Report on an unannounced short follow-up inspection of

# HMP Maidstone

14–16 September 2009

by HM Chief Inspector of Prisons

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# Contents

# Introduction

HMP Maidstone is an elderly, Victorian category C training prison. In June 2009 it became a specialist centre for sex offenders and foreign national prisoners. When we last visited, we were highly critical of its dilapidated state and a range of other failings, including poor standards of cleanliness and a lack of clarity over its role. On our return for this short unannounced inspection, we found a much improved and cleaner prison, beginning to focus on its new specialist function.

Safety had improved. Early days were adequately managed, but more use of professional interpreting services was needed on reception. Bullying did not appear to be a particular problem, but the new violence reduction policy required further development and time to bed down. Work to prevent suicide and self-harm continued to improve but, sadly, there had been two deaths in custody - one apparently self-inflicted - since the last inspection. Use of force was low and use of segregation had declined. Security appeared proportionate, but foreign national and black and minority ethnic prisoners believed that they were particularly targeted.

Cleanliness and hygiene standards at Maidstone were much improved, helped by the refurbishment of Weald wing. Staff-prisoner relationships now appeared good, supported by effective personal officer and incentives schemes. Work on the diversity agenda had developed and, while there had been considerable progress, still more effort was needed to address the needs of the much increased population of foreign national prisoners. Healthcare provided a good service.

Time out of cell was less than we expect but there was evidence of some improvements in the quantity and quality of some purposeful activity, together with improvements in the strategic management of learning and skills. However, still only 28% of prisoners were in education and the curriculum remained narrow. Employment had increased but, while there were some excellent vocational training opportunities, these were too few in number and many prisoners continued to undertake mundane tasks that did not attract accreditation. The library and PE were satisfactory, but the sports hall was in a poor state of repair.

Maidstone was beginning to focus on its new role, although the resettlement policy remained to be updated and needed to be informed by a comprehensive needs analysis of the new population. Work on offender management was progressing well, including much more attention to public protection issues as befitted a sex offender centre. However, work with indeterminate-sentenced prisoners was limited, and progress in putting in place provision on some of the resettlement pathways was also underdeveloped.

It is always pleasing to report on progress following a critical inspection, and staff at HMP Maidstone deserve considerable credit for what has been achieved since our last visit. The prison is now a specialist centre for sex offenders and foreign national prisoners and it has begun to respond to the specific needs of these populations. Considerable progress has also been made to remedy a range of other weaknesses, including the previously poor standards of cleanliness and hygiene. There remains scope for further improvement in both purposeful activity and resettlement, but the distance travelled in a short space of time is commendable.

Anne Owers — December 2009
HM Chief Inspector of Prisons

# Fact page

Task of the establishment
Category C male training prison holding sex offenders and foreign national prisoners.

Area organisation
South East

Number held
592

Certified normal accommodation
565

Operational capacity
600

Last inspection
Full announced inspection: February 2007.

Brief history
HMP Maidstone was completed in 1819, when it was the most advanced model of its time. It became a category C training prison in 2003, and completed its re-role to a specialist centre for sex offenders and foreign national prisoners in June 2009.

Description of residential units
Kent wing – foreign national prisoner unit
Weald wing – integrated induction wing
Medway wing – sex offender unit
Thanet wing – sex offender unit

Weald wing was re-commissioned in April 2009 following extensive refurbishment.

# Section 1: Healthy prison assessment

## Introduction

HP1 The purpose of this inspection was to follow up the recommendations made in our last full inspection of 2007 and examine progress achieved. We have commented where we have found significant improvements and where we believe little or no progress has been made and work remained to be done. All inspection reports include a summary of an establishment's performance against the model of a healthy prison. The four criteria of a healthy prison are:

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

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

...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 At our inspection in 2007 we found that Maidstone was not performing sufficiently well against this healthy prison test. We made 46 recommendations in this area, of which 40 had been achieved or partially achieved, and five had not been achieved. One recommendation was no longer applicable. We have made a further 30 recommendations.

HP5 Most transfers to Maidstone were planned and journeys were relatively short. Reception facilities were not open during the lunch period. A prison peer adviser helped to welcome new arrivals. There was some translated information in reception but very little use of professional interpreting for non-English speakers. The provision of meals and drinks depended on the presence of a prisoner orderly.

HP6 Staff were aware of the location of new arrivals, but there were no designated first night cells. There were no first night interviews. Staff were unaware they were required to make calls to families on behalf of prisoners unable to telephone due to public protection concerns, but this was clarified during the inspection. New arrivals could not obtain a reception pack until the Friday following their arrival.

HP7 The five-day induction programme was largely led by peer advisers. Feedback from prisoners was positive, although this information was not routinely collated.

HP8 A violence reduction policy had been published in July 2009 but did not sufficiently detail the anti-bullying scheme. The safer custody committee met regularly and was well attended, but did not discuss performance data on bullying. There were prisoner violence reduction representatives who met the safer custody manager regularly. The quality of bullying investigations was reasonable, but staff entries in monitoring logs for bullies and victims were purely observational, and there were no interventions for bullies or victims. Only 16 bullying-related security information reports had been submitted in the first eight months of 2009, and bullying did not appear to be a significant problem.

HP9 The safer custody committee did not analyse suicide and self-harm monitoring data produced by the safer custody coordinator. New arrivals were interviewed by a safer custody peer worker, and a Listener participated in induction. Fewer self-harm monitoring documents had been opened in 2009 than in 2008. The quality of assessments was good, care maps were updated, and reviews were multidisciplinary. Staff entries in monitoring logs showed knowledge of and engagement with prisoners. There were 18 Listeners in the prison, but none were on Kent wing. There were crisis suites on each wing. There had been two deaths in custody since the last inspection, one of which was self-inflicted. Action plans had been produced and were up to date.

HP10 Intelligence collation, analysis and management had improved, and 1,179 security information reports had been submitted in 2009 to date. A monthly intelligence report

was produced. There had been a reduction in reported incidents in 2009, which was linked to the re-role of the prison. Illegal finds around the prison were mainly mobile telephones. Foreign national and black and minority ethnic prisoners believed they were targeted disproportionately for security procedures. Governors had engaged with them about this, but information needed to be collected and analysed to ensure equality in application of security procedures.

HP11 Adjudications were well managed and the number had fallen. No tariff had been published, but prisoners were given paperwork outlining possible sanctions.

HP12 Use of force was low with only 21 incidents recorded in 2009 to date. De-escalation techniques were used. Forms were generally well completed, but injury to inmate forms were not always signed or fully completed by healthcare staff. The security committee segregation monitoring and review group meeting monitored use of force paperwork.

HP13 Use of the segregation unit had declined since the re-role of the prison. There were daily staff entries in segregation files, but little evidence of staff engagement with prisoners. Use of the special cell had been very low in 2008 and it had not been used at all in 2009. The special cell accommodation was unacceptable and required refurbishment. The quality of completed paperwork was poor.

HP14 Counselling, assessment, referral, advice and throughcare service (CARATs) staff saw all new arrivals. The prison had introduced the integrated drug treatment system (IDTS), but only two prisoners were on methadone maintenance. The lead IDTS nurse had input into CARATs work. Figures quoted at the time of inspection showed that the mandatory drug testing (MDT) rate was 6.31% to date against a target of 10.5%. Suspicion testing was generally completed within required timescales, with positive rates generally above 40% in the previous six months.

HP15 With the re-role of the establishment, the sex offender population had increased significantly and there was now an integrated regime. Maidstone held 368 sex offenders (62% of the population). Only 13 prisoners had been held in the segregation unit for own protection since the start of 2009.

HP16 At the conclusion of this short follow-up inspection, we found there had been improvements in safety, especially in safer custody, security and the segregation unit, and Maidstone was now performing reasonably well against this healthy prison test.

## Respect

HP17 At our previous inspection, we found that Maidstone was not performing sufficiently well against this healthy prison test. We made 75 recommendations in this area, of which 60 had been achieved or partially achieved and 13 had not been achieved, and two was no longer applicable. We have made a further 47 recommendations.

HP18 All wings were clean and well cared for, and the external area was litter-free and well maintained. Weald wing had had a major refurbishment and the standard of accommodation was good, although there was no policy on avoiding the allocation of top bunks to older prisoners in double cells. Toilet screening was also unsuitable. Cell bells were usually answered within five minutes, and the system was not misused by prisoners. Prisoners had good access to property that was bought or sent in. An

active prisoner consultative committee met staff regularly and was well managed and publicised.

HP19 The incentives and earned privileges (IEP) scheme was well understood by staff and prisoners, but the incentives of extra visits and private cash were of little benefit to many foreign national prisoners. No prisoners were on the basic regime. Monitoring checks took place, and appeals were made and sometimes upheld.

HP20 Staff-prisoner relationships were good, and prisoners said there was at least one staff member they could approach with problems. Prisoners were addressed respectfully in person and on the public address system. The personal officer scheme operated well. Twice-monthly entries were achieved and some were of a high standard reflecting a through knowledge of prisoners. However, much of the monitoring was superficial.

HP21 Many prisoners complained about the quality and quantity of food. The food we tasted was acceptable. Eighty per cent of meals were prepared in house, but meals were served too early. Prisoners were consulted about the menu and in preparation for religious festivals. Meal arrangements for Ramadan were well organised, although menu choices were more limited than had been planned. The transition to a new shop provider had gone well, although prices had increased. Staff had explained the increases and given advance notice of changes. There was good consultation with prisoners, through a monthly meeting. Prisoners were not normally able to obtain some religious artefacts, such as prayer mats, beads and oils, through the prison shop.

HP22 Diversity work was overseen by the diversity and race equality action team (DREAT), which met bi-monthly, and this area continued to be well managed. Prisoner consultation meetings took place in the intervening months, and there was good use of prisoner representatives. Work with disabled and older prisoners had developed well, with an effective buddy system, and there had been a thorough and positive approach to the management of a transgender prisoner.

HP23 Two race equality officers had been identified and trained, but their role lacked definition. The DREAT paid relatively cursory attention to data from ethnic monitoring that showed disparities in areas such as IEP, release on temporary licence (ROTL), use of force and recategorisation, which required close monitoring. Racist incident reports were carefully investigated and were countersigned by the governor, although no entries were on the quality of assessment. A range of cultural events over the last two years included work with the Gypsy and Traveller community.

HP24 The prison was a secondary centre, or 'spoke', for foreign national prisoners. These prisoners made up 42% of the population, and received regular but limited UK Border Agency (UKBA) input. Managers and staff working in this area had been active in supporting and advising their colleagues, but there needed to be a planned programme of training in foreign national issues. Achieving category D status and ROTL were particular concerns for foreign national prisoners. Consultation with foreign national prisoners had improved, with a well-established monthly consultation meeting and the recent introduction of foreign national forums. There was considerable use of peer interpretation, but little telephone interpreting, and there was an uneven range of translated material. Not all the multi-language information points were working. Outside bodies, such as immigration support agencies and embassies, were invited in to support and advise foreign national prisoners.

HP25 A new system to track applications had been introduced, but many were not responded to in a timely manner. The complaints system was now better managed and responses were received within agreed timescales, addressed prisoners respectfully and responded to the issues. The governor had also provided detailed responses to some complaints.

HP26 The chaplaincy team was well integrated into the prison, and more prisoners attended services. There was a range of sessional chaplains across the faiths, and the team led the delivery of the Sycamore Tree victim awareness programme. One of the chaplaincy team regularly attended assessment, care in custody and teamwork (ACCT) self-harm monitoring reviews.

HP27 Health services met the needs of the current population, and the range of primary care services compared well with those available in the community. There was good access to GPs and nurse-led and specialist clinics. Waiting times to see the dentist had grown. The re-role of the population had increased the proportion of prisoners requiring chronic disease services. Mental health provision was satisfactory and there was effective integration between primary mental health and the mental health in-reach service.

HP28 At the conclusion of the inspection, we found that Maidstone had made progress in addressing hygiene and environmental issues, improving staff-prisoner relationships, and supporting foreign national prisoners. We considered that Maidstone was now performing reasonably well against this healthy prison test.

## Purposeful activity

HP29 At our previous inspection, we found that Maidstone was not performing sufficiently well against this healthy prison test. We made 17 recommendations in this area, of which 14 had been achieved or partially achieved and three had not been achieved. We have made a further 12 recommendations.

HP30 This area had suffered from a lack of strategic direction and management. New providers had been identified for education and information, advice and guidance (IAG), but the new IAG provider had been unable to commence provision, which was being covered by the education provider. Nevertheless, there was good management of education and industries. An education needs analysis had been completed earlier in 2009, but there had been no recent learning and skills needs analysis.

HP31 New arrivals received a thorough education induction that assessed their learning needs, and there was good diagnostic testing. Only 28% of prisoners were in full- or part-time education. The curriculum was limited. There were three classes in English for speakers of other languages (ESOL) and a waiting list of 18 prisoners. Seventeen prisoners were on Open University courses and were supported well by education staff.

HP32 A labour allocation board met weekly and included representatives from PE and industries. It had some links to sentence planning objectives. There were excellent opportunities to develop employment skills in the bricks, and printing and graphic design workshops, Prisons Information Communication Technology Academy (PICTA), recycling and horticulture, but only 27% of prisoners were employed in these areas, which was low for a training prison. Only 17% were on courses that led to

vocational qualifications, which was also low. There were no opportunities to gain qualifications above level two, and most prisoners were pursuing level one qualifications, which did not reflect the potential learning opportunities and progression available. The proportion of prisoners engaged in purposeful activity had increased to 94% since the last inspection, but 18% were in low quality contract work in workshops, and over 100 prisoners were employed as wing orderlies.

HP33 Library facilities had not changed substantially. The library was relatively well used, and opening hours had increased to ensure all prisoners could visits at least once a week. There was a reasonable range of material for foreign national prisoners, including newspapers.

HP34 The PE department was well managed, but the sports hall was in a poor state of repair. The proportion of prisoners taking part in recreational PE had increased from 40% to 63%. An increased range of activity included sessions popular with prisoners over 50. There were improved links with healthcare and a focus on linking fitness and health.

HP35 The prison had recorded a time unlocked figure of 9.2 hours a day for the year to date. The maximum time out of cell achievable for a fully engaged prisoner under the published core day was about nine hours Monday to Thursday, below our expectation of 10 hours. Unemployed prisoners could expect to achieve six hours 40 minutes from Monday to Thursday. Association was reported as two hours a day, but the core day indicated one hour and 40 minutes. Association was rarely cancelled. There was no obvious slippage in the regime and the core day was delivered. We conducted a roll check, which showed that 14% of prisoners were on wings as unemployed or not required, which was high for a training prison. However, these prisoners could spend time unlocked on the wing during the morning and afternoon.

HP36 On the basis of this short follow-up inspection, we concluded that, although there had been some improvements in providing more employment opportunities for prisoners, there had not been enough progress on the quality and breadth of the curriculum and providing vocational qualifications opportunities to enhance employability. We therefore considered that the establishment was still not performing sufficiently well against this healthy prison test.

## Resettlement

HP37 At our previous inspection, we found that Maidstone was not performing sufficiently well against this healthy prison test. We made 52 recommendations in this area, of which 41 had been achieved or partially achieved and seven had not been achieved. Four recommendations were no longer applicable. We have made a further 32 recommendations.

HP38 There was no current resettlement policy informed by an up-to-date and comprehensive needs analysis, as a result of the relatively recent change in the prisoner population. The prison was aware of the gap and taking measures to address this. A reducing reoffending committee met every month. Pathway leads had been identified in some areas and attended, although work on some pathways was limited. The resettlement function had changed significantly since the last inspection and resources had decreased.

HP39 An induction passport was completed for all new arrivals, which covered a range of needs, including the reducing reoffending pathways. The passport was not sufficiently integrated with sentence planning processes, and relevant information could potentially be omitted.

HP40 The offender management unit operated well and allocated all prisoners to an offender supervisor, whether or not they were in scope. Of the total population, 305 prisoners were in scope, including 38 prisoners on indeterminate sentences for public protection (IPP), and 37 prisoners were serving life sentences. Approximately 65 offender assessment system (OASys) assessments and reviews were outstanding. Offender managers in the community were more engaged with sentence planning, which would improve with the installation of video conferencing facilities. Offender supervisors had reasonable levels of contact with prisoners.

HP41 There was a combined child protection and public protection unit. All new arrivals were screened and appropriate monitoring measures set in place. Identified cases were discussed at the monthly risk management meeting, which was well attended. All multi-agency public protection arrangements (MAPPA) level three cases were held by probation officers, and links to external MAPPA meetings was good.

HP42 Management arrangements for IPP and lifer prisoners were limited. Representatives were identified on all wings but their role lacked clarity. Lifer forum meetings took place. This area required further development given the increase in IPP prisoners.

HP43 Discharge meetings took place three months before release. Contributions from departments were inconsistent, meetings did not integrate risk management information, and offender supervisors did not attend.

HP44 Accommodation services were limited but there were few discharges from Maidstone, and many went to approved premises or supported accommodation. Shelter held a prison area contract and offered support when required, rather than regular sessions at Maidstone. Finance, benefit and debt services required further work and clarification of the pathway lead.

HP45 Provision to prepare prisoners for work, training or education on release was limited. There was no pre-release course, and insufficient links with employers and support agencies. Although the prison had links with Jobcentre Plus, visits from staff were sporadic, and the service was poorly promoted.

HP46 Healthcare staff were not always able to attend the discharge boards. All prisoners were given details of local GPs, dentists and NHS Direct on release. Prisoners known to local community mental health teams were referred back to them and there were arrangements for staff to make contact before release.

HP47 An integrated drug and alcohol strategy was led by a pathway manager and monitored through a regular meeting. The change in the prison population had reduced the CARATs caseload from approximately 200 active clients to 75. CARATs provided a range of group and individual interventions, including the Rubicon alcohol awareness programme. Compact based drug testing was clearly separated from MDT. All prisoners on enhanced status went on the compact, for which there was a waiting list of over 200 prisoners for up to 10 months. Prisoners who signed up to the compact were regarded as compliant. Links were made with external DIPs for prisoners who wished to continue to engage with substance use services.

HP48 Visitors could book future visits in the visits hall or by email, which was an improvement. There was now a visits centre and waiting area in the establishment, rather than in the town, and visitors could arrive as early as 12.15pm to attend visits from 1.30pm. Facilities were limited but had improved. The visits area remained largely the same, but the previous visits room for vulnerable prisoners was now used as an overflow to accommodate more visitors. There were still no toilet facilities for visitors or prisoners, and facilities for children were limited. There had been only two family visits in 2009.

HP49 Enhanced thinking skills and the sex offender treatment programme (SOTP) were still the only accredited programmes. All new arrivals were assessed for programme suitability. Other programmes included the alcohol programme and Sycamore Tree. The lack of a needs analysis made it difficult to identify other interventions that would benefit prisoners at Maidstone.

HP50 On the basis of this short follow-up inspection, we concluded that there had been progress in the development of the offender management unit and the public protection function, but there had been little progress in resettlement services. We considered that Maidstone was still not performing sufficiently well against this healthy prison test.

# Section 2: Progress since the last report

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

## Main recommendations (from the previous report)

2.1 There should be more robust systems for monitoring possible incidents of bullying to ensure that inappropriate behaviour is addressed consistently, and that bullies are challenged and their victims are supported. (HP44)

Partially achieved. The safer custody manager was routinely alerted to potential bullying incidents through security information reports (SIRs) and received copies of all injury to inmates forms (F213s) that reported unexplained injuries. The safer custody team also regularly monitored wing observation books for potential incidents. All other bullying incidents were reported through violence reduction reporting. Sixteen bullying-related SIRs had been submitted since the start of 2009, compared with 28 in 2008, and 90 violence reduction documents, compared with 103 in 2008. The latter included monitoring of victims as well as bullies. The safer custody manager maintained a monthly database of all violence and bullying-related incidents. Incidents were investigated to a reasonable standard. There was a three-stage violence reduction strategy. Stage one involved monitoring, and on stage two the prisoner's incentives and earned privileges (IEP) status was reviewed and restrictions on wing and activity placements considered. Stage three included segregation and possible transfer out of the establishment. The wing observation books we reviewed had few references to bullying and no evidence of under-reporting. Victims were routinely interviewed and monitored, and were referred for various support, including Listeners and the chaplaincy. There were no interventions for bullies or their victims.

