Report on an unannounced short follow-up inspection of

HMP & YOI Low Newton

20 – 23 April 2009

by HM Chief Inspector of Prisons

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Introduction

Low Newton is a women's local prison near Durham. Like all such prisons, it holds a large proportion of women, including young adults, who are vulnerable, self-harming or mentally ill. Over three-quarters of the women there had a history of problem drug or alcohol use. In addition, Low Newton also has to care for a very small number of women who require increased levels of security, and around 12 women who are receiving treatment for severe personality disorders.

This is a difficult and challenging population mix. It is therefore very creditable that Low Newton, which was a high performing prison at the time of the last inspection, had continued to improve in many areas. It had managed to implement two-thirds of our recommendations, including all our main recommendations, wholly or in part.

Low Newton remained a safe and calm environment, in spite of the vulnerability of many women, and the challenging behaviour of others. Recorded levels of self-harm had increased, and at any time one in 10 of the women were being supported under suicide and self-harm procedures. Lessons were learned from serious near-death incidents, and there was a range of intervention strategies, which were not yet well-integrated into care planning. Violence reduction and anti-bullying procedures were well managed. We were concerned that the use of force had increased considerably, and some appeared to be connected to self-harm incidents, and the arrangements for monitoring this and the use of special accommodation needed improvement.

Relationships between staff and prisoners continued to be good overall, though this was not yet reflected in proactive personal officer work. The environment was of good standard, though some women still had to share cells, and we did not believe it appropriate to house young adults in wings with long-term adult women. Race, diversity and support for foreign nationals had progressed, with more training and better services. Healthcare had also improved considerably, with a good level of primary, dentistry and mental health provision – though the limited counselling service and day care support could not meet demand.

The new national core day, implemented last year, had reduced time out of cell at Low Newton, from an average 10 hours a day to nine. This had also put pressure on some activities, for example physical education, and regime clashes significantly reduced opportunities for outdoor exercise. Nevertheless, time out of cell was still good for a local prison, and the relevance and quality of some of the education and work provided had improved, with better links to employability and more available for longer-sentenced women. In spite of some improvements, there was still insufficient vocational training.

Resettlement had also developed well, particularly for women in scope of offender management, with good relationships with external offender managers. Some of the resettlement pathways, including work with children and families, had improved, though it would benefit from a family support worker. The Primrose project, for women with severe personality disorders and complex needs, had started well, and women were integrated into the main population. Remanded and short-sentenced women still had no formal custody plans, however, and work with life-sentenced prisoners needed more strategic management.

This is another encouraging report on Low Newton, which has continued to provide a positive environment for the women it holds. Inevitably, there remain some concerns, particularly in relation to women and young adults at risk of self-harm and the need for more mental health and counselling support. It is also disappointing that the new core day has reduced the

previously excellent amount of time out of cell. However, it is very commendable that an already well-performing prison has continued to make improvements in all our key areas, in spite of the challenges posed by its increasingly diverse and needy population.

Anne Owers June 2009
HM Chief Inspector of Prisons

Fact page

Task of the establishment
HMP/YOI Low Newton is a closed women's prison, holding convicted and unconvicted adult prisoners and young offenders. Occasionally, juveniles are held, but only overnight. It serves the courts from the Scottish Borders to North Yorkshire across to Cumbria.

Prison Service operational area
North East Area

Number held
270 on 20 April 2009

Certified normal accommodation
314

Operational capacity
336

Last full inspection
April 2006

Brief history
Low Newton is situated on the outskirts of Durham City and was built in 1965 as a small remand centre for men and women. Additional accommodation was added in 1975. In 1998, it was re-roled to a women's prison. Low Newton now houses a DSPD unit for up to 12 prisoners and has been designated secure accommodation for holding restricted status women.

Description of residential units
There are five traditionally built wings: Aykley, Bede, Cuthbert, Dunelm and Elvet. Finchale wing was one of the first of the ready-to-use type. Giles and Induction wings were added later. The residential units are all cellular. All cells have in-cell television and the wings are equipped with laundry facilities.

Section 1: Healthy prison assessment

Introduction

HP1 All inspection reports include a summary of an establishment's performance against the model of a healthy prison. The four criteria of a healthy prison are:

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

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

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

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

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

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

HP3 This Inspectorate conducts unannounced follow-up inspections to assess progress against recommendations made in the previous full inspection. Follow-up inspections are proportionate to risk. Short follow-up inspections are conducted where the previous full inspection and our intelligence systems suggest that there are comparatively fewer concerns. Sufficient inspector time is allocated to enable inspection of progress and, where necessary, to note additional areas of concern observed by inspectors. Inspectors draw up a brief healthy prison summary setting out the progress of the establishment in the areas inspected. From the evidence available they also concluded whether this progress confirmed or required

amendment of the healthy prison assessment held by the Inspectorate on all establishments but only published since early 2004.

Safety

HP4 In 2006, Low Newton was performing reasonably well against this healthy prison test. Of the 33 recommendations in this area, 16 were assessed as achieved, six partially achieved, 10 not achieved and one was no longer relevant. We have made 16 further recommendations.

HP5 Although some women still spent long days at court, video links were now well used. Women were not given any advance information about what would happen when they arrived at Low Newton. They still travelled on vans with men and often arrived late so there was not always time to complete full reception procedures. The reception area was clean, staff were helpful and women said they were well treated there.

HP6 An informative first night interview was completed in reception, but the quality of first night support depended on what time women arrived. Many women who had arrived late said they had been locked up without being told how to use the cell bell or what would happen the next day. All women were given some basic written information the day after they arrived. The induction programme still did not fully occupy prisoners, but they were not locked in their cells when not involved in formal induction sessions. Women withdrawing from drugs on arrival were now accommodated separately, but mixed with other prisoners in medication queues.

HP7 The prison remained a safe and calm environment. Although the team was small, safer custody work was given a good profile, including discussions at prisoner consultative council meetings. Incidents of conflict were thoroughly analysed at the safer custody meeting and most involved disruptive behaviour associated with difficult relationships. The formal anti-bullying strategy was well used and an average of eight women were subject to monitoring each month. Reviews were regular, but there was too much focus on a punitive second stage with little engagement and no effective interventions to tackle underlying causes. New procedures were planned.

HP8 As in most women's local prisons, levels of self-harm were high, with an average of almost 80 incidents each month. This was a significant increase from around 48 at the previous inspection, even taking into account the growth in the population. There had been no self-inflicted death since 2004 despite the very risky population, but there had been a number of very serious near-death incidents. Efforts were made to learn lessons from investigations and a continuous improvement plan had been developed. It was usual for around 10% or more of the population to be on open ACCT documents. Staff from a range of disciplines were ACCT assessors, but reviews usually just involved officers. Safer cells were often used for women who self-harmed, but use of these cells and protective clothing was not monitored.

HP9 Use of force and segregation had increased considerably. Monthly figures were examined, but were not monitored or analysed over time. Some of the increase in use of force appeared to correlate to the increase in incidents of self-harm. There were no designated special or unfurnished cells, but there was a discrepancy between national monthly use of force returns, which indicated some use of special cells, and the local monitoring data, which indicated no use. The records examined suggested that safer cells were sometimes used as special accommodation without appropriate monitoring or safeguards. Two restricted status women were now held in the prison

and the increased security requirements had been introduced without impinging on the general routine.

HP10 At less than 6% against a target of 9.1%, the mandatory drug testing positive rate was relatively low. However, when the figure included buprenorphine (Subutex), the rate rose to 10.9%. Plans for the implementation of the integrated drug treatment system were well under way and the service was due to begin in July 2009.

HP11 On the basis of this short follow-up inspection, we considered that the prison was still performing reasonably well against this healthy prison test.

Respect

HP12 In 2006, Low Newton was performing reasonably well against this healthy prison test. Of the 51 recommendations in this area, 33 were assessed as achieved, 10 partially achieved, seven not achieved and one was no longer relevant. We have made 21 further recommendations.

HP13 Some women in groups said a minority of officers did not always treat them properly and were unhelpful, but most said relationships with the majority of staff were good. The interactions we observed were positive and relaxed, with much use of first names. All the women we asked knew who their personal officer was, but there were mixed opinions about how helpful they were. Personal officer work was not very proactive and the scheme was about to be re-launched. Most wing files had regular entries, but not necessarily from the allocated personal officer. Entries mostly continued to concentrate on observed behaviour, with little about sentence plan targets or other resettlement issues.

HP14 The prison was very clean and the accommodation mostly of a good standard. Improved laundry facilities had been provided and there were two well adapted cells for women with physical disabilities. Young adult women had recently been dispersed throughout the prison and we questioned whether it was appropriate to hold them, particularly those serving short sentences, on the longer-term wings.

HP15 Women in groups were still unhappy about the food, but the little we tried was satisfactory, although there were too many packed meals. Women were consulted about the food and the catering manager had made some changes as a result. New arrivals could still wait some time to place a shop order, although reception packs could be bought. Women were now allowed some items in jars and tins and fresh fruit, but some fresh items were available only to women on wings with a refrigerator. There was only a limited range of specialist hair products for black women.

HP16 The chaplaincy team continued to play an active part in prison life and ran a range of group activities. Women said they were well supported by chaplains and a community chaplain provided additional support to some women after release.

HP17 Race relations appeared reasonably good and a race action plan had been developed. Black and minority ethnic women were consulted about race impact policy assessments and race representatives were well involved in race equality action team meetings. Training had received some recent priority and the proportion of staff who had received diversity training had increased from 18% to 74%. Events to promote

diversity awareness had taken place across the prison. Racist incident reports were well investigated.

HP18 The foreign national strategy was based on a needs analysis and a new policy was awaiting area manager approval. Services and support for foreign national prisoners had improved and were developing well. All eligible women could get telephone calls home and there was more general information available in languages other than English.

HP19 Health services had generally improved and there was good access to primary services, with innovative use of a telephone appointment line for prisoners. Improvements had been made to the fabric of the dental surgery and waits for routine dental treatment were reasonable. A good range of clinics was run by suitably qualified nurses, with plans for further staff training. Clinical records were now electronic, accurate and appropriately kept. Women did not have direct access to a pharmacist, but pharmacy arrangements were better. Mental health services were mostly satisfactory, but there were no day care services and counselling provision was limited. No general mental health awareness training for staff was provided. Discharge planning was well organised and healthcare staff were appropriately involved in sentence planning where necessary.

HP20 On the basis of this short follow-up inspection, we considered that the prison was still performing reasonably well against this healthy prison test.

Purposeful activity

HP21 In 2006, Low Newton was performing well against this healthy prison test. Of the 13 recommendations in this area, two were assessed as achieved, nine partially achieved and two not achieved. We have made 13 further recommendations.

HP22 Time out of cell was relatively good compared to some other women's local prisons, but the introduction of a national core day had put pressure on the delivery of some activities and cut the overall time out of cell. There was not enough opportunity for exercise in the open air, which was offered first thing in the morning when many women also needed to collect medications, clean cells and take showers. Access to association rooms on some wings was regularly limited because medications were issued on the main corridor at that time. Staffing difficulties in the previous year had led to the cancellation of a number of association periods.

HP23 There had been some improvement in education. The education and vocational training provision was well managed, with good links between the prison and the education provider. Data were now well used to improve the quality of what was delivered and effectively informed the self assessment process. Progress reviews had improved, but short-term target setting remained weak. The quality of most teaching appeared good and there were some good achievements in education. Library services were well promoted and the learning shop was effectively used to extend learning to some women who might otherwise not be involved.

