy and confiscation orders. An appellant's register was maintained. The legal services officer also had a range of leaflets on civil law available on request. A full-time bail information officer was also in post but was unavailable during our inspection. There was a limited range of legal books in the library, but Prison Service Orders could be consulted through the intranet. The prison had no laptops for prisoners to use under the access to justice provision, but could call on laptops from other prisons in the cluster. There were 12 legal visits booths in the visits centre.

Further recommendation

2.125 The legal services officer should receive appropriate training.

## Substance use

2.126 Opiate users should be provided with first night symptom-relief medication, and health services staff should undertake the necessary training. (3.131)

Achieved. The integrated drug treatment system (IDTS) had been brought in, and there were patient group directions to provide first night symptomatic relief or to administer opioid substitute medication. The Crime Reduction Initiative (CRI) was contracted to provide the service across the cluster, and all staff were appropriately qualified and experienced.

2.127 An external specialist should be identified to review and develop clinical management protocols, and to offer consultation to the medical officer and the substance misuse team. (3.132)

Achieved. CRI had appointed a full-time psychiatrist as part of the IDTS team, and there was additional support from a visiting consultant psychiatrist who specialised in addiction. CRI medical officers provided support on Saturdays to assess new arrivals and to prescribe any necessary medication. The GPs covering health services provided clinical support in the absence of CRI doctors. Clinical protocols had been introduced and were regularly updated.

2.128 The substance misuse team should be adequately resourced, and should form part of a multidisciplinary team providing coordinated care to substance users. (3.133)

Achieved. The substance misuse team had been integrated into the IDTS team and there was strong multidisciplinary working. The team comprised a cluster service manager, and for Elmley, a lead nurse (RMN), one RGN and one RMN who were all full time. A further 10 agency nurses supported the CRI team. An additional two RMNs had been appointed and were awaiting clearance to work. One of the nurses was a specialist in HIV and blood-borne viruses. Four discipline officers were already in post and a further three were being recruited.

2.129 Prisoners undergoing detoxification should be housed in a dedicated area containing interviewing and group-work facilities. (3.134)

Partially achieved. House block 3 had been identified as a dedicated area for prisoners undergoing detoxification, although population pressures meant that overspill was inevitable. House block 3 was adequately resourced with dedicated groupwork rooms and a treatment area. However, IDTS prisoners were located on the other house blocks as well as inpatients and the segregation unit, and not all the house blocks had adequate accommodation or dedicated treatment rooms. House block 5 did not have a dedicated secure area to deliver medication, which was unsafe (see recommendation 2.9).
We repeat the recommendation.

2.130 Medication should be administered in a safe and suitable environment, and wing officers should assist in the supervision of prisoners. (3.135)

Partially achieved. Conditions in areas where medicines were administered were not always safe or suitable. However, in most areas, medicines were administered safely, and all areas had discipline officers present to supervise this.

2.131 Prisoners should be provided with structured psychosocial support during and following detoxification. (3.136)

Achieved. The IDTS team worked closely with the counselling, assessment, referral, advice and throughcare service (CARATs) to provide psychosocial support to prisoners. Nurses provided one-to-one support and CARATs delivered one-to-one and groupwork. The relationship between IDTS and CARATs was good, and the teams regularly met formally and informally to review practice and discuss clients.

## Additional information

2.132 The IDTS service responded well to the needs of prisoners, and provided a cohesive and effective clinical management system for substance-dependent prisoners. At the time of the inspection, approximately 130 prisoners were subject to such clinical support. However, support for alcohol users was very limited. The team worked well as part of a multidisciplinary approach to managing substance users. It promoted pro-social living and healthy lifestyles, and ensured continuity of treatment from admission to release. The CARAT team had integrated well and worked effectively with other inter-prison departments to provide appropriate programmes and psychosocial support for prisoners. It liaised well with community drug intervention programme teams, and met them regularly. The need for additional treatment areas had been recognised, and there had been a bid for the expansion of treatment areas on house blocks 1, 3, 4 and 5. Additional staffing resources would also be needed.

2.133 The positive mandatory drug testing level was 10.8% for 2008/9 against a target of 11.5%. Prisoners testing positive for a class A drug were placed on to a frequent testing programme; at the time of the inspection there were nine prisoners on such a programme. In the previous six months, opiates had accounted for 71% of all positives and cannabis 25%. The 5% random testing rate was consistently achieved.

2.134 Between October 2008 and March 2009, there had been 272 suspicion tests with only an average 34.2% positive rate (93 positive tests). There had been difficulties in completing suspicion tests on time during the previous year. Although this had apparently improved recently, in the six months to the end of March 2009, 56 tests had not been completed.

Further recommendations

2.135 The prison should pursue the bid for an increase in integrated drug treatment system (IDTS) services, with appropriate accommodation and sufficient personnel to meet the clinical and psychosocial needs of prisoners.

2.136 Suspicion drug testing should be undertaken consistently, and the success rate should be improved.

## Health services

2.137 The decoration and cleanliness of all rooms should be consistent with the promotion of health, and appropriate infection control facilities should be included. (4.43)

Partially achieved. The outpatient department was generally clean and tidy, and the décor was of a reasonable standard. The floor was being renewed and infection control measures were in place, including appropriate handwashing facilities in all areas. The inpatient area was also generally clean and tidy, but needed redecoration, and a business plan to decorate the department with specialist antimicrobial (see below) and anti-graffiti paint had been submitted. The association room was of a reasonable size with comfortable seating, and there was a large outside garden for patients. Health promotion literature was available throughout the health services department, and there was regular cleaning by prisoner cleaners.

Further recommendation

2.138 The redecoration of the inpatient unit should be carried out promptly.

2.139 The primary care trust (PCT) should undertake an infection control audit of the healthcare facilities. (4.44)

Achieved. The inpatient manager had cluster responsibility for infection control and had adapted a Department of Health audit to meet the needs of Elmley. She actively promoted hand hygiene and spoke to new arrivals on the induction course. There was a new uniform policy to reduce the risk of transmitting infections. The inpatient manager had good relationships with the local Health Protection Agency and met them regularly, and also attended the Eastern and Coastal Kent Primary Care Trust (PCT) infection control meetings. Handwashing procedures and facilities in health services had improved.

2.140 All staff should have access to clinical supervision. (4.45)

Achieved. Access to clinical supervision was fully supported and protected time allocated, although there was limited uptake by clinical staff. There were no trained supervisors on the staff. The lead for training and development had surveyed staff to assess the level of need and support, but nursing staff appeared reluctant to engage in supervision.

2.141 There should be formal arrangements with local health and social care agencies for the loan of occupational therapy equipment and the provision of specialist nursing advice. (4.46)

Achieved. There were negotiations with a local occupational therapy unit for the provision of medical equipment.

2.142 Prisoners should be made aware of how to complain using the NHS complaints system as well as the prison's system. (4.47)

Achieved. Prisoners' complaints were initially dealt with internally, but if a prisoner remained dissatisfied with the response, the complaint was forwarded to the PCT complaints department. A central log of complaints was maintained in the health services department. There was no Patient Advice and Liaison Service in the prison.

2.143 The health services department should have information-sharing protocols with appropriate agencies to ensure the efficient sharing of health and social care information. (4.48)

Achieved. There were cluster policies on the use and protection of patient information and the process for developing inter-agency information-sharing protocols within NHS guidelines. The consent of the prisoner was always obtained when there was a need to share or obtain his clinical information.

2.144 Prisoners who require medication on their first night in custody, including symptomatic relief for those with substance misuse problems, should receive it. (4.49)

Achieved. There was a small stock of medicines, including paracetamol, in reception. Prisoners who required prescribed medication could receive it from one of the night nurses, provided it was held in the prison. There were protocols for the administration of symptomatic relief for substance users. All new arrivals already on medication were seen by the GP on the day after their arrival.

2.145 Clinical records, such as the reception screen, should be available to health professionals when a patient is being seen. (4.50)

Not achieved. The system had not changed and health services staff who carried out secondary screening did not always have the initial screening with them.
We repeat the recommendation.

2.146 Triage algorithms should be developed to ensure consistency of advice and treatment to all prisoners. (4.51)

Partially achieved. A working template for algorithms was under review to assess its suitability for prisoners at Elmley.

2.147 All prisoners should have access to disease prevention programmes and screening programmes that mirror national campaigns and meet national service framework standards. (4.52)

Achieved. Health promotion and health screening were well supported and developing well. All new arrivals had a secondary health screening and they were offered a comprehensive range of immunisations and screening, including for chlamydia and hepatitis B. The accelerated hepatitis B course was available to participating prisoners. There had been a recent health day in the gym where prisoners and staff were offered simple health tests and advice. The healthcare officers had been trained to run smoking cessation clinics.

2.148 Prisoners should be able to obtain simple analgesia from health services staff throughout the 24-hour day. (4.53)

Achieved. Health services provided a 24-hour service, and prisoners who required simple analgesia could receive medication appropriately. An extra nurse had been allocated to night duty partly to address this issue and, where necessary, she was able to provide analgesics to prisoners in their cells during the night.

2.149 There should be a formal in-possession risk assessment for each patient with regard to each drug, and any reasons for a determination should be documented. (4.54)

Achieved. All prisoners on medication were risk assessed by the GP and nurse before they were prescribed it in possession.

2.150 The PCT should review the service level agreement to ensure that that there is provision of sufficient pharmacist time. The pharmacist should also be encouraged to take a more active role in health initiatives at the prison, including direct contact with patients. (4.55)

Partially achieved. There was no on-site pharmacist but a medicines management technician was employed full-time at the prison. Prisoners had access to the technician when they collected their medicines, and she also ran a warfarin clinic. The pharmacist visited twice a month and was able to see prisoners, although prisoners appeared unaware of this facility.

Further recommendation

2.151 The pharmacist should visit the prison more often, and prisoners should be informed of the opportunity to see the pharmacist during these visits.

2.152 The system of relying on faxed prescriptions should be subject to audit. The pharmacist should make regular visits to the prison, during which a random selection of dispensed faxes should be brought and compared against the original prescription forms. (4.56)

Achieved. The pharmacist checked a random selection of faxed prescriptions against originals when visiting the prison.

2.153 Formal procedures should be implemented to encourage appropriate recording of pharmaceutical interventions and incidents. (4.57)

Achieved. Formal procedures had been implemented to record interventions and incidents. A register was kept in the dispensary room in the main health services department. There were regular audits of incidents, which were discussed at clinical governance meetings.

