Report on an unannounced short follow-up inspection of

# HMP Gloucester

3–5 August 2010

by HM Chief Inspector of Prisons

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# Introduction

HMP Gloucester is a Victorian, city centre, category B, male local prison. Its site, age and population make it challenging to run. This short follow-up inspection was conducted in August this year and reports on the progress – or lack of it – the prison has made since our last full inspection three years ago in April 2007.

In 2007 we found the prison was performing reasonably well against three of the healthy prison tests but was poor in the purposeful activity it offered. It is disappointing that inspectors found the performance of the prison had deteriorated sharply at the time of this follow-up inspection.

The physical environment was a critical factor in this decline. For instance, the prison was reasonably safe for most prisoners – recorded violence and bullying was low and most prisoners reported feeling safe. However, there were a small number of vulnerable prisoners for whom there was not space on the vulnerable prisoner landing. This overspill was housed on the landing that also housed young adults. Poor practices then contributed to the problem by allowing these prisoners to be identified and they were then targeted for abuse and bullying such as urine, water and lit paper being pushed under their doors.

Inspectors concluded that, on the whole, relationships between staff and prisoners were decent and respectful. Individual relationships were good. The food was good. Diversity was well managed. Complaints and applications were dealt with effectively. The chaplaincy worked well in cramped conditions. Very positive plans to improve day care facilities for patients with mental health problems were well advanced.

However, the physical environment was simply degrading. C wing was in very poor condition and it was disappointing that hopes to tackle this issue reported at our last inspection had not progressed. Cells were small and badly ventilated. They had no toilets or basins and prisoners could only access these by an electronic call system or they had to rely on pots and slopping out. Recesses – the communal toilet, shower and slopping out areas – were in a poor state of repair and filthy. A and B shower facilities had been recently refurbished and so were a little better. They had in-cell toilets but in small shared cells these were not adequately screened. Many cells in these wings were dirty, run down, poorly ventilated and had graffiti. Outside areas were grubby.

The provision of purposeful activity for prisoners ought to have been something that was easier for the prison to improve. I recognise the difficulty of doing so in a place as old and cramped as Gloucester but it was a clear priority.

About 121 out of 295 prisoners had no work, training or education. These prisoners were locked in their cells for between 19 and 22 hours a day. For those prisoners who were fortunate enough to have some sort of activity, the quality was not good enough. Prisoners had low achievement on literacy and numeracy programmes. Our Ofsted colleagues reported that the prison's self-assessment of its learning and skills provision was overgenerous. Much of the work available was menial and low skill. The outcomes in purposeful activity for prisoners remained poor.

Resettlement provision overall was not much better and resettlement outcomes for prisoners were not sufficiently good. There were some welcome exceptions – housing advice and support for prisoners to maintain positive contact with their families was good. However, there was no evidence of a clear and focused resettlement strategy which had buy-in across the

prison. Inspectors had worrying concerns about the quality of the offender management programmes, and the effectiveness of some resettlement pathways had deteriorated.

Gloucester is a prison that causes concern. It has deteriorated since our last inspection. It is a very poor physical environment and there is evidence of a downward drift in performance across a range of areas. It needs urgent attention.

Nick Hardwick October 2010
HM Chief Inspector of Prisons

# Fact page

### Task of the establishment
HMP Gloucester is a category B male local prison that also houses a limited number of young offenders. It serves the Crown Courts of Gloucester, Hereford and Worcester and their associated Magistrates' Courts.

### Area organisation
South West

### Number held
295

### Certified normal accommodation
225

### Operational capacity
321

### Last inspection
16-20 April 2007

### Brief history
Gloucester was originally built in 1782 and substantially rebuilt in 1840 with a modern wing added in 1971. It is on a city centre site occupying 8.5 acres.

### Description of residential units
HMP Gloucester has three main wings (A, B and C). A and B wings are housed in the older part of the establishment and are of traditional Victorian style. Cells in these wings have integral sanitation and accommodate two prisoners each. C wing is newer and has 81 cells with night sanitation; it also houses the prison's voluntary drug testing unit. There is also a small, stand-alone health care centre on two floors with inpatient spaces, treatment rooms and other outpatient facilities.

# 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 2007 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:

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

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

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

- outcomes for prisoners are reasonably good against this healthy prison test.
There is evidence of adverse outcomes for prisoners in only a small number of areas. For the majority, there are no significant concerns. Procedures to safeguard outcomes are in place.

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

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

HP3 This Inspectorate conducts unannounced follow-up inspections to assess progress against recommendations made in the previous full inspection. Follow-up inspections are proportionate to risk. Short follow-up inspections are conducted where the

previous full inspection and our intelligence systems suggest that there are comparatively fewer concerns. Sufficient inspector time is allocated to enable inspection of progress and, where necessary, to note additional areas of concern observed by inspectors. Inspectors draw up a brief healthy prison summary setting out the progress of the establishment in the areas inspected. From the evidence available they also concluded whether this progress confirmed or required amendment of the healthy prison assessment held by the Inspectorate on all establishments but only published since early 2004.

## Safety

HP4 At our inspection in 2007, we found that Gloucester was performing reasonably well against this healthy prison test. We made 25 recommendations in this area, of which eight had been achieved, three partially achieved and 14 had not been achieved. We have made a further 16 recommendations.

HP5 Relationships and communication between escort staff and reception staff were good. Appropriate documentation and risk assessments arrived with prisoners and there were few late arrivals. The reception area was poor, needed refurbishment and could not be reached by prisoners with limited mobility. Reception staff were respectful to new arrivals and there was a relaxed atmosphere. Prisoner Insiders were available in reception from 6.30am until the last new arrival had been received.

HP6 First night risk assessments were completed in reception. There were protocols for staff to share information about new arrivals at shift handovers. Some cells on A wing, where most new arrivals were allocated, were designated as first night cells. The first night arrangements for vulnerable prisoners were poor, with most allocated to B1 landing or, more likely, overflowing on to B2, where accommodation was shared inappropriately with young adults. First night and induction arrangements for vulnerable prisoners, as well as access to regime, were less favourable than for other prisoners.

HP7 Adult prisoners on normal location and most young adults received a full induction, including input from specialist departments and presentations by Insiders. It was not clear from the records and from prisoners that vulnerable prisoners received the same level of input. Some young adults also questioned the quality of induction they received.

HP8 There was evidence that governance and management of safer custody had been drifting until some recent remedial management action. There had been little management information on violence reduction until June 2010 and its analysis was unsophisticated. Despite this, the level of recorded violence and bullying was low and prisoners reported feeling safe, with the notable exception of vulnerable prisoners on B2. The violence reduction strategy was comprehensive but not informed by any prisoner consultation. The anti-bullying policy was underused and victim support plans were underdeveloped.

HP9 A safer custody meeting met bimonthly and was given a high priority. There was a comprehensive and cohesive suicide prevention strategy. There were relatively low numbers of self-harm incidents and open assessment, care in custody and teamwork (ACCT) self-harm monitoring documents. Death in custody action plans were well developed and appropriately managed. ACCT documents were generally of good

quality with evidence of positive staff-prisoner engagement. All prisoners on ACCTs spoke of reasonable levels of care by most staff and there was some targeted support led by mental health staff and the drug strategy senior officer. The routine use of camera cells to monitor prisoners on ACCT documents was inappropriate and not guided by proper protocols.

HP10 The security department was adequately resourced, dynamic security was good and the number of security information reports had increased since our last visit. Information was communicated appropriately across other teams. Security restrictions did not impair access to the regime. Suspicion mandatory drug testing (MDT) levels remained low. The management of closed visits had improved but prisoners were still placed on closed visits inappropriately following a single piece of intelligence, often unrelated to visits

HP11 The number of adjudications was low and they were generally dealt with appropriately and fairly. Use of force was higher than at our last inspection but remained reasonably low, with evidence that de-escalation techniques were employed. Use of special accommodation was also low but completed documentation gave us limited assurance that its use was always warranted.

HP12 The segregation unit was not used excessively but the environment was poor, with graffiti in cells and no basic facilities, such as showers or telephones. Authorisation protocols and risk assessment screening were generally satisfactory. Staff-prisoner relationships were respectful but the regime was inadequate.

HP13 Integrated drug treatment system (IDTS) arrangements were now fully functioning with over 100 prisoners accessing substitute prescribing, stabilisation or detoxification. The prison's MDT outturn for the year to 31 March 2010 was 11.7% against a target of 12%. There was only limited suspicion drug testing.

HP14 Vulnerable prisoners on B1 landing reported feeling safe and were complimentary about the staff there, although the environment was poor. Vulnerable prisoners located on the overflow on B2, along with young adults and other adult prisoners, said that they felt less safe and less supported.

HP15 Young adults were located mainly on B2 but a significant proportion were also on A and C wings. All had full access to the regime. There was no strategy for managing young adults. Disaggregated management data provided information on the treatment of young prisoners which showed that force was used disproportionately against them and more were placed on the basic regime.

HP16 On the basis of this short follow-up inspection, we considered that outcomes for prisoners remained reasonably good against this healthy prison test.

## Respect

HP17 At our previous inspection, we found that Gloucester was performing reasonably well against this healthy prison test. We made 67 recommendations in this area, of which 29 had been achieved, 15 partially achieved and 22 had not been achieved. One recommendation was no longer applicable. We have made a further 17 recommendations.

HP18 The prison environment was very poor. Cells on A and B wings lacked natural light, were cramped and often dirty. Toilets were poorly screened in shared cells. The refurbishment of C wing had not taken place and prisoners could not access toilets except through the electronic call and queuing 'night sanitation' system. Conditions generally on C wing were poor and recesses were unacceptable. Prisoners complained about the cleanliness of showers, although access to showers and telephones was reasonable. Most prisoners could not wear their own clothes and laundry arrangements were inadequate. The external environment was also grubby.

HP19 The incentives and earned privileges (IEP) scheme was understood by staff and prisoners. Good monthly monitoring data was collated and showed that the scheme and its appeals process were fairly applied. However, disaggregated data showed that young adults were disproportionately represented in the number of warnings issued and those placed on basic regime. Differentials between the incentive levels were limited.

HP20 Staff-prisoner relationships were generally respectful. Most prisoners spoke well of the staff, and the quality of supervision and engagement continued to be good. The application of the personal officer policy was mixed and did not meet the expectations set.

HP21 The quality of food was very good and most prisoners confirmed that they were content with the catering. The kitchen was well run and consultation with prisoners was good. Prisoners on C wing were able to dine in association. The prison shop service appeared well run and again prisoners raised few concerns.

HP22 There were robust up-to-date policies for all the key diversity strands, except sexual orientation. There were good arrangements to monitor outcomes for prisoners by age and disability, as well as ethnic origin. There was regular consultation with minority groups and action points from these and monitoring data were fed into an action plan overseen by the diversity and race equality action team (DREAT). Within the limitations of the building, and absence of adapted cells, staff did what they could for prisoners with identified disabilities and a range of aids was available. Pay for retired prisoners was in line with that for most other prisoners.

HP23 About 17% of the population came from a black and minority ethnic background. There were bimonthly consultation meetings and prisoner representatives attended the bimonthly DREAT meetings, which also considered ethnic monitoring. The few anomalies shown in the monitoring were being addressed. Racist incident report forms were dealt with properly and subject to external scrutiny by Gloucester Race Equality Council.

HP24 There were 23 foreign national prisoners, just under 8% of the population. They had bimonthly focus group meetings, and the UK Border Agency held surgeries for foreign national prisoners every six to eight weeks. Foreign national new arrivals received a free five-minute telephone call and could apply for a further five-minute free call each month. Information was available to staff on how to access interpreting services but provision in English for speakers of other languages (ESOL) was underdeveloped.

HP25 Access to application and complaints procedures was good and we had few complaints from prisoners about how their concerns were dealt with. Tracking arrangements for general applications were limited but governance of complaints was more impressive.

HP26 The chapel and multi-faith room had been located in temporary accommodation during maintenance work. Although the temporary multi-faith room offered some washing facilities, it was only just big enough for the number of practising Muslim prisoners. Members of the chaplaincy were visible around the prison and were integrated into the work of the establishment.

HP27 Health services were well staffed and had a good skill mix. The health care environment was poor but there were well-advanced plans for improvements. Prisoners had good access to GPs but lifelong condition management was underdeveloped. Prisoners had only limited access to a pharmacist and there was secondary dispensing of medications during the evenings. Health promotion was reasonable and access to the dentist good. The primary and secondary mental health services were well integrated within the prison and with external agencies.

HP28 At this short follow-up inspection, we considered that Gloucester was a respectful prison but the very poor quality of the environment and the failure to improve C wing meant that outcomes for prisoners were not sufficiently good against this healthy prison test.

## Purposeful activity

HP29 At our previous inspection, we found that Gloucester was performing poorly against this healthy prison test. We made 17 recommendations in this area, of which six had been achieved, four partially achieved and seven had not been achieved. We have made a further six recommendations.

HP30 The main education provider was now A4e (Action for Employment). Tribal delivered the careers, information and advice support (CIAS). Quality assurance and self-assessment arrangements in education were underdeveloped. Participation in education and activities had decreased since the last inspection. The majority of the personal and social development programmes were satisfactory but prisoners on literacy, numeracy and ESOL programmes had a low achievement of qualifications.

HP31 The quality of the work available for prisoners had not changed significantly since the last inspection but the prison offered a few more opportunities for prisoners in employment-related accredited vocational training. These included industrial cleaning, food safety, health and safety in the PE department and a performing manufacturing (PMO) programme at national vocational qualification (NVQ) level 2 in the cycle workshop. Four prisoners had just started a customer service training programme at NVQ level 2. However, significantly fewer prisoners were engaged in education or vocational training than on our last visit. Much of the work was menial and low skill.

HP32 Time out of cell was limited but predictable. The core day suggested that nine hours out of cell was possible for a fully employed prisoner on certain days but significantly less than this was the norm for most prisoners. Evening association was available for individuals only twice a week, although sessions were rarely cancelled and domestic time was provided during the morning and at meal times. We found over half the population locked in cell during the working part of the day.

HP33 A rota ensured regular library access for most prisoners but the lack of evening and weekend opening restricted access for those who worked during the day. The library

was well organised and welcoming but there was little space to accommodate larger groups or prisoners requiring space to study or read.

HP34 Despite the limited facilities, prisoners had good access to the gym. A range of accredited programmes was available. There had been significant improvements in the range and structure of the PE provision. The sports hall and fitness room had been improved and the outside sports area had been refurbished. The PE staff had responded to a recent survey and had set up some dedicated exercise sessions for groups of prisoners with different needs. In January 2010, around 30% of prisoners had used the PE facilities and a more recent survey indicated that this had risen to around 61%.

HP35 At this short follow-up inspection, we considered that the lack of meaningful improvement in the quality and quantity of activity meant that outcomes for prisoners remained poor against this healthy prison test.

## Resettlement

HP36 At our previous inspection, we found that in Gloucester outcomes for prisoners were reasonably good against this healthy prison test. We made 37 recommendations in this area, of which 17 had been achieved, seven partially achieved and 12 had not been achieved. One recommendation was no longer applicable. We have made a further 17 recommendations.

HP37 The reducing reoffending strategy and needs analysis were out of date. There had been a more recent needs analysis based on survey responses but the methodology was limited. A quarterly reducing reoffending strategy group had not met since November 2009 and the interventions steering group was no longer convened. All new arrivals had an initial assessment of resettlement needs with referrals made but multidisciplinary pre-discharge boards no longer took place.

HP38 All prisoners serving over 12 months, irrespective of status, received offender management. Prisoners serving between six and 12 months had light touch offender management. There was insufficient custody planning for prisoners on remand or serving less than six months, although their needs were assessed. Data management did not enable the ready identification of the number or identity of prisoners formally in scope for offender management. Recorded evidence of contact between prisoners and offender supervisors or manager was limited and there were few links with personal officers.

HP39 There were 13 lifers and four prisoners on indeterminate sentences for public protection. The majority of lifers had been recalled from open conditions. New case management arrangements had been recently introduced, with a prison officer appointed as offender supervisor for this group. Some lifers, particularly those recalled from open conditions, expressed frustration at the length of time they remained at Gloucester.

HP40 Identification of prisoners for public protection purposes appeared efficient. The policy had been reviewed and there was meant to be a public protection policy meeting to monitor its effectiveness, although the last meeting had been in October 2009. Regular interdepartmental risk management meetings to discuss and manage individual cases were no longer convened, although offender supervisors did attend

external MAPPA (multi-agency public protection arrangements) meetings and there were internal public protection meetings to discuss specific cases.

HP41 One housing worker directly employed by prison provided an accommodation service for prisoners serving less than 12 months. Prisoners serving over 12 months who applied to the service were signposted to offender supervisors and community-based offender managers to source accommodation on release. The number of prisoners released with no fixed accommodation during the first six months of 2010 was low.

HP42 The learning and skills department provided an 'employment carousel' and the Way4ward programme. Both programmes had been implemented recently but were beginning to provide more structured and better targeted support and preparation for employment after release. Tribal staff provided initial CIAS and held reviews throughout the prisoner's sentence, culminating in an exit interview to support them in gaining employment on release. Opportunities for education and vocational training in the prison were not linked clearly or explicitly enough to job opportunities in the community on release.

HP43 The Citizens Advice Bureau visited the prison once a week to provide a one-to-one debt management advice. Jobcentre Plus provided a service to close down benefits on arrival. Debt management modules were also available through the education employment carousel. In all other respects, provision on this resettlement pathway was limited.