HP24 There were enough activity places and work to keep all women active and very few women were unemployed. Education, work and training opportunities for women with longer sentences had improved. A range of training courses had been developed and

recently introduced, with a good focus on employment skills such as in retail and hospitality.

HP25 Women had reasonably good access to physical education, but a number of gym sessions had been cancelled in the previous months due to staff shortages elsewhere in the prison. The gym facilities were satisfactory, but the outside sports area was in poor condition and consequently under-utilised. The cardiovascular equipment area was small and cramped.

HP26 On the basis of this short follow-up inspection, we considered that the prison was still performing well against this healthy prison test.

Resettlement

HP27 In 2006, Low Newton was performing reasonably well against this healthy prison test. Of the 31 recommendations in this area, 15 were assessed as achieved, three partially achieved, 12 not achieved and one was no longer relevant. We have made nine further recommendations.

HP28 There was an up-to-date reducing reoffending strategy and the resettlement policy committee met regularly to set strategic direction. The resettlement pathways approach was being developed, including those pathways specific to women.

HP29 An offender management unit had been established and prisoners were introduced to the system at an early stage. All sentenced women were allocated an offender supervisor and an initial assessment of housing and family needs was completed. All women on remand were seen to assess their suitability for bail and for an initial assessment of their needs, but there were no formal custody plans for remand or short-term prisoners to ensure assessed needs were met. Just over 60 women were formally in scope for offender management and there was good involvement of offender managers from the community.

HP30 There were 23 life-sentenced prisoners and 13 women serving indeterminate sentences for public protection. Some now lived on I wing where they had en suite showers, but there were no cooking facilities as on F wing, where the rest of the life-sentenced and long-term prisoners were held. There was still no strategic group to oversee lifer work and no regular consultation with lifers as a group. There were no staff on the lifer wings up to date with current lifer training, but some well focused lifer days had been held.

HP31 A range of programmes was run including enhanced thinking skills, P-ASRO and FOR. The Primrose project for women with severe personality disorders and very complex needs had begun and appeared to have made a good start. The women involved were integrated into the general population and lived with other long-term prisoners on F wing, which avoided labelling them as different.

HP32 There were not enough telephones on some wings and not all could be used in private. The visitors' centre provided some good support and information to visitors, but visits did not start at the advertised time. The visits play area was supervised and a range of children and family days was run and much appreciated. More support had been provided for women and families, particularly women whose children were to be adopted, but there was still no family support worker.

HP33 The drug strategy was updated annually and included detailed action plans and performance measures. Clinical and other drug workers had good joint working relationships and facilities had improved. Alcohol services were still too limited to meet need.

HP34 On the basis of this short follow-up inspection, we considered that the prison was still performing reasonably well against this healthy prison test.

Section 2: Progress since the last report

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

Main recommendation

To the Director General of NOMS

2.1 There should be a national protocol governing the transfer of at risk women, which should include discussion with healthcare managers and those providing other support, at both prisons, as well as consideration of the effect of isolation from family and community support. (HP44)
Achieved. The published national women's prisons allocation strategy, revised in March 2009, included these requirements.

Main recommendations

To the governor

2.2 The assessment, care in custody and teamwork procedures should involve more staff from a range of disciplines as assessors and case managers and reviews should be multidisciplinary with a key worker involved to provide consistency. (HP38)
Partially achieved. Some aspects of assessment, care in custody and teamwork (ACCT) procedures were more multidisciplinary. Notably, many staff from different disciplines were ACCT assessors, including nurses, psychology staff and chaplains. However, only senior officers acted as case managers. They were responsible for ensuring that appropriate staff were present at reviews. Records showed that many reviews took place with only the senior officer and an officer present when the ACCT document indicated that other staff could have made a useful contribution, particularly where the prisoner was on medication or known to the counselling, assessment, referral, advice and throughcare (CARAT) service.

2.3 There was not always continuity of case manager. Central detailing and allocation of staff did not always ensure that case managers were allocated to the residential wings where reviews were taking place of cases for which they were responsible (see also paragraph 2.64). There was still no concept of a key worker taking an active role in the individual care of a prisoner subject to ACCT procedures.

Further recommendation

2.4 Reviews should be chaired by consistent case managers and key workers should provide continuity of care for women identified as at risk.

2.5 The location and services for detoxifying women should be reviewed, taking specialist advice, to ensure they are held appropriately in safe accommodation and have access to a second stage detoxification facility and a supportive regime during and after detoxification with input from the CARAT service. (HP39)
Partially achieved. The detoxification unit had been relocated to E wing and co-located with the CARAT service, but there was still no secondary detoxification facility. The unit had been resourced for the planned implementation of the integrated drug treatment system (IDTS) later in the year.

Further recommendation

2.6 Second stage detoxification facilities should be introduced.

2.7 There should be a formal review of race relations in consultation with black and minority ethnic women prisoners, and an action plan for improvement should be developed and implemented that enables staff to tackle discrimination, challenge racism and promote diversity. (HP40)
Achieved. An action plan for improvement had been developed and progress on implementation was reviewed regularly by the race equality action team (REAT) and the senior management team (SMT). Black and minority ethnic women prisoners had been consulted through impact assessment focus groups. Prisoner representatives met regularly and identified ways in which women could raise diversity issues. Seventy-four per cent of staff across all disciplines had received diversity training. This was a significant improvement, with 215 staff trained since May 2008. Events to promote diversity awareness included a cultural entertainment evening on one wing and occasional themed menu nights with foreign national women involved in preparing the food. Diversity was also actively promoted through education.

2.8 Efforts should be made to improve the quality of the food, taking advice from a nutritionist and regularly consulting women prisoners on the quality and variety of the menu, with particular attention to the needs of minority groups. (HP41)
Achieved. Women in our groups were still negative about the food, but food we sampled was satisfactory. A nutritionist from County Durham and Darlington NHS Foundation Trust had reviewed the menus in 2007 and the catering department had acted on the constructive feedback provided. However, there was no ongoing involvement by a nutritionist. The catering manager attended prisoner consultative council meetings and carried out surveys and there was evidence that action was taken following consultation exercises. The comments book in the dining hall was frequently used and contained a balance of positive and negative comments. Religious and medical special diets were catered for. (See also section on catering.)

Further recommendation

2.9 The menus should be subject to the ongoing scrutiny of a nutritionist.

2.10 Better quality work and training opportunities should be introduced to meet the needs of life-sentenced and other longer-term women at Low Newton. (HP42)
Achieved. Opportunities for life-sentenced prisoners and those serving longer sentences had improved. Access was available to vocational courses, many of which now provided opportunities for progression to higher levels. There was better support for prisoners wanting to study higher-level courses such as the Open University and prisoners were supported and helped with their higher education studies in the learning shop. The adult learning support assistant level 2 qualification course had been introduced specifically for women serving longer sentences to help them develop mentoring and presentation skills, and prisoner mentors very effectively helped tutors to deliver learning sessions.

2.11 The resettlement policy should include practical strategies to provide more family support to allow mothers to maintain contact with their children and to help with children's legal proceedings. (HP43)
Achieved. The resettlement pathway lead for children and families held quarterly meetings attended by representatives from a range of voluntary organisations. Current provision included weekly child–parent visits and monthly extended visits between mothers and their children. NEPACS provided an induction session on maintaining family ties and supported families visiting the prison. Barnardos had conducted research into the needs of women at Low Newton and those caring for prisoners' children. 'After Adoption' worked in the prison with mothers post adoption. There was no family support worker (see paragraph 2.99) and release on temporary licence (ROTL) had not been used to support family ties.

2.12 Agreed first night procedures should be introduced to provide consistent information to newly arrived women. (HP 45)
Partially achieved. A comprehensive first night interview was undertaken with all new arrivals by a first night officer in reception and the records were seen by a member of the offender management unit the next day to follow up any outstanding issues. However, there was no published strategy setting out first night procedures and detailing the responsibilities of first night officers. Depending on a prisoner's time of arrival and staffing in reception, not all reception procedures were completed. Some new arrivals were given first night information before being locked in their cell, but others arriving close to or after lock-up did not. Insiders (peer supporters) were based in reception and on the induction wing, but their role was unclear. One said she would give support and information to a new arrival only if the woman requested it rather than as part of a planned first night process. New arrivals were given an information booklet, but some of the detail was incorrect (see paragraph 2.21).

Further recommendation

2.13 A first night strategy should be developed and published to ensure that all new arrivals receive consistent information and support irrespective of their time of arrival.

Recommendation

To the Director General

Self-harm and suicide

2.14 A national definition of serious and near-fatal incidents should be agreed. These incidents should be routinely investigated to learn lessons and promote good practice in saving prisoners' lives. (3.43)
Achieved. A national definition of a serious incident had been included in Prison Service Order 2700 Suicide and Self-Harm. It defined serious incidents as those where a prisoner requires resuscitation and/or transfer to an outside hospital as a result of the self-harm. Although not a mandatory requirement, governors are strongly recommended to carry out an investigation into such incidents. We had information about six incidents that met these criteria between January 2008 and March 2009. Four had led to a formal investigation. Some had been completed to a good standard and specifically analysed learning points from the incidents.

Courts, escorts and transfer

2.15 Women prisoners should be transported from courts in vehicles appropriate to their identified needs, including pregnancy. (1.9)
Not Achieved. Although there were published protocols for the suitable transportation of women with various needs, including pregnant women, the prison said that the escort contractor did not make separate provision for pregnant women.
We repeat the recommendation.

2.16 Prisoners should be transported to the establishment once they have completed their court appearance rather than being held in court holding cells for long periods. (1.10)
Not achieved. Many women prisoners continued to spend long days at court. The prisoner escort records of two women who arrived at 7pm on different days showed that one had finished her court appearance at 11.14am and the other at 11.21am. The reception records of women attending local courts between January and March 2009 showed that many arrived at Low Newton five to six hours after completing their court appearance.
We repeat the recommendation.

2.17 The prison should promote greater use of the video link for court appearances to minimise unnecessary journeys and long days at court. (1.11)
Achieved. Between October 2008 and March 2009, 455 women prisoners had physically attended court and another 224 had appeared using court video links.

2.18 Men and women prisoners should not be transported together. (1.12)
Not achieved. Men and women continued to be transported together and some women complained of verbal intimidation from male prisoners. The situation also resulted in extended journeys for many women as the van picked up from several courts and priority was given to taking men to their establishments in the area before delivering women to Low Newton.
We repeat the recommendation.

First days in custody

2.19 The reception interview should take place in private. (1.27)
Partially achieved. A separate interview room had recently been created in reception. Some reception staff said they interviewed women new to custody in private, but continued to interview prisoners known to them in the open reception area or gave them the option of being interviewed in private.

Further recommendation

2.20 All reception interviews should take place in private.

2.21 New arrivals should receive accurate, up-to-date, well presented information. (1.28)

Partially achieved. New arrivals were given an information booklet, although some of the detail was incorrect (see also paragraph 2.12). Prisoners were not given any information at court about what would happen to them on arrival at the prison.

Further recommendations

2.22 The prisoner information booklet should contain accurate information.

2.23 Prisoners should receive information at court about what to expect on arrival at the prison.

2.24 Detoxifying prisoners should not mix with other new arrivals without individual risk assessments. (1.29)
Partially achieved. Prisoners in need of detoxification were accommodated separately from other new arrivals and followed a separate regime while detoxifying. However, all prisoners mixed together at the twice-daily medication times.