2.154 Timing of supervised medication should be reviewed to ensure that patients receive the best treatment possible. (4.58)

Achieved. Medications were administered during regular medication rounds, at 8.30am, 1.30pm, 3.30pm and 7pm. GPs prescribed medication to meet these times, although medicines were sometimes prescribed during the evening, when they were administered by a night nurse. Two nurses were on night duty partly to meet this need, and their work included the administration of medicines to prisoners in their cells if necessary.

2.155 The introduction of patient group directions (PGDs) should be considered to enable the supply of more potent medication by the pharmacist and/or nurse, in order to avoid unnecessary consultations with the doctor. A copy of the original signed PGDs should be present in the health services suite, and should be read and signed by all relevant staff. (4.59)

Achieved. There were copies of signed PGDs in the health services department. There were no nurse prescribers as yet.

2.156 The beds in health services should not form part of the prison's certified normal accommodation, and admission should only be according to assessed clinical need. (4.60)

Not achieved. The beds remained on the certified normal accommodation and, although fewer prisoners were placed there inappropriately, there were still occasions when non-medical prisoners were held there. Some IDTS prisoners were placed there overnight. At the time of the inspection, one prisoner was in a bed inappropriately because there were no cells for prisoners with disabilities in the main prison.
We repeat the recommendation.

2.157 Mental health services should include the provision of primary mental health services. (4.61)

Partially achieved. Two whole-time equivalent RMNs had been recruited to provide primary mental health services, and a further three RMNs had been recruited and were awaiting clearance. The current team was unable to meet the needs of all prisoners, but worked well with the mental health in-reach team to manage prisoners with mental health needs. The team visited house blocks every day to meet their patients and liaise with wing staff, and they made appropriate entries in wing history records to inform staff. Team members attended ACCT reviews where possible, but not regularly.

Further recommendation

2.158 Primary and secondary care mental health nurses should aim to attend assessment, care in custody and teamwork (ACCT) reviews or provide verbal feedback if they are unable to do so.

2.159 Health services should provide day care for those less able to cope with life on the house blocks. (4.62)

Not achieved. There were no day care facilities. However, the need for such facilities had been recognised, and there were discussions at the Department of Health (Prison Health) about the potential for day services when the new house block was built.
We repeat the recommendation.

2.160 The health needs assessment planned for February 2007 should be used to plan, provide and quality assure health services. (4.63)

Achieved. A comprehensive health needs assessment had been completed in September 2007 and been followed by a PCT health needs assessment delivery action plan. There was also an HMIP health service action master plan, which addressed issues raised at previous inspections.

2.161 The clinical governance arrangements should include a formal skill mix review and confirmation of the staffing complement for the establishment. (4.64)

Achieved. See paragraph 2.11. There was an ongoing skill mix review, which was under constant review to meet the changes to service delivery and requirements that came with the new build.

## Additional information

2.162 There had been significant advances in improving health services and a recognition that further work was required. There was strong support from the PCT and robust leadership from the strategic healthcare lead. Primary care had improved and prisoners could access a wide range of clinical services on site. Recruitment and retention remained difficult and there was a heavy reliance on agency staff. Staffing levels had improved but would need further assessment following the opening of the new house block. Resettlement procedures had improved.

2.163 New arrivals had an initial health screen in reception on arrival. Although there was an electronic medical information system (EMIS) in reception, the initial assessment was completed on paper records because this was felt to be quicker than using the slow computer system. The record was put on to the computer later. (The EMIS was due to change to a prison-wide system compatible with the NHS.) There was a secondary screening on the next day in a health services room on the induction wing. This room did not have a computer terminal so the secondary screening was also completed on paper records again. There were no clinical notes available to the nurse completing the screening.

2.164 Prisoners who wished to use health services completed an application form and were assessed by a qualified nurse. A senior nurse held triage clinics in the health services department every weekday, and each house block had nurse triage on a specific day, which meant that prisoners could wait up to six days to be seen by the triage nurse – although they were seen the same day if they were very unwell or concerned.

2.165 In some instances, inpatients were subjected to wearing strip clothing, which should only be used as a last resort (see paragraph 2.3). There was no register to log and justify the use of strip clothing in a health setting.

2.166 Health promotion had improved and involved prisoners who had been trained as health trainers. These prisoners were based in the outpatient department for most of the day, and provided health advice and support for prisoners who wished to improve their health and fitness. The trainers met with health services and wing staff, and had a positive influence throughout the prison.

2.167 Dental services were good, with a waiting time of only three to four weeks. However, a large proportion of prisoners failed to attend their dental appointments. In February and March 2009, 35% of prisoners failed to attend appointments (131 out of 374).

2.168 Mental health services had improved, but needed further development. Secondary care services were out for tender. Primary mental health services were limited, and affected by demand and lack of resources. Referrals to the service were accepted from prisoners themselves, other prison departments and wing officers. New arrivals had a short reception mental health assessment and, if necessary, referred to the team. The team had a current caseload of 50 patients, with approximately six waiting to be seen. The RMNs had individual caseloads. Most mental health concerns were related to first time in prison, depression and

anxiety. There was good liaison with the GPs and the Kent and Medway NHS Partnership Trust MHIRT, who the team met weekly. Resettlement procedures for prisoners with mental health were well structured. There was support from the visiting psychiatrist, and all inpatients were seen by the psychiatrist and the GP during the weekly ward rounds. The MHIRT included three community psychiatric nurses (CPNs) who provided 13 sessions a week, and they were supported by a full-time psychiatrist, with access to psychology support if necessary. The MHIRT caseload was approximately 30, and one prisoner was awaiting assessment by an external psychiatrist. There was no mental health awareness training for prison staff.

Further recommendations

2.169 Prisoners attending triage clinics should not have to wait more than three days to see the triage nurse.

2.170 The use of strip clothing in a healthcare setting should be monitored and documented in the patient's clinical record, and there should be a central register in the inpatient area.

2.171 Senior management should investigate the cause of non-attendance at dental clinics and ensure that clinical time is not wasted due to non-attendance. Prisoners who fail to attend appointments should be followed up.

2.172 There should be mental health awareness training for prison staff.

## Learning and skills and work activities

2.173 Planning of individual learning and training should be improved, and linked more effectively to custody planning (5.8)

Partially achieved. Offender management unit (OMU) staff interviewed all new arrivals deemed as high risk and/or on indeterminate sentence for public protection (IPP) and assessed them against the resettlement pathways, including employment, training and education (ETE) and support needs. Literacy and numeracy needs were noted on their offender assessment system (OASys) assessment, but this was based on assumptions from the interview rather than basic skills screening results at induction. The majority of prisoners (approximately 80%) fell out of scope for OMU interventions and sentence planning, and although individual learning plans were drawn up for those participating in education (see paragraph 2.180), these were not clearly linked to the prisoner's time in the prison. The transfer of information between the OMU and education department was inadequate, and there was insufficient sharing or recording of learners' achievements on OASys or in prisoners' personal files.

Further recommendation

2.174 Planning of individual learning and training should be improved, include all prisoners and be linked more effectively to sentence and custody planning and prisoners' sentences.

2.175 Punctuality should be improved in both work and education and prisoners should attend sessions for the allocated time (5.9)

Achieved. Since the previous inspection, when punctuality and attendance had been poor, the

contracted education hours had been aligned with the regime hours, and punctuality in education was much better. Prisoners generally arrived and left at the correct times in the majority of education and work areas. Punctuality and attendance were subject to regular scrutiny by the head of function. Classroom efficiency had declined to around 60% due to the closure of some classrooms.

2.176 A strategy should be developed to increase access to the library for all prisoners (5.10)

Not achieved. Prisoners continued to have poor access to the library, and relied on officer escorts for their visits. Some prisoners had only about 10 to 15 minutes in their time slot. Although participation had improved from 64 to 109 prisoners a week, this was still only about 10% of the population. All house blocks had access to at least three library sessions a day, in the morning, afternoon and evening. The number of library users was low, and no prisoners attended from house block 3. There was no access to the library at weekends.
We repeat the recommendation.

## Additional information

2.177 Education was contracted to A4E under an Offender Learning and Skills Service (OLASS) contract. The prison provided information, advice and guidance (IAG). There was no education centre and all education was delivered in accommodation on the house blocks, with outreach provision on those where classrooms were no longer available. Some prisoners, except for vulnerable prisoners, could attend classes in other house blocks.

2.178 The education curriculum for most prisoners was broad. Opportunities included open and distance learning courses and, where possible, new arrivals who were part way through courses were encouraged and supported to complete studies. English for speakers of other languages (ESOL) was offered individually and in groups. A 'starting a business venture' course had been introduced. Learn Direct information and communications technology (ICT) courses were offered, and the Prisons Information Communication Technology Academy (PICTA ) workshop had reopened and offered a good range of qualifications, including the European computer driving licence (ECDL).

2.179 The management of data had improved and gave prison staff a clear view of learners' successes. Learners' achievements were generally satisfactory. Teaching and learning were satisfactory, although classes were sometimes cramped Most learners were engaged in learning, and classroom management promoted and supported groupwork effectively. Outreach education had been successfully integrated into some workshops.

2.180 Education staff had made progress in the development of individual learning plans. These were paper based and generally recorded all individual targets and achievements. There was also support for the review and recording of learners' interpersonal skills and development, such as motivation, concentration and attitude. OMU staff carried out initial assessment interviews relating to literacy, numeracy and ESOL support needs, and education staff carried out initial basic skills screening, but there was little sharing of this information and little evidence of clear education and training targets on OASys assessments.

2.181 Most work remained repetitive and mundane. It included headphone refurbishment, tea bag packing, envelop folding, balloon packing and guttering assembly. Employment opportunities were poor for vulnerable prisoners. The only work available was balloon packaging for 40 prisoners.

2.182 Some areas offered little real employment-related accredited training, for example the laundry, gardening and cleaning. Although there was some accredited vocational training, such as food hygiene, farms and gardens and a range of PE courses, some of the vocational training had yet to be introduced, for example, British Institute of Cleaning Sciences (BICS) cleaning programmes. Construction Skills Certificate Scheme (CSCS) awards were offered and were popular, with long waiting lists; more than 50 prisoners a month gained the award. The performing manufacturing operations (PMO) qualification had not been fully developed in the workshops. A recently introduced accredited employability programme aimed at recording interpersonal skills developed in the workplace in learners' portfolios, for example attitudes to work, punctuality and quality of work.