Further recommendation

2.2 There should be specific interventions for bullies and their victims.

2.3 The establishment should provide acceptable standards of cleanliness, decoration and care throughout. (HP45)

Achieved. Standards of cleanliness and decoration had improved substantially throughout the prison. The transformation in standards had been aided by the extensive refurbishment of Weald wing, but was mainly due to work by staff at all levels. Cells, communal and outside areas were very clean and tidy, and we saw no graffiti. There were well-supervised wing cleaners and cleaning schedules, and senior managers inspected residential areas quarterly to ensure that standards were maintained.

2.4 More activity places should be provided to enable all prisoners to be purposefully occupied during the working day. (HP46)

Partially achieved. The number of activity places had increased and 94% of the eligible population were actively occupied. However, many prisoners were engaged in low quality work, such as rag cutting, tailoring and paper folding. The number of cleaners employed, 112, was also still high.

Further recommendation

2.5 There should be a wider range of better quality work for prisoners.

2.6 A fully functioning offender management unit should be established to meet the establishment's obligations under the offender management model. (HP47)

Achieved. The offender management unit was well established. It consisted of 13 offender supervisors, including four probation officers and a probation service officer. The head of offender management was a senior probation officer. All prisoners were allocated to an offender supervisor, whether or not they were in scope for offender management.

2.7 There should be a resettlement needs analysis of the population to ascertain the resettlement services required and to form the basis of the resettlement strategy, which should include contributions from outside agencies. (HP48)

Partially achieved. Maidstone had undertaken a needs analysis of the population on which it had based a reducing reoffending policy for 2007/8. There had been no update since because of the change in the prison's population, although work was under way to address this. The absence of an up-to-date strategy meant that some aspects of resettlement, including the development of some resettlement pathways, was lacking.

Further recommendation

2.8 There should be an updated resettlement strategy informed by an up-to-date and comprehensive needs analysis that reflects the changes in the population and meets their needs.

2.9 All prisoners should have some form of custody plan irrespective of sentence length, and all OASys (offender assessment system) assessments should be completed within the set timescales. (HP49)

Partially achieved. Following the change in the prison's function and population, all prisoners were serving over 12 months and were meant to have an OASys assessment. The majority were up to date. Prisoners in scope under phase two of the offender management model were the responsibility of community-based offender managers. Most assessments were completed on time, but 11 had outstanding initial assessments and a further 44 reviews required completion. Offender supervisors were responsible for the assessment of all other prisoners. No initial assessments were outstanding for this group and only 14 reviews were still to be completed. Late reports for in-scope prisoners were escalated through the probation service, and planned video conferencing was expected to enhance this process. However, there had been some significant delays. One in-scope prisoner was almost 18 months past his review date, although he had been at Maidstone for only three months, and a further out-of-scope prisoner was more than six months beyond his planned review date, which had delayed his recategorisation review. The offender management senior officer responsible for quality assurance was aware of both cases and was taking appropriate action.

Further recommendation

2.10 All OASys (offender assessment system) assessments should be completed on time.

2.11 The visiting accommodation in the establishment should be replaced and provide acceptable facilities for all prisoners and their visitors as a matter of urgency. (HP50)

Achieved. The visitors' centre based in the Methodist chapel in the centre of town had been closed and replaced by a small visitors' waiting area inside the establishment. Visitors could use this facility, still called the Dinsmore centre, from 12.15pm on the day of visits, which ran from 1.30pm to 4.30pm every day except Tuesday. The centre offered little more than somewhere to sit and a drinks vending machine, but prison staff were on hand to answer questions and give advice, and it was a considerable improvement on the previous facility. There was a comments book and feedback forms for visitors, but there was no system to respond to concerns raised, although they were passed on to the resettlement manager who was responsible for the facility.

Further recommendation

2.12 Comments in the Dinsmore visitors' book should be responded to, and replies displayed in the centre.

2.13 Maidstone's function as an establishment holding sex offenders should be clarified. The establishment should focus either on sex offenders prepared to participate in programmes or on prisoners who continue to deny their sexual offending. (HP51)

Achieved. Since the last inspection, Maidstone had been identified to become a sex offender main centre for the South East. As a result, the sex offender population had risen to about 60% of prisoners. The psychology and programmes department had been increased to accommodate this change, and the resources for the sex offender treatment programme (SOTP) had been transferred in from HMP Elmley, which had received Maidstone's P-ASRO (prison addressing substance related offending) drug programme in exchange. The prison now delivered the core and rolling SOTPs, along with the better lives booster programme. At the previous inspection, approximately 42% of the sex offender population were not engaging in any form of treatment, because they refused to, denied their offence or were assessed as unsuitable. Despite progress and strategic commitment to clarify the role of Maidstone's work with sex offenders, we noted that the proportion of sex offenders denying their offence was similar to that at the last inspection. The psychology department had identified 403 prisoners as having a current or previous sexual offence, but 114 of the 286 so far assessed (40%) were broadly deemed unwilling to engage with the SOTP. The prison was aware of this issue and was working to establish an effective policy to manage those refusing treatment, although it had yet to be clearly defined.

Further recommendation

2.14 The prison should clearly identify a strategy for effectively managing prisoners unable or unwilling to engage in sex offender treatment.

# Recommendations

## Courts, escorts and transfers

2.15 Prisoners should not be required to remain on the escort vehicle during the midday meal break period. (1.6)

Partially achieved. Although we saw no evidence that prisoners had to remain on vehicles, the reception was not staffed over lunchtime and managers relied on the goodwill of staff to ensure that any prisoners who arrived during this period were disembarked from the escort vehicle.

Further recommendation

2.16 The reception should remain open over the lunch period.

2.17 A member of management should be in touch with escort contractors routinely to resolve operational issues. (1.7)

Not achieved. The prison reported a good relationship with G4S, the escort contractor responsible for inter-prison transfers, and Serco, responsible for court escorts. The head of security and operations said there had been some contact with managers, for example, during the re-role period when a large number of prisoners were transferred into the prison. However, the escort contractors did not attend the security committee meeting, and there was no forum for ongoing contact between the prison and escort contractors.

Further recommendation

2.18 Escort contractors should be invited to attend security committee meetings and regular meetings to resolve operational issues.

2.19 There should be improved arrangements for prisoners' property to accompany them when they are transferred out, or sent on within two working days of their departure. (1.8)

Partially achieved. Arrangements for the transfer of prisoners' property had improved, particularly with the reduction in the number of prisoners transferred, and there was usually sufficient space for property on escort vehicles. However, there were still some problems when prisoners were transferred to a prison with strict limits on the volume of prisoners' property accepted. Where excess property could not accompany the prisoner, it had to be sent to the Prison Service central property store, but this had a minimum for the number of boxes accepted, and property had to remain at Maidstone until this limit was reached, which resulted in considerable delay. For example, one prisoner's property was still in the reception corridor two months after he had been transferred.

Further recommendation

2.20 Prisoners' property should accompany them when they are transferred out or should be sent to the central property store within a week of their departure.

## Additional information

2.21 Most transfers were planned and staff reported that the number had reduced since the prison had re-roled. The prison had no video link facility, and prisoners attending out of area courts had to take all their property with them. The prison escort records we sampled showed that journey times were not excessive, at around two to two-and-a-half hours, and prisoners were routinely given a meal and drink during journeys. Late arrivals were rare.

## First days in custody

2.22 National instructions should be issued about searching arrangements to guide staff dealing with prisoners with disabilities. (1.24)

Achieved. The prison had used guidance from the national security framework to inform its own security strategy and develop instructions, which were available to guide staff in how to deal appropriately with older prisoners and those with disabilities, including wheelchair users.

2.23 Information to new arrivals should be available in a range of languages. (1.25)

Partially achieved. Only limited translated material was available to new arrivals. Reception staff had access to the national foreign national prisoner information booklet in a range of languages, and a little translated information was published on notice boards. Induction peer orderlies said that there was insufficient translated material. There was an over-reliance on the use of prisoners as interpreters, particularly on one induction orderly who spoke several languages. Telephone interpreting services were seldom used during reception, first night or induction.

Further recommendations

2.24 There should be sufficient translated material in a range of relevant languages to support new arrivals and ensure they can fully engage with reception and induction procedures.

2.25 Prisoners should have access to professional translation and interpretation services for matters that require accuracy and confidentiality.

2.26 Property received into the establishment should be issued to prisoners within five working days. (1.26)

Achieved. There was reception cover on weekday evenings and at weekends, chiefly to ensure prisoners' property could be processed. Although staff said that they could be regularly redeployed to other duties during these periods, there was no backlog of property in reception

during the inspection. A manager had checked on the level of property waiting to be issued before the weekend, and the facility had been staffed to deal with this.

2.27 Specific first night cells should be identified in Kent House, and should be certified as fully equipped before their occupation by a new arrival. (1.27)

No longer applicable. First night accommodation was now provided on Weald wing, other than for the few category B prisoners and those who required single cells on the ground floor. Weald had been extensively refurbished and provided a good standard of well-equipped accommodation.

2.28 The revised induction arrangements and their efficacy in identifying resettlement needs should be formally reviewed after they have been in place six months. (1.28)

Not achieved. Although the induction arrangements had been reviewed in 2008 and were extensively reviewed before the re-role of the population in 2009, the reviews had primarily focused on developing an integrated induction programme and had not identified resettlement needs. Induction peer workers routinely interviewed all new arrivals and recorded their resettlement needs in an induction portfolio, and onward referrals were recorded in the portfolio and on the electronic induction database. However, it was unclear how these referrals were taken forward (see paragraph 2.321). The published induction policy included only a minimal reference to links with resettlement.

Further recommendation

2.29 The induction policy should include detailed information on the role of the induction programme in identifying and addressing resettlement needs.

## Additional information

2.30 The reception area was very clean and well maintained. The two holding rooms were small but had a bench and reading material; only one had a television. A reception orderly was no longer available in reception full time, and new arrivals were only given a drink if the orderly was available. There was a shower in reception, although it was seldom used and prisoners normally showered on the unit.

2.31 All new arrivals were seen in a private interview room by healthcare staff and by a safer custody peer worker, who gave them information about how to contact the Samaritans or Listeners and an overview of the prison's safer custody arrangements.

2.32 New arrivals could select from smoker's or non-smoker's packs but did not receive these until Friday, when shop orders were distributed (see paragraph 2.304 and recommendation 2.305). Arrangements for first night telephone calls had been revised in the previous month, but although staff were meant to make a call on behalf of prisoners subject to public protection measures, this did not appear to be happening in practice either in reception or during induction. Procedures were clarified and staff made aware of the requirements during the inspection.

2.33 There were no designated first night cells but the names of new arrivals were clearly recorded in wing observation books to ensure staff could readily identify those on their first night. The first night interview pro forma, which was raised in reception, was supposed to be completed

by the wing senior officer following an interview with the prisoner, but we did not find any completed forms or recorded evidence of such interviews in prisoners' files.

2.34 The rolling induction programme was delivered over five days. It began the first working day after arrival with an interview by one of the three induction peer orderlies who were supported by a small pool of designated induction staff from Weald wing. The orderlies had developed an informative PowerPoint presentation to give new arrivals an overview of key aspects of life at Maidstone and its rules and regulations. A range of departments had input into the induction programme, and an electronic database tracked prisoners' progress to ensure no sessions were missed. Although feedback was routinely sought from prisoners who had completed induction, this data was not collated or monitored to inform further development and reviews of the programme.

Further recommendations

2.35 Both reception holding rooms should be equipped with a television.

2.36 New arrivals should be offered drinks in reception.

2.37 All new arrivals should have access to telephone calls on their first night.

2.38 All new arrivals should have an interview with a member of staff before they are locked up on their first night. Any immediate needs should be recorded and addressed with appropriate follow-up action.

## Residential units

2.39 Wing orderlies should be better managed by staff to ensure all residential areas are kept clean, and daily cleaning routines should support this. (2.17)

Achieved. See paragraph 2.3.

2.40 There should be sufficient time at the end of evening association for prisoners to clean self-catering areas thoroughly, and staff should visibly supervise this process. (2.18)

No longer applicable. All wing-based self-catering areas had been removed.

2.41 The communal areas on Weald House should be refurbished, including showers, association areas and flooring, and the painting parties should be expanded to improve the standard of decoration and remove all graffiti. (2.19)

Achieved. Weald wing had been extensively refurbished, including showers and association areas. It had been freshly painted and there was no evidence of damage or graffiti.

2.42 Staff on Weald should monitor the communal areas to ensure that prisoners do not have the opportunity to vandalise them. (2.20)

Achieved. Staff on Weald made regular patrols of all areas in the wing to dissuade prisoners from causing damage.

2.43 The cell bell call system on Weald should be replaced as a priority. In the meantime, there should be a contingency plan to provide a cell call system for prisoners if the current system fails. (2.21)

Achieved. The cell call system on Weald had been upgraded as part of the wing refurbishment.

2.44 The local environmental health officer should be asked to carry out a full inspection of all food preparation areas in the establishment, including those used exclusively by prisoners, and the prison should act on any recommendations. (2.22)

Achieved. There were annual environmental health inspections.

2.45 There should be toilet privacy screens in all double cells on Kent House. (2.23)

No longer applicable. The double cells on Kent were no longer used for shared occupancy.

2.46 Broken cell windows should be repaired promptly, and the general ventilation and temperature control on residential units should be improved. (2.24)

Partially achieved. There were many broken windows on Kent and a few on Thanet. Most of the broken windows on Kent still had sharp pieces of glass in frames that had not been removed. This was a real hazard as the glass could be used as potential weapons or for self-harm. As many cells had additional glazed closure windows, the broken and missing panes did not necessarily cause draughts. Ventilators were also fitted in the roof of the wings. We received a few complaints from older prisoners on the ground floor of Thanet that the cells were too cold in the winter. These prisoners could have an extra blanket if required.

Further recommendation

2.47 Broken cell windows should be repaired promptly.

2.48 Prisoners should have cell privacy keys. (2.25)

Not achieved. No cells were fitted with courtesy keys.
We repeat the recommendation.

2.49 Staff should respond to cell call bells as a priority, and unit managers should monitor this. (2.26)

Partially achieved. Following the refurbishment of Weald, response times to all emergency cell bells had been computerised. One of the residential principal officers regularly monitored staff responses and raised concerns with wing managers as required. A review of the computerised data confirmed that staff usually answered emergency cell bells within five minutes, but there were a few examples on Kent and Thanet where staff responses took longer.

Further recommendation

2.50 Staff should respond to cell call bells as a priority.

2.51 The use of the public address system should be modified and minimised at times when prisoners are likely to use the telephone. (2.27)

Achieved. The volume of the public address speakers on the wings had been turned down so that they were less intrusive, and staff only used them when it was essential.

2.52 Buddies to support prisoners with special needs should be introduced on all houses. (2.28)

Achieved. The buddy scheme had been implemented on all wings, and a policy document explaining it had been published. Buddies, who were paid an additional £2.50 a week, had been appointed for several prisoners with mobility problems. One buddy explained to us that he routinely collected the meals for a prisoner with severe mobility problems and helped to clean his cell.

2.53 Broken showers should be repaired, cleanliness improved and appropriate water pressure and temperatures be maintained. Showers on Thanet should have privacy screens. (2.29)

Achieved. All showers were clean and fully operational, with adequate water pressure and hot water. The showers on Thanet had been fitted with privacy screens.

2.54 There should be a system to security mark prisoner's valuable property. (2.30)

Achieved. Valuable items, such as radios and CD players, were sealed with foil security seals that had a unique number. The number and description of items were appended to the prisoner's property card.

2.55 Residential laundry facilities should be sufficient for the population, and there should be a contingency plan for when equipment fails. (2.31)

Achieved. Every wing had a small laundry. Prisoners could hand in their clothes to wash each week on a rota. In the event of equipment failure, the main laundry was used as backup.

2.56 All telephones should be checked regularly to ensure they are working, and prisoners should be able to make telephone calls in private. (3.84)

Partially achieved. Staff regularly checked the telephones on all wings, which were all currently working. Some of the telephones, especially on Thanet wing, lacked privacy hoods.

Further recommendation

2.57 All prisoners should be able to make telephone calls in private.

## Additional information

2.58 The previous governor had emphasised raising the standards of cleanliness across the prison, and the improvements in this area were impressive. This was also true of cell standards, and prisoners said they had good access to cleaning materials. Prisoners had daily access to showers, and the standard prison-issue clothes and bedding were good. Staff consistently enforced the published policy on offensive material.

2.59 Weald wing had been completely refurbished and provided good quality accommodation, although inadequate privacy screening in the double cells on the ground floor made them unsuitable for shared occupancy. The double cells on Weald had bunk beds, with a vertical ladder with very narrow steps to the top bunk. The establishment had no policy on the allocation of top bunks, and we were concerned to find a 72-year-old prisoner using one of them. We were told that he and his cell mate, who was 58, wanted to remain together and he was in the top bunk out of personal choice.

2.60 Cells on all wings, except Weald, had small lockable lockers for in-possession medication and personal items. The published facilities list enabled prisoners, subject to their IEP level, to have clothes and various items of property handed in on visits or sent in through the post.

2.61 Bi-monthly prison council meetings were well attended by senior managers and prisoner representatives from each wing. These meetings were a good forum for resolving issues before they resulted in formal complaints.

2.62 The number of telephones on Kent, Weald and Medway wings was sufficient, but Thanet had only six telephones for 174 prisoners, which fell short of our expectation of at least one per 20. However, one of these telephones was sited at height that was accessible for wheelchair users.

Further recommendations

2.63 Double cells on Weald should not be used for shared occupancy.

2.64 The establishment should have a policy on the allocation of top bunks, which takes into account the age of the prisoner.

2.65 All prisoners on Weald should be provided with a small lockable locker.

2.66 There should be at least one telephone per 20 prisoners.

## Staff-prisoner relationships

2.67 Staff should cease to address or refer to prisoners by their number over the public address system. (2.42)

Achieved. The previous governor had issued a leaflet on decency, which included instructions to staff on how to address prisoners over the public address system. All prisoner announcements were respectful, and staff addressed them as Mr or by their first name.

2.68 Managers should encourage staff to find more opportunities to engage positively with prisoners. Conversations through gates or hatches should be kept to a minimum. (2.43)

Partially achieved. Relationships between staff and prisoners had significantly improved overall. However, some staff remained distant and remote during opportunities for positive interaction, such as association. We noted better face-to-face contact between staff and prisoners, especially in dealing with concerns.

2.69 Information about the welfare of a prisoner should be properly recorded, shared with relevant staff and followed up to ensure the prison properly discharges its duty of care.

(2.44)

Not achieved. Although there had been significant improvements in recording in some areas of prisoner welfare, including personal officer entries and ACCT documentation, there were still important areas where this was not regular or records were poor. These included first night interviews, segregation unit records and special accommodation paperwork.
We repeat the recommendation.

## Additional information

2.70 Staff-prisoner relationships had improved since the last inspection. There was a positive atmosphere on all wings, and prisoners went to staff with their concerns. Many prisoners offered unsolicited positive comments about some staff on their wings. There had been a transformation with more opportunities for consultation and a strong emphasis on decency from the senior management team. However, there were still one or two areas, such as association, where increased contact between staff and prisoners was needed. Supervision on wings was good, and staff did not confine themselves to offices.