Further recommendation

2.25 Detoxifying prisoners should not mix with other prisoners without individual risk assessments.

2.26 Induction sessions should be evaluated to identify shortfalls in delivery and information provided and improved as necessary. (1.30)
Achieved. The induction programme had been evaluated and was delivered over 4.5 days. All prisoners were given a first day induction talk covering the regimes and services. Women new to custody or who had not been in the prison for six months went on to complete the full induction. Managers were re-evaluating the programme and were considering reducing it to a one-day presentation delivered every Wednesday.

2.27 Staff should receive appropriate training to deliver induction sessions. (1.31)
Not achieved. Induction officers had not received any training in group work or presentation skills.
We repeat the recommendation.

Residential units

2.28 Toilets in cells should be properly screened. (2.16)
Not achieved. Toilets were screened with curtains and hinged wooden flaps in single and shared cells. These were inadequate and did not provide appropriate privacy.
We repeat the recommendation.

2.29 Single cells should not be used as doubles. (2.17)
Not achieved. Single cells on C, D and E wings were still used for two prisoners.
We repeat the recommendation.

2.30 Insiders should have their own single cells. (2.18)
Achieved. Insiders had their own cells.

2.31 Lockable cupboards should be provided in cells. (2.19)
Achieved. All women had keys to their cells and each wardrobe in shared cells had been fitted with a lock so that women could secure their personal possessions.

2.32 Suitable accommodation for disabled prisoners should be provided. (2.20)
Achieved. A and E wings each had one cell suitable for a prisoner with physical disabilities. Both were suitable for wheelchair users, appropriately sized and fitted with grab rails. The cell on A wing had a suitable en suite shower, while on E wing an appropriate self-contained shower had been provided across the landing.

2.33 Increased laundry facilities should be provided on C and D wings. (2.21)
Achieved. Five industrial-strength washing machines and driers had been installed for use by women on C and D wings.

2.34 A kitchen should be provided on G wing. (2.22)
Not achieved. The fire officer had undertaken a feasibility study and concluded that the fire risk of installing a kitchen would be unacceptable. A toaster, sandwich maker and fridge had been provided and this was sufficient.

Additional information

2.35 At the previous inspection, young adult women had been accommodated separately, but discipline problems caused by holding young adult women together meant they had recently been dispersed throughout the prison. As a result, some young adult women serving short sentences were living on longer-term wings (see recommendation at paragraph 2.206).

Staff-prisoner relationships

2.36 A member of the senior management team should chair meetings of the prisoners' council, which should meet regularly with appropriate staff representation. (2.31)
Achieved. A prisoner consultative council met monthly chaired by a residential governor. Meetings were generally well attended, with appropriate departments represented. The governor in charge also usually attended, which demonstrated to prisoners that this consultation was valued.

2.37 Action points should be recorded at each prisoners' council meeting and progress on them publicised to prisoners. (2.32)
Achieved. Action points were clearly identified for named individuals and followed up at subsequent meetings as matters arising.

Personal officers

2.38 Personal officers should actively make themselves known to prisoners within a week of their arrival. (2.39)
Partially achieved. Some, but not all, wing files contained a clear record that the personal officer had introduced themselves.

Further recommendation

2.39 All personal officers should record in wing files that they have introduced themselves to prisoners.

2.40 Personal officer entries in wing history sheets should comment on prisoners' progress with sentence plans and resettlement issues. (2.40)
Partially achieved. Some personal officer entries, particularly on the longer-term wings, referred to sentence plan targets, but most continued to relate only to observed behaviour on the wings.

Additional information

2.41 There was no current personal officer policy and it was recognised that personal officer work was not as active and developed as it could have been. We were given a copy of a new written personal officer scheme that was about to be introduced. This gave some reasonable guidance about the role of the personal officer and the need to make entries in history sheets that went beyond recording comments about behaviour. However, it did not include examples of good personal officer entries, which would have been beneficial as there was no specific training in personal officer work.

Further recommendation

2.42 Personal officers should be given model entries of history sheet comments to help them make constructive contributions.

Bullying

2.43 The safer prisons report should include an analysis of trends that should be used to inform developments in policy and practice. (3.16)
Achieved. Monthly reports presented to the safer prisons meeting by the psychology department included data and analyses of a range of incidents. Most were recorded as aggressive or disruptive behaviour and were often associated with problematic relationships. Quarterly reports were produced and enabled the safer prisons team to identify any trends. Minutes of the February 2009 meeting noted gaps in the data provided from some wings. Discussion had led to identifying the need for some practical changes, such as improved lighting in some areas and improved supervision of queues.

2.44 Prisoners should be able to call the bullying information hotline anonymously and at no cost. (3.17)
Not achieved. A safer prisons 'at risk' line had replaced the previous 'hotline'. The number was published for visitors to report concerns about prisoners. The line was connected to the safer custody office and checked daily, but there was no specific log of calls received. The 'at risk' line number was not included in the prisoner information booklet and the line was not generally promoted to prisoners as a means to report bullying anonymously. It could not be used free of charge.

Further recommendation

2.45 The safer prisons 'at risk' line should be available free to prisoners and publicised widely around the prison.

2.46 Staff should actively supervise prisoners in areas where there is an increased risk of bullying. (3.18)
Achieved. Queues for medical treatment and in the dining hall, areas where bullying and intimidation had been a concern, were well supervised.

2.47 All bullying allegations should be investigated. (3.19)
Achieved. The safer prisons manager periodically checked wing observation books and other sources of information, including F213 forms (reports of injuries to prisoners), for incidents that could be related to bullying and, where relevant, cross-referenced the information to confirm that a bullying investigation had been instigated. Although limited resources meant it was not always possible to check these documents routinely, there was no evidence that incidents had not been investigated.

2.48 There should be a review of the severe restrictions imposed at the second stage of the anti-bullying strategy. The restrictions that apply should be clarified and any changes should be reflected in an amended policy document. (3.20)
Not achieved. The anti-bullying strategy and policy had not been changed. Women placed on stage two of the strategy were automatically downgraded to the basic regime. If the bullying occurred in the workplace, the prisoner was restricted to attending work only in the mornings. Meals had to be eaten in-cell.
We repeat the recommendation.

2.49 Interventions to challenge bullies should be developed and staff responsible for these should be trained and competent. (3.21)
Not achieved. Prisoners on stage two of the anti-bullying strategy were required to complete an anti-bullying workbook. Plans for psychology staff to offer training to officers to deliver interventions had not progressed. It was hoped that there would be greater involvement from the psychology department when proposed new procedures were introduced.
We repeat the recommendation.

Additional information

2.50 The prison continued to feel a safe environment. Safer custody work had a good profile and prisoners' concerns were discussed at the prisoner consultative council meetings. Since January 2009, violence reduction meetings were held monthly following the safer prisons meeting. There had been only three violence reduction meetings in 2008 and meetings over the previous quarter had recorded many apologies for absence. The most recent review of the violence reduction strategy document had been delayed while the introduction of a wider tackling anti-social behaviour strategy was considered.

2.51 The safer custody department was staffed by one senior officer who worked 30 hours as the safer custody manager, combining the roles of suicide prevention and violence reduction coordinators. This was a wide remit as there were no wing liaison officers to provide support. A full-time administrative officer acted as the Listeners' liaison officer.

2.52 The anti-bullying strategy was well used, with an average of eight prisoners monitored each month. Five women were being monitored during the inspection. The anti-bullying log recorded the reasons for bullying investigations. Many were associated with alleged bullying for property, including telephone credits and tobacco, but most involved medication. A small number of women were implicated in several incidents. Some women had successfully appealed against the decision to place them on the restrictive second stage of the strategy.

Further recommendation

2.53 Attendance at the safer prisons meetings should be improved and nominated people who are unable to attend should send a representative in their place.

Self-harm and suicide

2.54 Male officers should not be used on constant watch at night. (3.40)
Not achieved. We were told that efforts were made to avoid using male officers on constant watches on vulnerable women, but the times when they were used were not routinely monitored. During the inspection, the safer custody administrator reviewed all constant watches during both night and day periods between September 2008 and March 2009. The gender of staff used was not always known, but the available information indicated that more men than women were used. The availability of female staff at night and the number of women on constant watches at any one time made meeting this recommendation difficult. We met one woman who had specifically requested that a male officer was not allocated to this duty and this had been facilitated.
We repeat the recommendation.

2.55 Safer cells should be provided on residential units. (3.41)
Achieved. In addition to two cells with safer cell features in the healthcare centre, an additional cell had been provided on each residential wing apart from B wing. The physical aspects of these cells had been inspected against a safer cell inspection guide from the safer custody group and, where required, work completed to meet the specification. There was a comprehensive protocol for maintaining the physical condition of these cells.

2.56 Recommendations from death in custody investigation reports should be shared promptly with the safer prisons meeting and action plans implemented. (3.42)
No longer relevant. There had not been a self-inflicted death since the last inspection (see additional information).

2.57 More counselling services should be provided for prisoners as part of support plans for those at risk of self-harm. (3.44)
Not achieved. Despite efforts to promote different intervention strategies (see additional information), these were rarely considered by case managers for inclusion in support plans.
We repeat the recommendation.

2.58 Calls to the Samaritans and other help lines from landing telephones should be free of charge. (3.45)
Not achieved. Although prisoners could contact the Samaritans free of charge by requesting the dedicated portable telephone, calls to them or other help lines from

landing telephones could not be made free of charge or anonymously.
We repeat the recommendation.

2.59 Data collected on self-harm should be analysed for trends by the safer prisons meeting and the implications for practice discussed. (3.46)
Achieved. The psychology department presented monthly reports to the safer prisons meeting. These included data and an analysis of a range of variables associated with self-harming behaviour and included an analysis of the number, nature and location of self-harm incidents. Quarterly reports were also produced recording the number of women involved in self-harm, which enabled some analysis of trends. Between October and December 2008, five women had accounted for 35% of the 202 incidents recorded.

2.60 Data on ACCT procedures, such as number and location, were not included in these reports.

Further recommendation

2.61 The monthly and quarterly reports completed by the psychology department should include data on assessment, care in custody and teamwork procedures.

2.62 Listeners should be used on all locations throughout the prison and a Listener suite provided. (3.47)
Achieved. The nine Listeners had access to all areas of the prison. A Listener support suite opened in February 2009 on D1 landing had not yet been used. A comprehensive protocol describing how the support suite should be used had been published for staff. Listeners were well supported as a group, but said not all requests to see them were facilitated. This had been raised at the safer prisons meeting.

Further recommendation

2.63 Prisoners' access to Listeners should be facilitated at all times. Where this has not been possible, an explanation should be provided to the safer custody manager and this should be monitored by the safer prisons meeting.

2.64 There should be a more consistent approach to the case manager role. Case managers should chair the reviews of those prisoners they are responsible for. (3.48)
Not achieved. The central detailing or allocation of senior officers to particular duties did not help consistency. There was no assurance that senior officers would be located on wings where they were case managers for women on ACCT procedures. (See recommendation at paragraph 2.4.)

Additional information

2.65 The suicide and self-harm policy had recently been reviewed and was available in five different languages. Although the Listener scheme was introduced to prisoners in the induction booklet, there was little information about the other sources of help for women who were feeling suicidal.

2.66 As noted in the section on bullying, minutes of the safer prisons meeting recorded many absences. The meeting included relevant agenda items, including individual case discussion and a focus on training.