2.183 The library was well organised and welcoming, and library staff were responsive to prisoners' requests for books. There was a satisfactory range of foreign language books, and a well-displayed range of easy reading material for adults. Prisoners could read Prison Service Orders and obtain appropriate legal material. The library had few periodicals or newspapers – most were donated by outside agencies. There was a small collection of foreign language audiocassettes and CDs, and a new collection of talking books. Links with outside agencies to support job search activities had improved, and the library ran CV writing workshops.

Further recommendation

2.184 There should be more work opportunities for vulnerable prisoners.

## Physical education and health promotion

2.185 General aspects of health and fitness should be promoted more actively across the prison (5.19)

Achieved. The PE department had obtained funding from the PCT for a healthy training initiative. Staff and orderlies had been trained as health advisers to give prisoners information and guidance about health and fitness and diet and nutrition. There were 13 trained orderlies, six of whom worked actively with prisoners on the wings, health services department and the segregation unit. The orderlies could also gain an accredited level two qualification in understanding health.

2.186 A fair allocation system should be introduced for physical education (PE) (5.20)

Achieved. The allocation to PE activities was managed better and all prisoners had good access to PE. Those in education could attend PE according to their house block allocation. Most house blocks could access PE for three sessions a day, and house block 5 had access for six sessions a week. Prisoners in full-time work were offered evening PE. Access still depended on wing staff management and, although wing access was rotated, participation was still on a first come, first served basis on each wing. However, most prisoners were able to access PE if they wanted to.

## Additional information

2.187 There were approximately 300 spaces for PE each day. Facilities and equipment continued to be good, and there was a range of individual and team activities. Prisoners could use PE facilities from 8.30am to 8pm between Monday and Thursday, as well as in the evening for those who worked, and provision was available at weekends. Vulnerable prisoners had a

timetabled double session slot on Saturday morning. Induction continued to be thorough, included a health risk assessment, and emphasised health and safety, hygiene and clothing, as well as the benefits of regular gym use.

2.188 There continued to be a range of team and individual sports, with a large and well-equipped sports hall in addition to fitness suites with cardiovascular and weights equipment. There was a small classroom for theory sessions. Outside facilities included an Astroturf football pitch.

2.189 The PE department included a member of the education staff who supported prisoners with key skills. Development and learners' achievements were good in this area. Qualifications included first aid, the community sport leader award (CSLA) at standard and higher level, health and safety, manual handling, diet and nutrition. Most prisoners who took vocational qualifications were successful, and many achieved more than one qualification. Between September 2008 and February 2009, 36 prisoners achieved the CSLA.

## Faith and religious activity

2.190 Chaplains should be routinely informed when ACCT reviews are due to take place. (5.30)

Achieved. Chaplains could access a shared computer drive document that detailed dates of ACCT reviews. The ACCT documents that we inspected showed that chaplaincy staff played a key role in ACCT reviews when appropriate. Two members of the chaplaincy were also ACCT assessors and one was a trainer. Chaplaincy staff also attended suicide prevention meetings regularly.

## Additional information

2.191 There was a full-time coordinating chaplain and a large team of sessional chaplains. The chaplaincy team was active and well integrated into the prison regime, and provided a broad range of faith and non-faith activity. Religious services were offered on almost every day of the week, and approximately 200 prisoners a week took part. There was a weekly session for foreign national prisoners after Friday prayers, attended by approximately 40 prisoners a week. Weekly Muslim teaching sessions were open to anyone who wanted to learn more about Islam, and attracted over 50 prisoners. The chapel also hosted a Relate programme for prisoners and their partners, and supported the training programme for Listeners.

2.192 The chapel was large with several smaller rooms. There were no suitable washing facilities for Friday prayers. A multi-faith room was due to be completed in early 2010 to cope with the additional number of prisoners.

2.193 A member of the chaplaincy team saw new arrivals. The team also played a key role in supporting prisoners and their families in dealing with bereavement and ill health issues.

Further recommendation

2.194 There should be suitable washing facilities for Muslim prisoners.

## Time out of cell

2.195 Prisoners who are not assigned to an activity place should be given more opportunities during the working day to spend time out of their cells. (5.37)

Not achieved. Under the core day, unemployed prisoners could expect to spend about 4.5 hours unlocked during the working part of the week, increasing to 5.5 hours if they took exercise. For prisoners in part-time activity, time out of cell increased by about 2.5 hours a day, and a fully employed prisoner had more than nine hours. Those not engaged in activity were locked in their cells. During a random roll check during the inspection, we found about 44% of the population locked up during the working part of the day. This figure was broadly consistent with the fact that there were only enough activity places for about half the population (500 full-time equivalent places).
We repeat the recommendation.

2.196 Exercise yards should be thoroughly cleaned each day, and this task should be signed off by a member of staff on the daily wing register. (5.38)

Not achieved. Exercise yards were filthy, even after they had supposedly been cleaned. Some wings had a cleaning officer's checklist, but this did not show the standards required or achieved.
We repeat the recommendation.

2.197 Exercise should only be cancelled on the authorisation of the orderly officer. (5.39)

Achieved. Arrangements for exercise varied across the house blocks, and took place at different times on different units. Although the management of exercise was essentially at the discretion of wing staff, a notice issued to staff required approval before an exercise period could be cancelled.

2.198 Waterproof clothing should be available on request. (5.40)

Not achieved. Waterproof clothing was not available for prisoners taking exercise.

## Additional information

2.199 Although too many prisoners spent too long locked in cell, all prisoners were unlocked for about an hour in the morning to use the showers and telephones, and there was no rush to lock prisoners up when they returned from activity. There was evening association for about an hour and a half each evening. We were told that this was cancelled routinely, although this was done on a rota.

Further recommendation

2.200 Evening association periods should not be cancelled.

## Security and rules

2.201 Links should be developed between the security committee and the drug strategy committee. (6.9)

Partially achieved. Although the security department was clearly focused on illicit drug use and supply reduction, and had introduced measures to guard against trafficking, its attendance at drug strategy meetings was erratic. We were not given assurances that all relevant information was used effectively to inform the overarching drug strategy.

Further recommendation

2.202 Security managers should attend all drug strategy committee meetings to ensure that all relevant information is shared to help inform the prison's drug strategy.

## Additional information

2.203 The security department was effectively managed by a principal officer supported by two senior officers. There were effective systems to process information and use intelligence to inform risk assessments. Important elements of dynamic security were well established. Staff of all grades knew their prisoners, who received personal attention from officers, and there was effective communication between the residential units and the security department. A nominated security collator processed and categorised the many security information reports (1,610 in 2009 to date). Information was communicated to staff in all areas through monthly bulletins and published security assessments. Security committee meetings were well attended, and security objectives were set through appropriate consideration of intelligence.

2.204 The department, however, was not always able to respond immediately to all incoming information. Target drug testing and intelligence-led searches were not always conducted because security officers were often deployed to cover shortages elsewhere in the prison. The security department had lost over 400 staff hours in the previous six months due to this.

2.205 The modified free-flow system, with supervised prisoner movement during the beginning and end of planned regime activities, continued to be effective.

Further recommendation

2.206 The security department should be properly resourced to allow timely responses to intelligence-led work.

## Discipline

2.207 Unofficial or collective punishments should not be used. (6.31)

Achieved. The governor had issued an instruction prohibiting the use of unofficial and collective punishments. Staff were aware of the instruction, and there was no evidence that unofficial punishments were used.

2.208 Prisoners at adjudications should be issued with writing material, and a copy of Prison Rules should be made available to them. (6.32)

Achieved. Writing material and a copy of prison rules were available to prisoners before formal hearings (see additional information below).

2.209 Proper authority should be given and recorded for all uses of special accommodation, including special cells, dirty protest cells, safer cells and refractory cells. (6.33)

Partially achieved. Proper authority was given and recorded for the use of all special accommodation in the segregation unit. Records showed that the special accommodation here was only used in extreme conditions and only until the prisoner's behaviour could be managed safely in an ordinary cell. The average length of stay was 90 minutes. There had been a year-on-year reduction in the use of the two special cells in the segregation unit, from 21 times in the first four months of 2007 to 18 in the same period in 2008 and four occasions in 2009. Governance arrangements for the use of the two dirty protest cells had also improved, and these cells were only used when prisoners could not be managed in ordinary conditions. There were records of use and proper authorisation in all cases. However, proper authority was not sought for prisoners admitted to the high-dependency cells in strip conditions in the health services centre and there were no records of use (see paragraph 2.6 and further recommendation 2.7).

2.210 A full record of monitoring checks should be maintained for the use of special accommodation. (6.34)

Partially achieved. Records of monitoring were maintained for all prisoners in special accommodation, including dirty protest cells in the segregation unit. They showed that levels of observation were appropriate and were regularly reviewed by a senior manager. Records were not kept for prisoners put into strip conditions in the health services department.

2.211 Prisoners located in the segregation unit should have daily access to showers and telephones. (6.35)

Partially achieved. Prisoners could have a shower three times a week and a daily telephone call only through application in the morning.
We repeat the recommendation.

2.212 Planning systems should be in place to allow vulnerable prisoners and those under good order or discipline to return to normal prison location. (6.36)

Not achieved. There had been little change since the last inspection. Although the number of vulnerable prisoners segregated at their own request had reduced (see additional information below), systems to allow longer stay prisoners segregated under good order or discipline to return to normal prison location remained underdeveloped. Although algorithms were completed on time and case reviews took place, there was little information to show that progress in behaviour and circumstances was monitored or acted upon. There were no individual care plans with required action or desired outcomes. Behaviour targets were not set, and staff were not sufficiently engaged in planning processes.
We repeat the recommendation.

2.213 Management checks should take place regularly to ensure that entries in personal files are appropriate, and that they contain meaningful information about the mood and circumstances of segregated prisoners. (6.37)

Not achieved. As at the last inspection, written observations in personal files were generally poor. Most focused on single behaviour relating to the daily regime, such as access to exercise and showers. In some cases, entries indicated knowledge of the prisoner's personal circumstances, but most were not comprehensive enough to show that each prisoner's emotional and mental wellbeing had been effectively monitored.
We repeat the recommendation.

