Report on an unannounced short follow-up inspection of

HMP Leyhill

24 – 26 May 2010

by HM Chief Inspector of Prisons

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Introduction

HMP Leyhill in Gloucestershire is a category D prison with a mixed population of life- and determinate-sentenced prisoners considered sufficiently low risk to be able to be held in open conditions. This unannounced short follow-up inspection found a number of improvements, for example, with regard to safety arrangements. However, there also continued to be too many petty restrictions for the low risk population, and aspects of resettlement remained underdeveloped with the respective staff overstretched.

Leyhill was a very safe place. Early days in custody were well managed, violence and bullying were almost unknown, and few prisoners self-harmed. Drugs and alcohol were problems but good efforts were made to deal robustly with these issues. Staff rarely needed to resort to adjudications and did not use force or segregation at all.

The environment at Leyhill remained excellent and relationships between staff and prisoners were reasonable, supported by a functioning – if variable – personal officer scheme. However, given the low risk population, it was disappointing to find a number of disproportionate security procedures, such as routine strip searching on arrival. The diversity strategy was not comprehensive and the needs of some minority groups, such as foreign nationals, were not well met, although race equality issues were generally well managed. Physical and mental health services were good.

Prisoners had plenty of time out of their rooms and there were sufficient activity places, with increased vocational training since our last visit and an expanded range of opportunities for voluntary and paid work in the community for those assessed as suitable. However, education opportunities needed to be developed further.

The resettlement strategy was still not sufficiently comprehensive and governance arrangements were weak. Offender management staff were very stretched, with extremely large caseloads, and this continued to have a significant impact with a large backlog of assessments, little work with short-termers and delays in decisions on temporary licence. Work along the resettlement pathways was generally good.

Leyhill is in many ways an impressive open prison dealing with a relatively complex population. It is therefore pleasing that we are able to record some further improvements in already good levels of safety, together with some expansion in purposeful activity both inside and outside the prison. However, the reasonable staff-prisoner relationships were not helped by some petty security restrictions that appeared disproportionate for a low risk prison. It was also of concern that some staff working on key resettlement activities were overstretched. This was impacting on key work and leading to frustration among prisoners who felt that their opportunities for progression were being impeded.

Nigel Newcomen — July 2010
HM Deputy Chief Inspector of Prisons

Fact page

Task of the establishment
HMP Leyhill is a male category D/open prison holding life and determinate-sentenced prisoners. It is a large open establishment with a diverse population in terms of sentence length, offence background, ethnic origin, religious need and nationality, age and disability. The 'Leyhill Vision' is to provide learning, skills and training opportunities that recognise this diversity and allow the individual prisoner to take those opportunities to improve his chances of developing a law-abiding lifestyle. Staff responsibility is twofold: to assist prisoners in making those choices and/or to deliver those opportunities.

Brief history
Leyhill originally opened with hutted accommodation in 1946 (it was formerly a USAAF wartime hospital). It was the first independent, minimum security prison in England and Wales and has no perimeter security fence. From the outset, it was established to adopt an experimental approach to the rehabilitation of selected long-term prisoners. In 1986, prisoners were re-housed from the original hutted accommodation into two new large units, providing single room accommodation. The redevelopment programme provided a new central kitchen, dining room and staff club. During 1990, a new visits complex, reception, chapel, hospital and facilities for the farms and gardens, works department, physical education and education departments were completed.

Operational area
South West Area

Number held
528 (week beginning 23 May 2010)

Certified normal accommodation
530

Operational capacity
530

Last full inspection
5 – 9 March 2007

Description of residential units

A wing:	213
B wing:	211
C wing:	106

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:

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 In 2007, Leyhill was performing reasonably well against this healthy prison test. Of the 19 recommendations in this area, seven had been achieved, three partially achieved and nine not achieved. We have made two further recommendations.

HP5 Most men came to Leyhill on planned progressive moves, but a number of short-term prisoners transferred due to population pressures were given very little notice of their moves. There was no recent evidence that any men arrived handcuffed on vans. The reception building and reception process was little changed. Some effort had been made to ensure that men who arrived at lunchtime did not have to wait on vans, but this still occasionally happened. All continued to be strip searched on arrival.

HP6 There was a comprehensive two-week induction. New arrivals now had individual interviews with officers on the day after their arrival. All were given a tour of the prison and support from induction orderlies, which helped them adjust to open conditions.

HP7 The prison was a very safe environment and all the men we spoke to said they felt safe and that there was almost no bullying between prisoners. This was confirmed by exit surveys carried out by the prison. There were appropriate violence reduction and anti-bullying strategies and alleged bullies were well monitored and transferred from Leyhill if their behaviour continued to be unacceptable. Few prisoners were assessed as a risk of self-harm, but assessment, care in custody and teamwork (ACCT) procedures were very good. Records demonstrated excellent care for vulnerable men and there was wider multidisciplinary involvement in assessments and reviews than previously.

HP8 The principal security issues were drugs, alcohol finds and mobile telephones. There was some good monitoring of these areas and a clear knowledge of the circumstances behind individual incidents. Reasons for transfers and absconds were monitored. Some aspects of security, such as strip searches on arrival, restrictions on using mobile telephones when out of the prison and a requirement to wear prison clothes at visits, continued to be incongruous with the responsibility extended to prisoners in open conditions and the trust placed in them.

HP9 Adjudications records indicated that most were appropriately investigated. The procedures for suspension of release on temporary licence (ROTL) when a disciplinary charge was brought and following a finding of guilt at adjudication had been clarified with a separate explicit written policy. Some decisions were clearly based on an assessment of individual risk, but the publication in the policy of a tariff related to the seriousness of the offence gave the appearance that ROTL was suspended as an additional punishment rather than a risk-based assessment.

HP10 The positive mandatory drug test rate for the year 2009/10 was 9.7%, just above the target rate and not unreasonable for the type of prison. Some prisons still occasionally sent prisoners too early in their process of withdrawal from drugs, but this was not as big a problem as previously. There was now good joint care planning between drug workers and health care for prisoners with identified substance use problems.

HP11 On the basis of this short follow-up inspection, we considered that outcomes for prisoners were now good against this healthy prison test.

Respect

HP12 In 2007, Leyhill was performing reasonably well against this healthy prison test. Of the 55 recommendations in this area, 17 had been achieved, 10 partially achieved and 28 not achieved. We have made 14 further recommendations.

HP13 Interactions we observed between officers and prisoners were reasonably good and relaxed, although wing staff were usually office bound. Not all prisoners in groups were positive about staff and many referred to receiving lots of petty warnings from officers combined with threats to return them to closed conditions. It was difficult to find hard evidence to support this lack of trust in officers, but it was clearly a prevalent and often expressed feeling. Some of the restrictive security measures did not suggest to prisoners that they were given appropriate responsibility. Similar issues had been raised in the most recent measuring the quality of prison life exercise, but there was still no formal strategy or open forum to address these issues and help improve relationships.

HP14 The quality of personal officer work varied significantly, although some was very good. Most prisoners knew who their personal officer was, but many had relatively little contact with them. Personal officer entries in records were usually made monthly, but there was little focus on resettlement objectives.

HP15 The general environment of the prison was excellent, with very attractive grounds that prisoners appreciated. Living conditions were generally good, but some shower areas were in a poor state. Facilities for prisoners to cook their own meals were limited. The criteria for selection for C wing still had an unreasonable blanket exclusion of prisoners with any previous drug offences.

HP16 The diversity strategy did not cover all strands such as religion and sexuality. There was a good strategy for older prisoners and those with disabilities and some good attention had been paid to meeting the needs of older prisoners, but more active support and individual care plans were needed for those with disabilities. The previous very good day care centre was not running because the primary care trust no longer funded it, but there were plans to reinstate the service.

HP17 Race relations appeared good, with few signs of racial tensions. The number of race representatives had increased and they were well known to prisoners, but there were no regular open forums for black and minority ethnic prisoners or links with community groups. Ethnic monitoring suggested that variations in some areas needed more in-depth analysis to discover the reason. Racist incident reports were generally appropriately investigated, but it was not clear that prisoners always got written replies. In one case, the response to a complaint of the use of racist language

by a member of staff seemed inadequate. Insufficient attention was paid to ensuring the needs of foreign national men were met. There had been no assessment of what services they required and consequently no action plan to take work forward.

HP18 Prisoners in groups appeared less positive than previously about the quality of food, although most accepted it was of at least satisfactory quality. There was little promotion of healthy eating options and little formal consultation about food. Comments books were not readily available. Little has been done to address the previously identified relatively poor views of the quality of food expressed by black and minority ethnic prisoners. There were similar problems with consultation about the shop. The prisoner consultative committee had conducted a survey and made some suggested amendments to the canteen list, but little had been done in response and prisoners had little confidence that their views were considered.

HP19 Application and complaint forms were freely available on all living units. Many prisoners said they had to chase up applications, but applications could not be tracked to ensure prompt replies.

HP20 Physical and mental health services were comprehensive. Access to most health professionals was very good, but waiting times to see the dentist were too long. Additional sessions had been agreed to help meet this deficit. Mental health support was very good and prisoners were able to see specialist counsellors, including for sexual health and bereavement. Pharmacy services were good.

HP21 On the basis of this short follow-up inspection, we considered that outcomes for prisoners remained reasonably good against this healthy prison test.