2.67 There were on average 78 self-harm incidents each month, an increase from 48 a month reported at the previous inspection. A three-year research project into self-harm behaviour was under way in partnership with Durham University and Durham Primary Care Trust. The prison suspected a connection between higher self-harm rates and the fact that a much higher proportion of women came from over 100 miles away (32% compared to 21% at the time of the last inspection).

2.68 The ACCT log included some useful information, such as dates of the next review, court appearance or release dates. There were 25 open ACCT documents and it was usual for 10% or more of the population to be on open ACCTs. The safer custody manager completed monthly quality checks of open ACCTs. Those we looked at demonstrated regular interaction with, and care for, women identified as at risk. However, in two cases the ACCT had been closed within a very short time. One had been closed just six hours after the prisoner had cut herself and then refused to cooperate with the ACCT assessment. The written evidence suggested that the ACCT had been closed too early.

2.69 Efforts were made to promote the range of intervention strategies and these were reviewed through the continuous improvement plan. They included counselling through MIND and support from mental health-trained nurses, art therapy, acupuncture and relaxation groups. They were offered through healthcare, but were available to out-patients. There were substantial waiting lists for some services. The counsellor from MIND provided one-to-one counselling and had a caseload of 13, with a further 34 women on the waiting list. Patients were usually in treatment for 10 weeks. Sixteen women attended a mental health support group, with a further 25 on the waiting list. Twenty-nine women were waiting to see a community psychiatric nurse or registered mental health nurse and could wait around 14 days.

2.70 Copies of support plans were given to women when an ACCT was closed. More preventative support had also been offered through, for example, a well woman day. There were additional resources for women on the Primrose programme (see section on sentence and custody planning).

2.71 We heard various anecdotes about the use of protective clothing, but no records were kept showing how frequently it was used.

2.72 Resuscitation and other essential equipment was located in several areas of the prison and clearly identifiable to staff.

Further recommendations

2.73 More information should be included in the prisoner information booklet about the help available to prisoners who feel at risk of self-harm.

2.74 The use of protective clothing for prisoners at risk of self-harm should be monitored by the safer prisons meeting.

Race relations

2.75 Prisoner representatives should attend all the diversity management team meetings unless there are specific items to be discussed where this would not be appropriate. (3.62)
Achieved. Prisoner representatives were invited to all diversity management team meetings and were able to remain for the whole meeting. One prisoner representative had agreed to present the SMART monitoring data at the next race equality action team meeting after successfully doing so at a prisoner representative action group meeting.

2.76 The Darlington and Durham County Race Equality Team should be involved in meetings and in monitoring the effectiveness of investigations of alleged racist incidents. (3.63)
No longer relevant. The Darlington and Durham County Race Equality Team had been disbanded.

2.77 Black and minority ethnic prisoners groups should be held to give those prisoners a safe opportunity to air their concerns. (3.64)
Not achieved. There were no general group meetings for black and minority ethnic prisoners. Prisoner race representatives met monthly and this was publicised on the wings. Weekly drop-in sessions hosted by the race representatives had recently been introduced where any woman could raise a diversity issue individually. Take-up had been slow and the race equality officer had agreed to make access as easy as possible for women who wanted to attend.
We repeat the recommendation.

2.78 The race relations liaison officer should be trained in his role and in the conduct of simple investigations. (3.65)
Not achieved. Several different staff had acted as race relations liaison officer – now the race equality officer – since the previous inspection. The interim race equality officer had not been trained for the role. A new diversity manager was soon to take up post.

Further recommendation

2.79 The diversity manager should be trained in the role and in the conduct of simple investigations.

Additional information

2.80 Racist incident reports were well investigated and investigations were monitored by a representative of Newcastle College and the Independent Monitoring Board. The prison was actively pursuing community engagement and contact had been made with a minority-led women's health charity based in Sunderland, but there were limited local resources for black and minority ethnic women that the prison could call on.

Foreign nationals

2.81 The foreign nationals' policy should be developed to include a strategy informed by a needs analysis. (3.74)

Achieved. The psychology department had undertaken a needs analysis in May 2008 and this had been used to inform a revised policy that was awaiting approval by the area office. The policy document did not include an action plan to underpin and give effect to policy aims. Contact had been made with Hibiscus and, following an initial visit, a service level agreement was being developed similar to those agreed with other establishments.

Further recommendation

2.82 An action plan should be included in the foreign nationals policy.

2.83 The foreign nationals' liaison officers and their manager should receive appropriate training for their role. (3.75)
Achieved. The foreign national liaison officer (FNLO) had received training from the Leeds UK Border Agency office, attended area FNLO meetings and liaised with other establishments to share ideas and good practice.

2.84 A regular foreign nationals meeting should be introduced. (3.76)
Achieved. A monthly foreign nationals meeting had recently been introduced. However, it was not clear how issues raised at the meeting would be taken forward.

Further recommendation

2.85 Issues raised at the foreign nationals meeting should be discussed at the race equality action team meeting with appropriate feedback provided.

2.86 Information should be provided in relevant languages other than English. (3.77)
Achieved. Wing notices in 19 languages invited women to contact the FNLO if they required any information in a language other than English. Some documents were readily available in seven languages identified as most relevant when the translations had been ordered. Language needs changed frequently and invoices showed that translation services were used when a new language need was identified and appropriate use was also made of telephone interpreting services.

Additional information

2.87 There were 16 foreign national prisoners from 12 different countries. Their correspondence was subject to a greater degree of checking than that of other women in that all correspondence not in English, other than legal protected material, was routinely sent for translation before being given to the recipient.

2.88 Foreign national women received a telephone card each month giving 10 minutes of telephone credits. They could exchange regular letters for airmail letters and buy additional international telephone cards above their incentives and earned privileges level if they had money to do so.

Further recommendation

2.89 Correspondence in languages other than English should be subject to the same level of scrutiny as correspondence in English unless a specific risk is identified.

Family and friends

2.90 More telephones should be provided to meet prisoner need and all should be placed in booths. (3.93)
Partially achieved. Most wings met our expectation of at least one telephone per 20 prisoners. The exceptions were A and B wings, which had one telephone for up to 31 prisoners. Many telephones were fitted with ineffective metal hoods and some were sited in noisy areas of wings.

Further recommendation

2.91 Additional telephones should be provided on A and B wings and all telephones should be in booths.

2.92 Visits should start at the advertised time. (3.94)
Not achieved. Senior managers and the visit booking clerk said visits started at 2pm and this was the time given to women at the first day induction talk. However, the visiting order stated 2.15pm. Visitors' photographs and finger prints were taken and checked by just one officer and delays occurred when new visitors had to have these done from scratch or when the biometric system was not working efficiently. Minutes of the family and social support meeting from as far back as July 2008 recorded 'delays to visits starting due to the new finger identity system'. On one afternoon of the inspection, the first group of visitors entered the visits room at 2.20pm despite arriving at the prison in good time. As in 2006, visitors said visits were often late and that they were delayed by the search procedure.
We repeat the recommendation.

Further recommendation

2.93 The correct time of visits should be given to prisoners and visitors.

2.94 Women prisoners should not be required to wear bibs in the visits room. (3.95)
Partially achieved. Prisoners no longer wore bibs, but were required to wear a coloured sash despite having to sit in an identified chair in the visits room and the identification process for visitors.

Further recommendation

2.95 Prisoners should not have to wear a sash in the visits room.

2.96 Seating in the visits room should allow easy contact between women and their visitors. (3.96)
Not achieved. Seating was still regimented, with the prisoner seated on one chair opposite a low table and across from her visitors.
We repeat the recommendation.

2.97 The prisoners' visits waiting room should be appropriately supervised. (3.97)
Achieved. Officers supervised the waiting room and it was monitored by closed-circuit television.

2.98 Mothers testing positive for drugs should not be excluded from taking part in children's visits. (3.98)
Achieved. Mother and child visits continued to run on Friday mornings, as did longer monthly mother and child 'play days'. There were also quarterly visits days when up to two carers could visit alongside the child visiting their mother. These visits were open to all women and were subject to individual risk assessment when necessary.

2.99 A suitably experienced family support worker should be appointed to support women prisoners with issues to do with their children. (3.99)
Not achieved. There was no family support worker to help women prisoners maintain or re-build contact with their partners, children and families. Managers were liaising with a range of agencies with a view to obtaining specialist provision to support mothers and children. Women who had been, or were currently, involved in adoption proceedings could get information and support from After Adoption, a voluntary organisation.
We repeat the recommendation.

2.100 Greater use should be made of release on temporary licence to help women prisoners prepare for release and to help those who are primary carers maintain contact with their children and fulfil important family responsibilities. (3.100)
Not achieved. Very little use was made of temporary licence to help women prepare for release or maintain contact with their children.
We repeat the recommendation.

Additional information

2.101 Notices in the visitors' centre advised visitors that they had to have photographic identification and the visiting order stated that at least one form of identification had to contain the visitor's signature and photograph. Staff managing the visitors' centre and a visit booking clerk said photographic identification was essential. However, senior managers said other forms of identification were acceptable if a visitor did not have photographic identification.

Further recommendation

2.102 Visitors should be able to use other acceptable forms of identification, other than photographic, and this should be known by visitors and staff at all levels, including booking clerks and visitors' centre staff.

Applications and complaints

2.103 Senior managers should analyse trends in complaints as an indicator of potential problems and areas for improvement. (3.113)
Achieved. Monthly statistics were provided to the SMT and minutes of meetings indicated that these were discussed to identify emerging trends. A trend analysis for 2008 had been presented to the SMT in January 2009. This had provided a useful overview of the year and highlighted any key changes in the pattern and nature of complaints from the previous year.

Legal rights

2.104 A trained legal services officer should be detailed to these duties each working day. (3.119)
Not achieved. A legal services officer (LSO) was profiled for work in the mornings from Monday to Saturday, but staff shortages generally meant the officer worked elsewhere. No LSO had been available from 1 to 21 March 2009.
We repeat the recommendation.

Additional information

2.105 New arrivals were asked in reception if they had a solicitor, were intending to appeal or had any outstanding charges or fines. The four LSOs had been trained several years earlier and had not had refresher training. One said he kept himself updated on issues in his own time using the internet. When profiled to the work, the LSO saw all new arrivals to assess their needs and confirm they understood their legal rights and what was available to them. LSOs had access to relevant legal reference books and literature.

Further recommendation

2.106 Legal services officers should receive regular refresher training.

Healthcare

2.107 The in-patient beds should not be part of the prison's certified normal accommodation. (4.59)
Partially achieved. Four of the 12 in-patient beds were on the certified normal accommodation. Staff said the beds were rarely used other than for those with a healthcare need.

Further recommendation

2.108 The remaining four in-patient beds should be removed from the list of certified normal accommodation.

2.109 An emergency childbirth kit should be available. (4.60)
Achieved. An emergency childbirth kit was available for use by all healthcare staff, who were aware of the contents and trained in their use.

2.110 The dental surgery should be located in a larger room with space for a desktop and storage of paperwork. Worktops should be long enough to allow delineation of 'clean/dirty' areas. (4.61)
Achieved. The dental surgery was in the same room, but had been suitably modified. A reorganisation of the use of the room and installation of new furniture had improved access to equipment and assisted the management of the control of infection.

2.111 The electrical sockets in the dental surgery should be refitted at a height and position that both dentist and nurse can safely reach without standing on a chair. (4.62)
Achieved. All electrical sockets had been relocated to facilitate safer access by dental staff.