## Personal officers

2.71 There should be ongoing management checks to assess whether the core requirements of the personal officer scheme are met. (2.50)

Partially achieved. Wing managers made regular checks on the quality of personal officer entries in wing history files. However, in many cases, these were nothing more than a rubber stamp to confirm that a check had been made. These checks often appeared superficial and did not assure us that managers made a meaningful analysis of the quality of entries.

Further recommendation

2.72 Management checks of wing history file entries should be thorough and set out any improvements required in order to demonstrate appropriate quality assurance.

## Additional information

2.73 A published policy document explaining the personal officer scheme had been reviewed in April 2009. On Kent wing, personal officers were allocated on a landing basis. On all other wings, new arrivals were allocated to the personal officer with the current lowest caseload. The names of personal officers and their nominated relief were well publicised across the establishment and prisoners were able to name them. Many prisoners also spoke very highly of the work and support from their personal officers. Entries in wing history files were made fortnightly, and their quality was very high and consistently demonstrated knowledge and engagement. We found many examples of good personal officer work in wing files, including a member of staff on Thanet who had provided ongoing support to a prisoner with learning difficulties. Good links with offender supervisors were confirmed by staff in the offender management unit and personal officers themselves.

## Bullying and violence reduction

2.74 The results of the prison's prisoner survey should be incorporated into an action plan to support the new violence reduction strategy. (3.7)

Not achieved. There had been a survey in February 2009 but it had not been analysed. All prisoners had been given a copy of the survey but the response rate had been very poor with approximately only 60 returns.
We repeat the recommendation.

2.75 There should be a distinct and transparent process to investigate prisoner allegations of victimisation by staff. (3.8)

Achieved. Complaints against staff were dealt with through the normal complaint system or formal investigations commissioned by the governor. There had been 17 complaints against staff through the complaint system since the start of 2009, and a sample of these confirmed that they had been investigated appropriately.

## Additional information

2.76 The violence reduction policy had been revised in July 2009, but did not clearly explain how the anti-bullying procedures should be implemented. The safer custody team met monthly and was chaired by the head of residential. Meetings were well attended and included representatives from the local Samaritans, Listeners and violence reduction representatives. Monthly monitoring data was collated by the safer custody manager but did not routinely include all potential indicators of bullying identified in the violence reduction strategy document, for example, requests for own protection or transfers. The published minutes of the safer custody committee also gave no assurance that it discussed or analysed any data supplied for any trend analysis.

2.77 There were violence reduction prisoner representatives on each wing who had regular meetings with the safer custody manager. There were nine open violence reduction booklets at the time of inspection, seven on level one and two on level two. Staff made regular monitoring entries but they were generally observational with no real evidence of their engagement or support.

2.78 The level of violence at was low, at 17 reported assaults since the start of 2009.

Further recommendations

2.79 All potential indicators of bullying should be monitored monthly and trends established, and safer custody meetings should analyse and discuss figures.

2.80 Staff monitoring entries in violence reduction booklets should demonstrate their engagement and support.

## Vulnerable prisoners

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

## Additional information

2.81 The number of vulnerable prisoners had increased significantly since the last inspection. Medway, Thanet and half of Weald wings now held vulnerable prisoners. Most were sex offenders (368 prisoners), who made up 62% of the population. The establishment had introduced complete integration of free flow and activity placements since the last inspection, and these arrangements worked well. This was confirmed by the figure of only 13 prisoners held in the segregation unit for their own protection since the start of 2009.

## Self-harm and suicide

2.82 Care maps should address all issues highlighted through the initial assessment interview. (3.20)

Achieved. Care maps were relevant, well constructed and addressed all the main issues identified in the initial assessor's report. They were also regularly reviewed and updated.

2.83 There should be greater consistency of the case manager to ensure continuity of care to a prisoner in crisis. (3.21)

Achieved. Consistency of the case manager at case reviews had improved since the last inspection, although this was not always possible due to staff absences.

2.84 Staff interactions with prisoners at risk should be meaningful, detailed and respectful. (3.22)

Achieved. Monitoring entries in assessment, care in custody and teamwork (ACCT) self-harm monitoring documents were of a very high standard and demonstrated a real commitment from staff to the care of those identified as at risk. Staff had a good knowledge of the prisoners involved and went out of their way to engage actively with them.

2.85 All serious attempts at self-harm and/or suicide should be investigated and an action plan devised to reduce the possibility of a similar occurrence. (3.23)

Achieved. There had been 35 self-harm incidents in the eight months to the end of August 2009. The safer custody manager maintained a register of all self-harm incidents, and all had been appropriately investigated. Action plans were devised where necessary.

2.86 The practice of moving prisoners at risk, and/or Listeners in ratchet cuffs through the night state should cease, and ratchet cuffs should only be used to move prisoners on the basis of supporting security intelligence. (3.24)

Achieved. All wings had their own Listener suite so it was no longer necessary to move at-risk prisoners outside their own wings at night. Listeners were located on all wings except Kent. If Listeners had to be moved on to Kent at night, they were escorted by staff but were not cuffed.

2.87 The Listener rooms should be redecorated to provide a clean and welcoming environment for prisoners at risk of suicide or self-harm. (3.25)

Achieved. All Listener suites were clean, recently redecorated and welcoming. They had a

kettle and tea-making facilities, and a radio and distraction material, such as board games. The Listener suite on Weald also had a television.

2.88 A Listener room should be installed on the induction unit (Kent). (3.26)

Achieved. There were Listener suites on all wings, including Kent (see above).

2.89 Regular formal meetings should be established between Listeners and the Samaritans. (3.27)

Achieved. There was a formal monthly meeting between the Samaritans and the Listeners. The Samaritans also visited the establishment each week and toured the wings to speak to Listeners and any prisoners who wanted to see them.

2.90 The new ligature knives should be issued to staff immediately. (3.28)

Achieved. All frontline staff had personal issue anti-ligature knives, which they carried around on their belts.

## Additional information

2.91 All procedures relating to suicide and self-harm were managed through the safer custody committee. There was a suicide and self-harm policy document, last reviewed in July 2008. The safer custody manager provided key monitoring data to the committee, but published minutes gave no assurance that there was any analysis or review of this information.

2.92 A safer custody peer worker saw all new arrivals in reception in private. He gave them a safer custody handout, which included information on the Samaritans and Listeners. New arrivals were initially placed on Weald wing, where there were also Listeners, and had a group session with a Listener as part of the induction programme. Relevant safer custody information was also well publicised across the establishment.

2.93 The establishment had a very good relationship with the local Samaritans. There were 18 trained Listeners, and there were plans to train some suitable foreign national prisoners to cover Kent unit. There had been 58 ACCT documents opened in the first eight months of 2009, compared with 86 in 2008, which was not excessive. The high standard of ACCTs (see paragraph 2.84) was maintained through regular checks of open documents by the safer custody manager, who sent advisory notes to wing managers where shortcomings were identified.

2.94 There had been two deaths in custody since the last inspection, one self-inflicted and one due to natural causes. Action plans had been devised to address the recommendations in both reports and were up to date.

Further recommendation

2.95 The safer custody committee should discuss and analyse suicide and self-harm monitoring data provided by the safer custody manager, and this should be evidenced in the published minutes of the meetings.

Good practice

2.96 *The safer custody manager reviewed all assessment, care in custody and teamwork (ACCT) documents regularly and issued advisory notes to wing managers where shortcomings were identified. This had played a significant part in raising the standard of ACCT documents to a consistently high level.*

## Applications and complaints

2.97 Applications forms should be freely available to all prisoners throughout the day. (3.99)

Partially achieved. Although all wings had specialist application forms – including for healthcare, employment and other departments – displayed in communal areas, the general application form was usually issued each morning by staff rather than being freely available on the wings.
We repeat the recommendation.

2.98 Applications should be logged when they are sent out to departments, and the outcome and date of response should be recorded. (3.100)

Partially achieved. An applications database included a range of information, including the date the application was submitted, to whom it was forwarded and the date of the response. The only data not recorded was the outcome of the application. This system enabled applications to be tracked. However, in August 2009, a third of applications on one wing were awaiting a response. Some prisoners had waited over 40 days to receive a response.

Further recommendation

2.99 Outstanding applications should be followed up regularly by managers until a response is provided.

2.100 There should be a system to quality check the responses to complaints. (3.101)

Not achieved. There was no formal quality assurance process to check responses to complaints. Some checks took place, but these were ad hoc.
We repeat the recommendation.

2.101 There should be a detailed monthly analysis of complaints to identify and rectify any emerging trends. (3.102)

Not achieved. Although all complaints were logged on a comprehensive database by applicant, location, problem area, type of complaint and date of resolution, the information was not collated or reported to the senior management team.
We repeat the recommendation.

2.102 Prisoners who make complaints should receive a proper response rather than a standardised letter. (3.103)

Partially achieved. Prisoners received an individual response to complaints. Most were

respectful and addressed prisoners by name, although a few were curt. Some confidential access complaints deemed not to meet the criteria had been returned to prisoners with a standard letter that advised them to resubmit complaints on the correct form or raise the issue with identified staff. This response caused delays.

Further recommendation

2.103 There should be responses to complaints made erroneously under confidential access to avoid delays.

2.104 Confidential access complaints should be answered by the governing governor. (3.104)

Partially achieved. Confidential access complaints were usually answered by the governor or the deputy governor. However, we found examples of complaints that referred to other issues, for example, healthcare, that were referred to the relevant manager for a response.
We repeat the recommendation.

2.105 Explanatory information about the confidential access system should be circulated to prisoners. (3.105)

Achieved. The request complaints clerk had prepared an information board for each wing, which included information about the various stages of the complaints process, including confidential access. This was available in English only.

Further recommendation

2.106 Information about the complaints system, including confidential access, should be available in a range of languages.

2.107 Complaint forms should be available to prisoners in all houses. (3.106)

Achieved. Complaints forms and envelopes were available in all wings, and stocks were regularly replenished.

## Additional information

2.108 The night orderly officer opened the complaints boxes, and complaints were collected by the complaints clerk the following morning. Complaints were recorded on a database, and sent to the relevant department with a date when a response was required. Requests to other prisons also included a target date for responses. Most internal complaints were responded to within the agreed timescale and were progress chased.

2.109 In the previous three months, 435 complaints had been submitted, and there had been 999 in 2008. The prime areas for complaints were property and cash. A few complaints had been submitted to the Independent Monitoring Board and the area manager, and only one had been forwarded to the Prisons and Probation Ombudsman. We interviewed one prisoner who had withdrawn a complaint against a member of staff following a recommendation by a member of staff, as he felt under pressure to do so. This was inappropriate.

Further recommendation

2.110 The complaints clerk should empty the complaints boxes every day.

## Legal rights

2.111 The legal services scheme should be relaunched and publicised widely to prisoners and staff. (3.112)

Not achieved. There were no legal services officers in the prison and training had been suspended. One governor who had received training in the past offered advice on a case-by-case basis, but this was limited. An appellants' register was held in the discipline office.
We repeat the recommendation.

2.112 The library should provide a wider range of information on legal rights. (3.113)

Achieved. There was a reasonable range of legal texts and information in the library. In addition to Prison Service orders and instruction, relevant texts included Archbold, the Immigration Handbook, Prison Law, and texts on legal aid, bail for immigration detainees, and grant making trusts. This selection had increased since the last inspection. The library also stocked information on civil issues, such as family courts, contact with children and debt

## Additional information

2.113 Legal visits took place each weekday morning and could be booked for up to two hours. They took place in a facility separate from the main visits hall, and included 13 tables, two private interview rooms, and a closed visits facility. Since the beginning of 2009, 48 prisoners had registered as appellants. Legal mail was managed appropriately.

## Faith and religious activity

2.114 Worship areas should be equipped with appropriate facilities and resources for all faiths. (5.42)

Partially achieved. All faith-based activities took place in the large chapel where the rear section could be screened off for multi-faith activities. Separate lockable cupboards were provided for each faith and could be accessed by the chaplains. However, there were still no separate washing facilities for Muslim prisoners. Prisoners could use washing facilities on the wing before Friday prayers, and the Muslim chaplain said this was not presenting difficulties for prisoners.

Further recommendation

2.115 There should be washing facilities for Muslim prisoners in the worship area.

2.116 The searching policy for prisoners attending worship should be transparent and fairly applied, and its use monitored. (5.43)

Not achieved. Concerns had been raised at the previous inspection about the searching of Muslim prisoners following Friday prayers. The Muslim chaplain said that this was no longer a concern. However, prisoners who attended the bi-monthly Pentecostal service had been searched twice by passive drug dogs since the beginning of 2009. Many foreign national prisoners attended the Pentecostal service and believed they had been deliberately targeted by the security department. The security governor had recently met prisoners to listen to their concerns, but many prisoners raised this issue with us and clearly felt victimised.
We repeat the recommendation.

2.117 Residential staff should ensure that prisoners are unlocked at the correct time to attend religious services. (5.44)

Achieved. Chaplaincy staff confirmed that prisoners arrived for religious services at the required time and that there were no delays in their escort to the chapel and multi-faith area.

2.118 The chaplaincy team should be involved in ensuring the shop list and range of menus meet the needs of all faith groups. (5.45)

Achieved. The Muslim chaplain had been invited regularly to attend the shop consultation meeting, and this was reflected in the notes of the meetings. The coordinating chaplain had links with the catering manager and the kitchen, and had been invited to catering consultative meetings regularly since the last inspection. The Muslim chaplain also visited the kitchen regularly.

## Additional information

2.119 A full-time coordinating chaplain was supported by a large team of sessional chaplains. There was a pastoral approach from the chaplaincy, which was well integrated into the establishment. Chaplaincy activities included services or study on most days of the week.

2.120 Since the prison population had changed, there had been increased attendance at services, which had doubled at some faith groups. Chaplaincy staff were aware that the chaplaincy programme might need to change to meet prisoner demand.

2.121 The Sycamore Tree victim awareness programme was delivered through the chaplaincy. Three programmes had been funded in the previous year, and programmes were currently delivered when there was sufficient demand.

## Substance use

2.122 There should be a comprehensive clinical policy and protocol that reflects national guidance and incorporates the needs of prisoners under the integrated drug treatment system. (3.124)

Achieved. There was a current integrated drug treatment system (IDTS) treatment plan with appropriate clinical protocols for methadone and Subutex, client acceptance criteria and links with counselling, assessment, referral, advice and throughcare services (CARATs). The prison had decided in June 2009 to enable initiation of new clients alongside continued clinical provision and had accepted one client on this basis, but this decision had not yet been

reflected in the treatment policy criteria. The doctor providing the medical review role had recently resigned, but another GP was due to complete Royal College of General Practitioners part two substance use training, and the required 13-week medical reviews of individual cases would be completed appropriately

Further recommendations

2.123 The integrated drug treatment system (IDTS) treatment policy/acceptance criteria should be updated to reflect the decision to initiate methadone treatment.

2.124 The IDTS programme should have continuous medical cover to ensure compliance with required reviews.

2.125 There should be action to minimise the use of opiate-based medication and reduce the risk of its illicit use within the prison. (3.125)

Achieved. Prescribing of opiate-based medication was reviewed regularly through the prison's GP meeting and HMP Rochester's pharmacy prescribing reviews. We were told that levels of prescribing were within acceptable limits and there was no evidence of significant abuse of prescribed opiates. Nurses conducted regular medication checks, including on opiates, particularly where there was evidence of possible abuse of prescribed medication. There were lockable lockers in cells in all wings except Weald (see recommendation 2.65), and nurses said they had no concerns about significant illicit use of prescribed opiates on this wing.

2.126 There should be protocols and procedures to facilitate effective joint working between the counselling, assessment, referral, advice and throughcare service and the mental health in-reach team. (3.126)

Achieved. CARATs worked closely with all healthcare staff and services, including the mental health in-reach team, and the protocols reflected this relationship.

2.127 Drug testing figures should be collated by type and separated by house to provide effective management information. (3.127)

Achieved. We saw drug testing data for March to August 2009 inclusive. All data for mandatory drug testing (MDT) and compact based drug testing was collected by type and separated by wing. The data was analysed by test type, location, house and drug type, which enabled clear scrutiny of any variance.

2.128 Mandatory drug testing should have sufficient staff to ensure that it is carried out appropriately, within identified timescales and without gaps in provision. (3.128)

Achieved. The MDT suite was staffed by two officers. It usually operated for a morning and afternoon session each weekday, and undertook four tests a day. There was at least one random test a day. Most positive tests were suspicion tests, which we were told derived from good quality intelligence. In the previous six months, suspicion tests had almost always been achieved within the 72 hours limit. Positive suspicion rates were all between 40% and over 80%, except in July 2009 when the number was small and the rate dropped to 12.5%. There had been some instances, especially at weekends, when suspicion tests had not been carried out due to staff shortages. There was no data showing reception testing. There had been one prisoner on frequent testing in the previous six months, following adjudication, who was due for discharge.

## Additional information

2.129 There had been an alcohol needs analysis in 2008, but the demand for the Rubicon alcohol awareness programme and attendance by Alcoholics Anonymous indicated increased alcohol-related needs with the change in population.

Further recommendation

2.130 There should be an up-to-date alcohol needs analysis.

## Diversity

2.131 Prisoner representatives should attend the equal opportunities meeting. (3.38)

Achieved. The diversity and race equality action team (DREAT) met bi-monthly, and prisoner representatives were always present. In the intervening months, there were meetings of prisoner representatives for diversity, older prisoners, disability and foreign nationals with the diversity manager.

2.132 There should be active engagement with a range of community-based organisations to develop the diversity work. (3.39)

Achieved. There was now good liaison with Medway Human Rights and Equality Council, whose representative came in regularly, and attended the DREAT meeting when possible. The diversity manager had developed contact with the Maidstone Volunteer Bureau. The officer responsible for disabled and older prisoners' issues had good links with community organisations, including the organisation of a conference on disability hate crime.

2.133 All staff should receive diversity training. (3.40)

Partially achieved. Diversity training had been delivered regularly in alternate weeks since its national reintroduction in January 2009, and 62% of staff had completed it so far –133 uniformed and 57 non-uniformed staff. However, 117 remained to be trained. Other establishments had visited to learn from the delivery of this training.
We repeat the recommendation.

## Additional information

2.134 The diversity manager, who was also the community engagement manager, had recently taken on this role, and had not been able to access formal training as none was currently available. He was a member of the senior management team. There was a full-time disability and older prisoner manager, who had completed training on the management of older prisoners and who also assisted across the full range of diversity issues. The diversity manager produced clear and comprehensible monthly graphic presentations of patterns and trends in diversity issues for the senior management team and DREAT.

2.135 A transgender prisoner was resident during the inspection. A workshop had been held for 40 staff, facilitated by a transgender representative from Prison Service headquarters. This prisoner was very complimentary about her treatment at Maidstone. Searching had been

carefully arranged to ensure respectful treatment. Lesbian, gay, bisexual and transgender networks had been consulted to select appropriate films for the in-cell video channel.

2.136 The workload on disability and older prisoners had increased substantially with the recent change in the population profile; there were 74 prisoners over 60, including 23 over 70. Older prisoners were generally well cared for, although it was inappropriate for a 72-year-old to be allocated an upper bunk (see paragraph 2.59). Well-developed plans to deliver a social care national vocational qualification had been stopped on guidance from headquarters, as most of the likely candidates would have a record of sexual offending. The buddy scheme for older prisoners and those with a disability (see also paragraph 2.52) was supported by a clear protocol and appropriate selection criteria. There were library and gym sessions for older prisoners. Ten mobility scooters were available for prisoner use, and they were used daily. There was careful advance assessment of prisoners with disabilities being considered for transfer to Maidstone. There were two dedicated cells for prisoners with disabilities (on Weald and Kent wings), which were appropriately laid out and equipped.