HP44 The systems for ensuring that all prisoners had sufficient and relevant support in accessing community health services on release had recently fallen into abeyance. There was extremely good palliative care provision

HP45 The drug strategy and needs analysis were due to be reviewed. The counselling, assessment, referral, advice and throughcare service (CARATs) was introduced to prisoners on induction. The current CARATs caseload was about 52. Nurses and CARATs staff jointly ran a full psychosocial programme and there were good links with drug intervention programme workers in the community. The short duration drug programme had been discontinued.

HP46 The prison had a welcoming visitors centre (the Castle Gate Family Support Centre) that also provided a wider family support service, including a child support worker who worked with local schools. Due to the loss of funding, the court worker was no longer available but a bank of volunteers was endeavouring to continue to provide support to families at Gloucester Crown Court. The visits environment was reasonable with refreshments available and a staffed play area. Monthly family visits were open to all prisoners.

HP47 No accredited offending behaviour courses or non-accredited courses were available. There had been no needs assessment.

HP48 The weakness of the resettlement strategy, the lack of a needs analysis, concerns about the quality of offender management and the limitations of some pathway intervention led us to conclude that outcomes for prisoners were not sufficiently good against this healthy prison test.

# Section 2: Progress since the last report

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

## Main recommendations (from the previous report)

2.1 The reception facility should be refurbished or replaced. (HP53)

Not achieved. The reception was in the same place, up two sets of stairs, with no aids to assist prisoners with limited mobility. Prisoners who could not manage the stairs were processed on the lower floor. Space in the reception area was limited but it was clean and the atmosphere was friendly. The two main holding rooms were basic and had graffiti on the wooden benches. The cubicle for searching was in the corner of a busy room and the BOSS (body orifice security scanner) chair doubled as a seat for prisoners to have their photos taken.
We repeat the recommendation.

2.2 Vulnerable prisoners should not be held on B2 landing, and the quality and quantity of regime for these prisoners should be improved. (HP54)

Not achieved. At the time of the inspection, 11 vulnerable prisoners were located on B2 landing due to lack of space on the dedicated vulnerable prisoner unit on B1. Many had been located there on their first night in custody. B2 continued to accommodate young adult prisoners. While efforts were made to keep the two groups separated, the young adults identified vulnerable prisoners by the red strike through their cell cards (see recommendation 2.15) and consequently targeted them for verbal abuse and other bullying, such as throwing urine, water and lit paper under their cell doors. Vulnerable prisoners on B2 said they felt unsafe on that landing and less supported by B2 landing staff than those on B1, about whom they, and B1 prisoners, were extremely complimentary. Vulnerable prisoners on B2 were unlocked in the mornings, afternoons and for evening association and were taken to B1 to use the showers and telephones. However, once on B1 they were not permitted back to their cells on B2. If they were not engaged with any of the limited activities on B1 during the working day they were locked in their cells. Vulnerable prisoners accessed the gym three times a week and were allocated a slot to use the library on Friday morning, which was also the time when a few were allowed to use the IT classroom in education (see paragraph 2.69). Notwithstanding this, the quality and quantity of regime activities for vulnerable prisoners remained poor. Activities such as cell cleaning on B2 were allowed only sporadically and other prisoners on the wing resented any time that vulnerable prisoners were unlocked as this curtailed their regime. B2 remained an unsafe and inappropriate environment for vulnerable prisoners.
We repeat the recommendation.

2.3 The prison should formulate a strategy to assess and meet the specific needs of young adult prisoners. (HP55)

Not achieved. Although up to 50 young adult prisoners had been held at Gloucester in the previous six months, there was still no strategy to assess and meet their specific needs.
We repeat the recommendation.

2.4 There should be a protocol for the use of special accommodation at Gloucester, including the safer cells in health care and the segregation unit, covering the

circumstances in which they are to be used, the levels of authorisation necessary before prisoners are located in these cells and the levels of observations required by staff. (HP56)

Partially achieved. A protocol covered use of the special accommodation in the segregation unit but not the observation cells in either health care or the segregation unit.

Further recommendation

2.5 The protocol for use of the special accommodation should be extended to cover use of the observation cells in health care and the segregation unit

2.6 Minimum staffing levels for the segregation unit should be formally risk assessed to ensure that safe systems of work are operated at all times. (HP57)

Not achieved. We continued to have serious concerns around the management of the segregation unit. The segregation unit and B1 were in close proximity and separated by a metal partition. The staff supervising the segregation unit were also responsible for the vulnerable prisoners on B1 landing. The staff office was located in B1 and although staff were reasonably close by they were engaged with prisoners on B1 for much of the time and consequently there were frequent periods when there was no direct supervision of the residents of the segregation unit.
We repeat the recommendation.

2.7 C wing should be refurbished without further delay. (HP58)

Not achieved. C wing had not been refurbished since our last inspection. The accommodation remained in very poor condition. Cells were small and poorly ventilated with grated windows limiting the flow of air and natural light. There were no toilets or basins in cells and prisoners could only access toilets and washing facilities through the 'night sanitation' electronic call system. Recesses were in a poor state of repair and filthy. Flooring was in a poor condition and the general ambience was run down and depressing.
We repeat the recommendation.

2.8 The prison should increase the number and quality of activity places available, in particular educational and vocational training places. (HP59)

Not achieved. The prison still did not have sufficient learning and skills activities places to meet the needs of the population. The number of spaces validated by the prison during our inspection had increased slightly from 73 to 74, including 53 in education, 10 in vocational training and 10 in the gym, with one distance learning place. The vocational training activity in the enterprise centre covered work on bicycles and the recycling unit. There were also a further 36 essential workers and 64 cleaners. Prisoners with little English had no access to a qualification in English for speakers of other languages (ESOL). The proportion of prisoners taking part in learning and skills had decreased from 43% of the population at the Ofsted re-inspection in 2008 to approximately 24% currently.

Further recommendation

2.9 The prison should increase the number of vocational training places and ensure that prisoners with needs for English for speakers of other languages (ESOL) have access to the appropriate accredited qualification.

2.10 Prisoners should be able to spend more time out of cell. (HP60)

Not achieved. The prison recorded about 8.5 hours a day out of cell for prisoners. The core day routine suggested that for an employed prisoner fully engaged with the regime, more than nine hours was possible on the two days a week that he could access evening association, or about 7.5 hours on other days. For an unemployed prisoner, the reality was more likely to be between two and five hours, depending on access to association and the hour-long morning exercise period. During a random roll check, we found 58% of the population locked in cell during the working part of the day, which suggested that the majority of prisoners were unemployed or part-time employed.
We repeat the recommendation.

## Recommendations

### Courts, escorts and transfers

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

### Additional information

2.11 Relationships between reception staff and escort contractors were relaxed but professional. The prison received advance notification of who to expect from court and could determine approximate times of arrival. Documentation arriving with prisoners allowed proper first night risk assessments to be completed in reception before the prisoner went to his first night accommodation. Late arrivals to the prison were not regular.

### First days in custody

2.12 Holding rooms should be equipped with televisions, reading material and relevant information notices. (1.20)

Partially achieved. All three holding rooms – including one small room for vulnerable prisoners – had televisions but no reading materials or information notices. However, new arrivals were given an information pack about the prison before they went a second holding room to wait to see the nurse.

2.13 New arrivals should be given £2.00 telephone credit in reception if required. (1.21)

Not achieved. New arrivals were given just 30p credit in reception. First night staff on A1 told us that if a prisoner had had difficulty making the call in reception or had other concerns, they would make a call to his family to let them know that the prisoner was at Gloucester and the contact details.
We repeat the recommendation.

2.14 Supervising staff should know the cell location of new arrivals and any special needs. Observations should be made appropriately, according to individual needs. (1.22)

Achieved. Although there were identified first night cells on A1 and on B1, there were other processes to ensure that staff knew where new arrivals were located as they could be in other cells. A first night sheet listed prisoners spending their first night at Gloucester and any special needs to brief incoming staff. Staff made three irregular checks on all prisoners on their first night in custody and managers checked entries the next day to make sure these had been carried out.

2.15 The practice of identifying the cell cards of vulnerable prisoners should cease. (1.23)

Not achieved. The cell cards of all vulnerable prisoners were marked with a red diagonal stripe. We were told that this was to ensure that staff who were unused to working on B2 did not unlock a vulnerable prisoner when unlocking others. This system also identified vulnerable prisoners to other prisoners and we were told there had been instances of verbal bullying as well as water, urine and toilet paper being put under their cell doors (see paragraph 2.2).
We repeat the recommendation.

2.16 First night accommodation for vulnerable prisoners should be clean, properly prepared and provide a safe and comfortable environment. (1.24)

Not achieved. The cell identified for new arrivals on B1, the vulnerable prisoner wing, was often in use and vulnerable new arrivals often went to B2 instead (see paragraph 2.2). The accommodation for new arrivals on B2 was the same as other cells but newly arrived vulnerable prisoners could not be unlocked at the same time as other prisoners on the landing and could be subject to abuse from them.
We repeat the recommendation.

2.17 There should be a formal induction programme for vulnerable prisoners, and this should be delivered by trained staff in a quiet, discrete and designated area. (1.25)

Not achieved. Vulnerable prisoners could not access the formal induction programme for other prisoners and their needs were not addressed in the establishment's induction policy. An Insider based on B1 assisted newly arrived vulnerable prisoners with PIN telephone applications, meal selection forms and canteen sheets and could advise on the regime at Gloucester. Although some induction staff on A1 told us that induction was delivered one to one to vulnerable prisoners, it was not clear from prisoners' history sheets that this happened routinely.
We repeat the recommendation.

2.18 Induction records should be kept to ensure that all vulnerable prisoners have received a formal induction. (1.26)

Not achieved. It was not clear from the P-Nomis records we saw that vulnerable prisoners received a full induction comparable with that for other prisoners.
We repeat the recommendation.

## Additional information

2.19 Prisoner orderlies, who were all trained Listeners and Insiders, worked alongside reception staff from 6.30am until the last prisoner of the day had been received. They assisted with kit

packs, arriving property, prepared meals and drinks for new arrivals, and explained anything they wanted to know about the prison.

2.20 Initial health care screening in reception enabled immediate concerns about medication, drug or alcohol dependency or any disability to be identified. Prisoners were given a smokers or non-smokers pack and could buy telephone credit. Staff told us that some prisoners arrived from other prisons with large amounts of property that Gloucester was not equipped to handle. We saw an example of this with one new arrival.

2.21 Induction was a rolling programme that began the day after reception. Induction orderlies were available, including for vulnerable prisoners, to assist with explaining procedures and routines. All new arrivals met the doctor. Most adult and young adult prisoners attended a group induction session in the afternoon of their first day. This covered all aspects of the daily routine and had speakers from different areas of the prison, including the chaplaincy, counselling, assessment, referral, advice and throughcare service (CARATs), Listeners, offender management unit (OMU), Toe-by-Toe (reading mentoring) and diversity. Some young adults told us that they had not received a full induction and this seemed to be borne out by the records we looked at.

## Residential units

2.22 Cells designed for one prisoner should not accommodate two. (2.16)

Not achieved. Many cells on the 19th century A and B wings that had been designed for one person held two. Cells were cramped and natural light was limited. Many cells, both double and single, were dirty, run down, poorly ventilated and had graffiti. Furniture was generally inadequate, with, for example, no individual lockable cabinets and televisions in doubled cells were poorly positioned.
We repeat the recommendation.

2.23 Toilets in all cells should be adequately screened. (2.17)

Not achieved. Toilets in most shared cells were inadequately screened with shower curtains.
We repeat the recommendation.

2.24 All prisoners should have 24-hour access to toilet facilities. (2.18)

Not achieved. C wing had antiquated 'night sanitation' arrangements which only permitted intermittent access to communal toilets via a computerised intercom and remote locking arrangement. This created unacceptable restrictions on prisoners' access to basic facilities.
We repeat the recommendation.

2.25 The policy prohibiting offensive displays should be applied consistently. (2.19)

Achieved. A policy restricting the display of offensive material was in place and was enforced.

2.26 All prisoners should be allowed to wear their own clothes. (2.20)

Not achieved. The facilities list permitted only remand prisoners and those on enhanced regime to wear their own clothes.
We repeat the recommendation.

2.27 Prisoners should be supplied with clean and properly fitting prison clothing, as required. (2.21)

Achieved. Prisoners were issued with prison kit on reception and during induction. Most was in a reasonable state of repair and we saw no prisoner in ill-fitting clothes.

2.28 Prisoners should have personal access to laundry facilities. (2.22)

Not achieved. There were no wing laundries and prisoners had no access to laundry facilities. Some prisoners allowed their own clothes told us that they washed these in their sink.
We repeat the recommendation.

2.29 Towels and sheets should be provided to prisoners as they need them. (2.23)

Partially achieved. Prison kit could be exchanged only on a Friday and on a one-for-one basis. Stocks of sheets and towels were not readily available but we were told staff could use their discretion to supply additional towels if needed.
We repeat the recommendation.

2.30 Prisoners should have increased access to telephones during the evening. (3.78)

Partially achieved. The amount of evening association had increased since the last inspection but prisoners still only had access on alternate evenings. However, we were told that prisoners not on association could ask to use the telephone during the evening.

## Additional information

2.31 All accommodation at Gloucester was old and in a poor condition. Outside areas were grubby. Although recesses in A and B wings showed some refurbishment, prisoners complained about their cleanliness as well as leaks. The number of showers was also limited for the size of the population, with typically three showers on each landing. Showers were, however, adequately screened. Many prisoners complained repeatedly about poor ventilation, not helped by the small windows in many cells and the grilles on C wing.

2.32 There were sufficient telephones to meet need, except for B1 landing (vulnerable prisoners) which had one telephone for 30 prisoners. This situation was compounded because an additional 12 vulnerable prisoners held on B2 landing associated on B1 where they accessed the telephone. Procedures for the management of mail appeared adequate and prisoners raised no concerns about the service.

2.33 The prison held regular monthly consultation meetings with prisoners. Minutes suggested a satisfactory standing agenda and a reasonable consideration of the issues raised by prisoners.

Further recommendation

2.34 Access to telephones for vulnerable prisoners should be improved.

## Staff-prisoner relationships

2.35 Staff should engage more positively with prisoners during periods of exercise. (2.29)

Not achieved. Staff supervised exercise from outside the two secure exercise compounds, preventing any meaningful engagement.
We repeat the recommendation.

## Additional information

2.36 Prisoners spoke positively about the staff. A few suggested a degree of favouritism by some, although we saw no evidence to support this. Most prisoners indicated that staff were generally approachable and helpful and that interaction was usually respectful. Our observations supported this view. The quality of supervision was reasonable and the level of engagement during association acceptable. Staff appeared friendly and interested in prisoners, and the size of the establishment helped them develop a knowledge of individual prisoners and their personal circumstances. However, staff use of prisoners' preferred names or titles was not well embedded.

Further recommendation

2.37 Staff should address prisoners by their preferred name or title.

## Personal officers

2.38 Personal officer entries in wing history files should provide evidence of positive interaction with prisoners in their charge. (2.35)

Partially achieved. The personal officer policy required designated officers to ensure at least one weekly entry in wing history sheets. We found evidence that this was not always achieved. The quality of entries also varied greatly. Some personal officers demonstrated that they understood their role and commented on prisoners in an informed way. In many cases however, comments, if any, were just observational, concerned compliance with rules, were sometimes repetitive and failed to evidence a rounded knowledge of the prisoner.
We repeat the recommendation.

2.39 Wing file entries should be subject to regular quality checks by managers. (2.36)

Not achieved. Quality assurance of personal officer record keeping was inadequate. Management checks were few and/or perfunctory.
We repeat the recommendation.

2.40 Personal officers should attend assessment, care in custody and teamwork (ACCT) reviews wherever possible. (2.37)

Not achieved. Although the personal officer policy encouraged attendance at significant forums, such as ACCT reviews, there was little evidence that this was happening routinely.
We repeat the recommendation.

## Additional information

2.41 The personal officer policy was detailed and thorough but somewhat aspirational. Staff knowledge of prisoners and their expectations of the scheme were mixed. On some landings, the designation of personal officers allocated to cells was clearly stated on cell cards. On other

landings, there was no such designation. Personal officers had only passing or sporadic involvement in significant case management, such as offender management or sentence planning.

## Bullying and violence reduction

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

## Additional information

2.42 Governance arrangements for safer custody, including violence reduction, had recently changed. A developing prison service manager (DPSM), supported for eight hours a week by a senior officer, had been appointed in June 2010 to address the identified shortfalls. The DPSM had created good management information systems and we were assured that the management of violence reduction had consequently improved.

2.43 The violence reduction strategy had been updated in March 2010 but was not informed by any consultation with prisoners. The strategy was comprehensive but not particularly user friendly and it included elements, such as the antisocial behaviour programme workbook and violence reduction referral form for prisoners, which were not part of current practice.

2.44 The violence reduction committee monitored the effectiveness of the violence reduction strategy. The committee had no terms of reference or specified membership and did not appear to monitor all the indicators laid down in the strategy. The monthly meeting was chaired by the head of residence but often duplicated information presented to the bimonthly suicide prevention management team meeting. The violence reduction meeting was less well attended than the suicide prevention meeting and there had been no prisoner representation between January and May 2010. The meeting had good links with the security department, which was represented at each meeting. Minutes of the meetings demonstrated a reasonable level of debate but analysis of data was unsophisticated. A comprehensive violence reduction action plan was in place and discussed at each meeting.

2.45 There was effective dissemination of information from security information reports (SIRs) about bullying, antisocial behaviour and violent incidents. The safer custody team received copies of all injury to prisoners and violence reduction referral forms and investigated them. Eight recently appointed violence reduction liaison officers had sporadic facility time to assist the safer custody team investigate these incidents. Investigations were conducted to a reasonable standard and were overseen by the DPSM, who gave final approval for actions to be taken. The DPSM also checked observation books regularly to ensure that all appropriate incidents were consistently reported and managed.