2.112 Protocols should be developed and adhered to for thorough cross-infection control procedures in the dental surgery during treatment and between patients. (4.63)
Achieved. Protocols had been developed to manage safely the control of infection during treatment and between patients. Infection control audits were undertaken quarterly to monitor the procedures and resources used.

2.113 All clinical records should be written in line with professional guidance. Entries should be accurate, clear, dated, timed, signed and legible. Omits should be recorded on prescription administration charts. (4.64)
Achieved. Clinical records were clear and accurate and complied with appropriate levels of confidentiality. Omits were recorded on prescription administration charts. An electronic IT system had been introduced and was widely available to healthcare staff.

2.114 Prisoners should be given information quickly about when applications have been received and appointments made. (4.65)
Achieved. Prisoners had quick access to healthcare services. Written applications could be made for appointments, but most used a free telephone service, which was an efficient and innovative way of arranging appointments.

2.115 The controlled drugs registers should be properly maintained, in accordance with the legislation, to record accurately and clearly all transactions where schedule 2 controlled drugs are obtained or supplied. The running balance should be checked regularly against actual stock held and, where necessary, adjusted and recorded. Any significant discrepancies should immediately be reported to the pharmacist, who should make regular visits to audit the controlled drugs records. (4.66)
Achieved. The controlled drugs registers were properly and effectively maintained. Running balances were checked regularly and any discrepancies appropriately recorded and reported to the pharmacist. The pharmacist visited regularly and undertook periodic audits of the controlled drugs.

2.116 The controlled drugs registers should be thoroughly audited to identify the reasons for the apparent discrepancies and appropriate action should be taken to remedy the situation. (4.67)
Achieved. In conjunction with the primary care trust, the controlled drugs registers had

been thoroughly audited after the previous inspection and a system of regular audit established to monitor closely the management of controlled drugs.

2.117 A policy should be in place for dealing with discontinued controlled drug treatments. Returns of controlled drugs to HMP Durham should be properly documented so that the register and stock can be properly audited. (4.68)
Achieved. There was a policy for dealing with discontinued controlled drug treatments and returns of controlled drugs were clearly documented.

2.118 A medicines and therapeutics committee specific to Low Newton should be established. This could operate in conjunction with the existing medicines and therapeutics committee for the Durham cluster. The pharmacy technician should be invited to attend meetings. The committee should develop the following: an evidence-based drug formulary specifically for the prison; a policy for providing medication to patients attending court. Secondary dispensing should be avoided; a formal in-possession policy; a 'special sick' policy; a policy to determine under what circumstances general stock medication should be used. Wherever possible, named-patient dispensed medicines should be issued in preference to general stock; systems to audit the use of general stock medication so that the supply of stock is reconciled against the issue of prescriptions for the medication. (4.69)
Achieved. A medicines and therapeutics committee had been established in conjunction with the Durham cluster of prisons and met every two months. An evidence-based formulary had been created, policies for court attendance, special sick and the management of medications in possession were in place and systems for the management of stock items were more robust. However, prisoners were unable to see and speak personally to a pharmacist.

Further recommendation

2.119 Prisoners should be able to see a pharmacist.

2.120 The medicines and therapeutics committee should investigate the apparent high level of prescribing of opiate-based analgesia and benzodiazepines and provide alternative suggestions. (4.70)
Achieved. The medicines and therapeutics committee continually monitored the trends of prescribed medications across the prison cluster. Alternative suggestions were provided on a needs-led basis.

2.121 All healthcare procedures and policies should be formally reviewed and adopted. All staff should read and sign the agreed adopted procedures. (4.71)
Achieved. Healthcare procedures and policies were very well managed and local procedures were agreed and signed by staff. Appropriate primary care trust policies and procedures were available to all staff through the electronic network.

2.122 An electronic clinical IT system should be introduced. (4.72)
Achieved. The Egton Management Information System (EMIS) had been installed and was very effective. SystmOne was due to be introduced within the next 12 months.

2.123 Arrangements for visiting allied healthcare professionals should include cover for absences so that prisoners are provided with a full service. (4.73)
Partially achieved. Some arrangements had been made to include absence cover for

visiting allied health professionals, including negotiation with the commissioners of healthcare. Additional help was provided across the prison cluster to reduce waiting lists when required.

Further recommendation

2.124 A full service of clinics should be provided to include any absence cover for visiting allied health professionals.

2.125 All nurses who provide nurse-led services should have the relevant competencies and qualifications. (4.74)
Partially achieved. Most nurse-led services were provided by nurses with relevant competencies and qualifications. Training plans were progressing for those nurses with a specialist interest.

Further recommendation

2.126 Training for nurses providing nurse-led clinics should proceed as soon as possible.

2.127 Healthcare staff should be involved in preparing prisoners for release. Such involvement should include assisting them to register with community healthcare services and providing letters for GPs. (4.75)
Achieved. Discharge planning for prisoners was very well organised. Healthcare staff were closely involved with the management of prisoners before release and with sentence planning as required. Links with the community were good and the information provided for prisoners to assist with their access to future healthcare services was very good.

2.128 A therapeutic regime should be provided for in-patients. (4.76)
Partially achieved. Some efforts had been made to provide a structure for the in-patients' day, but this was largely around the range of services and treatment a patient was receiving. We saw some good evidence of care planning and patients spent most of their day unlocked, but they were not regularly engaged in therapeutic activities.

Further recommendation

2.129 A more structured and wider range of activities should be provided to enhance the therapeutic regime for in-patients.

2.130 In-patients who require discipline officers to be present when they are unlocked should have a clear planned routine for their care that is followed by all staff. (4.77)
Achieved. Care plans were clear and the routines for in-patients requiring the presence of discipline officers were well planned and followed by all staff.

2.131 Mental health services should have clear routes for referral. (4.78)
Achieved. An open referral system was used and routes for mental health referrals were much clearer, including a pathway through reception screening. Referrals meetings were held weekly in addition to monthly case management meetings.

2.132 Mental health day care services should be provided for those less able to cope with life on the wings. (4.79)
Partially achieved. A range of services was available to prisoners to help those who found it difficult to cope with life on the wings. Although these services were structured and provided regularly throughout the week in the healthcare centre, it was not a sufficient day care service to meet the needs of all appropriate prisoners.

Further recommendation

2.133 A full range of mental health day care facilities should be provided for those less able to cope with life on the wings.

2.134 Generic counselling services sufficient to meet prisoners' needs should be available. (4.80)
Partially achieved. A voluntary sector counselling service regularly visited and met some needs, and in addition some counselling was available through the chaplaincy, but there was still a demand for more generic counselling services.

Further recommendation

2.135 A full range of generic counselling services should be provided for prisoners in addition to that provided by MIND.

Additional information

2.136 Health services were commissioned by County Durham Primary Care Trust and provided by Darlington NHS Trust. The head of healthcare had been in post since the previous inspection and had made some significant changes to the management of health services. Staffing levels were very good, with only two vacancies together with the imminent arrival of additional staff to be employed in the new IDTS unit that was expected to be active later in the year. A health needs assessment and a regional service review of mental health services had been commissioned, but had not yet been completed. A baseline assessment of specialist mental health services was available in draft.

2.137 One of the healthcare rooms had been converted to deliver gynaecological services and equipment had been provided to run a colposcopy clinic with a visiting consultant from the provider trust. Prisoners could therefore have gynaecological consultations without leaving the prison.

2.138 Despite having the capacity, the mental health team did not deliver mental health awareness training to prison staff, because of problems with releasing staff and conflicting training arrangements.

Further recommendation

2.139 A programme of mental health awareness training should be provided for all prison staff

Education and library provision

2.140 Prisoners' progress reviews should be improved and should include challenging targets. (5.21)
Partially achieved. Progress reviews now took take place at least every six weeks and more often when required. Long-term aims were set for prisoners, but short-term target setting remained weak. In ICT, target setting was good, with specific and clear targets set for achievement. In most subject areas, short-term targets lacked detail and did not break down tasks into manageable bites for prisoners to achieve. Data provided for staff carrying out the progress review had improved, with staff having a clear view of progress made.

Further recommendation

2.141 Short-term target setting at prisoners' progress reviews should be more challenging and specific.

2.142 Individual learning plans should be improved to plan the learning accurately and document progression and achievements. (5.22)
Partially achieved. Individual learning plans (ILPs) were produced after prisoners had attended a detailed education induction including a thorough assessment of their learning needs. The ILP was used at reviews to record and assess prisoners' progress and accurately recorded whole target achievement, but did not record small target achievements such as personal and social development. A useful tracking document in most classrooms gave prisoners a clear picture of their progress. The prison had developed good links with the education provider and they worked together to develop ILPs that could be used across all the learning and skills provision.

Further recommendation

2.143 Individual learning plans should record small target achievement such as personal and social development.

2.144 Data should be collected and analysed to provide meaningful management information about prisoners and courses. (5.23)
Achieved. Data on all aspects of prisoners' activities were evaluated and well used by the education provider to plan and develop the curriculum. The education provider produced a monthly report for the head of learning and skills giving a clear view of progress made. Data were used at all levels as a good performance management tool to track and monitor prisoners' progress, set and monitor staff targets, identify strengths and areas for improvement and assess the impact of changes made to improve the curriculum.

2.145 The skills for life strategy should be developed to provide full support to prisoners and meet their individual needs. (5.24)
Partially achieved. A skills for life strategy had been developed and included a focus on developing wider key skills, but had only recently been implemented. The strategy now included routine testing and assessment of all prisoners to identify literacy and numeracy needs. Literacy and numeracy courses were well attended and overall

retention and achievement were good. Literacy and numeracy were embedded in most of the curriculum areas, but had not yet been fully linked to some of the vocational courses. A functional skills course was being piloted and English for speakers of other languages provision had been developed and successfully introduced. Staff training had taken place to raise awareness of how to support prisoners with literacy and numeracy needs.

Further recommendation

2.146 The skills for life strategy should be further developed to support all prisoners.

2.147 The range of talking books, newspapers, magazines and journals available in the library should be improved and the stock of materials to support educational programmes extended. (5.25)
Partially achieved. The number of talking books had significantly increased, but records showed they were rarely used. The current range had been appropriately reduced to reflect prisoner interest. Newspapers, magazines and journals were available, but were mostly donations by staff and prisoners and the range was poor. There was a better range of materials to support education and vocational training and the librarian worked with tutors to buy stock that linked to students' reading lists.

Further recommendation

2.148 A wider range of newspapers and periodicals should be available in the library.

Additional information

2.149 The promotion of library services had improved and included a range of events throughout the year. A reading group had been established to assess the Orange book award entrants and a local author had visited the prison to talk about the judging process. The librarian had developed good links with education and utilised resources and shared good practice with other librarians in the North East cluster of prisons. A writer in residence had worked with the prison and a book of prisoners' creative writing had been published.

2.150 The library was staffed by a qualified librarian for only two days a week. On the other days and two evenings when it was open, it was supervised by a voluntary organisation that operated the 'learning shop'. The welcoming and relaxed environment was effectively used by the learning shop to support vulnerable prisoners who would not otherwise have engaged with a learning activity. Work was under way with the psychology department to develop ways to measure effectively the personal and social skills development of prisoners taking part in the learning shop programmes.