Purposeful activity

HP22 In 2007, Leyhill was performing reasonably well against this healthy prison test. Of the seven recommendations in this area, four had been achieved and three not achieved. We have made eight further recommendations.

HP23 As we would expect in an open prison, men were allowed a good amount of time out of their rooms and previous restrictions about visiting other wings had been lifted. All prisoners still had to be back on their own wings by 8pm throughout the year and plans to change this to 8.30pm during the summer had not been implemented. Recent concerns about the possibility that men were leaving the prison at night had led to more frequent checks during the night and early morning and a number of prisoners said these were noisy and disrupted sleep.

HP24 The range of education was sufficient to meet prisoners' needs and some evening classes were now run, but the overall number of contracted education hours was relatively low for the population. The infrequency of some classes, such as in barbering and art, reduced opportunities to complete accredited qualifications. There was some overlap and duplication between the two main education providers, which led to some inefficiencies. Poor liaison and communication between the two providers meant the provision was not managed as effectively as it could have been to meet the needs of prisoners. Two different data management systems used to monitor performance were not compatible and some of the data were not accurate. There had been an unsuccessful attempt to integrate literacy and numeracy support into the workshops and, although an alternative strategy of providing discrete classes in

education has been introduced, it was not clear from data how successful this had been. Prisoners were very positive about the library service.

HP25 Overall, there were sufficient activity places. The prison had extended vocational opportunities in industries and now provided a range of industry-recognised qualifications. Prisoners' employability skills were developed through their work and accredited through wider key skills of managing their own learning, working with others and personal development. Other employability skills were recognised through RARPA (recognising and recording personal achievement). However, the process was underdeveloped. The amount of paid unsupervised work and supervised community placements had increased substantially and clear eligibility criteria were published to prisoners.

HP26 Prisoners could undertake a good range of qualifications in physical education that enabled them to become accredited fitness instructors. Qualified prisoners ran the well attended fitness suite. The range of provision catered well for the different ages and fitness levels of the population. The outdoor sports facilities were extensive, but the sports hall was small.

HP27 On the basis of this short follow-up inspection, we considered that outcomes for prisoners remained reasonably good against this healthy prison test.

Resettlement

HP28 In 2007, Leyhill was not performing sufficiently well against this healthy prison test. Of the 34 recommendations in this area, 15 had been achieved, three partially achieved and 16 not achieved. We have made four further recommendations.

HP29 The reducing reoffending strategy did not sufficiently reflect the specific needs of the different groups at Leyhill or identify how and when those needs would be met. There had been no meeting of the reducing reoffending committee since October 2009 and there was little apparent strategic steer from that meeting or clear oversight of the development of resettlement pathways. Although there were significant delays with offender management work, there was no evident oversight of this by the committee.

HP30 The offender management unit (OMU) played a central role in the lives and progress of prisoners at Leyhill, but ongoing delays with its work led to many frustrations. Staff in the OMU worked hard, but the services were stretched, leading to some difficult choices about priorities. Some offender supervisors had active case loads as high as 100, which was too many to provide an effective service. There was a backlog of over 150 offender assessments (OASys) and backlogs with completion of sentence plans and sentence planning boards, although there was little accurate data to assess the extent of these. Little was done for those arriving with a short time left to serve. Delays in decisions about release on temporary licence and home detention curfew, some of which were caused by external offender managers, were a continuing source of grievance for prisoners. Lifers who had come to Leyhill with a 12-month review found the delays particularly frustrating as they impacted on their ability to satisfy the Parole Board that their risk was reduced. In addition to delays in the prison, log jams in the parole system also affected prisoners.

HP31 The range of offending behaviour programmes run appeared appropriate for the population, but without an up-to-date needs analysis it was not possible to identify whether there were any gaps in provision.

HP32 Prisoners had good access to services such as accommodation, debt and finance advice and were referred to the advice centre before release for help on matters such as accommodation. There was a clear working out strategy and many more prisoners than previously were able to benefit from this.

HP33 There was still no visitors' centre to provide support for prisoners' families. Visitors were no longer refused a visit on the indication of a drug dog alone and visitors we spoke to said they were well treated. The play area was not always supervised, but fathers were able to play freely with their children in the indoor play area and outside. Four special family days were run each year and there were a number of parenting courses.

HP34 CARAT services were good and there was very positive interaction between the team, community drug action teams and all prison departments. An extensive range of group work modules included relapse prevention and alcohol awareness. There were effective links with local drug action teams to provide services on release.

HP35 On the basis of this short follow-up inspection, we considered that outcomes for prisoners were still 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 recommendation to NOMS, from the previous report

2.1 The National Offender Management Service should develop a clear strategy for managing life-sentenced prisoners in open conditions, including those convicted of sex offences and those regarded as high risk under MAPPA and OASys assessments. This should include guidance about appropriate community placements and how risk might be best tested to allow meaningful referrals to the parole board. (HP48)
Partially achieved. Guidance for managing prisoners serving life sentences and indeterminate sentences for public protection, including those identified as high or very high risk of harm, were included in *Implementation Manual Phase III Offender Management and Indeterminate Sentenced Prisoners* published by NOMS in January 2008. This did not include specific guidance about suitable community placements or risk testing, but clearly identified the factors to be addressed for referrals to the Parole Board, such as the identification of prisoner risks and progress to reduce these, an up-to-date assessment of the risks posed and a plan to manage these if suitable for release. The Sentinel project using enhanced monitoring was not used nationally, but had been devised and implemented at Leyhill. (See also section on resettlement pathways.)

Main recommendations to the governor, from the previous report

2.2 The induction programme should keep prisoners occupied and focus on the adjustments and responsibilities associated with a transfer to an open prison. (HP40)
Achieved. New arrivals began the two-week induction programme on their first day. This included a boundary walk accompanied by an induction officer, after which prisoners were expected to report to various departments as outlined in an induction timetable that varied according to what day the prisoner had arrived. Sessions were scheduled morning and afternoon on most days, with some free sessions to allow time for individual interviews. The responsibilities associated with transfer to open conditions were outlined in a new induction booklet and reinforced during the induction programme, particularly through prisoner orderlies.

2.3 Managers should develop a strategy to improve relationships between staff and prisoners, including regular open forums with prisoners to identify improvements, with regular feedback to all staff and prisoners. (HP41)
Not achieved. The prison's action plan referred to an intention to hold staff and prisoner focus groups, but consultation with prisoners was limited to meetings with representatives and there was little evidence of wider discussion. A measuring the quality of prison life (MQPL) research exercise carried out in November 2009 had identified some areas of relationships that were relatively negative compared to other open prisons, which merited some investigation. Senior managers had discussed these findings, but no formal strategy had been formulated.
We repeat the recommendation.

2.4 A written personal officer strategy should be produced with specific guidance to staff about their role and what is expected of them. (HP42)
Achieved. A revised personal officer scheme had been agreed at the end of 2007. Much of

the guidance in the document was generic, but it also covered some specific expectations of what was required of personal officers at Leyhill. Few personal officers we spoke to were aware of the guidance and some were surprised to see that it had appeared in wing offices on the second day of the inspection. A shorter document more precisely targeted at the needs of Leyhill might have been more effective.

2.5 A primary mental health nurse service should be provided. (HP43)
Achieved. A comprehensive primary mental health service operated well, with a full-time registered mental health nurse (RMN). The current caseload was over 30 prisoners and additional mental health input was provided by a visiting consultant psychiatrist. Two specialist counsellors were also available and their expertise included sexual abuse and bereavement counselling. Links with community mental health services were very good and care programme approach (CPA) reviews were well attended. The RMN accepted referrals from across the prison and had established excellent relationships with all prison departments, including safer custody and drugs workers. Up to three referrals were received weekly and were seen as soon as possible.

2.6 All jobs in the prison should provide recognised employability skills which are accredited. (HP44)
Achieved. The prison had extended opportunities in industries and now offered a range of vocational industry-recognised qualifications and key skills qualifications in managing own learning, working with others and personal development.

2.7 Prisoners should be made fully aware of all rules that apply to them. Rules should be proportionate and suited to an open prison. All transgressions should be dealt with through fair and transparent procedures subject to appropriate monitoring. (HP45)
Partially achieved. The prison rules were clearly covered in the induction booklet and were mostly proportionate to an open prison. However, some of the security procedures still placed unnecessary limitations on prisoners (see section on security and rules).

2.8 A new resettlement strategy should be agreed to reflect the specific needs of the different groups at Leyhill and describe how those needs will be met. (HP46)
Not achieved. The reducing reoffending strategy 2009/10 did not identify the different groups of prisoners or their needs. (See also section on strategic management of resettlement.)
We repeat the recommendation.

2.9 There should be sufficient work and training places in the community and sufficient internal prison infrastructure to support them, so that all eligible prisoners can benefit from these resettlement opportunities. (HP47)
Achieved. The amount of paid unsupervised work and supervised community placements had increased substantially. All prisoners, including those categorised as high risk, could participate in supervised community placements when they had met their sentence planning targets and met the criteria of the working out scheme. Staffing had been increased to provide supervision of placements.

Recommendations

Courts, escorts and transfers

2.10 Prisoners transferring to Leyhill should be given at least 24 hours' notice. (1.6)
Partially achieved. Most prisoners serving longer-term sentences who had been transferred in line with their sentence plan had been given sufficient notice. However, some prisoners with

short sentences who arrived from local prisons had been told only on the morning of the transfer.