2.46 Staff were aware of the four-stage anti-bullying strategy but it was not widely used. The stages ranged from observation and regime restrictions through to segregation for persistent or serious bullies. There had been 46 reported incidents in the previous six months but many had not resulted in the use of anti-bullying procedures and the prison was unable to provide us with information on the number of prisoners subject to anti-bullying measures between January and July 2010. The few anti-bullying documents that we were able to sample were not open for sufficient periods. Support plans for victims were underdeveloped and there were no interventions to support victims or to challenge bullies.

2.47 The levels of violence across the prison was relatively low and, except for vulnerable prisoners located on B2, prisoners reported feeling safe.

Further recommendation

2.48 The violence reduction strategy should be informed by consultation with prisoners, and the anti-bullying arrangements should be less complex and include support for victims of bullying and interventions to challenge bullies.

Housekeeping point

2.49 The violence reduction committee should have terms of reference and specified membership.

## Self-harm and suicide

2.50 Prisoners at risk of suicide or self-harm should never be accommodated in a special cell unless they are exceptionally violent. (3.16)

Not achieved. Since our last inspection, the special accommodation in the segregation unit had been used for a prisoner on an ACCT document to prevent him harming himself further. The completed documentation gave no indication that the prisoner was violent at any time.
We repeat the recommendation.

2.51 Special accommodation procedures should commence as soon as a prisoner is locked in the special cell or is placed in strip conditions in one of the safer cells. (3.17)

Not achieved. The special accommodation procedures were invoked in the segregation unit on only six occasions since the last inspection, one of which was following a prisoner being placed in strip conditions in the observation cell. However, records of the use of strip conditions in the safer cell in health care were not sufficiently maintained (see recommendation 2.114). We were assured that all use of the special accommodation or observation cell in the segregation unit for prisoners in strip conditions were logged appropriately but the documentation was often poorly completed and there were no ongoing logs for two of the six uses.
We repeat the recommendation.

## Additional information

2.52 A dedicated full-time DPSM managed the cohesive suicide and self-harm prevention strategy, which was monitored at the bimonthly suicide prevention management team meeting. This meeting was given a high priority as it was regularly chaired by the governor and was consequently well attended. There were effective systems to monitor incidents of self-harm, which were analysed during the meeting.

2.53 There was a helpful user guide to ACCT measures for staff, which was widely available. At the time of the inspection, almost 40% of staff were out of date with ACCT refresher training. There were 17 ACCT assessors from multidisciplinary backgrounds but only one member of staff had been trained in case management. Not all staff were trained in emergency response procedures but this was included in the continuous improvement plan and acknowledged by the safer custody manager.

2.54 Although not insignificant, the level of self-harm was reasonably low at 63 incidents between January and July 2010. During the same period, 129 ACCTs were opened, many on initial reception, which was also reasonably low. Since June 2010, the DPSM responsible for safer

custody had introduced a system for investigating any suicide or self-harm issues communicated to her through SIRs or other sources.

2.55 At the time of the inspection there were eight open ACCT documents. Individual case managers had recently been appointed but case management had not been consistent previously. ACCTs were generally well completed and showed evidence of positive engagement. Prisoners told us that they felt reasonably or well cared for. Reviews were completed on time but often lacked sufficient or multidisciplinary staff. Care maps were acceptable but frequently made no reference to activities. Many of the vulnerable prisoners on B2 landing who were on open ACCTs were not engaged with any constructive activity and spent significant periods locked in their cells. However, prisoners on ACCTs on A wing were actively encouraged and enabled to take part in regime activities. Activity packs were often provided through the mental health team to distract prisoners on ACCTs from thoughts of self-harm. Quality assurance systems were very good.

2.56 Prisoners on ACCTs were not routinely held in the segregation unit. When this happened, they were given a further safety screen and a review and the duty governor authorised the location. However, we found one example where the exceptional circumstances for locating a prisoner on an ACCT in the segregation unit were not explicit and the completed documentation did not assure us that this was the most appropriate location.

2.57 There was no log for prisoners who had been on constant watch and we were therefore unsure how many there had been. A prisoner was placed on constant watch during the inspection following a concerted attempt at suicide. He was complimentary about the staff intervention and subsequent levels of care and said that staff had dealt with him with compassion. Before the inspection, a prisoner had been placed on constant watch in the observation cell in the segregation unit and had been relocated to one of the three camera cells on A wing after about 25 minutes. The use of camera cells was not guided by a protocol. They were used too often and routinely to monitor prisoners on open ACCTs and we were concerned that this was as an alternative to staff interaction, which would have been more appropriate.

2.58 Since our last inspection, there had been three deaths at Gloucester, one of which was self-inflicted and two from natural causes. A comprehensive continuous improvement plan was informed by recommendations from the Prisons and Probation Ombudsman reports. The prison had commissioned local interim investigations about deaths in custody and any serious attempts at self-harm or suicide and used these to inform local action plans, which were subsequently well managed. Detailed clinical action plans were also in place and well managed.

2.59 There was a safer custody support group, facilitated by a member of the mental health team and the drug strategy senior officer. The group met weekly (fortnightly for vulnerable prisoners) and was open to anyone in need of additional support, not just those on ACCT documents. The group was well received by those who engaged with it.

2.60 There were eight trained Listeners who worked on a rota, of whom three were based in reception. The Listeners were adequately supported by the Samaritans and prison staff. There was one care suite on A wing. Although well used and comfortable, the suite did not have any beds for overnight use and no television or kettle. Listeners called on at night had to see prisoners in crisis in their cells.

Further recommendations

2.61 All staff should be trained or refreshed in assessment, care in custody and teamwork (ACCT) procedures and sufficient managers should be trained as case managers.

2.62 Prisoners on ACCT documents should be encouraged and enabled to take part in constructive regime activities during the working day.

2.63 CCTV should only be used to monitor prisoners on ACCT in exceptional circumstances to offer safeguards in addition to staff interaction.

2.64 Prisoners on ACCT documents should only be located in the segregation unit if there are exceptional circumstances to warrant this.

Housekeeping points

2.65 A log of prisoners on constant watch in the segregation unit and health care should be maintained.

2.66 The care suite should be equipped with beds, a television and kettle to offer an appropriate overnight facility for Listeners to work with prisoners in crisis.

Good practice

2.67 *A safer custody support group, facilitated by a member of the mental health team and the drug strategy senior officer, met regularly and was open to any prisoner in need of additional support.*

## Vulnerable prisoners

2.68 There should be formal first night procedures for vulnerable prisoners, who should not be located on B2 landing on their first night in Gloucester. (3.121)

Not achieved. A significant number of vulnerable prisoners continued to be located on B2 landing on their first night, where there were no dedicated first night cells for them (see paragraphs 2.2 and 2.16). The majority of those we spoke to said that they had not had the opportunity to speak with staff in private on their first night. An Insider had recently been introduced on B1 (see paragraph 2.17) and he tried to speak with all new arrivals but this was often difficult for those located on B2.
We repeat the recommendation.

2.69 The IT classroom for vulnerable prisoners should be opened up. (3.122)

Partially achieved. Since the last inspection, the IT classroom in the education department had become available for vulnerable prisoners to use, although only on Friday morning which was also their allocated time to use the library. This meant that their session in the IT classroom was often curtailed. IT classes were also inappropriately facilitated in an open area around the pool table on B1 at other times during the week when other prisoners were engaged in activities such as landing cleaning. The environment was not conducive to learning.

## Additional information

2.70 There was no strategy for the safe and consistent management of vulnerable prisoners. At the time of the inspection, the 27 vulnerable prisoners located on B1 landing reported feeling safe and were extremely complimentary about the staff who worked and supported them on that landing.

2.71 All vulnerable prisoners located on B1 or B2 had to request location there formally with reasons to justify it. These landings held prisoners with a variety of vulnerabilities, including sex offenders, poor copers and those in debt or with other problems on other units. The cell cards of all vulnerable prisoners were marked with a red strike, which identified them to other prisoners (see recommendation 2.15). Vulnerable prisoners on B2 were subject to formal reviews of their location, which were similar to good order or discipline reviews for segregation. These reviews took place every 28 days and it was unclear why they required only for those on B2.

2.72 The environment on B1 was poor and the facilities, which also served prisoners on B2, were inadequate. Induction arrangements for vulnerable prisoners were less well developed than for other prisoners. Activity places were restricted and even those offered on the unit were insufficient for the number of prisoners there. As B1 staff also managed the segregation unit, the poor regime for vulnerable prisoners was often made worse when they were locked up to facilitate adjudications or other regimes for segregated prisoners.

2.73 Vulnerable prisoners on B1 and B2 were always the last to collect their meals from the central servery. A few prisoners raised concerns that their food was tampered with, although none had made any formal complaints. We were offered no assurance that these concerns were monitored or addressed.

Further recommendations

2.74 The prison should have a vulnerability protocol that clearly describes the systems to support vulnerable prisoners.

2.75 Staff and managers should ensure that food for vulnerable prisoners is not contaminated and should be able to offer consistent assurance to prisoners.

## Young adult prisoners

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

## Additional information

2.76 At the time of the inspection, 20 young adult prisoners were located on B2 landing, nine on A wing and three on C wing. They were allowed full access to the regime. However, young adults on B2 landing told us they felt less well treated and less well respected than adult prisoners and that they were not offered the same opportunities for purposeful activity. Young adults on A wing reported a significantly better experience.

2.77 Since the last inspection, a new tool for monitoring the treatment of young adult prisoners had been introduced. This reviewed their access to activities, adjudications, segregation,

complaints, incentives and earned privileges (IEP), use of force, release on temporary licence, recategorisation and home detention curfew. It had highlighted some areas, including proved adjudications, segregation, use of force and use of the basic regime, where young adults were disproportionately over-represented compared with adult prisoners. Although there had been some informal discussion on the findings, there had been no formal investigation or action to address them.

Further recommendation

2.78 Where monitoring indicates that young adult prisoners are disproportionately represented, there should be a formal investigation to consider the reasons and to take action as necessary.

## Applications and complaints

2.79 Applications books should be kept on all wings to monitor applications that are sent off the wing and to log the results of applications. (3.91)

Not achieved. Applications could be receipted but there was no means of logging them or monitoring their progress.
We repeat the recommendation.

2.80 There should be a formal system to track, monitor and quality assure health care complaints. (3.92)

Achieved. Health care complaints submitted through the normal complaints procedure were subject to the standard tracking and quality assurances protocols. Comparative data and monitoring information produced monthly for the senior management team included information on complaints about health care. These made up about five of the average of 60 complaints a month. In addition to quantitative monitoring, a sample of 10% were reviewed for quality of response, with a monthly report to the senior management team. A log of all complaints about health care was also maintained separately and submitted to the health partnership board. The prison had plans to improve links with the patient advice and liaison service (PALS) health complaints arrangements and give prisoners more information about this.

## Additional information

2.81 Access to applications was very good. Each wing had large file dispensers with a number of forms used for a variety of applications. These included general applications and applications for the Independent Monitoring Board (IMB), health care, CARATs, PIN credits, visiting orders and catalogue orders. Applications could be made at any time and handed in to the wing office.

2.82 There was a comprehensive complaints policy. Access to the system was very good and governance provided assurance about its application. Prisoners raised few concerns with us about how their complaints were addressed. However, complaints boxes were opened by the night orderly officer, which could have affected the confidentiality of the complaints.

Further recommendation

2.83 Complaints boxes should be emptied by the complaints clerk.

## Faith and religious activity

2.84 There should be a formal risk assessment of the possibility of allowing vulnerable Muslim prisoners to attend Friday prayers with mainstream prisoners, in common with practice in other establishments. (5.44)

Achieved. Vulnerable Muslim prisoners could attend Friday prayers with other prisoners if they wished, and did so.

2.85 The prison should provide a new and larger multi-faith room. (5.45)

Partially achieved. Since the previous inspection, the chapel and multi-faith room had temporarily located to alternative accommodation to enable essential maintenance work. The multi-faith facility was a separate room entered via the chapel. The temporary accommodation had been used for over 18 months and it was unclear when a return to the permanent facilities would be possible. Although the temporary accommodation was on the ground floor and accessible to all prisoners, it was further away from the residential wings which affected chaplains informal contact with prisoners. The temporary multi-faith room included some washing facilities but was still only just big enough to accommodate the number of prisoners who attended Friday prayers. The temporary chapel was flexible enough to accommodate Muslim prayers if required but this was not ideal. The chaplains were visible around the prison and provided valuable pastoral and spiritual support to prisoners.

## Substance use

2.86 The prison, in partnership with the primary care trust, should introduce appropriate protocols and procedures, specialist clinical staff and a supportive regime so that drug/alcohol dependent prisoners receive effective clinical management and throughcare. (3.110)

Achieved. The integrated drug treatment system (IDTS) was in place. A team of IDTS nurses, led by a band six nurse, worked within the overall health services team but carried a caseload of prisoners requiring detoxification, stabilisation or maintenance therapy. Prisoners were able to receive prescribed first night opiate substitution therapy if required, as well as symptomatic relief. The nursing team worked in conjunction with CARATs to ensure that patients were reviewed within required timeframes. Nursing staff also helped deliver some of the psychosocial group modules.

2.87 Prescribing regimes for opiate users should be flexible, based on individual need, and include maintenance treatment. (3.111)

Achieved. The lead GP had relevant experience in opiate detoxification and maintenance prescribing. Prisoners were seen on the morning following their arrival, as well as five and 14 days after the commencement of their prescribing regime, to ensure that their individual needs were met. At the time of the inspection, there were 67 prisoners on substitute opiate prescribing, of whom 15 were receiving stabilisation therapy, 17 were on a detoxification programme and 35 were on a maintenance programme.

2.88 Joint working arrangements between health care and counselling, assessment, referral, advice and throughcare (CARAT) staff should be formalised to facilitate care planning and care coordination. (3.112)

Achieved. There was a joint protocol between Avon and Wiltshire Partnership Trust, which provided CARAT services, and Gloucestershire Care Services, which provided health services. The nursing team worked in conjunction with CARATs (see paragraph 2.86). There was also a weekly meeting between the teams to review all clients on the IDTS programme.

2.89 The establishment should ensure that sufficient resources are allocated to mandatory drug testing programmes. (3.113)

Achieved. There was a full-time MDT officer and a deputy, so that testing could take place seven days a week, but no tests were carried out in the evenings. The MDT target was 12% and in the year to 31 March 2010 the average was 11.7% positives, although the figure had been 19.35% in the first month, which was consistent with information about drugs being in the prison at that time. Twelve suspicion tests had been carried out in the period 1 April to 31 July 2010, resulting in two positive results (16.7%).

## Diversity

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

## Additional information

2.90 Work on diversity was coordinated via an action plan which was regularly reviewed by the diversity and race equality action team (DREAT). The DREAT met bimonthly, was chaired by the deputy governor and included wide representation from across the prison, as well as external representatives from Gloucester Race Equality Council (REC) and Gloucestershire Action for Refugees and Asylum Seekers (GARAS) and prisoner diversity representatives Alongside SMART (systematic monitoring and analysing of race equality treatment) ethnic monitoring data, DREAT meetings also discussed data on access to regimes and services monitored by age and disability.

## Race equality

2.91 The establishment should monitor the negative perceptions of black and minority ethnic prisoners in certain areas, and work with them to improve those perceptions. (3.45)

Achieved. The diversity team held regular focus groups (see below) and carried out analyses of racist incident report forms (RIRFs) and SMART data to identify any trends. As well as investigating RIRFs and general complaints that might have a racist component, the diversity manager reviewed and analysed all complaints by ethnicity to see if any problem areas were emerging. The team was aware of the negative perceptions of black and minority ethnic prisoners about the complaints procedures and had prioritised these for renewed diversity impact assessments (see paragraph 2.93).

2.92 The establishment should formally consult with black and minority ethnic prisoners on a regular basis. (3.46)

Achieved. There were bimonthly focus groups with black and minority ethnic prisoners. The action points from these meetings were put on to the diversity action plan and discussed at the

next DREAT meeting to confirm who should take the action forward. The DREAT also monitored progress against the action points.

2.93 Formal race impact assessments should be reassessed and published. (3.47)

Achieved. Diversity impact assessments were carried out using the NOMS equality impact assessment tool (NEAT). Complaints procedures had been prioritised for early assessment as the establishment's own monitoring had shown that black and minority ethnic prisoners were under-represented in making complaints. Black and minority ethnic prisoners told us that they lacked faith in the complaints procedures and were unlikely to use them for fear of being transferred elsewhere. Gloucester REC and GARAS had been asked to assist with these assessments

## Additional information

2.94 Black and minority ethnic prisoners made up about 17% of the prisoner population. Sixteen RIRFs had been submitted between 1 January 2010 and the start of the inspection. These were investigated properly and subject to scrutiny by the area diversity lead and Gloucester REC.

## Religion

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

## Additional information

2.95 Religion and access to worship was a standing agenda item at DREAT meetings. The establishment monitored the population by religion and held focus groups with Muslim prisoners. Preparations for observance of Ramadan were under way during the inspection. Issues identified for action formed part of the establishment's diversity and race equality plan and progress was monitored by the DREAT

## Foreign nationals

2.96 The establishment should routinely consult with foreign national prisoners. (3.60)

Achieved. The diversity team held bimonthly group meetings with foreign national prisoners. As with other diversity groups, the action points were fed into the diversity action plan and progress kept under review at DREAT meetings.

2.97 There should be support and information groups for foreign national prisoners, held at least monthly. (3.61)

Partially achieved. Meetings were being held bimonthly. These were supplemented by regular visits from the UK Border Agency (UKBA) to meet individual prisoners.