2.137 An IT programme had been effectively used for prisoners with difficulties in reading English – especially dyslexic prisoners – to present straightforward information on several topics in graphic form.

Further recommendation

2.138 Training should be available for all newly appointed diversity managers.

## Race equality

2.139 Race equality coordinators should be appointed on all houses. They should receive training in racist incident investigation, and provide cover for the race equality officer. (3.52)

Partially achieved. Two staff who had completed the national training for this role were functioning as race equality officers. Managers said the absence of further race equality coordinators was due to the current unavailability of this training.
We repeat the recommendation.

2.140 Use of force incidents should be reviewed to demonstrate that black and minority ethnic prisoners are not targeted unfairly or remedial action taken. (3.53)

Achieved. The diversity manager and his deputy attended the segregation monitoring and review group each month, where each use of force case was reviewed and diversity issues examined. The control and restraint instructors covered cultural differences in behaviour and language in interpreting and assessing risk. (See also paragraph 2.147.)

2.141 Relevant information about race equality action should be circulated to prisoners through prisoner council meetings, notice boards and information sheets. (3.54)

Achieved. Although there were no information sheets in circulation, notice boards carried up-to-date information, minutes of the DREAT, and photographs of the DREAT staff.

2.142 The establishment should engage more actively with the local community to foster positive race relations. (3.55)

Achieved. In addition to the close engagement with the local equality council (see paragraph 2.126), there had been consistent work to link with the Gypsy and Traveller community. The county council worker with the Gypsy and Traveller community had visited, and the diversity manager had worked with a local Gypsy and Traveller museum to mount a special event in the prison. The establishment had also supported a local black and minority ethnic periodical by producing it in the prison print shop.

2.143 Information on management trends, action taken and details of external auditing of racist incident complaints should be publicised to prisoners to foster confidence in the complaints system. (3.56)

Partially achieved. The Medway Human Rights and Equality Council representative had audited investigations of racist incident reports, and two reports from him were displayed for prisoners – but none more recent than June 2008. No other information about analysis, trends or actions in response to complaints was available to prisoners.

Further recommendation

2.144 Regular information about racist incident complaints should be issued to prisoners, covering patterns and trends, action taken, and details of external auditing.

2.145 Key staff should attend race impact assessment training. (3.57)

Achieved. Relevant staff had completed the training when it was available, including most of the senior management team. The diversity manager was doing one-to-one training with staff who carried out impact assessments.

## Additional information

2.146 Black and minority ethnic prisoners reported concerns about disproportionate searching, including when they were leaving visits and the chapel (see paragraph 2.116), and target searches of cells. The head of security was aware of some of these negative perceptions and there had been some engagement with black and minority ethnic prisoners (see paragraph 2.245), but the perceptions still needed to be addressed.

2.147 Although the DREAT had noted some issues emerging from ethnic monitoring, there was little evidence of substantive investigation. For example, 97% of those given release on temporary licence in the six months to August 2009 were white. Of 15 prisoners given category D status in the previous six months, 75% were white British (although most of these were in March, before the change of role). These facts had not been noted. The proportion of black and minority ethnic prisoners in use of force incidents had been consistently within, but towards the upper end of, the expected range over the last year, but there had been a significant over-representation in August 2009. In the incentives and earned privileges scheme, 56% of black and minority ethnic prisoners were on enhanced status, compared with 61% of white prisoners, although the numbers fell within the expected range.

2.148 Racist incident reporting forms were freely available on all wings and in the chapel, and were collected each night by two staff. Reports were properly investigated and were all signed off by the governor, but he had not recorded any comments on forms in 2009.

2.149 A three-day cultural festival had been held in 2008, with dancers, drumming and singers, and other cultural events had been held in 2007 and 2008. Such activities had been largely curtailed by the public acceptability test, introduced by the Ministry of Justice to curb activities that could be seen as unacceptable in the context of a prison sentence. However, black history month was well observed each October.

Further recommendations

2.150 The cell allocation of older prisoners and those with disabilities should be informed by an assessment of suitability, and a clinical assessment made in cases where wing staff are uncertain.

2.151 The diversity and race equality action team should discuss any ethnic or other imbalances that emerge from ethnic monitoring, and commission specific further investigation where necessary.

2.152 Completed racist incident reporting forms should include the governor's evaluation of the investigator's method and conclusions.

## Foreign national prisoners

2.153 There should be a survey of foreign national prisoners to establish their needs, inform the establishment's policy and to focus resources. (3.65)

Partially achieved. A survey had been carried out in November 2007, but none since then. The number of foreign national prisoners had almost doubled with the change of role in 2009. This necessitated a new survey, which would need to be repeated regularly given the changing nature of this population.

Further recommendation

2.154 There should be a survey of foreign national prisoners to establish their needs, and to inform policy and planning, and this should be repeated at regular intervals.

2.155 A foreign national officer should be appointed with protected facility time and should be given appropriate training. (3.66)

Achieved. The resettlement manager was the foreign national coordinator. Until recently, this had been a full-time role for a senior officer. A senior officer and an officer on Kent wing were given time to lead work with foreign national prisoners on that wing, where most were located. Staff were trained through familiarisation visits to HMP Canterbury, a specialist prison for foreign national prisoners.

2.156 Information about the support available to foreign national prisoners, including photographs of staff and prisoner representatives, should be displayed on the houses and should be available in a range of relevant languages. (3.67)

Partially achieved. Some information was displayed, and the full foreign national prisoner management policy was available on all wings. It was not yet translated into other languages, on the grounds of cost. An edited version, containing all the material directly relevant to

prisoners themselves, could be produced at about half the length of the full document, in liaison with the UK Border Agency, and translated into the most common languages spoken by foreign national prisoners. Photos of foreign national peer supporters and relevant staff not on the DREAT were not displayed on wings.
We repeat the recommendation.

Further recommendation

2.157 Guidance for foreign national prisoners should be drafted, in consultation with UKBA staff, and translated into the main languages spoken by foreign national prisoners.

2.158 A list of contact details for relevant consulates, embassies and support organisations should be drawn up and displayed prominently on the houses. (3.68)

Partially achieved. The contact details were contained in the new strategy document, but were not displayed on the wings. The diversity manager had contacted many embassies, and was arranging visits by staff from the Irish and Czech embassies. Details of some support organisations were displayed on some wings.
We repeat the recommendation.

2.159 Voluntary and community based organisations should be invited to the establishment to run monthly foreign national surgeries. (3.69)

Achieved. The Institute of Migration was due to attend to advise prisoners on the facilitated return scheme. The Detention Advice Service came in during the inspection, and the Immigration Advisory Service was due to visit. Discussions were also taking place with Migrant Helpline.

2.160 Administrative staff who deal with foreign national prisoner paperwork should receive appropriate training. (3.70)

Achieved. No Prison Service training was available, but administrative staff had visited other establishments in the area to gain knowledge and understanding from colleagues experienced in the field.

## Additional information

2.161 Maidstone had recently increased its foreign national population to more than 40%. This was part of a national programme to concentrate these prisoners in certain prisons. The more frequent attendance of immigration officers had relieved pressure on Prison Service staff, although some prisoners – particularly some transferred from Coldingley – were not happy that they had been transferred to Maidstone.

2.162 UK Border Agency (UKBA) staff were in the establishment on two days a week. On the Monday of the inspection, one immigration officer visited for half the morning, and departed early because of a lack of applications to see him. There were good working relationships between UKBA staff and uniformed and non-uniformed prison staff responsible for foreign national prisoners. Prisoners appreciated making appointments with an immigration officer, and uniformed staff felt that this reduced the burden on them.

2.163 A strategy for managing foreign national prisoners had recently been published. Foreign national meetings were held bi-monthly. A foreign national forum had also been launched, and two sessions had been held.

2.164 The issues most raised by foreign national prisoners were the difficulty of being recategorised to category D, and of being granted release on temporary licence (ROTL). The establishment was aware of these concerns and managers had met groups of prisoners to address them. The national requirement of evidence of 'very low risk' to attain category D raised the bar very high for foreign national prisoners, especially since there was no such category in OASys or any other formal risk assessment system. The foreign nationals coordinator had reviewed category D and ROTL applications for a six-month period, and had found no evidence of discrimination. However, the imbalance noted in paragraph 2.147 raised some concerns.

2.165 Staff confirmed that the free monthly telephone call to foreign national prisoners not receiving visitors was provided only through a written application. Some prisoners had not been aware of this and had missed the opportunity.

2.166 There was a list of staff and prisoners who could interpret in 27 languages. Peer interpreters were routinely used for adjudications. There was no evidence that telephone interpretation was used for adjudications, and, overall, use of telephone interpretation was rare.

2.167 There were information points with information in a range of languages on all wings, but not all were operative. Translated notices were distributed unevenly around the wings, with no evidence of establishment coordination and planning. There was insufficient translated material in the induction process. The library had newspapers in Turkish, Russian, Romanian, Polish and Portuguese, and several shelves of books in foreign languages.

Further recommendations

2.168 A free monthly telephone call should be offered to foreign national prisoners not receiving visits.

2.169 Photographs of foreign national liaison officers and foreign national peer supporters should be displayed on the wings.

2.170 Managers should monitor the award of release on temporary licence and category D status to ensure that, as far as possible, foreign national prisoners are considered on the same basis as British nationals, and to take appropriate action where there is an imbalance.

2.171 The multi-language electronic information points should be operative on all wings.

2.172 Professional interpretation should be used in all circumstances in which confidentiality is normally guaranteed.

2.173 There should be consistency across the prison in the notices displayed in translation.

2.174 The requirement that category D status for foreign national prisoners should be limited to those presenting very low risk should be revised to ensure consistent and fair treatment.

## Health services

2.175 The poorly maintained areas of the health centre should be refurbished to provide a hygienic and welcoming environment. (4.32)

Achieved. All areas apart from the general office had been refurbished, and a treatment room ceiling awaited repairs. The two waiting rooms were clean and bright and displayed health promotion material. The toilets in the waiting rooms were clean but had no soap or paper towels.

Housekeeping point

2.176 Toilets in the health centre waiting rooms should be checked regularly to ensure they have soap and paper towels.

2.177 There should be a prison-wide approach to the promotion and protection of the health and wellbeing of prisoners, including oral health. (4.33)

Achieved. A registered general nurse (RGN) was the lead for health promotion. A document described health promotion services, but there were no details of planned action. There was a health promotion committee chaired by a governor, although it had not met regularly. Health promotion materials were displayed across the healthcare department, library, gym and staff mess, and some leaflets in the healthcare department were available in foreign languages. Material on oral health was available. Health services had effective links with gym staff, particularly on exercise for the over-50s. The pharmacy technician and a bank nurse staffed regular stop smoking sessions.

2.178 Analysis of significant events should cover those with a potentially adverse effect on a prisoner's treatment and care, wherever and whenever they occur and whoever is involved. (4.34)

Partially achieved. All serious untoward incidents were logged and formally reviewed by a group of healthcare staff, including those directly involved in the incident. Only 11 incidents had been reported in the year to the end of March 2009 and two between April and September 2009, which was low for the number of consultations. All such incidents were reported to the clinical governance committee, primary care trust (PCT) and the partnership board. In 2008, there had been two similar instances of nurse transcribing errors involving confusion between two prescribed drugs. Since then, a pharmacy technician had been appointed, the nurse involved removed from this duty, and there was a new system that required two nurses to check all transcriptions.

Further recommendation

2.179 Health professionals should formally report all incidents and near-misses that could have an impact on patient care.

2.180 Responses to health complaints should be in plain English and acknowledge the concerns of prisoners. (4.35)

Achieved. There had been 29 complaints about healthcare in 2008 and 21 in 2009 to date. Responses were in plain English and were factual and respectful. Complaint forms were available on the wings. The NHS complaints telephone number had been added to prisoners personal identification number (PIN) telephone numbers and this information was available on the wings. Information about the Independent Complaints Advocacy Service (ICAS) was also displayed near wing telephones. All complaints received by the PCT were cross-referenced with the healthcare department to ensure that all internal mechanisms had been exhausted before the complaint could go to the PCT and/or the Ombudsman. Prisoners said that they were generally satisfied with healthcare.

2.181 The healthcare department should be able to demonstrate equity of access to health services. (4.36)

Not achieved. There was no formal system to monitor equity of access. There had been some efforts to review the available data manually, but there was no evidence that this was systematic or provided what was required.
We repeat the recommendation.

2.182 Prisoners should not be used to interpret for patients who do not speak English. (4.37)

Not achieved. Staff told us that other prisoners were sometimes used to interpret and that prisoners sometimes requested this. One of the GPs was multilingual and staff said that where possible he was used to interpret. Although a professional telephone interpreting service was available, it was not widely used, and could not be used in the healthcare room in reception, which had no telephone (see further recommendation 2.205). When prisoners were due to attend external hospital appointments, the hospital was notified in advance to ensure there was formal interpreting.
We repeat the recommendation.

2.183 Staff should be able to have external clinical supervision. (4.38)

Not achieved. There was a clinical supervision policy, but staff were not required to secure appropriate external supervision and most staff did not have formal supervision.
We repeat the recommendation.

2.184 Prisoners should be given information about health services and how to access them in plain English and with appropriate pictorial representations for people with poor literacy or little English. (4.39)

Partially achieved. A general information leaflet about health services was not easy to read and was in English only. The application form for healthcare was in simple language and had picture icons for the various healthcare professionals. There was a discharge leaflet that was simple to read and provided general information about local and national health services, as well as enabling healthcare staff to provide specific information for individual prisoners.
We repeat the recommendation.

2.185 The dentist should keep complete clinical records, and dental appointments should be noted in the patient's main clinical record. (4.40)

Achieved. The dentist kept separate detailed paper records and recorded a brief summary in the main paper clinical record. There was no evidence of recording in the electronic clinical record. Dental records were kept in a locked cabinet in the dental suite.

2.186 Health screening during reception should concentrate on identifying and meeting the immediate physical and mental healthcare needs of the prisoner, who should also have the opportunity to attend a secondary health screen or well man assessment. (4.41)

Achieved. All new arrivals received an initial health screen in reception. Any immediate physical health needs were dealt with by referral to the appropriate health professional. Prisoners with a previous history of mental health needs, or whose reception screen identified a need, were booked for a mental health assessment. All new arrivals were invited to a well man clinic (secondary screening) in the healthcare department within their first five days.

2.187 The healthcare department should contribute to induction. (4.42)

Not achieved. The induction programme did not include healthcare, although the department had contributed previously.
We repeat the recommendation.

2.188 Prisoners should be able to make a confidential application for a healthcare appointment and failure to attend should not be dealt with through the incentives and earned privileges system. (4.43)

Partially achieved. Prisoners could make an application to see any healthcare professionals through a specific form available on the wings, but there were no separate healthcare application boxes to ensure confidentiality. There was no formal triage system but a nurse ensured that all prisoners attending healthcare were dealt with by the appropriate health professional. We saw no complaints from prisoners about this system, and prisoners told us that they could usually see doctors and nurses as required. We found no evidence that non-attendance was dealt with through the IEP system.

Further recommendation

2.189 Prisoners should be able to make a confidential application for a healthcare appointment.

2.190 Clinical algorithms should be used for nurse-led activities to ensure consistency of advice and treatment. (4.44)

Not achieved. There were no clinical algorithms, although there were current discussions with HMP Canterbury on their use.
We repeat the recommendation.

2.191 The dental waiting list should be reduced. (4.45)

Achieved. There were 85 prisoners on the dental waiting list, with a maximum wait of up to seven weeks at the time of the inspection, compared with three months at the previous inspection. The PCT had commissioned additional sessions to reduce and maintain reasonable waiting times. Urgent cases, such as infections, were prioritised and seen within a week or sometimes sooner.

2.192 Prisoners should have access to the services of a pharmacist, who should also actively contribute to the development of effective medicines management in the prison. (4.46)

Partially achieved. There was no dedicated pharmacist, but a full-time accredited pharmacy technician had been employed since March 2009, which had improved pharmacy services.

HMP Rochester provided the pharmacy service and two pharmacists, or one pharmacist plus two technicians, from Rochester visited monthly to check stock, the register of controlled drugs and their disposal, refrigerator temperatures and to review prescribing practice. The prison also had two independent nurse prescribers, which supported the maintenance of an effective pharmacy service and enabled prisoners to have more rapid access to medication. Prescribing and pharmacy issues were reviewed at the GP team meeting, which the head of healthcare attended. A regional prison medicines and therapeutics committee scrutinised prescribing and pharmacy-related issues. While this was a significant improvement since our last inspection, it did not address the need for both staff and prisoners to have professional pharmacist advice for prescribing and therapeutic issues.
We repeat the recommendation.

2.193 The role of the doctor in risk assessment for medicines to be held in possession should be clarified. (4.47)

Achieved. There was an in-possession medication policy, which had been reviewed in March 2009. All prisoners were risk assessed for in-possession medication on a form that was completed by a nurse and countersigned by a GP.

2.194 Patients should be able to collect their medicines in privacy from other prisoners. (4.48)

Achieved. Since our last inspection, a privacy hood had been added to the medication hatch. We observed an orderly and well-controlled medication queue. However, the recent integration of all wings to collect medication had resulted in more prisoners queuing up, and they had to wait outside the healthcare department building. We were told that the maximum waiting time was approximately 30 minutes, and prisoners stood outdoors for much of this time. This was not a satisfactory arrangement, particularly for the increased number of older and frailer prisoners, and was unacceptable in poor weather.

Further recommendation

2.195 Prisoners should not have to queue outdoors for long periods to collect their medication.

2.196 There should be therapeutic day care options for prisoners with mental health problems. (4.49)

Not achieved. There were no day care options for prisoners. At the time of our visit, the mental health in-reach service was out for tender, which included day services with a focus on improving access to psychological therapies (IAPT).
We repeat the recommendation.

## Additional information

2.197 The re-role of the prison had increased the proportion of prisoners with chronic disease needs. In the previous six months, 85 external hospital appointments had been rearranged, largely related to specialist referrals for chronic disease. The proportion of diabetics in the population had increased by about 60%, from approximately 17 to just over 40.

2.198 There was a paper clinical record system and an electronic system, Vision. All new patients were entered on to the electronic system and recording was done well by the GPs, but other healthcare professionals did not use the system consistently. The current electronic system

was due to change to SystmOne. We noted a few examples in the paper records where signatures were illegible and it was not clear who had seen the patient. We did not see any healthcare professional with a name badge.

2.199 The healthcare room in reception had no telephone or alarm bell, which raised safety issues.

2.200 The segregation records showed that on one occasion in September 2009, no one from the healthcare team had signed to indicate a visit, although a prisoner was in the unit at that time.

Further recommendations

2.201 All healthcare professionals should make consistent recording across paper and electronic records where both exist.

2.202 All healthcare professionals should sign and print their names in the paper records to show who has seen the patient and to comply with guidance from professional registration and health regulatory organisations.

2.203 All healthcare professionals should wear name badges.

2.204 The healthcare room in reception should be fitted with an alarm bell and telephone.

2.205 Healthcare staff should visit the segregation unit every day when prisoners are located there and sign the segregation log each time.

Good practice

2.206 *There were two independent nurse prescribers, which enabled prisoners to have more rapid access to medication when required and supported the maintenance of effective prescribing and pharmacy services.*

## Learning and skills and work activities

2.207 Prisoners who are genuinely unemployed or who are exempt from working should be unlocked during the core day and given access to other regime activities. (5.18)

Achieved. Prisoners who were unemployed or exempt from working were unlocked each morning and afternoon and could attend other activities, such as PE and education.

2.208 The activity allocation system should incorporate cover for prisoner absence on education or courses. (5.19)

Achieved. All workshops and other activity areas were overallocated prisoners so that when they left to attend courses or education, the proportion of prisoners in each area remained high.