Work

2.151 The range of vocational training programmes should be increased to meet the needs of the population and potential skill shortage areas. (5.34)
Partially achieved. The vocational qualification provision had been reviewed and developed to reflect better prisoners' needs. The painting and decorating workshop had been closed due to insufficient demand and the space effectively used to develop

courses in hospitality and retail, with firm links to local skills shortages. Hairdressing and beauty therapy workshops had been refitted to industry standard. Cookery equipment had been replaced and cookery national vocational qualifications introduced to reflect employer requirements. Progression opportunities had improved, with some qualifications available at higher levels, but the range of accredited vocational training programmes linked to employment remained narrow.

Further recommendation

2.152 The range of vocational courses linked to employment should be further developed.

2.153 Literacy and numeracy support should be provided for all prisoners on vocational training courses. (5.35)
Partially achieved. Literacy and numeracy support had been introduced into some vocational areas, but was not yet fully in place. An experienced tutor from education was working with PE instructors to increase the level of literacy and numeracy support provided in a PE setting.

Further recommendation

2.154 Literacy and numeracy support to prisoners should continue to be developed across vocational courses.

Additional information

2.155 An employer engagement unit had been developed and opened in November 2008 in the preparation for work, hospitality and retail provision area. The provision had strong links to employers and was developing the employability skills of prisoners. The Job Club was also in this unit.

Physical education and health promotion

2.156 Outdoor sport facilities should be provided. (5.39)
Not achieved. The outside sports area was underused. It was large, but the hard surface was poor quality and uneven. There were no all-weather surfaces.

Further recommendation

2.157 The outdoor sports area should be improved to enable and encourage more activities.

2.158 The cardiovascular suite should be improved to include more space and additional equipment. (5.40)
Partially achieved. The cardiovascular equipment had recently been updated and improved. However, the space for it remained small and cramped, which limited how much equipment could safely be introduced.

Further recommendation

2.159 The space available for cardiovascular equipment should be increased.

Faith and religious activity

2.160 Decisions to prohibit prisoners from attending the chapel should be taken only after completing an individual risk assessment. (5.47)
Achieved. Decisions to prohibit prisoners from attending the chapel were taken only after an individual risk assessment.

Additional information

2.161 The chaplaincy team continued to play an active part in prison life, running group activities including a weekly bible study group for Chinese prisoners in their own language. A community chaplain supported some women after release. She could arrange transport to the station and housing and mentoring support in the community.

Time out of cell

2.162 Prisoners should be encouraged and supported to take up outdoor exercise. (5.54)
Not achieved. All prisoners complained about the timing of exercise, which was from 7.40am for 45 minutes on weekdays. Women still had to choose between taking exercise, collecting medication, showering and getting ready for work or education. Exercise was later at weekends, but prisoners had to choose between this and association, collecting medication and attending chapel services. There was no evidence that women were encouraged or supported to exercise outdoors and records showed that the exercise period was often unused, particularly on A, B, C and D wings. No prisoners had taken exercise on B wing for 13 consecutive days or on A wing for 11 consecutive days in March 2009. There was more take-up of exercise at weekends. The exercise areas on A/B and C/D were unattractive and did not encourage women to spend time outside (see paragraph 2.165).
We repeat the recommendation.

Further recommendations

2.163 All prisoners should be given the opportunity for at least one hour of exercise in the open air every day.

2.164 Exercise should not clash with other activities.

2.165 All prisoners should have access to exercise areas that are big enough and adequately equipped. (5.55)
Partially achieved. Women on C and D wings used an area adjacent to education that was larger than that used in 2006, but this and the exercise areas for women on A and B wings remained austere, with hard-surfaced yards with no greenery. The area next to

G wing was also a hard area, but prisoners said there were tubs that had recently been removed for replanting. Exercise areas on other wings had grass and plants. All exercise areas had seating.

Further recommendation

2.166 Exercise yards used by prisoners on A and B and C and D wings should be improved to encourage women to spend time in the fresh air.

2.167 All prisoners should be able to participate in some form of recreational or constructive activity during association. (5.56)
Partially achieved. All wings had association rooms. Prisoners on A, B, C and D wings continued to share association rooms. A and B wings used their room on alternate evenings and the room was small and contained little activity equipment. Women could not use the association rooms during the morning and evening medication times and in practice evening association was often curtailed or did not take place at all because of the time it took to deal with medication. Association rooms on other wings were attractively decorated and furnished, with music centres, televisions, reading material and some board games. F wing had a small kitchen and DVD room. Low staffing levels sometimes meant evening association was cancelled and this was managed on a planned rota.

Further recommendations

2.168 Prisoners on A, B, C and D wings should be able to access their association rooms without disruption.

2.169 The association room for A and B wings should be improved.

Additional information

2.170 The national core day had reduced time out of cell on Monday to Thursday from about 10 hours in 2006 to about nine hours. Women were unlocked for about 7.5 hours on Fridays and seven hours at weekends. Low staffing levels also resulted in the closure and reduction of activities during the day. Between December 2008 and the end of March 2009, 56 planned gym sessions had been cancelled.

Security and rules

2.171 Prisoners should be given a clear set of rules so that they and staff are clear about expected behaviour. (6.13)
Achieved. Women were given a clear set of rules and these were displayed on wings.

2.172 Prisoners' security categories should reflect the level of risk they pose rather than rely on the completion of sentence plan targets that could be completed in less secure conditions or after release on licence. (6.14)
Achieved. There was no evidence that women were unnecessarily prevented from moving to open conditions. Population pressures now meant the prison was expected to send sufficient women to HMP Askham Grange open prison each month to ensure that all places there were used.

Discipline

2.173 There should be a dedicated staff team in the segregation unit, selected by interview and with relevant training. (6.34)
Achieved. Staff allocated to the segregation unit (now called the care and separation unit) had been selected by interview and almost all were up to date with relevant training.

2.174 Standard punishments should set a more specific starting point for adjudicators. (6.35)
Achieved. Revised guidance on punishments had been issued in October 2006 and checks were made at regular adjudication standardisation meetings to ensure punishments adhered to the tariff guidance.

2.175 The segregation unit exercise yard should be made less oppressive. (6.36)
Achieved. The walls of the exercise yard had been painted white, which had improved the general environment.

Additional information

2.176 Use of force had increased considerably from about six incidents a month in 2006 to an average of 17 a month in the last six months of 2008-09. This could not be accounted for by a corresponding rise in prisoner numbers, but there had also been an increase in the number of self-harm incidents. There was regular monthly monitoring, but no monitoring over longer periods to examine and account for this significant increase over time. There was no designated special or unfurnished accommodation, but monthly use of force returns to Prison Service headquarters indicated some use of special cells while the local monitoring data suggested no use. We were told that relocations to safer cells had incorrectly been reported as use of special accommodation, but the records appeared to indicate that safer cells were sometimes used as special accommodation without appropriate monitoring or safeguards.

2.177 The small segregation unit did not appear over-used, but the number of women segregated had increased significantly. In January to March 2009, 17 different women had been segregated, a rate three times as high as previously.

2.178 Upgrades to security work had been completed to allow the prison to hold restricted status prisoners. Two restricted status women were held and we were told this was the maximum the prison would ever hold. The restricted status women had integrated well into the general population and the additional security procedures required for them had not affected the generally relaxed operation of the prison for the rest of the population.

Further recommendations

2.179 Managers should monitor the yearly use of force and segregation to satisfy themselves that all use is fully justified and with the aim of reducing the rate of use.

2.180 All use of safer cells should be approved by a manager and centrally logged to include the length of time women spend in them.

2.181 Safer cells should not be used as special accommodation without appropriate authorisation and monitoring.

Incentives and earned privileges

2.182 There should be greater differentials between standard and enhanced incentive and earned privileges levels other than through the pay system. (6.49)
Achieved. The current incentives and earned privileges policy dated May 2008 set out a range of incentives other than just through the pay system.

Catering

2.183 Lunch should be served between noon and 1.30pm. (7.12)
Achieved. Lunch was served at 1pm during the week.

Additional information

2.184 Women had packed meals at lunchtime on Tuesdays and in the evening from Thursday to Sunday. The catering manager had arranged to reinstate a hot evening meal on Thursdays from May 2009. Packed meals meant women ate in their cells rather than in the dining room. The evening meal packs contained dry noodles or soup, but women said these were unpopular as they had to choose between using hot water to make up the soup or noodles and having a hot drink between evening lock-up and unlock the following morning. A number of women were unaware that they could have two flasks of hot water to avoid this problem. Women also ate breakfast in their cells on weekdays. Breakfast, including milk, was provided pre-packed the day before use, but some women said they did not have bowls so ate their cereal from the milk carton. A hot brunch was provided at 10.30am at weekends.

Further recommendations

2.185 Women should be able to eat their meals in the dining room.

2.186 All women should have adequate equipment and sufficient hot water to use their meal and beverage packs.

2.187 Breakfast should be served on the morning it is eaten.

Prison shop

2.188 Prisoners should be able to use the shop within 24 hours of arrival. (7.21)
Not achieved. Women could place an order only once a week and could not use the shop within 24 hours of their arrival.
We repeat the recommendation.

2.189 The shop should stock fresh fruit and food in tins and jars. (7.22)
Achieved. The canteen list contained items in glass jars and tins and four choices of fruit.

2.190 The skin and hair products stocked should meet the needs of all prisoners. (7.23)
Partially achieved. The choice of skin and hair products was still too limited to meet all needs.

Further recommendation

2.191 There should be more consultation with women about suitable skin and hair products.

Resettlement strategy

2.192 Staff and prisoners should be fully briefed about the changes being introduced in resettlement and the role of case supervisors. (8.6)
Achieved. A staff information notice had been issued in January 2007 outlining the development of the offender management unit (OMU) and staff roles within it. Staff from the OMU contributed to prisoner induction and prisoners were given a leaflet describing the work of the unit and the roles of offender supervisor and offender manager. Prisoners we met in groups were familiar with the role of the OMU.

2.193 The resettlement policy committee should adopt a more strategic approach and should involve senior managers from the community. (8.7)
Achieved. Pathway leads had been identified for each of the strategic pathways, including the additional pathways specific to women's prisons. An update on each of the pathways was presented at the quarterly meetings of the resettlement policy committee. The leads convened separate sub-groups and reported back to the resettlement committee. Some sub-groups had made more progress than others. For example, staff had been identified to promote work on domestic violence, but had yet to receive training. Some useful contacts had been made with managers from a range of agencies, including the local police, colleges and NACRO. The only senior manager from the community represented on the resettlement committee was the assistant director from Durham probation service, but others were involved in sub-groups.

Additional information

2.194 There was an up-to-date resettlement strategy known as the reducing reoffending strategy and action plan (2008-2009). Women's resettlement needs were reviewed quarterly based on information from offender assessment system (OASys) records and these referenced the nine strategic resettlement pathways. The latest review in January 2009 was based on 224 available records, representing 74% of the population. The most prevalent needs identified were related to drugs and alcohol and to the life skills and offending behaviour pathways. Other key needs were healthcare and family and social support. The resettlement needs analysis was usefully supplemented by a focus on particular groups, such as those sentenced to indeterminate sentences for public protection (IPPs) and short-sentenced prisoners.

Sentence and custody planning

2.195 The healthcare department should provide written input to sentence planning reviews. (8.14)
Not achieved. Much of the liaison between the OMU and healthcare staff was informal. Healthcare staff did not provide a written contribution for all sentence planning reviews,

although this was provided for IPPs and life-sentenced prisoners.
We repeat the recommendation.