2.98 Newly arrived foreign national prisoners should be given sufficient free telephone credit to allow them to ring their home country. (3.62)

Achieved. Newly arrived foreign national prisoners were given a five-minute telephone call to their family on arrival.

2.99 Immigration agency staff should attend the establishment to update foreign national prisoners on their cases. (3.63)

Achieved. Staff from UKBA attended the establishment every four to six weeks to meet individual prisoners and update them on progress with their cases.

2.100 External support groups should be invited to attend the establishment to support foreign national prisoners. (3.64)

Achieved. Support was available to foreign national prisoners from Bristol Law Centre and GARAS.

## Additional information

2.101 There were 23 foreign nationals at Gloucester (just under 8% of the population) during the inspection. The foreign nationals coordinator was also the race equality officer and a full-time member of the diversity team. A clear policy was in place. Staff we spoke to were aware of the professional interpreting service and the list of staff who spoke foreign languages. Written information about Gloucester had been translated into the five languages most commonly required and the establishment had computer software that enabled other translations to be undertaken as required. Provision of English for speakers of other languages (ESOL) had not been sufficiently developed to meet requirements (see further recommendation 2.9).

2.102 Foreign national prisoners who did not receive domestic visits could apply for one free five-minute call home each month and could exchange two ordinary letters for one airmail letter. They were exempt from the restrictions on access to private cash to buy telephone credit. A recent problem when international telephone cards were removed from the prison shop sheet had quickly been resolved when brought to the attention of the foreign nationals coordinator.

## Disability and older prisoners

2.103 There should be an independent review of the prison's facilities to meet the needs of prisoners with disabilities and increase their access to key departments. Relevant recommendations from the review should be formulated into an action plan and taken forward. (3.27)

Partially achieved. There had not been an independent review but the area disability lead had carried out an access audit. The diversity team was picking up issues from focus groups with older prisoners and those with disabilities, and from complaints, to inform the action plan

2.104 The establishment should devise formalised support plans and personal evacuation plans for prisoners with disabilities. (3.28)

Achieved. Prisoners with disabilities were seen by the fire officer and, where required, personal emergency and evacuation plan were in place and held in the wing offices. During the inspection one prisoner had a care plan which covered his needs. The establishment had agreed to involve him in selecting a paid helper should the friend who was assisting him no longer be available. Staff were aware of his disability and the arrangements to help him in the custodial environment

2.105 Prisoners' retirement pay should be increased to the level of average pay in the establishment. (3.29)

Achieved. Prisoners who had reached retirement age and opted not to work were paid £4.50 a week, which was in line with average pay, and did not have to pay for their televisions.

2.106 Older prisoners and those with disabilities should have access to a regime that fully meets their needs and provides a range of appropriate activities. (3.30)

Not achieved. The regime for older prisoners and those with disabilities was the same as for other prisoners. There was no in-cell work available during the inspection but there were plans to introduce this in conjunction with a local charity.
We repeat the recommendation.

2.107 There should be consultative meetings with older prisoners and those with disabilities. (3.31)

Achieved. There were bimonthly focus group meetings with older prisoners and prisoners with disabilities. The action points from these meetings fed into the diversity action plan and progress was monitored at the DREAT meetings. As there were few prisoners of retirement age or older at the establishment, those aged 55 and over were invited to the group meetings.

2.108 Older prisoners should not be allocated to top bunks. (3.32)

Achieved. Policy documentation was explicit that older prisoners should not be allocated to top bunks.

2.109 All accidents should be reported in the accident book. (3.33)

Achieved. Staff were aware of how to record accidents and injuries. The health and safety manager had good arrangements to ensure that all relevant details were forwarded to him so that proper investigations could be completed and records kept.

## Diversity: gender and sexual orientation

2.110 Staff should receive guidance on how to deal with gay prisoners. (3.26)

Not achieved. There was no policy or specific guidance for staff on dealing with gay prisoners. Health care staff undertook some basic recording of men who declared their sexual orientation and informed the diversity manager of the number they were aware of who were gay or bisexual but not their identities. The race equality officer also saw new arrivals and asked about their sexual orientation. She was aware of one gay prisoner and the diversity manager had been told by health care that there were two bisexual prisoners.
We repeat the recommendation.

## Health services

2.111 The number of inpatient beds should be reviewed with a presumption in favour of a day care facility for patients with mental health problems and further development of primary care services. (4.47)

Partially achieved. The primary mental health team used an area that had previously been a

three-bedded ward on the inpatient unit for ad hoc day care activities. As a result of our recommendation, the team had succeeded in obtaining a grant from the King's Fund 'Enhancing the healing environment' project with top-up funding from Gloucestershire Care Services charity fund and a local mental health charity to provide better day care facilities for patients with mental health problems. We were shown the plans and presentations and evidence that prisoners had been involved in the planning of the new facilities. The project was due for completion by November 2010.

2.112 The inpatient beds in health care should not form part of the prison's certified normal accommodation and admission should only be on assessment of clinical need. (4.48)

Not achieved. All the beds in the inpatient unit, which had been reduced to eight, remained on the CNA, with an operational capacity of 11. The facilities were poor. However, at the time of the inspection there were no inpatients and we were assured that the unit was not often used. Whenever possible, prisoners were cared for on the wings.
We repeat the recommendation.

2.113 Evening association should be introduced for inpatients. (4.49)

Partially achieved. We were not able to speak to any prisoners who had used the inpatient unit but staff told us that the officer profile for the unit only allowed for one evening's association a week, which was considerably less than elsewhere in the establishment. However, staff assured us that they would try to allow access to facilities, such as a telephone, if a prisoner had a specific need in the evening.
We repeat the recommendation.

2.114 Patients should only be placed in strip clothing as a last resort and following discussion and authorisation from medical staff. All occasions where strip clothing is used should be documented and a central register held. (4.50)

Partially achieved. Staff assured us that strip clothing was only used as a last resort for prisoners at risk from self-harm and there was no strip clothing kept on the unit. However, staff could not recall when such an incident had last occurred and it was not clear how one would be recorded.
We repeat the recommendation.

2.115 Electricity should be supplied to all inpatient cells. (4.51)

Achieved. All the inpatient cells had an electricity supply.

2.116 The inpatient treatment room should be properly equipped with storage facilities and adequate ventilation. (4.52)

Partially achieved. The inpatient treatment room was still not fit for purpose but the plans mentioned in paragraph 2.112 included a refurbishment of the room.

2.117 A controlled drug cabinet should be installed in the inpatient treatment room as a matter of urgency. (4.53)

Achieved. A new controlled drugs cabinet had been installed in the inpatient treatment room.

2.118 Wing-based treatment rooms should have adequate storage facilities for patient medication. (4.54)

Achieved. Large freestanding lockable cabinets had been installed in treatment rooms on A and B wings. All patient medication was stored appropriately at the time of the inspection.

2.119 Emergency equipment should be provided in the dental surgery at all times. (4.55)

Partially achieved. Due to the current size of the dental suite (see recommendation 2.144), it was not possible to store emergency equipment there but there was relevant emergency equipment in the immediate vicinity. As there was also now emergency equipment on the main wings, it was less likely that the equipment in the health centre would not be available. We repeat the recommendation.

2.120 Barrier protection should be provided for prisoners as part of a communicable disease prevention strategy. (4.56)

Achieved. Prisoners could obtain packets of condoms and lubricants from health services staff. Due to ongoing problems with disposal, they were also given small clinical waste bags to return them to the nursing staff for safe disposal.

2.121 A health promotion strategy should be introduced and there should be a high profile health promotion programme. (4.57)

Partially achieved. There was a quarterly healthy prison forum, chaired by the head of drug strategy and attended by most heads of function, health services representatives and the chaplaincy. Its purpose was to provide, promote and encourage a comprehensive healthy living programme to prisoners. The strategy did not appear to have a high profile around the establishment and there were few posters and limited health promotion information on the wings. (See also paragraph 2.147 on oral health promotion.)

Further recommendation

2.122 The healthy prison forum should ensure that there is a high profile health promotion programme with relevant publicity.

2.123 The management of prisoners with long-term illnesses should be formalised with the introduction of a central register and a regular system for monitoring patients' progress. (4.58)

Partially achieved. Since the introduction of the SystmOne IT system, a central register of patients with lifelong conditions had been created. There were nurses with the relevant skills and competencies to provide evidence-based care to such patients in line with national guidelines. However, the information on SystmOne indicated that several patients were overdue for reviews of their condition and some prisoners were still awaiting second and third doses of their hepatitis B vaccination programme. These delays were partly because clinics for long-term conditions and vaccinations only took place when staff numbers allowed and there was inadequate provision when specific staff were on leave. There was also a suggestion that staff did not always update the waiting lists after patients had been seen.

Further recommendation

2.124 Patients should be seen in a timely fashion relevant to their need.

2.125 The pharmacy service level agreement should ensure that sufficient pharmacist and technician time is provided to deliver pharmacist-led clinics, clinical audit and medication review. (4.59)

Partially achieved. The pharmacy provider had changed since the last inspection and the new agreement allocated 7.5 pharmacist hours and 19 technician hours to the prison each week. Although this allowed the pharmacy to provide some support for medicines management and clinical audits, this time was underutilised and there were still no pharmacist-led clinics or opportunities for prisoners to consult a pharmacist. Although the pharmacist checked medication stocks during her visits, we found stock medication without expiry dates and batch numbers. The refrigerators in treatment rooms were not monitored adequately.

Further recommendation

2.126 The pharmacist and technician time should be used more effectively for medicines management, medication use reviews and pharmacist-led clinics.

Housekeeping points

2.127 Maximum and minimum temperatures on drug fridges should be recorded daily.

2.128 All medicines should be labelled in accordance with Medicines Act requirements.

2.129 The medicines and therapeutics committee should review the prescribing of opiates and benzodiazepines. (4.60)

Partially achieved. The prison had carried out a local audit of the use of benzodiazepines, although this had not been reviewed by the medicines and therapeutics committee. Benzodiazepines were mainly prescribed for patients undergoing detoxification, although they were also prescribed routinely for anxiety. There had been no formal audit of the use of opiate-based painkillers.

Further recommendation

2.130 The medicines and therapeutics committee should audit and regularly review the use of benzodiazepines and opiate-based painkillers.

2.131 The system of faxed prescriptions should be subject to audit. Dispensed faxes should be checked against original prescription forms, and there should be a means to reconcile the general stock medicines with the prescriptions issued. (4.61)

Partially achieved. The pharmacist attended the prison weekly to check the prescription charts, including those faxed to the pharmacy. Stock was supplied against an agreed list, although there did not appear to be a system to audit the use of general stock. We also had concerns about the system of ordering controlled drugs and their subsequent delivery to different cupboards in the establishment.

Further recommendations

2.132 There should be a system to reconcile the general stock medicines with the prescriptions issued.

2.133 There should be an audit trail showing the movement of controlled drugs around the prison and each controlled drugs cabinet should have a stock order book to document receipt and transfer of stock.

2.134 The medicines and therapeutics committee should develop a policy to determine the circumstances when general stock medication should be used. Wherever possible, named patient dispensed medicines should be issued in preference to general stock. (4.62)

Not achieved. The Avon, Gloucester and Wiltshire Prisons Drug and Therapeutic Committee had only recently reinstated regular meetings, and had no formal policy to identify the circumstances in which general stock medication should be used. The use of named-patient medication and medication held in possession had increased, although supplies were still frequently administered from stock.
We repeat the recommendation.

2.135 The pharmacy dual labelling system should be revised to ensure that packs are supplied appropriately in accordance with prescription, and that a professional check is made by the pharmacy. (4.63)

No longer applicable. Stock was supplied to the prison in manufacturers' original packs. No pre-packs or labelled items were supplied as the provider did not hold an assembly licence. There was no facility at the prison to enable nursing staff to label stock.

Further recommendation

2.136 NHS Gloucestershire, as commissioners of health services, should ensure that stock medicine packs, labelled in accordance with the regulations, can be supplied against a prescription to prisoners.

2.137 The administration of medicines against verbal orders should only be done in an emergency. (4.64)

Achieved. The need for verbal orders had reduced with the three independent nurse prescribers, the introduction of patient group directions and the increased accessibility of the prison doctor and these were now only rarely made in an emergency.

2.138 There should be standard operating procedures to cover the current arrangements for pharmacy service provision and delivery of medication to prisoners. These should be formally agreed through the medicines and therapeutics committee. All health care staff should read and sign the agreed adopted procedures. (4.65)

Partially achieved. There were some standard operating procedures for the pharmacy provision, although they were overdue for a review. It was not clear if they had been agreed through the medicines and therapeutics committee or that relevant staff had signed the policies.

Further recommendation

2.139 The pharmacy standard operating procedures should be reviewed to reflect current practice, be agreed by the medicines and therapeutics committee and should be signed by relevant staff.

2.140 Patient information leaflets should be supplied with medication wherever possible. Notices should be prominently displayed to advise patients of the availability of leaflets on request. (4.66)

Not achieved. Medication packs supplied in possession did not generally include patient information leaflets and there were no obvious notices in the treatment areas advising patients that they could be requested.
We repeat the recommendation.

2.141 Administration charts should be properly completed by nursing staff, and should include a clear record to show when patients have not attended or refused treatment. (4.67)

Not achieved. We found gaps in many of the prescription charts that we reviewed. These included a patient on citalopram tablets (an antidepressant) where there was no annotation of the chart for five days and it was not clear if medication had been administered. There were also gaps against prescriptions for detoxification symptomatic relief medications, so it was not clear if the items had been offered and declined or not offered at all.
We repeat the recommendation.

2.142 Additional dental sessions should be commissioned. (4.68)

Achieved. Since our last inspection two dental sessions were provided weekly by the local dental access clinic, making a total of three sessions a week. Some prisoners were reported to have been seen by two different dentists rather than one within a course of treatment because of the way the waiting lists for dental services were operated.

Further recommendation

2.143 The management of the dental waiting lists should ensure that patients receive continuity of care from the same dental practitioner throughout a course of treatment.

2.144 The dental surgery should be relocated to more suitable premises with sufficient room for all necessary equipment, thorough cross-infection control procedures and adequate ventilation. (4.69)

Not achieved. The dental surgery was small, cramped, lacked storage space and was oppressively hot. However, on the last day of our inspection the surgery was being cleared so that building work could start the following week to rectify the problems that we, and others, had previously identified. Part of the new working arrangements included an agreement that all instruments would be sent to a central sterilising unit off site to comply with infection control guidance. Prisoners who required dental treatment while the dental surgery was closed were due to be taken to the local dental access centre for treatment.
We repeat the recommendation.

2.145 There should be arrangements for out-of-hours emergency dental treatment. (4.70)

Not achieved. There were no formal arrangements for out-of-hours emergency dental treatment, although staff cited occasions when prisoners had been taken to the dental access clinic for treatment. Dental staff in the establishment told us that sometimes they received inappropriate 'urgent' referrals. Nursing staff commented that it was difficult for them always to know what constituted a dental emergency that required immediate treatment.
We repeat the recommendation.

Further recommendation

2.146 There should be specific triage algorithms for nurses to use in the absence of a dental practitioner.

2.147 There should be a programme of oral health promotion. (4.71)

Partially achieved. Dental staff told us that they provided chairside oral health promotion. Although the prison told us told that there had been an oral health promotion campaign, involving the local oral health promotion team and basic training for all the nursing staff in the promotion of oral health, the dentist and dental nurses to whom we spoke were not aware of this initiative.

Further recommendation

2.148 There should be formal documented meetings between the dental staff who provide services to the establishment and the health services manager to ensure that all parties are updated on health services activities in the establishment.

2.149 Air-conditioning should be installed in the dental surgery (4.72)

Not achieved There was no air conditioning in the surgery, which was oppressively hot on the day of our visit, but building work was due to rectify the problem (see recommendation 2.144).

## Additional information

2.150 Gloucestershire Care Services (the primary care trust, PCT) provided primary health services. The manager of the department was also responsible for health care for the homeless in the community and the potentially violent patients scheme. Her deputy, a band seven nurse, had day-to-day responsibility for the department, supported by three band six nurses. There was an establishment of approximately 20 whole-time-equivalent staff, which included registered general nurses (RGNs), registered mental health nurses (RMNs) – including some nurses with dual qualifications – and support workers.

2.151 Prisoners told us that health services were reasonable, they could see a doctor within a couple of days of a request and nurses were helpful, in the main. We were impressed with the level of care for some individual patients, including a young man with severe asthma who was to be transferred to another establishment to continue his sentence. Staff contacted the receiving establishment in advance to ensure that his needs could be met and arranged for the nurse who took the lead on caring for patients with asthma to escort him there. They also ensured that suitable transport was organised as the prisoner's condition made it difficult to travel in a

cellular vehicle. Despite these measures, the receiving establishment refused to accept him when he arrived, apparently due to his 'medical issues'.

2.152 Medications were administered four times a day from treatment rooms on the wings. IDTS medication was administered from the same rooms, sometimes at the same time as the main medication times, but from different hatches. A fifth treatment time at 7pm had recently been stopped to save money on staff. As a consequence, some prisoners received medications during the night patrol state, which increased the workload for night duty discipline staff. We were concerned by the practice employed by nurses during these times. Medications were put into labelled medication pots, which were then piled up and taken to individual prisoners. This constituted secondary dispensing by nursing staff. On the night we observed the practice, 17 prisoners received medications in this way but we were told there had been 25 during the previous week. When we checked the medication charts the next day we found that not all had been annotated correctly (see recommendation 2.141). When we brought our concerns to the health care managers they took immediate steps to stop the practice of secondary dispensing, including speaking to individual prisoners about why they would not be receiving their medications at 10pm, and they raised a clinical incident report to the PCT

2.153 Smoking cessation services were provided two days a week by the Gloucestershire stop smoking service. Referrals were received from a variety of sources, including the reception and secondary health screens, the GP or self-referrals. As prisoners preferred not to have group sessions, staff visited them on their wing or at their place of work to provide support and nicotine replacement therapy in the form of patches, lozenges or inhalators. If prisoners remained smoke-free after four weeks they received incentives such as a certificate and some toothpaste.