2.209 Allocation to activity places should be proactive and based on identified sentence planning needs. (5.20)

Achieved. The labour board had improved and all prisoners were considered for work as soon as they had completed induction. Account was taken of prisoners' needs, and the process of

allocation was informed by initial assessment results. Sentence plans were considered and security risks taken into account.

2.210 There should be a system for identifying and challenging those prisoners who are not willing to work. (5.21)

Achieved. The prisoner activity monitoring system (PAMS) introduced at the last inspection was now routinely used to identify prisoners' daily activities. There was quick identification of unemployed prisoners, who were placed into employment within a few weeks.

2.211 Course planning, goal setting and lesson planning in discrete literacy, numeracy and language provision should be improved. (5.22)

Achieved. A new tutor had been employed to lead on basic skills, and lessons were planned in line with Manchester College (the contractor) requirements. Outreach provision for literacy, numeracy and English for speakers of other languages (ESOL) had improved considerably with support to prisoners in their workplaces.

2.212 Art classes should have better facilities and resources. (5.23)

Not achieved. There had been no significant improvements to the art room in the education department. It remained small and cramped, although a small sink had been added. The room used for art on Thanet wing was not a specialised art room and learners were subject to distractions. The room was shared with a class for information technology (IT).
We repeat the recommendation.

2.213 The core working day should be extended to offer prisoners a more demanding and realistic work experience. (5.24)

Not achieved. There had been little change to the core working day, which remained at five and a quarter hours for most prisoners. The brick workshop continued to start one hour earlier than most other activities to simulate an industry-standard environment.
We repeat the recommendation.

2.214 Staff should ensure that prisoners arrive at workplaces on time. (5.25)

Achieved. Following the integration of vulnerable and mainstream prisoners into education and workshops areas, there had been good efforts to ensure that most prisoners now arrived at workplaces on time.

2.215 There should be an effective strategy for maximising prisoner access to and use of a properly equipped and organised library. (5.26)

Achieved. Revisions to the library timetable had improved the access for all prisoners, who could now visit at least once a week. The range of learning materials had improved for those on vocational courses. There was a small range of materials for foreign language speakers, although there had been no survey to ensure the range of languages stocked were appropriate for the prison population (see recommendation 2.221).

## Additional information

2.216 There was good management of education and industries and links between the two areas. However, there was inadequate coordination of learning and skills overall with a lack of clear

strategic direction. Following the last inspection, there had been long periods without a head of learning and skills. The recent appointment of a new head of learning and skills had yet to impact on the provision. The education department had completed a needs analysis in April 2009, although there had been no recent needs analysis to assess prisoners' learning and skills requirements. Younger prisoners were particularly disadvantaged by the narrow breadth of education courses and the lack of vocational training opportunities. There were plans to broaden the education curriculum. Pay was equitable, and although many prisoners complained of recent changes to the pay structure, they all had an opportunity to participate in part-time education.

2.217 Education staff were experienced, and they continued to undertake a thorough induction of prisoners. Information, advice and guidance (IAG) at induction was satisfactory. Manchester College staff currently covered this area as the new IAG contractor had not yet started. However, there was insufficient IAG beyond induction. Staff updated sentence plans following the initial assessment of prisoners' basic skills to ensure a clear interpretation of the results. Pass rates were high for those who undertook qualifications, and success was celebrated through regular presentation ceremonies. However, only 28% of the population were in part- or full-time education and only 17% were on courses leading to vocational qualifications, which was low. Seventeen prisoners were on Open University courses and were supported by education staff. There were insufficient opportunities for prisoners to gain qualifications above level two, and most were on courses at level one. There were three ESOL classes, with 18 prisoners on the waiting list. There were missed opportunities for prisoners to gain accreditation for their work.

2.218 There was good acquisition of skills in some areas, such as bricklaying, the Prisons Information Communication Technology Academy (PICTA), printing and graphic design, horticulture, food preparation, and recycling. However, this only engaged 27% of the work-eligible prison population, which was low for a training prison. Instructors in many of these areas were qualified teachers.

2.219 The proportion of prisoners actively employed had increased to around 94% of the eligible population. However, around 18% were employed in low quality contract work, and a large proportion of prisoners, over 100, engaged as wing orderlies.

2.220 There had been few changes to the library provision, although it was now fully staffed and opening hours had been revised. There was insufficient collection and analysis of data to identify library use.

Further recommendations

2.221 A learning and skills needs analysis and a library needs analysis should be undertaken.

2.222 A clear strategy for learning and skills should be developed and implemented across the prison.

2.223 Information, advice and guidance should be available for prisoners beyond induction.

2.224 There should be a broader range of purposeful education and vocational training opportunities.

2.225 There should be more classes in English for speakers of other languages.

2.226 Appropriate accreditation should be offered to prisoners developing skills in their work area.

2.227 Library use should be comprehensively monitored, and the data analysed to help improve provision.

## Physical education and health promotion

2.228 The gym facilities should be improved to increase the range of recreational gym provided and the learning opportunities for prisoners on courses. (5.33)

Achieved. Some facilities had improved and the range of recreational gym had increased significantly. There were new showers, and several pieces of cardiovascular equipment had been replaced. However, the sports hall remained small and needed refurbishment. There was an increased range of recreational PE, and timetable changes had helped to accommodate this. This included provision for prisoners over 50, such as bowls and darts, where competitions and a league helped to motivate prisoners. Learning opportunities on courses were satisfactory and appropriate. Twelve prisoners were currently on a level one course devised by prison staff. Ten prisoners had recently enrolled on a weekly level one yoga course. Prison officers working in the area planned to improve the range of courses to meet the needs of the re-profiled population.

Further recommendation

2.229 The sports hall should be refurbished to provide an adequate indoor recreation facility.

2.230 The proportion of prisoners who do or do not attend the gym should be monitored and the number of prisoners – particularly from Kent House – who attend the gym at least twice a week increased. (5.34)

Achieved. Monitoring of prisoner attendance was thorough and there had been improvements to ensure equitable access to the gym. There were clearly recorded registers of those attending, and weekly reports were sent to each wing to ensure those who had not attended were encouraged to do so. The proportion of prisoners who took part in recreational PE at least twice a week had increased significantly from 40% at the last inspection to 63%.

2.231 Prisoners should be able to shower after each PE session. (5.35)

Achieved. There were good facilities with new showers installed next to the sports hall, and a wet room facility for those with restricted mobility.

2.232 PE staff should be able to identify prisoners who have completed the gym induction. (5.36)

Achieved. There were systems to record and identify prisoners who had completed the PE induction programme. The recent introduction of colour-coded laminated cards helped to identify prisoners' levels of ability and support requirements when using the gym.

## Additional information

2.233 Management of the PE department was strong, and provision had improved since the last inspection. Facilities remained satisfactory, although the sports hall was in a poor state of repair. Plans to build a new sports hall were awaiting funding. Staff were suitably qualified in

GP referral treatment of injury. There were good links with healthcare, and regular meetings with healthcare staff and physiotherapists to ensure the correct level of PE support and guidance for prisoners where needed. All prisoners received a well-written PE induction booklet with clear and useful information on healthy living and the importance of physical fitness. There were good links between Charlton Athletic Football Club and the education department, who jointly ran a well-designed sports course aimed at foreign national prisoners.

## Time out of cell

2.234 Prisoners should spend at least 10 hours out of their cells on weekdays. (5.53)

Not achieved. The prison had reported a time unlocked figure of 9.2 hours a day in 2009 to date, short of our expectation of 10 hours. Under the published core day, the maximum achievable time unlocked for a fully employed prisoner was nine hours five minutes, Monday to Thursday, and 7.5 hours on Friday. We found evidence of some over-reporting of evening association time, which was one hour 40 minutes on four evenings a week, although regime monitoring returns from wings recorded this as two hours. Interruptions to activities were recorded. A random roll check during the inspection showed that 88 prisoners, 14% of the population, were either unemployed or not required for work and remained on the wing during the working part of the day. This figure appeared high for a training prison, although such prisoners were not locked in their cells for the duration of the day and had access to a morning and afternoon unlock period. However, unemployed prisoners were out of their cell for only just under seven hours, Monday to Thursday.
We repeat the recommendation.

Further recommendation

2.235 Regime monitoring returns should be an accurate record of the time prisoners are unlocked.

2.236 Prisoners should be encouraged to engage in out-of-cell activities, and a record kept of non-participation. (5.54)

Partially achieved. There was a system in which prisoners who did not participate in out-of-cell activities were recorded in the wing daily diary, which was checked by senior officers. Although we saw some evidence that staff were aware of prisoners who were reluctant to engage and provided additional appropriate support, we were not assured that all wings routinely using this system. For example, one wing recorded the names of prisoners who asked to return to their cells before the end of association. On another, wing staff said entries on non-participation were made in the prisoner's file and his personal officer then provided support to encourage him to engage in activities.

Further recommendation

2.237 All wings should keep records of prisoners who do not participate in out-of-cell activities.

2.238 Staff should supervise out-of-cell activities effectively and contribute to the quality of prisoners' free time by actively engaging with them during association and exercise periods. (5.55)

Partially achieved. We observed variable levels of staff engagement with prisoners during

unlock, although staff were a visible presence on the wings and were not confined to offices. During our evening visit, a member of staff was in the association room on one wing and in conversation with prisoners, but this was not the case on the other wings. However, some prisoners said that staff spent time in association areas interacting with them. Staff supervising the exercise period on Kent stood outside the outdoor area, which made interaction difficult.

Further recommendation

2.239 Managers should ensure that the level of staff supervision and engagement with prisoners is consistently high across the wings.

## Additional information

2.240 Prisoners said that the prison generally adhered to the published routines and association was rarely if ever cancelled. They had good access to recreational facilities, and on one wing had been actively involved in selecting new equipment.

2.241 Each wing provided a minimum half-hour exercise period, extended during the summer to include an additional period in the open air in the evening. The published weekend routine did not specify the times of exercise periods. Outdoor areas were landscaped and had seating, except for the exercise area used by Kent wing, for which the prison was seeking additional funding to improve.

## Security and rules

2.242 Intelligence staff should receive training in the operation of the 5x5 computer-based intelligence analyst system. (6.13)

Achieved. The prison had a full-time intelligence analyst who was appropriately trained. Cover was provided for absence.

2.243 The practice of withholding association equipment when items go missing is collective punishment and should stop. (6.14)

Achieved. Both staff and prisoners told us this practice had ceased since the previous inspection, and we saw no evidence that association equipment was withheld.

2.244 Action from security information reports should be completed while the information is still current. (6.15)

Achieved. The collation, analysis and management of intelligence had improved. The department had received 1,978 security information reports (SIRs) in 2008, and 1,179 in 2009 to date. SIRs were received from a broad range of departments, and most related to miscellaneous security issues, drugs and mobile telephones. We examined a sample of SIRs, which were processed in an efficient and timely manner.

2.245 Managers should ensure that all relevant departments in the prison attend the security meeting regularly. (6.16)

Partially achieved. The monthly security meeting, chaired by the head of security and

operations, was reasonably well attended, although the membership of the committee still did not include key departments, such as safer custody or diversity.

Further recommendation

2.246 The terms of reference of the security committee should ensure representation and attendance from all key departments in the prison.

2.247 There should be a monthly security bulletin to communicate all matters relating to security to all staff. (6.17)

Partially achieved. The establishment had introduced the prison intelligence model (PIM). The intelligence analyst compiled a comprehensive monthly intelligence assessment, which was discussed by a small intelligence executive committee before the security meeting. A condensed version of this report, with agreed recommendations, was presented to the security committee and individuals were given responsibility for taking forward agreed action points. Progress against actions was reviewed at the following month's meeting. Security managers expected security committee members to communicate identified security priorities to their staff through staff briefings. Security managers did not routinely check to ensure that all staff were given this information, although the flow of intelligence to the department indicated that staff were aware of the key issues.

Further recommendation

2.248 Security managers should routinely ensure all staff are aware of the prison's security priorities and objectives.

2.249 There should be consistent staffing of the censoring and telephone monitoring departments to ensure the required checks take place on time. (3.82)

Achieved. Staff who undertook telephone and mail monitoring were part of a wider team of operational support grade staff. Since the change in the prison population, there had been greater consistency with a core half dozen staff used most of the time. There was a comprehensive system for mail monitoring, with a file for each prisoner monitored recording details of people he could not contact. This information was regularly updated at the monthly risk management meetings. At the time of the inspection, mail for 17 identified prisoners was sent directly to the child protection unit to be screened by more experienced staff.

2.250 Staff in the censoring and telephone monitoring departments should be trained in public protection measures. (3.83)

Partially achieved. There was limited training for these staff, apart from basic awareness training by child protection unit staff and others in the OMU. There was also a glossary of terms that it was believed sex offenders, and in particular paedophiles, used as codes in letters, but the staff said they had never seen examples of these used. There was no up-to-date or ongoing advice and guidance, and staff said they simply used their common sense.

Further recommendation

2.251 Staff engaged in the monitoring of telephones and mail should have regular updated training and advice on public protection issues.

## Additional information

2.252 The security department was staffed by a principal officer and three senior officers. The prison had two dog handlers who operated both active and passive drug dogs. There was a published closed visits policy, with monthly reviews by the functional head, security manager and intelligence analyst. There was one prisoner subject to closed visits at the time of the inspection.

2.253 Target and intelligence-led searching was conducted by both residential and security staff, and finds were usually of illicit items, such as mobile telephones and accessories. The police intelligence officer had been in post for approximately four weeks and was a shared resource with Blantyre House. The prison had focused on establishing a positive relationship with local police, particularly to assist in the reduction of illicit items such as drugs and mobile telephones into the prison.

2.254 In 2009 to date, 74 incidents had been reported on the incident reporting system, which was a reduction on the total of 177 in 2008, and probably linked to the change in the prison population. During the inspection, black and minority ethnic and foreign national prisoners expressed negative views of some security procedures, particularly searching, which they perceived as unfairly targeting them. The head of security and operations was aware of these negative perceptions and had met prisoners to address specific concerns, such as the use of the passive drug after a church service (see paragraph 2.116). Ongoing monitoring was required to ensure equality in the application of procedures and to address these perceptions.

2.255 Prisoners were given an overview of the rules during the induction session delivered by induction peer orderlies.

Further recommendation

2.256 There should be ongoing monitoring by ethnicity and nationality of all search procedures to identify and address any developing trends, and prisoners should be given regular summaries of searches carried out, with explanations of any apparent imbalances between ethnic or other groups.

## Discipline

2.257 Adjudications should be heard in a location free from distractions, such as a ringing telephone. (6.43)

Achieved. The unit office had been relocated to the first floor and adjudications were now heard in a separate, appropriately furnished room on the ground floor.

2.258 Adjudication standardisation meetings should be held and should review recent adjudication awards and the performance of all adjudicating governors. (6.44)

Partially achieved. The governor chaired a quarterly adjudication standardisation meeting. The meeting reviewed some adjudication monitoring data, including the outcome of adjudications and the number of remanded adjudications. However, adjudication awards and the performance of adjudicating governors was not reviewed, although this data was available on the segregation unit electronic database. At the August 2009 meeting, the acting governor had requested that further statistics be provided to future meetings. In the previous five months, ethnic monitoring information showed that black and minority ethnic prisoners were above the expected range for receiving adjudications, but the DREAT had not considered this over-representation (see further recommendation 2.152).

Further recommendation

2.259 The quarterly adjudication standardisation meeting should review recent adjudication awards and the performance of all adjudicating governors.

2.260 Awards on adjudications should be consistent and not exceed the guidance in the tariff document. (6.45)

Achieved. We sampled completed adjudications for the previous three months, which showed that awards were consistent and within in the guidance in the tariff document. In one case, the adjudicator had awarded a punishment below the minimum in the tariff, but the reasons for doing so were clearly recorded in the adjudication paperwork.

2.261 Arrangements for the management of the documentation covering positive mandatory drug testing should be improved to ensure that evidence is received and charges laid within the prescribed time limits. (6.46)

Achieved. Segregation unit staff were unaware of any problems with the management of documentation, and the charges we viewed were laid within the required timescales.

2.262 A senior manager should review all use of force incidents to ensure that force is used appropriately. (6.47)

Achieved. The head of security and operations reviewed each use of force incident at the segregation monitoring review group and security committee meetings. In one case, the minutes showed that concerns about an incident had been followed up, and staff involved were required to provide more detailed statements.

2.263 Use of force incidents should be analysed to identify any developing trends. (6.48)

Partially achieved. There was some monitoring of use of force incidents, primarily linked to ethnicity, but there was no analysis by, for example, location or staff or prisoners involved. Ethnic monitoring data reviewed at the DREAT showed that in August 2009 there had been a significant over-representation of black and minority ethnic prisoners in incidents involving the use of force, and this required further monitoring and investigation (see paragraph 2.140).

Further recommendation

2.264 The monitoring and analysis of use of force should be extended to identify developing trends, for example, relating to location, staff or specific prisoner groups.

2.265 There should be an accurate and up to date register of the use of the special cell and mechanical restraints. (6.49)

Achieved. The register of the use of the special cell and mechanical restraints was held in the segregation unit. There had been no recorded uses in 2009 to date. There had been four uses of the special cell in 2008, but the relevant paperwork was incomplete and lacking in detail. The records were unclear about the level of search conducted before use of the accommodation or what clothing and possessions had been retained by the prison. Although there was frequent monitoring of prisoners in the special cell, staff comments in the records were observational and did not reflect positive engagement with the prisoner. On one occasion, the Independent Monitoring Board was only informed of the use of the accommodation when the prisoner had been relocated. The special accommodation cell was unacceptable and lacked natural light.

Further recommendations

2.266 Paperwork for the use of special accommodation should be properly completed, and monitoring records should demonstrate active staff engagement to ensure prisoners are returned to normal accommodation as quickly as possible.

2.267 The special accommodation cell should be refurbished.

2.268 The broken window panes in the segregation unit cells should be replaced. (6.50)

Not achieved. External vented Perspex screens had been fitted to minimise the draught from the broken window panes, but the prison had been unsuccessful in securing funding to replace the windows in the segregation unit cells.
We repeat the recommendation.

2.269 All segregation unit cells should be equipped with 'normal' cell furniture, including standard beds. Cardboard furniture should only be issued following a detailed risk assessment, which is regularly reviewed. (6.51)

Achieved. All cells were equipped with normal cell furniture and standard sized beds. Segregation staff were clear that cardboard furniture could only be used following a risk assessment, and could not recall an occasion when it had last been used.

2.270 Prisoners held in the segregation unit should be issued with more than one set of clothing. (6.52)

Achieved. On location to the segregation unit, all prisoners were strip searched without any assessment of risk and given a clean set of clothes. Socks and underwear could be exchanged daily and other clothing weekly basis. A two-tier regime had been introduced for

prisoners in the segregation unit under good order or discipline, and through this progressive regime, prisoners could access three sets of their own clothes, which could be laundered each week.

Further recommendation

2.271 The level of search for prisoners located in the segregation unit should be informed by a risk assessment.

2.272 Segregation unit files should be well maintained. Managers should ensure that segregation staff make regular entries to demonstrate meaningful interactions with the prisoner and to record their mental and physical wellbeing. (6.53)

Partially achieved. Unit files were well organised with separate sections for relevant paperwork. There were frequent entries in unit files, beyond the required minimum daily entry. However, entries did not demonstrate positive staff engagement and interaction with prisoners. For example, one prisoner located in the segregation unit at the start of the inspection had asked to use the Samaritans telephone and have access to a Listener while in the unit. Staff had clearly documented the requests and the subsequent access to these services, but there were no entries to provide assurance that they had engaged with the prisoner to find out how he was coping with segregation during a vulnerable period.

Further recommendation

2.273 Managers should ensure that segregation unit staff make regular entries in unit files that demonstrate meaningful interactions with prisoners and record their mental and physical wellbeing.