2.214 An activities regime should be provided for all prisoners located in the segregation unit. (6.38)

Not achieved. There was no evidence that in-cell education had been provided, and segregated prisoners were not able to attend workshops or education classes with other prisoners. They had no access to the library or to the gym. Prisoners segregated for good order or discipline remained unoccupied, and were locked in their cells for nearly the whole day.
We repeat the recommendation.

2.215 The segregation unit should not be used for holding prisoners for their own protection on a long-term basis. (6.39)

Achieved. There had been a big reduction in the number of prisoners segregated for their own protection, from an average of 27 in the six months to September 2008 to an average of one in the six months to end of March 2009. No prisoners had been segregated at their own request in the last three-month period, January to March 2009.

## Additional information

2.216 The number of formal adjudications, about 200 a month, was proportionate for the size and nature of the population. The adjudication room, in the segregation unit, was appropriately furnished with a large table and comfortable chairs for the adjudicating governor, assisting senior officer and the prisoner. Records of adjudications showed that hearings were conducted fairly and charges were fully investigated. Punishments were fair, and adjudicating governors had sometimes dismissed cases due to a lack of evidence or anomalies in process.

2.217 Adjudication standardisation meetings took place quarterly and were chaired by the deputy governor. They were well attended by adjudicating governors. Punishment tariffs had been published and were used consistently at formal hearings. Monthly statistics on the number and nature of adjudications were also presented. Results of proven offences were noted, categorised and communicated to adjudicators to identify trends and deal with problem areas as they arose.

2.218 Incidents involving the use of force had reduced significantly since the last inspection. There had been 292 incidents involving the use of force in 2008, which was a reduction of about 100 from 2007, and there had been 58 recorded incidents in the three months to the end of March 2009, a reduction of about 15 compared with the same period in 2008.

2.219 A use of force committee had been set up to ensure that protocols and procedures were carried out correctly. Information on the nature of the incident, its location and the ethnicity of the prisoners involved was collated each month and presented for analysis. Little of this useful information and analysis was used to inform the overarching violence reduction strategy, and this committee's links with the violence reduction committee were underdeveloped

2.220 Planned intervention was well organised, properly carried out and documentation was completed correctly. Proper authority was recorded and all incidents were appropriately supervised by senior staff. Statements by the staff involved gave assurance that intervention techniques were used properly and only when necessary. Health services staff attended planned interventions, and saw those involved in spontaneous incidents soon afterwards. Searching following an incident was sensitive, and there was always a formal debriefing of prisoners.

2.221 We saw many examples to show that de-escalation was used effectively during difficult situations, and there was evidence that managers consistently encouraged these responses. The use of force committee regularly reviewed intervention documentation, and staff were challenged appropriately where necessary.

2.222 The segregation unit was in the main part of the prison, away from the residential units. Accommodation consisted of 28 cells, including two special cells, one designated safer cell, a further two cells modified to accommodate prisoners on dirty protest, and 23 normal segregation cells. The ground floor had a staff office, adjudication room, interview room and a prisoners' shower, and there was an outside secure exercise yard. Communal areas were generally clean and well maintained. Notice boards displayed up-to-date information, and the unit's rules were clearly displayed. Segregation cells were generally clean and adequately furnished. The two special cells were unfurnished, with just a fixed plinth for a bed and no mattress, and had no sanitation facilities.

2.223 There were seven prisoners in the segregation unit at the time of the inspection. The average stay in segregation was about three weeks, although some had remained there for more than four months. Prisoners arriving on the unit were searched thoroughly and respectfully. They were only strip searched following an assessment of risk, and when authorised by the senior officer in charge. Prisoners had daily access to a governor and the chaplain in private, and there was a record of such visits. Relationships between staff and prisoners were good.

Further recommendation

2.224 Links between the use of force committee and the violence reduction committee should be improved.

## Incentives and earned privileges

2.225 Quality checks of entries in wing files should be made to ensure that they are fair and consistent, and that they explore the reasons for behaviour. (6.48)

Not achieved. The incentives and earned privileges (IEP) policy had been updated in November 2008 and, although it outlined a mechanism for monthly checks of wing files, we saw no evidence that this system was applied consistently. We reviewed a random selection of wing files from each house block and saw few management checks, and those that took place were simply signed by managers with no comments on areas requiring improvements. Weekly checks were rare. We saw some files with monthly entries, but others with no entries for two to three months. A significant number of files included mostly red entries, indicating warnings to prisoners, but with poor staff explanations for the behaviour. Although the IEP policy indicated a need for staff to be consistent, it seemed that some staff warned prisoners informally while others were more likely to use the formal warning system.
We repeat the recommendation.

## Additional information

2.226 The mechanism for reviewing the IEP status of prisoners was appropriate, although not consistent. For example, some prisoners who denied their offences and so were not engaged in offending behaviour work were told they could not reach enhanced status, in line with the IEP policy, whereas other prisoners in this situation could reach enhanced. At the time of the inspection, 200 prisoners (approximately 18%) were enhanced status and eight were on a basic regime. Enhanced status had limited benefits, which included an extra visit a month, extra money to spend in the shop and a few extra possessions. Prisoners on basic could still engage in education and/or work as well as attend offending behaviour programmes if appropriate.

Further recommendations

2.227 The incentives and earned privileges (IEP) scheme should be applied consistently.

2.228 There should be a greater distinction between standard and enhanced IEP levels to encourage progress.

## Catering

2.229 Prisoners working in the kitchen or on house block serveries should be properly health screened. (7.9)

Achieved. Prisoners were health screened before they were employed as hot plate servers. All wore appropriate protective clothing and had been trained in basic food hygiene.

2.230 Meals should be served in accordance with the published mealtimes. (7.10)

Achieved. Lunch was served between noon and 12.30pm and the evening meal between 5pm and 5.50pm, as published in the core day schedule.

2.231 Breakfast should be distributed at the servery on the morning when it is to be eaten, and should include fresh bread and a piece of fruit. (7.11)

Partially achieved. Breakfast packs were issued every morning and included fresh bread, cereal and milk. Prisoners were offered a cooked breakfast on Sunday mornings. Fresh fruit was available at either lunch or the evening meal every day.

2.232 Prisoners should be provided with a flask of hot water and some drinking water when they are locked up for the night. (7.12)

Partially achieved. Cell kettles had been provided for many prisoners, but some did not have kettles or flasks. All had access to clean drinking water.

Further recommendation

2.233 All prisoners should be provided with a kettle or flask for hot water.

2.234 Where prisoners are required to eat their meals in their cells, they should be able to sit at a table with the cell toilet fully screened off. (7.13)

Not achieved. Multi-occupant cells did not have enough table and chairs, and toilet screening remained inadequate in many cells (see paragraph 2.38). There were no facilities for prisoners to dine out of their cells.
We repeat the recommendation.

Further recommendation

2.235 There should be facilities for prisoners to dine out of their cells.

2.236 Prisoners in the segregation unit should be allowed to pre-select their meals. (7.14)

Achieved. Prisoners in the segregation were permitted to pre-select meals. Staff contacted the kitchen each morning to report any changes in the population of the unit.

2.237 All complaints about food should be passed to the catering manager. (7.15)

Achieved. There were food comments book on all house blocks, and catering staff visited each one at least once a week. Prisoners received answers to comments quickly, and comments were used to inform changes to the menu.

## Additional information

2.238 The main kitchen was large, clean and well ordered. Food was stored in proper conditions, and there were regular recorded stock control and quality checks. Religious and cultural dietary requirements for food preparation, distribution and quality were observed. Prisoners were offered pre-select menus for midday and evening meals over a three-week cycle. There was a wide range of choices, including a healthy option, and fresh fruit was offered every day. Meals were taken to the wing serveries in clean and working heated trolleys, and food temperature was taken on arrival. The serveries were generally clean and well equipped. There were monthly consultation meetings between the catering manager and prisoner food representatives from all house blocks, and the results of twice-yearly catering surveys were used to inform menu changes

## Prison shop

2.239 A prisoners' survey should be conducted to inform decisions on what items should be stocked. (7.22)

Achieved. Although there had been no survey, the prison had extended consultation on the shop goods list and wider issues. Prisoner forums oriented to the shop needs of prisoners took place every month with wing representatives from each house block. There was also an open forum every Friday afternoon where prisoners could raise any concerns. This forum was believed to a better means to reflect the needs of prisoners, given the relatively high turnover. The new shop contract included revisions to the shop list every 13 weeks, and this consultation process was used to inform decisions. Twice-yearly surveys to ascertain how effective and useful prisoners found the shop were also anticipated under the new contract.

2.240 The range of goods available should reflect the diverse needs of the prisoner population. (7.23)

Achieved. The number and range of goods in the prison shop had increased by 15% since the last inspection and there were now 379 items, including more that reflected the diversity of the population. The catering manager, who also oversaw the shop contract, attended the race equality action team and foreign national meetings and attempted to reflect the needs of these groups.

## Additional information

2.241 The contract for prison shop had changed in February 2009 to DHL Booker. The main store and administrative centre was in HMP Swaleside, from which deliveries were made across the area and not just within the Sheppey cluster. New arrivals received a smoker's or non-smoker's pack until they could make a full order. Orders had to be in by Wednesday morning, and we were told that there was no flexibility with this system. If prisoners arrived on Wednesday or were at court and missed the usual order timetable, they had to wait a week to access the shop. Extra smoker's and non-smoker's packs were available, and prisoners who could afford it could buy extra packs if they missed the timetable. Given that the shop was based in the Sheppey cluster, we were surprised that a more flexible approach was not possible. Prisoners could order goods from a reasonable range of catalogues, and they were not charged for delivery.

Further recommendation

2.242 Prisoners who miss the usual weekly shop order timescale because of the day of their arrival or court appearances should be able to submit late orders.

## Strategic management of resettlement

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

## Additional information

2.243 Resettlement work was incorporated into the wider Sheppey prison cluster reducing reoffending model. At the time of the inspection, there was no up-to-date reducing reoffending strategy document, and the prison still operated to the three-year service level agreement published in 2005. Although this document was comprehensive and covered all key aspects of delivery, it was now out of date and did not accurately reflect some aspects of provision. Similarly, the needs analysis on which the document was based was also out of date, and it was unclear if the identified needs still accurately reflected the prison's population.