2.154 Since our last inspection, mental health services had increased. Primary mental health services were provided by the PCT, although the team of RMNs also undertook generic duties. The team received referrals and held a weekly clinic. It provided low-level support and some in-cell cognitive behaviour therapy work. It also used the inpatient unit for some group sessions. Anger awareness sessions for primary mental health care patients, equivalent to those run in the community, had recently been stopped by the prison, apparently because they did not have Prison Service accreditation. When we made enquiries about the validity of this decision, we were assured that accreditation was not required and the sessions would be reinstated as soon as practicable.

2.155 Secondary mental health services were provided by the 2gether mental health trust. The mental health in-reach team had a caseload of about 20 patients, including five who had been transferred to secure mental health beds in the community. The team received about 30 referrals a month and aimed to see all new referrals within three days. It had good links with prison discipline staff and workshop instructors and also a joint working protocol with local learning disability services. The team met the primary mental health team weekly and had a separate meeting with the consultant psychiatrist, who provided one session a week. Two members of the team were responsible for the safer custody support group, provided in-cell distraction packs for prisoners on ACCTs and facilitated a weekly group (see paragraph 2.59).

Further recommendations

2.156 Nurses should follow Nursing and Midwifery Council guidance on the administration of medications and secondary dispensing should cease.

2.157 There should be sufficient consultant psychiatrist time to allow a single point referral meeting and clinical interventions.

## Learning and skills and work activities

2.158 There should be a clear and realistic strategy for learning and skills in line with the overall strategy for reducing reoffending, and there should be sufficient teaching and specialist management staff to implement this. (5.21)

Partially achieved. Although the prison had submitted its proposed learning and skills delivery plan for 2010-11 to the funding body, there was still no clear, formalised strategy for learning and skills in line with the overall strategy for reducing reoffending. The existing strategy was out of date and still reflected the provision delivered by the three previous providers. Although the new provider had a written formalised Skills for Life strategy this had not yet been appropriately reviewed and agreed by the prison. The prison had increased the number of dedicated outreach Skills for Life tutors and there was now also an English for speakers of other languages (ESOL) teacher qualified to the appropriate level. There had been no formal qualification achievement targets for the prison's learning and skills providers in the past two years. The recently appointed A4e (Action for Employment) manager was only working towards achieving the minimum performance target of 62% success rate set by the government's funding body.

Further recommendation

2.159 The prison should create a realistic but challenging learning and skills strategy that feeds into the overall strategy for reducing reoffending.

2.160 Target-setting for prisoners should be improved, and there should be systems to recognise and reward their progress and achievement. (5.22)

Not achieved. Target setting remained insufficiently specific about the activities needed to enable prisoners to progress through their course. In some cases, the targets just referred to the units of the qualification that needed to be achieved. Individual learning plans (ILPs) had insufficient comments from learners reflecting on their own progress and learning as part of their progress review. There was too much emphasis on describing the activity that had taken place instead of highlighting the learning and measuring the progress the learner had made. Some ILPs did not detail the support strategies to meet identified needs and they rarely made good use of the individual's preferred learning styles. There was insufficient recording of the development of personal and social skills. The prison had not reviewed learners' ILPs since June 2009. The newly appointed education manager for A4e had planned several training events for staff to improve target setting.
We repeat the recommendation.

Further recommendation

2.161 The prison should monitor the quality of the learning processes more frequently to identify areas for improvement.

2.162 Vulnerable prisoners should be offered full-time education. (5.23)

Partially achieved. Vulnerable prisoners had access to learning and skills provision in the education centre for one half-day a week. A weekly programme of activities in the vulnerable prisoner wing encompassed art and performing art, a family course, information and communications technology (ICT) and business. Plans to deliver classes to vulnerable prisoners in a suitable classroom had been abandoned due to security staffing issues. The current classes were delivered in the association area which was not suitable for effective teaching and learning.

Further recommendation

2.163 Activities for vulnerable prisoners should take place in an environment that is sufficiently effective for teaching and learning.

2.164 There should be a fair and equitable pay policy for prisoners. (5.24)

Achieved. A pay review in 2008 had eliminated the past pay differentials for training and education. However, prisoners employed as essential workers in the kitchen, tray washing and reception areas continued to be the highest paid in the prison. The head of regimes was due to undertake a pay review.

2.165 The collection and use of meaningful data to manage and evaluate learning and skills provision should be improved. (5.25)

Partially achieved. Although there had been some improvements in the collection of data relating to the main education provider, achievement data from the vocational provider was very limited. There had been an improvement in the achievement of qualifications over the last two years and achievement was high for most programmes, except literacy and numeracy. However, data was not yet sufficiently analysed to monitor achievement across the different programmes and levels and to inform managerial decisions fully. Data had not been used well in the learning and skills self-assessment to identify poor performance and areas for improvement. We highlighted discrepancies on data sets that the new education manager and head of learning and skills were not aware of.

Further recommendation

2.166 The learning and skills department should analyse data more effectively to monitor and manage the provision offered to all prisoners.

2.167 There should be better prisoner attendance rates on all learning and skills provision. (5.26)

Achieved. Attendance had been greatly improved in 2010 and attendance rates for the last six months of the academic year were high at 80%. There were some effective strategies to manage attendance, which was now well monitored and managed. The education officer tracked the reasons why prisoners had not attended education sessions. Those who refused to attend education were identified, their attendance was closely monitored and appropriate action taken.

2.168 The library should open in the evening and at weekends to cater for working prisoners and to increase prisoner visits. (5.27)

Not achieved. Although the library was open for 25 hours a week spread over four and a half weekdays, it was not open during the evenings and at weekends. Library and prison staff responded flexibly to requests from working prisoners to visit the library but their access was poor.
We repeat the recommendation.

2.169 The library should provide more reading material appropriate for those studying English for speakers of other languages (ESOL). (5.28)

Achieved. The library had increased the range of specialist books for prisoners with ESOL needs, as well as the stock for prisoners with poor reading skills, although the librarians were not fully aware of the current population's range of languages.

2.170 The library should be expanded to provide adequate private study space. (5.29)

Not achieved. The prison had put in a bid for funds to increase the library to accommodate a larger study area but it had not yet expanded and there was no additional space in the library or anywhere else for private study.
We repeat the recommendation.

## Additional information

2.171 The learning and skills department was managed by the head of learning and skills. Since August 2009, it had been decided to reduce the number of education and activity providers, and the main education provider was now A4e (Action for Employment). As a consequence, the number of outreach support literacy and numeracy tutors had increased as it was easier to distribute the funding according to the prison's needs. Tribal delivered the careers information and advice support (CIAS) interventions, but it had suffered some cuts in the support hours delivered in the prison. CIAS had been prioritised for the initial stages of prisoners' sentences, although some still received it towards the final stages of their stay if Tribal had the resources available.

2.172 The prison did not use data sufficiently to evaluate the success of the programmes it delivered. Participation in education and activities had decreased since the last inspection. Although most personal and social development programmes performed well and achievement had consistently increased in the last two years, the prison had not correctly identified the low achievement of qualifications by prisoners on literacy and numeracy programmes. The learning and skills department had no formal strategy and senior management placed too much emphasis on supporting literacy and numeracy skills development rather than helping prisoners towards achieving a recognised qualification in literacy or numeracy. There were no ambitious targets for the achievement of prisoners' qualifications, and there were no ESOL qualifications.

2.173 Since the role of the learning and skills coordinator had been eliminated in July 2009, the learning and skills department had not monitored procedures frequently and regularly to evaluate the quality of the provision. The self-assessment report was over-generous in the grades it had awarded and it was not informed by the respective self-assessment reports of the current main providers.

2.174 The quality of the work available for prisoners had not changed significantly since the last inspection, although the prison now offered more opportunities for employment-related accredited vocational training (see paragraph 2.269).

2.175 The library was provided under contract with Gloucestershire County Council. It was managed by a librarian who was working towards a full qualification and an unqualified library assistant, who were both part time. One full-time orderly supported the library staff, but this post was currently vacant. Library orderlies received a short internal training programme but none had taken part in the NVQ customer services programme. There were good records of prisoners who had joined the library and the number and frequency of visits. Records indicated that most prisoners had satisfactory access but those in work visited less frequently.

2.176 The library had a good stock of around 6,500 volumes, including fiction and non-fiction, easy readers and talking books. A small collection of books in foreign languages was supplemented by a contract with an organisation that provided books in foreign languages when requested. However, there was little communication between the prison and the library about the range of foreign national prisoners. The library included a good selection of up-to-date legal books and Prison Service Orders and a small range of newspapers and magazines.

## Physical education and health promotion

2.177 Classroom facilities should be provided for the gym. (5.37)

Partially achieved. The PE department had recently started the British Safety Council certificated health and safety course at level 2, a one-week course for around 10 prisoners every other month. Although the PE department did not have access to a dedicated classroom, it used the classroom in the cycle workshop nearby.

2.178 A healthy lifestyle programme should be available to prisoners. (5.38)

Not achieved. Although the prison had now begun to offer remedial programmes for those with particular needs – such as older prisoners, beginners to exercise, those with weight or alcohol and drug abuse problems – there was no specific healthy lifestyle programme. PE staff had begun to focus more clearly on the links between PE and health promotion and had already offered a session for prisoners promoting fitness development without the use of performance enhancing drugs. Further sessions on fitness and nutrition and fitness and mental health were planned.
We repeat the recommendation.

## Additional information

2.179 Since the last inspection, there had been significant improvements in the range and structure of the PE provision. The sports hall and fitness room had been reorganised to be a more spacious and safer environment and the range of cardiovascular equipment had improved. A table tennis club had also been introduced. The outside area had been refurbished and was used for a wider variety of sports, including cricket, basketball and volleyball. PE staff had been responsive to a recent prisoner survey and had set up dedicated exercise sessions for groups of prisoners with different needs (see above). In January 2010, around 30% of prisoners used the PE facilities. A more recent survey indicated that this had risen to around 61%. PE staff had developed good links with other areas of the prison, such as CARATs and the health care department, and planned to develop the current accredited provision to include first aid and a possible safeguarding children in sport course.

## Time out of cell

2.180 The daily routine should accurately reflect the scheduled times of activities, and the published times should be adhered to. (5.52)

Achieved. The core day had been revised since our last visit. We observed some slippage in routines but, in the main, they were followed. Arrangements that permitted some domestic time in the morning and at meal times were good and mitigated in part some of the general limitations on unlocked time.

2.181 Access to association should be increased for standard level prisoners. (5.53)

Not achieved. Prisoners on all the incentives and earned privileges (IEP) regime levels received the same access to association, but from Monday to Thursday they only had association on alternate evenings.

Further recommendation

2.182 Prisoners should be able to go on association every evening.

2.183 Enhanced prisoners on B wing should not receive less access to association than those on other wings. (5.54)

Achieved. Enhanced prisoners in all parts of the prison had the same access to association.

2.184 Cancellation of association periods should be kept to a minimum. (5.55)

Achieved. Cancellation of association periods was infrequent.

## Security and rules

2.185 The number of suspicion drug tests, subject to and based on intelligence, should be increased. (6.11)

Not achieved. Between January and July 2010, more than 300 security information reports (SIRs) about drugs were received and only 17 suspicion drug tests had been authorised, of which only six were positive. We were told there were often insufficient MDT trained staff to respond to intelligence quickly enough and we recognised that it was inappropriate to act upon some intelligence due to the transient and short-term nature of the some of the population. However, the positive rate of suspicion drug tests was poor and we concluded that suspicion testing protocols remained underdeveloped.
We repeat the recommendation.

2.186 Procedures for reviewing prisoners on closed visits should be formalised, based on recorded evidence and include a recorded justification for decisions taken. Prisoners should be informed in writing following every closed visits review. (6.12)

Achieved. Governance of decisions to place prisoners on closed visits, and subsequent reviews, had improved and records were well maintained. We were, however, concerned that only two of the 10 prisoners on closed visits at the time of the inspection were subject to this

measure as a result of activity or intelligence related to visits, and half were on closed visits as a result of a single activity or piece of intelligence. Reviews were timely but prisoners remained on closed visits for three months, even when there was no further intelligence that this was warranted.

Further recommendation

2.187 Prisoners should only be placed on and remain on closed visits when there is sufficient security-based evidence to support this.

## Additional information

2.188 The security department was small but adequately resourced and received support from a full-time police intelligence officer. Drugs and mobile telephones were the most common security issues raised by staff and the prison's response was proportionate and not overly restrictive to prisoners.

2.189 A well-appointed security committee met monthly and was chaired by the head of security or sometimes the deputy governor. Attendance at meetings was good. A basic security report was presented to the committee but it lacked depth or analysis. The minutes of meetings indicated that all relevant areas were discussed and actions taken appropriately.

2.190 Between January and July 2010, more than 1,300 security information reports had been submitted, which was a significant increase since our last inspection. Dynamic security arrangements were good and there was appropriate dissemination of intelligence to departments across the prison. Target searches were undertaken appropriately as a result of intelligence received.

2.191 Local prison rules were given to new arrivals in an information booklet and were reinforced through induction and prominently displayed on residential units.

## Discipline

2.192 Prisoners should not be subject to unofficial punishments without going through the formal procedure of an adjudication. (6.31)

Not achieved. The previous unofficial removal of gym sessions still took place. Gym staff told us that they imposed loss of gym sessions if, for example, a prisoner took gym kit out of the gym without permission. There was evidence from the violence reduction meeting that prisoners had lost gym sessions without going through the formal adjudication procedure. We repeat the recommendation.

2.193 The disparity between the establishment's sets of figures for use of special accommodation should be investigated and rectified. (6.32)

Partially achieved. There was a log for use of the special accommodation and observation cell in the segregation unit including when strip clothing had been issued. However, we were not assured that the use of strip clothing in the observation cell in health care was appropriately logged and monitored (see paragraph 2.51).

2.194 Following the spillage of blood or other body fluids in the special cell, it should be properly cleaned in accordance with the health care department's policy for the cleaning of prisoners' accommodation. (6.33)

Achieved. The special accommodation was clean and well maintained at the time of inspection and arrangements for cleaning the cell between uses were appropriate.

## Additional information

## Disciplinary procedures

2.195 There had been 260 adjudications, including 36 referrals to the independent adjudicator, between January and July 2010. Charges were appropriate and the number was relatively low for the type and size of the prison.

2.196 Adjudication hearings were conducted in a small office in the segregation unit, which was suitable for purpose. Prisoners were not routinely offered a pen and paper to make notes during the proceedings. In the adjudication hearings we observed, charges were fully investigated and prisoners were allowed to contribute to the process. Adjournments for prisoners to seek legal advice or to call witnesses were granted. Our analysis of records of adjudication hearings assured us that hearings were generally conducted appropriately. Punishments were fair and in line with the published tariffs. However, some guilty findings were concluded without full and proper exploration of the charges.

2.197 An adjudication standardisation meeting met quarterly and discussed data on overturned adjudications, awards and consistency. Best practice was shared and feedback given to adjudicators. Staff and prisoners were consulted about adjudications but rarely provided any input to the meeting.

Further recommendation

2.198 Written adjudication records should demonstrate full and thorough exploration of the circumstances of the charge before guilt is proved.

Housekeeping point

2.199 Prisoners should be given a pen and paper to make notes during adjudication hearings.

## Use of force

2.200 The use of force was marginally higher than at our last inspection. Between January and July 2010, force had been used on 50 occasions, although 12 of these related to one problematic prisoner. Although not high, the figure was not insignificant but did include many cases of low-level physical coercion. Efforts to de-escalate situations were evident. The number of planned interventions was low but they were not filmed when they took place.

2.201 The security senior officer completed a checklist to ensure that all relevant paperwork was included with use of force records. There was, however, no qualitative check of use of force paperwork. Documentation that we analysed sometimes lacked depth but was generally completed to a reasonable standard. There was still no separate use of force committee but a quarterly report was submitted to the violence reduction committee for consideration.

2.202 Governance of the use of special accommodation remained underdeveloped. The cell in the segregation unit was very basic and still had no plinth. It had been used on only five occasions since our last inspection but the paperwork authorising its use was often poor and incomplete, and we were not assured that all uses were fully warranted. Logs were not always completed. On one occasion, a prisoner remained in the cell for over half an hour after it was recorded that he was calm. The use of strip clothing in the observation cell in the segregation unit was now appropriately authorised and monitored.

Further recommendations

2.203 All planned use of force interventions should be recorded.

2.204 Special accommodation should only be used, with appropriate authority, in exceptional circumstances to house violent and/or refractory prisoners for the least time possible, and all paperwork should be fully completed.

## Segregation unit

2.205 Very little had changed in the segregation unit since our last inspection. It had four cells, a gated observation cell, a special cell and an adjudication room. Cells were graffiti-covered and some had damaged flooring. There were no facilities, such as an exercise yard, staff office, showers or telephone. Prisoners in the unit had to use showers and telephones in the adjacent vulnerable prisoner unit, B1, when the prisoners there were out on exercise or locked in their cells.

2.206 At the time of the inspection there were two prisoners in the segregation unit. There were frequent periods when there was no supervision on the unit as staff were engaged on B1 with vulnerable prisoners. All prisoners were assessed as requiring a minimum of two staff to unlock them and could be risk assessed as requiring more but not fewer.