2.274 Rule 45 paperwork should be completed fully and properly. Access to regime activities should be based on individual needs and include access to offending behaviour work, unless there are exceptional reasons why this should not be the case. (6.54)

Achieved. Prisoners located in the segregation unit under good order or discipline were given a copy of the regime activities they could access, and all prisoners were given a copy of the unit regime and core day. All prisoners had daily access to showers, exercise, a telephone call, cell clean and library books. They could continue to attend offending behaviour programmes and attend religious services following a risk assessment. Education staff visited the unit on one day a week and gave prisoners in-cell work.

2.275 The 'refusers' regime should be withdrawn and alternative methods sought to encourage prisoners to return to normal location. (6.55)

Achieved. The ‘refusers’ regime had been withdrawn. Prisoners who refused to transfer or relocate were dealt with under the prison discipline system.

2.276 Prisoners located in the segregation unit should be able to make telephone calls at times that are convenient to the recipient. (6.56)

Partially achieved. Prisoners in the segregation unit were still unable to make telephone calls in the evening, although they were asked if there was a time during the morning or afternoon when they wished to make a call and staff endeavoured to meet such requests.

Further recommendation

2.277 Prisoners in the segregation unit should be able to make telephone calls at a time convenient to the recipient, including during the evening.

## Additional information

2.278 There had been 403 charges laid to date in 2009, which was a reduction of approximately 200 since the same period in 2008. The hearing we observed was well conducted. A pen and pencil was available for the prisoner, and they were asked if they could read and write at the beginning of the adjudication. Prisoners had the opportunity to seek legal advice, and most charges we reviewed were thoroughly investigated. When there was a finding of guilt, prisoners were given written notification of their award. Telephone interpreting services were seldom used during adjudications. The tariff was regularly reviewed and changes were announced at the prisoner council meetings. A copy of the relevant section of the tariff guidelines was attached to the adjudication paperwork given to the prisoner before the hearing.

2.279 The use of force was low and the rate had decreased from 52 incidents in 2008 to 21 in the eight months to the end of August 2009. In the use of force forms we viewed, staff provided a detailed account of events leading up to the incident and there was evidence that de-escalation techniques were actively used. Completed use of force paperwork included a copy of the injury to inmate form (F213), but in some cases these had not been signed by a member of healthcare staff. In other cases, only the front copy of the form was filed ,although it was clear from medical records that prisoners had been seen by a member of healthcare staff and/ or a doctor following the use of control and restraint. The one planned use of force incident in 2009 had not been video recorded.

2.280 The segregation unit was staffed by specially selected officers from the operations group. They had not attended mental health awareness training, but did report a positive relationship with healthcare staff. All staff had access to an electronic database, which provided monitoring data to inform the segregation monitoring review meetings and reports. There were three prisoners in the unit at the start of the inspection, all of whom were on punishment. In the three months to the end of August 2009, 13 prisoners had been in the unit overnight pending adjudication, 22 were held under rule 45 (good order or discipline) and 20 were held under cellular confinement. The average length of stay in August 2009 was five days.

2.281 Communal areas and most cells in the segregation unit were clean, although we saw some obscene graffiti on the back of a cell door. The shower, toilet and telephone were on the first floor, which made them inaccessible to prisoners with restricted mobility or wheelchair users. The shower and bathroom were in a very poor state of repair. The prison had recognised this and was planning to refurbish the facility.

Further recommendations

2.282 A full copy of the completed injury to inmate form (F213) should be filed with use of force paperwork.

2.283 All planned incidents of use of force should be video recorded.

2.284 Segregation unit staff should attend mental health awareness training.

2.285 Older prisoners or those with restricted mobility located in the segregation unit should have access to all amenities and regime facilities.

2.286 The segregation unit shower facilities should be refurbished urgently.

## Incentives and earned privileges

2.287 The incentives and earned privileges scheme should not be used following an event of self-harm, no matter how provocative the behaviour of the prisoner. (6.66)

Achieved. We found no examples where prisoners had received an IEP warning following acts of self-harm, regardless of how provocative their associated behaviour was. Staff we spoke to were clear that IEP warnings should not be issued under such circumstances.

## Additional information

2.288 The policy document supporting IEP had been last reviewed in July 2008. Prisoners normally joined the scheme on standard, but those transferring in could retain enhanced status achieved at their previous establishment. Those on standard had to remain on that level for at least three months before they could be considered for enhanced, which was excessive. At the time of inspection, 62% of prisoners were enhanced, 38% standard and none were on the basic level. We looked at the files of recent basic level prisoners and were satisfied that all decisions to place them there had been justified. The system was applied consistently across all wings, and we saw several examples where appeals against IEP warnings or downgrading had been upheld.

2.289 Two written IEP warnings within 28 days triggered a final warning. A further written IEP warning within the following 28 days resulted in an IEP board and could result in downgrading, although this was not automatic. Prisoners could also receive a positive entry for good work. Although these did not cancel out an IEP warning, they were taken into account by the IEP board. The published policy document explained that key people, such as work supervisors, could attend IEP boards, but we found no evidence that they did.

2.290 The additional privileges for enhanced prisoners included extra visits and private cash, plus a range of additional items through the facilities list such, as PlayStations. They could also have extra PE and apply for orderly jobs, but these were limited. The range of additional privileges at enhanced level did not offer much incentive to many foreign national prisoners, who usually do not always receive their full entitlement of visits or have private cash sent in.

Further recommendations

2.291 Work supervisors and other key staff should contribute directly to incentives and earned privileges review boards.

2.292 The range of privileges for enhanced prisoners should offer meaningful incentives to foreign national prisoners.

## Catering

2.293 The main kitchen building should be replaced or refurbished to ensure it meets food safety and hygiene requirements. (7.9)

Not achieved. Apart from the refurbishment of a section of flooring in the wash area, the prison had been unsuccessful in securing funding for a more extensive refurbishment or rebuild, and there had been no other changes to the main kitchen building. The kitchen was kept clean but had broken and damaged tiles and door and window frames. Equipment was generally well maintained and repaired.
We repeat the recommendation

2.294 The midday meal should be served between noon and 1.30pm and the evening meal between 5 and 6pm. (7.10)

Not achieved. Both the midday meal and evening meal were served too early at 11.40am and 4.40pm. The breakfast meal was pre-packed and issued on the day before. New packs were being introduced during the inspection.
We repeat the recommendation.

Further recommendation

2.295 The breakfast meal should be served on the morning it is to be eaten.

2.296 Suitable food should be provided as part of all celebrations of major religious festivals. (7.11)

Achieved. In addition to providing food to celebrate major religious festivals, such as Passover and Ramadan, the catering manager was keen to reflect the cultural and religious diversity of the population throughout the menu cycle. During the inspection, a small team of prisoners were providing meals for the 66 prisoners celebrating Ramadan. There had been a prisoner survey before the festival to consult Muslim prisoners about the menu choices, but the response had been very low.

2.297 Separate serving implements for halal food should be issued to house serveries, and religious, cultural and special dietary requirements fully observed in the serving of food. (7.12)

Achieved. There were separate halal serving tools on each servery, and prisoners who worked in these areas were appropriately trained and effectively supervised by staff.

2.298 Communal dining areas should be appropriately furnished and decorated to encourage prisoners to dine in association. (7.13)

Partially achieved. The prison had recently provided new tables and chairs on each wing to give prisoners the opportunity to dine in association. These tables were in the association room on some wings as there was no separate dining area. Take up of the provision was mixed, although prisoners who dined in the communal areas were reasonably positive about the opportunity.

Further recommendation

2.299 The prison should continue to monitor the use of communal dining facilities and encourage prisoners to use them.

## Additional information

2.300 Catering services were delivered by a team of eight directly employed staff and one manager. During the inspection, 25 prisoners were employed in the kitchen full time, three of whom were working towards a level one national vocational qualification. As at the previous inspection, the prisoners' working time was limited to five hours a day.

2.301 We received many negative comments from prisoners about the quality and size of meals, although the two meals we sampled were of reasonable quality and were served hot. On Weald wing, we saw prisoners dispose of an almost full tray of pasta that had been left in the servery overnight. The catering manager acknowledged that there were some concerns about food waste, and that more work was needed with servery workers to ensure portion sizes were consistent and waste minimised. Despite the recent reduction in the catering budget, approximately 80% of meals in the four-week menu cycle were prepared in house. Recent problems with the quality and reliability of supplier deliveries had resulted in withdrawal of a menu choice.

2.302 Food comment books were readily available on all wing serveries and were well used by prisoners. Comments were regularly checked by wing managers and the catering manager, prisoners were not always given a response beyond 'comments noted'. The catering manager chaired a monthly catering consultative committee attended by prisoner representatives from across the prison. Attendance at the July 2009 meeting had been poor, but a second meeting that month had a marked improvement in attendance. A limited catering survey in June 2009 had produced just 55 responses, but some problems with the distribution of the survey had been identified and there were plans to increase participation in the next survey.

Further recommendation

2.303 Waste food should not be left on serveries overnight, and food waste should be kept to a minimum.

## Prison shop

2.304 Prisoners should be able to submit orders to the prison shop within 24 hours of their arrival. (7.19)

Partially achieved. New arrivals could choose reception packs, but these were not given to them until the following Friday when shop orders were delivered. New arrivals should have been able to receive packs immediately as well as place full orders before the next weekly cycle.
We repeat the recommendation.

Further recommendation

2.305 Reception packs should be available for issue on the prisoner's day of arrival.

2.306 Consultation mechanisms should be improved to ensure the prison shop provides a diverse enough range of goods to meet the needs of the population. (7.20)

Achieved. Consultation systems were good. Prisoner representatives met staff every month, and the contractor's local manager had attended every meeting but one. The chaplaincy was regularly represented, and the race equality officer attended occasionally. The goods on sale were sufficiently diverse to cater for a range of ethnic groups. In preparation for Ramadan, purchases to support Muslim prayer during the festival had been made available.

## Additional information

2.307 The new national contractor had taken over the supply of shop goods in March 2009, and the arrangements had bedded down satisfactorily. There were few complaints about the shop, although prisoners had noted that the nationally set prices had risen significantly over the last year. At the time of inspection, planned price changes were already displayed with itemised explanations of the reasons. However, some out-of-date notices referring to the previous shop contractor were still displayed on the wings. Some personal care products were available. Although available temporarily for Ramadan (see above), important religious artefacts, such as prayer mats, beads and oils, were not normally available from the shop. Daily and weekly newspapers were available from a local newsagent, and there were some foreign language newspapers, including a Turkish newspaper that was regularly delivered.

Further recommendations

2.308 Up-to-date notices on prison shop arrangements should be displayed on all wings.

2.309 In consultation with the chaplaincy, the shop should routinely stock a range of core religious artefacts.

## Strategic management of resettlement

2.310 The drop-in centre for prisoners should be reopened, and should be staffed by resettlement staff. (8.9)

No longer applicable. With the change in population, the prison had restructured its resettlement group and the drop-in centre was no longer functioning.

2.311 Action points in the reducing reoffending strategy should be time-bound and indicate who is responsible for the action required. (8.10)

Not achieved. The absence of an up-to-date reducing reoffending strategy meant that there were no identified action points or objectives.
We repeat the recommendation.

2.312 Resettlement meetings should include representatives from outside agencies. (8.11)

No longer relevant. There was no resettlement committee as this function was now covered by the reducing reoffending committee. This group met monthly and included staff from the resettlement pathways and some involvement with outside agencies. Shelter and the Maidstone Volunteer Bureau were among groups represented but their attendance was not regular. Attendance was usually limited to staff based at the prison.

Further recommendation

2.313 Reducing reoffending committee meetings should consistently include representatives from outside and community agencies.

2.314 There should be a greater use of release on temporary licence to assist prisoner preparing for release in appropriate cases. (8.12)

Achieved. In the previous six months, there had been 55 applications for release on temporary licence (ROTL). Of these, 22 remained outstanding with information and reports still being collated. Of the other 33, eight prisoners had been granted temporary release on 21 occasions between them, either day or overnight release. This was a considerable improvement since the previous inspection. There had been one occasion of special purpose licence.

2.315 There should be greater use of home detention curfew in appropriate cases. (8.13)

Achieved. In the previous six months, eight prisoners had applied for home detention curfew (HDC). Five applications were ongoing and three had been successful. There was a reasonable process to review applications, and prisoners were given appropriate information about HDC and how they could apply.

2.316 The establishment should seek feedback from prisoners, ex-prisoners, offender managers and staff to help improve current resettlement services. (8.14)

Partially achieved. Exit questionnaires had been used to ascertain prisoner views on resettlement services and support, but had stopped the previous year. The offender management unit (OMU) asked visiting offender managers to complete questionnaires and to give feedback. Although these questionnaires were used to identify and address specific issues, they were not analysed to obtain an overall view of provision. However, all those we saw were extremely positive about the OMU and its management of prisoners.

Further recommendation

2.317 The prison should undertake exit surveys of prisoners being released and analyse them, along with questionnaires to offender managers, to inform the development of resettlement provision.

2.318 Resettlement officers should not be redeployed, and should attend to resettlement issues daily. (8.15)

No longer applicable. The restructure of the resettlement function had removed the resettlement officers and resettlement peer advisers.

2.319 The management structure of the resettlement function should be clarified and should clearly identify responsibilities for the elements of strategic delivery. (8.16)

Partially achieved. The resettlement function was part of the wider reducing reoffending strategy. Because of the establishment's change in function, the resettlement structure had been altered and now consisted of only a resettlement manager and administrative support. The resettlement manager, who had been in post for three months, was also the lead for foreign national prisoners, approximately 40% of the population, which significantly diminished the time available for resettlement work. Pathway leads had been identified for drugs and alcohol, employment, training and education, mental and physical health, and attitudes, thinking and behaviour, but not for finance, benefit and debt, and accommodation. The resettlement manager was responsible for these two areas as well as the children and families pathway; the resettlement administrator also undertook significant aspects of this latter pathway but did not have sufficient authority to drive it forward.
We repeat the recommendation.

## Additional information

2.320 During the week-long induction programme, all prisoners were assessed against the seven resettlement pathways through the passport model (see paragraph 2.28). The passport was meant to be the starting point for planning resettlement and be used in conjunction with other documents, such as offender assessment system (OASys) assessment. However, the use of the passport remained unclear. Some were kept in wing files and some were sent to the OMU. There was no clear indication that these documents were used as the basis for planning custody. In practice, offender supervisors undertook their own assessments, but these did not focus specifically on the resettlement pathways.

2.321 All prisoners attended a pre-release meeting approximately three months before release. All departments, including offender supervisors, were invited to make written contributions, although contributions were rare and only the resettlement manager attended. Departments only contributed if they had been involved with the prisoner, and even then not always. Offender supervisors did not routinely contribute. As a consequence, issues relating to risk management, progress against sentence planning targets, and post-release supervision arrangements were not covered and were left to offender supervisors to manage independently.

Further recommendations

2.322 The prison should clarify the resettlement information to be collected during induction, how it is used and where it should be held.

2.323 The role of the pre-release meeting should be clarified and contributions from offender supervisors should be consistent.

## Offender management and planning

2.324 The proposed offender management unit (OMU) should be staffed immediately so that the relevant trained personnel are in place to start its operation; staffing should include administrative support. (8.28)

Achieved. Along with the offender supervisor support (see paragraph 2.9) case administrators and wider administrative support were also in place.

2.325 The OMU should have a clear management structure to identify who is responsible for delivery and supervision in each area. This structure should include a quality assurance framework. (8.29)

Achieved. The management structure of the offender management unit was clearly defined and well understood by its staff. Although the four probation officers in the team were responsible for the supervision of multi-agency public protection arrangements (MAPPA) level three, all other cases, including prisoners on indeterminate sentences for public protection (IPPs) and lifers were shared across the team. All reports were quality checked appropriately, and the prison used a management quality assurance model based on the NOMS' national standards for offender management. Although probation offender supervisors received monthly supervision, which partly focused on quality of delivery and case management, this was not the case for officer offender supervisors.

Further recommendations

2.326 Quality assurance of the work of offender supervisors should focus on both procedures and the quality of engagement.

2.327 All offender supervisors should receive regular supervision that focuses on quality of delivery and case management.

2.328 Offender managers should be identified and contacted so that effective sentence planning can be carried out as required under phase two of the offender management roll out. (8.30)

Achieved. Links with community-based offender managers was generally good. There were still some problems in getting offender managers to visit, although this was primarily an issue for services based a considerable distance away, and the situation would improve with the planned introduction of video conferencing facilities for offender management.

2.329 The officer in charge of the child protection unit should receive training appropriate to her specialist role. (8.31)

Achieved. With the change in population, the child protection unit had been expanded to include two offender supervisors and a further one due to join it. The two current officers had both received training and guidance through the Kent safeguarding children board.

2.330 Residential staff should be made aware of prisoners monitored by the child protection unit. (8.32)

Achieved. At the time of the inspection, 262 prisoners had their telephone calls monitored under safeguarding children or harassment guidelines. The mail of 285 prisoners was also censored. The wing files of prisoners who were monitored were clearly marked, and staff were aware of the procedures and where and how to find further information if required.

2.331 The lifer committee should include life-sentenced prisoners. (8.33)

Achieved. Every wing had both an IPP and a lifer prisoner representative who attended the bi-monthly lifer group with prison managers.

2.332 A prisoner's security category should be reviewed following a significant change in circumstances. (6.18)

Not achieved. The prison reviewed prisoners' security category either annually or at six-monthly intervals, depending on their sentence length and proximity to release. Although prisoners could apply to have their category reviewed following a significant change in circumstances, such as the completion of an offending behaviour programme, the prison did not carry out such reviews as a matter of course.
We repeat the recommendation.

2.333 Prisoners who are unsuccessful for progression to category D status should have the appeal process formally explained to them. (6.19)

Partially achieved. Prisoners received written notification of the outcome of their categorisation review, which included clear information about their avenue of appeal to the deputy governor. The appeal system was active, and we saw examples where prisoners had had appeals upheld. However, at recent prisoner council meetings, prisoner representatives had raised concerns that written notifications were placed in pigeon holes or under cell doors rather than given to individuals personally.

Further recommendation

2.334 Prisoners should be informed personally about unsuccessful recategorisation decisions.

## Additional information

2.335 At the time of the inspection, 305 prisoners were in scope for offender management, including 38 IPPs and 37 lifers; 250 prisoners were not in scope. There was an induction slot on offender management, and all new arrivals were allocated an offender supervisor within two days. There was a comprehensive database that included all necessary offender management information, which could be accessed by all staff. An electronic contact log was linked to this database and included all external communication as well as actual contacts. Our review of this indicated that offender supervisors had a good understanding of their cases, and this was reflected in discussions with them.

2.336 Public protection arrangements were comprehensive and generally good. The case files of all new arrivals were screened, first by case administrators and then by staff in the child protection unit. Any indications of child protection or harassment resulted in referral of cases to the monthly risk management board. Although most new cases were taken to the board, not all were and there was the potential for some cases to slip though unnoticed. All cases subject to telephone or mail monitoring were reviewed at appropriate frequencies, and all MAPPA three cases (15 at the time of the inspection) were reviewed monthly. MAPPA two cases (124) and those marked as MAPPA X (317) were reviewed within the last six months of sentence or if there were particular issues or concerns. Minutes of meetings were reasonably comprehensive. Offender supervisors took cases they were responsible for to the board and including any recommendations, such as continuation or termination of monitoring levels. Offender supervisors attended MAPPA meetings in the community where appropriate.