Further recommendation

2.11 Prisoners transferring from local prisons should be given at least 24 hours notice of their move.

2.12 Sending prisons should accurately assess prisoners' suitability for open conditions. (1.7)
Achieved. Allocation criteria agreed with the regional custodial manager and updated in December 2009 had been sent to all prisons in the south west that regularly transferred prisoners to Leyhill. Managers believed few unsuitable prisoners arrived, but actual numbers were not monitored and accounts were anecdotal. A small number of prisoners had been transferred to Leyhill too early in the detoxification process and had been returned (see section on substance use).

2.13 Prisoners should not be handcuffed when put on vans or during the journey to Leyhill. (1.8)
Achieved. The prison had rejected this recommendation on the basis that escort contractors were obliged to respond to previous warning markers. This suggested that it might sometimes be appropriate for prisoners to be handcuffed en route to an open prison, which was inconsistent with an appropriate assessment of suitability. However, no prisoners arrived in handcuffs during the inspection.

2.14 Prisoners should be allowed to disembark from vans immediately on arrival at Leyhill. (1.9)
Not achieved. Prisoners and staff said new arrivals sometimes waited on vans outside reception. It was not unusual for vans to arrive at lunchtime and this had happened four times in April 2010 alone. Recent staffing changes allowed some cover for reception at lunchtime, but officers were often redeployed to other duties and staff were not always notified of expected times of arrival.
We repeat the recommendation.

First days in custody

2.15 The reception area should be improved, with a holding room with sufficient seating, better access to toilets and appropriate information about what to expect at Leyhill. (1.25)
Not achieved. Reception was little changed. The holding room contained three old chairs and a single bench, there was no direct access to toilets and only limited information about Leyhill was displayed.
We repeat the recommendation.

2.16 Prisoners arriving from closed prisons should not be required to undergo a strip search unless there is a clear basis for suspicion. (1.26)
Not achieved. All new arrivals were strip searched. Managers agreed this was time consuming and unnecessary, but said they were required to comply with the national security framework.
We repeat the recommendation.

2.17 An induction officer should interview all new receptions privately on the day of their arrival and explain and help complete the required documentation when necessary. (1.27)
Not achieved. The first day procedures had not changed. New arrivals were taken to A wing office from reception and allocated a room. Induction began at 6pm on the first evening when the induction orderly outlined the various compacts that prisoners had to sign. The orderly asked about any debt and accommodation needs and made appointments for further advice where requested. A formal one-to-one meeting with an induction officer was scheduled for the day after arrival.
We repeat the recommendation.

2.18 The initial induction presentation should be improved and delivered by trained staff. (1.28)
Not achieved. The initial induction presentation was read from a set of prepared notes. No visual aids were used and there had been no specific training for induction officers.
We repeat the recommendation.

Residential units

2.19 The criteria for selecting prisoners for C wing should be published to prisoners and should be based on prisoners' progress and achievements during their sentence. (2.11)
Not achieved. The criteria for C wing, which were listed on the application form, excluded prisoners who had had an adjudication in the previous six months, had previous adjudications related to drugs, alcohol or possession of cash or mobile telephones or had been convicted of a drug-related offence. This was unfair on prisoners who did not meet the criteria, some of whom had been in prison for several years, were drug-free and had made progress during their sentence.
We repeat the recommendation.

2.20 An offensive displays policy should be published to prisoners and applied consistently across all wings. (2.12)
Achieved. A comprehensive and detailed offensive material policy had been published in February 2009 and appeared to be applied across the prison.

2.21 Shower areas should be deep cleaned and refurbished where necessary. (2.13)
Not achieved. Some shower areas, particularly on B wing, were in very poor condition. Linings had been penetrated by damp and there were leaks in toilet areas. Many showers and toilet areas were in need of a deep clean and some contained broken wooden chairs and had missing tiles. Most shower areas had two or three shower heads, but these were not in separate cubicles. C3 had only one shower area for 40 prisoners as the shower area on the ground floor was being refurbished over several months.
We repeat the recommendation.

2.22 Prisoners with disabilities who need support should have paid prisoner helpers overseen by staff. (2.14)
Not achieved. The prison had questioned the appropriateness of such a scheme and there was no formal provision of trained and paid helpers for prisoners with disabilities. (See also section on diversity.)
We repeat the recommendation.

2.23 The facilities on B wing should be adapted to ensure that they meet the needs of prisoners with disabilities. (2.15)
Not achieved. The facilities on B wing for prisoners with disabilities had not changed. Rooms

where the doors had been widened to allow wheelchair access were too small to manoeuvre wheelchairs or motorised scooters. Light switches had not been lowered and wash basins were difficult for prisoners in wheelchairs to use.
We repeat the recommendation.

Additional information

2.24 Many prisoners in groups complained that they lost lots of sleep because of frequent noisy checks throughout the night. More frequent checks had recently been introduced following some unverified security intelligence that one or two prisoners were leaving the prison at night, but the actions taken seemed disproportionate.

Recommendation

2.25 The need for additional checks on prisoners throughout the night should be reviewed and those that do take placer should be carried out without unnecessarily disturbing prisoners' sleep.

Staff-prisoner relationships

2.26 The prisoner consultative committee should identify action points for named individual managers who should attend the next meeting to report progress or provide a written report outlining action taken. (9.25)
Not achieved. No clear action points for individual managers were identified in the prisoner consultative committee (PCC) minutes and subsequent meetings did not deal with matters arising from previous meetings to check what had been achieved. The minutes did not include attendees so it was difficult to know which managers had been present. We were told that some issues were resolved between meetings, but the lack of a clear report back to demonstrate what action had been taken reinforced the view among a number of prisoners that the PCC was just a 'talking shop' and did little to reassure them that their views were taken seriously.
We repeat the recommendation.

2.27 Staff should be encouraged to move informally among prisoners when they are on the wings. (9.26)
Not achieved. Although the action plan said unit officers were encouraged to move around the wings and interact with prisoners, in practice we saw little evidence of this. At times when most prisoners were on the wing, most officers were based in the wing office dealing with queries from prisoners who came to them. Managers agreed this was usually the case and the small number of officers on wings sometimes made this inevitable. The new head of residence was considering ways to encourage better informal interaction.
We repeat the recommendation.

Personal officers

2.28 The personal officer scheme should be clearly advertised in all communal areas and on notice boards at the entrance to wing spurs. (9.27)
Achieved. There were notices clearly identifying personal offices on all wings including posters with photographs of them on A and B wings, but not on C.

2.29 All personal officers should introduce themselves to prisoners, get to know their personal circumstances and record contact in wing files to build up an accurate chronological account of their time at Leyhill and any significant events. (9.28)
Partially achieved. Many prisoners in groups said their personal officers did not come to speak to them and a number of the records examined did not include a clear entry to show that the personal officer had spoken to and introduced themselves to the prisoner. Most records contained regular monthly entries from personal officers, although some had significant gaps. Some entries were very good, but most continued to focus on behaviour rather than resettlement issues or family concerns.

Further recommendation

2.30 Wing managers should ensure that personal officers introduce themselves to prisoners and record this in their records along with progress against resettlement objectives and any issues of concern.

2.31 Personal officers should help their prisoners access services they require, deal with and respond to matters they raise and support them by attending case reviews and sentence planning boards where possible. (9.29)
Partially achieved. Many officers helped prisoners with their queries, often related to progress on applications for release on temporary licence or other matters dealt with by the offender management unit, but in most cases it was the officer on duty on the wing rather than the personal officer. Personal officers had relatively little involvement in sentence planning, not helped by the fact that the prison had a significant shortage of officers.

Further recommendation

2.32 Personal officers should attend sentence planning boards.

Bullying and violence reduction

2.33 Exit surveys relating to safer custody issues should be conducted, of prisoners being released or transferred from the prison, to inform the development of the safer custody strategy. (3.7)
Achieved. Exit surveys were given to prisoners the day before discharge and any issues arising were discussed and responded to at the monthly safer custody meeting. Returns indicated that few prisoners had ever experienced bullying behaviour from other prisoners.

Self-harm and suicide

2.34 Non-residential staff with a knowledge of individual prisoners, such as psychology and workplace managers, should be involved in their ACCT management. (3.17)
Partially achieved. The management of the assessment, care in custody and teamwork (ACCT) process on a case by case basis was excellent, with particularly good initial interviews and assessments providing a thorough insight into a prisoner's circumstances. Relevant staff from a range of disciplines attended case reviews in only about half of cases.
We repeat the recommendation.

2.35 Staff from other disciplines such as the CARAT service, the chaplaincy and psychology should be trained to act as case managers to provide a more multidisciplinary

approach. (3.18)
Not achieved. Staff from disciplines other than uniform grades, including psychology and probation, had received ACCT assessor training, but none had received ACCT case management training.
We repeat the recommendation.

Applications and complaints

2.36 Application and complaint forms should be available on all wings and envelopes should be provided. (3.88)
Achieved. Forms and envelopes were provided on all wings.

2.37 The return of applications should be recorded, tracked and monitored by managers. (3.89)
Not achieved. General applications and applications for senior officers and the offender management unit were recorded in separate books. All had similar formats, recording the prisoner's name and number and the nature of the application, but not when the application had been responded to or when this had been received by the prisoner. Many prisoners said applications went astray or had to be chased up.
We repeat the recommendation.