2.207 We observed respectful exchanges between staff and prisoners in the unit but, although there was a nominal personal officer scheme, daily history sheets and case notes on P-Nomis indicated limited engagement. Prisoners had limited access to the regime or activities in association. However, the unit had an incentives and earned privileges (IEP) scheme and prisoners there for good order or for their own interest were routinely allowed a television, kettle and their own property.

2.208 Location in the segregation unit was generally a last resort and throughput was low. Many prisoners spent only short periods there. All prisoners were routinely strip searched on location to the unit without a risk assessment. Authorisation was appropriate and safety screens were completed within two hours of location. Good order review documentation was not always completed thoroughly, and we saw one example where no IMB or health care representative was present. There were no care plans for the few prisoners who remained in the segregation unit for more than 28 days. There was no meeting where segregation was reviewed.

Further recommendations

2.209 Prisoners should only be strip searched on location to the segregation unit following an assessment of risk.

2.210 There should be multidisciplinary care plans for prisoners residing in the segregation unit for longer than 28 days to prevent psychological deterioration.

2.211 Segregation monitoring and review group meetings should take place consistently and should monitor adherence to Prison Service Order 1700 and any trends or patterns in use of the segregation unit.

Housekeeping points

2.212 Cells in the segregation unit should be free of graffiti.

2.213 Good order review paperwork should be completed thoroughly.

## Incentives and earned privileges

2.214 Access to privileges under the incentives and earned privileges scheme should not vary between wings. (6.41)

Achieved. Prisoners on all wings had the same access to privileges. Access to association was no longer a key earnable privilege under the incentives and earned privileges (IEP) scheme but association was still listed as a privilege in the published IEP policy. There were still limited differentials between the standard and enhanced level of the scheme, except for access to additional private cash and visits.

Housekeeping point

2.215 The list of key earnable privileges in the published incentives and earned privileges (IEP) policy should be updated.

2.216 The criteria for prisoners to achieve enhanced status should be transparent. (6.42)

Achieved. Prisoners were clear about the criteria required to attain enhanced status and we saw examples of prisoners submitting applications to be considered for enhanced. At the time of the inspection, just over a quarter of the population were on the enhanced level of the scheme.

## Additional information

2.217 The IEP scheme was well publicised on the residential wings and was understood by staff and prisoners. Comprehensive monthly monitoring data was collated, which included figures on the IEP warnings issued, IEP boards convened and prisoners progressed and downgraded each month. The review paperwork we sampled was properly completed and IEP warnings had been issued for appropriate reasons. The monthly monitoring data evidenced an active appeal system.

2.218 Although there was only one prisoner on the basic level of the scheme during the inspection, and prisoners did not appear to spend long periods on basic, the monthly monitoring data showed that young adult prisoners were over-represented in the number of warnings issued and number of prisoners placed on the basic level. It was unclear what action was taken in response to this over-representation (see paragraph 2.77 and further recommendation 2.78).

## Catering

2.219 All servery equipment past its functional life should be replaced, particularly that on the A and B wing main servery. (7.7)

Achieved. Servery equipment was generally satisfactory and fit for purpose and halal equipment was marked. However, the tray wash was dirty and the environment in the A and B servery, in keeping with the rest of the prison, was grubby.

2.220 Prisoners working at the servery on C wing should be allowed to clean the area immediately after the serving of meals is completed. (7.8)

Achieved. Serveries were cleaned straight after meals had been served.

2.221 The breakfast meal should be served on the morning it is eaten, and fresh milk provided. (7.9)

Not achieved. Breakfast packs were issued to prisoners the night before consumption, although a cooked breakfast was provided at weekends.
We repeat the recommendation.

2.222 The midday meal should be served between noon and 1.30pm, and the evening meal between 5 and 6.30pm. (7.10)

Not achieved. Lunch was served between 11.50am and 12.30pm and the evening meal between 4.20pm and 5.10pm.
We repeat the recommendation.

2.223 Drinking water should be readily available for all prisoners. (7.11)

Achieved. Only prisoners on C wing did not have access to running water in their cells but jugs were provided.

## Additional information

2.224 Prisoners were complimentary about the quality of the food and almost everyone we spoke to thought it was good or very good. There was a two-week menu cycle but daily ordering allowed flexibility in menu choices. A full range of special or religious diets was offered. The kitchen was small but well equipped and there was some opportunity for prisoner kitchen workers to gain some low-level qualifications, although this work was limited. Prisoners on C wing could dine in association.

## Prison shop

2.225 A range of fresh fruit should be included on the shop list. (7.16)

Achieved. Five choices of fresh fruit were available on the shop list.

## Additional information

2.226 The prison operated the standard DHL contract for the provision of shop services. Orders were taken weekly and we had few complaints from prisoners. Special smokers' and non-smokers' packs could be bought by prisoners who missed submitting their weekly orders. Catalogue purchases could also be made by application. Consultation arrangements were generally very good. The prison shop was a standing agenda item for the prisoner consultation committee and the canteen list was reviewed quarterly.

## Strategic management of resettlement

2.227 The area manager and governing governor should ratify the 2007-08 reducing reoffending strategy. (8.7)

Achieved. The published reducing reoffending strategy and action plan 2008-09 had been ratified by the regional custody manager and the governing governor but was out of date. The strategy was linked to national and regional reducing reoffending objectives and was informed by a needs analysis from 2008. The strategy described current pathway provision and development objectives against each resettlement pathway. It was not clear how progress against identified action points was monitored. The strategy included an overview of the role of the offender management unit (OMU) and public protection arrangements but did not describe how the needs of specific groups of prisoners – including indeterminate-sentenced prisoners, sex offenders, remand, foreign national, recalled and short-term prisoners – would be met. There were separate policy documents covering offender management and public protection arrangements.

Further recommendation

2.228 The prison's reducing reoffending strategy should be reviewed and updated regularly and should identify how the needs of specific groups of prisoners – including indeterminate-sentenced prisoners, young adults, sex offenders, remand, foreign national, recalled and short-term prisoners – will be met.

2.229 Representatives from all key functions at the prison, including residence, should regularly attend the reducing reoffending strategy group, and membership should be extended to include prisoner and partner organisation representatives. (8.8)

Not achieved. Delivery of the reducing reoffending strategy was managed through the quarterly reducing reoffending strategy group, chaired by the head of reducing reoffending. The published membership included the head of residence but there had been no representative from residence at the most recent meeting in November 2009. Although membership included the mental health in-reach team and family support centre coordinator, other partner representatives were not invited to attend strategy meetings.
We repeat the recommendation.

2.230 The monthly interventions steering group should publish a record of its discussions, including action points and outcomes. It should focus on developing work in each pathway to ensure provision matches prisoner needs. (8.9)

Not achieved. The monthly interventions steering group was no longer convened.

Interventions and resettlement staff felt this affected information sharing between partner organisations and limited the opportunity to discuss work across each pathway. There were no designated lead officers to support the delivery of work across each pathway.

Further recommendations

2.231 The monthly interventions steering group should be re-established and meet regularly and a record of its discussions, including action points and outcomes, should be published. It should focus on developing work in each pathway to ensure provision matches prisoner needs.

2.232 There should be designated pathway lead officers to support and coordinate the development of work across each resettlement pathway.

2.233 The prisoner needs analysis should be repeated every six months, trends identified and discussions undertaken to ensure that interventions delivered to prisoners best match needs and resources. (8.10)

Not achieved. The most recent needs analysis had been in May 2009 and had been a self-report survey, which 37% of the population had competed. The questionnaire had been fragmented and was not structured around the resettlement pathways. The analysis included an overview of the prison population profile. Data from OASys (offender assessment system) assessments were not used to inform the needs analysis, and there was no disaggregation of data for specific groups of prisoners, such as remand prisoners or young adults. The needs assessment did not include a trend analysis.
We repeat the recommendation.

## Additional information

2.234 The legal services and bail information officer made an initial assessment of the resettlement needs of new arrivals using the local case management assessment tool. Onward referrals to relevant departments were made and recorded on P-Nomis.

2.235 We were told that pre-discharge boards, held approximately four to six weeks before a prisoner's release and attended by a range of appropriate intervention staff and representatives from key departments, had not been convened for several months.

2.236 The prison continued to work in partnership with community organisations and had recently embarked upon a new restorative justice project. An officer from Gloucester was funded by Gloucester Criminal Justice Board from October 2009 to April 2011 to be the restorative justice coordinator. A second part-time support worker was funded through the Futures Job Fund, and 18 volunteers had been recruited and trained. Prisoners participated in the project on a voluntary basis, with prolific or priority offenders (PPOs) from the Gloucestershire area identified as a priority target group. Following substantial preliminary assessment work with both prisoners and victims, three face-to-face meetings had been held to date, with a fourth planned for the week of the inspection. The coordinator was also focused on an evaluation of the project and working to secure additional funding to sustain it beyond April 2011.

Further recommendation

2.237 A multidisciplinary pre-discharge board should review the resettlement needs of all prisoners to ensure any outstanding needs can be identified and addressed.

## Offender management and planning

2.238 The system used to identify prisoners in scope of offender management should ensure accurate and speedy identification and allocation. Management checks should be introduced. (8.22)

Partially achieved. The OMU case administrator was responsible for checking reception lists each day and identifying and allocating prisoners appropriately to offender supervisors. The OMU senior officer checked the identification and allocation process to ensure accuracy. Cases were only allocated each Wednesday, which meant that prisoners arriving on Thursday were not allocated to an offender supervisor until the following week. The prison allocated all prisoners serving over 12 months to an offender supervisor, irrespective of whether or not they were formally in scope. Prisoners sentenced to between six and 12 months, and therefore not eligible for an OASys assessment, were also initially allocated to an offender supervisor for a basic resettlement needs assessment, using a locally developed assessment tool, with onward referrals made. There was not usually any further ongoing contact with these prisoners during their sentence, unless they made an application to the OMU. An OMU database tracked the completion of sentence plans, OASys reviews and other risk assessment processes. However, it was not possible to extract information from the database readily about how many prisoners were formally in scope for offender management. Approximately 29% of the population were formally in scope, and a further 29% were eligible for an OASys assessment.

Further recommendation

2.239 Prisoners should be allocated to an offender supervisor speedily.

2.240 All prisoners subject to offender management arrangements should be held at the prison routinely until assessment and sentence plans are complete. (8.23)

Achieved. The OMU case administrator gave the observation, classification and allocation (OCA) officer a list of prisoners currently subject to assessment and awaiting completion of a sentence plan, which was updated weekly. Records showed that in most cases prisoners were routinely held at Gloucester until their sentence plan was completed.

2.241 Sentence plans should drive the type and sequence of interventions that are delivered. (8.24)

Achieved. Offender supervisors had begun to attend the weekly allocations board to ensure that interventions at Gloucester were appropriately sequenced in line with identified sentence planning targets. Information about sentence planning targets was also shared with the OCA officer to ensure prisoners could be appropriately allocated.

2.242 Personal officers should be invited routinely to sentence planning boards. (8.25)

Not achieved. Offender supervisors said personal officers were not routinely invited to attend

sentence planning boards and almost all the personal officers we spoke to said they had not attended one. Offender supervisors tended to use information entered by personal officers in P-Nomis case notes to inform sentence planning boards. We saw little evidence of links between personal officers and offender supervisors.
We repeat the recommendation.

2.243 The work of the offender management unit (OMU) should be better publicised to prisoners, who should be encouraged to provide their feedback and views. (8.26)

Partially achieved. A member of staff from the OMU attended induction each day to give prisoners an overview of the work of the unit and there were OMU noticeboards on residential units. We saw no evidence that prisoners were encouraged to provide feedback.

Further recommendation

2.244 Prisoners should be encouraged to provide their feedback and views on the work of the offender management unit (OMU).

2.245 The newly introduced needs identification and case management system for short-term and remand prisoners should be evaluated to ensure it is achieving its aims. Prisoner views should be canvassed, and an exit survey introduced. (8.27)

Not achieved. The needs identification system was still in use. Since the introduction of P-Nomis, referrals were now logged on this system. The needs identification and case management system was not referred to in the reducing reoffending or OMU strategy. We saw no evidence of an evaluation of its effectiveness or any exit survey to canvass prisoner views. Custody planning for remand prisoners and those serving less than 12 months was insufficient. Although the needs identification system and OMU work with prisoners serving between six and 12 months allowed for an assessment of initial needs and appropriate referrals, there was no subsequent monitoring or review of their resettlement needs.
We repeat the recommendation.

Further recommendation

2.246 There should be custody planning for remand prisoners and those serving less than 12 months, which should be monitored and reviewed.

2.247 There should be greater use of release on temporary licence to help prisoners prepare for a structured and phased release. (8.28)

Not achieved. Records showed that there had been only limited use of release on temporary licence (ROTL), with just three uses in the previous four months. Most prisoners were released on an accompanied licence.
We repeat the recommendation.

2.248 Key functions at the prison, including OMU, security, the police liaison officer, residence, health care and mental health in-reach, should attend the monthly public protection review meeting. (8.29)

Not achieved. The public protection policy, which had been reviewed in 2009, described the structure of interdepartmental risk management meetings. OMU staff said that no meetings

had been convened since the senior probation officer who had chaired them had left the prison three months previously. Offender supervisors attended external MAPPA (multi-agency public protection arrangements) meetings and the offender supervisor responsible for public protection convened internal public protection meetings to discuss individual cases. A separate public protection policy meeting to monitor the effectiveness of the policy and public protection arrangements had taken place in October 2009 but was poorly attended.

Further recommendation

2.249 All newly arrived prisoners identified as a risk to children or MAPPA (multi-agency public protection arrangements) level two or three should be reviewed by an interdepartmental risk management board with representation from key departments in the prison, including OMU, security, the police liaison officer, residence, health care and mental health in-reach. Further reviews should be scheduled if there are any significant changes in circumstances.

2.250 Managers should ensure that systems in place to identify potential public protection cases on reception to the prison are regularly maintained and working effectively. (8.30)

Partially achieved. The public protection administrative officer checked reception lists daily to identify potential public protection cases. This included a check of OASys, previous convictions and VISOR (violent and sexual offenders register) information. Identified cases were forwarded to the OMU case administrator who allocated them to offender supervisors for a further detailed risk assessment. Completed risk assessments were countersigned by the head of OMU and forwarded to the deputy governor who authorised public protection monitoring. The public protection administrator was on leave during the inspection and it was unclear who was responsible for the initial identification of public protection cases during this period. In the October 2009 public protection strategy meeting, the public protection administrator had commented that the policy of only allocating work on a weekly basis (see paragraph 2.238) delayed the timeliness of completion of risk assessments. At the time of the inspection, 38 prisoners were subject to public protection monitoring, which was conducted by the security department. There were regular reviews of monitoring.

Further recommendation

2.251 There should be clear arrangements to provide cover for the public protection administrator.

## Additional information

2.252 The OMU strategy document stated that offender supervisors should have weekly contact with prisoners to ensure that they remained motivated to address sentence planning targets. Offender supervisors used both the OMU database and P-Nomis to record contact with prisoners. In our sample of P-Nomis case notes, we saw very few entries by offender supervisors and none that evidenced discussion of progress against sentence planning targets. OASys assessments and sentence planning boards took place within required timescales.

2.253 The OMU had good facilities for sentence planning boards. Relationships with local community-based offender managers were good but the OMU had no video-link or telephone conferencing facility to aid communication with offender managers further afield.

2.254 Category C prisoners serving less than 12 months were unlikely to be transferred elsewhere to serve their sentence, although the prison was sometimes required to send short-term prisoners on overcrowding drafts at the request of the population management unit. Prisoners were given as much notice as possible before transfer, usually the week before. Most prisoners were not at Gloucester long enough for a review of their categorisation but for those who were, review paperwork was collated a month in advance of their review date to enable decisions to be timely.

2.255 There were plans to restructure the OMU to create two offender management pods. As part of this restructuring, a prison officer had recently become the offender supervisor for the four prisoners serving indeterminate sentences for public protection (IPP) and 13 life-sentenced prisoners. Newly arrived indeterminate-sentenced prisoners were allocated to the officer and cases previously allocated to other offender supervisors were being handed over. The officer had attended MISAR (managing indeterminate sentences and risk) training.

2.256 All but one of the life-sentenced prisoners had been recalled from open conditions or from release. OMU staff told us the number of life-sentenced prisoners had recently reduced following the intervention of the regional custody manager. However, it could still be difficult to move prisoners on, particularly vulnerable prisoners. One lifer we spoke to had been recalled to custody approximately two and half years ago and had been at Gloucester for all that time. There could also be delays in the timeliness of parole board hearings.

2.257 Sentence management processes for the one life-sentenced prisoner received from court were timely and, following the completion of the multi-risk assessment panel, he was awaiting transfer to a first-stage prison.

2.258 There were informal arrangements to identify potential indeterminate-sentenced prisoners but no further work was done with them. The prison did not hold any events specifically for indeterminate-sentenced prisoners, such as lifer days or forums.

Further recommendations

2.259 Offender supervisors should have regular active engagement with prisoners to implement sentence plans and monitor progress against targets.

2.260 The needs of potential life-sentenced prisoners should be monitored and reviewed while they are remanded.

2.261 Facilities for life-sentenced prisoners should be extended to include regular forums and other specific support.

## Resettlement pathways

### Accommodation

2.262 The accommodation services available should be prominently advertised to prisoners. (8.37)

Partially achieved. Resettlement noticeboards on residential wings included posters advertising accommodation services. The full-time housing adviser was directly employed by the prison and was based in the OMU. His remit was to provide an accommodation service to

prisoners sentenced to less than 12 months. Applications from prisoners serving over 12 months were directed to their community-based offender manager and offender supervisor, although the housing advisor worked closely with offender supervisors to assist in securing accommodation. Posters on display did not make these arrangements clear.