2.244 There were two monthly strategy meetings across the cluster; one oriented to the strategic management of the service, the other to performance management. Both meetings were attended by senior managers responsible for the delivery of core aspects of the service, including the heads of offender management and pathway leads. Some sub-groups in the cluster also met monthly. The cluster drug strategy group met to review drug service provision, and managers from each of the offender management teams also met. However, there was no forum for service or pathway providers in each establishment to meet together and, while staff were knowledgeable about their own areas, they did not always appreciate the wider resettlement and reducing reoffending provision in the establishment. This was of greatest

concern for prisoners serving less than 12 months or on remand, for whom there was very little planned resettlement work.

Further recommendations

2.245 The reducing reoffending policy and strategy document should be updated annually and be supported by an up-to-date needs analysis.

2.246 Elmley should develop its own resettlement group to ensure the dissemination and implementation of cluster-based reducing reoffending strategic objectives.

## Offender management and planning

2.247 A formal custody planning system should be introduced for remand prisoners and prisoners serving less than 12 months. (8.15)

Not achieved. Prisoners on remand and those serving sentences of less than 12 months still had no formal custody planning. Planning for these prisoners had started, but required considerable further work. All new arrivals completed an induction portfolio, which included a basic analysis of resettlement needs. Although prisoners serving over 12 months were subject to sentence planning and, if within target, further offender management contact, there was no further assessment or analysis for those serving less than 12 months or on remand. The induction resettlement assessment was completed with help from one of the four prisoner peer supporters, who could forward referrals to resettlement departments. In practice, they rarely made referrals outside the information, advice and guidance (IAG) department, where they were based. There was no system to ensure that appropriate referrals were made or followed up, and it was not clear what happened to the assessment document once induction was completed. We were variously told that they were held by IAG, offender management and the wings. We saw several wing files that contained the document, but personal officers and others were not aware of the content. Approximately six weeks before release, prisoners were called up for an interview with the employment, training and education (ETE) worker and, we were told, peer supporters often undertook these as well to support the process. Although all aspects of resettlement could be evaluated at this interview, in practice it focused primarily on accommodation and training/education need, along with signposting for finance, benefit and debt issues, which were all areas covered by the IAG department.
We repeat the recommendation.

Further recommendation

2.248 Induction resettlement assessments should be stored in an agreed location, and they should be used to inform the resettlement needs of prisoners, especially those serving less than 12 months and on remand.

2.249 All prisoners sentenced to 12 months or more – particularly those requiring offender management – should have an initial offender assessment system (OASys) assessment carried out by their offender manager. (8.16)

Partially achieved. The majority of initial OASys assessments had been completed. Depending on the prisoners' sentence, some were completed by offender supervisors at the prison and some by offender managers in the community. There were only three initial

assessments outstanding for the 195 prisoners in-scope for offender management and with allocated offender managers, although one dated back to January 2009. A further 17 had reviews that were out of date. Of the OASys assessments that were the prison's responsibility, two initial assessments and 13 reviews were outstanding.

Further recommendation

2.250 All prisoners sentenced to 12 months or more should have an up-to-date initial offender assessment system (OASys) assessment or review to inform their sentence planning and risk assessment.

2.251 The prison should make much greater proactive use of release on licence, subject to risk assessment, to facilitate prisoners' preparation for release. (8.30)

Not achieved. Although the process for reviewing and agreeing release on temporary licence (ROTL) was appropriate, its use was still low. Only nine prisoners had applied for ROTL in the previous six months, of whom only two had been successful. From the information available to us during the inspection, it was not possible to ascertain how many prisoners would have qualified for consideration during this period, but offender management staff did not inform the prisoners they were responsible for when or if they qualified, and we saw no information about the process on the wings.
We repeat the recommendation.

### Indeterminate-sentenced prisoners

2.252 Indeterminate- and life-sentenced prisoners should be transferred to a suitable establishment as soon as possible after sentence, once the appropriate assessments have taken place, and should not be left for months in local prisons unable to achieve targets set for them. (8.13)

Achieved. At the time of the inspection, there were 54 mandatory and discretionary life-sentenced prisoners and 39 prisoners subject to indeterminate sentences for public protection (IPP). All IPP prisoners were allocated to one of the eight core offender supervisors. A recent change in lifer management had resulted in the allocation of all discretionary and mandatory lifers to one specialist offender supervisor. The general management and progress of these prisoners was reasonable. Transfers of indeterminate-sentenced prisoners, especially IPPs, had improved in the previous 12 months, and newly sentenced prisoners could be moved with relative ease once appropriate assessments had been completed. Since August 2008, 27 mandatory and discretionary lifers had been moved to Swaleside.

2.253 Prisoners serving indeterminate sentences for public protection and who have short tariffs should, subject to risk assessment and the availability of appropriate interventions, be able to transfer directly to a category C prison. (8.14)

Achieved. Recategorisation and allocation of IPP prisoners had improved in the previous 12 months and, subject to assessment, they could be transferred to category C conditions with relative ease. At the time of the inspection, nine of the 39 IPP prisoners (23%) were category C and on house block 5.

2.254 All staff acting as personal officers to life- and indeterminate-sentenced prisoners should be lifer trained. (8.17)

Not achieved. Personal officers were allocated to prisoners on the basis of their cell location. There was no consideration of the individual needs of prisoners and, although all indeterminate-sentenced prisoners were allocated to a personal officer, these officers were not necessarily lifer trained. Relatively few staff had been lifer trained. Most of the offender supervisors, based in offender management, had undertaken training but few house block staff had, and for those who had, this was some time ago. We were told that the relatively new managing indeterminate sentences and risk (MISaR) training was planned, but no dates had been agreed.
We repeat the recommendation.

2.255 A peer support group should be set up for lifers. (8.18)

Not achieved. At the time of the inspection, there was no lifer peer support group. We were told that they had been introduced since the last inspection, along with lifer representatives, but that they had stopped as demand and attendance had declined. There were plans to reintroduce these meetings. There were also no lifer family days, although indeterminate-sentenced prisoners on the category C wing of house block five (28 in total, including IPPs), could attend the occasional family days run there. There was no specific strategy for managing indeterminate-sentenced prisoners, although a new strategy was due to be launched.
We repeat the recommendation.

Further recommendation

2.256 There should be a specific strategy for indeterminate-sentenced prisoners, which should incorporate a full range of provision and support for this group.

## Additional information

2.257 At the time of the inspection, 195 prisoners, including IPPs, were in-scope for offender management. The level of service for these prisoners was reasonable. The eight offender supervisors saw prisoners each month, and the file information indicated that they had a reasonable knowledge of their needs and risk factors. Links had also been established with community-based offender managers, and the video-conferencing facilities had helped offender managers facilitate sentence planning meetings.

2.258 For the remaining sentenced population serving over 12 months but not in-scope for offender management – approximately 200 at any time – an offender supervisor was allocated and an OASys completed, However, following the initial assessment of sentence planning and resettlement needs, there was no further planned contact until the next annual review, if there was one. Prisoners serving less than 12 months and those on remand or awaiting sentence did not have any planned offender management contact, and there was no structured mechanism to assess or monitor resettlement need.

2.259 Prisoners could see someone from the offender management unit (OMU) if they wished, even if they had not been allocated an officer, although priority was given to those who had been. To offer a more effective service, offender supervisors had begun to run open surgeries on Friday afternoons on a five-week cycle across all house blocks.

2.260 Public protection arrangements were good. In total, 264 prisoners had been identified as subject to multi-agency public protection arrangements (MAPPA). MAPPA two and three

cases were reviewed regularly, as were the 92 prisoners subject to risk to children and harassment. Public protection meetings were fortnightly and attended by a multidisciplinary group. Offender supervisors who were responsible for the prisoners being reviewed presented cases to the board.

### Resettlement pathways

### Reintegration planning

### Accommodation

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

### Additional information

2.261 New arrivals were interviewed by prisoner peer supporters during induction to complete an initial housing needs assessment . Although this partly replicated the basic resettlement induction analysis, it was more detailed. In the previous six months, 99% of prisoners had been assessed. If issues were identified further contact was available, although usually not until the prisoner was within six months of planned release. The prison had a reasonable range of contacts with community-based service providers. In the previous six months, 99% of the 472 prisoners released had gone into settled accommodation –only two prisoners had left with no fixed accommodation.

2.262 The two prison officers and four peer supporters who worked in the IAG department had had some training through Shelter, and one peer supporter was undertaking a level three national vocational qualification in advice and guidance through the St Giles Trust.

### Education, training and employment

2.263 All prisoners should be able to access a suitable job-search facility in the weeks before their release (8.29)

Achieved. Jobcentre Plus staff offered job search through the IAG department. At the time of inspection, Elmley had only two to three days a week support from Jobcentre Plus, and the prison was addressing this. The library had a computer resource to support CV and letter writing for job application, and a small supply of college and careers advice brochures. A pastoral care and support member of the education staff worked closely with the IAG staff to help prisoners go into distance learning programmes and further training on release.

Further recommendation

2.264 There should be increased support from Jobcentre Plus.

### Additional information

2.265 New arrivals received support from peer orderlies during induction and were signposted to relevant pathway staff in the IAG department. The A4E education and training support worker worked closely with IAG staff to determine the most appropriate support for prisoners, and arranged their access to Jobcentre Plus staff for employment opportunities.

2.266 The prison offered a Construction Skills Certificate Scheme (CSCS) award, and in the previous five months, over 50 learners a month had gained it. A 'starting a business venture' course had recently been introduced for those seeking self-employment. The prison was investigating forklift truck training to support employment chances. Those eligible for ROTL were often relocated to HMP Standford Hill, where there was a working out programme.

2.267 Prisoners had access to a 'transit to work' course before release. The one-week course supported CV writing, interview techniques and disclosure. Prisoners generally within 12 weeks of release were identified and given an exit interview with peer support orderlies or the education, training and employment officer and offered the course, if appropriate. Prisoners with less than 12 weeks to serve were accommodated where possible.

### Finance, benefit and debt

2.268 The current situation with regard to the provision of services by CAB on financial and debt-related issues should be resolved, and provision of services against this pathway should be restored as a priority. (8.31)

No longer relevant. The prison no longer had a contract with the Citizens Advice Bureau (CAB).