Legal rights

2.38 Information about the role of the legal services officers and the services available should be better promoted, given to prisoners during induction and included in the prisoner induction book. (3.97)
Not achieved. No information about legal services was included in the induction booklet or the initial induction talk. Legal services notice boards on A and B wings contained inaccurate information, including stating that a legal services officer was available on A wing for an hour a day when this was not the case.
We repeat the recommendation.

Substance use

2.39 Joint care planning and care coordination should be developed between health care and the CARAT service. (3.107)
Achieved. There was excellent joint working between health care and the counselling, assessment, referral, advice and throughcare (CARAT) team. The integrated drug treatment system (IDTS) was due to be introduced imminently and there were well advanced plans to relocate CARAT staff to the health care department to allow better communication and improve services for prisoners. Health care staff, including the RMN, attended CARAT team meetings and there was good coordination of pre-release management.

2.40 Prisoners who have recently completed detoxification programmes should not transfer to Leyhill until they have had time to consolidate their drug free state. (3.108)
Not achieved. Prisoners who had recently completed detoxification treatment were still transferred to Leyhill and had to be returned to the sending prison.
We repeat the recommendation.

Diversity

2.41 A diversity policy should be produced in consultation with prisoners that includes all anti-discrimination legislation and outlines how the needs of all minority groups will be met. (3.26)
Not achieved. Diversity work was underdeveloped. A diversity and race equality policy covered race, but contained little about faith and nothing on gender and sexual orientation. There were separate foreign national and disability/older prisoner policies.
We repeat the recommendation.

2.42 A strategy should be developed to ensure that the long-term needs of older prisoners and those with disabilities are properly met. (3.27)
Achieved. There was a good quality strategy for older prisoners and prisoners with disabilities.

2.43 A forum should be established for groups such as health services and residential staff to meet to case-manage the special needs of older prisoners and those with disabilities. (3.28)
Not achieved. We were told that care plans had been raised in the past for prisoners who experienced extreme difficulties due to their disabilities, and that multidisciplinary meetings had been held to coordinate these, but we were not given any evidence to support this.
We repeat the recommendation.

Additional information

2.44 There were a large number of older prisoners and staff were aware of prisoners with disabilities on B wing, but there were no care plans. Prisoners who would require help in an emergency had been identified and personal evacuation plans produced, but the plans were kept in the disability liaison officer's office and wing staff were unaware of the specific details. One prisoner was providing significant levels of help to an older prisoner and had signed a personal evacuation plan agreeing to take responsibility for him in an emergency, which was inappropriate.

Further recommendations

2.45 All older prisoners and prisoners with disabilities should be assessed to indentify specific needs and a regularly reviewed care plan produced to manage them.

2.46 Wing staff should be aware of the needs of and take responsibility for prisoners who require assistance in an emergency.

Race equality

2.47 The over-representation of black and minority ethnic prisoners in adjudications and their under-representation on C wing should be examined and addressed. (3.39)
Not achieved. Monthly ethnic monitoring indicated that black and minority ethnic prisoners had been consistently under-represented on C wing in 10 of the previous 12 months. Minutes from the diversity and race equality action team (DREAT) meeting indicated that this issue had been raised, but there had been no further discussion or investigation. Black and minority ethnic prisoners had also been consistently under-represented in release on temporary licence and this had not been fully investigated.

Further recommendation

2.48 Where relevant data indicate under or over-representation of black and minority ethnic prisoners in any area, the reasons for this should be investigated and appropriate action taken to address identified issues where necessary.

2.49 Prisoners from black and minority ethnic backgrounds should have the opportunity to meet regularly and directly with prison managers to discuss concerns. (3.40)
Not achieved. No forum was held.
We repeat the recommendation.

2.50 More race relations orderlies should be recruited and trained. (3.41)
Achieved. There were now four race representatives compared to one at the previous inspection.

2.51 Links should be made with outside community groups to improve the promotion of race relations within the prison. (3.42)
Not achieved. The prison had no established links with community groups to promote race relations.
We repeat the recommendation.

2.52 Racist incident report forms should be responded to in writing. (3.43)
Partially achieved. It was not apparent that prisoners always received a written reply. Investigations into racist incident reports were mostly appropriate, but in one case response to a complaint about the use of racist language by a member of staff appeared inadequate.

Further recommendation

2.53 All prisoners who report a racist incident should receive a written response that appropriately addresses the matter raised.

Foreign national prisoners

2.54 The foreign national policy should contain an action plan based on identified need. (3.55)
Not achieved. There was no foreign national action plan or needs assessment. Foreign national issues were a standing agenda item at the DREAT committee meetings, but the foreign national liaison officer (FNLO) had not attended in recent months and the DREAT action plan did not contain any action points related to foreign nationals.
We repeat the recommendation.

2.55 The foreign national liaison officer should have a job description and receive the necessary time and training for the role. She should introduce herself to all foreign national prisoners. (3.56)
Not achieved. The FNLO post was now held by a reception officer. She had not had any specific training, had no job description and was allocated about half a day a week to the role. She did not routinely introduce herself to foreign national prisoners.
We repeat the recommendation.

2.56 The foreign national working group meetings should be attended by staff from across the prison and include prisoner representation. (3.57)
Partially achieved. The foreign national working group meeting had been discontinued and foreign national issues were now a standing agenda item at DREAT meetings. Prisoner diversity representatives attended these meetings, but not specifically foreign national prisoners and the minutes indicated little, if any, discussion of foreign national issues.

Further recommendation

2.57 There should be regular formal consultation with foreign national prisoners, with identified issues brought to the diversity and race equality action team committee for further discussion and action where necessary.

2.58 Foreign national prisoners should be interviewed on arrival to identify their status and any specific needs. They should receive appropriate information about the regimes and services available to them in a language they can understand. This should be recorded. (3.58)
Not achieved. There were no formal systems to ensure this happened. We were told that the process relied on foreign national prisoners speaking informally to the FNLO when necessary.
We repeat the recommendation.

2.59 Accurate records should be kept of staff and prisoners able to speak languages other than English and prepared to work as translators. (3.59)
Not achieved. The DREAT manager said there was a list, but it had not been updated in over a year. The FNLO was not aware of any list and simply approached prisoners known to speak other languages as required.
We repeat the recommendation.

2.60 Issues raised and discussed at foreign national meetings and any action taken as a result should be recorded. (3.60)
Not achieved. See paragraph 2.54.
We repeat the recommendation.

2.61 Information on the touch-screen centres should be updated and added to as necessary. (3.61)
Achieved. The information was updated in French, German, Spanish and Urdu when necessary using a software translator package.

Health services

2.62 A staff skill mix review should be undertaken to ensure that there are sufficient appropriately qualified nursing staff to deliver a comprehensive health service. (4.30)
Achieved. A new health provider had taken over responsibility for health services at Leyhill and HMP Eastwood Park and a review of skill mix and training requirements was under way as a result, coordinated by the head of health care. Leyhill was well staffed with appropriately qualified registered general and mental health nurses. Ongoing professional training and clinical supervision were supported by management. Administrative staffing levels were due to increase by 0.5.

2.63 Prisoners with appointments and/or continuing treatment with specialist services should not be transferred unless arrangements have been made with the new

establishment to ensure continuity of care. (4.31)
Achieved. The problem of prisoners being transferred into Leyhill with outstanding appointments had largely abated.

2.64 All emergency equipment held in health care should be reviewed and brought up to standard as a matter of urgency. Equipment should be checked at least weekly and after use. A code for attending medical emergencies should be identified. (4.32)
Partially achieved. The medical emergency equipment in the health care centre had been reviewed and replaced and was fit for purpose, but there was no system to ensure it was checked regularly. A colour code system was in place and extra defibrillators were now held on some residential areas and wing staff had been trained in their use.

Further recommendation

2.65 All resuscitation equipment held in health care should be checked at least weekly and after use and a complete record maintained in the department.

2.66 Nursing staff should receive annual training in resuscitation procedures. (4.33)
Achieved. Staff received annual updates on resuscitation methods from a specialist company.

2.67 Lockable metal cupboards should be used for storing medicines, which should be administered safely and free from interruption from other activities. (4.34)
Partially achieved. Pharmacy items were kept in appropriate sturdy and lockable cupboards. However, the room used for administering medicines was also a treatment/examination room so there could be some disruption. However, a new pharmacy room was due to come into use when the IDTS programme was introduced (see section on substance use).

Further recommendation

2.68 The new pharmacy room should be brought into use.

2.69 The pharmacist should retain faxed copies of prescriptions and the system should be subject to audit. (4.35)
Achieved. A new pharmacy service had been introduced in April 2010 and was still bedding in. The pharmacist said faxed copies of selected prescriptions were audited regularly.

2.70 The 'special sick' policy should be reviewed regularly by the medicines and therapeutics committee to ensure that appropriate medicines can be supplied. Patient group directions should be produced to allow supply of more potent medicines where appropriate. (4.36)
Achieved. A comprehensive range of over-the-counter remedies was available for nurses to give to prisoners. The health care centre held stocks of Paracetamol, Ibuprofen and antacids. The general restocking of pharmacy items was good, but stocks of Paracetamol were excessive and unnecessary. Patient group directions were also available and used by nursing staff. One of the senior nurses was a prescriber.