Housekeeping point

2.263 The accommodation services available should be clearly described and prominently advertised to prisoners.

2.264 There should be contact with all prisoners with an identified accommodation need at an early stage after their reception, who should be notified when the team would intervene to secure them accommodation pre-release. (8.38)

Achieved. There were clear systems through P-Nomis for the housing adviser to pick up referrals from the initial assessment of resettlement need and, therefore, to identify accommodation needs at an early stage. He prioritised his caseload according to release date, and started to work actively with prisoners to secure accommodation in the last six to eight weeks of their sentence. When he was notified of their accommodation needs, he sent prisoners a reply slip indicating that he was aware of their circumstances and accommodation needs. The housing adviser also used P-Nomis and updated prisoners' case notes with new information. Despite these arrangements, some prisoners seemed unclear about the work being done to assist them with their housing needs.

2.265 The planned good tenant programme should be introduced. (8.39)

Not achieved. The Nacro housing adviser who had planned to deliver the programme had left the prison post approximately two years previously and the good tenant programme was not delivered in the prison.
We repeat the recommendation.

## Additional information

2.266 The housing adviser had been in post for around two years. There had been no handover between him and the previous post holder and he had had to spend time building links with community housing providers, including local councils. He worked closely with the Gloucester city council homeless prevention coordinator, who attended the prison at least once a week. The adviser had no access to the internet, which presented difficulties in processing some applications. There was also a service for remand prisoners and assistance with the maintenance or closure of tenancies.

2.267 The prison reported that almost 92% of prisoners were released to settled accommodation in the previous reporting year. In the year to date, 25 prisoners had been discharged with no address arranged.

Housekeeping point

2.268 The housing adviser should have access to the internet to enable him to process accommodation applications efficiently.

## Education, training and employment

2.269 There should be more opportunities for prisoners to engage in employment-related vocational training linked to skill shortage areas and vacancies in the labour market, and the prison should work with specialist agencies to develop a strategy to achieve this. (8.42)

Partially achieved. The prison now offered more opportunities for prisoners to engage in employment-related accredited vocational training. These included industrial cleaning, food safety, health and safety in the PE department and a performing manufacturing (PMO) programme at national vocational qualification (NVQ) level 2 in the cycle workshop. Four prisoners had started a customer service training programme at NVQ level 2. Due to internal changes, there were currently no learners following the NVQ food preparation course. A short accredited business venture course prepared prisoners for self-employment. An employment carousel programme offered prisoners a range of accredited job search and employment related units. The prison had recently developed a joint-funded 'Way 4ward' programme to prepare prisoners due for release for employment. The learning and skills area had contributed to the prison's reducing reoffending strategy, in consultation with key local specialist partners, but this was now out of date (see paragraph 2.227 and further recommendation 2.228).

2.270 The 'through the gate' programme should place more emphasis on enhancing employability, for example, through direct input from employers, practice interviews and application forms, and opportunities for job search. (8.43)

Achieved. The prison now offered two employability programmes. The four-week employment carousel programme offered accredited employment-related units at NOCN (National Open College Network) level 1. These included IT, welfare at work and preparation for work. The course was available to all prisoners, subject to risk assessment, with priority to those due to be released into the community. The second programme provided intensive employment-related support tailored to the individual needs of the prisoner, including mentoring in employment or training, for example, in CV writing, disclosure or interview techniques. The prison worked with a wide range of outside agencies, including employers, the Gloucestershire Probation Trust, training organisations, Jobcentre Plus and other prisons, and support was provided for a period appropriate to the prisoner's individual need. Prisoners were often enrolled on to both programmes at the same time. The prison could hold prisoners to enable them to complete these and other training programmes to minimise disruption to their learning.

2.271 Current vacancies should be prominently publicised to prisoners. These should be regularly updated and prisoners offered a means of following up appropriate job applications. (8.44)

Not achieved. Careers, information and advice support (CIAS), provided by Tribal, had only recently erected a noticeboard to publicise current job vacancies. The service produced a useful monthly report identifying the geographical areas of prisoners due for release along with data on their preferred types of employment. However, this information had not yet been used to monitor and publicise job vacancies. Where an individual CIAS interview identified a possible job for which a prisoner could apply, the CIAS service offered support for the prisoner to make a job application.
We repeat the recommendation.

## Additional information

2.272 The learning and skills department contracted with A4E to provide the employment carousel and the Way4ward programmes. Both programmes had been implemented relatively recently. They were beginning to provide a more structured and better targeted range of support and preparation for employment after release, but only two prisoners so far had successfully gained employment on release as a result of the Way4ward programme. Prisoners were carefully selected for these programmes according to their individual needs and likely release date. Tribal conducted CIAS reviews throughout the prisoner's sentence, culminating in an exit interview for most to support them in gaining employment on release. Education and vocational training in the prison were not linked clearly or explicitly enough to job opportunities in the community on release.

## Finance, benefit and debt

2.273 The interventions team should offer an individualised debt management service to prisoners. (8.49)

Achieved. Under an 18-month contract funded by the Legal Services Commission, which began in October 2009, a worker from the Citizens Advice Bureau (CAB) visited the prison one day a week to provide a debt advice service. Once a prisoner had seen the adviser, there were no follow-up interviews in the prison, but he could be signposted to further CAB advice and support in the community. There were also procedures to manage bankruptcy proceedings in custody. Since October 2009, the adviser had seen 91 prisoners to offer debt advice. The short-term case management tool used to identify initial resettlement needs did not include specific questions about whether prisoners needed debt advice.

Further recommendation

2.274 Prisoners should be asked if they need assistance with debt management during the initial assessment of their resettlement needs and should be referred onwards to the Citizens Advice Bureau if needed.

2.275 The prison should offer a debt management course for prisoners. (8.50)

Achieved. Debt management modules were incorporated into the parenting and family carousel courses delivered by the education department. Prisoners could also access a more general financial planning module through the employment carousel delivered by education.

## Additional information

2.276 An adviser from Jobcentre Plus was based in the OMU for about three days a week. It was no longer possible for her to provide the service full time. Prisoners were referred to the service from the initial assessment of resettlement needs, and the adviser could assist in closing down benefit claims or contacting employers. As the pre-release discharge boards no longer took place (see paragraph 2.235), the adviser regularly checked discharge lists and saw all prisoners individually before their release to arrange appointments in their local job centre. The adviser had access to a laptop that could link with the Jobcentre Plus network to enable prisoners to carry out a live job search, but she was no longer allowed to bring it into the prison

for security reasons and had to use a telephone service for prisoners to job search. Prisoners requiring support with more general preparation for work, such as writing CVs, were signposted to the A4E provision.

2.277 Although managers told us there were facilities in place for prisoners to open bank accounts, resettlement staff were unaware of this provision.

Further recommendations

2.278 Authorisation should be in place to allow the Jobcentre Plus worker access to the use of the internet linked laptop.

2.279 All resettlement staff should be aware of procedures to assist prisoners to open bank accounts before their release.

## Mental and physical health

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

## Additional information

2.280 On our last inspection, arrangements for prisoners due for release had been comprehensive and were organised through pre-discharge clinics. Since the nurse responsible for these had left, systems had fallen into abeyance. We were not assured that prisoners were receiving any assistance or support to engage with community services on release. However, the pre-discharge clinics were to be reinstated.

2.281 Prisoners under the care of the mental health in-reach team were well catered for, with good arrangements to ensure that they were linked into community services, using the enhanced care programme approach.

2.282 Palliative care arrangements were excellent. A nurse with a special interest in end-of-life care took the lead and had instigated new arrangements in light of recommendations in a Prisons and Probation Ombudsman report about a prisoner who had died of natural causes in 2008. We were told of a life-sentenced prisoner who had recently died, and were shown evidence of good clinical care and contact with his family.

Further recommendation

2.283 Prisoners should be given assistance and support to engage with community health services on release.

## Drugs and alcohol

2.284 The drug and alcohol strategy should incorporate integrated drug treatment system action plans. (8.68)

Achieved. The drug and alcohol strategy was due to be reviewed the following month. There was also an IDTS treatment plan (strategic summary, needs assessment and key priorities) for 2010-11 which was to be included in the drug and alcohol strategy when it was updated.

2.285 The counselling, assessment, referral, advice and throughcare (CARAT) service, in partnership with the new integrated drug treatment system service, should provide structured psychosocial support to prisoners undergoing detoxification. (8.69)

Achieved. The service level agreement with Avon and Wiltshire Partnership Trust, which provided CARAT services together with prison staff, referred to the provision of structured psychosocial support to prisoners undergoing detoxification. We observed groups being facilitated jointly by IDTS nurses and CARATs staff.

2.286 A peer support scheme should be developed for prisoners who have completed the short duration programme. (8.70)

No longer applicable. The short duration drugs programme was no longer provided at Gloucester.

2.287 The purpose and the remit of C wing, the prison's voluntary drug testing unit, should be clarified. Additional support should be offered to prisoners who want to remain drug free. (8.71)

Partially achieved C wing remained the designated voluntary drug testing unit, although prisoners who were on the compact based drug testing programmes could reside anywhere in the prison. During the inspection, 103 prisoners were signed up for voluntary testing and approximately 80 were undertaking testing as part of their enhanced status. In the previous three months, there had been an average of 143 tests a month. Some prisoners who had been on frequent testing in the community could continue weekly or fortnightly testing while at the establishment.

## Children and families of offenders

2.288 Opportunities for visitors to book visits should be improved. This should include longer opening times for the visits booking line and arrangements for visitors to book their next visit while in the establishment. (3.79)

Not achieved. The arrangements for booking visits remained unchanged. The telephone booking line was only open from 8.30am to 12 noon Monday to Friday, and there was no opportunity for visitors to book their next visit while in the prison. All visits had to be booked at least 24 hours in advance.
We repeat the recommendation.

2.289 A positive indication by a drug dog should only result in a closed visit where there is other supporting intelligence. (3.80)

Not achieved. The policy on positive indications by the passive drug dog was described in the visits policy, which had been updated in January 2010. A positive indication resulted in the offer of a visit under closed conditions or, if this was not accepted, the visitor was refused entry without other supporting intelligence.

2.290 Prisoners should not be held for long periods in the visits holding room. (3.81)

Achieved. We did not see any prisoners in the visits holding room during the inspection. We were told prisoners usually chose to remain in the visits area to wait for their visitors to arrive rather than return to the wing.

2.291 Closed visit booths should be fitted with a microphone and speaker system. (3.82)

Achieved. The three closed visits booths had recently been refurbished and were now fitted with a microphone and speaker system.

2.292 Residential staff should be able to contribute to closed visit reviews. Such reviews should be formalised and records maintained. (3.83)

Partially achieved. Although formal reviews of closed visits had been introduced and records were maintained, residential staff did not currently contribute to the review process.
We repeat the first part of the recommendation.

2.293 The visits holding room should be repainted. (3.84)

Achieved. The holding room had recently been painted and the walls were clean and free from graffiti. However, the wooden benches and rear of the door were covered in graffiti. The room was small and lacked ventilation. The flooring was badly damaged and needed to be replaced.

Further recommendation

2.294 The visits holding room should be free from graffiti and well maintained and ventilated.

2.295 Evening visit sessions should be introduced. (8.77)

Not achieved. Social visits took place on weekday afternoons from 2.15pm to 4pm. There were two one-hour visits sessions on Saturday afternoon and one session on Sunday afternoon from 2pm to 3.45pm. There were no evening visits and no visits on Monday.
We repeat the recommendation.

2.296 Prisoners with identified needs should be able to access accredited parenting programmes. (8.78)

Achieved. The education department delivered a parenting carousel programme through which prisoners could gain accreditation in a range of units linked to the children and families resettlement pathway. Prisoners either self-referred to the carousel or were referred by OMU staff. Approximately 12 courses a year were delivered on a part-time basis over a four to six week period.

2.297 Prisoners should have the opportunity to undertake general relationship counselling with their immediate family where necessary. (8.79)

Not achieved. Relationship counselling provided through Relate was no longer available.
We repeat the recommendation.

## Additional information

2.298 Unconvicted prisoners could have three visits a week, including one at the weekend. Newly convicted prisoners were entitled to a reception visit within the first seven days after conviction. These visits had to be booked but did not require prisoners to send out a visiting order. Convicted prisoners on the basic level of the incentives and earned privileges scheme were

entitled to two visiting orders a month, prisoners on the standard level received an additional two privilege visiting orders (PVOs) a month, and those on the enhanced received an additional four PVOs.

2.299 The prison had a clean and welcoming visitors' centre, the Castle Gate Family Support Centre, which was open for all visits sessions except Sunday and was staffed by seconded probation staff. The Castle Gate Family Trust also operated from the centre and provided a range of support services to visitors and prisoners families, including three play workers who staffed the play area in the visits hall. Various departments in the prison used the centre as an opportunity to meet prisoners' families, including the Jobcentre Plus adviser and staff from the mental health in-reach team. No refreshments were available in the centre but there was some play equipment and a range of appropriate literature, including information about assisted prison visits and a useful pictorial guide to the visits searching procedures.

2.300 Visitors booked in at the centre but had their identification checked at the gate. Admission procedures were efficient, although the entrance to the visits area was small. The searches we observed were conducted respectfully.

2.301 The environment in the main visits room was reasonable. It had fixed furniture. There was a small refreshment facility, open for one hour of each session, and a play area.

2.302 All prisoners were eligible to apply for monthly family visits sessions. Family visits were held in the main visits room on a Monday but were more relaxed and prisoners were able to move around the room.

2.303 Two child support workers employed by the Castle Gate Trust visited schools in the area and provided a range of support services to local children and their families. This included helping children stay in touch with a father during a period in custody or preparing children for their first visit. Until April 2010, the trust had also had a court support worker to provide support and information for families in the crown court. Following the loss of funding for this post, a bank of volunteers was endeavouring to continue to provide some support.

2.304 The Castle Gate Family Support Centre also had good links with a local support service for vulnerable families, the Family Haven. A member of staff from Family Haven attended the prison weekly, worked alongside the play worker and was able to signpost families to community provision.

## Attitudes, thinking and behaviour

2.305 The interventions team should ensure that any future life coaching programmes are evaluated to establish prisoner outcomes. (8.84)

Achieved. The initial pilot course had been evaluated and a second course had been delivered. Although the life coaching programme was not being run at the time of the inspection, there were plans to resume delivery.

2.306 The interventions team should ensure that all short duration, non-accredited programmes adhere to the principles outlined in the relevant regime interventions Prison Service Order (4350). (8.85)

Achieved. The prison was focused on ensuring that any non-accredited programmes adhered to the relevant Prison Service Order.

## Additional information

2.307 The short duration drug programme was no longer delivered in the prison, and the prison currently offered no accredited or non-accredited interventions, other than group work for IDTS clients. Gloucestershire Probation had delivered one thinking skills course in 2008 but none subsequently. There was no current needs analysis to inform the future provision of accredited and non-accredited programmes.

Further recommendation

2.308 There should be a detailed needs assessment to inform the future delivery of accredited and non-accredited interventions.

# 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 of offender management

3.1 C wing should be refurbished without further delay. (2.7)

## Recommendations

To the governor

### First days in custody

3.2 The reception facility should be refurbished or replaced. (2.1)

3.3 New arrivals should be given £2.00 telephone credit in reception if required. (2.13)

3.4 The practice of identifying the cell cards of vulnerable prisoners should cease. (2.15)

3.5 First night accommodation for vulnerable prisoners should be clean, properly prepared and provide a safe and comfortable environment. (2.16)

3.6 There should be a formal induction programme for vulnerable prisoners, and this should be delivered by trained staff in a quiet, discrete and designated area. (2.17)

3.7 Induction records should be kept to ensure that all vulnerable prisoners have received a formal induction. (2.18)

### Residential units

3.8 Cells designed for one prisoner should not accommodate two. (2.22)

3.9 Toilets in all cells should be adequately screened. (2.23)

3.10 All prisoners should have 24-hour access to toilet facilities. (2.24)

3.11 All prisoners should be allowed to wear their own clothes. (2.26)

3.12 Prisoners should have personal access to laundry facilities. (2.28)

3.13 Towels and sheets should be provided to prisoners as they need them. (2.29)

3.14 Access to telephones for vulnerable prisoners should be improved. (2.34)

### Staff-prisoner relationships

3.15 Staff should engage more positively with prisoners during periods of exercise. (2.35)

3.16 Staff should address prisoners by their preferred name or title. (2.37)

## Personal officers

3.17 Personal officer entries in wing history files should provide evidence of positive interaction with prisoners in their charge. (2.38)

3.18 Wing file entries should be subject to regular quality checks by managers. (2.39)

3.19 Personal officers should attend assessment, care in custody and teamwork (ACCT) reviews wherever possible. (2.40)

## Bullying and violence reduction

3.20 The violence reduction strategy should be informed by consultation with prisoners, and the anti-bullying arrangements should be less complex and include support for victims of bullying and interventions to challenge bullies. (2.48)

## Self-harm and suicide

3.21 Prisoners at risk of suicide or self-harm should never be accommodated in a special cell unless they are exceptionally violent. (2.50)

3.22 Special accommodation procedures should commence as soon as a prisoner is locked in the special cell or is placed in strip conditions in one of the safer cells. (2.51)

3.23 All staff should be trained or refreshed in assessment, care in custody and teamwork (ACCT) procedures and sufficient managers should be trained as case managers. (2.61)

3.24 Prisoners on ACCT documents should be encouraged and enabled to take part in constructive regime activities during the working day. (2.62)

3.25 CCTV should only be used to monitor prisoners on ACCT in exceptional circumstances to offer safeguards in addition to staff interaction. (2.63)