2.196 Field probation officers should be invited and encouraged to attend sentence planning reviews. (8.15)
Achieved. The OMU sent standard letters to probation officers inviting them to attend sentence planning reviews. In many cases, these were supplemented by telephone conversations and email contacts, but attendance was variable. Attendance at sentence planning boards was good for prisoners in scope, with 78% of boards attended by offender managers. This was commendable given that 63% of IPP prisoners were from out of the local area. Attendance at sentence planning boards for those out of scope was poorer, particularly if probation officers had to make long journeys.

2.197 A custody planning system should be introduced to address needs of prisoners not dealt with through OASys. (8.16)
Not achieved. The position for remand prisoners and those serving short sentences was little changed. All remand prisoners were seen to assess their suitability for bail through Clear Springs and an initial assessment of their housing and family needs, but there were no formal custody plans for this group or for short-term prisoners. Prisoners with short sentences were allocated a case administrator and their suitability for transfer to open conditions was considered. Where prisoners were not motivated, their needs were unlikely to be met as there was no active case management approach.
We repeat the recommendation.

Additional information

2.198 Offender management was working reasonably well for the 61 prisoners in scope. The OMU included a head of offender management, a senior officer responsible for categorisation and allocation, seven offender supervisors and four case administrators. In addition, there was an executive officer and a probation officer to refer women on bail or HDC to Clearsprings accommodation. The offender supervisors were a mix of prison and probation officers and probation service officers. This led to some confusion for prisoners, particularly for those allocated a prison officer as offender supervisor. Prisoners also had to make the distinction between the personal officer and offender supervisor role. One of the three prison officers in the offender supervisor role was cross-deployed one day a week for residential tasks.

2.199 OASys assessments and reviews were largely up to date. Only two initial assessments had not been completed within the required timescale and one review was around one week overdue. The head of offender management quality assured all completed OASys assessments and the head of resettlement checked 10% each month.

2.200 Four parole dossiers were waiting completion and were past disclosure date to the prisoner. In two cases, the prison was awaiting reports from field probation officers and in the other cases delays were due to prisoners requesting a deferral, which was then refused by the Parole Board.

2.201 Offending behaviour programmes included enhanced thinking skills (ETS), prisons – addressing substance-related offending (P-ASRO) and FOR (a pilot cognitive-motivational programme aiming to increase prisoners' motivation to be involved in their resettlement). The fire setters and anger management courses had not run for over a year.

2.202 A major change since 2006 had been the development of the Primrose project, a national pilot treatment programme for dangerous women with severe personality disorders. This had begun in September 2006 and had recently started the treatment phase for the first women after the assessment stage had been completed. The 12 women involved in the programme lived on F wing with other lifers and long-term prisoners. Some of the women on the wing were young adult women and we questioned the appropriateness of this situation (see paragraph 2.35). The women involved in the Primrose project took part in the programme off the wing as their principal activity. This meant they were fully integrated into the life of the prison and could take part in all other daily activities such as education, eating meals, attending religious activities and recreation with other women.

2.203 The Primrose programme included a range of elements aimed at reducing risk, including one called 'life minus violence' for women with a history of habitual aggression, and dialectical behaviour therapy designed to replace maladaptive behaviour for women with borderline personality disorders. The programme was still in its early days, but appeared to have become well established and offered an opportunity for treatment for some women with very complex needs.

2.204 Prisoners with 70 days left to serve were identified and assessed for their suitability for transfer to open conditions at HMP Askham Grange for the last 56 days of their sentence. Those serving a sentence of less than 12 months were prioritised. The prison aimed to identify four prisoners a month for transfer to Askham Grange. Between June 2008 and April 2009, 57 prisoners had been assessed as suitable for open conditions, although not all were subsequently transferred. Between October 2007 and September 2008, 44 women had been transferred to open conditions and four to semi-open prisons.

Further recommendations

2.205 The role of offender supervisors should be explained more clearly to prisoners.

2.206 Young adult women should not be accommodated on the same wing as women participating in the Primrose project.

Life-sentenced prisoners

2.207 All new life- and indeterminate-sentenced women arriving on F wing should have a full induction to ensure that they understand the lifer system and process and the arrangements at Low Newton. (8.33)
Not achieved. Life and indeterminate-sentenced women were now accommodated on F and I wings and had no specific induction. They completed the standard induction programme and were seen by an offender supervisor within 10 days.

Further recommendation

2.208 All new life and indeterminate-sentenced women arriving on F and I wings should have a full induction to ensure that they understand the lifer system and process and the arrangements at Low Newton.

2.209 The facilities list should be reviewed in consultation with F wing residents to ensure it meets the needs of longer-term prisoners. (8.34)
Partially achieved. The facilities list had last been reviewed in May 2008 and some items available only to life-sentenced prisoners had been added. Most of these were insignificant and included a shower cap, pencil case and hot water bottle. Other items could be used to enhance a prisoner's cell. There had been no regular meetings with lifer managers to discuss their specific needs (see paragraph 2.211).

2.210 A multidisciplinary lifer team should meet regularly to decide priorities, review cases and consider the strategy and arrangements for indeterminate-sentenced prisoners. (8.35)
Not achieved. There had been only two multidisciplinary meetings to discuss indeterminate-sentenced prisoners. The first, in December 2007, discussed the implications of IPP cases coming in scope for offender management. The second, in October 2008, had reviewed issues that had subsequently arisen for this group of prisoners and for those with a life sentence.
We repeat the recommendation.

2.211 The lifer governor and lifer manager should hold regular recorded meetings with indeterminate-sentenced women. (8.36)
Not achieved. In the previous year, there had been only one meeting in January 2009. This was an opportunity to discuss domestic arrangements, including the facilities list, the life sentence system and other issues for women with these sentences. All life and indeterminate-sentenced prisoners had been invited, but we understood only around eight attended. No minutes were taken.
We repeat the recommendation.

2.212 Two lifer days should be held each year. (8.37)
Achieved. A lifer day had been held in 2006 and 2007 and two in 2008.

Additional information

2.213 There were 21 life and indeterminate-sentenced women on F wing, 14 on I wing and one each on H and C wings. Those on I wing had improved rooms with en suite showers, but did not have the cooking facilities available on F wing. Of the 16 officers working on F and I wings, only four had been trained in working with life-sentenced prisoners. New training in managing indeterminate sentences and risk (MISaR) had been introduced, but no officer had yet completed it.

Further recommendations

2.214 All indeterminate-sentenced women should have the opportunity to prepare their own food.

2.215 There should be sufficient trained staff to work with life and indeterminate-sentenced prisoners.

Reintegration planning

2.216 A cost benefit analysis should be carried out to determine if a job centre terminal should be purchased. (8.47)

Achieved. A cost benefit analysis had taken place and had established that it was not cost effective to introduce a job centre terminal.

Public protection

2.217 The public protection coordinator should have direct access to information about previous convictions. (8.56)
Achieved. Although there was no police national computer terminal in the prison, two staff had been trained in its use and visited HMP Durham weekly to obtain information about previous convictions of new prisoners. This had considerably reduced the previous delays.

2.218 A comprehensive public protection policy should be produced. (8.57)
Achieved. Although there was still no single public protection policy, the different areas of public protection were covered in a separate public protection document and available on the intranet. These included safeguarding vulnerable children, sex offender registration, multi-agency public protection arrangements and protection from harassment. There were separate briefing instructions for staff and these were updated in line with the revised public protection manual (PSI 08/2009).

Substance use

2.219 The drug strategy document should be updated, include alcohol and contain detailed action plans and performance measures. (8.78)
Achieved. The drug strategy document was updated annually. Detailed action plans and performance measures were included, together with programmes for the management of alcohol awareness.

2.220 The drug strategy coordinator should be given adequate time to focus on the development and implementation of the strategy. (8.79)
Not achieved. The drug strategy coordinator had a number of other roles that impinged on his ability to focus on the drug strategy. He was due to retire three months after the inspection and we were told the roles were to be divided.
We repeat the recommendation.

2.221 Following consultation with the clinical adviser for women's prisons, prescribing regimes should be more flexible and based on individual need. (8.80)
Achieved. The national protocols for the clinical management of substance-dependent women were followed and there was a more flexible approach to prescribing regimes based on prisoners' individual needs.

2.222 Detoxification and CARAT staff and mental health services should formalise joint working arrangements to improve care coordination. (8.81)
Achieved. Good joint working relationships between detoxification and CARAT staff and mental health services had improved the coordination of care. There was no waiting list for prisoners referred to the CARAT services.

2.223 The CARAT service should introduce group work modules to meet the needs of remand, short-term prisoners, and of cocaine/crack users. (8.82)
Achieved. Group work modules had been introduced by the CARAT service, including support from a crack/cocaine specialist. We were told that all prisoners were given

access to the modules as required following initial assessment. The IDTS was also due to start in September 2009.

2.224 More alcohol services should be provided, particularly to meet the needs of young women. (8.83)
Not achieved. Although some effort had been made to identify and introduce more alcohol services, there was no dedicated service to meet the needs of young women. Comprehensive information and advice about community services was given to prisoners on release.
We repeat the recommendation.

2.225 Adequate accommodation for the CARAT service should be provided. (8.84)
Achieved. The CARAT team now had more space that provided good accommodation for its purposes. The detoxification unit had also been co-located on E wing with the CARAT service.

2.226 Dedicated physical education sessions for P-ASRO participants should re-commence and a peer support scheme should be developed to provide additional post-programme support. (8.85)
Not achieved. Staff said dedicated PE sessions for P-ASRO participants had started following the previous inspection, but had not continued. P-ASRO participants did not have access to any dedicated PE sessions or any peer support scheme following completion of their programme.
We repeat the recommendation.

2.227 A separate compliance testing compact should be in place for prisoners on G wing. (8.86)
No longer relevant. The role of G wing had been altered and included fewer enhanced prisoners. Compliance testing was considered inappropriate.

Additional information

2.228 The CARAT team caseload averaged about 120 prisoners. All clients were seen individually. Clinical management of substance-dependent prisoners was provided by the detoxification unit that was about to start the IDTS programme. All prison staff had been given the opportunity to attend IDTS awareness training in preparation for the scheme to be delivered to prisoners.

2.229 Voluntary drug testing (VDT) was carried out on E wing and available to all prisoners. The facilities were clean and well equipped and provided sufficient privacy. The VDT positive rate fluctuated between 2% and 20% with 120 compacts. The number of tests performed each month varied due to the demands placed on prison staff. The mandatory drug testing (MDT) positive rate year to date stood at 5.76% against a target of 9.1%. With buprenorphine (subutex) positive tests included, the random MDT positive rate was 10.93%.