### Additional information

2.269 Since the CAB contract had ended in April 2008, there had been no formal provision of finance, benefit and debt advice (although a contract for the service was currently out to tender). IAG staff assessed finance, benefit and debt need at the same time as they looked at new arrivals' housing requirements, and through the induction portfolio. In the previous six months, 1,115 assessments had indicated a finance, benefit and debt issue and, although there had been an equal number of interventions, it was not clear what this work had involved. We were told that it was almost always signposting at the point of release. There were no records to indicate the range of problems presented.

2.270 The education department provided a money management programme as part of its life and social skills package, but this was operated in isolation from the IAG provision.

Further recommendation

2.271 Finance, benefit and debt support for prisoners should be developed and integrated with the range of resettlement provision.

### Mental and physical health

2.272 Prisoners should be given information and assistance to access health and social services on their release, and if necessary support in accessing these services. (8.32)

Achieved. Health services staff saw all prisoners in reception before their release. They were given enough medication to last them until they saw their GP, where relevant, as well as a letter outlining their care in prison. If they did not have a GP they were advised how to register with one.

## Drugs and alcohol

2.273 Relevant departments should attend drug strategy meetings to improve communication and the coordination of services. (8.48)

Partially achieved. There were monthly prison drug strategy meetings and quarterly cluster meetings. Staff from the integrated drug treatment system (IDTS) and counselling, assessment, referral, advice and throughcare service (CARATs) attended regularly, but health services and other areas were unable to send a representative regularly due to staffing pressures.
We repeat the recommendation.

2.274 The drug strategy should detail action plans, targets and monitoring arrangements relating to the clinical management of substance users. (8.49)

Partially achieved. The 2009/10 drug strategy had been produced, but it had no specific reference to action plans for the clinical management of substance users, other than to support and improve clinical and psychological interventions.
We repeat the recommendation.

2.275 Joint working protocols should be developed between the health services department, the substance misuse service, and the counselling, assessment, referral, advice and throughcare (CARAT) service. Regular multidisciplinary meetings should take place to facilitate joint care planning and coordination. (8.50)

Not achieved. There were no joint working protocols between these departments, although there was evidence of joint working, particularly between CARATs and IDTS. This had been facilitated by their co-location, and CARATs and IDTS regularly met informally and formally. There was good cooperation between health services, IDTS and CARATs staff for the care planning of individual prisoners.
We repeat the recommendation.

2.276 CARAT and programme staff should have adequate office accommodation, IT facilities and administrative support. (8.51)

Partially achieved. The CARAT team offices were large but overcrowded, and working conditions were difficult. There was not enough IT equipment, with only three computer terminals for the team. Administrative support was limited to one worker, which was not adequate.

Further recommendation

2.277 The CARAT team offices should be improved, and the team should have additional computers and administrative support.

2.278 CARAT team resources should be increased, to allow structured support for prisoners undergoing detoxification, and to decrease caseloads and waiting lists. (8.52)

Partially achieved. The CARAT team had been increased, but it was currently fully stretched to handle its caseload of 474 prisoners. The additional house block would increase demands for its services when it opened. The team comprised a full-time manager and senior worker, six

full-time CARAT workers, two officers and a short duration drug programme (SDP) link worker. There was one vacancy for a CARAT worker.

Further recommendation

2.279 There should be adequate space, accommodation and personnel for the CARAT team to care and support all prisoners who need the service, and to handle the increased caseload when the new house block opens.

2.280 The prison should develop a designated drug-free spur, and a peer support scheme for prisoners undertaking or completing programmes. (8.53)

Achieved. A drug-free spur had been allocated on house block 3, and two peer supporters worked with prisoners undertaking programmes.

2.281 Compacts should clearly state that the prison is running a compliance testing scheme. Sufficient officer time should be detailed for this task. (8.54)

Not achieved. The compact and arrangements governing compliance and voluntary drug testing remained unclear. There was only one compact to cover both voluntary and compliance testing programmes, with no distinction between them. Prisoners on enhanced status, and those on the SDP and P-ASRO (prison addressing substance related offending) programme were expected to sign up to voluntary drug testing, but this was in effect compliance testing. We were told that it was rare for the full number of voluntary drug tests required to be completed. In March 2009, although 830 prisoners had signed a compact, only 815 tests had been completed, against a target of 1,245 (1.5 tests per compact).

Further recommendation

2.282 The prison should clearly differentiate between compliance and voluntary drug testing, and operate two separate systems with two separate compacts.

## Children and families of offenders

2.283 Prisoners' outgoing mail should be posted within 24 hours, and incoming mail should be delivered within 24 hours of its receipt into the prison. (3.99)

Not achieved. We were told that both incoming and outgoing mail could be delayed by up to 24 hours when there were staff shortages in the mailroom. Incoming mail usually arrived in the prison at about 10am, and the prison aimed to deliver registered and special items before the lunchtime lock up. Outgoing mail was collected from the wings at the same time. Although staff endeavoured to process mail on time, the volume of mail and staff shortages meant that some ingoing and outgoing mail could be delayed until at least the next day. Some prisoners told us of their lack of confidence in the mail arrangements, and we saw several formal complaints about delayed mail.

Further recommendation

2.284 All mail should be delivered to prisoners on the day it arrives in the prison and all mail sent by prisoners should be dispatched on that day.

2.285 Procedures for setting up telephone PIN credit should be improved. (3.100)

Achieved. All new arrivals were given a PIN (personal identification number) and £2.00 telephone credit, which gave them immediate access to the telephone. They were not required to repay this advance. Failure by prisoners to complete a PIN telephone compact no longer prevented their access to telephones, as at our last inspection.

2.286 Residential staff on the induction wing should help prisoners to book a reception visit. (3.101)

Achieved. All new arrivals were permitted a reception visit, usually within seven days of arrival. Induction staff and peer supporters gave advice on how to access a reception visit, and this was noted in the induction portfolio checklist. Convicted prisoners did not need a visiting order for the reception visit, as long as it was booked 24 hours in advance. Some tables in the visits room were reserved each day to accommodate late-booked reception visits.

2.287 The process of taking visitors across to the main prison after they have checked in at the visitors' centre should begin at least 30 minutes before visits begin. (3.102)

Not achieved. The visitors' centre, which was outside the prison, opened at 10.30am to allow visitors to book in, although visits did not start until 2pm. Visitors were allocated a tally on a first come, first served basis, which determined when they were taken across to the prison. Visitors arrived very early to get to the front of the queue and maximise their visiting time. Visitors were allowed into the prison from 1.40pm and were taken across in batches of 10, so the earliest the first group could enter the prison was 15 or 20 minutes before visits began. Each batch of visitors took about 10 minutes to be processed at the gate. There were usually 50 to 60 visits a day – and sometimes as many as 85 – which meant potential delays for many visitors. Visitors who arrived early could potentially have a two-hour visit, space permitting. Late arrivals could book in at the visitors' centre as late as 3.30pm. Visits sessions concluded at 4.14pm.
We repeat the recommendation.

2.288 The visits holding area for prisoners should be improved. (3.103)

Not achieved. The prisoners' holding room for visits was unchanged from our last inspection. It was small and bare, with just two benches, and was also covered in graffiti.
We repeat the recommendation.

2.289 The crèche should be supervised by trained staff. (3.104)

Not achieved. There were no trained staff in the crèche and few toys for children. The only resource was some children's videos.

Further recommendation

2.290 Toys and children's books should be provided in the children's play area in visits, which should be supervised by trained staff.

2.291 The development plans outlined in the reducing reoffending strategy that relate to improving family involvement should be implemented. (8.61)

Partially achieved. The Sheppey cluster reducing reoffending service level agreement (SLA) included plans for development of the resettlement pathways. Although out of date, some of the plans for the children and families pathway had been achieved. For example, two members of the cluster IAG team now led on children and families work for the cluster. Although there was no family resource centre, as outlined in the SLA, the visitors' centre was welcoming, well equipped and provided a range of information for visitors, although mainly in English only. It had good play facilities for children, including an outside play area. The prison worked with Relate to provide periodic family learning sessions for prisoners, and a parallel programme of sessions for prisoners with their partners. Other plans set out in the SLA had either lapsed or were underdeveloped. There had been an extended family or children's visit session at Christmas, but there was no continuing programme. The Storybook Dad programme was limited. Only one prisoner had completed a unit of the education, social and life skills programme that dealt with family relationships. The SLA plan had a commitment to provide an information pack for families, and a booklet had been produced but was still only in draft form, three years on from the SLA. Most work in support of this pathway was limited and underdeveloped.

Further recommendations

2.292 The prison should revise and update the plan to deliver work in support of the children and families pathway, and the plan should be implemented.

2.293 Information provided in the visitors' centre should be available in a range of languages.

2.294 The information for families and friends booklet should be published without further delay.

## Additional information

2.295 There were more than 50 telephones for prisoners, which more than met our expectation of at least one per 20 prisoners. Prisoners raised some concerns about delays in repairing broken telephones on house block 5, but access was generally good.

2.296 Visits booking arrangements were satisfactory. A booking line was available for about nine hours a day, visits could be booked by email, and visitors could book further visits when they visited.

2.297 Visiting arrangements were good, with at least two-hour sessions on seven days a week. The visitors' centre was complemented by a spacious and welcoming visits hall, although there was fixed furniture for the 89 places. There were five closed visits booths of a reasonable standard, which were sufficient to meet demand. The centre and the visits hall had tea bars operated by

a contractor. The atmosphere in the visits hall was relaxed, despite the large number of visits, and supervision by staff was good but unobtrusive. There was a photograph ID card system to identify prisoners in the room, but the requirement for prisoners to wear orange bibs on visits was excessive.

Further recommendation

2.298 Prisoners should not be required to wear bibs during visits.

## Attitudes, thinking and behaviour

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

## Additional information

2.299 The regimes team provided programmes across all three prisons in the cluster, except for those oriented to substance misuse. Programmes included extended thinking skills (ETS), cognitive skills booster and CALM (controlling anger and learning to manage it). In the last 12 months, ETS had run eight times with a total of 80 prisoners, and CALM just once, with eight prisoners. The cognitive booster programme was relatively new and had yet to be delivered. Although referrals for these programmes could come from any department or a self-referral, because an OASys was required, referrals were usually always through the OMU. At the time of the inspection, 50 prisoners at Elmley were on the waiting list for ETS.

2.300 The sex offender treatment programme was no longer available in the Sheppey prison cluster and the resources had been moved to HMP Maidstone. Where appropriate, prisoners could be moved there to complete the course.