2.337 The management of indeterminate-sentenced prisoners remained underdeveloped. There was no specific indeterminate-sentenced prisoner policy or clear model of what was available. Bi-monthly lifer meetings were well attended, but the involvement of lifer prisoner representatives was relatively new and only three meetings had been held so far. Previously, all indeterminate-sentenced prisoners had been invited to the meetings, which had become unwieldy. Indeterminate-sentenced representatives remained unclear of their roles. They had no mentoring or support role with new arrivals, and there was no specific information for indeterminate-sentenced prisoners about what was available at Maidstone. There were no formally identified lifer officers. Three staff were trainers on the managing indeterminate sentences and risk (MISAR) course, and training for all staff was planned to be rolled out in the next few months, starting with the OMU.

2.338 In the previous six months, there had been 319 recategorisation reviews and 15 prisoners had successfully progressed to category D. The prison had difficulty in securing progressive places for category D sex offenders. Seven prisoners were waiting to move on progressive transfers at the time of the inspection, four of whom had been recategorised in 2008 and one of whom had being waiting for over 12 months.

2.339 Managers were aware of the frustrations of foreign national prisoners regarding recategorisation and progression. The head of security and operations had met foreign national prisoners to discuss their concerns and to explain the national guidance within which the prison had to operate (see paragraph 2.164). To evidence 'very low risk', the prison was encouraging foreign national prisoners to apply for release on temporary licence if they were eligible.

Further recommendations

2.340 All new arrivals should be referred initially to the monthly risk management board.

2.341 There should be a specific policy on indeterminate-sentenced prisoners, or one included in an up-to-date reducing reoffending policy, to direct service provision and development.

2.342 The role of lifer and indeterminate sentence for public protection (IPP) prisoner representatives should be clarified, and should include guidance and support for lifer and IPP new arrivals.

2.343 There should be information booklets for IPP and lifer prisoners outlining the provision available at Maidstone.

2.344 Prisoners who successfully progress to category D should be transferred to suitable prisons in a timely manner.

## Resettlement pathways

### Accommodation

2.345 Resettlement peer workers or resettlement officers should keep prisoners up to date with progress on finding them accommodation. (8.17)

Partially achieved. Since the new model of resettlement had been introduced, there were no resettlement officers or peer workers to support prisoners with accommodation needs. The role

was undertaken by the resettlement manager, although this was primarily a signposting function as he had no training in this area.

Further recommendation

2.346 The prison should identify a housing officer or adviser and ensure they receive specialist training for the role.

## Additional information

2.347 A large number of prisoners returned to their home address or accommodation agreed through offender managers. Since 1 April 2009, 108 prisoners had left Maidstone – 37 had been deported or moved to a deportation centre, almost 44% (31) of the remainder had been released to a hostel, and a further 42% had returned to community-based permanent accommodation. Where appropriate, offender supervisors had undertaken the liaison role and kept prisoners informed about decisions. During this period, only four prisoners (5.6%) had been released with no fixed accommodation.

2.348 Shelter had an area contract to offer housing advice and guidance to prisoners but did not deliver any regular sessions at Maidstone. They attended if there were specific needs, but had not done so for some time.

## Education, training and employment

2.349 All prisoners should undertake a relevant pre-release resettlement course. (8.41)

Not achieved. No pre-release course had been introduced, although the education department had run a short 'life challenge' course for a few prisoners, taught in conjunction with the bricklaying instructor. Although this course was not specifically aimed at prisoners who were about to leave, it benefited prisoners before their release.
We repeat the recommendation.

2.350 The number of prisoners who take up education, training and viable employment after release should be increased. (8.42)

2.351 Achieved. The number of released prisoners who went into education, training or work had increased. However, the prison recognised that, following the recent re-profiling of the population, the proportion of prisoners likely to enter employment or training in the future could change.

## Additional information

2.352 Provision to prepare prisoners for work, training or education on release was limited. As identified at the last inspection, there was no pre-release course for prisoners coming to the end of their sentence to help prepare them for employment or resettlement into the community. Prisoners had insufficient support with writing curriculum vitae (CVs), for example, or guidance on interview techniques. There were few links with employers and support agencies. Although the prison had links with Jobcentre Plus, visits from their staff were sporadic, and the service poorly advertised to prisoners. Some staff had created their own links with employers, although pre-release and preparation for work provision lacked coordination. A business enterprise

course had been introduced to support prisoners considering self-employment, and 14 prisoners had achieved qualifications in the previous year.

## Finance, benefit and debt

2.353 The establishment should carry out a needs analysis to clarify the need for financial assistance. (8.45)

Not achieved. There had been no needs analysis to establish the need for financial assistance since 2007.
We repeat the recommendation.

2.354 The financial assistance available and courses offered in the prison should be well advertised. (8.46)

Partially achieved. There was no specialist financial advice or debt counselling. Citizens Advice had offered some support through its monthly session at the prison, but the contract for this had ended in 2008. The resettlement manager was the pathway lead and also picked up referrals but, given the limited provision and lack of specialist support, this role was limited. He had received no specific training. The prison was planning to identify peer advisers to develop this course further. We were told that all prisoners had PIN telephone access to the national debt line. The only course oriented to financial advice was the five-week money management programme delivered by the education department as part of the preparation for work course accredited by the Open College Network.

Further recommendation

2.355 The prison should offer specialist debt counselling and money management advice.

2.356 Assistance for prisoners to open a bank account should be put in place. (8.47)

Achieved. All prisoners seen at the pre-release meeting (see paragraph 2.321) were offered the opportunity to open a bank account.

## Mental and physical health

2.357 Healthcare staff should assist every prisoner to register with a GP near their accommodation before release, and facilitate any continuing health and social care requirements. (8.51)

Achieved. Healthcare staff were notified of all potential discharges. A designated healthcare representative who was invited to all pre-release meetings but was not always able to attend, and had not done so in the previous six weeks. A discharge leaflet given to all prisoners had information about local and national health services. A prisoner due for discharge without a GP and/or dentist was given specific details about finding and registering with a GP and dentist in his area. Prisoners were not given a pre-release healthcare appointment routinely. Those with identified health needs were booked for a GP appointment seven to 10 days before discharge and given up to two weeks prescribed medication and details of outstanding hospital and clinic appointments.

Further recommendation

2.358 The healthcare department should be regularly represented at pre-release meetings.

2.359 Adequate information should be provided to every prisoner on release to support him to protect his health and to access health services. (8.52)

Achieved. Prisoners were given details of any outstanding hospital or clinic appointments, and those with continuing mental health needs were linked with their local community mental health team, where their discharge address was known. If their destination was not known, they were given information to give to their new GP to enable links with local mental health services. The mental health in-reach team led arrangements for prisoners on the care programme approach, although there had been no such prisoners in the last year.

2.360 Prisoners should be offered condoms before their release. (8.53)

Achieved. Prisoners were given a discharge pack containing condoms, lubricant and sexual health information. Condoms were usually available on request from healthcare staff, which was to ensure an audit trail between requests and any misuse of condoms.

2.361 The prison should incorporate healthcare into resettlement planning. (8.54)

Partially achieved. There had been some efforts to incorporate healthcare into resettlement planning. A lead registered mental nurse (RMN) linked with resettlement processes, such as MAPPA and the discharge boards. However, contributions and attendance at discharge boards was not consistent.
We repeat the recommendation.

## Drugs and alcohol

2.362 The drug strategy document should include developmental targets and objectives. (8.66)

Achieved. There was a current integrated drug and alcohol strategy linked to national guidance and area strategy. The strategy detailed key priorities to reduce supply and support prisoners, and the developmental targets of alcohol counselling and implementation of the integrated drug treatment system (IDTS) had both been achieved. Regular meetings monitored progress against objectives.

2.363 There should be a comprehensive needs analysis of prisoners to inform service development and ensure appropriate counselling, assessment, referral, advice and through care (CARAT) provision. (8.67)

Not achieved. There was no up-to-date CARATs needs analysis, but the current 2009 needs analysis was due to report in November 2009.

2.364 The CARATs team should prioritise cases to ensure the most effective use of resources. (8.68)

Partially achieved. The change in the prison population had resulted in a significant reduction in the active caseload from over 200 prisoners to 75. The Rubicon alcohol awareness

programme had been introduced and prisoners had responded positively to it. The programme, commissioned from an external provider, incorporated group sessions and opportunity for individual sessions. We were told that CARATs was refocusing its approach to meet the needs of the changed population. It was notified of prisoners categorised as prolific or priority offenders (PPOs), MAPPA cases or IDTS clients, and clients were also prioritised on a needs-led basis. Without a current needs analysis, it was not possible to confirm that this approach met the needs of the changed population.
We repeat the recommendation.

2.365 The case management board should focus attention on high profile and complex cases allowing other teams, including CARATs, to take responsibility for clinical and treatment judgments. (8.69)

Not achieved. The board met fortnightly and considered an average of seven cases. It was not clear whether these cases were the most appropriate for it to consider. Although the board's membership enabled an integrated approach, regular attendance from different departments was variable.
We repeat the recommendation.

Further recommendation

2.366 All relevant departments should be consistently represented at case management boards.

2.367 Appropriate arrangements should be put in place for voluntary drug testing to ensure that testing patterns are not predictable and that the scheme is applied fairly. (8.70)

Achieved. There was a compact-based drug testing programme (see below). The compact provided for 300 prisoners to be tested, and the required minimum of 1.5 tests a prisoner was carried out consistently. Testing patterns were not predictable by day, time or location. As required, prisoners were notified the night before morning testing or on the morning of afternoon testing. There were approximately 23 tests a day over two sessions. All tests were carried out on the wings in dedicated suites. We saw the suite on Kent wing, which was clean and tidy with appropriate privacy screening for the toilet area. Test materials were kept in a locked cabinet.

2.368 Voluntary drug testing should include compliance testing, where appropriate, and this should be clearly differentiated from voluntary testing and reflected in prisoner compacts. (8.71)

Achieved. All prisoners on enhanced status were required to sign up to the drug testing compact, and some prison roles required compliance. The compact explained the basis of testing clearly, and differentiated the sanctions for prisoners on enhanced status and those on standard or basic. No voluntary testing was carried out.

2.369 The provisional alcohol strategy should be finalised and set out a range of treatment options to be provided at Maidstone. (8.72)

Achieved. The integrated drugs and alcohol strategy detailed interventions for alcohol treatment options, including the Rubicon alcohol awareness programme (see paragraph 2.364). Alcoholics Anonymous also met regularly.

## Additional information

2.370 There was a waiting list of approximately 200 for the compact-based drug testing programme and prisoners could wait up to 10 months to be tested on the programme. Checks were made with the previous establishment for prisoners who transferred in on enhanced status to ensure that they had a good record of compliance. Prisoners who had lost enhanced status were also encouraged to remain on the programme, and prisoners who wanted to upgrade their status were regarded as compliant if they signed up to the compact. We saw no evidence that prisoners were disadvantaged by the waiting list and the cap of numbers on the compact. Links were made with external drug intervention programmes for those prisoners who wished to continue to engage with substance use services.

2.371 The change in population since the last inspection had increased the number of older prisoners. Data from drug testing since the change indicated different patterns of drug use, and the uptake of the Rubicon programme and evidence from CARATs work pointed to increased use of alcohol (see also paragraph 2.129 and recommendation 2.130).

## Children and families of offenders

2.372 Prisoners should be able to have a visit within one week of their arrival. (3.85)

Achieved. Most of the delays in booking visits had been resolved or mitigated (see below) and prisoners could have visits within their first week .

2.373 There should be a clear protocol for the treatment of visitors on whom the drug dog has indicated. A visitor should not be offered a closed visit on the basis of a dog indication alone without supporting intelligence and should be treated respectfully throughout. (3.86)

Not achieved. The policy on the treatment of visitors following a positive drug dog indication had not changed. If a drug dog indicated a visitor the search was repeated and a further indication resulted in a closed visit or no visit at all. The decision for a closed visit was for that occasion, and any decision to extend the restriction depended on the monthly security committee, who usually only extended it if there was further supporting intelligence. We were not told by prisoners that their visitors were treated disrespectfully.

Further recommendation

2.374 Closed visits should only be imposed following a drug dog indication if there is corroborating intelligence.

2.375 The main visits hall should be refurbished to include toilet facilities for visitors and prisoners, the furniture should be replaced, and the children's play area should be supervised. (3.87)

Partially achieved. As the prison was now integrated and there was no vulnerable prisoner population, there was one main visits hall, which had previously been for mainstream prisoners. The smaller visits area used previously for vulnerable prisoners was now used for legal visits in the morning and as an overflow for domestic visits. There was space for up to 41 visits. Although the visits areas had been decorated and some of the furniture replaced, it

remained fundamentally unchanged. There were still no toilet facilities for prisoners – who had to return to their wings if necessary – or visitors, who had to return to the visits entry area to use toilets. The children's play area in the main visits room was still unsupervised.

Further recommendations

2.376 The visits halls should provide toilet facilities for both prisoners and their visitors.

2.377 The children's play area in the main visits hall should be supervised.

2.378 There should be a visits holding room for prisoners. (3.88)

Not achieved. There was still no holding room for prisoners waiting for visits and they had to wait in the main visits area.
We repeat the recommendation.

2.379 There should be an appeal system for visitors placed on closed visits, and visitors should be informed in writing in advance that closed visits have been imposed. (3.89)

Achieved. If a visitor was banned from visiting the prison or placed on a period of closed visits, they and the prisoner(s) they visited were informed in writing. The information included details of how they could appeal against the decision.

2.380 The visits booking system should be able to deal with the number of visitors and their needs, and visitors should be able to book their next visit while they are at the establishment. (3.90)

Achieved. The visits booking line was staffed Monday to Friday from 9.30am to 4.30pm. To deal with the previous problems in booking visits, the booking clerk also attended the Dinsmore visits centre before visits took place to allow visitors to book their next visit. The prison had also introduced email booking.

2.381 Formal training should be offered to the family and friends worker and volunteers who work with visitors in the Dinsmore centre. (8.75)

No longer applicable. There was no longer a family and friend worker based at the Dinsmore centre.

2.382 Release on temporary licence should be available for prisoners who are primary carers or to be with their children during important events. (8.76)

Achieved. There was now greater use of release on temporary licence (see paragraph 2.314). It was not unusual for prisoners to take such leave to attend important family events.

2.383 There should be accredited programmes or interventions to improve parenting skills and relationships for prisoners with an identified need. (8.77)

Partially achieved. The education department had delivered a parentcraft course but, following the change in population, this was felt to be inappropriate and it had been replaced by a more generic 'understanding healthy relationships' programme. A programme run with a children's author for parents to write and illustrate stories for their children had also been dropped pending decisions about suitable provision.

Further recommendation

2.384 The prison should clearly define the courses on relationships and parenting that should be available and for whom. Prisoners with no identified risk factors should not be prevented from receiving necessary help and support with their parenting.

2.385 The head of crime reduction should hold further surgeries with visitors to ensure that they are given the opportunity to contribute to the resettlement of prisoners (8.78)

Partially achieved. The head of reducing reoffending had run some workshops/consultation exercises with visitors to ascertain views about what would best meet their needs and those they were visiting, but these had not been held for over a year. There were no formal visitors' surveys.

Further recommendation

2.386 The prison should undertake regular visitors' surveys, publish the results and use the data to inform developments in resettlement provision.

## Additional information

2.387 The head of resettlement was the pathway lead for children and families, although much of the work was taken forward by the resettlement administrative workers. There had been six family visits in 2008 and two in 2009, but none since April. The next family day was scheduled for October 2009 but there was confusion about who would be able to attend and the criteria, and how it would be facilitated; it had yet to be advertised on residential wings.

Further recommendations

2.388 There should be clear strategic guidance on the children and families resettlement pathway to ensure that the needs of the population are met.

2.389 The prison should clarify the criteria for family visits, reintroduce them as soon as possible, and ensure that they are appropriately advertised.

## Attitudes, thinking and behaviour

2.390 Residential staff on Thanet House should be prioritised for staff awareness training so that they can support and assist prisoners on programmes. (8.86)

Achieved. A rota for officers working as facilitators on the sex offender treatment programme (SOTP) ensured that one was always based on Thanet wing to advise and support staff and prisoners participating in the programme. Although Thanet was still the primary location for sex offenders, given their number (approximately 368 of the population of 590, 62%) they were integrated across the establishment. As a consequence, awareness training had been spread across all four wings. In the previous three months,108 staff, including CARATs, education and OMU, had received this training, which was oriented to the SOTP and related work.

2.391 OASys profiles of prisoners should be used to determine the scheduling of programmes. (8.87)

Achieved. OASys was used as the primary tool to base treatment need, and as all prisoners were serving sentences over 12 months they were expected to have an assessment. If, following a sentence plan or review, a prisoner was identified as potentially needing access to the SOTP, a referral was made to the psychology department. The psychology department also sifted every case that came into the establishment. All prisoners with an identified current or previous sex offence were assessed for treatment suitability.

2.392 The range of interventions available should be increased to include alcohol and anger management. (8.88)

Partially achieved. Since the last inspection, the P-ASRO (prison addressing substance related offending) programme had been moved to HMP Elmley and its SOTP resources transferred to Maidstone. Apart from the SOTP, the only other accredited programme now delivered by Maidstone was enhanced thinking skills (ETS). Both programmes had recently been audited and had received scores of 95% and 100%. They were on target to achieve their objectives of 42 completions for SOTP and 63 for ETS. Based on the last population needs analysis in 2007, the prison had introduced the Rubicon alcohol programme, which was scheduled to be delivered six times during 2009/10. Alcoholics Anonymous also met weekly. (See paragraph 2.369.)There was no anger management programme. The Sycamore Tree victim awareness programme, provided through the chaplaincy, was delivered on the basis of need, rather than scheduled, although we were told that it was not an appropriate programme for those completing SOTP. The lack of a current needs analysis made it impossible to identify the treatment programme needs of the population.

Further recommendation

2.393 The prison should undertake regular needs analysis, drawing on data from OASys, to establish the treatment and programme needs of the population, and develop a range of services to meet these needs.