Further recommendation

2.71 The visiting pharmacy technicians should check stocks at least weekly and excessive stock should be removed.

2.72 A written in possession policy should be produced and adopted by the medicines and therapeutics committee to include documented risk assessment to determine the length of treatment that can be supplied in possession for each patient. (4.37)
Not achieved. There was no specific in possession policy. Prisoners transferring into Leyhill invariably already received their medicines in possession and the prison relied on other establishments' policies, which was not appropriate.
We repeat the recommendation.

2.73 Standard operating procedures should be in place to cover the arrangements for pharmacy 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 procedures. (4.38)
Partially achieved. The new pharmacy provider had published standard operating procedures covering pharmacy services. Not all health care staff had yet had the opportunity to read and sign the procedures.

Further recommendation

2.74 All health care staff should sign and agree the standard operating procedures for pharmacy services.

2.75 The pharmacist should visit the prison regularly to exercise professional control and take a more active role in health initiatives. (4.39)
Partially achieved. The new pharmacist visited monthly to support staff and prisoners and two pharmacy technicians visited twice a week. Pharmacy items were ordered daily and returned within 48 hours, or the same day if marked as urgent. There were some teething issues, but the pharmacist was trying to resolve prisoners' concerns about late delivery of medicines. No pharmacy-led clinics were run, but these were being considered.

Further recommendation

2.76 Pharmacy-led clinics should be introduced.

2.77 A nurse should be appointed to the medicines and therapeutics committee. (4.40)
Achieved. A senior nurse was on the medicines and therapeutics committee. The committee had not met regularly during the transition to new providers, but the aim was to reinstate this as soon as possible.

2.78 All prisoners should have equal access to dental treatment. (4.41)
Not achieved. Dental services were under considerable strain. The dentist held two sessions a week in an attempt to reduce the waiting list, but there was no evidence that continuing treatment was managed well. The dentist arranged the waiting list and it appeared that efforts to reduce waiting times for new prisoners meant those who had already received treatment had lengthy waits to continue it. The current wait was up to 16 weeks. Many of the problems were exacerbated by the high number of new prisoners, up to 100 a month, who came from

large local prisons and needed initial treatment. The dentist treated six routine and two emergency appointments a week. Additional sessions had been introduced, but were making little headway. Prisoners could register with local dentists, but many were unable to do so because of extensive existing waiting lists. An initiative to reduce the waiting list was under way.

We repeat the recommendation.

Learning and skills and work activities

2.79 Literacy and numeracy should be integrated into workshops. (5.14)

Not achieved. The prison had promoted the development of skills for life in workshops. After evaluating the strategy and noting that achievement outcomes were very low, the prison had produced a new strategy focusing on the development, recognition and accreditation of work and employability skills in workshops. Education offered classes to develop prisoners' literacy and numeracy skills. Initial screening to identify need appeared thorough, but data to show that prisoners' needs were being met were inaccurate and could not measure skills improvements.

Further recommendations

2.80 The take-up of skills for life programmes against identified need should be monitored.

2.81 The accuracy of achievement data collection should be improved to measure whether prisoners' needs are being met and they are achieving accredited qualifications.

Additional information

2.82 The range of education was sufficient, but the lack of regular classes reduced prisoners' opportunities to complete accredited qualifications. The barbering course ran for only two days a week and the popular art class only once a week. The contracted hours of just over 15,000 were insufficient for the size of the population.

2.83 There were two education providers, with some overlap and duplication of programmes, which was not cost effective. Communication between the providers was poor, resulting in inefficiencies that limited opportunities for prisoners. The providers used different and incompatible data management systems to monitor learner performance and the data did not take into consideration prisoners who transferred out before completing their qualifications. Data were not aggregated to give managers a clear view of the providers' performance in terms of prisoner achievement rates.

2.84 One of the education providers was satisfactorily developing and accrediting prisoners' employability skills through wider key skills (see paragraph 2.6). The other education provider used an internal system to recognise and record prisoners' personal achievement while at work. This system was under-developed and did not show or record prisoners' progress or improvement over time in the development of important work skills. Some work place supervisors employed by the prison to manage workshops did not fully promote the work ethic with prisoners under their supervision. Too many prisoners were allowed to be inactive in workshops.

Further recommendations

2.85 The amount and frequency of education classes should be extended to give prisoners more opportunity to develop vocational and personal development skills.

2.86 The delivery of the education provision should be improved to make it more efficient and reduce duplication.

2.87 The collection and accuracy of prisoner achievement data should be improved to allow better monitoring of prisoners' achievement of qualifications.

2.88 The measuring and monitoring of prisoners' personal achievement of employability skills should improve to enable prisoners' to evidence improvements in skills to help gain employment on release.

2.89 Work place supervisors should ensure prisoners remain active and develop good work place skills that will help them find employment on release.

Physical education and health promotion

2.90 The free weights area in the gym should be improved and expanded to meet the needs of the prison population. (5.20)
Not achieved. Leyhill offered a wide range of physical education (PE) activities, but the popular free weights room was unchanged and too small to meet demand. Some cardiovascular equipment had been moved into the corridor to create more space, but this was not an ideal place for it.
We repeat the recommendation.

Additional information

2.91 The range of PE qualifications offered allowed prisoners to qualify as fitness instructors. These prisoners ran the fitness suite, which was well attended and valued by prisoners. The range of provision catered to the different ages and fitness levels among prisoners and there were extensive outdoor sports activities, but the indoor sports hall was too small.

Further recommendation

2.92 The indoor sports hall should be extended to meet demand.

Time out of room

2.93 Prisoners should be allowed to visit friends on other wings, particularly during the winter when the weather may inhibit some prisoners from associating outside. (5.34)
Achieved. The restrictions had been lifted and prisoners could visit other wings until 8pm each evening.

2.94 The time prisoners are allowed to associate off the wings during the evening should be extended during the summer. (5.35)
Not achieved. Plans to extend the summer association period off the wing from 8pm to

8.30pm had been withdrawn just before implementation as it had been considered that any extension could jeopardise good order. There did not appear to be sufficient evidence to justify this.
We repeat the recommendation.

2.95 There should be evening education activities. (5.36)
Achieved. Information and communication technology had been introduced on two evenings a week and the library was open, providing an opportunity for self study.

Security and rules

2.96 Actions recommended on security information reports such as target searching should be prioritised and completed. (6.9)
Achieved. A proforma was completed whenever searching was identified as a necessary outcome from a submitted security information report. These were monitored by the security analyst to ensure they were carried out, with the intelligence each search was based on dictating priority.

2.97 The Prison Service should review the security baselines for open prisons to check that all are necessary and consistent with the status of the prison. (6.10)
Not achieved. Certain security procedures, including searching all returning outside workers and the requirement for prisoners to wear prison clothes at visits, were not proportionate for an open prison. They were not a result of centrally imposed security baselines, but were due to prison managers applying discretionary measures from the national security framework.

Further recommendation

2.98 Security procedures should be proportionate for an open prison. Where the national security framework allows discretion, only baselines appropriate for an open prison should be applied.

2.99 Prison moves for good order reasons and absconds from the prison should be analysed for trends. (6.11)
Achieved. Prison moves for good order reasons and absconds from the prison were analysed monthly over a minimum 12-month timeline.

Discipline

2.100 Adjudicators should fully investigate all charges and consider possible defences, even when a guilty plea has been entered. (6.19)
Achieved. A sample of adjudications indicated that charges were appropriately investigated regardless of the plea submitted by the prisoner.

2.101 Adjudicators should consider evidence in cases of possession of mobile telephones before deciding whether to refer such charges to the independent adjudicator. (6.20)
Not achieved. The prison had rejected this recommendation on the basis of the threat to security posed by mobile telephones because they could not be monitored in the same way as prison telephones. This seemed a redundant argument given the large number of prisoners on ROTL daily, the opportunities they would have to use other telephones and the few prison telephone calls actually monitored.
We repeat the recommendation.

2.102 There should be a clearly publicised policy about reviewing risk for release on temporary licence (ROTL) following findings of guilt at adjudication. Decisions to suspend access to ROTL should be taken by a risk management board based on risk alone and not used as an additional sanction, and should be subject to routine monitoring including on the basis of ethnicity. (6.21)
Partially achieved. Decisions on whether a prisoner lost existing ROTL privileges following a proven adjudication were distinct from the imposition of a punishment, but were made by a principal officer, often in isolation. There was also a tariff, with the length of the 'ban' related to the seriousness of the offence and dependent on whether it was the first, second or third proven adjudication rather than on the basis of individual risk.
We repeat the recommendation.

Incentives and earned privileges

2.103 Officers should comment in wing files about prisoners' positive behaviour and refer to progress made in sentencing planning as part of the incentives and earned privileges decisions. (6.31)
Achieved. Wing files contained much more balanced comments than previously. There were plenty of entries relating to positive behaviour, but not as many positive or negative entries about sentence planning.

2.104 Prisoners should sign to confirm receipt of a written warning. (6.32)
Achieved. Prisoners signed for all behaviour warnings issued and were given a copy.

Catering

2.105 Healthy eating options should be promoted. (7.10)
Not achieved. There was still no pre-select menu and the daily published menu did not indicate healthy options. The only promotion of healthy eating was through a few pictures around the dining hall and a folder containing some articles on eating and health.
We repeat the recommendation.

2.106 The opportunity to record comments on the food should be advertised and made available in the dining room. (7.11)
Not achieved. There was no food comments book in the dining hall or any indication that one was available. A food comments book in the kitchen included one comment from 2009 and several from 2008.
We repeat the recommendation.