2.301 Elmley had two substance misuse programmes, P-ASRO and SDP (see also Drugs and alcohol above), which offered a total of 216 places a year for Elmley prisoners. Facilities and provision for these programmes were generally good.

2.302 There were currently no non-accredited programmes, although one on victims' issues for IPP prisoners was due to start in May 2009. As there was no up-to-date needs analysis, it was not possible to establish whether the current range and level of programmes met the needs of the prisoner population at Elmley.

Further recommendations

2.303 The level of accredited offending behaviour programme provision should match the needs of the population.

2.304 Shorter non-accredited programmes should be provided to meet the needs of the population not covered by accredited courses.

# 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 the Director General, NOMS

3.1 Written information about the prison should be routinely issued to prisoners at court, before their transfer, in a language they understand. (2.17)

## Recommendations — To the Chief Executive Officer of the Sheppey cluster

### Substance use

3.2 The administration of medicines in house block 5 should take place in a safe and appropriate environment. (2.9)

3.3 Prisoners undergoing detoxification should be housed in a dedicated area containing interviewing and group-work facilities. (2.129)

3.4 The prison should pursue the bid for an increase in integrated drug treatment system (IDTS) services, with appropriate accommodation and sufficient personnel to meet the clinical and psychosocial needs of prisoners. (2.135)

3.5 Suspicion drug testing should be undertaken consistently, and the success rate should be improved. (2.136)

### Health services

3.6 The redecoration of the inpatient unit should be carried out promptly. (2.138)

3.7 Clinical records, such as the reception screen, should be available to health professionals when a patient is being seen. (2.145)

3.8 The pharmacist should visit the prison more often, and prisoners should be informed of the opportunity to see the pharmacist during these visits. (2.151)

3.9 The beds in health services should not form part of the prison's certified normal accommodation, and admission should only be according to assessed clinical need. (2.156)

3.10 Primary and secondary care mental health nurses should aim to attend assessment, care in custody and teamwork (ACCT) reviews or provide verbal feedback if they are unable to do so. (2.158)

3.11 Health services should provide day care for those less able to cope with life on the house blocks. (2.159)

3.12 Prisoners attending triage clinics should not have to wait more than three days to see the triage nurse. (2.169)

3.13 The use of strip clothing in a healthcare setting should be monitored and documented in the patient's clinical record, and there should be a central register in the inpatient area. (2.170)

3.14 Senior management should investigate the cause of non-attendance at dental clinics and ensure that clinical time is not wasted due to non-attendance. Prisoners who fail to attend appointments should be followed up. (2.171)

3.15 There should be mental health awareness training for prison staff. (2.172)

## Learning and skills and work activities

3.16 More activity and work should be provided and include more education and accredited training. (2.12)

3.17 Planning of individual learning and training should be improved, include all prisoners and be linked more effectively to sentence and custody planning and prisoners' sentences. (2.174)

3.18 A strategy should be developed to increase access to the library for all prisoners (2.176)

3.19 There should be more work opportunities for vulnerable prisoners. (2.184)

## Strategic management of resettlement

3.20 There should be much greater integration of resettlement services across the range of pathways. A properly equipped facility should be found to enable everyone working on reintegration services to be brought together to provide effective and coordinated provision, easily accessible by all prisoners approaching release. (2.13)

3.21 The reducing reoffending policy and strategy document should be updated annually and be supported by an up-to-date needs analysis. (2.245)

3.22 Elmley should develop its own resettlement group to ensure the dissemination and implementation of cluster-based reducing reoffending strategic objectives. (2.246)

## Offender management and planning

3.23 A formal custody planning system should be introduced for remand prisoners and prisoners serving less than 12 months. (2.247)

3.24 Induction resettlement assessments should be stored in an agreed location, and they should be used to inform the resettlement needs of prisoners, especially those serving less than 12 months and on remand. (2.248)

3.25 All prisoners sentenced to 12 months or more should have an up-to-date initial offender assessment system (OASys) assessment or review to inform their sentence planning and risk assessment. (2.250)

3.26 The prison should make much greater proactive use of release on licence, subject to risk assessment, to facilitate prisoners' preparation for release. (2.251)

3.27 All staff acting as personal officers to life- and indeterminate-sentenced prisoners should be lifer trained. (2.254)

3.28 A peer support group should be set up for lifers. (2.255)

3.29 There should be a specific strategy for indeterminate-sentenced prisoners, which should incorporate a full range of provision and support for this group. (2.256)

## Resettlement pathways

3.30 There should be increased support from Jobcentre Plus. (2.264)

3.31 Finance, benefit and debt support for prisoners should be developed and integrated with the range of resettlement provision. (2.271)

3.32 Relevant departments should attend drug strategy meetings to improve communication and the coordination of services. (2.273)

3.33 The drug strategy should detail action plans, targets and monitoring arrangements relating to the clinical management of substance users. (2.274)

3.34 Joint working protocols should be developed between the health services department, the IDTS and the counselling, assessment, referral, advice and throughcare (CARAT) service. Regular multidisciplinary meetings should take place to facilitate joint care planning and coordination. (2.275)

3.35 The CARAT team offices should be improved, and the team should have additional computers and administrative support. (2.277)

3.36 There should be adequate space, accommodation and personnel for the CARAT team to care and support all prisoners who need the service, and to handle the increased caseload when the new house block opens.(2.279)

3.37 The prison should clearly differentiate between compliance and voluntary drug testing, and operate two separate systems with two separate compacts. (2.282)

3.38 All mail should be delivered to prisoners on the day it arrives in the prison and all mail sent by prisoners should be dispatched on that day. (2.284)

3.39 The process of taking visitors across to the main prison after they have checked in at the visitors' centre should begin at least 30 minutes before visits begin. (2.287)

3.40 The visits holding area for prisoners should be improved. (2.288)

3.41 Toys and children's books should be provided in the children's play area in visits, which should be supervised by trained staff. (2.290)

3.42 The prison should revise and update the plan to deliver work in support of the children and families pathway, and the plan should be implemented. (2.292)

3.43 Information provided in the visitors' centre should be available in a range of languages. (2.293)

3.44 The information for families and friends booklet should be published without further delay. (2.294)

3.45 Prisoners should not be required to wear bibs during visits. (2.298)

3.46 The level of accredited offending behaviour programme provision should match the needs of the population. (2.303)

3.47 Shorter non-accredited programmes should be provided to meet the needs of the population not covered by accredited courses. (2.304)

## Recommendations

To the governor

### First days in custody

3.48 A trained Listener should be used in reception. (2.22)

3.49 All cells used to accommodate first night prisoners should be clean, properly equipped and well decorated. (2.25)

3.50 Patrol staff should be aware of the cell locations of any prisoners who arrived on that day. (2.26)

3.51 Holding rooms in reception should be clean and adequately decorated. (2.37)

### Residential units

3.52 Cells should hold only the number of prisoners they were designed for. (2.38)

3.53 The offensive display policy should be enforced. (2.39)

3.54 Communal areas on house block 5 should be decorated and maintained. (2.40)

3.55 All cells should be kept clean and free from graffiti. (2.41)

3.56 The prison grounds should be clean and without food and animal waste, and should be free from vermin. (2.48)

### Personal officers

3.57 Prisoners should not have to change personal officer when they change cell location within the same house block. (2.51)

3.58 There should be regular management checks and quality assurance to ensure consistent delivery of the personal officer scheme. (2.53)

### Bullying and violence reduction

3.59 The violence reduction strategy should be updated and relaunched, and the violence reduction committee should oversee its implementation. (2.2)

3.60 The violence reduction coordinator should have regular meetings with anti-violence wing liaison officers. (2.55)

3.61 The violence reduction coordinator should receive appropriate training and support. (2.57)

3.62 The collection and analysis of data on bullying and intimidation should be improved. Patterns and trends should be identified and submitted to the violence reduction committee for scrutiny. (2.58)

3.63 Health services staff should pass on details of all unexplained injuries to the violence reduction coordinator. (2.60)

3.64 There should be regular victimisation surveys, and their results should be analysed and used to inform the violence reduction strategy. (2.61)

3.65 There should be appropriate interventions in place for bullies and victims of bullying. (2.62)

3.66 Bullying investigations should be carried out to a high standard and completed within the designated timescales. (2.66)

3.67 A representative from the security department should attend the violence reduction committee meeting. (2.67)

3.68 Victim support logs should be introduced to give evidence of support for victims. (2.68)

3.69 There should be a quality assurance scheme to oversee the management of bullying investigations. (2.69)

## Vulnerable prisoners

3.70 Plans should be introduced to support the active reintegration of suitable prisoners to normal location. (2.71)

## Self-harm and suicide

3.71 Unfurnished accommodation should only be used to manage prisoners who are self-harming in the most exceptional circumstances. (2.4)

3.72 The safer custody coordinator should always be advised when prisoners subject to assessment, care in custody and teamwork (ACCT) self-harm monitoring are placed in unfurnished accommodation or strip clothing. (2.5)

3.73 Health services staff should be represented at all safer custody meetings. (2.73)

3.74 Ongoing analysis should be carried out by the safer custody committee to monitor and follow up trends detected in the data produced by the safer custody officer. (2.74)

3.75 Agency nurses should complete assessment, care in custody and teamwork (ACCT) training. (2.76)

3.76 The quality assurance system should emphasise the quality of work rather than the process. (2.77)

3.77 A permanent crisis suite should be available at all times. (2.81)

3.78 The safer custody coordinator should receive appropriate training and support. (2.85)

3.79 The prison should introduce activities and therapeutic interventions for prisoners in crisis. (2.86)

3.80 Interim action plans should be developed following a death in custody to identify immediate improvements. (2.87)

## Diversity

3.81 Older prisoners should have access to a regime that fully meets their needs and provides a range of age-appropriate activities. (2.88)

3.82 The diversity strategy should address the needs of older prisoners. (2.89)

3.83 Retired prisoners should receive the additional retirement payment outlined in the prison's action plan, and the level of this should be subject to annual review. (2.91)

3.84 The diversity policy should be revised and relaunched, and include specific sections on age and sexuality, as well as disability and race equality. (2.95)

3.85 The diversity and race equality committee should receive quarterly information that highlights trends and patterns over time. (2.96)