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 (from the previous report) To the Governor

3.1 Reviews should be chaired by consistent case managers and key workers should provide continuity of care for women identified as at risk. (2.4)

3.2 Second stage detoxification facilities should be introduced. (2.6)

3.3 The menus should be subject to the ongoing scrutiny of a nutritionist. (2.9)

3.4 A first night strategy should be developed and published to ensure that all new arrivals receive consistent information and support irrespective of their time of arrival. (2.13)

Recommendations To the Governor

Courts, escorts and transfer

3.5 Women prisoners should be transported from courts in vehicles appropriate to their identified needs, including pregnancy. (2.15)

3.6 Prisoners should be transported to the establishment once they have completed their court appearance rather than being held in court holding cells for long periods. (2.16)

3.7 Men and women prisoners should not be transported together. (2.18)

First days in custody

3.8 All reception interviews should take place in private. (2.20)

3.9 The prisoner information booklet should contain accurate information. (2.22)

3.10 Prisoners should receive information at court about what to expect on arrival at the prison. (2.23)

3.11 Detoxifying prisoners should not mix with other prisoners without individual risk assessments. (2.25)

3.12 Staff should receive appropriate training to deliver induction sessions. (2.27)

Residential units

3.13 Toilets in cells should be properly screened. (2.28)

3.14 Single cells should not be used as doubles. (2.29)

Personal officers

3.15 All personal officers should record in wing files that they have introduced themselves to prisoners. (2.39)

3.16 Personal officers should be given model entries of history sheet comments to help them make constructive contributions. (2.42)

Bullying

3.17 The safer prisons 'at risk' line should be available free to prisoners and publicised widely around the prison. (2.45)

3.18 There should be a review of the severe restrictions imposed at the second stage of the anti-bullying strategy. The restrictions that apply should be clarified and any changes should be reflected in an amended policy document. (2.48)

3.19 Interventions to challenge bullies should be developed and staff responsible for these should be trained and competent. (2.49)

3.20 Attendance at the safer prisons meetings should be improved and nominated people who are unable to attend should send a representative in their place. (2.53)

Self-harm and suicide

3.21 Male officers should not be used on constant watch at night. (2.54)

3.22 More counselling services should be provided for prisoners as part of support plans for those at risk of self-harm. (2.57)

3.23 Calls to the Samaritans and other help lines from landing telephones should be free of charge. (2.58)

3.24 The monthly and quarterly reports completed by the psychology department should include data on assessment, care in custody and teamwork procedures. (2.61)

3.25 Prisoners' access to Listeners should be facilitated at all times. Where this has not been possible, an explanation should be provided to the safer custody manager and this should be monitored by the safer prisons meeting. (2.63)

3.26 More information should be included in the prisoner information booklet about the help available to prisoners who feel at risk of self-harm. (2.73)

3.27 The use of protective clothing for prisoners at risk of self-harm should be monitored by the safer prisons meeting. (2.74)

Race relations

3.28 Black and minority ethnic prisoners groups should be held to give those prisoners a safe opportunity to air their concerns. (2.77)

3.29 The diversity manager should be trained in the role and in the conduct of simple investigations. (2.79)

Foreign nationals

3.30 An action plan should be included in the foreign nationals policy. (2.82)

3.31 Issues raised at the foreign nationals meeting should be discussed at the race equality action team meeting with appropriate feedback provided. (2.85)

3.32 Correspondence in languages other than English should be subject to the same level of scrutiny as correspondence in English unless a specific risk is identified. (2.89)

Family and friends

3.33 Additional telephones should be provided on A and B wings and all telephones should be in booths. (2.91)

3.34 Visits should start at the advertised time. (2.92)

3.35 The correct time of visits should be given to prisoners and visitors. (2.93)

3.36 Prisoners should not have to wear a sash in the visits room. (2.95)

3.37 Seating in the visits room should allow easy contact between women and their visitors. (2.96)

3.38 A suitably experienced family support worker should be appointed to support women prisoners with issues to do with their children. (2.99)

3.39 Greater use should be made of release on temporary licence to help women prisoners prepare for release and to help those who are primary carers maintain contact with their children and fulfil important family responsibilities. (2.100)

3.40 Visitors should be able to use other acceptable forms of identification, other than photographic, and this should be known by visitors and staff at all levels, including booking clerks and visitors' centre staff. (2.102)

Legal rights

3.41 A trained legal services officer should be detailed to these duties each working day. (2.104)

3.42 Legal services officers should receive regular refresher training. (2.106)

Healthcare

3.43 The remaining four in-patient beds should be removed from the list of certified normal accommodation. (2.108)

3.44 Prisoners should be able to see a pharmacist. (2.119)

3.45 A full service of clinics should be provided to include any absence cover for visiting allied health professionals. (2.124)

3.46 Training for nurses providing nurse-led clinics should proceed as soon as possible. (2.126)

3.47 A more structured and wider range of activities should be provided to enhance the therapeutic regime for in-patients. (2.129)

3.48 A full range of mental health day care facilities should be provided for those less able to cope with life on the wings. (2.133)

3.49 A full range of generic counselling services should be provided for prisoners in addition to that provided by MIND. (2.135)

3.50 A programme of mental health awareness training should be provided for all prison staff. (2.139)

Education and library provision

3.51 Short-term target setting at prisoners' progress reviews should be more challenging and specific. (2.141)

3.52 Individual learning plans should record small target achievement such as personal and social development. (2.143)

3.53 The skills for life strategy should be further developed to support all prisoners. (2.146)

3.54 A wider range of newspapers and periodicals should be available in the library. (2.148)

Work

3.55 The range of vocational courses linked to employment should be further developed. (2.152)

3.56 Literacy and numeracy support to prisoners should continue to be developed across vocational courses. (2.154)

Physical education and health promotion

3.57 The outdoor sports area should be improved to enable and encourage more activities. (2.157)

3.58 The space available for cardiovascular equipment should be increased. (2.159)

Time out of cell

3.59 Prisoners should be encouraged and supported to take up outdoor exercise. (2.162)

3.60 All prisoners should be given the opportunity for at least one hour of exercise in the open air every day. (2.163)

3.61 Exercise should not clash with other activities. (2.164)

3.62 Exercise yards used by prisoners on A and B and C and D wings should be improved to encourage women to spend time in the fresh air. (2.166)

3.63 Prisoners on A, B, C and D wings should be able to access their association rooms without disruption. (2.168)

3.64 The association room for A and B wings should be improved. (2.169)

Discipline

3.65 Managers should monitor the yearly use of force and segregation to satisfy themselves that all use is fully justified and with the aim of reducing the rate of use. (2.179)

3.66 All use of safer cells should be approved by a manager and centrally logged to include the length of time women spend in them. (2.180)

3.67 Safer cells should not be used as special accommodation without appropriate authorisation and monitoring. (2.181)

Catering

3.68 Women should be able to eat their meals in the dining room. (2.185)

3.69 All women should have adequate equipment and sufficient hot water to use their meal and beverage packs. (2.186)

3.70 Breakfast should be served on the morning it is eaten. (2.187)

Prison shop

3.71 Prisoners should be able to use the shop within 24 hours of arrival. (2.188)

3.72 There should be more consultation with women about suitable skin and hair products. (2.191)

Sentence and custody planning

3.73 The healthcare department should provide written input to sentence planning reviews. (2.195)

3.74 A custody planning system should be introduced to address needs of prisoners not dealt with through OASys. (2.197)

3.75 The role of offender supervisors should be explained more clearly to prisoners. (2.205)

3.76 Young adult women should not be accommodated on the same wing as women participating in the Primrose project. (2.206)

Life-sentenced prisoners

3.77 All new life and indeterminate-sentenced women arriving on F and I wings should have a full induction to ensure that they understand the lifer system and process and the arrangements at Low Newton. (2.208)

3.78 A multidisciplinary lifer team should meet regularly to decide priorities, review cases and consider the strategy and arrangements for indeterminate-sentenced prisoners. (2.210)

3.79 The lifer governor and lifer manager should hold regular recorded meetings with indeterminate-sentenced women. (2.211)

3.80 All indeterminate-sentenced women should have the opportunity to prepare their own food. (2.214)

3.81 There should be sufficient trained staff to work with life and indeterminate-sentenced prisoners. (2.215)

Substance use

3.82 The drug strategy coordinator should be given adequate time to focus on the development and implementation of the strategy. (2.220)

3.83 More alcohol services should be provided, particularly to meet the needs of young women. (2.224)

3.84 Dedicated physical education sessions for P-ASRO participants should re-commence and a peer support scheme should be developed to provide additional post-programme support. (2.226)

Appendix 1: Inspection team

Michael Loughlin	Team leader
Joss Crosbie	Inspector
Paul Fenning	Inspector
Angela Johnson	Inspector
Mick Bowen	Healthcare inspector
Stephen Miller	Ofsted inspector

Appendix 2: Prison population profile[1]

Population breakdown by:

(i) Status	Number of prisoners	%
Sentenced	226 Adults / 23 YP	84.41
Convicted but unsentenced	14 Adult / 6 YP	6.78
Remand	23 Adult / 2 YP	8.47
Civil prisoners	1	0.34
Detainees (single power status)	0 (included in sentenced prisoners)	
Detainees (dual power status)	0	
Total	295 (based on 31st March 09)	100

(ii) Sentence	Number of sentenced prisoners	%
Less than 6 months	27 Adults / 5 YP	12.03
6 months to less than 12 months	22 Adults / 4 YP	9.77
12 months to less than 2 years	38 Adult / 6 YP	16.54
2 years to less than 4 years	62 Adults / 11 YP	27.44
4 years to less than 10 years	46 Adults / 3YP	18.42
10 years and over (not life)	2 Adults / 1 YP	1.13
Life	37 Adults / 2 YP	14.66
Total	266	100

(iii) Length of stay	Sentenced prisoners		Unsentenced prisoners	
	Number	%	Number	%
Less than 1 month	0	0	20	37.8
1 month to 3 months	9	4	17	32.0
3 months to 6 months	17	7	11	20.8
6 months to 1 year	21	8	5	9.4

[1] The prison population profile was provided by the establishment and any errors or discrepancies are their responsibility.

1 year to 2 years	39	16	0	0
2 years to 4 years	67	28	0	0
4 years or more	89	37	0	0
Total	242	100	53	100

(iv) Main offence	Number of prisoners	%
Violence against the person	87	32.6
Sexual offences	9	3.37
Burglary	20	7.5
Robbery	44	16.5
Theft & handling	29	10.68
Fraud and forgery	12	4.49
Drugs offences	31	11.61
Other offences	33	12.36
Civil offences	1	0.37
Offence not recorded/holding warrant	1	0.37
Total	267 (discrepancies due to ECL)	100

(v) Age	Number of prisoners	%
17 years to 21 years	25	9.36
21 years to 29 years	109	40.82
30 years to 39 years	75	28.09
40 years to 49 years	39	14.61
50 years to 59 years	17	6.37
60 years to 69 years	2	0.75
Total	267 (discrepancies due to ECL)	100

(vi) Home address	Number of prisoners	%
Within 50 miles of the prison	113	43.3
Between 50 and 100 miles of the prison	38	14.6

Over 100 miles from the prison	83	31.8
Overseas	2 (included in NFA)	-
NFA	27	10.34
Total	261 (remaining prisoners on ECL)	100

(vii) Nationality	Number of prisoners	%
British	278	94.6
Foreign nationals	16	5.44
Total	294 (based on 31 March 09)	100

(viii) Ethnicity	Number of prisoners	%
White		
British	260	88.43
Irish	1	0.34
Other White	11	3.74
Mixed		
White and Black Caribbean	2	0.68
White and Black African	1	0.34
White and Asian	2	0.68
Other Mixed		
Asian or Asian British		
Indian	0	0
Pakistani	0	0
Bangladeshi	0	0
Other Asian	1	0.34
Black or Black British		
Caribbean	3	0.10
African	5	1.70
Other Black	4	1.36
Chinese or other ethnic group		
Chinese	2	0.68

Other ethnic group	2	0.68
Total	294 (based on 31 March 09)	100

(ix) Religion	Number of prisoners	%
Baptist	0	0
Church of England	78	26.52
Roman Catholic	52	17.68
Other Christian denominations	4	1.36
Muslim	8	2.72
Sikh	0	0
Hindu	0	0
Buddhist	0	0
Jewish	0	0
Other	5	1.7
No religion	147	50
Total	294 (based on 31 March 09)	100