2.107 The reasons for the apparent dissatisfaction of black and minority ethnic prisoners with the food should be explored. (7.12)
Not achieved. No specific effort had been made through the prisoner consultative committee or the DREAT to explore the previously reported dissatisfaction of black and minority ethnic prisoners with the food. Two catering surveys had been completed in the previous year, but response rates had been poor, with only 35 prisoners completing the survey in January 2009 and eight in August 2009, and there was no specific targeting of black and minority ethnic prisoners to ascertain their views.
We repeat the recommendation.

2.108 More opportunity should be taken to promote cultural diversity through the catering department. (7.13)
Not achieved. Promotion of cultural diversity was limited to themed meals, four of which had

taken place in 2009. There had been some cooperation with the chaplaincy to provide food for the festivals of Eid and Baisakhi, but little consultation with other departments or through prisoner forums to promote cultural diversity through catering.
We repeat the recommendation.

2.109 Long-term prisoners should have facilities to allow them the opportunity to develop or retain cooking skills. (7.14)
Partially achieved. Facilities for prisoners to cook meals for themselves were unchanged and limited to microwaves and toasters. However, the education department ran full-time cookery skills courses over five weeks and these were popular and well attended.

Further recommendation

2.110 Long-term prisoners should be provided with improved facilities to cook their own meals on the residential units.

Prison shop

2.111 A shop system appropriate to the needs of prisoners in an open establishment should be introduced, including the opportunity to buy goods while on temporary release from the prison. (7.23)
Not achieved. The standard national canteen contract operated. Prisoners on ROTL for work, home leave or town visits were not routinely allowed to go shopping and property was checked on return to Leyhill. In exceptional circumstances, prisoners were allowed to buy goods after a governor's application.
We repeat the recommendation.

2.112 Black and minority ethnic prisoners should be consulted about the range of goods stocked. (7.24)
Not achieved. There had been no specific consultation with black and minority ethnic prisoners about the range of goods stocked.
We repeat the recommendation.

2.113 Prisoners should be able to buy from the prison shop within 24 hours of arrival. (7.25)
Not achieved. New arrivals were offered a reception pack and anyone arriving on or before Thursday could place a canteen order for collection the following Monday. Prisoners who arrived on Friday had to wait around nine days before receiving their canteen order.
We repeat the recommendation.

2.114 A selection of cheaper items should be included on the canteen list. (7.26)
Achieved. The canteen provider had changed and the current canteen list included a reasonable range of economy items.

Additional information

2.115 The prisoner consultative committee had completed a review of canteen provision in March 2010 and had suggested some changes, but had expressed concerns about the extent to which it could influence the choice of goods included on the canteen list. This concern was also raised by the Independent Monitoring Board. There had been some changes to the canteen list in 2009, but the procedure and rationale behind these had not been well communicated.

Further recommendation

2.116 A comprehensive survey of the shop provision should be completed in cooperation with the prisoner consultative committee and changes should be made as appropriate taking into account the needs of minority groups.

Strategic management of resettlement

2.117 An up-to-date needs analysis of the criminogenic and resettlement needs of prisoners at Leyhill should be completed to inform the development of the resettlement strategy. (8.12)
Not achieved. A full needs analysis had not been undertaken.
We repeat the recommendation.

2.118 The resettlement committee should meet regularly to provide strategic direction and to review progress with all service providers involved in delivering against the resettlement pathways. (8.13)
Not achieved. The reducing reoffending committee was scheduled to meet quarterly, but there had not been a meeting for seven months. Minutes showed only limited discussion of some resettlement issues, and pathway areas were often not discussed. For example, the minutes of April, July and October 2009 recorded no discussion of the children and families pathway.
We repeat the recommendation.

2.119 Prisoners should be consulted about the development of the resettlement strategy and services. (8.14)
Not achieved. There was no formal planned consultation with prisoners about the resettlement strategy and services.
We repeat the recommendation.

Offender management and planning

2.120 All prisoners serving 12 months or more should have an annual sentence plan review board. (8.25)
Not achieved. There were delays to initial sentence planning meetings and reviews, but the prison could not provide a figure of the extent or reasons for the delays.
We repeat the recommendation.

2.121 A clear system should be in place for assessing and addressing needs of prisoners expected to be at Leyhill for a short time. (8.26)
Not achieved. There was no system to identify and address the needs of prisoners who would be at Leyhill for a short time.
We repeat the recommendation.

2.122 All OASys assessments and reviews should be up to date. (8.27)
Not achieved. About 156 OASys were outstanding, including 81 from 2009 to date, 71 from 2008 and two each from 2006 and 2007. The pressure the offender management unit (OMU) was under meant OASys reviews were prioritised according to risk.
We repeat the recommendation.

2.123 The specific needs of lifers should be taken into consideration during induction, with particular arrangements to identify lifers who have become institutionalised and to help

them to settle into open conditions. (8.28)
Achieved. All prisoners serving an indeterminate sentence were allocated to a psychologist on arrival. The psychologist completed an assessment that included questions to identify and help address institutionalisation.

2.124 A minimum of two days a year should be designated to lifer events that aim to enable lifers to understand and engage with risk reduction and eventual reintegration. (8.29)
Not achieved. There were no events specifically for lifers.
We repeat the recommendation.

2.125 Any additional offence-related assessments or offending behaviour work for lifers should be identified and completed as soon as possible after arrival at Leyhill. (8.30)
Not achieved. Some life-sentenced prisoners, including those with 12 month reviews, waited too long for assessment and the opportunity to complete work. Many complained that new issues were identified that had not previously been raised as risk factors at previous prisons or by the Parole Board and this could delay their opportunity for release.
We repeat the recommendation.

Additional information

2.126 The OMU comprised a head of offender management and 7.5 full-time equivalent offender supervisors consisting of probation officers, two probation service officers (PSOs) and a discipline officer, managed by a senior probation officer. Administrative staff dealt with ROTL, home detention curfew (HDC), public protection procedures, court appearances, transfers and prisoners serving less than 12 months. The PSOs and discipline officer worked with men serving 12 months and more and carried caseloads of around 100 each. The probation officers worked with IPPs and high risk men and carried caseloads of around 45. Caseloads of 100 were too high to be managed effectively and all OMU staff were struggling to manage heavy workloads. There were delays to procedures such as ROTL and HDC, although the length of delay could not be identified.

2.127 In our groups and individual conversations, the overriding complaint from prisoners related to resettlement and offender management. They were frustrated by being unable to source information about their progress, which led to increased dissatisfaction and more applications to an already overwhelmed OMU. Several prisoners were confused about their position in relation to offending behaviour courses and ROTL. Prisoners had requested an OMU 'surgery' at which they could ask questions about their cases and general matters, but had been told there were insufficient resources. The MQPL undertaken in November 2009 highlighted similar complaints that the OMU 'was not efficient in processing applications for home leave, town visits and outside work'.

Further recommendations

2.128 Applications for home detention curfew and release on temporary licence should be processed within the expected timescale.

2.129 Staffing levels in the offender management unit should be increased to match the high case loads.

2.130 Senior managers should work to improve communication between the offender management unit and prisoners.

Resettlement pathways

2.131 There should be better promotion of reintegration services available to prisoners, including accommodation and debt and finance advice. (8.56)
Achieved. All prisoners were introduced to prisoners working in the advice centre who gave them information about the services available. A Citizens Advice worker also gave a presentation during induction and took referrals from the group as necessary.

2.132 An automatic pre-release referral should be made to the advice centre to discuss whether further assistance is required in setting up accommodation. (8.57)
Achieved. Prisoners were referred to the advice centre three months before their release date.

2.133 The criteria and process to undertake unsupervised outside employment and training opportunities should be simplified and communicated so that staff and prisoners fully understand it. (8.58)
Partially achieved. The criteria and process for outside working were set out in a useful booklet that explained the criteria for voluntary supervised placements and unpaid and paid work in the community. The guide said prisoners had to have addressed any offending behaviour before obtaining voluntary work. Many prisoners complained that they were prevented from getting ROTL until they had completed offending behaviour courses to address risk identified after their arrival at the prison. However, some staff said it was possible for prisoners to undertake community work while completing offender behaviour courses in the prison.

Further recommendation

2.134 Staff and prisoners should be clear about the circumstances in which it is possible to undertake voluntary work in the community while still waiting to complete offending behaviour courses.

2.135 Clear guidance should be provided about prisoners identified in OASys as 'high' or 'very high' risk in open prison and their opportunities for release on temporary licence. (8.59)
Achieved. Prisoners categorised as high risk were risk assessed and many were able to work out in community placements and so avoid being disadvantaged for parole consideration. A notice to governors dated November 2007 gave advice on the consideration of ROTL for high and very high risk prisoners. A subsequent undated notice to prisoners advised them that the approval of ROTL in such cases might involve them in the Sentinel project, providing focused enhanced monitoring of high risk prisoners in open conditions for six months.

2.136 The Sentinel project had been developed and was only run at Leyhill and involved prisoners working individually with a forensic psychologist to explore risk factors and ways of managing these. Regular reviews were carried out with the prisoner, his offender manager, offender supervisor and anyone else working with him in the prison or community, including his family. Weekly comment was sought from residential staff and monthly feedback from all others in contact with the prisoner about how he was managing, which the prisoner, psychologist and offender supervisor met monthly to discuss. At the end of the six months, the psychologist produced a report for the Parole Board outlining how risk had been managed during the monitoring period, with a recommendation to end or extend the monitoring.