3.26 Prisoners on ACCT documents should only be located in the segregation unit if there are exceptional circumstances to warrant this. (2.64)

## Vulnerable prisoners

3.27 Vulnerable prisoners should not be held on B2 landing, and the quality and quantity of regime for these prisoners should be improved. (2.2)

3.28 There should be formal first night procedures for vulnerable prisoners, who should not be located on B2 landing on their first night in Gloucester. (2.68)

3.29 The prison should have a vulnerability protocol that clearly describes the systems to support vulnerable prisoners. (2.74)

3.30 Staff and managers should ensure that food for vulnerable prisoners is not contaminated and should be able to offer consistent assurance to prisoners. (2.75)

## Young adults

3.31 The prison should formulate a strategy to assess and meet the specific needs of young adult prisoners. (2.3)

3.32 Where monitoring indicates that young adult prisoners are disproportionately represented, there should be a formal investigation to consider the reasons and to take action as necessary. (2.78)

## Applications and complaints

3.33 Applications books should be kept on all wings to monitor applications that are sent off the wing and to log the results of applications. (2.79)

3.34 Complaints boxes should be emptied by the complaints clerk. (2.83)

## Diversity

3.35 Older prisoners and those with disabilities should have access to a regime that fully meets their needs and provides a range of appropriate activities. (2.106)

3.36 Staff should receive guidance on how to deal with gay prisoners. (2.110)

## Health services

3.37 The inpatient beds in health care should not form part of the prison's certified normal accommodation and admission should only be on assessment of clinical need. (2.112)

3.38 Evening association should be introduced for inpatients. (2.113)

3.39 Patients should only be placed in strip clothing as a last resort and following discussion and authorisation from medical staff. All occasions where strip clothing is used should be documented and a central register held. (2.114)

3.40 Emergency equipment should be provided in the dental surgery at all times. (2.119)

3.41 The healthy prison forum should ensure that there is a high profile health promotion programme with relevant publicity. (2.122)

3.42 Patients should be seen in a timely fashion relevant to their need. (2.124)

3.43 The pharmacist and technician time should be used more effectively for medicines management, medication use reviews and pharmacist-led clinics. (2.126)

3.44 The medicines and therapeutics committee should audit and regularly review the use of benzodiazepines and opiate-based painkillers. (2.130)

3.45 There should be a system to reconcile the general stock medicines with the prescriptions issued. (2.132)

3.46 There should be an audit trail showing the movement of controlled drugs around the prison and each controlled drugs cabinet should have a stock order book to document receipt and transfer of stock. (2.133)

3.47 The medicines and therapeutics committee should develop a policy to determine the circumstances when general stock medication should be used. Wherever possible, named patient dispensed medicines should be issued in preference to general stock. (2.134)

3.48 NHS Gloucestershire, as commissioners of health services, should ensure that stock medicine packs, labelled in accordance with the regulations, can be supplied against a prescription to prisoners. (2.136)

3.49 The pharmacy standard operating procedures should be reviewed to reflect current practice, be agreed by the medicines and therapeutics committee and should be signed by relevant staff. (2.139)

3.50 Patient information leaflets should be supplied with medication wherever possible. Notices should be prominently displayed to advise patients of the availability of leaflets on request. (2.140)

3.51 Administration charts should be properly completed by nursing staff and should include a clear record to show when patients have not attended or refused treatment. (2.141)

3.52 The management of the dental waiting lists should ensure that patients receive continuity of care from the same dental practitioner throughout a course of treatment. (2.143)

3.53 The dental surgery should be relocated to more suitable premises with sufficient room for all necessary equipment, thorough cross-infection control procedures and adequate ventilation. (2.144)

3.54 There should be arrangements for out-of-hours emergency dental treatment. (2.145)

3.55 There should be specific triage algorithms for nurses to use in the absence of a dental practitioner. (2.146)

3.56 There should be formal documented meetings between the dental staff who provide services to the establishment and the health services manager to ensure that all parties are updated on health services activities in the establishment. (2.148)

3.57 Nurses should follow Nursing and Midwifery Council guidance on the administration of medications and secondary dispensing should cease. (2.156)

3.58 There should be sufficient consultant psychiatrist time to allow a single point referral meeting and clinical interventions. (2.157)

## Learning and skills and work activities

3.59 The prison should increase the number of vocational training places and ensure that prisoners with needs for English for speakers of other languages (ESOL) have access to the appropriate accredited qualification. (2.9)

3.60 The prison should create a realistic but challenging learning and skills strategy that feeds into the overall strategy for reducing reoffending. (2.159)

3.61 Target-setting for prisoners should be improved and there should be systems to recognise and reward their progress and achievement. (2.160)

3.62 The prison should monitor the quality of the learning processes more frequently to identify areas for improvement. (2.161)

3.63 Activities for vulnerable prisoners should take place in an environment that is sufficiently effective for teaching and learning. (2.163)

3.64 The learning and skills department should analyse data more effectively to monitor and manage the provision offered to all prisoners. (2.166)

3.65 The library should open in the evening and at weekends to cater for working prisoners and to increase prisoner visits. (2.168)

3.66 The library should be expanded to provide adequate private study space. (2.170)

## Physical education and health promotion

3.67 A healthy lifestyle programme should be available to prisoners. (2.178)

## Time out of cell

3.68 Prisoners should be able to spend more time out of cell. (2.10)

3.69 Prisoners should be able to go on association every evening. (2.182)

## Security and rules

3.70 The number of suspicion drug tests, subject to and based on intelligence, should be increased. (2.185)

3.71 Prisoners should only be placed on and remain on closed visits when there is sufficient security-based evidence to support this. (2.187)

## Discipline

3.72 The protocol for use of the special accommodation should be extended to cover use of the observation cells in health care and the segregation unit (2.5)

3.73 Minimum staffing levels for the segregation unit should be formally risk assessed to ensure that safe systems of work are operated at all times. (2.6)

3.74 Prisoners should not be subject to unofficial punishments without going through the formal procedure of an adjudication. (2.192)

3.75 Written adjudication records should demonstrate full and thorough exploration of the circumstances of the charge before guilt is proved. (2.198)

3.76 All planned use of force interventions should be recorded. (2.203)

3.77 Special accommodation should only be used, with appropriate authority, in exceptional circumstances to house violent and/or refractory prisoners for the least time possible, and all paperwork should be fully completed. (2.204)

3.78 Prisoners should only be strip searched on location to the segregation unit following an assessment of risk. (2.209)

3.79 There should be multidisciplinary care plans for prisoners residing in the segregation unit for longer than 28 days to prevent psychological deterioration. (2.210)

3.80 Segregation monitoring and review group meetings should take place consistently and should monitor adherence to Prison Service Order 1700 and any trends or patterns in use of the segregation unit. (2.211)

## Catering

3.81 The breakfast meal should be served on the morning it is eaten, and fresh milk provided. (2.221)

3.82 The midday meal should be served between noon and 1.30pm, and the evening meal between 5 and 6.30pm. (2.222)

## Strategic management of resettlement

3.83 The prison's reducing reoffending strategy should be reviewed and updated regularly and should identify how the needs of specific groups of prisoners – including indeterminate-sentenced prisoners, young adults, sex offenders, remand, foreign national, recalled and short-term prisoners – will be met. (2.228)

3.84 Representatives from all key functions at the prison, including residence, should regularly attend the reducing reoffending strategy group, and membership should be extended to include prisoner and partner organisation representatives. (2.229)

3.85 The monthly interventions steering group should be re-established and meet regularly and a record of its discussions, including action points and outcomes, should be published. It should focus on developing work in each pathway to ensure provision matches prisoner needs. (2.231)

3.86 There should be designated pathway lead officers to support and coordinate the development of work across each resettlement pathway. (2.232)

3.87 The prisoner needs analysis should be repeated every six months, trends identified and discussions undertaken to ensure that interventions delivered to prisoners best match needs and resources. (2.233)

3.88 A multidisciplinary pre-discharge board should review the resettlement needs of all prisoners to ensure any outstanding needs can be identified and addressed. (2.237)

## Offender management and planning

3.89 Prisoners should be allocated to an offender supervisor speedily. (2.239)

3.90 Personal officers should be invited routinely to sentence planning boards. (2.242)

3.91 Prisoners should be encouraged to provide their feedback and views on the work of the offender management unit (OMU). (2.244)

3.92 The newly introduced needs identification and case management system for short-term and remand prisoners should be evaluated to ensure it is achieving its aims. Prisoner views should be canvassed and an exit survey introduced. (2.245)

3.93 There should be custody planning for remand prisoners and those serving less than 12 months, which should be monitored and reviewed. (2.246)

3.94 There should be greater use of release on temporary licence to help prisoners prepare for a structured and phased release. (2.247)

3.95 All newly arrived prisoners identified as a risk to children or MAPPA (multi-agency public protection arrangements) level two or three should be reviewed by an interdepartmental risk management board with representation from key departments in the prison, including OMU, security, the police liaison officer, residence, health care and mental health in-reach. Further reviews should be scheduled if there are any significant changes in circumstances. (2.249)

3.96 There should be clear arrangements to provide cover for the public protection administrator. (2.251)

3.97 Offender supervisors should have regular active engagement with prisoners to implement sentence plans and monitor progress against targets. (2.259)

3.98 The needs of potential life-sentenced prisoners should be monitored and reviewed while they are remanded. (2.260)

3.99 Facilities for life-sentenced prisoners should be extended to include regular forums and other specific support. (2.261)

## Resettlement pathways

3.100 The planned good tenant programme should be introduced. (2.265)

3.101 Current vacancies should be prominently publicised to prisoners. These should be regularly updated and prisoners offered a means of following up appropriate job applications. (2.271)

3.102 Prisoners should be asked if they need assistance with debt management during the initial assessment of their resettlement needs and should be referred onwards to the Citizens Advice Bureau if needed. (2.274)

3.103 Authorisation should be in place to allow the Jobcentre Plus worker access to the use of the internet linked laptop. (2.278)

3.104 All resettlement staff should be aware of procedures to assist prisoners to open bank accounts before their release. (2.279)

3.105 Prisoners should be given assistance and support to engage with community health services on release. (2.283)

3.106 Opportunities for visitors to book visits should be improved. This should include longer opening times for the visits booking line and arrangements for visitors to book their next visit while in the establishment. (2.288)

3.107 Residential staff should be able to contribute to closed visit reviews. (2.292)

3.108 The visits holding room should be free from graffiti and well maintained and ventilated. (2.294)

3.109 Evening visit sessions should be introduced. (2.295)

3.110 Prisoners should have the opportunity to undertake general relationship counselling with their immediate family where necessary. (2.297)

3.111 There should be a detailed needs assessment to inform the future delivery of accredited and non-accredited interventions. (2.308)

# Housekeeping points

### Bullying and violence reduction

3.112 The violence reduction committee should have terms of reference and specified membership. (2.49)

### Self-harm and suicide

3.113 A log of prisoners on constant watch in the segregation unit and health care should be maintained. (2.65)

3.114 The care suite should be equipped with beds, a television and kettle to offer an appropriate overnight facility for Listeners to work with prisoners in crisis. (2.66)

### Health services

3.115 Maximum and minimum temperatures on drug fridges should be recorded daily. (2.127)

3.116 All medicines should be labelled in accordance with Medicines Act requirements. (2.128)

### Discipline

3.117 Prisoners should be given a pen and paper to make notes during adjudication hearings. (2.199)

3.118 Cells in the segregation unit should be free of graffiti. (2.212)

3.119 Good order review paperwork should be completed thoroughly. (2.213)

### Incentives and earned privileges

3.120 The list of key earnable privileges in the published incentives and earned privileges (IEP) policy should be updated. (2.215)

### Resettlement pathways

3.121 The accommodation services available should be clearly described and prominently advertised to prisoners. (2.263)

3.122 The housing adviser should have access to the internet to enable him to process accommodation applications efficiently. (2.268)

## Example of good practice

3.123 A safer custody support group, facilitated by a member of the mental health team and the drug strategy senior officer, met regularly and was open to any prisoner in need of additional support. (2.67)

# Appendix I: Inspection team

| | |
|---|---|
| Martin Lomas | Team leader |
| Angela Johnson | Inspector |
| Kevin Parkinson | Inspector |
| Kellie Reeve | Inspector |
| Andrea Walker | Inspector |

Specialist inspectors

| | |
|---|---|
| Elizabeth Tysoe | Health services/substance use inspector |
| Maria Navarro | Ofsted inspector |
| Linda Truscott | 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 | 23 | 154 | *60* |
| Recall | 0 | 2 | *0.7* |
| Convicted unsentenced | 6 | 53 | *20* |
| Remand | 8 | 48 | *19* |
| Detainees | 0 | 1 | *0.3* |
| Total | 37 | 258 | *100* |

| Sentence | 18–20 yr olds | 21 and over | % |
|---|---|---|---|
| Unsentenced | 14 | 79 | *31.5* |
| Less than 6 months | 7 | 20 | *9.1* |
| 6 months to less than 12 months | 4 | 17 | *7.1* |
| 12 months to less than 2 years | 5 | 43 | *16.4* |
| 2 years to less than 4 years | 5 | 44 | *6.4* |
| 4 years to less than 10 years | 1 | 36 | *10.5* |
| 10 years and over (not life) | 0 | 3 | *13.2* |
| ISPP | 0 | 4 | *1.1* |
| Life | 1 | 12 | *4.7* |
| Total | 37 | 258 | *100* |

| Age | Number of prisoners | % |
|---|---|---|
| Under 21 years: *minimum age=18* | 37 | *12.5* |
| 21 years to 29 years | 113 | *38.3* |
| 30 years to 39 years | 98 | *33.2* |
| 40 years to 49 years | 35 | *11.9* |
| 50 years to 59 years: *maximum age=59* | 12 | *4.1* |
| Total | 295 | *100* |

| Nationality | 18–20 yr olds | 21 and over | % |
|---|---|---|---|
| British | 35 | 237 | *92.2* |
| Foreign nationals | 2 | 21 | *7.8* |
| Total | 34 | 248 | 100 |

| Security category | 18–20 yr olds | 21 and over | % |
|---|---|---|---|
| Uncategorised unsentenced | - | 79 | *26.8* |
| Uncategorised sentenced | - | 141 | *47.8* |
| Cat C | - | 33 | *11.2* |
| Cat D | - | 5 | *1.7* |
| Other | 37 | - | *12.5* |
| Total | 37 | 258 | *100* |

| Ethnicity | 18–20 yr olds | 21 and over | % |
|---|---|---|---|
| *White:* | | | |
| British | 28 | 203 | *78.3* |
| Irish | 1 | 3 | *1.4* |
| Other white | 1 | 10 | *3.7* |
| *Mixed:* | | | |
| White and black Caribbean | 2 | 3 | *1.7* |
| Other mixed | 1 | 1 | *0.7* |
| *Asian or Asian British:* | | | |
| Indian | 1 | 4 | *1.7* |

| | | | |
|---|---|---|---|
| Pakistani | 0 | 4 | *1.3* |
| Other Asian | 0 | 1 | *0.3* |
| *Black or black British:* | | | |
| Caribbean | 1 | 16 | *5.8* |
| African | 2 | 5 | *2.4* |
| Other black | 0 | 3 | *1* |
| *Chinese or other ethnic group:* | | | |
| Chinese | 0 | 1 | *0.3* |
| *Not stated:* | 0 | 4 | *1.4* |
| Total | 37 | 258 | *100* |

| Religion | 18–20 yr olds | 21 and over | % |
|---|---|---|---|
| Church of England | 6 | 32 | *12.9* |
| Roman Catholic | 4 | 28 | *10.8* |
| Other Christian denominations | 3 | 28 | *10.5* |
| Muslim | 5 | 15 | *6.8* |
| Sikh | 0 | 1 | *0.3* |
| Hindu | 0 | 1 | *0.3* |
| Buddhist | 0 | 2 | *0.7* |
| Other | 0 | 4 | *1.4* |
| No religion | 19 | 147 | *56.3* |
| Total | 37 | 258 | *100* |

Sentenced prisoners only

| Length of stay | 18–20 yr olds | | 21 and over | |
|---|---|---|---|---|
| | Number | % | Number | % |
| Less than 1 month | 13 | *54.2* | 65 | *34.4* |
| 1 month to 3 months | 8 | *33.3* | 66 | *34.9* |
| 3 months to 6 months | 3 | *12.5* | 41 | *21.7* |
| 6 months to 1 year | 0 | *0.0* | 13 | *6.9* |
| 1 year to 2 years | 0 | *0.0* | 4 | *2.1* |
| Total | 24 | *100* | 189 | *100* |

Unsentenced prisoners only

| Length of stay | 18–20 yr olds | | 21 and over | |
|---|---|---|---|---|
| | Number | % | Number | % |
| Less than 1 month | 8 | *61.5* | 36 | *52.2* |
| 1 month to 3 months | 2 | *15.4* | 15 | *21.7* |
| 3 months to 6 months | 3 | *23.1* | 13 | *18.8* |
| 6 months to 1 year | 0 | *0.0* | 5 | *7.2* |
| Total | 13 | *100* | 69 | *100* |

| Main offence | 18–20 yr olds | 21 and over | % |
|---|---|---|---|
| Violence against the person | 14 | 77 | *30.9* |
| Sexual offences | 0 | 25 | *8.5* |
| Burglary | 7 | 49 | *19* |
| Robbery | 5 | 24 | *9.8* |
| Theft and handling | 2 | 23 | *8.5* |
| Fraud and forgery | 0 | 3 | *1* |
| Drugs offences | 3 | 39 | *14.2* |
| Other offences | 5 | 10 | *5.1* |
| Offence not recorded/holding warrant | 1 | 8 | *3* |
| Total | 37 | 258 | *100* |