# 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.

## Recommendations — To NOMS

3.1 Training should be available for all newly appointed diversity managers. (2.138)

3.2 The requirement that category D status for foreign national prisoners should be limited to those presenting very low risk should be revised to ensure consistent and fair treatment. (2.174)

3.3 Prisoners who successfully progress to category D should be transferred to suitable prisons in a timely manner. (2.344)

## Recommendations — To the governor

### Courts, escorts and transfers

3.4 The reception should remain open over the lunch period. (2.16)

3.5 Escort contractors should be invited to attend security committee meetings and regular meetings to resolve operational issues. (2.18)

3.6 Prisoners' property should accompany them when they are transferred out or should be sent to the central property store within a week of their departure. (2.20)

### First days in custody

3.7 There should be sufficient translated material in a range of relevant languages to support new arrivals and ensure they can fully engage with reception and induction procedures. (2.24)

3.8 Prisoners should have access to professional translation and interpretation services for matters that require accuracy and confidentiality. (2.25)

3.9 The induction policy should include detailed information on the role of the induction programme in identifying and addressing resettlement needs. (2.29)

3.10 Both reception holding rooms should be equipped with a television. (2.35)

3.11 New arrivals should be offered drinks in reception. (2.36)

3.12 All new arrivals should have access to telephone calls on their first night. (2.37)

3.13 All new arrivals should have an interview with a member of staff before they are locked up on their first night. Any immediate needs should be recorded and addressed with appropriate follow-up action. (2.38)

## Residential units

3.14 Broken cell windows should be repaired promptly. (2.47)

3.15 Prisoners should have cell privacy keys. (2.48)

3.16 Staff should respond to cell call bells as a priority. (2.50)

3.17 All prisoners should be able to make telephone calls in private. (2.57)

3.18 Double cells on Weald should not be used for shared occupancy. (2.63)

3.19 The establishment should have a policy on the allocation of top bunks, which takes into account the age of the prisoner. (2.64)

3.20 All prisoners on Weald should be provided with a small lockable locker. (2.65)

3.21 There should be at least one telephone per 20 prisoners. (2.66)

## Staff-prisoner relationships

3.22 Information about the welfare of a prisoner should be properly recorded, shared with relevant staff and followed up to ensure the prison properly discharges its duty of care. (2.69)

## Personal officers

3.23 Management checks of wing history file entries should be thorough and set out any improvements required in order to demonstrate appropriate quality assurance. (2.72)

## Bullying and violence reduction

3.24 There should be specific interventions for bullies and their victims. (2.2)

3.25 The results of the prison's prisoner survey should be incorporated into an action plan to support the new violence reduction strategy. (2.74)

3.26 All potential indicators of bullying should be monitored monthly and trends established, and safer custody meetings should analyse and discuss figures. (2.79)

3.27 Staff monitoring entries in violence reduction booklets should demonstrate their engagement and support. (2.80)

## Self-harm and suicide

3.28 The safer custody committee should discuss and analyse suicide and self-harm monitoring data provided by the safer custody manager, and this should be evidenced in the published minutes of the meetings. (2.95)

## Applications and complaints

3.29 Applications forms should be freely available to all prisoners throughout the day. (2.97)

3.30 Outstanding applications should be followed up regularly by managers until a response is provided. (2.99)

3.31 There should be a system to quality check the responses to complaints. (2.100).

3.32 There should be a detailed monthly analysis of complaints to identify and rectify any emerging trends. (2.101)

3.33 There should be responses to complaints made erroneously under confidential access to avoid delays. (2.103)

3.34 Confidential access complaints should be answered by the governing governor. (2.104)

3.35 Information about the complaints system, including confidential access, should be available in a range of languages. (2.106)

3.36 The complaints clerk should empty the complaints boxes every day. (2.110)

## Legal rights

3.37 The legal services scheme should be relaunched and publicised widely to prisoners and staff. (2.111)

## Faith and religious activity

3.38 There should be washing facilities for Muslim prisoners in the worship area. (2.115)

3.39 The searching policy for prisoners attending worship should be transparent and fairly applied, and its use monitored. (2.116)

## Substance use

3.40 The integrated drug treatment system (IDTS) treatment policy/acceptance criteria should be updated to reflect the decision to initiate methadone treatment. (2.123)

3.41 The IDTS programme should have continuous medical cover to ensure compliance with required reviews. (2.124)

3.42 There should be an up-to-date alcohol needs analysis. (2.130)

## Diversity

3.43 All staff should receive diversity training. (2.133)

## Race equality

3.44 Race equality coordinators should be appointed on all houses. They should receive training in racist incident investigation, and provide cover for the race equality officer. (2.139)

3.45 Regular information about racist incident complaints should be issued to prisoners, covering patterns and trends, action taken, and details of external auditing. (2.144)

3.46 The cell allocation of older prisoners and those with disabilities should be informed by an assessment of suitability, and a clinical assessment made in cases where wing staff are uncertain. (2.150)

3.47 The diversity and race equality action team should discuss any ethnic or other imbalances that emerge from ethnic monitoring, and commission specific further investigation where necessary. (2.151)

3.48 Completed racist incident reporting forms should include the governor's evaluation of the investigator's method and conclusions. (2.152)

## Foreign national prisoners

3.49 There should be a survey of foreign national prisoners to establish their needs, and to inform policy and planning, and this should be repeated at regular intervals. (2.154)

3.50 Information about the support available to foreign national prisoners, including photographs of staff and prisoner representatives, should be displayed on the houses and should be available in a range of relevant languages. (2.156)

3.51 Guidance for foreign national prisoners should be drafted, in consultation with UKBA staff, and translated into the main languages spoken by foreign national prisoners. (2.157)

3.52 A list of contact details for relevant consulates, embassies and support organisations should be drawn up and displayed prominently on the houses. (2.158)

3.53 A free monthly telephone call should be offered to foreign national prisoners not receiving visits. (2.168)

3.54 Photographs of foreign national liaison officers and foreign national peer supporters should be displayed on the wings. (2.169)

3.55 Managers should monitor the award of release on temporary licence and category D status to ensure that, as far as possible, foreign national prisoners are considered on the same basis as British nationals, and to take appropriate action where there is an imbalance. (2.170)

3.56 The multi-language electronic information points should be operative on all wings. (2.171)

3.57 Professional interpretation should be used in all circumstances in which confidentiality is normally guaranteed. (2.172)

3.58 There should be consistency across the prison in the notices displayed in translation. (2.173)

## Health services

3.59 Health professionals should formally report all incidents and near-misses that could have an impact on patient care. (2.179)

3.60 The healthcare department should be able to demonstrate equity of access to health services. (2.181)

3.61 Prisoners should not be used to interpret for patients who do not speak English. (2.182)

3.62 Staff should be able to have external clinical supervision. (2.183)

3.63 Prisoners should be given information about health services and how to access them in plain English and with appropriate pictorial representations for people with poor literacy or little English. (2.184)

3.64 The healthcare department should contribute to induction. (2.187)

3.65 Prisoners should be able to make a confidential application for a healthcare appointment. (2.189)

3.66 Clinical algorithms should be used for nurse-led activities to ensure consistency of advice and treatment. (2.190)

3.67 Prisoners should have access to the services of a pharmacist, who should also actively contribute to the development of effective medicines management in the prison. (2.192)

3.68 Prisoners should not have to queue outdoors for long periods to collect their medication. (2.195)

3.69 There should be therapeutic day care options for prisoners with mental health problems. (2.196)

3.70 All healthcare professionals should make consistent recording across paper and electronic records where both exist. (2.201)

3.71 All healthcare professionals should sign and print their names in the paper records to show who has seen the patient and to comply with guidance from professional registration and health regulatory organisations. (2.202)

3.72 All healthcare professionals should wear name badges. (2.203)

3.73 The healthcare room in reception should be fitted with an alarm bell and telephone. (2.204)

3.74 Healthcare staff should visit the segregation unit every day when prisoners are located there and sign the segregation log each time. (2.205)

## Learning and skills and work activities

3.75 There should be a wider range of better quality work for prisoners. (2.5)

3.76 Art classes should have better facilities and resources. (2.212)

3.77 The core working day should be extended to offer prisoners a more demanding and realistic work experience. (2.213)

3.78 A learning and skills needs analysis and a library needs analysis should be undertaken. (2.221)

3.79 A clear strategy for learning and skills should be developed and implemented across the prison. (2.222)

3.80 Information, advice and guidance should be available for prisoners beyond induction. (2.223)

3.81 There should be a broader range of purposeful education and vocational training opportunities. (2.224)

3.82 There should be more classes in English for speakers of other languages. (2.225)

3.83 Appropriate accreditation should be offered to prisoners developing skills in their work area. (2.226)

3.84 Library use should be comprehensively monitored, and the data analysed to help improve provision. (2.227)

## Physical education and health promotion

3.85 The sports hall should be refurbished to provide an adequate indoor recreation facility. (2.229)

## Time out of cell

3.86 Prisoners should spend at least 10 hours out of their cells on weekdays. (2.234)

3.87 Regime monitoring returns should be an accurate record of the time prisoners are unlocked. (2.235)

3.88 All wings should keep records of prisoners who do not participate in out-of-cell activities. (2.237)

3.89 Managers should ensure that the level of staff supervision and engagement with prisoners is consistently high across the wings. (2.239)

## Security and rules

3.90 The terms of reference of the security committee should ensure representation and attendance from all key departments in the prison. (2.246)

3.91 Security managers should routinely ensure all staff are aware of the prison's security priorities and objectives. (2.248)

3.92 Staff engaged in the monitoring of telephones and mail should have regular updated training and advice on public protection issues. (2.251)

3.93 There should be ongoing monitoring by ethnicity and nationality of all search procedures to identify and address any developing trends, and prisoners should be given regular summaries of searches carried out, with explanations of any apparent imbalances between ethnic or other groups. (2.256)

## Discipline

3.94 The quarterly adjudication standardisation meeting should review recent adjudication awards and the performance of all adjudicating governors. (2.259)

3.95 The monitoring and analysis of use of force should be extended to identify developing trends, for example, relating to location, staff or specific prisoner groups. (2.264)

3.96 Paperwork for the use of special accommodation should be properly completed, and monitoring records should demonstrate active staff engagement to ensure prisoners are returned to normal accommodation as quickly as possible. (2.266)

3.97 The special accommodation cell should be refurbished. (2.267)

3.98 The broken window panes in the segregation unit cells should be replaced. (2.268)

3.99 The level of search for prisoners located in the segregation unit should be informed by a risk assessment. (2.271)

3.100 Managers should ensure that segregation unit staff make regular entries in unit files that demonstrate meaningful interactions with prisoners and record their mental and physical wellbeing. (2.273)

3.101 Prisoners in the segregation unit should be able to make telephone calls at a time convenient to the recipient, including during the evening. (2.277)

3.102 A full copy of the completed injury to inmate form (F213) should be filed with use of force paperwork. (2.282)

3.103 All planned incidents of use of force should be video recorded. (2.283)

3.104 Segregation unit staff should attend mental health awareness training. (2.284)

3.105 Older prisoners or those with restricted mobility located in the segregation unit should have access to all amenities and regime facilities. (2.285)

3.106 The segregation unit shower facilities should be refurbished urgently. (2.286)

## Incentives and earned privileges

3.107 Work supervisors and other key staff should contribute directly to incentives and earned privileges review boards. (2.291)

3.108 The range of privileges for enhanced prisoners should offer meaningful incentives to foreign national prisoners. (2.292)

## Catering

3.109 The main kitchen building should be replaced or refurbished to ensure it meets food safety and hygiene requirements. (2.293)

3.110 The midday meal should be served between noon and 1.30pm and the evening meal between 5 and 6pm. (2.294)

3.111 The breakfast meal should be served on the morning it is to be eaten. (2.295)

3.112 The prison should continue to monitor the use of communal dining facilities and encourage prisoners to use them.(2.299)

3.113 Waste food should not be left on serveries overnight, and food waste should be kept to a minimum. (2.303)

## Prison shop

3.114 Prisoners should be able to submit orders to the prison shop within 24 hours of their arrival. (2.304)

3.115 Reception packs should be available for issue on the prisoner's day of arrival. (2.305)

3.116 Up-to-date notices on prison shop arrangements should be displayed on all wings. (2.308)

3.117 In consultation with the chaplaincy, the shop should routinely stock a range of core religious artefacts. (2.309)

## Strategic management of resettlement

3.118 There should be an updated resettlement strategy informed by an up-to-date and comprehensive needs analysis that reflects the changes in the population and meets their needs. (2.8)

3.119 Action points in the reducing reoffending strategy should be time-bound and indicate who is responsible for the action required. (2.311)

3.120 Reducing reoffending committee meetings should consistently include representatives from outside and community agencies. (2.313)

3.121 The prison should undertake exit surveys of prisoners being released and analyse them, along with questionnaires to offender managers, to inform the development of resettlement provision. (2.317)

3.122 The management structure of the resettlement function should be clarified and should clearly identify responsibilities for the elements of strategic delivery. (2.319)

3.123 The prison should clarify the resettlement information to be collected during induction, how it is used and where it should be held. (2.322)

3.124 The role of the pre-release meeting should be clarified and contributions from offender supervisors should be consistent. (2.323)

## Offender management and planning

3.125 All OASys (offender assessment system) assessments should be completed on time. (2.10)

3.126 Quality assurance of the work of offender supervisors should focus on both procedures and the quality of engagement. (2.326)

3.127 All offender supervisors should receive regular supervision that focuses on quality of delivery and case management. (2.327)

3.128 A prisoner's security category should be reviewed following a significant change in circumstances. (2.332)

3.129 Prisoners should be informed personally about unsuccessful recategorisation decisions. (2.334)

3.130 All new arrivals should be referred initially to the monthly risk management board. (2.340)

3.131 There should be a specific policy on indeterminate-sentenced prisoners, or one included in an up-to-date reducing reoffending policy, to direct service provision and development. (2.341)

3.132 The role of lifer and indeterminate sentence for public protection (IPP) prisoner representatives should be clarified, and should include guidance and support for lifer and IPP new arrivals. (2.342)

3.133 There should be information booklets for IPP and lifer prisoners outlining the provision available at Maidstone. (2.343)

## Resettlement pathways

3.134 The prison should identify a housing officer or adviser and ensure they receive specialist training for the role. (2.346)

3.135 All prisoners should undertake a relevant pre-release resettlement course. (2.349)

3.136 The establishment should carry out a needs analysis to clarify the need for financial assistance. (2.353)

3.137 The prison should offer specialist debt counselling and money management advice. (2.355)

3.138 The healthcare department should be regularly represented at pre-release meetings. (2.358)

3.139 The prison should incorporate healthcare into resettlement planning. (2.361)

3.140 The CARATs team should prioritise cases to ensure the most effective use of resources. (2.364)

3.141 The case management board should focus attention on high profile and complex cases allowing other teams, including CARATs, to take responsibility for clinical and treatment judgments. (2.365)

3.142 All relevant departments should be consistently represented at case management boards. (2.366)

3.143 Comments in the Dinsmore visitors' book should be responded to, and replies displayed in the centre. (2.12)

3.144 Closed visits should only be imposed following a drug dog indication if there is corroborating intelligence. (2.374)

3.145 The visits halls should provide toilet facilities for both prisoners and their visitors. (2.376)

3.146 The children's play area in the main visits hall should be supervised. (2.377)

3.147 There should be a visits holding room for prisoners. (2.378)

3.148 The prison should clearly define the courses on relationships and parenting that should be available and for whom. Prisoners with no identified risk factors should not be prevented from receiving necessary help and support with their parenting. (2.384)

3.149 The prison should undertake regular visitors' surveys, publish the results and use the data to inform developments in resettlement provision. (2.386)

3.150 There should be clear strategic guidance on the children and families resettlement pathway to ensure that the needs of the population are met. (2.388)

3.151 The prison should clarify the criteria for family visits, reintroduce them as soon as possible, and ensure that they are appropriately advertised. (2.389)

3.152 The prison should clearly identify a strategy for effectively managing prisoners unable or unwilling to engage in sex offender treatment. (2.14)

3.153 The prison should undertake regular needs analysis, drawing on data from OASys, to establish the treatment and programme needs of the population, and develop a range of services to meet these needs. (2.393)

## Housekeeping point

3.154 Toilets in the health centre waiting rooms should be checked regularly to ensure they have soap and paper towels. (2.176)

## Good practice

3.155 The safer custody manager reviewed all assessment, care in custody and teamwork (ACCT) documents regularly and issued advisory notes to wing managers where shortcomings were identified. This had played a significant part in raising the standard of ACCT documents to a consistently high level. (2.96)

3.156 There were two independent nurse prescribers, which enabled prisoners to have more rapid access to medication when required and supported the maintenance of effective prescribing and pharmacy services. (2.206)

# Appendix I: Inspection team

| | |
|---|---|
| Marie Orrell | Team leader |
| Martin Kettle | Inspector |
| Keith McInnis | Inspector |
| Steve Moffat | Inspector |
| Andrea Walker | Inspector |
| Nicola Rabjohns | Health services inspector |
| Neil Edwards | Ofsted |

# Appendix II: Prison population profile

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

| Status | 21 and over | % |
|---|---|---|
| Sentenced | 548 | *92.57* |
| Recall | 40 | *6.76* |
| Convicted unsentenced | 0 | *0* |
| Remand | 2 | *0.34* |
| Civil prisoners | 0 | *0* |
| Detainees | 2 | *0.34* |
| Total | 592 | |

| Sentence | 21 and over | % |
|---|---|---|
| Unsentenced | 2 | *0.34* |
| Less than 6 months | 0 | *0* |
| 6 months to less than 12 months | 0 | *0* |
| 12 months to less than 2 years | 18 | *3.04* |
| 2 years to less than 4 years | 83 | *14.02* |
| 4 years to less than 10 years | 348 | *58.78* |
| 10 years and over (not life) | 65 | *10.98* |
| ISPP | 40 | *6.76* |
| Life | 36 | *6.08* |
| Total | 592 | |

| Age | Number of prisoners | % |
|---|---|---|
| Under 21 years: *minimum age=21* | 0 | *0* |
| 21 years to 29 years | 149 | *25.17* |
| 30 years to 39 years | 148 | *25.00* |
| 40 years to 49 years | 141 | *23.82* |
| 50 years to 59 years | 80 | *13.51* |
| 60 years to 69 years | 51 | *8.61* |
| 70 plus years: *maximum age=82* | 23 | *3.89* |
| Total | 592 | |

| Nationality | 21 and over | % |
|---|---|---|
| British | 350 | *59.12* |
| Foreign nationals | 242 | *40.88* |
| Total | 592 | |

| Security category | 21 and over | % |
|---|---|---|
| Uncategorised sentenced | 2 | *0.34* |
| Cat A | 0 | *0* |
| Cat B | 8 | *1.35* |
| Cat C | 574 | *96.96* |
| Cat D | 8 | *1.35* |
| Other | | |
| Total | 592 | |

| Ethnicity | 21 and over | % |
|---|---|---|
| *White:* | | |
| British | 323 | *54.56* |
| Irish | 4 | *0.68* |
| Other White | 89 | *15.03* |
| *Mixed:* | | |
| White and Black Caribbean | 1 | *0.17* |

| | | |
|---|---|---|
| White and Black African | 1 | *0.17* |
| White and Asian | 2 | *0.34* |
| Other Mixed | 2 | *0.34* |
| *Asian or Asian British:* | | |
| Indian | 7 | *1.18* |
| Pakistani | 5 | *0.84* |
| Bangladeshi | 4 | *0.68* |
| Other Asian | 18 | *3.04* |
| *Black or Black British:* | | |
| Caribbean | 48 | *8.11* |
| African | 57 | *9.63* |
| Other Black | 19 | *3.21* |
| *Chinese or other ethnic group:* | | |
| Chinese | 3 | *0.51* |
| Other ethnic group | 7 | *1.18* |
| Not stated | 2 | *0.34* |
| Total | 592 | |

| Religion | 21 and over | % |
|---|---|---|
| Baptist | 1 | *0.17* |
| Church of England | 205 | *34.63* |
| Roman Catholic | 87 | *14.70* |
| Other Christian denominations | 38 | *6.43* |
| Muslim | 70 | *11.83* |
| Sikh | 0 | *0* |
| Hindu | 6 | *1.01* |
| Buddhist | 40 | *6.76* |
| Jewish | 3 | *0.51* |
| Other | 23 | *3.89* |
| No religion | 119 | *20.10* |
| Total | 592 | |

Sentenced prisoners only

| Length of stay | 21 and over | |
|---|---|---|
| | Number | % |
| Less than 1 month | 33 | 5.59 |
| 1 month to 3 months | 59 | 10.00 |
| 3 months to 6 months | 293 | 49.66 |
| 6 months to 1 year | 89 | 15.08 |
| 1 year to 2 years | 64 | 10.85 |
| 2 years to 4 years | 43 | 7.29 |
| 4 years or more | 9 | 1.53 |
| Total | 590 | |

Unsentenced prisoners only

| Length of stay | 21 and over | |
|---|---|---|
| | Number | % |
| Less than 1 month | 0 | *0* |
| 1 month to 3 months | 1 | *50* |
| 3 months to 6 months | 0 | *0* |
| 6 months to 1 year | 0 | *0* |
| 1 year to 2 years | 1 | *50* |
| 2 years to 4 years | 0 | *0* |
| 4 years or more | 0 | *0* |
| Total | 2 | |

| Main offence | 21 and over | % |
|---|---|---|
| Violence against the person | 72 | *12.16* |
| Sexual offences | 368 | *62.16* |
| Burglary | 2 | *0.34* |
| Robbery | 24 | *4.05* |
| Theft and handling | 4 | *0.68* |
| Fraud and forgery | 15 | *2.53* |
| Drugs offences | 84 | *13.68* |
| Other offences | 24 | *4.05* |
| Total | 590 | |