2.137 The prison should aim to ensure that MAPPA consultation does not unduly delay release on temporary licence decisions. (8.60)
Achieved. All prisoners were risk assessed by a multidisciplinary ROTL panel, and offender supervisors were aware of the need to ensure speedy responses to MAPPA meetings.

2.138 Prisoners should be assisted to open bank accounts at the earliest opportunity. (8.61)
Partially achieved. All prisoners had previously been able to open a bank account, but the bank involved had recently withdrawn the facility. Managers were negotiating with another bank to provide the service.

2.139 Psychological input to identify and reduce institutionalisation in long-term prisoners should be more widely available. (8.62)
Achieved. Such work was provided when identified as an issue.

2.140 The establishment's substance misuse committee should forge strategic links with local drug action teams and drug intervention programmes. (8.73)
Achieved. The substance misuse team had established strong links with community partners and support networks in the local area and nationally. CARAT staff attended all drug strategy meetings and encouraged community substance misuse groups, including local drug action teams and drug intervention programmes, to work with the prison and prisoners at every level. CARAT staff arranged for prisoners to be admitted to rehabilitation units on release where appropriate and community drug workers regularly visited the prison to see existing and new clients.

2.141 The drug and alcohol strategy's action plan should include demand reduction measures. (8.74)
Achieved. The strategy was reviewed every month at the drug strategy meeting and included a number of demand reduction measures surrounding the CARAT service and the imminent implementation of IDTS.

2.142 CARATs and short duration programme clients should have access to a dedicated counselling service. (8.75)
Achieved. Prisoners had access to counselling services through the RMN, chaplaincy and two dedicated counsellors specialising in sexual abuse and cognitive behaviour and psychotherapy. The waiting list for the counsellors was reasonable.

2.143 A clearer distinction should be made between voluntary and compliance testing. (8.76)
Not achieved. While there were separate compacts for voluntary and compliance testing, the policy remained unclear on how distinct the arrangements were for dealing with positive tests for each.
We repeat the recommendation.

Contact with the outside world

2.144 All telephones should be maintained in full working order. (3.71)
Achieved. All telephones were in working order.

2.145 Prisoners on external placements should be allowed to use mobile telephones to contact family and friends. (3.72)
Not achieved. Prisoners could not take personal mobiles with them on external placements and were given a prison issue telephone that restricted calls to the prison only.
We repeat the recommendation.

2.146 Visitors indicated by the drug dog should not be turned away unless this is justified by additional security intelligence. (3.73)
Achieved. Visitors indicated by the drug dog were no longer turned away.

2.147 A properly equipped visitors' centre should be provided. (3.74)
Not achieved. There was still just an unstaffed waiting room that opened only 25 minutes before the start of visits. The vending machine had been out of order for over a year, but visitors could get refreshments once in the visits room.
We repeat the recommendation.

2.148 Restrictions in the visits room for child protection reasons should be based on individual risk assessment. (3.75)
Achieved. Restrictions in the visits room for child protection reasons were managed according to individual risk assessment.

2.149 The play area should be supervised by trained staff and the toys and furniture provided should be safety checked. (3.76)
Not achieved. The play area was still supervised only when volunteers were available and some toys presented a choking hazard to young children.
We repeat the recommendation.

2.150 Prisoners should not have to wear prison-issue clothes in the visits hall. (3.77)
Not achieved. Prisoners had to wear blue jeans and a prison issue shirt in the visits room.
We repeat the recommendation.

2.151 Prisoners who do not receive visits should be able to exchange unused visiting orders for extra telephone credit. (8.92)
Achieved. Prisoners could exchange unused visiting orders for telephone credit and, although a number we spoke to were unaware of this, about 30 prisoners a month did so. Information about this was not included in the prisoner information booklet.

Housekeeping point

2.152 Information about the exchange of visiting order for telephone credit should be included in the prisoner information booklet.

2.153 Prisoners identified as carers should be provided with free letters and telephone calls to maintain contact with their children. (8.93)
Not achieved. A notice dated September 2007 informed staff about the availability of pre-planned telephone calls for carers by application. However, none of the prisoners we spoke to were aware of this and it was not included in the information booklet.
We repeat the recommendation.

2.154 Provision should be made for prisoners to receive incoming telephone calls from children or to deal with arrangements for them. (8.94)
Not achieved. Prisoners could not receive calls from their children or to deal with arrangements for them.
We repeat the recommendation.

2.155 The confidential information telephone line should be responded to daily. (8.95)
Achieved. A notice in the visits waiting room advised that the confidential telephone line was

out of order and gave an alternative number. This connected with gate staff and was answered immediately when we rang.

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.

Main recommendations — To the governor

3.1 Managers should develop a strategy to improve relationships between staff and prisoners, including regular open forums with prisoners to identify improvements, with regular feedback to all staff and prisoners. (2.3)

3.2 A new resettlement strategy should be agreed to reflect the specific needs of the different groups at Leyhill and describe how those needs will be met. (2.8)

Recommendation — To NOMS

Substance use

3.3 Prisoners who have recently completed detoxification programmes should not transfer to Leyhill until they have had time to consolidate their drug free state. (2.40)

Recommendations — To the governor

Courts, escorts and transfers

3.4 Prisoners transferring from local prisons should be given at least 24 hours notice of their move. (2.11)

3.5 Prisoners should be allowed to disembark from vans immediately on arrival at Leyhill. (2.14)

First days in custody

3.6 The reception area should be improved, with a holding room with sufficient seating, better access to toilets and appropriate information about what to expect at Leyhill. (2.15)

3.7 Prisoners arriving from closed prisons should not be required to undergo a strip search unless there is a clear basis for suspicion. (2.16)

3.8 An induction officer should interview all new receptions privately on the day of their arrival and explain and help complete the required documentation when necessary. (2.17)

3.9 The initial induction presentation should be improved and delivered by trained staff. (2.18)

Residential units

3.10 The criteria for selecting prisoners for C wing should be published to prisoners and should be based on prisoners' progress and achievements during their sentence. (2.19)

3.11 Shower areas should be deep cleaned and refurbished where necessary. (2.21)

3.12 Prisoners with disabilities who need support should have paid prisoner helpers overseen by staff. (2.22)

3.13 The facilities on B wing should be adapted to ensure that they meet the needs of prisoners with disabilities. (2.23)

Staff-prisoner relationships

3.14 The prisoner consultative committee should identify action points for named individual managers who should attend the next meeting to report progress or provide a written report outlining action taken. (2.26)

3.15 Staff should be encouraged to move informally among prisoners when they are on the wings. (2.27)

3.16 The need for additional checks on prisoners throughout the night should be reviewed and those that do take placer should be carried out without unnecessarily disturbing prisoners' sleep. (2.25)

Personal officers

3.17 Wing managers should ensure that personal officers introduce themselves to prisoners and record this in their records along with progress against resettlement objectives and any issues of concern. (2.30)

3.18 Personal officers should attend sentence planning boards. (2.32)

Self-harm and suicide

3.19 Non-residential staff with a knowledge of individual prisoners, such as psychology and workplace managers, should be involved in their ACCT management. (2.34)

3.20 Staff from other disciplines such as the CARAT service, the chaplaincy and psychology should be trained to act as case managers to provide a more multidisciplinary approach. (2.35)

Applications and complaints

3.21 The return of applications should be recorded, tracked and monitored by managers. (2.37)

Legal rights

3.22 Information about the role of the legal services officers and the services available should be better promoted, given to prisoners during induction and included in the prisoner induction book. (2.38)

Diversity

3.23 A diversity policy should be produced in consultation with prisoners that includes all anti-discrimination legislation and outlines how the needs of all minority groups will be met. (2.41)

3.24 A forum should be established for groups such as health services and residential staff to meet to case-manage the special needs of older prisoners and those with disabilities. (2.43)

3.25 All older prisoners and prisoners with disabilities should be assessed to indentify specific needs and a regularly reviewed care plan produced to manage them. (2.45)

3.26 Wing staff should be aware of the needs of and take responsibility for prisoners who require assistance in an emergency. (2.46)

Race equality

3.27 Where relevant data indicate under or over-representation of black and minority ethnic prisoners in any area, the reasons for this should be investigated and appropriate action taken to address identified issues where necessary. (2.48)

3.28 Prisoners from black and minority ethnic backgrounds should have the opportunity to meet regularly and directly with prison managers to discuss concerns. (2.49)

3.29 Links should be made with outside community groups to improve the promotion of race relations within the prison. (2.51)

3.30 All prisoners who report a racist incident should receive a written response that appropriately addresses the matter raised. (2.53)

Foreign national prisoners

3.31 The foreign national policy should contain an action plan based on identified need. (2.54)

3.32 The foreign national liaison officer should have a job description and receive the necessary time and training for the role. She should introduce herself to all foreign national prisoners. (2.55)

3.33 There should be regular formal consultation with foreign national prisoners, with identified issues brought to the diversity and race equality action team committee for further discussion and action where necessary. (2.57)

3.34 Foreign national prisoners should be interviewed on arrival to identify their status and any specific needs. They should receive appropriate information about the regimes and services available to them in a language they can understand. This should be recorded. (2.58)

3.35 Accurate records should be kept of staff and prisoners able to speak languages other than English and prepared to work as translators. (2.59)