## Race equality

3.86 The prison should continue to explore black and minority ethnic prisoners' perceived differential access to the regime with prisoner representatives. (2.98)

3.87 There should be staff back-up arrangements to cover the absence of the diversity and race equality officer. (2.101)

3.88 The diversity and race equality committee should receive and analyse trend data from racist incident report forms. (2.102)

## Foreign national prisoners

3.89 The foreign nationals coordinator should have the necessary time and resources to cover the responsibilities involved and to develop the role. (2.103)

3.90 Effective arrangements should be put in place to cover absences of both the foreign nationals coordinator and the immigration clerk. (2.105)

3.91 The diversity consultation meetings with prisoners should be used to explore further the wide variations in perceptions in many areas between foreign and British prisoners. (2.106)

3.92 There should be regular surveys of foreign national prisoners. (2.107)

3.93 Staff should be briefed on the specific needs of foreign national prisoners. (2.111)

3.94 The prison should approach the UK Border Agency to arrange regular surgeries with immigration officials. (2.112)

3.95 The prison should establish access to independent immigration advice services for prisoners. (2.113)

3.96 The library should provide foreign language newspapers and magazines. (2.114)

## Applications and complaints

3.97 Complaints should not be filed away as dealt with until a substantive response has been produced. (2.115)

3.98 Complaints submitted to the area manager through confidential access that are not deemed suitable to be dealt with through this channel should be forwarded to and addressed by the relevant department. (2.116)

3.99 Responses to complaints should be respectful and deal thoroughly with the issue raised. (2.118)

3.100 The applications system should record when prisoners receive a response to their application. (2.121)

3.101 Information on complaints should be analysed more thoroughly by type, location and resolution, and reported regularly to the senior management team. (2.122)

3.102 Complaints should be quality assured on a regular basis. (2.123)

## Legal rights

3.103 The legal services officer should receive appropriate training. (2.125)

## Faith and religious activity

3.104 There should be suitable washing facilities for Muslim prisoners. (2.194)

## Time out of cell

3.105 Prisoners who are not assigned to an activity place should be given more opportunities during the working day to spend time out of their cells. (2.195)

3.106 Exercise yards should be thoroughly cleaned each day, and this task should be signed off by a member of staff on the daily wing register. (2.196)

3.107 Evening association periods should not be cancelled. (2.200)

## Security and rules

3.108 Security managers should attend all drug strategy committee meetings to ensure that all relevant information is shared to help inform the prison's drug strategy. (2.202)

3.109 The security department should be properly resourced to allow timely responses to intelligence-led work. (2.206)

## Discipline

3.110 Prison Service procedures for the use of special accommodation should be incorporated into an operational instruction, which also covers level of authorisation and governance of use. Staff should be trained in the procedures, which should be applied in line with the instruction. (2.7)

3.111 Prisoners located in the segregation unit should have daily access to showers and telephones. (2.211)

3.112 Planning systems should be in place to allow vulnerable prisoners and those under good order or discipline to return to normal prison location. (2.212)

3.113 Management checks should take place regularly to ensure that entries in personal files are appropriate, and that they contain meaningful information about the mood and circumstances of segregated prisoners. (2.213)

3.114 An activities regime should be provided for all prisoners located in the segregation unit. (2.214)

3.115 Links between the use of force committee and the violence reduction committee should be improved. (2.224)

## Incentives and earned privileges

3.116 Quality checks of entries in wing files should be made to ensure that they are fair and consistent, and that they explore the reasons for behaviour. (2.225)

3.117 The incentives and earned privileges (IEP) scheme should be applied consistently. (2.227)

3.118 There should be a greater distinction between standard and enhanced IEP levels to encourage progress. (2.228)

## Catering

3.119 All prisoners should be provided with a kettle or flask for hot water. (2.233)

3.120 Where prisoners are required to eat their meals in their cells, they should be able to sit at a table with the cell toilet fully screened off. (2.234)

3.121 There should be facilities for prisoners to dine out of their cells. (2.235)

3.122 Prisoners who miss the usual weekly shop order timescale because of the day of their arrival or court appearances should be able to submit late orders. (2.242)

# Appendix I: Inspection team

| | |
|---|---|
| Martin Lomas | Team leader |
| Keith McInnis | Inspector |
| Marie Orrell | Inspector |
| Gordon Riach | Inspector |
| Bridget McEvilly | Health services inspector |
| Bob Cowdrey | Ofsted 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 | 18–20 yr olds | 21 and over | % |
|---|---|---|---|
| Sentenced | 17 | 474 | *53.89* |
| Recall | 6 | 69 | *8.23* |
| Convicted unsentenced | 17 | 112 | *14.16* |
| Remand | 28 | 176 | *22.39* |
| Civil prisoners | 0 | 1 | *0.10* |
| Detainees | 3 | 8 | *1.20* |
| Total | 71 | 840 | |

| Sentence | 18–20 yr olds | 21 and over | % |
|---|---|---|---|
| Unsentenced | 51 | 285 | *36.88* |
| Less than 6 months | 0 | 64 | *7.02* |
| 6 months to less than 12 months | 2 | 55 | *6.25* |
| 12 months to less than 2 years | 6 | 71 | *8.45* |
| 2 years to less than 4 years | 8 | 133 | *15.47* |
| 4 years to less than 10 years | 1 | 110 | *12.18* |
| 10 years and over (not life) | 0 | 38 | *4.17* |
| ISPP | 2 | 32 | *3.73* |
| Life | 1 | 52 | *5.81* |
| Total | 71 | 840 | |

| Age | Number of prisoners | % |
|---|---|---|
| Under 21 years: *minimum age=18* | 71 | *7.79* |
| 21 years to 29 years | 317 | *34.79* |
| 30 years to 39 years | 256 | *28.10* |
| 40 years to 49 years | 176 | *19.31* |
| 50 years to 59 years | 54 | *5.92* |
| 60 years to 69 years | 33 | *3.62* |
| 70 plus years: *maximum age=80* | 4 | *0.43* |
| Total | 911 | |

| Nationality | 18–20 yr olds | 21 and over | % |
|---|---|---|---|
| British | 57 | 718 | *85.07* |
| Foreign nationals | 14 | 122 | *14.92* |
| Total | 71 | 840 | |

| Security category | 18–20 yr olds | 21 and over | % |
|---|---|---|---|
| Uncategorised unsentenced | 47 | 293 | *37.32* |
| Uncategorised sentenced | 10 | 87 | *10.64* |
| Cat B | | 74 | *8.12* |
| Cat C | | 361 | *39.62* |
| Cat D | | 25 | *2.74* |

| | | | |
|---|---|---|---|
| Other | 14 | | *1.53* |
| Total | 71 | 840 | |

| Ethnicity | 18–20 yr olds | 21 and over | % |
|---|---|---|---|
| *White:* | | | |
| British | 48 | 615 | *72.66* |
| Irish | | 5 | *0.54* |
| Other White | 3 | 55 | *6.36* |
| *Mixed:* | | | |
| White and Black Caribbean | 2 | 5 | *0.76* |
| White and Black African | | 5 | *0.54* |
| White and Asian | | | |
| Other mixed | 1 | 6 | *0.76* |
| *Asian or Asian British:* | | | |
| Indian | 3 | 10 | *1.42* |
| Pakistani | | 3 | *0.32* |
| Bangladeshi | | 5 | *0.54* |
| Other Asian | 4 | 19 | *2.52* |
| *Black or Black British:* | | | |
| Caribbean | 3 | 23 | *2.85* |
| African | 5 | 25 | *3.29* |
| Other Black | 1 | 21 | *2.41* |
| *Chinese or other ethnic group:* | | | |
| Chinese | | 37 | *4.06* |
| Other ethnic group | 1 | 6 | *0.76* |
| Total | 71 | 840 | |

| Religion | 18–20 yr olds | 21 and over | % |
|---|---|---|---|
| Baptist | 1 | 4 | *0.54* |
| Church of England | 11 | 264 | *30.18* |
| Roman Catholic | 9 | 126 | *14.81* |
| Other Christian denominations | 1 | 51 | *5.70* |
| Muslim | 9 | 56 | *7.13* |
| Sikh | 2 | 6 | *0.87* |
| Hindu | 0 | 6 | *0.65* |
| Buddhist | 3 | 8 | *1.20* |
| Jewish | 0 | 4 | *0.43* |
| Other | 3 | 15 | *1.97* |
| No religion | 32 | 300 | *36.44* |
| Total | 71 | 840 | |

Sentenced prisoners only

| Length of stay | 18–20 yr olds | | 21 and over | |
|---|---|---|---|---|
| | Number | % | Number | % |
| Less than 1 month | 4 | *19.04* | 94 | *16.78* |
| 1 month to 3 months | 5 | *23.80* | 115 | *20.50* |
| 3 months to 6 months | 4 | *19.04* | 94 | *16.78* |
| 6 months to 1 year | 7 | *33.33* | 109 | *19.46* |
| 1 year to 2 years | 1 | *4.76* | 80 | *14.24* |
| 2 years to 4 years | | | 41 | *7.32* |
| 4 years or more | | | 27 | *4.82* |
| Total | 21 | | 560 | |

Unsentenced prisoners only

| Length of stay | 18–20 yr olds | | 21 and over | |
|---|---|---|---|---|
| | Number | % | Number | % |
| Less than 1 month | 16 | *32* | 86 | *30.71* |
| 1 month to 3 months | 12 | *24* | 119 | *42.5* |
| 3 months to 6 months | 8 | *16* | 50 | *17.85* |
| 6 months to 1 year | 14 | *28* | 21 | *7.5* |
| 1 year to 2 years | | | 4 | *1.4* |
| Total | 50 | | 280 | |

| Main offence | 18–20 yr olds | 21 and over | % |
|---|---|---|---|
| Violence against the person | 26 | 199 | *24.69* |
| Sexual offences | 2 | 78 | *8.78* |
| Burglary | 8 | 117 | *13.72* |
| Robbery | 9 | 76 | *9.33* |
| Theft and handling | 4 | 45 | *5.37* |
| Fraud and forgery | 1 | 18 | *2.08* |
| Drugs offences | 5 | 151 | *17.12* |
| Other offences | 15 | 153 | *18.44* |
| Civil offences | 0 | 1 | *0.10* |
| Offence not recorded / holding warrant | 1 | 2 | *0.32* |
| Total | 71 | 840 | |