3.36 Issues raised and discussed at foreign national meetings and any action taken as a result should be recorded. (2.60)

Health services

3.37 All resuscitation equipment held in health care should be checked at least weekly and after use and a complete record maintained in the department. (2.65)

3.38 The new pharmacy room should be brought into use. (2.68)

3.39 The visiting pharmacy technicians should check stocks at least weekly and excessive stock should be removed. (2.71)

3.40 A written in possession policy should be produced and adopted by the medicines and therapeutics committee to include documented risk assessment to determine the length of treatment that can be supplied in possession for each patient. (2.72)

3.41 All health care staff should sign and agree the standard operating procedures for pharmacy services. (2.74)

3.42 Pharmacy-led clinics should be introduced. (2.76)

3.43 All prisoners should have equal access to dental treatment. (2.78)

Learning and skills and work activities

3.44 The take-up of skills for life programmes against identified need should be monitored. (2.80)

3.45 The accuracy of achievement data collection should be improved to measure whether prisoners' needs are being met and they are achieving accredited qualifications. (2.81)

3.46 The amount and frequency of education classes should be extended to give prisoners more opportunity to develop vocational and personal development skills. (2.85)

3.47 The delivery of the education provision should be improved to make it more efficient and reduce duplication. (2.86)

3.48 The collection and accuracy of prisoner achievement data should be improved to allow better monitoring of prisoners' achievement of qualifications. (2.87)

3.49 The measuring and monitoring of prisoners' personal achievement of employability skills should improve to enable prisoners' to evidence improvements in skills to help gain employment on release. (2.88)

3.50 Work place supervisors should ensure prisoners remain active and develop good work place skills that will help them find employment on release. (2.89)

Physical education and health promotion

3.51 The free weights area in the gym should be improved and expanded to meet the needs of the prison population. (2.90)

3.52 The indoor sports hall should be extended to meet demand. (2.92)

Time out of room

3.53 The time prisoners are allowed to associate off the wings during the evening should be extended during the summer. (2.94)

Security and rules

3.54 Security procedures should be proportionate for an open prison. Where the national security framework allows discretion, only baselines appropriate for an open prison should be applied. (2.98)

Discipline

3.55 Adjudicators should consider evidence in cases of possession of mobile telephones before deciding whether to refer such charges to the independent adjudicator. (2.101)

3.56 There should be a clearly publicised policy about reviewing risk for release on temporary licence (ROTL) following findings of guilt at adjudication. Decisions to suspend access to ROTL should be taken by a risk management board based on risk alone and not used as an additional sanction, and should be subject to routine monitoring including on the basis of ethnicity. (2.102)

Catering

3.57 Healthy eating options should be promoted. (2.105)

3.58 The opportunity to record comments on the food should be advertised and made available in the dining room. (2.106)

3.59 The reasons for the apparent dissatisfaction of black and minority ethnic prisoners with the food should be explored. (2.107)

3.60 More opportunity should be taken to promote cultural diversity through the catering department. (2.108)

3.61 Long-term prisoners should be provided with improved facilities to cook their own meals on the residential units. (2.110)

Prison shop

3.62 A shop system appropriate to the needs of prisoners in an open establishment should be introduced, including the opportunity to buy goods while on temporary release from the prison. (2.111)

3.63 Black and minority ethnic prisoners should be consulted about the range of goods stocked. (2.112)

3.64 Prisoners should be able to buy from the prison shop within 24 hours of arrival. (2.113)

3.65 A comprehensive survey of the shop provision should be completed in cooperation with the prisoner consultative committee and changes should be made as appropriate taking into account the needs of minority groups. (2.116)

Strategic management of resettlement

3.66 An up-to-date needs analysis of the criminogenic and resettlement needs of prisoners at Leyhill should be completed to inform the development of the resettlement strategy. (2.117)

3.67 The resettlement committee should meet regularly to provide strategic direction and to review progress with all service providers involved in delivering against the resettlement pathways. (2.118)

3.68 Prisoners should be consulted about the development of the resettlement strategy and services. (2.119)

Offender management and planning

3.69 All prisoners serving 12 months or more should have an annual sentence plan review board. (2.120)

3.70 A clear system should be in place for assessing and addressing needs of prisoners expected to be at Leyhill for a short time. (2.121)

3.71 All OASys assessments and reviews should be up to date. (2.122)

3.72 A minimum of two days a year should be designated to lifer events that aim to enable lifers to understand and engage with risk reduction and eventual reintegration. (2.124)

3.73 Any additional offence-related assessments or offending behaviour work for lifers should be identified and completed as soon as possible after arrival at Leyhill. (2.125)

3.74 Applications for home detention curfew and release on temporary licence should be processed within the expected timescale. (2.128)

3.75 Staffing levels in the offender management unit should be increased to match the high case loads. (2.129)

3.76 Senior managers should work to improve communication between the offender management unit and prisoners. (2.130)

Resettlement pathways

3.77 Staff and prisoners should be clear about the circumstances in which it is possible to undertake voluntary work in the community while still waiting to complete offending behaviour courses. (2.134)

3.78 A clearer distinction should be made between voluntary and compliance testing. (2.143)

3.79 Prisoners on external placements should be allowed to use mobile telephones to contact family and friends. (2.145)

3.80 A properly equipped visitors' centre should be provided. (2.147)

3.81 The play area should be supervised by trained staff and the toys and furniture provided should be safety checked. (2.149)

3.82 Prisoners should not have to wear prison-issue clothes in the visits hall. (2.150)

3.83 Prisoners identified as carers should be provided with free letters and telephone calls to maintain contact with their children. (2.153)

3.84 Provision should be made for prisoners to receive incoming telephone calls from children or to deal with arrangements for them. (2.154)

Housekeeping point

Resettlement pathways

3.85 Information about the exchange of visiting order for telephone credit should be included in the prisoner information booklet. (2.152)

Appendix I: Inspection team

Michael Loughlin	Team leader
Joss Crosbie	Inspector
Paul Fenning	Inspector
Martin Owens	Inspector
Bridget McEvilly	Health care inspector
Sheila Willis	Ofsted

Appendix II: Prison population profile[1]

Population breakdown by:

Status	18–20 yr olds	21 and over	%
Sentenced		519	98.3
Recall		9	1.7
Convicted unsentenced			
Remand			
Civil prisoners			
Detainees			
Total		528	100

Sentence	18–20 yr olds	21 and over	%
Unsentenced		0	
Less than 6 months		7	1.3
6 months to less than 12 months		14	2.7
12 months to less than 2 years		37	7
2 years to less than 4 years		93	17.7
4 years to less than 10 years		219	41.5
10 years and over (not life)		38	7.2
ISPP		16	1.1
Life		104	19.7
Total		528	100

Age	Number of prisoners	%
Please state minimum age		
Under 21 years		
21 years to 29 years	125	23.7
30 years to 39 years	172	32.6
40 years to 49 years	115	21.8
50 years to 59 years	79	14.9
60 years to 69 years	25	4.7
70 plus years	12	2.3
Please state maximum age	81	
Total	528	100

Nationality	18–20 yr olds	21 and over	%
British		502	95.1
Foreign nationals		26	4.9
Total		528	100

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

Security category	18–20 yr olds	21 and over	%
Uncategorised unsentenced			
Uncategorised sentenced			
Cat A			
Cat B			
Cat C			
Cat D		528	100
Other			
Total		528	100

Ethnicity	18–20 yr olds	21 and over	%
White			
British		385	72.9
Irish		1	0.2
Other white		26	4.9
Mixed			
White and black Caribbean		8	1.5
White and black African		2	0.4
White and Asian		2	0.4
Other mixed		2	0.4
Asian or Asian British			
Indian		15	2.8
Pakistani		8	1.5
Bangladeshi		1	0.2
Other Asian		12	2.3
Black or black British			
Caribbean		32	6.1
African		20	3.8
Other black		10	1.9
Chinese or other ethnic group			
Chinese		1	0.2
Other ethnic group		2	0.4
Not stated		1	0.2
Total		528	100

Religion	18–20 yr olds	21 and over	%
Baptist			
Church of England		150	28.4
Roman Catholic		74	14
Other Christian denominations		14	2.7
Muslim		50	9.5
Sikh		7	1.3
Hindu		4	0.8
Buddhist		16	3
Jewish		1	0.2

Other		42	7.9
No religion		170	32.2
Total		528	100

Sentenced prisoners only

Length of stay	18–20 yr olds		21 and over	
	Number	%	Number	%
Less than 1 month			58	11
1 month to 3 months			137	25.9
3 months to 6 months			116	21.9
6 months to 1 year			114	21.6
1 year to 2 years			79	15
2 years to 4 years			15	2.8
4 years or more			9	1.7
Total			528	100

Unsentenced prisoners only

Length of stay	18–20 yr olds		21 and over	
	Number	%	Number	%
Less than 1 month				
1 month to 3 months				
3 months to 6 months				
6 months to 1 year				
1 year to 2 years				
2 years to 4 years				
4 years or more				
Total				

Main offence	18–20 yr olds	21 and over	%
Violence against the person		56	10.61
Sexual offences		67	12.69
Burglary		35	6.63
Robbery		40	7.58
Theft and handling		25	4.73
Fraud and forgery		53	10.04
Drugs offences		123	23.30
Other offences		123	23.30
Civil offences		0	0
Offence not recorded/holding warrant		6	1.14
Total		528	100